SB2286

LRB10410418BABAB20493b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB2286

Introduced 2/7/2025, by Sen. Mike Simmons

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.62
215 ILCS 200/78 new

Amends the Prior Authorization Reform Act. Provides that, notwithstanding any other provision of law, a health insurance issuer or a contracted utilization review organization may not require prior authorization for preventive health services recommended by a health care professional. Amends the Illinois Insurance Code. Provides that a policy of group health insurance coverage or individual health insurance coverage shall, at a minimum, provide coverage and shall not require prior authorization or impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for specified preventive health services. Effective January 1, 2027.

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A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Section 356z.62 as follows:

(215 ILCS 5/356z.62)

Sec. 356z.62. Coverage of preventive health services.

(a) A policy of group health insurance coverage or individual health insurance coverage as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act shall, at a minimum, provide coverage ~~for~~ and shall not require prior authorization or impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) with respect to infants, children, and

adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) of this subsection (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

(b) For purposes of this Section, and for purposes of any other provision of State law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(c) For office visits:

(1) if an item or service described in subsection (a) is billed separately or is tracked as individual encounter data separately from an office visit, then a policy may impose cost-sharing requirements with respect to the office visit;

(2) if an item or service described in subsection (a) is not billed separately or is not tracked as individual encounter data separately from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a policy may not impose cost-sharing requirements with respect to the office

visit; and

(3) if an item or service described in subsection (a) is not billed separately or is not tracked as individual encounter data separately from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a policy may impose cost-sharing requirements with respect to the office visit.

(d) A policy must provide coverage pursuant to subsection (a) for plan or policy years that begin on or after the date that is one year after the date the recommendation or guideline is issued. If a recommendation or guideline is in effect on the first day of the plan or policy year, the policy shall cover the items and services specified in the recommendation or guideline through the last day of the plan or policy year unless either:

(1) a recommendation under paragraph (1) of subsection (a) is downgraded to a "D" rating; or

(2) the item or service is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during the plan or policy year.

(e) Network limitations.

(1) Subject to paragraph (3) of this subsection, nothing in this Section requires coverage for items or services described in subsection (a) that are delivered by

an out-of-network provider under a health maintenance organization health care plan, other than a point-of-service contract, or under a voluntary health services plan that generally excludes coverage for out-of-network services except as otherwise required by law.

(2) Subject to paragraph (3) of this subsection, nothing in this Section precludes a policy with a preferred provider program under Article XX-1/2 of this Code, a health maintenance organization point-of-service contract, or a similarly designed voluntary health services plan from imposing cost-sharing requirements for items or services described in subsection (a) that are delivered by an out-of-network provider.

(3) If a policy does not have in its network a provider who can provide an item or service described in subsection (a), then the policy must cover the item or service when performed by an out-of-network provider and it may not impose cost-sharing with respect to the item or service.

(f) Nothing in this Section prevents a company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsection (a) to the extent not specified in the recommendation or guideline.

(g) Nothing in this Section shall be construed to prohibit a policy from providing coverage for items or services in

addition to those required under subsection (a) or from denying coverage for items or services that are not required under subsection (a). Unless prohibited by other law, a policy may impose cost-sharing requirements for a treatment not described in subsection (a) even if the treatment results from an item or service described in subsection (a). Nothing in this Section shall be construed to limit coverage requirements provided under other law.

(h) The Director may develop guidelines to permit a company to utilize value-based insurance designs. In the absence of guidelines developed by the Director, any such guidelines developed by the Secretary of the U.S. Department of Health and Human Services that are in force under 42 U.S.C. 300gg-13 shall apply.

(i) For student health insurance coverage as defined at 45 CFR 147.145, student administrative health fees are not considered cost-sharing requirements with respect to preventive services specified under subsection (a). As used in this subsection, "student administrative health fee" means a fee charged by an institution of higher education on a periodic basis to its students to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

(j) For any recommendation or guideline specifically referring to women or men, a company shall not deny or limit

the coverage required or a claim made under subsection (a) based solely on the individual's recorded sex or actual or perceived gender identity, or for the reason that the individual is gender nonconforming, intersex, transgender, or has undergone, or is in the process of undergoing, gender transition, if, notwithstanding the sex or gender assigned at birth, the covered individual meets the conditions for the recommendation or guideline at the time the item or service is furnished.

(k) This Section does not apply to grandfathered health plans, excepted benefits, or short-term, limited-duration health insurance coverage.

(Source: P.A. 103-551, eff. 8-11-23.)

Section 10. The Prior Authorization Reform Act is amended by adding Section 78 as follows:

(215 ILCS 200/78 new)

Sec. 78. Prior authorization for preventive care recommended by a physician. Notwithstanding any other provision of law, a health insurance issuer or a contracted utilization review organization may not require prior authorization for preventive health services recommended by a health care professional, as defined in Section 10 of the Managed Care Reform and Patient Rights Act.

Section 99. Effective date. This Act takes effect January

1, 2027.