



Sen. Ann Gillespie

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1 AMENDMENT TO SENATE BILL 3130

2 AMENDMENT NO. _____. Amend Senate Bill 3130 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Department of Insurance Law of the Civil
5 Administrative Code of Illinois is amended by changing Section
6 1405-50 as follows:

7 (20 ILCS 1405/1405-50)

8 Sec. 1405-50. Marketplace Director of the Illinois Health
9 Benefits Exchange. The Governor shall appoint, with the advice
10 and consent of the Senate, a person within the Department of
11 Insurance to serve as the Marketplace Director of the Illinois
12 Health Benefits Exchange. The Marketplace Director shall serve
13 for a term of 2 years, and until a successor is appointed and
14 qualified; except that the term of the first Marketplace
15 Director appointed under this Law shall expire on the third
16 Monday in January 2027. The Marketplace Director may serve for

1 more than one term. The Governor may make a temporary
2 appointment until the next meeting of the Senate. ~~This person~~
3 ~~may be an existing employee with other duties.~~ The Marketplace
4 Director shall receive an annual salary as set by the Governor
5 and shall be paid out of the appropriations to the Department.
6 The Marketplace Director shall ~~not~~ be subject to the Personnel
7 Code. The Marketplace Director, under the direction of the
8 Director, shall manage the operations and staff of the
9 Illinois Health Benefits Exchange to ensure optimal exchange
10 performance.

11 (Source: P.A. 103-103, eff. 6-27-23.)

12 Section 10. The Illinois Insurance Code is amended by
13 adding Section 356z.40a as follows:

14 (215 ILCS 5/356z.40a new)

15 Sec. 356z.40a. Pregnancy as a qualifying life event for
16 qualified health plans. Beginning with the operation of a
17 State-based exchange in plan year 2026, a pregnant individual
18 has the right to enroll in a qualified health plan through a
19 special enrollment period within 60 days after any qualified
20 health care professional, including a licensed certified
21 professional midwife, licensed or certified under the laws of
22 this State or any other state to provide pregnancy-related
23 health care services certifies that the individual is
24 pregnant. Upon enrollment, coverage shall be effective on and

1 after the first day of the month in which the qualified health
2 care professional certifies that the individual is pregnant,
3 unless the individual elects to have coverage effective on the
4 first day of the month following the date that the individual
5 received certification of the pregnancy.

6 Section 15. The Illinois Health Insurance Portability and
7 Accountability Act is amended by changing Sections 30, 50, and
8 60 as follows:

9 (215 ILCS 97/30)

10 Sec. 30. Guaranteed renewability of coverage for employers
11 in the group market.

12 (A) In general. Except as provided in this Section, if a
13 health insurance issuer offers health insurance coverage in
14 the small or large group market in connection with a group
15 health plan, the issuer must renew or continue in force such
16 coverage at the option of the plan sponsor of the plan.

17 (B) General exceptions. A health insurance issuer may
18 nonrenew or discontinue health insurance coverage offered in
19 connection with a group health plan in the small or large group
20 market based only on one or more of the following:

21 (1) Nonpayment of premiums. The plan sponsor has
22 failed to pay premiums or contributions in accordance with
23 the terms of the health insurance coverage or the issuer
24 has not received timely premium payments.

1 (2) Fraud. The plan sponsor has performed an act or
2 practice that constitutes fraud or made an intentional
3 misrepresentation of material fact under the terms of the
4 coverage.

5 (3) Violation of participation or contribution rules.
6 The plan sponsor has failed to comply with a material plan
7 provision relating to employer contribution or group
8 participation rules, as permitted under Section 40(D) in
9 the case of the small group market or pursuant to
10 applicable State law in the case of the large group
11 market.

12 (4) Termination of coverage. The issuer is ceasing to
13 offer coverage in such market in accordance with
14 subsection (C) and applicable State law.

15 (5) Movement outside service area. In the case of a
16 health insurance issuer that offers health insurance
17 coverage in the market through a network plan, there is no
18 longer any enrollee in connection with such plan who
19 lives, resides, or works in the service area of the issuer
20 (or in the area for which the issuer is authorized to do
21 business) and, in the case of the small group market, the
22 issuer would deny enrollment with respect to such plan
23 under Section 40(C)(1)(a).

24 (6) Association membership ceases. In the case of
25 health insurance coverage that is made available in the
26 small or large group market (as the case may be) only

1 through one or more bona fide association, the membership
2 of an employer in the association (on the basis of which
3 the coverage is provided) ceases but only if such coverage
4 is terminated under this paragraph uniformly without
5 regard to any health status-related factor relating to any
6 covered individual.

7 (C) Requirements for uniform termination of coverage.

8 (1) Particular type of coverage not offered. In any
9 case in which an issuer decides to discontinue offering a
10 particular type of group health insurance coverage offered
11 in the small or large group market, coverage of such type
12 may be discontinued by the issuer in accordance with
13 applicable State law in such market only if:

14 (a) the issuer provides notice to each plan
15 sponsor provided coverage of this type in such market
16 (and participants and beneficiaries covered under such
17 coverage) of such discontinuation at least 90 days
18 prior to the date of the discontinuation of such
19 coverage;

20 (b) the issuer offers to each plan sponsor
21 provided coverage of this type in such market, the
22 option to purchase all (or, in the case of the large
23 group market, any) other health insurance coverage
24 currently being offered by the issuer to a group
25 health plan in such market; and

26 (c) in exercising the option to discontinue

1 coverage of this type and in offering the option of
2 coverage under subparagraph (b), the issuer acts
3 uniformly without regard to the claims experience of
4 those sponsors or any health status-related factor
5 relating to any participants or beneficiaries who may
6 become eligible for such coverage.

7 (2) Discontinuance of all coverage.

8 (a) In general. In any case in which a health
9 insurance issuer elects to discontinue offering all
10 health insurance coverage in the small group market or
11 the large group market, or both markets, in Illinois,
12 health insurance coverage may be discontinued by the
13 issuer only in accordance with Illinois law and if:

14 (i) the issuer provides notice ~~to the~~
15 ~~Department and~~ to each plan sponsor (and
16 participants and beneficiaries covered under such
17 coverage) of such discontinuation at least 180
18 days prior to the date of the discontinuation of
19 such coverage and to the Department as provided in
20 Section 60 of this Act; and

21 (ii) all health insurance issued or delivered
22 for issuance in Illinois in such market (or
23 markets) are discontinued and coverage under such
24 health insurance coverage in such market (or
25 markets) is not renewed.

