MEMO

To: Dana Popish Severinghaus, Acting Director, IL Department of Insurance

From: Laura Minzer, President, IL Life and Health Insurance Council

Cc: Joanna Coll, General Counsel, IL Department of Insurance
KC Stralka, Chief of Staff, IL Department of Insurance
Ryan Gillespie, Deputy Director of Health Products, IL Department of Insurance

Date: June 16, 2021

Subject: Health Maintenance Organization (HMO) Referral Requirements

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On behalf of our health insurance member plans, ILHIC respectfully submits this memo outlining our interpretation of current statutes and regulations governing HMO products in Illinois with respect to referral requirements.

HMO Act and Statutory Governance of "Referrals"

Illinois law requires that, "(n)o organization shall establish or operate a Health Maintenance Organization in this State without obtaining a certificate of authority…"[1] In order for DOI to authorize a certificate of authority, the Director of Public Health must certify that the HMO plan of operation meets the requirements of the HMO Act.[2]

77 Ill Adm Code 240.50(b) provides provision of care requirements necessary to acquire an HMO Certificate of Authority. While 77 Ill Adm Code 240.50(b) requires a description of an HMO referral system as part of the application, the referral system required for submission ***only*** refers to occasions where the enrollee needs services covered by the plan but care *is not available through participating in-network health professionals.* Language is absent regarding any additional requirement to provide a referral system for in-network providers. Therefore, to require the referral system for in-network providers would be outside of the scope and authority of the Illinois Department of Public Health (IDPH).

The Director of Public Health must determine that the applicant's proposed plan of operation meets the requirements of the HMO Act under 215 ILCS 215/2-2. Specifically, IDPH's Director must determine if the applicant has: 1. Demonstrated willingness and ability to assure the healthcare service will be provided in a manner to provide availability and accessibility of

[1] 215 ILCS 125/ 2-1
[2] *Id*.

adequate personnel and facilities and in a manner enhancing availability, accessibility, and continuity of service; and 2. Has arrangements, established in accordance with the regulations promulgated by the IDPH for an ongoing program concerning healthcare processes and outcomes.[3] The application process and determination procedures in statute do not include any requirement of providing an in-network referral system. In addition, as stated above, regulations promulgated by IDPH only require referral systems for out-of-network providers.

50 Ill Adm Code 4521.130 provides required standards to be considered Basic Health Care Services. Emergency treatment for mental health problems is the only referral requirement explicitly stated in rule.[4] The rule does describe referrals on a broader basis, but the language is permissive, leaving the HMO plan to require if referrals are necessary.[5] The rule does not explicitly address any requirement of in-network referral systems.

This permissive referral language is not an anomaly for HMO products as evidenced in 215 ILCS 134/40, which states that "…enrollee(s) ***may be*** required by the health care plan to select a specialist physician or other health care provider who has a referral arrangement with the enrollee's primary care physician or to select a new primary care physician who has a referral arrangement with the specialist physician or other health care provider chosen by the enrollee." There is no evidence to suggest that permissive language should result in an explicit in-network referral requirement. If in-network referral systems were required, the language would explicitly state as such, similar to emergency services in 50 Ill Adm Code 4521.130.

Finally, there is no additional language presented in the HMO Act of the Insurance Code that mandates referrals as part of the provision of providing services to enrollees. The only reference to a "referral" under the HMO Act (215 ILCS 125/) is in reference to point-of-service products wherein a POS product may not consider emergency services, authorized referral services, or non-routine services obtained out of the service are to be the point-of-service services; and furthermore, the POS product must track out-of-plan or non-point of service, out-of-plan emergency care, referral care, and urgent care out of the service area utilization.[6]

With the absence of any language mandating in-network referrals, ILHIC believes that IDPH does not possess the authority of requiring additional information that is not placed in statute or rule. Therefore, in-network referral systems should not be required to obtain a certificate of authority. Furthermore, the ability of HMOs to offer a network with referrals is further underscored by provisions set forth in the Managed Care and Patient Rights Act.

