



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

HB4709

by Rep. Rita Mayfield

#### SYNOPSIS AS INTRODUCED:

New Act

215 ILCS 5/356z.66

215 ILCS 5/370c

215 ILCS 124/10

305 ILCS 5/5-5.12e

215 ILCS 200/Act rep.

from Ch. 73, par. 982c

Creates the Standardized Prior Authorization Act. Requires a health insurance issuer to maintain a complete list of services for which prior authorization is required and to make any current prior authorization requirements and restrictions readily accessible and conspicuously posted on its website or online portals to enrollees, health care professionals, and health care providers. Sets forth further provisions concerning disclosure and review of prior authorization requirements; standard prior authorizations; expedited prior authorizations; notifications of adverse determinations; appeals of adverse determinations; prohibitions on revocation of prior authorization and nonpayment by a health insurance issuer; the length of approvals; approvals for chronic conditions; continuity of prior approvals; and enforcement and administration of the Act. Requires a health insurance issuer to periodically review its prior authorization requirements and consider removal of prior authorization requirements. Provides that a failure by a health insurance issuer to comply with the deadlines and other requirements specified in the Act shall result in any health care services subject to review to be automatically deemed authorized by the health insurance issuer or its contracted private review agent. Establishes reporting and notification requirements for health insurance issuers. Grants rulemaking authority to the Department of Insurance. Repeals the Prior Authorization Reform Act. Amends the Illinois Insurance Code and the Illinois Public Aid Code to make conforming changes. Effective January 1, 2027.

LRB104 17431 BAB 30856 b

1 AN ACT concerning regulation.

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

4 Section 1. Short title. This Act may be cited as the  
5 Standardized Prior Authorization Act.

6 Section 5. Purpose. The purpose of this Act is to regulate  
7 prior authorization by:

8 (1) protecting the health care professional-patient  
9 relationship from unreasonable third-party interference;

10 (2) preventing prior authorization programs from  
11 hindering the independent medical judgment of a physician  
12 or other health care provider; and

13 (3) ensuring the transparency of a fair and consistent  
14 process for health care providers and their patients.

15 Section 10. Applicability and scope. This Act applies to  
16 health insurance coverage as defined in the Illinois Health  
17 Insurance Portability and Accountability Act, and policies  
18 issued or delivered in this State to the Department of  
19 Healthcare and Family Services and providing coverage to  
20 persons who are enrolled under Article V of the Illinois  
21 Public Aid Code or under the Children's Health Insurance  
22 Program Act, amended, delivered, issued, or renewed on or

1 after the effective date of this Act, except employee or  
2 employer self-insured health benefit plans under the federal  
3 Employee Retirement Income Security Act of 1974 or health care  
4 provided pursuant to the Workers' Compensation Act or the  
5 Workers' Occupational Diseases Act. This Act does not diminish  
6 a health care plan's duties and responsibilities under other  
7 federal or State law or rules adopted pursuant to those laws.  
8 This Act is not intended to alter or impede the provisions of  
9 any consent decree or judicial order to which the State or any  
10 of its agencies is a party.

11 Section 15. Definitions. In this Act, unless the context  
12 requires otherwise:

13 "Adverse determination" means a determination by a health  
14 insurance issuer that, based on the information provided, a  
15 pre-service request for a benefit under the health insurance  
16 issuer's health benefit plan upon application of any  
17 utilization review technique does not meet the health  
18 insurance issuer's requirements for medical necessity,  
19 appropriateness, health care setting, level of care, or  
20 effectiveness or is determined to be experimental or  
21 investigational and the requested benefit is therefore denied.

22 "Appeal" means a formal request, either orally or in  
23 writing, to reconsider an adverse determination.

24 "Approval" means a determination by a health insurance  
25 issuer that a health care service has been reviewed and, based

1 on the information provided, satisfies the health insurance  
2 issuer's requirements for medical necessity and  
3 appropriateness.

4 "Clinical review criteria" means the written screening  
5 procedures, decision abstracts, clinical protocols, and  
6 practice guidelines used by a health insurance issuer to  
7 determine the necessity and appropriateness of health care  
8 services.

9 "Department" means the Department of Insurance.

10 "Emergency medical condition" means a medical condition  
11 manifesting itself through acute symptoms of sufficient  
12 severity, including, but not limited to, severe pain, such  
13 that a prudent layperson who possesses an average knowledge of  
14 health and medicine could reasonably expect the absence of  
15 immediate medical attention to result in:

16 (1) placing the health of the individual or, with  
17 respect to a pregnant woman, the health of the woman or her  
18 unborn child in serious jeopardy;

19 (2) serious impairment to bodily functions; or

20 (3) serious dysfunction of any bodily organ or part.

21 "Emergency services" means health care items and services  
22 furnished or required to evaluate and treat an emergency  
23 medical condition.

24 "Enrollee" means any person and the person's dependents  
25 enrolled in or covered by a health care plan.

26 "Expedited prior authorization request" means a request

1 for prior authorization of a health care service when, in the  
2 opinion of a treating health care professional or health care  
3 provider with knowledge of the enrollee's medical condition,  
4 nonexpedited prior authorization:

5 (1) could seriously jeopardize the life or health of  
6 the enrollee or the ability of the enrollee to regain  
7 maximum function;

8 (2) could subject the enrollee to severe pain that  
9 cannot be adequately managed without the care or treatment  
10 that is the subject of the utilization review; or

11 (3) could lead to a likely onset of an emergency  
12 medical condition if the service is not rendered during  
13 the time period to render a prior authorization  
14 determination for an urgent medical service.

15 "Expedited prior authorization request" does not include  
16 emergency services.

17 "Health care professional" means a physician licensed to  
18 practice medicine under the Medical Practice Act of 1987, a  
19 nurse licensed under the Nurse Practice Act, a physician  
20 assistant licensed under the Physician Assistant Practice Act  
21 of 1987, or any other individual that is licensed or otherwise  
22 authorized to deliver health care services.

23 "Health care provider" means any physician, hospital,  
24 ambulatory surgical treatment center, or other person or  
25 facility that is licensed or otherwise authorized to deliver  
26 health care services.

1 "Health care service" means any service or level of  
2 service included in the furnishing to an individual of medical  
3 care or the hospitalization incident to the furnishing of such  
4 care, as well as the furnishing to any person of any other  
5 services for the purpose of preventing, diagnosing, screening  
6 for, alleviating, curing, or healing human illness or injury,  
7 including behavioral health, mental health, home health and  
8 pharmaceutical services, products, and medications.

9 "Health insurance issuer" has the meaning given to that  
10 term in Section 5 of the Illinois Health Insurance Portability  
11 and Accountability Act.

12 "Medically necessary" means when a health care  
13 professional exercising prudent clinical judgment would  
14 provide care to a patient for the purpose of preventing,  
15 diagnosing, or treating an illness, injury, or a disease or  
16 its symptoms that are:

17 (1) in accordance with generally accepted standards of  
18 medical practice; and

19 (2) clinically appropriate in terms of type,  
20 frequency, extent, site, and duration and are considered  
21 effective for the patient's illness, injury, or disease;  
22 and not primarily for the convenience of the patient,  
23 treating physician, other health care professional,  
24 caregiver, family member, or other interested party, and  
25 focused on what is best for the patient's health outcome.

26 "NCPDP SCRIPT Standard" means the National Council for

1 Prescription Drug Programs SCRIPT Standard Version 2017071 or  
2 the most recent Standard adopted by the United States  
3 Department of Health and Human Services. "NCPDP SCRIPT  
4 Standard" includes subsequently released versions of the NCPDP  
5 SCRIPT Standard.

6 "Physician" means any person licensed by the State of  
7 Illinois to practice medicine in all its branches. "Physician"  
8 includes any person holding a temporary license, as provided  
9 in the Medical Practice Act of 1987.

10 "Prior authorization" means the process by which a health  
11 insurance issuer determines the medical necessity and medical  
12 appropriateness of an otherwise covered health care service  
13 before rendering the health care service. "Prior  
14 authorization" includes any notification required of an  
15 enrollee, health care professional, or health care provider by  
16 the health insurance issuer before, at the time of, or  
17 concurrent with providing a health care service, regardless of  
18 whether explicit approval is requested by the health insurance  
19 issuer.

20 "Private review agent" means a third-party entity hired by  
21 a health insurance issuer to perform utilization review.

22 "Utilization review" means to assess the medical  
23 necessity, appropriateness, and cost-effectiveness of health  
24 care services for prior authorization, concurrent review, or  
25 retrospective auditing.

1           Section 20. Disclosure and review of prior authorization  
2 requirements.

3           (a) A health insurance issuer shall maintain a complete  
4 list of services for which prior authorization is required,  
5 including for all services where prior authorization is  
6 performed by an entity under contract with the health  
7 insurance issuer.

8           (b) A health insurance issuer shall make any current prior  
9 authorization requirements and restrictions, including written  
10 clinical review criteria, readily accessible and conspicuously  
11 posted on its website or online portals to enrollees, health  
12 care professionals, and health care providers. Content  
13 published by a third party and licensed for use by a health  
14 insurance issuer may be made available through the health  
15 insurance issuer's secure, password-protected website or  
16 online portals, so long as the access requirements of the  
17 website do not unreasonably restrict access. Requirements  
18 shall be described in detail, written in easily understandable  
19 language, and readily available to the health care  
20 professional and health care provider at the point of care.  
21 The website shall indicate for each service subject to prior  
22 authorization:

23           (1) when prior authorization became required for  
24 policies issued or health benefit plan documents delivered  
25 in Illinois, including the effective date or dates and the  
26 termination date or dates, if applicable, in Illinois;

1           (2) the date the Illinois-specific requirement was  
2 listed on the health insurance issuer's, health benefit  
3 plan's, or private review agent's website; and

4           (3) when applicable, access to a standardized  
5 electronic prior authorization request transaction  
6 process.