26 (b) Prohibition on market reentry. In the case of

1 a discontinuation under subparagraph (a) in a market,
2 the issuer may not provide for the issuance of any
3 health insurance coverage in the Illinois market
4 involved during the 5-year period beginning on the
5 date of the discontinuation of the last health
6 insurance coverage not so renewed.

7 (D) Exception for uniform modification of coverage. At the
8 time of coverage renewal, a health insurance issuer may modify
9 the health insurance coverage for a product offered to a group
10 health plan:

11 (1) in the large group market; or

12 (2) in the small group market if, for coverage that is
13 available in such market other than only through one or
14 more bona fide associations, such modification is
15 consistent with State law and effective on a uniform basis
16 among group health plans with that product.

17 (E) Application to coverage offered only through
18 associations. In applying this Section in the case of health
19 insurance coverage that is made available by a health
20 insurance issuer in the small or large group market to
21 employers only through one or more associations, a reference
22 to "plan sponsor" is deemed, with respect to coverage provided
23 to an employer member of the association, to include a
24 reference to such employer.

25 (Source: P.A. 90-30, eff. 7-1-97.)

1 (215 ILCS 97/50)

2 Sec. 50. Guaranteed renewability of individual health
3 insurance coverage.

4 (A) In general. Except as provided in this Section, a
5 health insurance issuer that provides individual health
6 insurance coverage to an individual shall renew or continue in
7 force such coverage at the option of the individual.

8 (B) General exceptions. A health insurance issuer may
9 nonrenew or discontinue health insurance coverage of an
10 individual in the individual market based only on one or more
11 of the following:

12 (1) Nonpayment of premiums. The individual has failed
13 to pay premiums or contributions in accordance with the
14 terms of the health insurance coverage or the issuer has
15 not received timely premium payments.

16 (2) Fraud. The individual has performed an act or
17 practice that constitutes fraud or made an intentional
18 misrepresentation of material fact under the terms of the
19 coverage.

20 (3) Termination of plan. The issuer is ceasing to
21 offer coverage in the individual market in accordance with
22 subsection (C) of this Section and applicable Illinois
23 law.

24 (4) Movement outside the service area. In the case of
25 a health insurance issuer that offers health insurance
26 coverage in the market through a network plan, the

1 individual no longer resides, lives, or works in the
2 service area (or in an area for which the issuer is
3 authorized to do business), but only if such coverage is
4 terminated under this paragraph uniformly without regard
5 to any health status-related factor of covered
6 individuals.

7 (5) Association membership ceases. In the case of
8 health insurance coverage that is made available in the
9 individual market only through one or more bona fide
10 associations, the membership of the individual in the
11 association (on the basis of which the coverage is
12 provided) ceases, but only if such coverage is terminated
13 under this paragraph uniformly without regard to any
14 health status-related factor of covered individuals.

15 (C) Requirements for uniform termination of coverage.

16 (1) Particular type of coverage not offered. In any
17 case in which an issuer decides to discontinue offering a
18 particular type of health insurance coverage offered in
19 the individual market, coverage of such type may be
20 discontinued by the issuer only if:

21 (a) the issuer provides notice to each covered
22 individual provided coverage of this type in such
23 market of such discontinuation at least 90 days prior
24 to the date of the discontinuation of such coverage;

25 (b) the issuer offers, to each individual in the
26 individual market provided coverage of this type, the

1 option to purchase any other individual health
2 insurance coverage currently being offered by the
3 issuer for individuals in such market; and

4 (c) in exercising the option to discontinue
5 coverage of that type and in offering the option of
6 coverage under subparagraph (b), the issuer acts
7 uniformly without regard to any health status-related
8 factor of enrolled individuals or individuals who may
9 become eligible for such coverage.

10 (2) Discontinuance of all coverage.

11 (a) In general. Subject to subparagraph (c), in
12 any case in which a health insurance issuer elects to
13 discontinue offering all health insurance coverage in
14 the individual market in Illinois, health insurance
15 coverage may be discontinued by the issuer only if:

16 (i) the issuer provides notice ~~to the Director~~
17 ~~and~~ to each individual of the discontinuation at
18 least 180 days prior to the date of the expiration
19 of such coverage and to the Director as provided
20 in Section 60 of this Act;

21 (ii) all health insurance issued or delivered
22 for issuance in Illinois in such market is
23 discontinued and coverage under such health
24 insurance coverage in such market is not renewed;
25 and

26 (iii) in the case where the issuer has

1 affiliates in the individual market, the issuer
2 gives notice to each affected individual at least
3 180 days prior to the date of the expiration of the
4 coverage of the individual's option to purchase
5 all other individual health benefit plans
6 currently offered by any affiliate of the carrier.

7 (b) Prohibition on market reentry. In the case of
8 a discontinuation under subparagraph (a) in the
9 individual market, the issuer may not provide for the
10 issuance of any health insurance coverage in Illinois
11 involved during the 5-year period beginning on the
12 date of the discontinuation of the last health
13 insurance coverage not so renewed.

14 (c) If an issuer elects to discontinue offering
15 all health insurance coverage in the individual market
16 under subparagraph (a), its affiliates that offer
17 health insurance coverage in the individual market in
18 Illinois shall offer individual health insurance
19 coverage to all individuals who were covered by the
20 discontinued health insurance coverage on the date of
21 the notice provided to affected individuals under
22 subdivision (iii) of subparagraph (a) of this item (2)
23 if the individual applies for coverage no later than
24 63 days after the discontinuation of coverage.

25 (d) Subject to subparagraph (e) of this item (2),
26 an affiliate that issues coverage under subparagraph

1 (c) shall waive the preexisting condition exclusion
2 period to the extent that the individual has satisfied
3 the preexisting condition exclusion period under the
4 individual's prior contract or policy.

5 (e) An affiliate that issues coverage under
6 subparagraph (c) may require the individual to satisfy
7 the remaining part of the preexisting condition
8 exclusion period, if any, under the individual's prior
9 contract or policy that has not been satisfied, unless
10 the coverage has a shorter preexisting condition
11 exclusion period, and may include in any coverage
12 issued under subparagraph (c) any waivers or
13 limitations of coverage that were included in the
14 individual's prior contract or policy.

