HB4585

LRB104 17523 BAB 30950 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4585

Introduced 2/3/2026, by Rep. Lindsey LaPointe

SYNOPSIS AS INTRODUCED:

215 ILCS 5/370c from Ch. 73, par. 982c

Amends the Illinois Insurance Code. Provides that coverage for treatment in a residential treatment center shall include residential coverage for the diagnosis and treatment of substance use disorders. Provides that this coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings. Prohibits the coverage from applying financial requirements or treatment limitations to residential substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to other medical and surgical benefits covered by the policy. Sets forth provisions concerning cost sharing; application of coverage requirements; prior authorization; clinical review; discharge plans; other forms of utilization review; and the criteria for medical necessity determinations.

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A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Section 370c as follows:

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

Sec. 370c. Mental and emotional disorders.

(a)(1) On and after January 1, 2022 (the effective date of Public Act 102-579), every insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness shall provide coverage for the medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions consistent with the parity requirements of Section 370c.1 of this Code.

(2) Each insured that is covered for mental, emotional, nervous, or substance use disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance

Use Disorder Act of his or her choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his or her profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, licensed marriage and family therapists, licensed speech-language pathologists, and other licensed or certified professionals at programs licensed pursuant to the Substance Use Disorder Act, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, licensed

marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act has informed the patient of the desirability of the patient conferring with the patient's primary care physician.

(4) "Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the World Health Organization's International Classification of Disease or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. "Mental, emotional, nervous, or substance use disorder or condition" includes any mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(5) Medically necessary treatment and medical necessity determinations shall be interpreted and made in a manner that is consistent with and pursuant to subsections (h) through (y).

(b)(1) (Blank).

(2) (Blank).

(2.5) (Blank).

(3) Unless otherwise prohibited by federal law and

consistent with the parity requirements of Section 370c.1 of this Code, the insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance, a qualified health plan offered through the health insurance marketplace, or a provider of treatment of mental, emotional, nervous, or substance use disorders or conditions shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. Nothing in this paragraph (3) supersedes the prohibition on prior authorization requirements to the extent provided under subsections (g) and (w) and subparagraph (A) of paragraph (6.5) of this subsection. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for mental, emotional, nervous, or substance use disorders or conditions, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders.

(4) A group health benefit plan amended, delivered,

issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024) or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall provide coverage based upon medical necessity for the treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the parity requirements of Section 370c.1 of this Code; provided, however, that in each calendar year coverage shall not be less than the following:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A); and

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient

visits covered under the plan.

(C) (Blank).

(5) An issuer of a group health benefit plan or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(5.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after September 9, 2015 (the effective date of Public Act 99-480) shall offer coverage for medically necessary acute treatment services and medically necessary clinical stabilization services. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for substance use disorders in accordance with the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for medication-assisted treatment in accordance with the most current Treatment Criteria for Addictive,

Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

As used in this subsection:

"Acute treatment services" means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

"Clinical stabilization services" means 24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

"Prior authorization" has the meaning given to that term in Section 15 of the Prior Authorization Reform Act.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(6.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall not impose prior authorization requirements, including limitations on dosage, other than those established under the Treatment Criteria for Addictive,

Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine, on a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(B) shall not impose any step therapy requirements;

(C) shall place all prescription medications approved by the United States Food and Drug Administration prescribed or administered for the treatment of substance use disorders on, for brand medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers brand medications and, for generic medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers generic medications; and

(D) shall not exclude coverage for a prescription medication approved by the United States Food and Drug Administration for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

(7) (Blank).

(8) (Blank).

(9) With respect to all mental, emotional, nervous, or substance use disorders or conditions, coverage for inpatient

treatment shall include coverage for treatment in a residential treatment center certified or licensed by the Department of Public Health or the Department of Human Services.

