



Illinois Department of Insurance

Fact Sheet

Provider Networks

Updated - December 2014

Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (Insurance industry) and interested parties should contact the Department.

When Shopping for health insurance, whether on or off the Marketplace, one of the most important considerations is the provider network. This fact sheet provides important information about provider networks used by the health insurance industry.

Types of Plans that Use Networks:

Preferred Provider Networks (PPO) vs. Health Maintenance Organization Networks (HMO)

PPOs:

1. Providers are not required to notify their patients if they are leaving a network;
2. Carriers are not required to notify their members if a provider is leaving a network;
3. Generally, there is not a designated primary care physician and referrals are not required; it is ALWAYS the patient's responsibility to verify that providers are within their network;
4. There is a benefit available if a member seeks services out of network; however, the benefit is not based on billed charges. Most carriers base the out of network benefit on a percentage of Medicare allowance or on a fee schedule which is far lower than usual and customary (see Out-of-Network Benefits – Proceed with Caution Fact Sheet);
5. Networks vary from PPO plan to PPO plan (even with the same carrier).

HMOs:

1. HMOs are required to give their members at least 60 days notice if their provider is leaving the network;
2. Members must select a primary care physician to direct all care. Referrals are required to see specialists (even in-network specialists);
3. There is no benefit available if members seek services without a referral from the primary care physician and/or Medical Director (except Woman's Principal Health Care Provider), whether in or out of network;
4. HMOs are required to provide members with a transitional care option with a provider to continue course of treatment if the member files such a request within 30 days of receiving notice of termination of the provider contract. (50 IL Admin Code 4520.60);
5. Networks may vary from HMO plan to HMO plan (even with same carrier).

General Information about Provider Networks

It is **IMPORTANT** to understand that the carrier may have multiple provider networks. As you are comparing plans, make sure you view the network which goes with the particular plan you are considering. Doctors, hospitals and other providers may be in one of the carrier's provider networks, but not in others.

For instance, you may notice that a carrier has three bronze level plans in your area which are priced differently. One of the differences is likely the provider network. The smaller networks are less expensive. The least expensive network is generally known as a Narrow Network. This network meets all adequacy requirements imposed by the federal and state laws; however, it has a more limited choice of providers.

As you look at each carrier's provider networks with this information in mind, you will notice the differences by looking at the number of primary care physicians and specialists that are available to you and the geographic locations of those providers. Obviously, the larger the network, the more choice you will have when you need medical services. Even if you do not currently have a health condition that warrants medical attention; pay attention to the specialists in the networks you are reviewing to ensure you are comfortable with them should the need arise.

Looking for specific provider(s)

When verifying a provider is within a network, follow these steps:

1. Call the carrier's customer service and request verification that the provider is within your plan.
2. Ask "Does Dr. Jones participate on Carrier's XYZ Network?" DO NOT ask, "Does Dr. Jones participate with this carrier?"
3. Verify online, if possible, if the provider contracts with your specific plan. Make sure you are viewing the network which goes with the plan you are considering. Take a screen shot of the information for your records (with a date included) in case questions arise later.
4. Ask the provider's office if they participate with your specific plan in your specific network with a carrier. Do not ask if they participate under the carrier only. Again, "Are you contracted on this carrier's XYZ Network?"

CAUTION: Many members mistakenly verify that a specific provider participates with a particular carrier, but neglect to verify that that provider contracts with a specific plan under that carrier. Unfortunately, the member's responsibility for services may be higher if the provider does not contract with their specific plan.

NOTE: Health care providers may leave the network during the year; the provider contract does not necessarily run concurrently with your health insurance contract year. If you are in a PPO plan, it is your responsibility to ensure your providers are still in the network before each visit.

What is Network Adequacy?

A "network" consists of the facilities, providers and suppliers a health insurer or plan has contracted with to provide health care services. Network adequacy refers to the ability of a health plan to provide its enrollees with timely access to a sufficient number and type of in-network providers, including primary care physicians, specialty physicians, and providers that treat substance use and mental health conditions.

Do All Plans Have to Meet Network Adequacy Requirements?

The Affordable Care Act (ACA) requires that all plans (referred to as "Qualified Health Plans" or "QHPs") sold on the Illinois Health Marketplace meet minimum network adequacy standards. All other individual and small group plans issued after January 1, 2014, even those not sold on the Illinois Health Marketplace, must meet the ACA network adequacy standards as well as the Illinois standards. Illinois standards exceed those of the ACA. Plans not subject to the ACA, such as grandfathered plans, transitional plans, and excepted benefit plans are subject to Illinois standards.