15 (D) Exception for uniform modification of coverage. At the
16 time of coverage renewal, a health insurance issuer may modify
17 the health insurance coverage for a policy form offered to
18 individuals in the individual market so long as the
19 modification is consistent with Illinois law and effective on
20 a uniform basis among all individuals with that policy form.

21 (E) Application to coverage offered only through
22 associations. In applying this Section in the case of health
23 insurance coverage that is made available by a health
24 insurance issuer in the individual market to individuals only
25 through one or more associations, a reference to an
26 "individual" is deemed to include a reference to such an

1 association (of which the individual is a member).

2 The changes to this Section made by this amendatory Act of
3 the 94th General Assembly apply only to discontinuances of
4 coverage occurring on or after the effective date of this
5 amendatory Act of the 94th General Assembly.

6 (Source: P.A. 94-502, eff. 8-8-05.)

7 (215 ILCS 97/60)

8 Sec. 60. Notice requirement. In any case where a health
9 insurance issuer elects to uniformly modify coverage,
10 uniformly terminate coverage, or discontinue coverage in a
11 marketplace in accordance with Sections 30 and 50 of this Act,
12 the issuer shall provide notice to the Department prior to
13 notifying the plan sponsors, participants, beneficiaries, and
14 covered individuals. The notice shall be sent by certified
15 mail to the Department 45 ~~90~~ days in advance of any
16 notification of the company's actions sent to plan sponsors,
17 participants, beneficiaries, and covered individuals. The
18 notice shall include: (i) a complete description of the action
19 to be taken, (ii) a specific description of the type of
20 coverage affected, (iii) the total number of covered lives
21 affected, (iv) a sample draft of all letters being sent to the
22 plan sponsors, participants, beneficiaries, or covered
23 individuals, (v) time frames for the actions being taken, (vi)
24 options the plans sponsors, participants, beneficiaries, or
25 covered individuals may have available to them under this Act,

1 and (vii) any other information as required by the Department.
2 The Department may designate an email address or online
3 platform to receive electronic notification in lieu of
4 certified mail.

5 This Section applies only to discontinuances of coverage
6 occurring on or after the effective date of this amendatory
7 Act of the 94th General Assembly.

8 (Source: P.A. 94-502, eff. 8-8-05.)

9 Section 20. The Network Adequacy and Transparency Act is
10 amended by changing Sections 3, 5, 10, and 25 as follows:

11 (215 ILCS 124/3)

12 Sec. 3. Applicability of Act. This Act applies to an
13 individual or group policy of accident and health insurance
14 with a network plan amended, delivered, issued, or renewed in
15 this State on or after January 1, 2019. This Act does not apply
16 to an individual or group policy for excepted benefits or
17 short-term, limited-duration health insurance coverage dental
18 or vision insurance or a limited health service organization
19 with a network plan amended, delivered, issued, or renewed in
20 this State on or after January 1, 2019, except to the extent
21 that federal law establishes network adequacy and transparency
22 standards for stand-alone dental plans, which the Department
23 shall enforce.

24 (Source: P.A. 100-502, eff. 9-15-17; 100-601, eff. 6-29-18.)

1 (215 ILCS 124/5)

2 Sec. 5. Definitions. In this Act:

3 "Authorized representative" means a person to whom a
4 beneficiary has given express written consent to represent the
5 beneficiary; a person authorized by law to provide substituted
6 consent for a beneficiary; or the beneficiary's treating
7 provider only when the beneficiary or his or her family member
8 is unable to provide consent.

9 "Beneficiary" means an individual, an enrollee, an
10 insured, a participant, or any other person entitled to
11 reimbursement for covered expenses of or the discounting of
12 provider fees for health care services under a program in
13 which the beneficiary has an incentive to utilize the services
14 of a provider that has entered into an agreement or
15 arrangement with an insurer.

16 "Department" means the Department of Insurance.

17 "Director" means the Director of Insurance.

18 "Excepted benefits" has the meaning given to that term in
19 42 U.S.C. 300gg-91(c).

20 "Family caregiver" means a relative, partner, friend, or
21 neighbor who has a significant relationship with the patient
22 and administers or assists the patient with activities of
23 daily living, instrumental activities of daily living, or
24 other medical or nursing tasks for the quality and welfare of
25 that patient.

1 "Insurer" means any entity that offers individual or group
2 accident and health insurance, including, but not limited to,
3 health maintenance organizations, preferred provider
4 organizations, exclusive provider organizations, and other
5 plan structures requiring network participation, excluding the
6 medical assistance program under the Illinois Public Aid Code,
7 the State employees group health insurance program, workers
8 compensation insurance, and pharmacy benefit managers.

9 "Material change" means a significant reduction in the
10 number of providers available in a network plan, including,
11 but not limited to, a reduction of 10% or more in a specific
12 type of providers, the removal of a major health system that
13 causes a network to be significantly different from the
14 network when the beneficiary purchased the network plan, or
15 any change that would cause the network to no longer satisfy
16 the requirements of this Act or the Department's rules for
17 network adequacy and transparency.

18 "Network" means the group or groups of preferred providers
19 providing services to a network plan.

20 "Network plan" means an individual or group policy of
21 accident and health insurance that either requires a covered
22 person to use or creates incentives, including financial
23 incentives, for a covered person to use providers managed,
24 owned, under contract with, or employed by the insurer.

25 "Ongoing course of treatment" means (1) treatment for a
26 life-threatening condition, which is a disease or condition

1 for which likelihood of death is probable unless the course of
2 the disease or condition is interrupted; (2) treatment for a
3 serious acute condition, defined as a disease or condition
4 requiring complex ongoing care that the covered person is
5 currently receiving, such as chemotherapy, radiation therapy,
6 or post-operative visits; (3) a course of treatment for a
7 health condition that a treating provider attests that
8 discontinuing care by that provider would worsen the condition
9 or interfere with anticipated outcomes; or (4) the third
10 trimester of pregnancy through the post-partum period.

11 "Preferred provider" means any provider who has entered,
12 either directly or indirectly, into an agreement with an
13 employer or risk-bearing entity relating to health care
14 services that may be rendered to beneficiaries under a network
15 plan.

16 "Providers" means physicians licensed to practice medicine
17 in all its branches, other health care professionals,
18 hospitals, or other health care institutions that provide
19 health care services.

