Rep. Lou Lang

Filed: 3/4/2014

AMENDMENT TO SENATE BILL 1547

AMENDMENT NO. _____. Amend Senate Bill 1547, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 370g and 370h and by adding Sections 370d.1 and 370u as follows:

(215 ILCS 5/370d.1 new)

Sec. 370d.1. Exclusive provider organization plans.

(a) For the purpose of this Section:

"Exclusive provider organization plan" or "EPO" means a benefit plan that utilizes a network of contracted health care providers and that excludes benefits for services provided by non-contracted health care providers, except for emergency services or when services are not available to an insured from a contracted provider within a

designated service area.

"Designated service area" means a geographic service area as specified in a health insurance policy for an EPO with approval from the Department.

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including, but not limited to, ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not include post-stabilization medical services.

(b) An insurer having authority under Class 1(b) or 2(a) of Section 4 of this Code to write accident and health insurance under the provisions of this Code shall be authorized to issue policies for exclusive provider organization plans for either group or individual policies, provided such policies otherwise conform to the terms of this Section, the Uniform Health Care Service Benefits Information Card Act, and the Health Carrier External Review Act. An insurer issuing exclusive provider organization plans under this Section shall not be required to be licensed as a health maintenance organization under the Health Maintenance Organization Act in order to issue a policy under this Section.

(c) An insurer writing policies for an EPO shall limit enrollment in such a plan solely to those individuals who

either live, work, or reside in the designated service area.

(d) Except as otherwise stated in this Section, an EPO shall comply with all other provisions of this Code, and regulations issued hereunder, relating to accident and health insurance policies that utilize a contracted health care provider network to provide the benefits under such policies.

(e) This Section does not apply to:

(1) the Children's Health Insurance Program issued under the Children's Health Insurance Program Act;

(2) a Medicaid managed care program issued under Article V of the Illinois Public Aid Code; or

(3) the State Employees' Group Insurance Act.

(f) An insurer writing policies for an EPO shall provide within the contract and evidence of coverage a description of benefits and services available out of the EPO's designated service area, including any limitations and exclusions.

(g) An insurer shall not require a health care professional or health care provider, as a condition of participating in the EPO, to sign a contract requiring the health care professional or health care provider to provide services under another of the company's networks or plans.

(h) An insurer shall not require a health care professional or health care provider, as a condition of participating in any of the company's networks or plans, to sign a contract requiring the health care professional or health care provider to provide services under the insurer's EPO.

(i) An EPO issued or renewed in this State must prominently display on the cover page of the policy, evidence of coverage, and any marketing materials, that it is an exclusive provider organization benefit plan and that services, other than emergency services, provided by non-contracted health care providers may not be covered under the plan, as well as the components of an EPO plan, including explanations of in-network and out-of-network services.

(j) An EPO must clearly state on the health care benefit information card that it is an EPO.

(k) An insurer that issues, delivers, amends, or renews an individual or group EPO in this State after the effective date of this amendatory Act of the 98th General Assembly must include the following disclosure on its contracts and evidences of coverage: "WARNING, NO BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that no benefits shall be available under this plan except for emergency services or when services are not available from a contracted provider within the designated service area. YOU WILL HAVE TO PAY FOR ANY SERVICE OR TREATMENT OUTSIDE OF THE EXCLUSIVE PROVIDER ORGANIZATION PLAN NETWORK. Non-participating providers may bill members for any treatments and services provided to the patient. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than copayments, co-insurance, and deductible amounts. You may

obtain further information about the participating status of professional providers by calling the toll-free telephone number on your identification card.".

(l) Any insurer that issues, delivers, amends, or renews an individual or group EPO in this State after the effective date of this amendatory Act of the 98th General Assembly must comply with Sections 20, 25, 30, 35, 45, 65, 70, 85, 95, and 100 of the Managed Care Reform and Patient Rights Act.

