



Rep. Hoan Huynh

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LRB104 09757 BAB 24954 a

1 AMENDMENT TO HOUSE BILL 3796

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 3796 by replacing  
3 everything after the enacting clause with the following:

4 "Section 5. The Network Adequacy and Transparency Act is  
5 amended by changing Section 20 as follows:

6 (215 ILCS 124/20)

7 Sec. 20. Transition of services.

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

10 (1) If a beneficiary's provider leaves the network  
11 plan's network of providers for reasons other than  
12 termination of a contract in situations involving imminent  
13 harm to a patient or a final disciplinary action by a State  
14 licensing board and the provider remains within the  
15 network plan's service area, if benefits provided under  
16 such network plan with respect to such provider or

1 facility are terminated because of a change in the terms  
2 of the participation of such provider or facility in such  
3 plan, or if a contract between a group health plan and a  
4 health insurance issuer offering a network plan in  
5 connection with the group health plan is terminated and  
6 results in a loss of benefits provided under such plan  
7 with respect to such provider, then the network plan shall  
8 permit the beneficiary to continue an ongoing course of  
9 treatment with that provider during a transitional period  
10 for the following duration:

11 (A) 90 days from the date of the notice to the  
12 beneficiary of the provider's disaffiliation from the  
13 network plan if the beneficiary has an ongoing course  
14 of treatment; ~~or~~

15 (A-5) 90 days from the date of the notice to the  
16 beneficiary of the provider's disaffiliation from the  
17 network plan if the beneficiary has a confirmed  
18 appointment and the provider attests that the  
19 appointment was scheduled prior to the date of  
20 notification; or

21 (B) if the beneficiary has entered the third  
22 trimester of pregnancy at the time of the provider's  
23 disaffiliation, a period that includes the provision  
24 of post-partum care directly related to the delivery.

25 (2) Notwithstanding the provisions of paragraph (1) of  
26 this subsection (a), such care shall be authorized by the

1 network plan during the transitional period in accordance  
2 with the following:

3 (A) the provider receives continued reimbursement  
4 from the network plan at the rates and terms and  
5 conditions applicable under the terminated contract  
6 prior to the start of the transitional period;

7 (B) the provider adheres to the network plan's  
8 quality assurance requirements, including provision to  
9 the network plan of necessary medical information  
10 related to such care; and

11 (C) the provider otherwise adheres to the network  
12 plan's policies and procedures, including, but not  
13 limited to, procedures regarding referrals and  
14 obtaining preauthorizations for treatment.

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

22 (4) The provisions of this Section governing health  
23 care provided during the transition period do not apply if  
24 the provider or the beneficiary, as set forth in item  
25 (A-5) of paragraph (1) of this subsection (a), reschedules  
26 an appointment or schedules any follow up appointments

1       after 90 days from the date of notice provided in Section  
2       15.

3       (b) A network plan shall provide for continuity of care  
4 for new beneficiaries as follows:

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

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

15           (A-5) of 90 days from the effective date of  
16 enrollment if the beneficiary has a confirmed  
17 appointment and the current provider attests that the  
18 appointment was scheduled prior to the effective date  
19 of enrollment; or

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

24           (2) If a beneficiary, or a beneficiary's authorized  
25 representative, elects in writing to continue to receive  
26 care from such provider pursuant to paragraph (1) of this

1 subsection (b), such care shall be authorized by the  
2 network plan for the transitional period in accordance  
3 with the following:

4 (A) the provider receives reimbursement from the  
5 network plan at rates established by the network plan;

6 (B) the provider adheres to the network plan's  
7 quality assurance requirements, including provision to  
8 the network plan of necessary medical information  
9 related to such care; and

10 (C) the provider otherwise adheres to the network  
11 plan's policies and procedures, including, but not  
12 limited to, procedures regarding referrals and  
13 obtaining preauthorization for treatment.

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

21 (4) The provisions of this Section governing health  
22 care provided during the transition period do not apply if  
23 the provider or the beneficiary, as set forth in item  
24 (A-5) of paragraph (1) of this subsection (b), reschedules  
25 an appointment or schedules any follow up appointments  
26 after 90 days from the date of enrollment.