20 "Short-term, limited-duration health insurance coverage
21 has the meaning given to that term in Section 5 of the
22 Short-Term, Limited-Duration Health Insurance Coverage Act.

23 "Stand-alone dental plan" has the meaning given to that
24 term in 45 CFR 156.400.

25 "Telehealth" has the meaning given to that term in Section
26 356z.22 of the Illinois Insurance Code.

1 "Telemedicine" has the meaning given to that term in
2 Section 49.5 of the Medical Practice Act of 1987.

3 "Tiered network" means a network that identifies and
4 groups some or all types of provider and facilities into
5 specific groups to which different provider reimbursement,
6 covered person cost-sharing or provider access requirements,
7 or any combination thereof, apply for the same services.

8 "Woman's principal health care provider" means a physician
9 licensed to practice medicine in all of its branches
10 specializing in obstetrics, gynecology, or family practice.
11 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

12 (215 ILCS 124/10)

13 Sec. 10. Network adequacy.

14 (a) An insurer providing a network plan shall file a
15 description of all of the following with the Director:

16 (1) The written policies and procedures for adding
17 providers to meet patient needs based on increases in the
18 number of beneficiaries, changes in the
19 patient-to-provider ratio, changes in medical and health
20 care capabilities, and increased demand for services.

21 (2) The written policies and procedures for making
22 referrals within and outside the network.

23 (3) The written policies and procedures on how the
24 network plan will provide 24-hour, 7-day per week access
25 to network-affiliated primary care, emergency services,

1 and women's principal health care providers.

2 An insurer shall not prohibit a preferred provider from
3 discussing any specific or all treatment options with
4 beneficiaries irrespective of the insurer's position on those
5 treatment options or from advocating on behalf of
6 beneficiaries within the utilization review, grievance, or
7 appeals processes established by the insurer in accordance
8 with any rights or remedies available under applicable State
9 or federal law.

10 (b) Insurers must file for review a description of the
11 services to be offered through a network plan. The description
12 shall include all of the following:

13 (1) A geographic map of the area proposed to be served
14 by the plan by county service area and zip code, including
15 marked locations for preferred providers.

16 (2) As deemed necessary by the Department, the names,
17 addresses, phone numbers, and specialties of the providers
18 who have entered into preferred provider agreements under
19 the network plan.

20 (3) The number of beneficiaries anticipated to be
21 covered by the network plan.

22 (4) An Internet website and toll-free telephone number
23 for beneficiaries and prospective beneficiaries to access
24 current and accurate lists of preferred providers,
25 additional information about the plan, as well as any
26 other information required by Department rule.

1 (5) A description of how health care services to be
2 rendered under the network plan are reasonably accessible
3 and available to beneficiaries. The description shall
4 address all of the following:

5 (A) the type of health care services to be
6 provided by the network plan;

7 (B) the ratio of physicians and other providers to
8 beneficiaries, by specialty and including primary care
9 physicians and facility-based physicians when
10 applicable under the contract, necessary to meet the
11 health care needs and service demands of the currently
12 enrolled population;

13 (C) the travel and distance standards for plan
14 beneficiaries in county service areas; and

15 (D) a description of how the use of telemedicine,
16 telehealth, or mobile care services may be used to
17 partially meet the network adequacy standards, if
18 applicable.

19 (6) A provision ensuring that whenever a beneficiary
20 has made a good faith effort, as evidenced by accessing
21 the provider directory, calling the network plan, and
22 calling the provider, to utilize preferred providers for a
23 covered service and it is determined the insurer does not
24 have the appropriate preferred providers due to
25 insufficient number, type, unreasonable travel distance or
26 delay, or preferred providers refusing to provide a

1 covered service because it is contrary to the conscience
2 of the preferred providers, as protected by the Health
3 Care Right of Conscience Act, the insurer shall ensure,
4 directly or indirectly, by terms contained in the payer
5 contract, that the beneficiary will be provided the
6 covered service at no greater cost to the beneficiary than
7 if the service had been provided by a preferred provider.
8 This paragraph (6) does not apply to: (A) a beneficiary
9 who willfully chooses to access a non-preferred provider
10 for health care services available through the panel of
11 preferred providers, or (B) a beneficiary enrolled in a
12 health maintenance organization. In these circumstances,
13 the contractual requirements for non-preferred provider
14 reimbursements shall apply unless Section 356z.3a of the
15 Illinois Insurance Code requires otherwise. In no event
16 shall a beneficiary who receives care at a participating
17 health care facility be required to search for
18 participating providers under the circumstances described
19 in subsection (b) or (b-5) of Section 356z.3a of the
20 Illinois Insurance Code except under the circumstances
21 described in paragraph (2) of subsection (b-5).

22 (7) A provision that the beneficiary shall receive
23 emergency care coverage such that payment for this
24 coverage is not dependent upon whether the emergency
25 services are performed by a preferred or non-preferred
26 provider and the coverage shall be at the same benefit

1 level as if the service or treatment had been rendered by a
2 preferred provider. For purposes of this paragraph (7),
3 "the same benefit level" means that the beneficiary is
4 provided the covered service at no greater cost to the
5 beneficiary than if the service had been provided by a
6 preferred provider. This provision shall be consistent
7 with Section 356z.3a of the Illinois Insurance Code.

8 (8) A limitation that, if the plan provides that the
9 beneficiary will incur a penalty for failing to
10 pre-certify inpatient hospital treatment, the penalty may
11 not exceed \$1,000 per occurrence in addition to the plan
12 cost sharing provisions.

13 (c) The network plan shall demonstrate to the Director a
14 minimum ratio of providers to plan beneficiaries as required
15 by the Department.