(A) Coverage for treatment in a residential treatment center shall include residential coverage for the diagnosis and treatment of substance use disorders, including at American Society of Addiction Medicine levels of treatment 3.5 (Clinically Managed High-Intensity Residential) and 3.7 (Medically Managed Residential). This coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings. This coverage shall not apply financial requirements or treatment limitations, including concurrent or utilization review requirements, to residential substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to other medical and surgical benefits covered by the policy.

(B) Coverage for treatment in a residential treatment center may be subject to annual deductibles, coinsurance, or other cost sharing that is consistent with those imposed on other benefits covered by the policy.

(C) This paragraph (9) shall apply to facilities in this State that are licensed, certified, or otherwise authorized and participating in a provider network.

Coverage for treatment in a residential treatment center shall not be subject to prior authorization and shall not be subject to concurrent utilization review during the first 3 days of American Society of Addiction Medicine Level 3.7 and the first 28 days of American Society of Addiction Medicine Level 3.5 residential admission, so long as the facility notifies the insurer of both the admission and the initial treatment plan within 3 business days after admission. The facility shall perform clinical review of the patient, including consultation with the insurer at or just prior to the 14th day of treatment to ensure that the facility is using the American Society of Addiction Medicine review tool to ensure that the residential treatment is medically necessary for the patient.

(D) Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan, which shall describe arrangements for additional services needed following discharge from the residential facility, as determined using the evidence-based and peer-reviewed clinical review tool used by the insurer and designated by the relevant Illinois State agencies. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available.

(E) Any utilization review of treatment provided in a

residential treatment center may include a review of all services provided during such residential treatment, including all services provided during the first 35 days of residential treatment. The insurer shall only deny coverage for any portion of the initial 35-day residential treatment on the basis that the treatment was not medically necessary if the residential treatment was contrary to the evidence-based and peer-reviewed clinical review tool used by the insurer and designated by the relevant Illinois State agencies. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph (E), other than any copayment, coinsurance, or deductible otherwise required under the policy.

(F) The criteria for medical necessity determinations under the policy with respect to residential substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(c) This Section shall not be interpreted to require coverage for speech therapy or other habilitative services for those individuals covered under Section 356z.15 of this Code.

(d) With respect to a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace, the Department and, with respect to medical assistance, the

Department of Healthcare and Family Services shall each enforce the requirements of this Section and Sections 356z.23 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under, those Acts, including, but not limited to, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and final regulations applying the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans. Specifically, the Department and the Department of Healthcare and Family Services shall take action:

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers submit comparative analyses, as set forth in paragraph (6) of subsection (k) of Section 370c.1, demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits;

(2) evaluating all consumer or provider complaints regarding mental, emotional, nervous, or substance use

disorder or condition coverage for possible parity violations;

(3) performing parity compliance market conduct examinations or, in the case of the Department of Healthcare and Family Services, parity compliance audits of individual and group plans and policies, including, but not limited to, reviews of:

(A) nonquantitative treatment limitations, including, but not limited to, prior authorization requirements, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates, and geographic restrictions;

(B) denials of authorization, payment, and coverage; and

(C) other specific criteria as may be determined by the Department.

The findings and the conclusions of the parity compliance market conduct examinations and audits shall be made public.

The Director may adopt rules to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

(e) Availability of plan information.

(1) The criteria for medical necessity determinations made under a group health plan, an individual policy of accident and health insurance, or a qualified health plan

offered through the health insurance marketplace with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) The reason for any denial under a group health benefit plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace (or health insurance coverage offered in connection with such plan or policy) of reimbursement or payment for services with respect to mental, emotional, nervous, or substance use disorders or conditions benefits in the case of any participant or beneficiary must be made available within a reasonable time and in a reasonable manner and in readily understandable language by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary upon request.

(f) As used in this Section, "group policy of accident and health insurance" and "group health benefit plan" includes (1) State-regulated employer-sponsored group health insurance plans written in Illinois or which purport to provide coverage for a resident of this State; and (2) State, county,

municipal, or school district employee health plans. References to an insurer include all plans described in this subsection.

