HB5557

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5557

Introduced 2/13/2026, by Rep. Maura Hirschauer

SYNOPSIS AS INTRODUCED:

215 ILCS 5/355.8 new

Amends the Illinois Insurance Code. Contains findings. Requires each health carrier to annually submit completed templates with both plan-level and carrier-level data to the Director of Insurance in the form, manner, and time prescribed by the Director by no later than July 1 of each year for data from the previous calendar year. Provides that data must be sufficient to support independent technical evaluation and to enable meaningful public understanding of access to and coverage for each facility type and specified professional provider type. Requires each health carrier to report, disaggregated by facility type, professional provider type, youth, adult, in-person, and telehealth, the specified data elements. Requires the Director to post, in an easily accessible, consumer-friendly manner, on a public website, all underlying data and data files reported no later than 3 months after receipt. Sets forth provisions concerning certification of health carriers and administration and enforcement of the provisions. Provides that the data submission requirements apply to health benefit plans issued or renewed on or after January 1, 2027. Effective immediately.

LRB104 20200 BAB 33651 b

A BILL FOR

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. This Act may be referred to as the Truth in
5 Mental Health Coverage Act.

6 Section 2. Findings. The General Assembly finds that:
7 (1) Analyses by Milliman (2017, 2019) and RTI
8 International (2024) demonstrate that, over multiple
9 years, Illinois residents have experienced substantially
10 greater difficulty accessing in-network mental health and
11 substance use disorder services than accessing medical or
12 surgical services.
13 (2) In 2021, Illinois residents were 90% more likely
14 to receive outpatient behavioral health services out of
15 network than outpatient medical or surgical services; 190%
16 percent more likely to receive outpatient facility
17 behavioral health services out of network; and 350% more
18 likely to receive inpatient behavioral health services out
19 of network.
20 (3) In Illinois, average in-network reimbursement in
21 2021 for medical or surgical clinicians was 21%higher than
22 for behavioral health clinicians, indexed to Medicare
23 reimbursement. This gap discourages behavioral health

1 clinicians from joining insurance networks and further
2 limits access to care for enrollees. More recent
3 Illinois-specific data are unavailable due to the absence
4 of standardized public reporting requirements.
5 (4) Federal regulators have cited the RTI
6 International data as evidence of the need for greater
7 accountability and transparency by health plans and
8 issuers.
9 (5) Youth face even greater barriers to access due to
10 health benefit plans' narrow networks that lack sufficient
11 child and adolescent behavioral health providers.
12 (6) Independent economic analyses by McKinsey &
13 Company show that individuals with behavioral health
14 diagnoses incur between 2 times and 4 times higher total
15 medical costs than those without such diagnoses, largely
16 because untreated behavioral health conditions worsen
17 physical health outcomes. Analyses by Milliman show that
18 individuals with behavioral health diagnoses incur between
19 3.2 times and 6.2 times higher medical costs. Earlier
20 access to effective treatment reduces these downstream
21 costs.
22 (7) Transparent, comparable information on coverage
23 and access, including information maintained on a public
24 dashboard, is an essential regulatory function necessary
25 to effectuate compliance with State insurance laws,
26 protect consumers and employers as informed purchasers,

1 and reduce the higher downstream medical costs associated
2 with untreated mental health and substance use disorders.

3 Section 5. The Illinois Insurance Code is amended by
4 adding Section 355.8 as follows:

5 (215 ILCS 5/355.8 new)
6 Sec. 355.8. Truth in mental health coverage reporting
7 requirements.
8 (a) In this Section:
9 "Adult" means an individual 18 years of age or older.
10 "Facility type" means categories of facilities and levels
11 of care in which mental health disorder services, substance
12 use disorder services, behavioral health services, or medical
13 or surgical services are delivered, including outpatient
14 facilities such as intensive outpatient programs, partial
15 hospitalization programs, and outpatient surgery facilities,
16 acute inpatient facilities, and subacute inpatient facilities
17 such as residential and skilled nursing facilities.
18 "Health benefit plan" has the meaning given to that term
19 in Section 370c of this Code.
20 "Health carrier" has the meaning given to that term in
21 Section 370c of this Code.
22 "Mental health and substance use disorders" means mental,
23 emotional, nervous, or substance use disorders, as that term
24 is used in Section 370c of this Code.