16 (1) The ratio of physicians or other providers to plan
17 beneficiaries shall be established annually by the
18 Department in consultation with the Department of Public
19 Health based upon the guidance from the federal Centers
20 for Medicare and Medicaid Services. The Department shall
21 not establish ratios for vision or dental providers who
22 provide services under dental-specific or vision-specific
23 benefits, except to the extent provided under federal law
24 for stand-alone dental plans. The Department shall
25 consider establishing ratios for the following physicians
26 or other providers:

- 1 (A) Primary Care;
- 2 (B) Pediatrics;
- 3 (C) Cardiology;
- 4 (D) Gastroenterology;
- 5 (E) General Surgery;
- 6 (F) Neurology;
- 7 (G) OB/GYN;
- 8 (H) Oncology/Radiation;
- 9 (I) Ophthalmology;
- 10 (J) Urology;
- 11 (K) Behavioral Health;
- 12 (L) Allergy/Immunology;
- 13 (M) Chiropractic;
- 14 (N) Dermatology;
- 15 (O) Endocrinology;
- 16 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- 17 (Q) Infectious Disease;
- 18 (R) Nephrology;
- 19 (S) Neurosurgery;
- 20 (T) Orthopedic Surgery;
- 21 (U) Physiatry/Rehabilitative;
- 22 (V) Plastic Surgery;
- 23 (W) Pulmonary;
- 24 (X) Rheumatology;
- 25 (Y) Anesthesiology;
- 26 (Z) Pain Medicine;

1 (AA) Pediatric Specialty Services;

2 (BB) Outpatient Dialysis; and

3 (CC) HIV.

4 (2) The Director shall establish a process for the
5 review of the adequacy of these standards, along with an
6 assessment of additional specialties to be included in the
7 list under this subsection (c).

8 (3) If the federal Centers for Medicare and Medicaid
9 Services establishes minimum provider ratios for
10 stand-alone dental plans in the type of exchange in use in
11 this State for a given plan year, the Department shall
12 enforce those standards for stand-alone dental plans for
13 that plan year.

14 (d) The network plan shall demonstrate to the Director
15 maximum travel and distance standards for plan beneficiaries,
16 which shall be established annually by the Department in
17 consultation with the Department of Public Health based upon
18 the guidance from the federal Centers for Medicare and
19 Medicaid Services. These standards shall consist of the
20 maximum minutes or miles to be traveled by a plan beneficiary
21 for each county type, such as large counties, metro counties,
22 or rural counties as defined by Department rule.

23 The maximum travel time and distance standards must
24 include standards for each physician and other provider
25 category listed for which ratios have been established.

26 The Director shall establish a process for the review of

1 the adequacy of these standards along with an assessment of
2 additional specialties to be included in the list under this
3 subsection (d).

4 If the federal Centers for Medicare and Medicaid Services
5 establishes appointment wait-time standards for qualified
6 health plans, including stand-alone dental plans, in the type
7 of exchange in use in this State for a given plan year, the
8 Department shall enforce those standards for the same types of
9 qualified health plans for that plan year. If the federal
10 Centers for Medicare and Medicaid Services establishes time
11 and distance standards for stand-alone dental plans in the
12 type of exchange in use in this State for a given plan year,
13 the Department shall enforce those standards for stand-alone
14 dental plans for that plan year.

15 (d-5)(1) Every insurer shall ensure that beneficiaries
16 have timely and proximate access to treatment for mental,
17 emotional, nervous, or substance use disorders or conditions
18 in accordance with the provisions of paragraph (4) of
19 subsection (a) of Section 370c of the Illinois Insurance Code.
20 Insurers shall use a comparable process, strategy, evidentiary
21 standard, and other factors in the development and application
22 of the network adequacy standards for timely and proximate
23 access to treatment for mental, emotional, nervous, or
24 substance use disorders or conditions and those for the access
25 to treatment for medical and surgical conditions. As such, the
26 network adequacy standards for timely and proximate access

1 shall equally be applied to treatment facilities and providers
2 for mental, emotional, nervous, or substance use disorders or
3 conditions and specialists providing medical or surgical
4 benefits pursuant to the parity requirements of Section 370c.1
5 of the Illinois Insurance Code and the federal Paul Wellstone
6 and Pete Domenici Mental Health Parity and Addiction Equity
7 Act of 2008. Notwithstanding the foregoing, the network
8 adequacy standards for timely and proximate access to
9 treatment for mental, emotional, nervous, or substance use
10 disorders or conditions shall, at a minimum, satisfy the
11 following requirements:

12 (A) For beneficiaries residing in the metropolitan
13 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
14 network adequacy standards for timely and proximate access
15 to treatment for mental, emotional, nervous, or substance
16 use disorders or conditions means a beneficiary shall not
17 have to travel longer than 30 minutes or 30 miles from the
18 beneficiary's residence to receive outpatient treatment
19 for mental, emotional, nervous, or substance use disorders
20 or conditions. Beneficiaries shall not be required to wait
21 longer than 10 business days between requesting an initial
22 appointment and being seen by the facility or provider of
23 mental, emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment or to wait longer than
25 20 business days between requesting a repeat or follow-up
26 appointment and being seen by the facility or provider of

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment; however, subject to
3 the protections of paragraph (3) of this subsection, a
4 network plan shall not be held responsible if the
5 beneficiary or provider voluntarily chooses to schedule an
6 appointment outside of these required time frames.

7 (B) For beneficiaries residing in Illinois counties
8 other than those counties listed in subparagraph (A) of
9 this paragraph, network adequacy standards for timely and
10 proximate access to treatment for mental, emotional,
11 nervous, or substance use disorders or conditions means a
12 beneficiary shall not have to travel longer than 60
13 minutes or 60 miles from the beneficiary's residence to
14 receive outpatient treatment for mental, emotional,
15 nervous, or substance use disorders or conditions.
16 Beneficiaries shall not be required to wait longer than 10
17 business days between requesting an initial appointment
18 and being seen by the facility or provider of mental,
19 emotional, nervous, or substance use disorders or
20 conditions for outpatient treatment or to wait longer than
21 20 business days between requesting a repeat or follow-up
22 appointment and being seen by the facility or provider of
23 mental, emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment; however, subject to
25 the protections of paragraph (3) of this subsection, a
26 network plan shall not be held responsible if the

1 beneficiary or provider voluntarily chooses to schedule an
2 appointment outside of these required time frames.

3 (2) For beneficiaries residing in all Illinois counties,
4 network adequacy standards for timely and proximate access to
5 treatment for mental, emotional, nervous, or substance use
6 disorders or conditions means a beneficiary shall not have to
7 travel longer than 60 minutes or 60 miles from the
8 beneficiary's residence to receive inpatient or residential
9 treatment for mental, emotional, nervous, or substance use
10 disorders or conditions.