(m) Any insurer that issues, delivers, amends, or renews an individual or group EPO in this State after the effective date of this amendatory Act of the 98th General Assembly must comply with the following provisions:

(1) An EPO shall provide annually to enrollees and prospective enrollees, upon request, a complete list of participating health care providers in the health care plan's service area and a description of the following terms of coverage:

(A) the service area;

(B) the covered benefits and services with all exclusions, exceptions, and limitations;

(C) the pre-certification and other utilization review procedures and requirements;

(D) the emergency coverage and benefits, including specifics on the differences in benefits between emergency care and non-emergency care, including any restrictions on emergency care services, so long as

such specifics and restrictions allow coverage for medical conditions within the meaning of an emergency medical condition as defined in Section 10 of the Managed Care Reform and Patient Rights Act;

(E) the out-of-area coverage and benefits, if any;

(F) the enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses;

(G) the provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by that provider; and

(H) the appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process.

(2) An EPO shall provide the information required to be disclosed under this Section upon enrollment and annually thereafter in a legible and understandable format.

(3) The written disclosure requirements of this Section may be met by disclosure to one enrollee in a household.

(n) The following provisions shall apply concerning EPO restrictions on primary care physicians.

(1) An EPO is prohibited from requiring enrollees to choose a primary care physician for the coordination of care.

(2) Enrollees may at any time select any physician from within the EPO network to provide care.

(3) An EPO is prohibited from requiring enrollees to obtain prior authorization from any participating physician in the network before seeing an EPO network provider of their choice.

(o) An insurer that issues, delivers, amends, or renews an individual or group EPO shall provide an internal claims and appeals process that incorporates the claims and appeals procedures set forth in Section 45 of the Managed Care Reform and Patient Rights Act.

(p) The Director of Insurance shall adopt rules necessary to implement this Section.

(215 ILCS 5/370g) (from Ch. 73, par. 982g)

Sec. 370g. Definitions. As used in this Article, the following definitions apply:

(a) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision and pharmaceutical services or products.

(b) "Insurer" means an insurance company or a health

service corporation authorized in this State to issue policies or subscriber contracts which reimburse for expenses of health care services.

(c) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

(d) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

(e) "Noninstitutional provider" means any person licensed under the Medical Practice Act of 1987, as now or hereafter amended.

(f) "Beneficiary" means an individual entitled to reimbursement for expenses of or the discount of provider fees for health care services under a program where the beneficiary has an incentive to utilize the services of a provider which has entered into an agreement or arrangement with an administrator.

(g) "Administrator" means any person, partnership or corporation, other than an insurer or health maintenance organization holding a certificate of authority under the "Health Maintenance Organization Act", as now or hereafter amended, that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.

(h) "Emergency medical condition" means a medical

condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(i) "Exclusive provider organization plan" or "EPO" means a benefit plan that utilizes a network of contracted health care providers and that excludes benefits for services provided by non-contracted health care providers, except for emergency services and subject to the requirements of Section 356z.3a or when services are not available to an insured from a contracted provider within a designated service area.

(j) "Designated service area" means a geographic area as specified in a health insurance policy for an EPO.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 5/370h) (from Ch. 73, par. 982h)

Sec. 370h. Noninstitutional providers.

(a) Before entering into any agreement under this Article an insurer or administrator shall establish terms and conditions that must be met by noninstitutional providers

wishing to enter into an agreement with the insurer or administrator. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers. Neither difference in prices among noninstitutional providers produced by a process of individual negotiation nor price differences among other noninstitutional providers in different geographical areas or different specialties constitutes unreasonable discrimination.

(b) An insurer or administrator shall not refuse to contract with any noninstitutional provider who meets the terms and conditions established by the insurer or administrator.

(c) Any insurer that issues, delivers, amends, or renews an individual or group EPO in this State after the effective date of this amendatory Act of the 98th General Assembly shall not be obligated to comply with this Section solely with respect to the EPO product.

(Source: P.A. 90-655, eff. 7-30-98.)

(215 ILCS 5/370u new)

Sec. 370u. Exclusive provider organization plans permitted.

(a) An insurer having authority under Class 1(b) or 2(a) of Section 4 of this Code to write accident and health insurance as applicable under this Code, may offer an EPO, provided that the administrator meets the requirements of this Code and the Director determines that:

(1) the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions to beneficiaries, or insured individuals does not operate unreasonably to restrict the access and availability of health care services for the insured; or

(2) the EPO has established an exclusive network that is adequate to provide health care services as required.

(b) Until the effective date of the rules adopted by the Director for EPO plans, insurers must file a description of the services to be offered through an EPO. The description shall include all of the following:

(1) The method of marketing the program.