(g) (1) As used in this subsection:

"Benefits", with respect to insurers that are not Medicaid managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (High-Intensity Outpatient), 3.1 (Clinically Managed Low-Intensity Residential), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Managed Residential) and OMT (Opioid Maintenance Therapy) services.

"Benefits", with respect to Medicaid managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (High-Intensity Outpatient), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Managed Residential) and OMT (Opioid Maintenance Therapy) services.

"Substance use disorder treatment provider or facility" means a licensed physician, licensed psychologist, licensed psychiatrist, licensed advanced practice registered nurse, or licensed, certified, or otherwise State-approved facility or provider of substance use disorder treatment.

(2) A group health insurance policy, an individual health benefit plan, or qualified health plan that is offered through the health insurance marketplace, small employer group health plan, and large employer group health plan that is amended, delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State, on or after January 1, 2019 (the effective date of Public Act 100-1023) shall comply with the requirements of this Section and Section 370c.1. The services for the treatment and the ongoing assessment of the patient's progress in treatment shall follow the requirements of 77 Ill. Adm. Code 2060.

(3) Prior authorization shall not be utilized for the benefits under this subsection. Except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification, the insurer may require the substance use disorder treatment provider or facility to notify the insurer of the initiation of treatment. For an insurer that is not a Medicaid managed care organization, the substance use disorder treatment provider or facility may be required to give notification for the initiation of treatment of the covered person within 2 business days. For Medicaid managed care organizations, the substance use disorder treatment provider or facility may be required to give notification in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the Medicaid managed care

organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization. Treatment plans shall be developed in accordance with the requirements and timeframes established in 77 Ill. Adm. Code 2060. No such coverage shall be subject to concurrent review prior to the applicable notification deadline. If coverage is denied retrospectively, neither the provider or facility nor the insurer shall bill, and the covered individual shall not be liable, for any treatment under this subsection through the date the adverse determination is issued, other than any copayment, coinsurance, or deductible for the treatment or stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for benefits that were furnished at a participating substance use disorder facility prior to the applicable notification deadline except for the following:

(A) upon reasonable determination that the benefits were not provided;

(B) upon determination that the patient receiving the treatment was not an insured, enrollee, or beneficiary under the policy;

(C) upon material misrepresentation by the patient or provider. As used in this subparagraph (C), "material"

means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation;

(D) upon determination that a service was excluded under the terms of coverage. For situations that qualify under this subparagraph (D), the limitation to billing for a copayment, coinsurance, or deductible shall not apply;

(E) upon determination that a service was not medically necessary consistent with subsections (h) through (n); or

(F) upon determination that the patient did not consent to the treatment and that there was no court order mandating the treatment.

(4) For an insurer that is not a Medicaid managed care organization, if an insurer determines that benefits are no longer medically necessary, the insurer shall notify the covered person, the covered person's authorized representative, if any, and the covered person's health care provider in writing of the covered person's right to request an external review pursuant to the Health Carrier External Review Act. The notification shall occur within 24 hours following the adverse determination.

Pursuant to the requirements of the Health Carrier External Review Act, the covered person or the covered person's authorized representative may request an expedited external review. An expedited external review may not occur if

the substance use disorder treatment provider or facility determines that continued treatment is no longer medically necessary.

If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization shall make a final determination of medical necessity within 72 hours. If an independent review organization upholds an adverse determination, an insurer shall remain responsible to provide coverage of benefits through the day following the determination of the independent review organization. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(5) The substance use disorder treatment provider or facility shall provide the insurer with 7 business days' advance notice of the planned discharge of the patient from the substance use disorder treatment provider or facility and notice on the day that the patient is discharged from the substance use disorder treatment provider or facility.

(6) The benefits required by this subsection shall be provided to all covered persons with a diagnosis of substance use disorder or conditions. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection.