7           (c) The clinical review criteria must:

8           (1) be consistent with nationally accepted standards  
9 generally recognized by physicians and health care  
10 providers practicing in relevant medical and clinical  
11 specialties except where state law provides its own  
12 standard;

13           (2) be developed in accordance with the current  
14 standards of a national medical accreditation entity;

15           (3) ensure quality of care and access to needed health  
16 care services;

17           (4) use evidence based on sources, such as  
18 peer-reviewed scientific studies;

19           (5) be sufficiently flexible to allow deviations from  
20 norms when justified on a case-by-case basis; and

21           (6) be evaluated and updated, if necessary, at least  
22 annually.

23           (d) A health insurance issuer shall not deny a claim for  
24 failure to obtain prior authorization if the prior  
25 authorization requirement was not in effect on the date of  
26 service on the claim or if prior authorization requirements

1 were not publicly disclosed by the plan on the health  
2 insurance issuer's website or other materials.

3 (e) A health insurance issuer shall not deem as incidental  
4 or deny supplies or health care services that are routinely  
5 used as part of a health care service when:

6 (1) an associated health care service has received  
7 prior authorization; or

8 (2) prior authorization for the health care service is  
9 not required.

10 (f) If a health insurance issuer intends either to  
11 implement a new prior authorization requirement or restriction  
12 or amend an existing requirement or restriction, the health  
13 insurance issuer shall provide impacted enrollees, contracted  
14 health care professionals, and contracted health care  
15 providers of enrollees written notice of the new or amended  
16 requirement or amendment no less than 60 days before the  
17 requirement or restriction is implemented. Written notice may  
18 take the form of a conspicuous notice posted on the health  
19 insurance issuer's public website or portal for contracted  
20 health care professionals and contracted health care  
21 providers, or email notice to health care professionals or  
22 providers. A health insurance issuer shall provide email  
23 notices to all impacted enrollees and to health care  
24 professionals or health care providers if the health care  
25 professional or health care provider has requested to receive  
26 the notice through email. A new or amended requirement shall

1 not be implemented unless the health insurance issuer's  
2 website has been updated to reflect the new or amended  
3 requirement or restriction. Written notice of a new, amended,  
4 or restricted prior authorization requirement, as required by  
5 this subsection (f), may be provided less than 60 days in  
6 advance if a health insurance issuer determines and  
7 contemporaneously notifies the Department in writing that:

8 (1) the health insurance issuer has identified  
9 fraudulent or abusive practices related to the health care  
10 service;

11 (2) the health care service is unavailable or scarce,  
12 which necessitates the use of an alternative health care  
13 service;

14 (3) the health care service is newly introduced to the  
15 health care market, and a delay in providing coverage for  
16 the health care service would not be in the best interest  
17 of enrollees;

18 (4) the health care service is the subject of a  
19 clinical trial authorized by the United States Food and  
20 Drug Administration;

21 (5) changes to the health care service or its  
22 availability are otherwise required by law to be made by  
23 the health insurance issuer in less than 60 days; or

24 (6) the prior authorization requirement is being  
25 removed.

26 (g) Health insurance issuers using prior authorization

1 shall make statistics available regarding prior authorization  
2 approvals and denials on the health insurance issuer's website  
3 in a readily accessible format. Following each calendar year,  
4 the statistics must be updated annually by June 1 and include  
5 all of the following information:

6 (1) a list of all health care services, including  
7 medications, that are subject to prior authorization;

8 (2) the percentage of standard prior authorization  
9 requests that were approved, aggregated for all items and  
10 services;

11 (3) the percentage of standard prior authorization  
12 requests that were denied, aggregated for all items and  
13 services;

14 (4) the percentage of prior authorization requests  
15 that were approved, aggregated for all items and services;

16 (5) the percentage of prior authorization requests for  
17 which the time frame for review was extended, and the  
18 request was approved, aggregated for all items and  
19 services;

20 (6) the percentage of expedited prior authorization  
21 requests that were approved, aggregated for all items and  
22 services;

23 (7) the percentage of expedited authorization requests  
24 that were denied, aggregated for all items and services;

25 (8) the average and median time that elapsed between  
26 the submission of a request and a determination by the

1 payer, plan, or health insurance issuer for standard prior  
2 authorization, aggregated for all items and services; and

3 (9) the average and median time that elapsed between  
4 the submission of a request and a decision by the payer,  
5 plan, or health insurance issuer for expedited prior  
6 authorization, aggregated for all times and services.

7 (h) In the case of a prior authorization request for a  
8 clinical laboratory test, a health insurance issuer must  
9 accept a prior authorization request prior to the date of  
10 specimen collection or at any time between the date of  
11 specimen collection and the date on which a timely claim for  
12 reimbursement is submitted to the health insurance issuer.

13 (i) A health insurance issuer may request from a provider  
14 or supplier only medical or other documentation that is  
15 reasonably necessary to evaluate a prior authorization  
16 request.

17 Section 25. Standardized electronic prior authorization  
18 request transaction process.

19 (a) On and after January 1, 2028, and until December 31,  
20 2028, if any health insurance issuer requires prior  
21 authorization of a health care service, the health insurance  
22 issuer's or its designee's utilization review organization  
23 shall make available a standardized electronic prior  
24 authorization request transaction process using an Internet  
25 webpage, Internet webpage portal, or similar Internet-based

1 system. On and after January 1, 2029, a health insurance  
2 issuer must accept and respond to prior authorization requests  
3 under the pharmacy benefit through a secure electronic  
4 transmission using NCPDP SCRIPT Standard ePA transactions.

5 (b) On and after January 1, 2029, all health care  
6 professionals and health care providers shall be required to  
7 use the standardized electronic prior authorization request  
8 transaction process made available as required by subsection  
9 (a).

10 Section 30. Standard prior authorizations.

11 (a) As used in this Section, "necessary information"  
12 includes the results of any face-to-face clinical evaluation,  
13 second opinion, or other clinical information that is directly  
14 applicable to the requested service that may be required.

15 (b) If a health insurance issuer requires prior  
16 authorization of a health care service, the health insurance  
17 issuer must make an approval or adverse determination and  
18 notify the enrollee and the enrollee's health care  
19 professional or provider of the approval or adverse  
20 determination as expeditiously as the enrollee's condition  
21 requires but no later than 5 calendar days after obtaining all  
22 necessary information to make the approval or adverse  
23 determination, unless a longer minimum time frame is required  
24 under federal law for the health insurance issuer and the  
25 health care service at issue.

1           (c) Notwithstanding any other provision of this Section,  
2 health insurance issuers must comply with the requirements of  
3 the Illinois Insurance Code that apply to prior authorization  
4 requirements for pharmaceutical services.

5           Section 35. Expedited prior authorizations.

6           (a) If requested by a treating health care provider or  
7 health care professional for an enrollee, a health insurance  
8 issuer must render an approval or adverse determination  
9 concerning urgent health care services and notify the enrollee  
10 and the enrollee's health care professional or provider of  
11 that approval or adverse determination as expeditiously as the  
12 enrollee's condition requires but no later than 24 hours after  
13 receiving all information needed to complete the review of the  
14 requested health care services, unless a longer minimum time  
15 frame is required under federal law for the health insurance  
16 issuer and the urgent health care service at issue.

17           (b) To facilitate the rendering of a prior authorization  
18 determination in conformance with this Section, a health  
19 insurance issuer must establish a mechanism to ensure health  
20 care professionals have access to appropriately trained and  
21 licensed physicians of the same specialty for consultation who  
22 are designated by the plan to make such determinations for  
23 prior authorization concerning urgent care services.

24           Section 40. Notifications of adverse determinations;

1 appeals. If a health insurance issuer makes an adverse  
2 determination, the health insurance issuer shall include the  
3 following in the notification to the enrollee and the  
4 enrollee's health care professional or health care provider:

5 (1) the reasons for the adverse determination and  
6 related evidence-based criteria, including a description  
7 of any missing or insufficient documentation;

8 (2) the right to appeal the adverse determination;

9 (3) instructions on how to file the appeal; and

10 (4) additional documentation necessary to support the  
11 appeal.

12 Section 45. Personnel qualified to review appeals. A  
13 health insurance issuer must ensure that all appeals are  
14 reviewed by a physician when the request is by a physician or a  
15 representative of a physician. The physician must:

16 (1) possess a current and valid unrestricted license  
17 to practice medicine with substantially similar licensing  
18 requirements to this State;

19 (2) be certified by the boards of the American Board  
20 of Medical Specialties or the American Board of Osteopathy  
21 within the relevant specialty of a physician who typically  
22 manages the medical condition or disease;

23 (3) have training, knowledge, or experience of  
24 providing the health care services under appeal;

25 (4) not have been directly involved in making the

1 adverse determination; and

2 (5) consider all known clinical aspects of the health  
3 care service under review, including a review of all  
4 pertinent medical records provided to the health insurance  
5 issuer by the enrollee's health care professional or  
6 health care provider, the health plan's clinical  
7 guidelines, as well as peer-reviewed scientific studies.

8 Section 50. Health insurance issuer review of prior  
9 authorization requirements. A health insurance issuer shall  
10 periodically review its prior authorization requirements and  
11 consider removal of prior authorization requirements.

12 Section 55. Revocation of prior authorizations.

13 (a) A health insurance issuer may not revoke or further  
14 limit, condition, or restrict a previously issued prior  
15 authorization approval while it remains valid under this Act  
16 unless:

17 (1) the health insurance issuer has identified  
18 fraudulent or abusive practices related to the health care  
19 service;

20 (2) the health care service is unavailable, which  
21 necessitates the use of an alternative health care  
22 service;

23 (3) the health care service is the subject of a new  
24 safety alert from the United States Food and Drug

1 Administration or is in response to a public health  
2 emergency;

3 (4) the change is based on nationally recognized,  
4 generally accepted standards developed in accordance with  
5 current standards of a national medical accreditation  
6 entity or specialty society; or

7 (5) changes to the health care service or its  
8 availability are otherwise required by law to be made by  
9 the health insurance issuer in less than 60 days.

