HB6562

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99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB6562

by Rep. Gregory Harris - Chad Hays - Ann M. Williams - Jeanne M Ives - Tom Demmer, et al.

SYNOPSIS AS INTRODUCED:

New Act

Creates the Network Adequacy and Transparency Act. Provides that administrators and insurers, prior to going to market, must file with the Department of Insurance for review and approval a description of the services to be offered through a health care network plan with certain criteria included in the description. Provides that the health care network plan shall demonstrate to the Department, prior to approval, a minimum ratio of full-time equivalent providers to plan beneficiaries and maximum travel and distance burdens for plan beneficiaries based in the maximum minutes or miles to be traveled by a plan beneficiary for each county type as defined under the Act. Provides that the Department shall conduct periodic audits of health care network plan to verify compliance with network adequacy standards. Establishes certain notice requirements. Provides that a health care network plan shall provide for continuity of care for its beneficiaries based on certain circumstances. Provides that a health care network plan shall post electronically a current and accurate provider directory and make available in print, upon request, a provider directory each subject to the provision's specifications. Provides that the provisions of the Act are deemed incorporated into the health care providers service contracts entered into on or before the effective date of the Act. Provides that the Department is granted specific authority to issue a cease and desist order against, fine, or otherwise penalize any insurer or administrator for violations of any provision of the Act. Effective January 1, 2017.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Network Adequacy and Transparency Act.

Section 5. Definitions. In this Act:

"Active course of treatment" means (1) ongoing treatment for a life threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) ongoing treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; or (3) ongoing course of treatment for a health condition that a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes; or

"Administrator" means any third party administrator regulated by the Department.

"Beneficiary" means an insured, enrollee, or covered person participating in a health care network plan.

"County type" means population and density parameters as

established by the designations of large, metro, micro, or rural.

"Large" means a county that meets the following population and density thresholds:

(1) a population greater than or equal to 1,000,000 persons and a population density of greater than or equal to 1000 persons per square mile;

(2) a population between 500,000 and 999,999 persons and a population density of greater than or equal to 1500 persons per square mile; or

(3) a population of any number of persons and a population density of greater than or equal to 5000 persons per square mile.

"Metro" means a county that meets the following population and density thresholds:

(1) a population greater than or equal to 1,000,000 persons and a population density of 10 to 999.9 persons per square mile;

(2) a population of between 500,000 to 999,999 persons and a population density of 10 to 1,499.9 persons per square mile;

(3) a population of between 200,000 to 499,999 persons and a population density of 10 to 4999.9 persons per square mile;

(4) a population of between 50,000 and 199,999 persons and a population density of 100 to 4,999.9 persons per

square mile; or

(5) a population of between 10,000 to 49,999 persons and a population density of 1,000 to 4,999.9 persons per square mile.

"Micro" means a county that meets the following population and density thresholds:

(1) a population of between 50,000 and 199,999 persons and a population density of 10 to 99.9 persons per square mile; or

(2) a population between 10,000 and 49,999 persons and a population density of 50 to 999.99 persons per square mile.

"Rural" means a county that meets the following population and density thresholds:

(1) a population between 10,000 and 49,999 persons and a population density of 10 to 49.9 persons per square mile; or

(2) a population less than 10,000 persons and a population density of 10 to 4,999.9 persons per square mile.

"Department" means the Department of Insurance.

"Health care network plan" means an individual or group policy of accident and health insurance that either requires a beneficiary to use, or creates incentives, including financial incentives, for a beneficiary to use providers managed, owned, under contract with, or employed by any insurer or

administrator.

"Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, Health Maintenance Organizations, Preferred Provider Organizations, exclusive provider organizations, Accountable Care Organizations, and other plan structures, excluding the medical assistance program and the state employees' health insurance program.

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

"Material change" means a significant reduction in the number of providers or hospitals available in a health care network plan, including, but not limited to, a reduction in a specific type of providers, or a change in inclusion of a major health system that causes a network to be significantly different from the network when the beneficiary purchased the health care network plan.

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

Section 10. Network adequacy.

(a) Prior to going to market, administrators and insurers must file with the Department for review and approval a description of the services to be offered through a health care network plan. The description shall include all of the following:

(1) The method of marketing the health care network plan;

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

(3) The names, addresses, and specialties of the providers who have entered into preferred provider agreements under the program;

(4) The number of beneficiaries anticipated to be covered by the providers listed under paragraph (3);

(5) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers, additional information about the plan, as well as any other information necessary established by the Department rule;

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

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

(B) The ratio of full-time equivalent physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population; and

(C) The travel and distance burdens for plan beneficiaries.