11 (3) If there is no in-network facility or provider
12 available for a beneficiary to receive timely and proximate
13 access to treatment for mental, emotional, nervous, or
14 substance use disorders or conditions in accordance with the
15 network adequacy standards outlined in this subsection, the
16 insurer shall provide necessary exceptions to its network to
17 ensure admission and treatment with a provider or at a
18 treatment facility in accordance with the network adequacy
19 standards in this subsection.

20 (4) If the federal Centers for Medicare and Medicaid
21 Services establishes a more stringent standard in any county
22 than specified in paragraph (1) or (2) of this subsection
23 (d-5) for qualified health plans in the type of exchange in use
24 in this State for a given plan year, the federal standard shall
25 apply in lieu of the standard in paragraph (1) or (2) of this
26 subsection (d-5) for qualified health plans for that plan

1 year.

2 (e) Except for network plans solely offered as a group
3 health plan, these ratio and time and distance standards apply
4 to the lowest cost-sharing tier of any tiered network.

5 (f) The network plan may consider use of other health care
6 service delivery options, such as telemedicine or telehealth,
7 mobile clinics, and centers of excellence, or other ways of
8 delivering care to partially meet the requirements set under
9 this Section.

10 (g) Except for the requirements set forth in subsection
11 (d-5), insurers who are not able to comply with the provider
12 ratios, ~~and~~ time and distance standards, and appointment
13 wait-time standards established under this Act or federal law
14 ~~established by the Department~~ may request an exception to
15 these requirements from the Department. The Department may
16 grant an exception in the following circumstances:

17 (1) if no providers or facilities meet the specific
18 time and distance standard in a specific service area and
19 the insurer (i) discloses information on the distance and
20 travel time points that beneficiaries would have to travel
21 beyond the required criterion to reach the next closest
22 contracted provider outside of the service area and (ii)
23 provides contact information, including names, addresses,
24 and phone numbers for the next closest contracted provider
25 or facility;

26 (2) if patterns of care in the service area do not

1 support the need for the requested number of provider or
2 facility type and the insurer provides data on local
3 patterns of care, such as claims data, referral patterns,
4 or local provider interviews, indicating where the
5 beneficiaries currently seek this type of care or where
6 the physicians currently refer beneficiaries, or both; or

7 (3) other circumstances deemed appropriate by the
8 Department consistent with the requirements of this Act.

9 (h) Insurers are required to report to the Director any
10 material change to an approved network plan within 15 days
11 after the change occurs and any change that would result in
12 failure to meet the requirements of this Act. Upon notice from
13 the insurer, the Director shall reevaluate the network plan's
14 compliance with the network adequacy and transparency
15 standards of this Act.

16 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
17 102-1117, eff. 1-13-23.)

18 (215 ILCS 124/25)

19 Sec. 25. Network transparency.

20 (a) A network plan shall post electronically an
21 up-to-date, accurate, and complete provider directory for each
22 of its network plans, with the information and search
23 functions, as described in this Section.

24 (1) In making the directory available electronically,
25 the network plans shall ensure that the general public is

1 able to view all of the current providers for a plan
2 through a clearly identifiable link or tab and without
3 creating or accessing an account or entering a policy or
4 contract number.

5 (2) The network plan shall update the online provider
6 directory at least monthly. Providers shall notify the
7 network plan electronically or in writing of any changes
8 to their information as listed in the provider directory,
9 including the information required in subparagraph (K) of
10 paragraph (1) of subsection (b). The network plan shall
11 update its online provider directory in a manner
12 consistent with the information provided by the provider
13 within 10 business days after being notified of the change
14 by the provider. Nothing in this paragraph (2) shall void
15 any contractual relationship between the provider and the
16 plan.

17 (3) The network plan shall audit periodically at least
18 25% of its provider directories for accuracy, make any
19 corrections necessary, and retain documentation of the
20 audit. The network plan shall submit the audit to the
21 Director upon request. As part of these audits, the
22 network plan shall contact any provider in its network
23 that has not submitted a claim to the plan or otherwise
24 communicated his or her intent to continue participation
25 in the plan's network.

26 (4) A network plan shall provide a printed ~~print~~ copy

1 of a current provider directory or a printed ~~print~~ copy of
2 the requested directory information upon request of a
3 beneficiary or a prospective beneficiary. Printed ~~Print~~
4 copies must be updated quarterly and an errata that
5 reflects changes in the provider network must be updated
6 quarterly.

7 (5) For each network plan, a network plan shall
8 include, in plain language in both the electronic and
9 print directory, the following general information:

10 (A) in plain language, a description of the
11 criteria the plan has used to build its provider
12 network;

13 (B) if applicable, in plain language, a
14 description of the criteria the insurer or network
15 plan has used to create tiered networks;

16 (C) if applicable, in plain language, how the
17 network plan designates the different provider tiers
18 or levels in the network and identifies for each
19 specific provider, hospital, or other type of facility
20 in the network which tier each is placed, for example,
21 by name, symbols, or grouping, in order for a
22 beneficiary-covered person or a prospective
23 beneficiary-covered person to be able to identify the
24 provider tier; and

25 (D) if applicable, a notation that authorization
26 or referral may be required to access some providers.

1 (6) A network plan shall make it clear for both its
2 electronic and print directories what provider directory
3 applies to which network plan, such as including the
4 specific name of the network plan as marketed and issued
5 in this State. The network plan shall include in both its
6 electronic and print directories a customer service email
7 address and telephone number or electronic link that
8 beneficiaries or the general public may use to notify the
9 network plan of inaccurate provider directory information
10 and contact information for the Department's Office of
11 Consumer Health Insurance.

12 (7) A provider directory, whether in electronic or
13 print format, shall accommodate the communication needs of
14 individuals with disabilities, and include a link to or
15 information regarding available assistance for persons
16 with limited English proficiency.