10 (b) Notwithstanding any other provision of law, if a claim  
11 is properly coded and submitted timely to a health insurance  
12 issuer, the health insurance issuer shall make payment  
13 according to the terms of coverage on claims for health care  
14 services for which prior authorization was required and  
15 approval received before the rendering of health care  
16 services, unless one of the following occurs:

17 (1) it is determined that the enrollee's health care  
18 professional or health care provider knowingly and without  
19 exercising prudent clinical judgment provided health care  
20 services that required prior authorization from the health  
21 insurance issuer or its contracted private review agent  
22 without first obtaining prior authorization for those  
23 health care services;

24 (2) it is timely determined that the health care  
25 services claimed were not performed;

26 (3) it is timely determined that the health care

1 services rendered were contrary to the instructions of the  
2 health insurance issuer or its contracted private review  
3 agent or delegated reviewer if contact was made between  
4 those parties before the service being rendered;

5 (4) it is timely determined that the enrollee  
6 receiving such health care services was not an enrollee of  
7 the health care plan; or

8 (5) the approval was based upon a material  
9 misrepresentation by the enrollee, health care  
10 professional, or health care provider; as used in this  
11 paragraph, "material" means a fact or situation that would  
12 have resulted in a substantial change in the determination  
13 had it accurately been disclosed in the submission.

14 (c) Nothing in this Section shall preclude a private  
15 review agent or a health insurance issuer from performing  
16 post-service reviews of health care claims for purposes of  
17 payment integrity or for the prevention of fraud, waste, or  
18 abuse.

19 Section 60. Length of approvals.

20 (a) A prior authorization approval shall be valid for the  
21 lesser of 12 months after the date the health care  
22 professional or health care provider receives the prior  
23 authorization approval or the length of the treatment as  
24 determined by the patient's health care professional. However,  
25 a health insurance issuer and an enrollee or the enrollee's

1 health care professional may extend a prior authorization  
2 approval for a longer period, by agreement. All dosage  
3 increases must be based on established evidentiary standards,  
4 and nothing in this Section shall prohibit a health insurance  
5 issuer from having safety edits in place. This Section shall  
6 not apply to the prescription of benzodiazepines or Schedule  
7 II narcotic drugs, such as opioids.

8 (b) Nothing in this Section shall require a policy or plan  
9 to cover any care, treatment, or services for any health  
10 condition that the terms of coverage otherwise completely  
11 exclude from the policy's or plan's covered benefits without  
12 regard for whether the care, treatment, or services are  
13 medically necessary.

14 Section 65. Approvals for chronic conditions.

15 (a) If a health insurance issuer requires a prior  
16 authorization for a recurring health care service or  
17 maintenance medication for the treatment of a chronic or  
18 long-term condition, including, but not limited to,  
19 chemotherapy for the treatment of cancer, the approval shall  
20 remain valid for the lesser of 12 months from the date the  
21 health care professional or health care provider receives the  
22 prior authorization approval or the length of the treatment as  
23 determined by the patient's health care professional. However,  
24 a health insurance issuer and an enrollee or the enrollee's  
25 health care professional may extend a prior authorization

1 approval for a longer period, by agreement. This Section shall  
2 not apply to the prescription of benzodiazepines or Schedule  
3 II narcotic drugs, such as opioids.

4 (b) Nothing in this Section shall require a policy or plan  
5 to cover any care, treatment, or services for any health  
6 condition that the terms of the coverage otherwise completely  
7 exclude from the policy's or plan's covered benefits without  
8 regard for whether the care, treatment, or services are  
9 medically necessary.

10 Section 70. Continuity of prior approvals.

11 (a) On receipt of information documenting a prior  
12 authorization approval from the enrollee or from the  
13 enrollee's health care professional or health care provider, a  
14 health insurance issuer shall honor a prior authorization  
15 granted to an enrollee from a previous health insurance issuer  
16 for at least the initial 90 days of an enrollee's coverage  
17 under a new health plan, subject to the terms of the member's  
18 coverage agreement.

19 (b) During the time period described in subsection (a), a  
20 health insurance issuer may perform its own review to grant a  
21 prior authorization approval subject to the terms of the  
22 member's coverage agreement.

23 (c) If there is a change in coverage of or approval  
24 criteria for a previously authorized health care service, the  
25 change in coverage or approval criteria does not affect an

1 enrollee who received prior authorization approval before the  
2 effective date of the change for the remainder of the  
3 enrollee's plan year.

4 (d) Except to the extent required by medical exceptions  
5 processes for prescription drugs, nothing in this Section  
6 shall require a policy or plan to cover any care, treatment, or  
7 services for any health condition that the terms of coverage  
8 otherwise completely exclude from the policy's or plan's  
9 covered benefits without regard for whether the care,  
10 treatment, or services are medically necessary.

11 Section 75. Effect of health insurance issuer's failure to  
12 comply. A failure by a health insurance issuer to comply with  
13 the deadlines and other requirements specified in this Act  
14 shall result in any health care services subject to review to  
15 be automatically deemed authorized by the health insurance  
16 issuer or its contracted private review agent.

17 Section 80. Enforcement and administration.

18 (a) In addition to the enforcement powers granted to it by  
19 law to enforce the provisions of this Act, the Department is  
20 granted specific authority to issue a cease and desist order  
21 or require a private review agent or health insurance issuer  
22 to submit a plan of correction for violations of this Act, or  
23 both. Subject to rules adopted by the Department under the  
24 provisions of the Illinois Administrative Procedure Act, and

1 after proper notice and opportunity for a hearing, the  
2 Department may impose upon a private review agent, health  
3 benefit plan, or health insurance issuer an administrative  
4 fine not to exceed \$2,000 per violation for failure to submit a  
5 requested plan of correction, failure to comply with its plan  
6 of correction, or repeated violations of this Act. All fines  
7 collected by the Department under this Section shall be  
8 deposited into the General Revenue Fund.

9 (b) Any person or the person's treating physician who has  
10 evidence that the person's health insurance issuer or health  
11 benefit plan is in violation of the provisions of this Act may  
12 file a complaint with the Department. The Department shall  
13 review all complaints received and investigate all complaints  
14 that it deems to state a potential violation. The Department  
15 shall fairly, efficiently, and timely review and investigate  
16 complaints. Health insurance issuers, health benefit plans,  
17 and private review agents found to be in violation of this Act  
18 shall be penalized in accordance with this Section.

19 (c) Nothing in this Act may be construed to create a  
20 private right of action.

21 Section 85. Reports to the Department.

22 (a) By June 1, 2028 and each June 1 thereafter, a health  
23 insurance issuer shall report to the Department, on a form  
24 issued by the Department, the following aggregated trend data,  
25 de-identified of protected health information, related to the

1 health insurance issuer's practices and experience for the  
2 prior plan year for health care services submitted for  
3 payment:

4 (1) the number of prior authorization requests;

5 (2) the percentage of prior authorization requests  
6 denied;

7 (3) the percentage of prior authorization appeals  
8 received;

9 (4) the percentage of adverse determinations reversed  
10 on appeal;

11 (5) the percentage of prior authorization requests  
12 that were not submitted electronically;

13 (6) as a percentage of service, the 10 health care  
14 services that were most frequently denied through prior  
15 authorization; and

16 (7) the 5 reasons prior authorization requests were  
17 most frequently denied.

18 (b) All reports required by this Section shall be  
19 considered public records, and the Department shall make the  
20 reports freely available upon request and post all reports to  
21 its public website without redactions.

22 Section 90. False requests for prior authorization. If a  
23 health insurance issuer has clear and convincing evidence that  
24 a health care professional or health care provider has  
25 knowingly and willfully submitted false or fraudulent requests

1 for prior authorization to the health insurance issuer, the  
2 issuer shall notify and provide that information to the  
3 Department of Insurance. After receiving such information, the  
4 Department of Insurance shall forward these reports to the  
5 Department of Financial and Professional Regulation and the  
6 Illinois Attorney General.

7 Section 95. Rulemaking. The Department shall adopt rules  
8 necessary to implement and administer this Act.

9 Section 900. The Illinois Insurance Code is amended by  
10 changing Sections 356z.66 and 370c as follows:

11 (215 ILCS 5/356z.66)

12 Sec. 356z.66. Proton beam therapy.

13 (a) As used in this Section:

14 "Medically necessary" has the meaning given to that term  
15 in the Standardized Prior Authorization Act ~~Prior~~  
16 ~~Authorization Reform Act~~.

17 "Proton beam therapy" means a type of radiation therapy  
18 treatment that utilizes protons as the radiation delivery  
19 method for the treatment of tumors and cancerous cells.

20 "Radiation therapy treatment" means the delivery of  
21 biological effective doses with proton therapy, intensity  
22 modulated radiation therapy, brachytherapy, stereotactic body  
23 radiation therapy, three-dimensional conformal radiation

1 therapy, or other forms of therapy using radiation.

2 (b) A group or individual policy of accident and health  
3 insurance or managed care plan that is amended, delivered,  
4 issued, or renewed on or after January 1, 2025 that provides  
5 coverage for the treatment of cancer shall not apply a higher  
6 standard of clinical evidence for the coverage of proton beam  
7 therapy than the insurer applies for the coverage of any other  
8 form of radiation therapy treatment.

9 (c) A group or individual policy of accident and health  
10 insurance or managed care plan that is amended, delivered,  
11 issued, or renewed on or after January 1, 2025 that provides  
12 coverage or benefits to any resident of this State for  
13 radiation oncology shall include coverage or benefits for  
14 medically necessary proton beam therapy for the treatment of  
15 cancer.

16 (Source: P.A. 103-325, eff. 1-1-24; 103-605, eff. 7-1-24.)