(7) The written policies and procedures for determining when the plan is closed to new providers desiring to enter into a health care network plan;

(8) The 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, and increased demand for services;

(9) The procedures for making referrals within and outside the network;

(10) How the health care network plan will provide 24 hour, 7 day per week access to network affiliated primary care and women's principal health care providers;

(11) A provision ensuring that whenever a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient numbers, type, or distance,

the administrator or 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 a preferred provider;

(12) 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;

(13) A provision that the beneficiary shall receive emergency care coverage such that payment for this 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 purposes of this paragraph (13), "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; and

(14) 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.

(b) The health care network plan shall demonstrate to the Department, prior to approval, a minimum ratio of full-time equivalent providers to plan beneficiaries.

(1) The ratio of full-time equivalent physician providers to plan beneficiaries shall be as follows:

(A) Primary Care Physician: 1 per 1,000

(B) Pediatrician: 1 per 1,000

(C) Cardiology: 1 per 10,000

(D) Gastroenterology: 1 per 10,000

(E) General Surgery: 1 per 5,000

(F) Neurology: 1 per 20,000

(G) OB/GYN: 1 per 2,500

(H) Oncology/Radiation: 1 per 15,000

(I) Ophthalmology: 1 per 10,000

(J) Urology: 1 per 10,000

(K) Behavioral Health: 1 per 5,000

(L) Allergy/Immunology: 1 per 15,000

(M) Chiropractor: 1 per 10,000

(N) Dermatology: 1 per 10,000

(O) Endocrinology: 1 per 10,000

(P) Ears, Nose, and Throat (ENT)/Otolaryngology: 1 per 15,000

(Q) Infectious Disease: 1 per 15,000

(R) Nephrology: 1 per 10,000

(S) Neurosurgery: 1 per 20,000

(T) Orthopedic Surgery: 1 per 10,000

(U) Physiatry/Rehabilitative: 1 per 15,000

(V) Plastic Surgery: 1 per 20,000

(W) Pulmonary: 1 per 10,000

(X) Rheumatology: 1 per 10,000

(2) The health care network plan shall also demonstrate the ratio of full-time equivalent physician providers to plan beneficiaries related to pediatrics specialty care. The ratio of full-time equivalent pediatric specialty providers to plan beneficiaries shall be calculated separately from ratio requirements set forth in paragraph (1) of this subsection (b). The ratio of full-time equivalent pediatric specialty providers to plan beneficiaries shall be the same as those set forth in paragraph (1) of this subsection (b) as related to each applicable pediatric specialty.

(3) The Department shall establish a process for the annual review of the adequacy of these standards, along with an assessment of additional specialties to be included in the list under this subsection.

(c) The health care network plan shall demonstrate to the Department, prior to approval, maximum travel and distance burdens for plan beneficiaries based on the maximum minutes or miles to be traveled by a plan beneficiary for each county type as defined in this Act.

(1) The maximum travel time and distance burdens for each provider specialty are as follows:

(A) Primary Care:

Large: 10 minutes or 5 miles

Metro: 15 minutes or 10 miles

Micro: 30 minutes or 20 miles

Rural 40 minutes or 30 miles

(B) OB/GYN/Pediatrics

Large 10 minutes or 5 miles

Metro 15 minutes or 10 miles

Micro 30 minutes or 20 miles

Rural40 minutes or 30 miles

(C) Dental

Large: 30 minutes or 15 miles

Metro: 45 minutes or 30 miles

Micro: 80 minutes or 60 miles

Rural: 90 minutes or 75 miles

(D) Endocrinology

Large: 30 minutes or 15 miles

Metro: 60 minutes or 40 miles

Micro: 100 minutes or 75 miles

Rural: 110 minutes or 90 miles

(E) Infectious Diseases

Large: 30 minutes or 15 miles

Metro: 60 minutes or 40 miles

Micro: 100 minutes or 75 miles

Rural: 110 minutes or 90 miles

(F) Oncology - Surgical

Large: 20 minutes or 10 miles

Metro: 45 minutes or 30 miles

Micro: 60 minutes or 45 miles

Rural: 75 minutes or 60 miles

(G) Oncology - Radiology

Large: 30 minutes or 15 miles

Metro: 60 minutes or 40 miles

Micro: 100 minutes or 75 miles

Rural: 110 minutes or 90 miles

(H) Mental Health

Large: 20 minutes or 10 miles

Metro: 45 minutes or 30 miles

Micro: 60 minutes or 45 miles

Rural: 75 minutes or 60 miles

(I) Cardiology

Large: 20 minutes or 10 miles

Metro: 30 minutes or 20 miles

Micro: 50 minutes or 35 miles

Rural: 75 minutes or 60 miles

(J) Rheumatology

Large: 30 minutes or 15 miles

Metro: 60 minutes or 40 miles

Micro: 100 minutes or 75 miles

Rural: 110 minutes or 90 miles

(K) Outpatient Dialysis

Large: 30 minutes or 15 miles

Metro: 45 minutes or 30 miles

Micro: 80 minutes or 60 miles

Rural: 90 minutes or 75 miles

(L) Inpatient Psychiatry

Large: 30 minutes or 15 miles

Metro: 70 minutes or 45 miles

Micro: 100 minutes or 75 miles

Rural: 90 minutes or 75 miles

(M) Hospital-based services, including, but not limited to, emergency medicine, radiology, pathology, anesthesiology, trauma surgery, and other hospital based specialties, shall demonstrate the following travel and distance burdens:

Large: 20 minutes or 10 miles

Metro: 45 minutes or 30 miles

Micro: 80 minutes or 60 miles

Rural: 75 minutes or 60 miles

(2) The health care network plan must be able to demonstrate the maximum travel and distance burdens for plan beneficiaries related to pediatric care. The maximum travel and distance burdens for plan beneficiaries related to pediatric specialties shall be calculated separately from the travel and distance burdens set forth in paragraph (1) of this subsection (c). The maximum travel time and distance burdens related to pediatric specialties shall be the same as those set forth in paragraph (1) of this subsection (c) as related to each applicable pediatric specialty.

(3) The Department shall establish a process for the

annual review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection.

(d) These ratio and time and distance standards apply separately to each cost-sharing tier of any tiered network.

(e) Insurers and administrators are required to report to the Department when any material change is made to any approved health care network plan within 15 days after the change occurs. Upon such notice from the carrier, the Department must reevaluate the health care network plan's ability to meet network adequacy standards.

(f) The Department shall conduct periodic audits of health care network plan to verify compliance with network adequacy standards. These audits shall include surveys to be sent to plan beneficiaries and providers for the purpose of assessing health care network plan compliance with the provisions of this Section.

Section 20. Notice of nonrenewal or termination. A health care network plan must give at least 60 days' notice of nonrenewal or termination of a health care provider to the health care provider and to the beneficiaries served by the health care provider. The notice shall include a name and address to which a beneficiary or health care provider may direct comments and concerns regarding the nonrenewal or termination and the telephone number maintained by the

Department for consumer complaints. Immediate written notice may be provided without 60 days' notice when a health care provider's license has been disciplined by a State licensing board.

Section 25. Transition of services.

(a) A health care network plan shall provide for continuity of care for its beneficiaries as follows:

(1) If a beneficiary's provider leaves the health care network plan's network of health care providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider remains within the healthcare network plan's service area, the healthcare network plan shall permit the beneficiary to continue an ongoing course of treatment with that provider during a transitional period for the following duration:

(A) 90 days from the date of the notice of provider's termination from the healthcare network plan to the beneficiary of the provider's disaffiliation from the healthcare network plan if the beneficiary has an active course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the time of the provider's disaffiliation, that includes the provision of

post-partum care directly related to the delivery.

(2) Notwithstanding the provisions in paragraph (1) of this subsection (a), such care shall be authorized by the health care network plan during the transitional period only if the provider agrees to all the following provisions:

(A) to continue to accept reimbursement from the health care network plan at the rates and terms and conditions, applicable prior to the start of the transitional period;

(B) to adhere to the health care network plan's quality assurance requirements and to provide to the health care network plan necessary medical information related to such care; and

(C) to otherwise adhere to the healthcare network plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorizations for treatment.

(3) The provisions of this Section governing health care provided during the transition period do not apply if the beneficiary has successfully transitioned to another provider participating in the health care network plan, if the beneficiary has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary.

(b) The termination or departure of a beneficiary's primary

care provider from a health care network plan shall constitute a qualifying event, allowing beneficiaries to select a new health care network plan outside of a standard open enrollment period within 60 days of notice of termination or departure.

(c) A health care network plan shall provide for continuity of care for new beneficiaries as follows:

(1) If a new beneficiary whose provider is not a member of the health care network plan's provider network, but is within the health care network plan's service area, enrolls in the healthcare network plan, the health care network plan shall permit the beneficiary to continue an ongoing course of treatment with the beneficiary's current physician during a transitional period:

(A) of 90 days from the effective date of enrollment if the beneficiary has an ongoing active course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.

(2) If a beneficiary elects to continue to receive care from such provider pursuant to paragraph (1) of this subsection (c), such care shall be authorized by the health care network plan for the transitional period only if the physician agrees to all of the following provisions:

(A) to accept reimbursement from the healthcare

network plan at rates established by the healthcare network plan;

(B) to adhere to the health care network plan's quality assurance requirements and to provide to the health care network plan necessary medical information related to such care; and

(C) to otherwise adhere to the health care network plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorization for treatment.

(3) The provisions of this Section governing health care provided during the transition period do not apply if the beneficiary has successfully transitioned to another provider participating in the health care network plan, if the beneficiary has already met or exceeded the benefit limitations of the plan, or the care provided is not medically necessary.