(7) Nothing in this subsection shall be construed to require an insurer to provide coverage for any of the benefits

in this subsection.

(8) Any concurrent or retrospective review permitted by this subsection must be consistent with the utilization review provisions in subsections (h) through (n).

(h) As used in this Section:

"Generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its

symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities in a manner that is all of the following:

(1) in accordance with the generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

"Utilization review" means either of the following:

(1) prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to insureds.

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is

covered as medically necessary for an insured.

"Utilization review criteria" means patient placement criteria or any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

(i)(1) Every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State and Medicaid managed care organizations providing coverage for hospital or medical treatment on or after January 1, 2023 shall, pursuant to subsections (h) through (s), provide coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions.

(2) An insurer shall not set a specific limit on the duration of benefits or coverage of medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions or limit coverage only to alleviation of the insured's current symptoms.

(3) All utilization review conducted by the insurer concerning diagnosis, prevention, and treatment of insureds diagnosed with mental, emotional, nervous, or substance use disorders or conditions shall be conducted in accordance with the requirements of subsections (k) through (w).

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this Section shall not rescind or modify the authorization after that provider

renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent cancellation or modification of the insured's or policyholder's contract, or the insured's or policyholder's eligibility. Nothing in this Section shall require the insurer to cover a treatment when the authorization was granted based on a material misrepresentation by the insured, the policyholder, or the provider. Nothing in this Section shall require Medicaid managed care organizations to pay for services if the individual was not eligible for Medicaid at the time the service was rendered. Nothing in this Section shall require an insurer to pay for services if the individual was not the insurer's enrollee at the time services were rendered. As used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results in or could result in a substantial change in the situation.

(j) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public

entitlement program. Nothing in this subsection shall be construed to require an insurer to cover benefits that have been authorized and provided for a covered person by a public entitlement program. Medicaid managed care organizations are not subject to this subsection.

(k) An insurer shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions on current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care. All denials and appeals shall be reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.

(l) In conducting utilization review of all covered health care services for the diagnosis, prevention, and treatment of mental, emotional, and nervous disorders or conditions, an insurer shall apply the criteria and guidelines set forth in the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty or, for Medicaid managed care organizations, criteria and guidelines determined by the Department of Healthcare and Family Services that are consistent with generally accepted standards of mental,

emotional, nervous or substance use disorder or condition care. Pursuant to subsection (b), in conducting utilization review of all covered services and benefits for the diagnosis, prevention, and treatment of substance use disorders an insurer shall use the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine.

(m) In conducting utilization review relating to level of care placement, continued stay, transfer, discharge, or any other patient care decisions that are within the scope of the sources specified in subsection (l), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the assessment of the insured using the relevant patient placement criteria as specified in subsection (l). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its assessment using the relevant criteria as specified in subsection (l) to the provider of the service and the patient.

If an insurer purchases or licenses utilization review criteria pursuant to this subsection, the insurer shall verify and document before use that the criteria were developed in accordance with subsection (k).

(n) In conducting utilization review that is outside the scope of the criteria as specified in subsection (l) or relates to the advancements in technology or in the types or levels of care that are not addressed in the most recent versions of the sources specified in subsection (l), an insurer shall conduct utilization review in accordance with subsection (k).

(o) This Section does not in any way limit the rights of a patient under the Medical Patient Rights Act.

(p) This Section does not in any way limit early and periodic screening, diagnostic, and treatment benefits as defined under 42 U.S.C. 1396d(r).

(q) To ensure the proper use of the criteria described in subsection (l), every insurer shall do all of the following:

(1) Educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the utilization review criteria.

(2) Make the educational program available to other stakeholders, including the insurer's participating or contracted providers and potential participants, beneficiaries, or covered lives. The education program must be provided at least once a year, in-person or digitally, or recordings of the education program must be made available to the aforementioned stakeholders.