1 "Mental health disorders" means mental, emotional, or
2 nervous disorders other than substance use disorders, as
3 classified in the mental and behavioral disorders chapters of
4 the most current version of the International Classification
5 of Diseases and the mental disorder diagnostic categories of
6 the most current version of the Diagnostic and Statistical
7 Manual of Mental Disorders.

8 "Medical or surgical disorders" means all physical health
9 conditions or diseases that are not mental health disorders or
10 substance use disorders.

11 "Medical or surgical services" means health care services
12 or benefits for the diagnosis or treatment of medical or
13 surgical disorders.

14 "Out-of-network allowed claims" means claims allowed at
15 the out-of-network benefit level, with corresponding enrollee
16 cost-sharing, rather than the in-network benefit level.

17 "Plan level" means a carrier's product or health benefit
18 plan, as defined by the Director for purposes of public
19 comparison.

20 "Professional provider type" means categories of health
21 care professionals that furnish mental health disorder
22 services, substance use disorder services, behavioral health
23 services, or medical or surgical services in an office
24 setting, including, but not limited to, psychiatrists,
25 psychologists, psychiatric nurse practitioners, other
26 independently licensed behavioral health clinicians, primary

1 care physicians, medical or surgical specialist physicians,
2 physician assistants, and medical or surgical nurse
3 practitioners, and includes youth-serving providers.
4 "Substance use disorders" means disorders classified in
5 the substance-related and addictive disorders chapters of the
6 most current version of the International Classification of
7 Diseases and the substance-related and addictive disorders
8 diagnostic categories of the most current version of the
9 Diagnostic and Statistical Manual of Mental Disorders.
10 "Templates" means Microsoft Excel or similar documents
11 containing embedded formulas for quantitative data using
12 definitions and instructions specified by the Director.
13 "Utilization review" has the meaning given to that term in
14 Section 370c of this Code.
15 "Youth" means an individual under 18 years of age.
16 (b)(1) Each health carrier shall annually submit completed
17 templates with both plan-level and carrier-level data to the
18 Director in the form, manner, and time prescribed by the
19 Director by no later than July 1 of each year for data from the
20 previous calendar year.
21 (2) Data must be sufficient to support independent
22 technical evaluation and to enable meaningful public
23 understanding of access to and coverage for each facility type
24 and professional provider type of:
25 (A) mental health disorder services;
26 (B) substance use disorder services;

1 (C) behavioral health services;
2 (D) medical or surgical services;
3 (E) youth and adult services, separately and combined;
4 (F) in-person and telehealth services, separately and
5 combined;
6 (G) geographic area, as specified by the Director; and
7 (H) whether the facility or professional provider is
8 affiliated with, owned by, or under common control with
9 the health carrier.
10 (3) Any data cell containing fewer than 11 enrollees must
11 be suppressed consistent with Centers for Medicare and
12 Medicaid Services cell-suppression standards.
13 (c) Each health carrier shall report, disaggregated by
14 facility type, professional provider type, youth, adult,
15 in-person, and telehealth:
16 (1) utilization review, including the number and
17 percentage of approvals, modified approvals, denials, and
18 partial denials, average decision timeframes, top denial
19 reasons, and other measures specified by the Director to
20 assess the effects of utilization review on access to
21 timely, clinically appropriate care;
22 (2) out-of-network utilization rates using allowed
23 claims data;
24 (3) in-network reimbursement, including average
25 allowed amounts and allowed amounts at the 50th, 75th, and
26 95th percentiles, each indexed to Medicare;