17 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

18 Sec. 370c. Mental and emotional disorders.

19 (a) (1) On and after January 1, 2022 (the effective date of  
20 Public Act 102-579), every insurer that amends, delivers,  
21 issues, or renews group accident and health policies providing  
22 coverage for hospital or medical treatment or services for  
23 illness shall provide coverage for the medically necessary  
24 treatment of mental, emotional, nervous, or substance use  
25 disorders or conditions consistent with the parity

1 requirements of Section 370c.1 of this Code.

2 (2) Each insured that is covered for mental, emotional,  
3 nervous, or substance use disorders or conditions shall be  
4 free to select the physician licensed to practice medicine in  
5 all its branches, licensed clinical psychologist, licensed  
6 clinical social worker, licensed clinical professional  
7 counselor, licensed marriage and family therapist, licensed  
8 speech-language pathologist, or other licensed or certified  
9 professional at a program licensed pursuant to the Substance  
10 Use Disorder Act of his or her choice to treat such disorders,  
11 and the insurer shall pay the covered charges of such  
12 physician licensed to practice medicine in all its branches,  
13 licensed clinical psychologist, licensed clinical social  
14 worker, licensed clinical professional counselor, licensed  
15 marriage and family therapist, licensed speech-language  
16 pathologist, or other licensed or certified professional at a  
17 program licensed pursuant to the Substance Use Disorder Act up  
18 to the limits of coverage, provided (i) the disorder or  
19 condition treated is covered by the policy, and (ii) the  
20 physician, licensed psychologist, licensed clinical social  
21 worker, licensed clinical professional counselor, licensed  
22 marriage and family therapist, licensed speech-language  
23 pathologist, or other licensed or certified professional at a  
24 program licensed pursuant to the Substance Use Disorder Act is  
25 authorized to provide said services under the statutes of this  
26 State and in accordance with accepted principles of his or her

1 profession.

2 (3) Insofar as this Section applies solely to licensed  
3 clinical social workers, licensed clinical professional  
4 counselors, licensed marriage and family therapists, licensed  
5 speech-language pathologists, and other licensed or certified  
6 professionals at programs licensed pursuant to the Substance  
7 Use Disorder Act, those persons who may provide services to  
8 individuals shall do so after the licensed clinical social  
9 worker, licensed clinical professional counselor, licensed  
10 marriage and family therapist, licensed speech-language  
11 pathologist, or other licensed or certified professional at a  
12 program licensed pursuant to the Substance Use Disorder Act  
13 has informed the patient of the desirability of the patient  
14 conferring with the patient's primary care physician.

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

1 postpartum depression.

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

6 (b) (1) (Blank).

7 (2) (Blank).

8 (2.5) (Blank).

9 (3) Unless otherwise prohibited by federal law and  
10 consistent with the parity requirements of Section 370c.1 of  
11 this Code, the insurer that amends, delivers, issues, or  
12 renews a group or individual policy of accident and health  
13 insurance, a qualified health plan offered through the health  
14 insurance marketplace, or a provider of treatment of mental,  
15 emotional, nervous, or substance use disorders or conditions  
16 shall furnish medical records or other necessary data that  
17 substantiate that initial or continued treatment is at all  
18 times medically necessary. Nothing in this paragraph (3)  
19 supersedes the prohibition on prior authorization requirements  
20 to the extent provided under subsections (g) and (w) and  
21 subparagraph (A) of paragraph (6.5) of this subsection.  
22 Nothing prevents the insured from agreeing in writing to  
23 continue treatment at his or her expense. When making a  
24 determination of the medical necessity for a treatment  
25 modality for mental, emotional, nervous, or substance use  
26 disorders or conditions, an insurer must make the

1 determination in a manner that is consistent with the manner  
2 used to make that determination with respect to other diseases  
3 or illnesses covered under the policy, including an appeals  
4 process. Medical necessity determinations for substance use  
5 disorders shall be made in accordance with appropriate patient  
6 placement criteria established by the American Society of  
7 Addiction Medicine. No additional criteria may be used to make  
8 medical necessity determinations for substance use disorders.

9 (4) A group health benefit plan amended, delivered,  
10 issued, or renewed on or after January 1, 2019 (the effective  
11 date of Public Act 100-1024) or an individual policy of  
12 accident and health insurance or a qualified health plan  
13 offered through the health insurance marketplace amended,  
14 delivered, issued, or renewed on or after January 1, 2019 (the  
15 effective date of Public Act 100-1024):

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

22 (i) 45 days of inpatient treatment; and

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

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

8 (B) may not include a lifetime limit on the number of  
9 days of inpatient treatment or the number of outpatient  
10 visits covered under the plan.

11 (C) (Blank).

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

21 (5.5) An individual or group health benefit plan amended,  
22 delivered, issued, or renewed on or after September 9, 2015  
23 (the effective date of Public Act 99-480) shall offer coverage  
24 for medically necessary acute treatment services and medically  
25 necessary clinical stabilization services. The treating  
26 provider shall base all treatment recommendations and the

1 health benefit plan shall base all medical necessity  
2 determinations for substance use disorders in accordance with  
3 the most current edition of the Treatment Criteria for  
4 Addictive, Substance-Related, and Co-Occurring Conditions  
5 established by the American Society of Addiction Medicine. The  
6 treating provider shall base all treatment recommendations and  
7 the health benefit plan shall base all medical necessity  
8 determinations for medication-assisted treatment in accordance  
9 with the most current Treatment Criteria for Addictive,  
10 Substance-Related, and Co-Occurring Conditions established by  
11 the American Society of Addiction Medicine.

12 As used in this subsection:

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

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

25 "Prior authorization" has the meaning given to that term  
26 in the Standardized Prior Authorization Act ~~Section 15 of the~~

1 ~~Prior Authorization Reform Act.~~

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

5 (6.5) An individual or group health benefit plan amended,  
6 delivered, issued, or renewed on or after January 1, 2019 (the  
7 effective date of Public Act 100-1024):

8 (A) shall not impose prior authorization requirements,  
9 including limitations on dosage, other than those  
10 established under the Treatment Criteria for Addictive,  
11 Substance-Related, and Co-Occurring Conditions  
12 established by the American Society of Addiction Medicine,  
13 on a prescription medication approved by the United States  
14 Food and Drug Administration that is prescribed or  
15 administered for the treatment of substance use disorders;

16 (B) shall not impose any step therapy requirements;

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

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

7 (7) (Blank).

8 (8) (Blank).

9 (9) With respect to all mental, emotional, nervous, or  
10 substance use disorders or conditions, coverage for inpatient  
11 treatment shall include coverage for treatment in a  
12 residential treatment center certified or licensed by the  
13 Department of Public Health or the Department of Human  
14 Services.

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

18 (d) With respect to a group or individual policy of  
19 accident and health insurance or a qualified health plan  
20 offered through the health insurance marketplace, the  
21 Department and, with respect to medical assistance, the  
22 Department of Healthcare and Family Services shall each  
23 enforce the requirements of this Section and Sections 356z.23  
24 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici  
25 Mental Health Parity and Addiction Equity Act of 2008, 42  
26 U.S.C. 18031(j), and any amendments to, and federal guidance

1 or regulations issued under, those Acts, including, but not  
2 limited to, final regulations issued under the Paul Wellstone  
3 and Pete Domenici Mental Health Parity and Addiction Equity  
4 Act of 2008 and final regulations applying the Paul Wellstone  
5 and Pete Domenici Mental Health Parity and Addiction Equity  
6 Act of 2008 to Medicaid managed care organizations, the  
7 Children's Health Insurance Program, and alternative benefit  
8 plans. Specifically, the Department and the Department of  
9 Healthcare and Family Services shall take action:

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

20 (2) evaluating all consumer or provider complaints  
21 regarding mental, emotional, nervous, or substance use  
22 disorder or condition coverage for possible parity  
23 violations;

24 (3) performing parity compliance market conduct  
25 examinations or, in the case of the Department of  
26 Healthcare and Family Services, parity compliance audits

1 of individual and group plans and policies, including, but  
2 not limited to, reviews of:

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

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

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

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

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

18 (e) Availability of plan information.

19 (1) The criteria for medical necessity determinations  
20 made under a group health plan, an individual policy of  
21 accident and health insurance, or a qualified health plan  
22 offered through the health insurance marketplace with  
23 respect to mental health or substance use disorder  
24 benefits (or health insurance coverage offered in  
25 connection with the plan with respect to such benefits)  
26 must be made available by the plan administrator (or the

1 health insurance issuer offering such coverage) to any  
2 current or potential participant, beneficiary, or  
3 contracting provider upon request.

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

17 (f) As used in this Section, "group policy of accident and  
18 health insurance" and "group health benefit plan" includes (1)  
19 State-regulated employer-sponsored group health insurance  
20 plans written in Illinois or which purport to provide coverage  
21 for a resident of this State; and (2) State, county,  
22 municipal, or school district employee health plans.  
23 References to an insurer include all plans described in this  
24 subsection.

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

26 "Benefits", with respect to insurers that are not Medicaid

1 managed care organizations, means the benefits provided for  
2 treatment services for inpatient and outpatient treatment of  
3 substance use disorders or conditions at American Society of  
4 Addiction Medicine levels of treatment 2.1 (Intensive  
5 Outpatient), 2.5 (High-Intensity Outpatient), 3.1 (Clinically  
6 Managed Low-Intensity Residential), 3.5 (Clinically Managed  
7 High-Intensity Residential), and 3.7 (Medically Managed  
8 Residential) and OMT (Opioid Maintenance Therapy) services.

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

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

22 (2) A group health insurance policy, an individual health  
23 benefit plan, or qualified health plan that is offered through  
24 the health insurance marketplace, small employer group health  
25 plan, and large employer group health plan that is amended,  
26 delivered, issued, executed, or renewed in this State, or

1 approved for issuance or renewal in this State, on or after  
2 January 1, 2019 (the effective date of Public Act 100-1023)  
3 shall comply with the requirements of this Section and Section  
4 370c.1. The services for the treatment and the ongoing  
5 assessment of the patient's progress in treatment shall follow  
6 the requirements of 77 Ill. Adm. Code 2060.