What are the Network Adequacy Standards?

Network adequacy standards aim to provide enrollees of plans accessibility to an adequate variety of providers.

Standards required under the ACA and Illinois law for qualified health plans and all non-excepted health plans effective on or after January 1, 2014:

1. **Essential Community Providers.** Under the ACA, the plan network must include a sufficient number and geographic distribution of Essential Community Providers to ensure reasonable and timely access to care. Essential Community Providers are providers that serve predominately low-income and medically underserved individuals.
2. **Provider Information.** Illinois law and the ACA require the plan to provide information to enrollees and prospective enrollees on the availability of both in-network and out-of-network providers, including information regarding whether a provider is accepting new patients.
3. **Sufficient Numbers and Types of Providers.** Illinois law and the ACA require the plan network have sufficient number and types of providers, including providers in medical areas that have historically raised network adequacy concerns, including:
 - a. Hospital systems
 - b. Mental health providers
 - c. Oncology providers
 - d. Primary care providers
4. **Access 24 hours a day/7 days a week.** Illinois law and the ACA require all networks have a sufficient number of primary care providers and specialists with hospital admitting privileges at facilities that are accessible 24 hours a day/7 days a week. In addition, there must be at least one hospital in-network located in each geographic county, if available.
5. **Choice of Healthcare Professional.** Illinois law and the ACA require plans which base benefits upon the utilization of a primary care physician (PCP), allow the enrollees to choose their PCP. If a plan designates a primary care physician, it must notify the enrollee of their right to change the designation.
6. **Greatest Travel Distance.** Under the ACA, the plan must ensure adequate access to healthcare, the distance from any point in the network's service area to a service provider can be no greater than:
 - a. In an urban area:
 1. 30-45 miles for primary care, OB-GYN and general hospital care providers
 2. 45-60 miles for specialist providers
 - b. In a rural area:
 1. 60-100 miles for primary care, OB-GYN and general hospital care providers
 2. 75-100 miles for specialist providers

Grandfathered plans, transitional plans and excepted benefit plans networks are subject to the requirements noted in numbers 2 through 6 above; however, Illinois uses a stricter standard for travel distance as explained below.

How Are Network Adequacy Standards Enforced?

Under the ACA, as part of the qualified health plan review process, DOI requires all Marketplace plans to meet the more stringent HMO network adequacy standards under Illinois state law. Carriers are required to submit the following information regarding their provider networks to the Department as part of the review process:

1. A geographic map of contracted providers;
2. A list of provider names, addresses, and specialties;
3. Ratios of providers to anticipated beneficiaries for primary care doctors and specialists;
4. Inclusion of primary care and specialist physicians with admitting privileges who are accessible 24/7;
5. A 30 miles/minutes travel distance for primary care physicians in urban areas (times and miles could be increased in rural areas);
6. Policies for closing and opening providers within the network;
7. Referral procedures, inclusion of essential community providers with geographic maps and a justification that a sufficient number and type are included in low-income areas; and
8. An online provider directory that identifies providers that are not accepting new patients with hard copies available upon request.

The Department also conducts plan oversight throughout the year to ensure the plans remain in compliance with network adequacy standards, including investigation of consumer complaints.

For grandfathered plans, transitional plans and excepted benefits plans, the Department reviews the networks for numbers 1 through 8 above; however, there is no Illinois requirement for inclusion of essential community providers.

What if a specific type of provider is not in-network under my plan?

For PPO plans, Illinois Administrative Code states “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 number, type or distance, the administrator 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.” (50 IL Admin Code 2051.310)

Member responsibility under this provision includes:

1. Verifying with their primary care physician and carrier that no providers with the required specialty are available in their network;
2. Obtaining written approval from the carrier indicating that claims for that provider will be paid with no greater cost to the beneficiary than if he/she had seen an in-network provider.

Carrier responsibility under this provision includes

1. Provide an adequate network as described above;
2. Provide a list of available providers within a specific provider type that are accepting patients to the member upon request;
3. Provide the member with an option to seek approval to see an out of network provider with no additional cost to the member than if the provider was in network under special circumstances.

For More Information

Call our Office of Consumer Health Insurance at 877-527-9431

<http://insurance.illinois.gov>