1 (4) the number of unique enrollees served by listed
2 in-network professional providers, including
3 youth-serving providers;
4 (5) the percentage of listed in-network providers
5 relative to State-licensed providers of the same type,
6 including youth-serving providers;
7 (6) network admission evaluation, including the
8 average time from completed application to network
9 admission for each facility and professional provider
10 type, including youth-serving facilities and professional
11 providers;
12 (7) psychiatric Collaborative Care Model data,
13 including the number of enrollees, pediatric and adult
14 collaborative care separately, penetration rate per
15 100,000 covered lives with a behavioral health diagnosis,
16 and reimbursement indexed to Medicare;
17 (8) appeals and external review, including counts and
18 outcomes of adverse benefit determinations and independent
19 review decisions; and
20 (9) additional metrics the Director determines
21 necessary for public comparison or oversight.
22 (d) In specifying the templates, the Director shall review
23 formats that are:
24 (1) used by state insurance regulators;
25 (2) endorsed and used by one or more employer
26 coalitions, human resources associations, or mental health

1 nonprofit organizations; and
2 (3) cited by the United States Department of Labor or
3 the United States Department of Health and Human Services.
4 (e)(1) The Director shall post, in an easily accessible,
5 consumer-friendly manner, on a public website, all underlying
6 data and data files reported under this Section no later than 3
7 months after receipt.
8 (2) The posting must include raw data and downloadable
9 files in a machine-readable format to permit public analysis,
10 research, and independent comparison.
11 (3) Data must be posted separately for the plan level and
12 aggregated at the carrier level.
13 (4) Information collected under this Section is not
14 proprietary or confidential and must be publicly disclosed,
15 subject only to cell-suppression standards.
16 (f)(1) The Director shall maintain an interactive public
17 dashboard that visually presents the posted data, including
18 separate display of youth and adult outcomes, and allows
19 comparison across plans and carriers.
20 (2) The dashboard must allow users to view metrics for
21 mental health disorder services, substance use disorder
22 services, behavioral health services, and medical or surgical
23 services, separately and combined.
24 (3) The dashboard must be updated no later than 3 months
25 after receipt of the data.
26 (g) Each health carrier shall submit a certification, in a

1 form and manner specified by the Director, signed under
2 penalty of perjury by the chief financial officer of the
3 carrier, stating that the reported data are complete and
4 accurate and follow template definitions and instructions.
5 (h)(1) The Director shall adopt uniform templates,
6 definitions, audit procedures, and correction protocols to
7 ensure comparability across carriers and over time. The
8 Director may satisfy reporting requirements under this Section
9 by using data already collected or maintained by the
10 Department for any regulatory, oversight, or enforcement
11 purpose. Data used or incorporated for purposes of this
12 Section is deemed collected for public reporting and must be
13 made available in accordance with this Section.
14 (2) The Director may adopt rules to carry out this
15 Section.
16 (3) Each health carrier must retain all data underlying
17 the reported information for at least 3 years and make such
18 records available to the Director upon request.
19 (i) A health carrier's failure to comply with this Section
20 constitutes an unfair or deceptive act or practice under this
21 Code and is subject to enforcement by the Director, including
22 referral to the Attorney General.
23 (j) The costs of implementing and administering this Act
24 shall be paid from the Insurance Producer Administration Fund
25 or another appropriate regulatory fund administered by the
26 Department, and such costs shall reflect the actual and

1 reasonable costs incurred by the Department in administering,
2 overseeing, and enforcing this Section with respect to health
3 carriers subject to this Section.
4 (k) This Section applies to health benefit plans issued or
5 renewed on or after January 1, 2027.
6 (l) The provisions of this Section are severable under
7 Section 1.31 of the Statute on Statutes.

8 Section 99. Effective date. This Act takes effect upon
9 becoming law.