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

5 (d) A provider shall comply with the requirements of 42  
6 U.S.C. 300gg-138.

7 (Source: P.A. 103-650, eff. 1-1-25.)

8 Section 10. The Managed Care Reform and Patient Rights Act  
9 is amended by changing Section 25 as follows:

10 (215 ILCS 134/25)

11 Sec. 25. Transition of services.

12 (a) A health care plan shall provide for continuity of  
13 care for its enrollees as follows:

14 (1) If an enrollee's health care provider leaves the  
15 health care plan's network of health care providers for  
16 reasons other than termination of a contract in situations  
17 involving imminent harm to a patient or a final  
18 disciplinary action by a State licensing board and the  
19 provider remains within the health care plan's service  
20 area, or if benefits provided under such health care plan  
21 with respect to such provider are terminated because of a  
22 change in the terms of the participation of such provider  
23 in such plan, or if a contract between a group health plan,  
24 as defined in Section 5 of the Illinois Health Insurance

1 Portability and Accountability Act, and a health care plan  
2 offered in connection with the group health plan is  
3 terminated and results in a loss of benefits provided  
4 under such plan with respect to such provider, the health  
5 care plan shall permit the enrollee to continue an ongoing  
6 course of treatment with that provider during a  
7 transitional period:

8 (A) of 90 days from the date of the notice of  
9 provider's termination from the health care plan to  
10 the enrollee of the provider's disaffiliation from the  
11 health care plan if the enrollee has an ongoing course  
12 of treatment; ~~or~~

13 (A-5) of 90 days from the date of the notice to the  
14 enrollee of the provider's disaffiliation from the  
15 health care plan if the enrollee has a confirmed  
16 appointment and the provider attests that the  
17 appointment was scheduled prior to the date of  
18 notification; or

19 (B) if the enrollee has entered the third  
20 trimester of pregnancy at the time of the provider's  
21 disaffiliation, that includes the provision of  
22 post-partum care directly related to the delivery.

23 (2) Notwithstanding the provisions in item (1) of this  
24 subsection, such care shall be authorized by the health  
25 care plan during the transitional period only if the  
26 provider agrees:

1 (A) to continue to accept reimbursement from the  
2 health care plan at the rates applicable prior to the  
3 start of the transitional period;

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

8 (C) to otherwise adhere to the health care plan's  
9 policies and procedures, including but not limited to  
10 procedures regarding referrals and obtaining  
11 preauthorizations for treatment.

12 (2.5) The provisions of this Section governing health  
13 care provided during the transition period do not apply if  
14 the provider or the enrollee as set forth in item (A-5) of  
15 paragraph (1) of this subsection (a) reschedules an  
16 appointment or schedules any follow up appointments after  
17 90 days from the date of notice provided in Section 20.

18 (3) During an enrollee's plan year, a health care plan  
19 shall not remove a drug from its formulary or negatively  
20 change its preferred or cost-tier sharing unless, at least  
21 60 days before making the formulary change, the health  
22 care plan:

23 (A) provides general notification of the change in  
24 its formulary to current and prospective enrollees;

25 (B) directly notifies enrollees currently  
26 receiving coverage for the drug, including information

1           on the specific drugs involved and the steps they may  
2           take to request coverage determinations and  
3           exceptions, including a statement that a certification  
4           of medical necessity by the enrollee's prescribing  
5           provider will result in continuation of coverage at  
6           the existing level; and

7           (C) directly notifies in writing through an  
8           electronic transmission the prescribing provider of  
9           all health care plan enrollees currently prescribed  
10          the drug affected by the proposed change; the notice  
11          shall include a one-page form by which the prescribing  
12          provider can notify the health care plan in writing or  
13          electronically that coverage of the drug for the  
14          enrollee is medically necessary.

15          The notification in paragraph (C) may direct the  
16          prescribing provider to an electronic portal through which  
17          the prescribing provider may electronically file a  
18          certification to the health care plan that coverage of the  
19          drug for the enrollee is medically necessary. The  
20          prescribing provider may make a secure electronic  
21          signature beside the words "certification of medical  
22          necessity", and this certification shall authorize  
23          continuation of coverage for the drug.