7 (3) Prior authorization shall not be utilized for the  
8 benefits under this subsection. Except to the extent  
9 prohibited by Section 370c.1 with respect to treatment  
10 limitations in a benefit classification or subclassification,  
11 the insurer may require the substance use disorder treatment  
12 provider or facility to notify the insurer of the initiation  
13 of treatment. For an insurer that is not a Medicaid managed  
14 care organization, the substance use disorder treatment  
15 provider or facility may be required to give notification for  
16 the initiation of treatment of the covered person within 2  
17 business days. For Medicaid managed care organizations, the  
18 substance use disorder treatment provider or facility may be  
19 required to give notification in accordance with the protocol  
20 set forth in the provider agreement for initiation of  
21 treatment within 24 hours. If the Medicaid managed care  
22 organization is not capable of accepting the notification in  
23 accordance with the contractual protocol during the 24-hour  
24 period following admission, the substance use disorder  
25 treatment provider or facility shall have one additional  
26 business day to provide the notification to the appropriate

1 managed care organization. Treatment plans shall be developed  
2 in accordance with the requirements and timeframes established  
3 in 77 Ill. Adm. Code 2060. No such coverage shall be subject to  
4 concurrent review prior to the applicable notification  
5 deadline. If coverage is denied retrospectively, neither the  
6 provider or facility nor the insurer shall bill, and the  
7 covered individual shall not be liable, for any treatment  
8 under this subsection through the date the adverse  
9 determination is issued, other than any copayment,  
10 coinsurance, or deductible for the treatment or stay through  
11 that date as applicable under the policy. Coverage shall not  
12 be retrospectively denied for benefits that were furnished at  
13 a participating substance use disorder facility prior to the  
14 applicable notification deadline except for the following:

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

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

20 (C) upon material misrepresentation by the patient or  
21 provider. As used in this subparagraph (C), "material"  
22 means a fact or situation that is not merely technical in  
23 nature and results or could result in a substantial change  
24 in the situation;

25 (D) upon determination that a service was excluded  
26 under the terms of coverage. For situations that qualify

1 under this subparagraph (D), the limitation to billing for  
2 a copayment, coinsurance, or deductible shall not apply;

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

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

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

18 Pursuant to the requirements of the Health Carrier  
19 External Review Act, the covered person or the covered  
20 person's authorized representative may request an expedited  
21 external review. An expedited external review may not occur if  
22 the substance use disorder treatment provider or facility  
23 determines that continued treatment is no longer medically  
24 necessary.

25 If an expedited external review request meets the criteria  
26 of the Health Carrier External Review Act, an independent

1 review organization shall make a final determination of  
2 medical necessity within 72 hours. If an independent review  
3 organization upholds an adverse determination, an insurer  
4 shall remain responsible to provide coverage of benefits  
5 through the day following the determination of the independent  
6 review organization. A decision to reverse an adverse  
7 determination shall comply with the Health Carrier External  
8 Review Act.

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

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

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

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

26 (h) As used in this Section:

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

17           "Medically necessary treatment of mental, emotional,  
18 nervous, or substance use disorders or conditions" means a  
19 service or product addressing the specific needs of that  
20 patient, for the purpose of screening, preventing, diagnosing,  
21 managing, or treating an illness, injury, or condition or its  
22 symptoms and comorbidities, including minimizing the  
23 progression of an illness, injury, or condition or its  
24 symptoms and comorbidities in a manner that is all of the  
25 following:

26           (1) in accordance with the generally accepted

1 standards of mental, emotional, nervous, or substance use  
2 disorder or condition care;

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

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

8 "Utilization review" means either of the following:

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

16 (2) evaluating the medical necessity, appropriateness,  
17 level of care, service intensity, efficacy, or efficiency  
18 of health care services, benefits, procedures, or  
19 settings, under any circumstances, to determine whether a  
20 health care service or benefit subject to a medical  
21 necessity coverage requirement in an insurance policy is  
22 covered as medically necessary for an insured.

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

26 (i)(1) Every insurer that amends, delivers, issues, or

1 renews a group or individual policy of accident and health  
2 insurance or a qualified health plan offered through the  
3 health insurance marketplace in this State and Medicaid  
4 managed care organizations providing coverage for hospital or  
5 medical treatment on or after January 1, 2023 shall, pursuant  
6 to subsections (h) through (s), provide coverage for medically  
7 necessary treatment of mental, emotional, nervous, or  
8 substance use disorders or conditions.

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

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

19 (4) An insurer that authorizes a specific type of  
20 treatment by a provider pursuant to this Section shall not  
21 rescind or modify the authorization after that provider  
22 renders the health care service in good faith and pursuant to  
23 this authorization for any reason, including, but not limited  
24 to, the insurer's subsequent cancellation or modification of  
25 the insured's or policyholder's contract, or the insured's or  
26 policyholder's eligibility. Nothing in this Section shall

1 require the insurer to cover a treatment when the  
2 authorization was granted based on a material  
3 misrepresentation by the insured, the policyholder, or the  
4 provider. Nothing in this Section shall require Medicaid  
5 managed care organizations to pay for services if the  
6 individual was not eligible for Medicaid at the time the  
7 service was rendered. Nothing in this Section shall require an  
8 insurer to pay for services if the individual was not the  
9 insurer's enrollee at the time services were rendered. As used  
10 in this paragraph, "material" means a fact or situation that  
11 is not merely technical in nature and results in or could  
12 result in a substantial change in the situation.

13 (j) An insurer shall not limit benefits or coverage for  
14 medically necessary services on the basis that those services  
15 should be or could be covered by a public entitlement program,  
16 including, but not limited to, special education or an  
17 individualized education program, Medicaid, Medicare,  
18 Supplemental Security Income, or Social Security Disability  
19 Insurance, and shall not include or enforce a contract term  
20 that excludes otherwise covered benefits on the basis that  
21 those services should be or could be covered by a public  
22 entitlement program. Nothing in this subsection shall be  
23 construed to require an insurer to cover benefits that have  
24 been authorized and provided for a covered person by a public  
25 entitlement program. Medicaid managed care organizations are  
26 not subject to this subsection.

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

12           (1) In conducting utilization review of all covered health  
13 care services for the diagnosis, prevention, and treatment of  
14 mental, emotional, and nervous disorders or conditions, an  
15 insurer shall apply the criteria and guidelines set forth in  
16 the most recent version of the treatment criteria developed by  
17 an unaffiliated nonprofit professional association for the  
18 relevant clinical specialty or, for Medicaid managed care  
19 organizations, criteria and guidelines determined by the  
20 Department of Healthcare and Family Services that are  
21 consistent with generally accepted standards of mental,  
22 emotional, nervous or substance use disorder or condition  
23 care. Pursuant to subsection (b), in conducting utilization  
24 review of all covered services and benefits for the diagnosis,  
25 prevention, and treatment of substance use disorders an  
26 insurer shall use the most recent edition of the patient

1 placement criteria established by the American Society of  
2 Addiction Medicine.

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

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

22 (n) In conducting utilization review that is outside the  
23 scope of the criteria as specified in subsection (l) or  
24 relates to the advancements in technology or in the types or  
25 levels of care that are not addressed in the most recent  
26 versions of the sources specified in subsection (l), an

1 insurer shall conduct utilization review in accordance with  
2 subsection (k).

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

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

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

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

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

21 (3) Provide, at no cost, the utilization review  
22 criteria and any training material or resources to  
23 providers and insured patients upon request. For  
24 utilization review criteria not concerning level of care  
25 placement, continued stay, transfer, discharge, or other  
26 patient care decisions used by the insurer pursuant to

1 subsection (m), the insurer may place the criteria on a  
2 secure, password-protected website so long as the access  
3 requirements of the website do not unreasonably restrict  
4 access to insureds or their providers. No restrictions  
5 shall be placed upon the insured's or treating provider's  
6 access right to utilization review criteria obtained under  
7 this paragraph at any point in time, including before an  
8 initial request for authorization.

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

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

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

21 (7) Achieve interrater reliability pass rates of at  
22 least 90% and, if this threshold is not met, immediately  
23 provide for the remediation of poor interrater reliability  
24 and interrater reliability testing for all new staff  
25 before they can conduct utilization review without  
26 supervision.

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

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

14          (s) This Section applies to an insurer that amends,  
15          delivers, issues, or renews a group or individual policy of  
16          accident and health insurance or a qualified health plan  
17          offered through the health insurance marketplace in this State  
18          providing coverage for hospital or medical treatment and  
19          conducts utilization review as defined in this Section,  
20          including Medicaid managed care organizations, and any entity  
21          or contracting provider that performs utilization review or  
22          utilization management functions on an insurer's behalf.

23          (t) If the Director determines that an insurer has  
24          violated this Section, the Director may, after appropriate  
25          notice and opportunity for hearing, by order, assess a civil  
26          penalty between \$1,000 and \$5,000 for each violation. Moneys

1 collected from penalties shall be deposited into the Parity  
2 Advancement Fund established in subsection (i) of Section  
3 370c.1.