(3) Provide, at no cost, the utilization review

criteria and any training material or resources to providers and insured patients upon request. For utilization review criteria not concerning level of care placement, continued stay, transfer, discharge, or other patient care decisions used by the insurer pursuant to subsection (m), the insurer may place the criteria on a secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access to insureds or their providers. No restrictions shall be placed upon the insured's or treating provider's access right to utilization review criteria obtained under this paragraph at any point in time, including before an initial request for authorization.

(4) Track, identify, and analyze how the utilization review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decision making that covers how medical necessity decisions are made; this assessment shall cover all aspects of utilization review as defined in subsection (h).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization review process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at

least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(8) Maintain documentation of interrater reliability testing and the remediation actions taken for those with pass rates lower than 90% and submit to the Department of Insurance or, in the case of Medicaid managed care organizations, the Department of Healthcare and Family Services the testing results and a summary of remedial actions as part of parity compliance reporting set forth in subsection (k) of Section 370c.1.

(r) This Section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions covered by an insurance policy, including prescription drugs.

(s) This Section applies to an insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and conducts utilization review as defined in this Section, including Medicaid managed care organizations, and any entity or contracting provider that performs utilization review or

utilization management functions on an insurer's behalf.

(t) If the Director determines that an insurer has violated this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty between $1,000 and $5,000 for each violation. Moneys collected from penalties shall be deposited into the Parity Advancement Fund established in subsection (i) of Section 370c.1.

(u) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this Section.

(v) The provisions of this Section are severable. If any provision of this Section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(w) Beginning January 1, 2026, coverage for medically necessary treatment of mental, emotional, or nervous disorders or conditions shall comply with the following requirements:

(1) No policy shall require prior authorization for outpatient or partial hospitalization services for treatment of mental, emotional, or nervous disorders or conditions provided by a physician licensed to practice medicine in all branches, a licensed clinical psychologist, a licensed clinical social worker, a

licensed clinical professional counselor, a licensed marriage and family therapist, a licensed speech-language pathologist, or any other type of licensed, certified, or legally authorized provider, including trainees working under the supervision of a licensed health care professional listed under this subsection, or facility whose outpatient or partial hospitalization services the policy covers for treatment of mental, emotional, or nervous disorders or conditions. Such coverage may be subject to concurrent and retrospective review consistent with the utilization review provisions in subsections (h) through (n) and Section 370c.1. Nothing in this paragraph (1) supersedes a health maintenance organization's referral requirement for services from nonparticipating providers. An insurer may require providers or facilities to notify the insurer of the initiation of treatment as specified in this subsection, except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification. No such coverage shall be subject to concurrent review for any services furnished before an applicable notification deadline, subject to the following:

(A) In the case of outpatient treatment, for an insurer that is not a Medicaid managed care organization, the insurer may set a notification

deadline of 2 business days after the initiation of the covered person's treatment. A Medicaid managed care organization may set a deadline of 24 hours after the initiation of treatment. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol within the 24-hour period following initiation, the treatment provider or facility shall have one additional business day to provide the notification to the Medicaid managed care organization.

(B) In the case of a partial hospitalization program, for an insurer that is not a Medicaid managed care organization, the insurer may set a notification deadline of 48 hours after the initiation of the covered person's treatment. A Medicaid managed care organization may set a deadline of 24 hours after the initiation of treatment. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following initiation, the treatment provider or facility shall have one additional business day to provide the notification to the Medicaid managed care organization.

(2) No policy shall require prior authorization for

inpatient treatment at a hospital for mental, emotional, or nervous disorders or conditions at a participating provider. Additionally, no such coverage shall be subject to concurrent review for the first 72 hours after admission, provided that the provider must notify the insurer of both the admission and the initial treatment plan within 48 hours of admission. A discharge plan must be fully developed and continuity services prepared to meet the patient's needs and the patient's community preference upon release. Recommended level of care placements identified in the discharge plan shall comply with generally accepted standards of care, as defined in subsection (h).

