HB1448

LRB104 04999 RPS 15027 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB1448

Introduced 1/28/2025, by Rep. Nabeela Syed - Lindsey LaPointe, Will Guzzardi and Dagmara Avelar

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.17 new
65 ILCS 5/10-4-2.9 new
105 ILCS 5/10-22.3g new
215 ILCS 5/370c.3 new
215 ILCS 125/5-3 from Ch. 111 1/2, par. 1411.2
215 ILCS 200/85
305 ILCS 5/5-5.12g new

Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026, shall not impose any prior authorization or utilization management controls on covered behavioral health services. Makes conforming changes to the State Employees Group Insurance Act of 1971, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, and the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Insurance and the Department of Healthcare and Family Services to establish a process for receiving complaints from providers and covered individuals for violations of the mandate. Grants the Department of Insurance and the Department of Healthcare and Family Services the authority to issue cease and desist orders and administrative fines. Amends the Prior Authorization Reform Act. Provides that the Department of Healthcare and Family Services shall adopt rules consistent with the Act. Provisions amending the Prior Authorization Reform Act are effective immediately.

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A BILL FOR

AN ACT concerning insurance.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by adding Section 6.17 as follows:

(5 ILCS 375/6.17 new)

Sec. 6.17. Behavioral health services; no utilization or prior approval mandates. The program of health benefits is subject to the provisions of Section 370c.3 of the Illinois Insurance Code prohibiting the implementation of prior authorization mandates or utilization management controls for the delivery of behavioral health services.

Section 10. The Illinois Municipal Code is amended by adding Section 10-4-2.9 as follows:

(65 ILCS 5/10-4-2.9 new)

Sec. 10-4-2.9. Behavioral health services; no utilization or prior approval mandates. The corporate authorities of all municipalities are subject to the provisions of Section 370c.3 of the Illinois Insurance Code prohibiting the implementation of prior authorization mandates or utilization management controls for the delivery of behavioral health services.

Section 15. The School Code is amended by adding Section 10-22.3g as follows:

(105 ILCS 5/10-22.3g new)

Sec. 10-22.3g. Behavioral health services; no utilization or prior approval mandates. Insurance protection and benefits for employees are subject to the provisions of Section 370c.3 of the Illinois Insurance Code prohibiting the implementation of prior authorization mandates or utilization management controls for the delivery of behavioral health services.

Section 20. The Illinois Insurance Code is amended by adding Section 370c.3 as follows:

(215 ILCS 5/370c.3 new)

Sec. 370c.3. Behavioral health services; no utilization or prior approval mandates.

(a) As used in this Section:

"Behavioral health service" means any service, including a preventive service, intended to treat a mental, emotional, nervous, or substance use disorder or condition across an individual's entire life span.

"Mental, emotional, nervous, or substance use disorder or condition" has the meaning given to that term in Section 370c.1 of this Code.

(b) For all group or individual policies of accident and health insurance or managed care plans that are amended, delivered, issued, or renewed on or after January 1, 2026, a health insurance issuer offering a health benefit plan in the State of Illinois shall not impose any prior authorization or utilization management controls on covered behavioral health services.

(c) This Section shall not be construed to conflict with any federal law, including, but not limited to, the federal Social Security Act or any implementing regulations, agreements, or decrees.

(d) The Department shall establish a process for receiving complaints from providers and covered individuals for violations of this Section. The Department shall timely review and investigate all complaints received in accordance with this Section. The Department shall adopt rules related to enforcement of this Section and post information about how providers can make complaints for violations of this Section on the Department's publicly available website.

(e) The Department shall enforce the provisions of this Section in accordance with the enforcement powers granted to it by law. The Department is granted the specific authority to issue a cease and desist order for violations of this Section. Subject to the provisions of the Illinois Administrative Procedure Act, the Department may impose upon a managed care organization an administrative fine not to exceed $250,000 for

failure to comply with the requirements of this Section or repeated violations of this Section.

Section 25. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

(Text of Section before amendment by P.A. 103-808)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75, 356z.77, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c,

368d, 368e, 370c, 370c.1, 370c.3, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other

acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance

of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit

or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751,

eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

(Text of Section after amendment by P.A. 103-808)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355.6, 355b, 355c, 356f, 356g, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 356z.71, <u>356z.72, 356z.73, 356z.74, 356z.75, 356z.77,</u> 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, <u>370c.3,</u> 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2,

XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not

apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its

enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or

enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised

11-26-24.)

Section 30. The Prior Authorization Reform Act is amended by changing Section 85 as follows:

(215 ILCS 200/85)

Sec. 85. Administration and enforcement.

(a) The Department shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law. To enforce the provisions of this Act, the Director is hereby granted specific authority to issue a cease and desist order or require a utilization review organization or health insurance issuer to submit a plan of correction for violations of this Act, or both, in accordance with the requirements and authority set forth in Section 85 of the Managed Care Reform and Patient Rights Act. Subject to the provisions of the Illinois Administrative Procedure Act, the Director may, pursuant to Section 403A of the Illinois Insurance Code, impose upon a utilization review organization or health insurance issuer an administrative fine not to exceed $250,000 for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this Act.

(b) Any person who believes that his or her utilization review organization or health insurance issuer is in violation of the provisions of this Act may file a complaint with the

Department. The Department shall review all complaints received and investigate all complaints that it deems to state a potential violation. The Department shall fairly, efficiently, and timely review and investigate complaints. Health insurance issuers and utilization review organizations found to be in violation of this Act shall be penalized in accordance with this Section.

(c) The Department of Healthcare and Family Services shall enforce the provisions of this Act as it applies to persons enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act and shall adopt rules consistent with this Act.

(Source: P.A. 102-409, eff. 1-1-22.)

Section 35. The Illinois Public Aid Code is amended by adding Section 5-5.12g as follows:

(305 ILCS 5/5-5.12g new)

Sec. 5-5.12g. Behavioral health services; no utilization or prior approval mandates.

(a) As used in this Section:

"Behavioral health service" means any service, including a preventive service, intended to treat a mental, emotional, nervous, or substance use disorder or condition across an individual's entire life span.

"Mental, emotional, nervous, or substance use disorder or

condition" has the meaning given to that term in Section 370c.1 of the Illinois Insurance Code.

(b) Notwithstanding any other provision of this Code to the contrary, for the purpose of removing barriers to the timely treatment of behavioral health conditions, including both mental health and substance use disorders, beginning on January 1, 2026, prior authorization, or any other utilization management controls, shall be prohibited under the fee-for-service and managed care medical assistance programs on any behavioral health service.

(c) This Section shall not be construed to conflict with any federal law, including, but not limited to, the federal Social Security Act or any implementing regulations, agreements, or decrees.

(d) The Department shall establish a process to accept complaints from providers or individuals eligible for medical assistance for any violations of this Section. The Department shall review and investigate all complaints received. The Department shall fairly, efficiently, and timely review and investigate complaints. The Department shall adopt rules related to enforcement of this Section and post information about how providers can make complaints for violations of this Section on the Department's publicly available website.

(e) The Department shall enforce the provisions of this Section in accordance with the enforcement powers granted to it by law. The Department is granted the specific authority to

issue a cease and desist order for violations of this Section. Subject to the provisions of the Illinois Administrative Procedure Act, the Department may impose upon a managed care organization an administrative fine not to exceed $250,000 for failure to comply with the requirements of this Section or repeated violations of this Section.

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 99. Effective date. This Section and Section 30 take effect upon becoming law.