17 (b) For each network plan, a network plan shall make
18 available through an electronic provider directory the
19 following information in a searchable format:

20 (1) for health care professionals:

21 (A) name;

22 (B) gender;

23 (C) participating office locations;

24 (D) specialty, if applicable;

25 (E) medical group affiliations, if applicable;

26 (F) facility affiliations, if applicable;

1 (G) participating facility affiliations, if
2 applicable;

3 (H) languages spoken other than English, if
4 applicable;

5 (I) whether accepting new patients;

6 (J) board certifications, if applicable; and

7 (K) use of telehealth or telemedicine, including,
8 but not limited to:

9 (i) whether the provider offers the use of
10 telehealth or telemedicine to deliver services to
11 patients for whom it would be clinically
12 appropriate;

13 (ii) what modalities are used and what types
14 of services may be provided via telehealth or
15 telemedicine; and

16 (iii) whether the provider has the ability and
17 willingness to include in a telehealth or
18 telemedicine encounter a family caregiver who is
19 in a separate location than the patient if the
20 patient wishes and provides his or her consent;

21 (2) for hospitals:

22 (A) hospital name;

23 (B) hospital type (such as acute, rehabilitation,
24 children's, or cancer);

25 (C) participating hospital location; and

26 (D) hospital accreditation status; and

1 (3) for facilities, other than hospitals, by type:

2 (A) facility name;

3 (B) facility type;

4 (C) types of services performed; and

5 (D) participating facility location or locations.

6 (c) For the electronic provider directories, for each
7 network plan, a network plan shall make available all of the
8 following information in addition to the searchable
9 information required in this Section:

10 (1) for health care professionals:

11 (A) contact information; and

12 (B) languages spoken other than English by
13 clinical staff, if applicable;

14 (2) for hospitals, telephone number; and

15 (3) for facilities other than hospitals, telephone
16 number.

17 (d) The insurer or network plan shall make available in
18 print, upon request, the following provider directory
19 information for the applicable network plan:

20 (1) for health care professionals:

21 (A) name;

22 (B) contact information;

23 (C) participating office location or locations;

24 (D) specialty, if applicable;

25 (E) languages spoken other than English, if
26 applicable;

1 (F) whether accepting new patients; and

2 (G) use of telehealth or telemedicine, including,
3 but not limited to:

4 (i) whether the provider offers the use of
5 telehealth or telemedicine to deliver services to
6 patients for whom it would be clinically
7 appropriate;

8 (ii) what modalities are used and what types
9 of services may be provided via telehealth or
10 telemedicine; and

11 (iii) whether the provider has the ability and
12 willingness to include in a telehealth or
13 telemedicine encounter a family caregiver who is
14 in a separate location than the patient if the
15 patient wishes and provides his or her consent;

16 (2) for hospitals:

17 (A) hospital name;

18 (B) hospital type (such as acute, rehabilitation,
19 children's, or cancer); and

20 (C) participating hospital location and telephone
21 number; and

22 (3) for facilities, other than hospitals, by type:

23 (A) facility name;

24 (B) facility type;

25 (C) types of services performed; and

26 (D) participating facility location or locations

1 and telephone numbers.

2 (e) The network plan shall include a disclosure in the
3 print format provider directory that the information included
4 in the directory is accurate as of the date of printing and
5 that beneficiaries or prospective beneficiaries should consult
6 the insurer's electronic provider directory on its website and
7 contact the provider. The network plan shall also include a
8 telephone number in the print format provider directory for a
9 customer service representative where the beneficiary can
10 obtain current provider directory information.

11 (f) The Director may conduct periodic audits of the
12 accuracy of provider directories. A network plan shall not be
13 subject to any fines or penalties for information required in
14 this Section that a provider submits that is inaccurate or
15 incomplete.

16 (g) This Section applies to network plans that are not
17 otherwise exempt under Section 3, including stand-alone dental
18 plans that are subject to provider directory requirements
19 under federal law.

20 (Source: P.A. 102-92, eff. 7-9-21; revised 9-26-23.)

21 Section 25. The Health Maintenance Organization Act is
22 amended by changing Section 5-3 as follows:

23 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

24 Sec. 5-3. Insurance Code provisions.

1 (a) Health Maintenance Organizations shall be subject to
2 the provisions of Sections 133, 134, 136, 137, 139, 140,
3 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
4 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49,
5 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356v,
6 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6,
7 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14,
8 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22,
9 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30,
10 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35,
11 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a,
12 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49,
13 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57,
14 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65,
15 356z.67, 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i,
16 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402,
17 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c)
18 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,
19 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
20 Illinois Insurance Code.

21 (b) For purposes of the Illinois Insurance Code, except
22 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
23 Health Maintenance Organizations in the following categories
24 are deemed to be "domestic companies":

25 (1) a corporation authorized under the Dental Service
26 Plan Act or the Voluntary Health Services Plans Act;

1 (2) a corporation organized under the laws of this
2 State; or

3 (3) a corporation organized under the laws of another
4 state, 30% or more of the enrollees of which are residents
5 of this State, except a corporation subject to
6 substantially the same requirements in its state of
7 organization as is a "domestic company" under Article VIII
8 1/2 of the Illinois Insurance Code.

9 (c) In considering the merger, consolidation, or other
10 acquisition of control of a Health Maintenance Organization
11 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

12 (1) the Director shall give primary consideration to
13 the continuation of benefits to enrollees and the
14 financial conditions of the acquired Health Maintenance
15 Organization after the merger, consolidation, or other
16 acquisition of control takes effect;

17 (2) (i) the criteria specified in subsection (1) (b) of
18 Section 131.8 of the Illinois Insurance Code shall not
19 apply and (ii) the Director, in making his determination
20 with respect to the merger, consolidation, or other
21 acquisition of control, need not take into account the
22 effect on competition of the merger, consolidation, or
23 other acquisition of control;

24 (3) the Director shall have the power to require the
25 following information:

26 (A) certification by an independent actuary of the

1 adequacy of the reserves of the Health Maintenance
2 Organization sought to be acquired;

3 (B) pro forma financial statements reflecting the
4 combined balance sheets of the acquiring company and
5 the Health Maintenance Organization sought to be
6 acquired as of the end of the preceding year and as of
7 a date 90 days prior to the acquisition, as well as pro
8 forma financial statements reflecting projected
9 combined operation for a period of 2 years;

10 (C) a pro forma business plan detailing an
11 acquiring party's plans with respect to the operation
12 of the Health Maintenance Organization sought to be
13 acquired for a period of not less than 3 years; and

14 (D) such other information as the Director shall
15 require.

16 (d) The provisions of Article VIII 1/2 of the Illinois
17 Insurance Code and this Section 5-3 shall apply to the sale by
18 any health maintenance organization of greater than 10% of its
19 enrollee population (including, without limitation, the health
20 maintenance organization's right, title, and interest in and
21 to its health care certificates).