(2) A geographic map of the area proposed to be served by the program by county and zip code, including marked locations for providers.

(3) The names, addresses, and specialties of the providers who have entered into EPO contracts under the program.

(4) The names of available primary care physicians and the encouragement of each enrollee to select such a physician to handle their care coordination.

(5) The number of beneficiaries anticipated to be covered by the providers listed in paragraph (3) of this subsection (b).

(6) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access

regarding up-to-date lists of providers. A plan shall identify specific providers in a beneficiary's area, confirm specific provider participation, or provide a listing of providers by mail. Provider lists requested by phone must be sent within 3 working days after the request is made. The up-to-date provider list applies to all providers that have entered arrangements to provide services under the program either directly or indirectly through another administrator. Insurers' Internet website addresses shall be prominently displayed on all advertisements, marketing materials, brochures, benefit cards, and identification cards.

(7) A description of how health care services to be rendered under the EPO provider program are reasonably accessible and available to beneficiaries. Standards shall address the following:

(A) The ratio of providers to beneficiaries, by specialty applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population such that there shall be at least one full-time physician for each 1,200 enrollees.

(B) The greatest distance or time that the beneficiary may be required to travel to access:

(i) provider hospital services when applicable under the contract;

(ii) primary care physician and women's principal health care provider services when applicable under the contract; and

(iii) any applicable health care service providers.

(C) A process for tracking when providers within the network stop accepting new EPO patients.

(D) A process for encouraging all EPO providers to utilize an electronic system to ensure the timely exchange of health records between and among providers who have entered into EPO contracts listed in paragraph (3) of this subsection (b).

(E) Written policies and procedures for determining when the program is closed to new providers desiring to enter into EPO arrangements.

(F) Written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient to provider ratio, changes in medical and health care capabilities, changes in number of providers accepting new patients, and increased demand for services.

(G) The provision of 24 hour, 7 day-per-week access to network-affiliated primary care and women's principal health care providers.

(H) The procedures for making referrals outside the network when procedures cannot be provided within

the network.

(I) A provision that whenever a beneficiary has made a good faith effort to utilize EPO providers for a covered service and it is determined the insurer does not have the appropriate EPO providers due to insufficient number or type or distance, the insurer shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by an EPO provider. This subparagraph (G) does not apply to a beneficiary who willfully chooses to access a non-preferred provider for health care services reasonably available through the insurer's panel of participating providers. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply.

(J) The procedures for paying benefits when particular physician specialties are not represented within the provider network or the services of such providers are not available at the time care is sought. In any case in which a beneficiary has made a good faith effort to utilize network providers, by satisfying contractual obligations specified in the benefit contract or certificate, for a covered service and the insurer does not have the appropriate preferred

specialty providers (including, but not limited to, radiologists, anesthesiologists, pathologists and emergency room physicians) under contract due to the inability of the insurer to contract with the specialists, or due to the insufficient number or type of, or travel distance to, specialists, the insurer shall ensure that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by an EPO provider. This subparagraph (J) does not apply to a beneficiary who willfully chooses to access a non-preferred provider for health care services reasonably available through the insurer's panel of participating providers. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply.

(K) A provision that the beneficiary shall receive emergency care coverage such that payment for the coverage is not dependent upon whether the services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For the purposes of this subparagraph (K), "the same benefit level" means that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service

had been provided by a preferred provider.

(L) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence.

(M) Efforts to address the needs of beneficiaries with limited English proficiency and literacy or diverse cultural and ethnic backgrounds, and to comply with the Americans With Disabilities Act of 1990.

(N) A sample beneficiary identification card in conformity with the Uniform Health Care Service Benefits Information Card Act and the Uniform Prescription Drug Information Card Act when pharmaceutical services are provided as part of the program's health care services.

(8) The process for encouraging EPO providers to utilize an electronic system to ensure the timely exchange of health records between and among providers who have entered into EPO agreements listed in paragraph (3) of this subsection (b).

(9) The educational efforts the insurer will use to inform beneficiaries that they are purchasing an EPO product, including the major differences between an EPO, an HMO and a PPO.

(c) The Director of Insurance shall adopt rules necessary to implement this Section.".