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

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

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

16 (1) No policy shall require prior authorization for  
17 outpatient or partial hospitalization services for  
18 treatment of mental, emotional, or nervous disorders or  
19 conditions provided by a physician licensed to practice  
20 medicine in all branches, a licensed clinical  
21 psychologist, a licensed clinical social worker, a  
22 licensed clinical professional counselor, a licensed  
23 marriage and family therapist, a licensed speech-language  
24 pathologist, or any other type of licensed, certified, or  
25 legally authorized provider, including trainees working  
26 under the supervision of a licensed health care

1 professional listed under this subsection, or facility  
2 whose outpatient or partial hospitalization services the  
3 policy covers for treatment of mental, emotional, or  
4 nervous disorders or conditions. Such coverage may be  
5 subject to concurrent and retrospective review consistent  
6 with the utilization review provisions in subsections (h)  
7 through (n) and Section 370c.1. Nothing in this paragraph  
8 (1) supersedes a health maintenance organization's  
9 referral requirement for services from nonparticipating  
10 providers. An insurer may require providers or facilities  
11 to notify the insurer of the initiation of treatment as  
12 specified in this subsection, except to the extent  
13 prohibited by Section 370c.1 with respect to treatment  
14 limitations in a benefit classification or  
15 subclassification. No such coverage shall be subject to  
16 concurrent review for any services furnished before an  
17 applicable notification deadline, subject to the  
18 following:

19 (A) In the case of outpatient treatment, for an  
20 insurer that is not a Medicaid managed care  
21 organization, the insurer may set a notification  
22 deadline of 2 business days after the initiation of  
23 the covered person's treatment. A Medicaid managed  
24 care organization may set a deadline of 24 hours after  
25 the initiation of treatment. If the Medicaid managed  
26 care organization is not capable of accepting the

1 notification in accordance with the contractual  
2 protocol within the 24-hour period following  
3 initiation, the treatment provider or facility shall  
4 have one additional business day to provide the  
5 notification to the Medicaid managed care  
6 organization.

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

21 (2) No policy shall require prior authorization for  
22 inpatient treatment at a hospital for mental, emotional,  
23 or nervous disorders or conditions at a participating  
24 provider. Additionally, no such coverage shall be subject  
25 to concurrent review for the first 72 hours after  
26 admission, provided that the provider must notify the

1 insurer of both the admission and the initial treatment  
2 plan within 48 hours of admission. A discharge plan must  
3 be fully developed and continuity services prepared to  
4 meet the patient's needs and the patient's community  
5 preference upon release. Recommended level of care  
6 placements identified in the discharge plan shall comply  
7 with generally accepted standards of care, as defined in  
8 subsection (h).

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

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

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

20 (D) In this subsection, residential treatment that  
21 is not otherwise identified in the discharge plan is  
22 not inpatient hospitalization.

23 (3) Treatment provided under this subsection may be  
24 reviewed retrospectively. If coverage is denied  
25 retrospectively, neither the insurer nor the participating  
26 provider shall bill, and the insured shall not be liable,

1 for any treatment under this subsection through the date  
2 the adverse determination is issued, other than any  
3 copayment, coinsurance, or deductible for the stay through  
4 that date as applicable under the policy. Coverage shall  
5 not be retrospectively denied for the first 72 hours of  
6 admission to inpatient hospitalization for treatment of  
7 mental, emotional, or nervous disorders or conditions, or  
8 before the applicable deadline under paragraph (1) of this  
9 subsection for outpatient treatment or partial  
10 hospitalization programs, at a participating provider  
11 except:

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

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

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

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

26 (E) for outpatient treatment or partial

1 hospitalization programs only, upon determination that  
2 a service was not medically necessary consistent with  
3 subsections (h) through (n); or

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

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

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

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

17 (x) Notwithstanding any provision of this Section, nothing  
18 shall require the medical assistance program under Article V  
19 of the Illinois Public Aid Code or the Children's Health  
20 Insurance Program Act to violate any applicable federal laws,  
21 regulations, or grant requirements, including requirements for  
22 utilization management, or any State or federal consent  
23 decrees. Nothing in subsection (g) or (w) shall prevent the  
24 Department of Healthcare and Family Services from requiring a  
25 health care provider to use specified level of care,  
26 admission, continued stay, or discharge criteria, including,

1 but not limited to, those under Section 5-5.23 of the Illinois  
2 Public Aid Code, as long as the Department of Healthcare and  
3 Family Services, subject to applicable federal laws,  
4 regulations, or grant requirements, including requirements for  
5 utilization management, does not require a health care  
6 provider to seek prior authorization or concurrent review from  
7 the Department of Healthcare and Family Services, a Medicaid  
8 managed care organization, or a utilization review  
9 organization under the circumstances expressly prohibited by  
10 subsections (g) and (w). Nothing in this Section prohibits a  
11 health plan, including a Medicaid managed care organization,  
12 from conducting reviews for medical necessity, clinical  
13 appropriateness, safety, fraud, waste, or abuse and reporting  
14 suspected fraud, waste, or abuse according to State and  
15 federal requirements. Nothing in this Section limits the  
16 authority of the Department of Healthcare and Family Services  
17 or another State agency, or a Medicaid managed care  
18 organization on the State agency's behalf, to (i) implement or  
19 require programs, services, screenings, assessments, tools, or  
20 reviews to comply with applicable federal law, federal  
21 regulation, federal grant requirements, any State or federal  
22 consent decrees or court orders, or any applicable case law,  
23 such as *Olmstead v. L.C.*, 527 U.S. 581 (1999), or (ii)  
24 administer or require programs, services, screenings,  
25 assessments, tools, or reviews established under State or  
26 federal laws, rules, or regulations in compliance with State

1 or federal laws, rules, or regulations, including, but not  
2 limited to, the Children's Mental Health Act and the Mental  
3 Health and Developmental Disabilities Administrative Act.

4 (y) (Blank).

5 (Source: P.A. 103-426, eff. 8-4-23; 103-650, eff. 1-1-25;  
6 103-1040, eff. 8-9-24; 104-28, eff. 1-1-26; 104-417, eff.  
7 8-15-25.)

8 Section 905. The Network Adequacy and Transparency Act is  
9 amended by changing Section 10 as follows:

10 (215 ILCS 124/10)

11 Sec. 10. Network adequacy.

12 (a) Before issuing, delivering, or renewing a network  
13 plan, an issuer providing a network plan shall file a  
14 description of all of the following with the Director:

15 (1) The written policies and procedures for adding  
16 providers to meet patient needs based on increases in the  
17 number of beneficiaries, changes in the  
18 patient-to-provider ratio, changes in medical and health  
19 care capabilities, and increased demand for services.

20 (2) The written policies and procedures for making  
21 referrals within and outside the network.

22 (3) The written policies and procedures on how the  
23 network plan will provide 24-hour, 7-day per week access  
24 to network-affiliated primary care, emergency services,

1           and    obstetrical    and    gynecological    health    care  
2           professionals.

3           An issuer shall not prohibit a preferred provider from  
4   discussing any specific or all treatment options with  
5   beneficiaries irrespective of the issuer's position on those  
6   treatment options or from advocating on behalf of  
7   beneficiaries within the utilization review, grievance, or  
8   appeals processes established by the issuer in accordance with  
9   any rights or remedies available under applicable State or  
10   federal law.

11           (b) Before issuing, delivering, or renewing a network  
12   plan, an issuer must file for review a description of the  
13   services to be offered through a network plan. The description  
14   shall include all of the following:

15                   (1) A geographic map of the area proposed to be served  
16                   by the plan by county service area and zip code, including  
17                   marked locations for preferred providers.

18                   (2) As deemed necessary by the Department, the names,  
19                   addresses, phone numbers, and specialties of the providers  
20                   who have entered into preferred provider agreements under  
21                   the network plan.

22                   (3) The number of beneficiaries anticipated to be  
23                   covered by the network plan.

24                   (4) An Internet website and toll-free telephone number  
25                   for beneficiaries and prospective beneficiaries to access  
26                   current and accurate lists of preferred providers in each

1 plan, additional information about the plan, as well as  
2 any other information required by Department rule.

3 (5) A description of how health care services to be  
4 rendered under the network plan are reasonably accessible  
5 and available to beneficiaries. The description shall  
6 address all of the following:

7 (A) the type of health care services to be  
8 provided by the network plan;

9 (B) the ratio of physicians and other providers to  
10 beneficiaries, by specialty and including primary care  
11 physicians and facility-based physicians when  
12 applicable under the contract, necessary to meet the  
13 health care needs and service demands of the currently  
14 enrolled population;

15 (C) the travel and distance standards for plan  
16 beneficiaries in county service areas; and

17 (D) a description of how the use of telemedicine,  
18 telehealth, or mobile care services may be used to  
19 partially meet the network adequacy standards, if  
20 applicable.

21 (6) A provision ensuring that whenever a beneficiary  
22 has made a good faith effort, as evidenced by accessing  
23 the provider directory, calling the network plan, and  
24 calling the provider, to utilize preferred providers for a  
25 covered service and it is determined the issuer does not  
26 have the appropriate preferred providers due to

1 insufficient number, type, unreasonable travel distance or  
2 delay, or preferred providers refusing to provide a  
3 covered service because it is contrary to the conscience  
4 of the preferred providers, as protected by the Health  
5 Care Right of Conscience Act, the issuer shall give the  
6 beneficiary a network exception and shall ensure, directly  
7 or indirectly, by terms contained in the payer contract,  
8 that the beneficiary will be provided the covered service  
9 at no greater cost to the beneficiary than if the service  
10 had been provided by a preferred provider. This paragraph  
11 (6) does not apply to: (A) a beneficiary who willfully  
12 chooses to access a non-preferred provider for health care  
13 services available through the panel of preferred  
14 providers, or (B) a beneficiary enrolled in a health  
15 maintenance organization, except that the health  
16 maintenance organization must notify the beneficiary when  
17 a referral has been granted as a network exception based  
18 on any preferred provider access deficiency described in  
19 this paragraph or under the circumstances applicable in  
20 paragraph (3) of subsection (d-5). In these circumstances,  
21 the contractual requirements for non-preferred provider  
22 reimbursements shall apply unless Section 356z.3a of the  
23 Illinois Insurance Code requires otherwise. In no event  
24 shall a beneficiary who receives care at a participating  
25 health care facility be required to search for  
26 participating providers under the circumstances described

1 in subsection (b) or (b-5) of Section 356z.3a of the  
2 Illinois Insurance Code except under the circumstances  
3 described in paragraph (2) of subsection (b-5).