24          If the prescribing provider certifies to the health  
25          care plan either in writing or electronically that the  
26          drug is medically necessary for the enrollee as provided

1 in paragraph (C), a health care plan shall authorize  
2 coverage for the drug prescribed based solely on the  
3 prescribing provider's assertion that coverage is  
4 medically necessary, and the health care plan is  
5 prohibited from making modifications to the coverage  
6 related to the covered drug, including, but not limited  
7 to:

8 (i) increasing the out-of-pocket costs for the  
9 covered drug;

10 (ii) moving the covered drug to a more restrictive  
11 tier; or

12 (iii) denying an enrollee coverage of the drug for  
13 which the enrollee has been previously approved for  
14 coverage by the health care plan.

15 Nothing in this item (3) prevents a health care plan  
16 from removing a drug from its formulary or denying an  
17 enrollee coverage if the United States Food and Drug  
18 Administration has issued a statement about the drug that  
19 calls into question the clinical safety of the drug, the  
20 drug manufacturer has notified the United States Food and  
21 Drug Administration of a manufacturing discontinuance or  
22 potential discontinuance of the drug as required by  
23 Section 506C of the Federal Food, Drug, and Cosmetic Act,  
24 as codified in 21 U.S.C. 356c, or the drug manufacturer  
25 has removed the drug from the market.

26 Nothing in this item (3) prohibits a health care plan,

1 by contract, written policy or procedure, or any other  
2 agreement or course of conduct, from requiring a  
3 pharmacist to effect substitutions of prescription drugs  
4 consistent with Section 19.5 of the Pharmacy Practice Act,  
5 under which a pharmacist may substitute an interchangeable  
6 biologic for a prescribed biologic product, and Section 25  
7 of the Pharmacy Practice Act, under which a pharmacist may  
8 select a generic drug determined to be therapeutically  
9 equivalent by the United States Food and Drug  
10 Administration and in accordance with the Illinois Food,  
11 Drug and Cosmetic Act.

12 This item (3) applies to a policy or contract that is  
13 amended, delivered, issued, or renewed on or after January  
14 1, 2019. This item (3) does not apply to a health plan as  
15 defined in the State Employees Group Insurance Act of 1971  
16 or medical assistance under Article V of the Illinois  
17 Public Aid Code.

18 (b) A health care plan shall provide for continuity of  
19 care for new enrollees as follows:

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

26 (A) of 90 days from the effective date of

1 enrollment if the enrollee has an ongoing course of  
2 treatment; or

3 (A-5) of 90 days from the effective date of  
4 enrollment if the enrollee has a confirmed appointment  
5 and the current provider attests that the appointment  
6 was scheduled prior to the effective date of  
7 enrollment; or

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

12 (2) If an enrollee elects to continue to receive care  
13 from such physician pursuant to item (1) of this  
14 subsection, such care shall be authorized by the health  
15 care plan for the transitional period only if the  
16 physician agrees:

17 (A) to accept reimbursement from the health care  
18 plan at rates established by the health care plan;  
19 such rates shall be the level of reimbursement  
20 applicable to similar physicians within the health  
21 care plan for such services;

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

26 (C) to otherwise adhere to the health care plan's

1 policies and procedures including, but not limited to  
2 procedures regarding referrals and obtaining  
3 preauthorization for treatment.

4 (3) The provisions of this Section governing health  
5 care provided during a transition period do not apply if  
6 the provider or the enrollee as set forth in item (A-5) of  
7 paragraph (1) of this subsection (b) reschedules an  
8 appointment or schedules any follow up appointments after  
9 90 days from the date of enrollment.

10 (c) In no event shall this Section be construed to require  
11 a health care plan to provide coverage for benefits not  
12 otherwise covered or to diminish or impair preexisting  
13 condition limitations contained in the enrollee's contract. In  
14 no event shall this Section be construed to prohibit the  
15 addition of prescription drugs to a health care plan's list of  
16 covered drugs during the coverage year.

17 (d) In this Section, "ongoing course of treatment" has the  
18 meaning ascribed to that term in Section 5 of the Network  
19 Adequacy and Transparency Act.

20 (Source: P.A. 103-650, eff. 1-1-25.)

21 Section 99. Effective date. This Act takes effect January  
22 1, 2027."