22 (e) In considering any management contract or service
23 agreement subject to Section 141.1 of the Illinois Insurance
24 Code, the Director (i) shall, in addition to the criteria
25 specified in Section 141.2 of the Illinois Insurance Code,
26 take into account the effect of the management contract or

1 service agreement on the continuation of benefits to enrollees
2 and the financial condition of the health maintenance
3 organization to be managed or serviced, and (ii) need not take
4 into account the effect of the management contract or service
5 agreement on competition.

6 (f) Except for small employer groups as defined in the
7 Small Employer Rating, Renewability and Portability Health
8 Insurance Act and except for medicare supplement policies as
9 defined in Section 363 of the Illinois Insurance Code, a
10 Health Maintenance Organization may by contract agree with a
11 group or other enrollment unit to effect refunds or charge
12 additional premiums under the following terms and conditions:

13 (i) the amount of, and other terms and conditions with
14 respect to, the refund or additional premium are set forth
15 in the group or enrollment unit contract agreed in advance
16 of the period for which a refund is to be paid or
17 additional premium is to be charged (which period shall
18 not be less than one year); and

19 (ii) the amount of the refund or additional premium
20 shall not exceed 20% of the Health Maintenance
21 Organization's profitable or unprofitable experience with
22 respect to the group or other enrollment unit for the
23 period (and, for purposes of a refund or additional
24 premium, the profitable or unprofitable experience shall
25 be calculated taking into account a pro rata share of the
26 Health Maintenance Organization's administrative and

1 marketing expenses, but shall not include any refund to be
2 made or additional premium to be paid pursuant to this
3 subsection (f)). The Health Maintenance Organization and
4 the group or enrollment unit may agree that the profitable
5 or unprofitable experience may be calculated taking into
6 account the refund period and the immediately preceding 2
7 plan years.

8 The Health Maintenance Organization shall include a
9 statement in the evidence of coverage issued to each enrollee
10 describing the possibility of a refund or additional premium,
11 and upon request of any group or enrollment unit, provide to
12 the group or enrollment unit a description of the method used
13 to calculate (1) the Health Maintenance Organization's
14 profitable experience with respect to the group or enrollment
15 unit and the resulting refund to the group or enrollment unit
16 or (2) the Health Maintenance Organization's unprofitable
17 experience with respect to the group or enrollment unit and
18 the resulting additional premium to be paid by the group or
19 enrollment unit.

20 In no event shall the Illinois Health Maintenance
21 Organization Guaranty Association be liable to pay any
22 contractual obligation of an insolvent organization to pay any
23 refund authorized under this Section.

24 (g) Rulemaking authority to implement Public Act 95-1045,
25 if any, is conditioned on the rules being adopted in
26 accordance with all provisions of the Illinois Administrative

1 Procedure Act and all rules and procedures of the Joint
2 Committee on Administrative Rules; any purported rule not so
3 adopted, for whatever reason, is unauthorized.

4 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
5 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
6 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
7 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
8 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
9 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
10 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
11 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
12 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
13 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

14 Section 30. The Managed Care Reform and Patient Rights Act
15 is amended by changing Section 45.3 as follows:

16 (215 ILCS 134/45.3)

17 Sec. 45.3. Prescription drug benefits; plan choice.

18 (a) Notwithstanding any other provision of law, beginning
19 January 1, 2023, every health insurance carrier that offers an
20 individual health plan that provides coverage for prescription
21 drugs shall ensure that at least 10% of individual health care
22 plans offered in each applicable service area and at each
23 level of coverage as defined in 42 U.S.C. 18022(d) apply a
24 flat-dollar copayment structure to the entire drug benefit.

1 Beginning January 1, 2024, every health insurance carrier that
2 offers an individual health plan that provides coverage for
3 prescription drugs shall ensure that at least 25% of
4 individual health care plans offered in each applicable
5 service area and at each level of coverage as defined in 42
6 U.S.C. 18022(d) apply a flat-dollar copayment structure to the
7 entire drug benefit. If a health insurance carrier offers
8 fewer than 4 plans in a service area, then the health insurance
9 carrier shall ensure that one plan applies a flat-dollar
10 copayment structure to the entire drug benefit.

11 ~~(b) Beginning January 1, 2023, every health insurance~~
12 ~~carrier that offers a group health plan that provides coverage~~
13 ~~for prescription drugs shall offer at least one group health~~
14 ~~plan in each applicable service area and at each level of~~
15 ~~coverage as defined in 42 U.S.C. 18022 that applies a~~
16 ~~flat dollar copayment structure to the entire drug benefit.~~
17 Every Beginning January 1, 2024, every health insurance
18 carrier that offers a small group health plan that provides
19 coverage for prescription drugs shall offer at least 2 small
20 group health plans in each applicable service area and at each
21 level of coverage as defined in 42 U.S.C. 18022(d) that apply a
22 flat-dollar copayment structure to the entire drug benefit.

23 (c) The flat-dollar copayment structure for prescription
24 drugs under subsections (a) and (b) must be applied
25 pre-deductible and be reasonably graduated and proportionately
26 related in all tier levels such that the copayment structure

1 as a whole does not discriminate against or discourage the
2 enrollment of individuals with significant health care needs.
3 Notwithstanding the other provisions of this subsection,
4 beginning January 1, 2025, each level of coverage that a
5 health insurance carrier offers of a standardized option in
6 each applicable service area shall be deemed to satisfy the
7 requirements for a flat-dollar copay structure in subsection
8 (a).

9 For purposes of this subsection, "standardized option" has
10 the meaning given to that term in 45 CFR 155.20 or, when
11 Illinois has a State-based exchange, a substantially similar
12 definition to "standardized option" in 45 CFR 155.20 that
13 substitutes the Illinois Health Benefits Exchange for the
14 United States Department of Health and Human Services.

15 (d) A health insurance carrier that offers individual or
16 small group health care plans shall clearly and appropriately
17 name the plans described in subsections (a) and (b) to aid in
18 the individual or small group plan selection process.

19 (e) A health insurance carrier shall market plans
20 described in subsections (a) and (b) in the same manner as
21 plans not described in subsections (a) and (b).

22 (f) The Department shall adopt rules necessary to
23 implement and enforce the provisions of this Section.

24 (Source: P.A. 102-391, eff. 1-1-23.)

25 Section 99. Effective date. This Act takes effect upon

1 becoming law, except that the changes to Sections 3, 5, 10, and
2 25 of the Network Adequacy and Transparency Act take effect
3 January 1, 2025."