Managed Care and Patient Rights Act and Corresponding Regulations

The legislative history of HMOs in Illinois (and nationally) during the mid- to late-1990s was particularly challenged by views that these products were anti-consumer. During that time, Illinois legislators debated several bills that sought managed care reforms before they were finally successful in passing what is now known as the Managed Care and Patient Rights Act in

[3] 215 ILCS 125/ 2-2
[4] Section d of 50 Ill Adm Code 4521.130
[5] Section a of 50 Ill Adm Code 4521.130
[6] 215 ILCS 125/4.5-1

the 91st General Assembly. P.A. 91-0617, which took effect on January 1, 2000, included provisions aimed at providing greater consumer protections for those individuals enrolled in an HMO, including the provision that allowed for arrangements under which enrollees may access health care services from contracted providers ***without a referral or authorization from their primary care physician.***[7]

During legislative debate of SB 251, which would eventually become P.A. 91-0617, lawmakers made it clear that their intent was to provide "open access to contracted physicians within a healthcare plan's network."[8]

The provisions set forth in 215 ILCS 134/60 also gave authority to the Departments of Insurance and Public Health to promulgate rules to ensure appropriate access to and quality of care for enrollees in any plan that allows enrollees to access health care services from contractual providers without a referral or authorization from a primary care physician, and these rules ***may*** include, but shall not be limited to, a system for the retrieval and compilation of enrollees' medical records.[9]

The Department of Insurance did promulgate rules implementing this section, which is now 50 Ill. Adm Code 4520.100 that took effect, and has remained unchanged (except for recodification), since February 10, 2000.[10]

While those provisions state in Section 4520.100(b) "the health care plan's centralized record keeping system for access and quality of care shall be described in detail, filed with and deemed acceptable by the Director of Public Health," the provisions set forth in that Section of the Administrative Code appear duplicative of provisions set forth in 77 Ill Adm Code 240.40, 240.50, 240.60, and 240.90 that details the HMO provider site record keeping and provision of care requirements (including referrals to out-of-network care) that must be approved by IDPH as one of the qualifying requirements for the HMO to obtain a Certificate of Authority.

As set forth in 77 Ill Adm Code 240.30, the application requirements pertaining to information required by IDPH are described in Sections 240.40, 240.50, and 240.60. The provisions under 77 Ill Adm Code 240.40, 240.50, and 240.60 outline requirements regarding personnel, organization and providers, provision of care, and the self-evaluation structure demonstrating quality and availability and access to care that must be approved by the Director of Public Health for an HMO to obtain a Certificate of Authority.

Specifically, 77 Ill Adm Code 240.50(c) requires an application for an HMO Certificate of Authority to include a "description of the medical record system of the HMO or HMO providers" and in accordance with 245.50(c)(1) "[t]he medical records system shall be organized to facilitate retrieval and compilation of medical records information necessary to

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[7] 215 ILCS 134/60

[8] State of Illinois 91st General Assembly, House of Representatives Transcription Debate – 59th Legislative Day, May 26, 1999; Pg. 127: T052699.PDF (ilga.gov)

[9] Section 60, subsection (c) of the Managed Care and Patient Rights Act

[10] 24 Ill. Reg. 3374, eff. 2/10/00

provide continuity of care among various member and nonmember providers who are directly involved in the care of the enrollee."

Furthermore, 77 Ill Adm Code 240.40(b) requires applicants to file a "flow of care chart or narrative which illustrates the movement and contacts of the enrollees through the primary and specialty care physicians of the HMO care system."

ILHIC does not disagree that the regulations set forth under 50 Ill Adm Code 4520.100(b) could have been clearer as to how those provisions related back to IDPH's existing authority to require HMO Certificate of Authority applications to include a description of the medical record system used by the HMO and HMO providers to facilitate care. However, it stands to reason that if the Director of Public Health has approved the application for the certificate, including the medical record system that falls under its jurisdiction for review, then the system would have been deemed acceptable.

Conclusion

ILHIC and its member health plans respect the ability of our state agencies to review governing statutes and regulations to ensure interpretation and implementation are in line with the letter and spirit of the law. Practices and procedures that have been in place for 10 years or in this case, even 20 years, do not necessarily mean those practices and procedures were appropriately aligned with the law.

We would respectfully submit to you, however, that in this case we strongly believe the letter and spirit of the law is clear that when taken with the lack of statutory reference to referrals and stated legislative intent of the Managed Care and Patient Rights Act, consumers can have access to an HMO product that provides for "open access to contracted physicians within a healthcare plan's network."

Furthermore, when taken with existing authority granted to both the Departments of Public Health and Insurance to review and approve applications for HMO Certificates of Authority that must demonstrate the HMO and its providers can access medical records to ensure enrollees' care is appropriately facilitated, we believe those health care plans with an approved HMO Certificate of Authority have sufficiently demonstrated the mechanisms necessary to "provide or arrange for and pay for or reimburse the cost of basic health services" with or without referrals.[11]

Mandating additional requirements not explicitly stated in law discourages consumer coverage options in the marketplace, and we strongly believe runs counter to legislative intent explicitly set forth in the Managed Care and Patient Rights Act.

ILHIC welcomes further discussion on this matter with the Department and appropriate staff.

[11] 215 ILCS 125/1-2