(d) In no event shall this Section be construed to require a healthcare network plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the beneficiary's contract.

Section 30. Network transparency.

(a) A health care network plan shall post electronically a current and accurate provider directory for each of its health care network plans with the information and search functions,

as described in this Section.

In making the directory available electronically, the health care network plan shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

The health care network plan shall provide real time updates to the online provider directory.

The health care network plan shall audit monthly at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the Department upon request.

A health care network plan shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information upon request of a beneficiary or a prospective beneficiary. Print copies must be updated monthly or provide an errata that reflects changes in the provider network, to be updated monthly.

For each health care network plan, a healthcare network plan shall include in plain language in both the electronic and print directory, the following general information:

(1) In plain language, a description of the criteria the plan has used to build its provider network;

(2) If applicable, in plain language, a description of the criteria the administrator, insurer, or health care network plan has used to create tiered networks;

(3) If applicable, in plain language, how the health care network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a beneficiary covered person or a prospective beneficiary covered person to be able to identify the provider tier; and

(4) If applicable, note that authorization or referral may be required to access some providers.

A health care network plan shall make it clear for both its electronic and print directories what provider directory applies to which health care network plan, such as including the specific name of the health care network plan as marketed and issued in this State. The healthcare network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the health care network plan of inaccurate provider directory information.

For the pieces of information required in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health care network plan shall make available through the directory the source of the information and any limitations, if applicable.

A provider directory, whether in electronic or print

format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) The health care network plan shall make available through an electronic provider directory, for each health care network plan, the information under this subsection (b) in a searchable format:

(1) For health care professionals:

(A) Name;

(B) Gender;

(C) Participating office locations;

(D) Specialty, if applicable;

(E) Medical group affiliations, if applicable;

(F) Facility affiliations, if applicable;

(G) Participating facility affiliations, if applicable;

(H) Languages spoken other than English, if applicable; and

(I) Whether accepting new patients.

(2) For hospitals:

(A) Hospital name;

(B) Hospital type (such as acute, rehabilitation, children's, cancer);

(C) Participating hospital location; and

(D) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(A) Facility name;

(B) Facility type;

(C) Types of services performed; and

(D) Participating facility locations.

(c) For the electronic provider directories, for each health care network plan, a healthcare network plan shall make available the following information all of the information:

(1) For health care professionals:

(A) Contact information;

(B) Board certifications; and

(C) Languages spoken other than English by clinical staff, if applicable;

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

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

(1) For health care professionals:

(A) Name;

(B) Contact information;

(C) Participating office location(s);

(D) Specialty, if applicable;

(E) Languages spoken other than English, if

applicable; and

(F) Whether accepting new patients.

(2) For hospitals:

(A) Hospital name;

(B) Hospital type (such as acute, rehabilitation, children's, cancer); and

(C) Participating hospital location and telephone number; and

(3) For facilities, other than hospitals, by type:

(A) Facility name;

(B) Facility type;

(C) Types of services performed; and

(D) Participating facility locations and telephone number.

(e) The health care network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website. The health care network plan shall also include a telephone number in the print format provider directory for a customer service representative or serve where the beneficiary can obtain current provider directory information.

(f) Where the violation results in an enrollee's use of an out-of-network provider despite the enrollee's reasonable

efforts to remain in network, require the health insurer to:

(1) pay the non-contracted provider's charge as stated on the claim form;

(2) ensure that the enrollee's financial obligations are no greater than if the service had provided by an in-network provider; and

(3) apply the enrollee's out-of-pocket expenses to any out-of-pocket maximum under his or her health insurance plan.

(g) The Department shall conduct periodic audits of the accuracy of provider directories to ensure health plan compliance.

Section 40. Administration and enforcement.

(a) Insurers and administrators have a continuing obligation to comply with the requirements of this Act. Other than the duties specifically created in this Act, nothing in this Act is intended to preclude, prevent, or require the adoption, modification, or termination of any utilization management, quality management, or claims processing methodologies or other provisions of a contract applicable to services provided under a contract between an insurer, health care network plan, or physician hospital organization and a health care professional or health care provider.

(b) Nothing in this Act precludes, prevents, or requires the adoption, modification, or termination of any health care

network plan term, benefit, coverage or eligibility provision, or payment methodology.

(c) The provisions of this Act are deemed incorporated into health care provider service contracts entered into on or before the effective date of this Act and do not require a health care network plan to renew or renegotiate the contracts with a health care provider.

(d) The Department shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law.

(e) The Department is hereby granted specific authority to issue a cease and desist order against, fine, or otherwise penalize any insurer or administrator for violations of any provision of this Act.

(f) The Department shall adopt rules to enforce compliance with this Act.

Section 99. Effective date. This Act takes effect January 1, 2017.