4 (7) A provision that the beneficiary shall receive  
5 emergency care coverage such that payment for this  
6 coverage is not dependent upon whether the emergency  
7 services are performed by a preferred or non-preferred  
8 provider and the coverage shall be at the same benefit  
9 level as if the service or treatment had been rendered by a  
10 preferred provider. For purposes of this paragraph (7),  
11 "the same benefit level" means that the beneficiary is  
12 provided the covered service at no greater cost to the  
13 beneficiary than if the service had been provided by a  
14 preferred provider. This provision shall be consistent  
15 with Section 356z.3a of the Illinois Insurance Code.

16 (8) A limitation that complies with the following  
17 prior authorization requirements: subsections (d) and (e)  
18 of Section 55 of the Prior Authorization Reform Act.

19 (A) If a health insurance issuer imposes a  
20 monetary penalty on the enrollee for the enrollee's,  
21 health care professional's, or health care provider's  
22 failure to obtain any form of prior authorization for  
23 a health care service, the penalty may not exceed the  
24 lesser of:

25 (i) the actual cost of the health care  
26 service; or

1                    (ii) \$1,000 per occurrence in addition to the  
2                    plan cost-sharing provisions.

3                    (B) A health insurance issuer may not require both  
4                    the enrollee and the health care professional or  
5                    health care provider to obtain any form of prior  
6                    authorization for the same instance of a health care  
7                    service, nor otherwise require more than one prior  
8                    authorization for the same instance of a health care  
9                    service.

10                  (9) For a network plan to be offered through the  
11                  Exchange in the individual or small group market, as well  
12                  as any off-Exchange mirror of such a network plan,  
13                  evidence that the network plan includes essential  
14                  community providers in accordance with rules established  
15                  by the Exchange that will operate in this State for the  
16                  applicable plan year.

17                  (c) The issuer shall demonstrate to the Director a minimum  
18                  ratio of providers to plan beneficiaries as required by the  
19                  Department for each network plan.

20                  (1) The minimum ratio of physicians or other providers  
21                  to plan beneficiaries shall be established by the  
22                  Department in consultation with the Department of Public  
23                  Health based upon the guidance from the federal Centers  
24                  for Medicare and Medicaid Services. The Department shall  
25                  not establish ratios for vision or dental providers who  
26                  provide services under dental-specific or vision-specific

1 benefits, except to the extent provided under federal law  
2 for stand-alone dental plans. The Department shall  
3 consider establishing ratios for the following physicians  
4 or other providers:

5 (A) Primary Care;

6 (B) Pediatrics;

7 (C) Cardiology;

8 (D) Gastroenterology;

9 (E) General Surgery;

10 (F) Neurology;

11 (G) OB/GYN;

12 (H) Oncology/Radiation;

13 (I) Ophthalmology;

14 (J) Urology;

15 (K) Behavioral Health;

16 (L) Allergy/Immunology;

17 (M) Chiropractic;

18 (N) Dermatology;

19 (O) Endocrinology;

20 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

21 (Q) Infectious Disease;

22 (R) Nephrology;

23 (S) Neurosurgery;

24 (T) Orthopedic Surgery;

25 (U) Physiatry/Rehabilitative;

26 (V) Plastic Surgery;

- 1 (W) Pulmonary;
- 2 (X) Rheumatology;
- 3 (Y) Anesthesiology;
- 4 (Z) Pain Medicine;
- 5 (AA) Pediatric Specialty Services;
- 6 (BB) Outpatient Dialysis;
- 7 (CC) HIV; and
- 8 (DD) Genetic Medicine and Genetic Counseling.

9 (1.5) Beginning January 1, 2026, every issuer shall  
10 demonstrate to the Director that each in-network hospital  
11 has at least one radiologist, pathologist,  
12 anesthesiologist, and emergency room physician as a  
13 preferred provider in a network plan. The Department may,  
14 by rule, require additional types of hospital-based  
15 medical specialists to be included as preferred providers  
16 in each in-network hospital in a network plan.

17 (2) The Director shall establish a process for the  
18 review of the adequacy of these standards, along with an  
19 assessment of additional specialties to be included in the  
20 list under this subsection (c).

21 (3) Notwithstanding any other law or rule, the minimum  
22 ratio for each provider type shall be no less than any such  
23 ratio established for qualified health plans in  
24 Federally-Facilitated Exchanges by federal law or by the  
25 federal Centers for Medicare and Medicaid Services, even  
26 if the network plan is issued in the large group market or

1 is otherwise not issued through an exchange. Federal  
2 standards for stand-alone dental plans shall only apply to  
3 such network plans. In the absence of an applicable  
4 Department rule, the federal standards shall apply for the  
5 time period specified in the federal law, regulation, or  
6 guidance. If the Centers for Medicare and Medicaid  
7 Services establish standards that are more stringent than  
8 the standards in effect under any Department rule, the  
9 Department may amend its rules to conform to the more  
10 stringent federal standards.

11 (4) If the federal Centers for Medicare and Medicaid  
12 Services establishes minimum provider ratios for  
13 stand-alone dental plans in the type of exchange in use in  
14 this State for a given plan year, the Department shall  
15 enforce those standards for stand-alone dental plans for  
16 that plan year.

17 (d) The network plan shall demonstrate to the Director  
18 maximum travel and distance standards and appointment  
19 wait-time standards for plan beneficiaries, which shall be  
20 established by the Department in consultation with the  
21 Department of Public Health based upon the guidance from the  
22 federal Centers for Medicare and Medicaid Services. These  
23 standards shall consist of the maximum minutes or miles to be  
24 traveled by a plan beneficiary for each county type, such as  
25 large counties, metro counties, or rural counties as defined  
26 by Department rule.

1           The maximum travel time and distance standards must  
2 include standards for each physician and other provider  
3 category listed for which ratios have been established.

4           The Director shall establish a process for the review of  
5 the adequacy of these standards along with an assessment of  
6 additional specialties to be included in the list under this  
7 subsection (d).

8           Notwithstanding any other law or Department rule, the  
9 maximum travel time and distance standards and appointment  
10 wait-time standards shall be no greater than any such  
11 standards established for qualified health plans in  
12 Federally-Facilitated Exchanges by federal law or by the  
13 federal Centers for Medicare and Medicaid Services, even if  
14 the network plan is issued in the large group market or is  
15 otherwise not issued through an exchange. Federal standards  
16 for stand-alone dental plans shall only apply to such network  
17 plans. In the absence of an applicable Department rule, the  
18 federal standards shall apply for the time period specified in  
19 the federal law, regulation, or guidance. If the Centers for  
20 Medicare and Medicaid Services establish standards that are  
21 more stringent than the standards in effect under any  
22 Department rule, the Department may amend its rules to conform  
23 to the more stringent federal standards.

24           If the federal area designations for the maximum time or  
25 distance or appointment wait-time standards required are  
26 changed by the most recent Letter to Issuers in the

1 Federally-facilitated Marketplaces, the Department shall post  
2 on its website notice of such changes and may amend its rules  
3 to conform to those designations if the Director deems  
4 appropriate.

5 If the federal Centers for Medicare and Medicaid Services  
6 establishes appointment wait-time standards for qualified  
7 health plans, including stand-alone dental plans, in the type  
8 of exchange in use in this State for a given plan year, the  
9 Department shall enforce those standards for the same types of  
10 qualified health plans for that plan year. If the federal  
11 Centers for Medicare and Medicaid Services establishes time  
12 and distance standards for stand-alone dental plans in the  
13 type of exchange in use in this State for a given plan year,  
14 the Department shall enforce those standards for stand-alone  
15 dental plans for that plan year.

16 (d-5) (1) Every issuer shall ensure that beneficiaries have  
17 timely and proximate access to treatment for mental,  
18 emotional, nervous, or substance use disorders or conditions  
19 in accordance with the provisions of paragraph (4) of  
20 subsection (a) of Section 370c of the Illinois Insurance Code.  
21 Issuers shall use a comparable process, strategy, evidentiary  
22 standard, and other factors in the development and application  
23 of the network adequacy standards for timely and proximate  
24 access to treatment for mental, emotional, nervous, or  
25 substance use disorders or conditions and those for the access  
26 to treatment for medical and surgical conditions. As such, the

1 network adequacy standards for timely and proximate access  
2 shall equally be applied to treatment facilities and providers  
3 for mental, emotional, nervous, or substance use disorders or  
4 conditions and specialists providing medical or surgical  
5 benefits pursuant to the parity requirements of Section 370c.1  
6 of the Illinois Insurance Code and the federal Paul Wellstone  
7 and Pete Domenici Mental Health Parity and Addiction Equity  
8 Act of 2008. Notwithstanding the foregoing, the network  
9 adequacy standards for timely and proximate access to  
10 treatment for mental, emotional, nervous, or substance use  
11 disorders or conditions shall, at a minimum, satisfy the  
12 following requirements:

13 (A) For beneficiaries residing in the metropolitan  
14 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,  
15 network adequacy standards for timely and proximate access  
16 to treatment for mental, emotional, nervous, or substance  
17 use disorders or conditions means a beneficiary shall not  
18 have to travel longer than 30 minutes or 30 miles from the  
19 beneficiary's residence to receive outpatient treatment  
20 for mental, emotional, nervous, or substance use disorders  
21 or conditions. Beneficiaries shall not be required to wait  
22 longer than 10 business days between requesting an initial  
23 appointment and being seen by the facility or provider of  
24 mental, emotional, nervous, or substance use disorders or  
25 conditions for outpatient treatment or to wait longer than  
26 20 business days between requesting a repeat or follow-up

1 appointment and being seen by the facility or provider of  
2 mental, emotional, nervous, or substance use disorders or  
3 conditions for outpatient treatment; however, subject to  
4 the protections of paragraph (3) of this subsection, a  
5 network plan shall not be held responsible if the  
6 beneficiary or provider voluntarily chooses to schedule an  
7 appointment outside of these required time frames.