(A) If the provider satisfies the conditions of paragraph (2), then the insurer shall approve coverage of the recommended level of care, if applicable, upon discharge subject to concurrent review.

(B) Nothing in this paragraph supersedes a health maintenance organization's referral requirement for services from nonparticipating providers upon a patient's discharge from a hospital or facility.

(C) Concurrent review for such coverage must be consistent with the utilization review provisions in subsections (h) through (n).

(D) In this subsection, residential treatment that is not otherwise identified in the discharge plan is

not inpatient hospitalization.

(3) Treatment provided under this subsection may be reviewed retrospectively. If coverage is denied retrospectively, neither the insurer nor the participating provider shall bill, and the insured shall not be liable, for any treatment under this subsection through the date the adverse determination is issued, other than any copayment, coinsurance, or deductible for the stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for the first 72 hours of admission to inpatient hospitalization for treatment of mental, emotional, or nervous disorders or conditions, or before the applicable deadline under paragraph (1) of this subsection for outpatient treatment or partial hospitalization programs, at a participating provider except:

(A) upon reasonable determination that the inpatient mental health treatment was not provided;

(B) upon determination that the patient receiving the treatment was not an insured, enrollee, or beneficiary under the policy;

(C) upon material misrepresentation by the patient or health care provider. In this item (C), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation;

(D) upon determination that a service was excluded under the terms of coverage. In that case, the limitation to billing for a copayment, coinsurance, or deductible shall not apply;

(E) for outpatient treatment or partial hospitalization programs only, upon determination that a service was not medically necessary consistent with subsections (h) through (n); or

(F) upon determination that the patient did not consent to the treatment and that there was no court order mandating the treatment.

Nothing in this subsection shall be construed to require a policy to cover any health care service excluded under the terms of coverage.

This subsection does not apply to coverage for any prescription or over-the-counter drug.

Nothing in this subsection shall be construed to require the medical assistance program to reimburse for services not covered by the medical assistance program as authorized by the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(x) Notwithstanding any provision of this Section, nothing shall require the medical assistance program under Article V of the Illinois Public Aid Code or the Children's Health Insurance Program Act to violate any applicable federal laws, regulations, or grant requirements, including requirements for

utilization management, or any State or federal consent decrees. Nothing in subsection (g) or (w) shall prevent the Department of Healthcare and Family Services from requiring a health care provider to use specified level of care, admission, continued stay, or discharge criteria, including, but not limited to, those under Section 5-5.23 of the Illinois Public Aid Code, as long as the Department of Healthcare and Family Services, subject to applicable federal laws, regulations, or grant requirements, including requirements for utilization management, does not require a health care provider to seek prior authorization or concurrent review from the Department of Healthcare and Family Services, a Medicaid managed care organization, or a utilization review organization under the circumstances expressly prohibited by subsections (g) and (w). Nothing in this Section prohibits a health plan, including a Medicaid managed care organization, from conducting reviews for medical necessity, clinical appropriateness, safety, fraud, waste, or abuse and reporting suspected fraud, waste, or abuse according to State and federal requirements. Nothing in this Section limits the authority of the Department of Healthcare and Family Services or another State agency, or a Medicaid managed care organization on the State agency's behalf, to (i) implement or require programs, services, screenings, assessments, tools, or reviews to comply with applicable federal law, federal regulation, federal grant requirements, any State or federal

consent decrees or court orders, or any applicable case law, such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii) administer or require programs, services, screenings, assessments, tools, or reviews established under State or federal laws, rules, or regulations in compliance with State or federal laws, rules, or regulations, including, but not limited to, the Children's Mental Health Act and the Mental Health and Developmental Disabilities Administrative Act.

(y) (Blank).

(Source: P.A. 103-426, eff. 8-4-23; 103-650, eff. 1-1-25; 103-1040, eff. 8-9-24; 104-28, eff. 1-1-26; 104-417, eff. 8-15-25.)