8 (B) For beneficiaries residing in Illinois counties  
9 other than those counties listed in subparagraph (A) of  
10 this paragraph, network adequacy standards for timely and  
11 proximate access to treatment for mental, emotional,  
12 nervous, or substance use disorders or conditions means a  
13 beneficiary shall not have to travel longer than 60  
14 minutes or 60 miles from the beneficiary's residence to  
15 receive outpatient treatment for mental, emotional,  
16 nervous, or substance use disorders or conditions.  
17 Beneficiaries shall not be required to wait longer than 10  
18 business days between requesting an initial appointment  
19 and being seen by the facility or provider of mental,  
20 emotional, nervous, or substance use disorders or  
21 conditions for outpatient treatment or to wait longer than  
22 20 business days between requesting a repeat or follow-up  
23 appointment and being seen by the facility or provider of  
24 mental, emotional, nervous, or substance use disorders or  
25 conditions for outpatient treatment; however, subject to  
26 the protections of paragraph (3) of this subsection, a

1 network plan shall not be held responsible if the  
2 beneficiary or provider voluntarily chooses to schedule an  
3 appointment outside of these required time frames.

4 (2) For beneficiaries residing in all Illinois counties,  
5 network adequacy standards for timely and proximate access to  
6 treatment for mental, emotional, nervous, or substance use  
7 disorders or conditions means a beneficiary shall not have to  
8 travel longer than 60 minutes or 60 miles from the  
9 beneficiary's residence to receive inpatient or residential  
10 treatment for mental, emotional, nervous, or substance use  
11 disorders or conditions.

12 (3) If there is no in-network facility or provider  
13 available for a beneficiary to receive timely and proximate  
14 access to treatment for mental, emotional, nervous, or  
15 substance use disorders or conditions in accordance with the  
16 network adequacy standards outlined in this subsection, the  
17 issuer shall provide necessary exceptions to its network to  
18 ensure admission and treatment with a provider or at a  
19 treatment facility in accordance with the network adequacy  
20 standards in this subsection at the in-network benefit level.

21 (A) For plan or policy years beginning on or after  
22 January 1, 2026, the issuer also shall provide reasonable  
23 reimbursement to a beneficiary who has received an  
24 exception as outlined in this paragraph (3) for costs  
25 including food, lodging, and travel.

26 (i) Reimbursement for food and lodging shall be at

1 the prevailing federal per diem rates then in effect,  
2 as set by the United States General Services  
3 Administration. Reimbursement for travel by vehicle  
4 shall be reimbursed at the current Internal Revenue  
5 Service mileage standard for miles driven for  
6 transportation or travel expenses.

7 (ii) At the time an issuer grants an exception  
8 under this paragraph (3), the issuer shall give  
9 written notification to the beneficiary of potential  
10 eligibility for reimbursement under this subparagraph  
11 (A) and instructions on how to file a claim for such  
12 reimbursement, including a link to the claim form on  
13 the issuer's public website and a phone number for a  
14 beneficiary to request that the issuer send a hard  
15 copy of the claim form by postal mail. The Department  
16 shall create the template for the reimbursement  
17 notification form, which issuers shall fill in and  
18 post on their public website.

19 (iii) An issuer may require a beneficiary to  
20 submit a claim for food, travel, or lodging  
21 reimbursement within 60 days of the last date of the  
22 health care service for which travel was undertaken,  
23 and the beneficiary may appeal any denial of  
24 reimbursement claims.

25 (iv) An issuer may deny reimbursement for food,  
26 lodging, and travel if the provider's site of care is

1           neither within this State nor within 100 miles of the  
2           beneficiary's residence unless, after a good faith  
3           effort, no provider can be found who is available  
4           within those parameters to provide the medically  
5           necessary health care service within 10 business days  
6           of a request for appointment.

7           (B) Notwithstanding any other provision of this  
8           Section to the contrary, subparagraph (A) of this  
9           paragraph (3) does not apply to policies issued or  
10          delivered in this State that provide medical assistance  
11          under the Illinois Public Aid Code or the Children's  
12          Health Insurance Program Act.

13          (4) If the federal Centers for Medicare and Medicaid  
14          Services establishes or law requires more stringent standards  
15          for qualified health plans in the Federally-Facilitated  
16          Exchanges, the federal standards shall control for all network  
17          plans for the time period specified in the federal law,  
18          regulation, or guidance, even if the network plan is issued in  
19          the large group market, is issued through a different type of  
20          Exchange, or is otherwise not issued through an Exchange.

21          (5) If the federal Centers for Medicare and Medicaid  
22          Services establishes a more stringent standard in any county  
23          than specified in paragraph (1) or (2) of this subsection  
24          (d-5) for qualified health plans in the type of exchange in use  
25          in this State for a given plan year, the federal standard shall  
26          apply in lieu of the standard in paragraph (1) or (2) of this

1 subsection (d-5) for qualified health plans for that plan  
2 year.

3 (e) Except for network plans solely offered as a group  
4 health plan, these ratio and time and distance standards apply  
5 to the lowest cost-sharing tier of any tiered network.

6 (f) The network plan may consider use of other health care  
7 service delivery options, such as telemedicine or telehealth,  
8 mobile clinics, and centers of excellence, or other ways of  
9 delivering care to partially meet the requirements set under  
10 this Section.

11 (g) Except for the requirements set forth in subsection  
12 (d-5), issuers who are not able to comply with the provider  
13 ratios, time and distance standards, and appointment wait-time  
14 standards established under this Act or federal law may  
15 request an exception to these requirements from the  
16 Department. The Department may grant an exception in the  
17 following circumstances:

18 (1) if no providers or facilities meet the specific  
19 time and distance standard in a specific service area and  
20 the issuer (i) discloses information on the distance and  
21 travel time points that beneficiaries would have to travel  
22 beyond the required criterion to reach the next closest  
23 contracted provider outside of the service area and (ii)  
24 provides contact information, including names, addresses,  
25 and phone numbers for the next closest contracted provider  
26 or facility;

1           (2) if patterns of care in the service area do not  
2           support the need for the requested number of provider or  
3           facility type and the issuer provides data on local  
4           patterns of care, such as claims data, referral patterns,  
5           or local provider interviews, indicating where the  
6           beneficiaries currently seek this type of care or where  
7           the physicians currently refer beneficiaries, or both; or

8           (3) other circumstances deemed appropriate by the  
9           Department consistent with the requirements of this Act.

10          (h) Issuers are required to report to the Director any  
11          material change to an approved network plan within 15 business  
12          days after the change occurs and any change that would result  
13          in failure to meet the requirements of this Act. The issuer  
14          shall submit a revised version of the portions of the network  
15          adequacy filing affected by the material change, as determined  
16          by the Director by rule, and the issuer shall attach versions  
17          with the changes indicated for each document that was revised  
18          from the previous version of the filing. Upon notice from the  
19          issuer, the Director shall reevaluate the network plan's  
20          compliance with the network adequacy and transparency  
21          standards of this Act. For every day past 15 business days that  
22          the issuer fails to submit a revised network adequacy filing  
23          to the Director, the Director may order a fine of \$5,000 per  
24          day.

25          (i) If a network plan is inadequate under this Act with  
26          respect to a provider type in a county, and if the network plan

1 does not have an approved exception for that provider type in  
2 that county pursuant to subsection (g), an issuer shall cover  
3 out-of-network claims for covered health care services  
4 received from that provider type within that county at the  
5 in-network benefit level and shall retroactively adjudicate  
6 and reimburse beneficiaries to achieve that objective if their  
7 claims were processed at the out-of-network level contrary to  
8 this subsection. Nothing in this subsection shall be construed  
9 to supersede Section 356z.3a of the Illinois Insurance Code.

10 (j) If the Director determines that a network is  
11 inadequate in any county and no exception has been granted  
12 under subsection (g) and the issuer does not have a process in  
13 place to comply with subsection (d-5), the Director may  
14 prohibit the network plan from being issued or renewed within  
15 that county until the Director determines that the network is  
16 adequate apart from processes and exceptions described in  
17 subsections (d-5) and (g). Nothing in this subsection shall be  
18 construed to terminate any beneficiary's health insurance  
19 coverage under a network plan before the expiration of the  
20 beneficiary's policy period if the Director makes a  
21 determination under this subsection after the issuance or  
22 renewal of the beneficiary's policy or certificate because of  
23 a material change. Policies or certificates issued or renewed  
24 in violation of this subsection may subject the issuer to a  
25 civil penalty of \$5,000 per policy.

26 (k) For the Department to enforce any new or modified

1 federal standard before the Department adopts the standard by  
2 rule, the Department must, no later than May 15 before the  
3 start of the plan year, give public notice to the affected  
4 health insurance issuers through a bulletin.

5 (Source: P.A. 103-650, eff. 1-1-25; 103-656, eff. 1-1-25;  
6 103-718, eff. 7-19-24; 103-777, eff. 1-1-25; 103-906, eff.  
7 1-1-25; 104-28, eff. 1-1-26; 104-175, eff. 1-1-26; 104-334,  
8 eff. 8-15-25; revised 10-28-25.)

9 Section 910. The Illinois Public Aid Code is amended by  
10 changing Section 5-5.12e as follows:

11 (305 ILCS 5/5-5.12e)

12 Sec. 5-5.12e. Managed care organization prior  
13 authorization of health care services.

14 (a) As used in this Section, "health care service" has the  
15 meaning given to that term in the Standardized Prior  
16 Authorization Act ~~Prior Authorization Reform Act.~~

17 (b) Notwithstanding any other provision of law to the  
18 contrary, all managed care organizations shall comply with the  
19 requirements of the Prior Authorization Reform Act.

20 (Source: P.A. 102-409, eff. 1-1-22; 102-813, eff. 5-13-22.)

21 (215 ILCS 200/Act rep.)

22 Section 915. The Prior Authorization Reform Act is  
23 repealed.

1           Section 999. Effective date. This Act takes effect January  
2    1, 2027.