

# SB3024



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

SB3024

Introduced 1/28/2026, by Sen. Mike Simmons

#### SYNOPSIS AS INTRODUCED:

215 ILCS 5/370c

from Ch. 73, par. 982c

Amends the Illinois Insurance Code. Requires a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2027 to cover up to 12 mental health provider visits per plan year, with no visitation restrictions, if a local or State emergency is declared due to immigration enforcement activity and the insured has experienced loss, trauma, or displacement due to such activity. Provides that the coverage shall not be subject to deductibles, copayments, or other forms of cost sharing. Effective immediately.

LRB104 18555 BAB 31998 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 5. The Illinois Insurance Code is amended by  
5 changing Section 370c as follows:

6 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

7 Sec. 370c. Mental and emotional disorders.

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

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

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

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

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

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

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

23 (b) (1) (Blank).

24 (2) (Blank).

25 (2.5) (Blank).

26 (3) Unless otherwise prohibited by federal law and

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

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

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

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

13 (i) 45 days of inpatient treatment; and

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

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

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

1 visits covered under the plan.

2 (C) (Blank).

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

12 (5.5) An individual or group health benefit plan amended,  
13 delivered, issued, or renewed on or after September 9, 2015  
14 (the effective date of Public Act 99-480) shall offer coverage  
15 for medically necessary acute treatment services and medically  
16 necessary clinical stabilization services. The treating  
17 provider shall base all treatment recommendations and the  
18 health benefit plan shall base all medical necessity  
19 determinations for substance use disorders in accordance with  
20 the most current edition of the Treatment Criteria for  
21 Addictive, Substance-Related, and Co-Occurring Conditions  
22 established by the American Society of Addiction Medicine. The  
23 treating provider shall base all treatment recommendations and  
24 the health benefit plan shall base all medical necessity  
25 determinations for medication-assisted treatment in accordance  
26 with the most current Treatment Criteria for Addictive,

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

3 As used in this subsection:

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

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

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

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

21 (6.5) An individual or group health benefit plan amended,  
22 delivered, issued, or renewed on or after January 1, 2019 (the  
23 effective date of Public Act 100-1024):

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

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

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

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

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

23 (7) (Blank).

24 (8) (Blank).

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

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

5 (10) A group or individual policy of accident and health  
6 insurance or a managed care plan that is amended, delivered,  
7 issued, or renewed on or after January 1, 2027 shall cover up  
8 to 12 mental health provider visits per plan year, with no  
9 visitation restrictions, if a local or State emergency is  
10 declared due to immigration enforcement activity and the  
11 insured has experienced loss, trauma, or displacement due to  
12 such activity. The coverage shall not be subject to  
13 deductibles, copayments, or other forms of cost sharing.

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

17 (d) With respect to a group or individual policy of  
18 accident and health insurance or a qualified health plan  
19 offered through the health insurance marketplace, the  
20 Department and, with respect to medical assistance, the  
21 Department of Healthcare and Family Services shall each  
22 enforce the requirements of this Section and Sections 356z.23  
23 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici  
24 Mental Health Parity and Addiction Equity Act of 2008, 42  
25 U.S.C. 18031(j), and any amendments to, and federal guidance  
26 or regulations issued under, those Acts, including, but not

1 limited to, final regulations issued under the Paul Wellstone  
2 and Pete Domenici Mental Health Parity and Addiction Equity  
3 Act of 2008 and final regulations applying the Paul Wellstone  
4 and Pete Domenici Mental Health Parity and Addiction Equity  
5 Act of 2008 to Medicaid managed care organizations, the  
6 Children's Health Insurance Program, and alternative benefit  
7 plans. Specifically, the Department and the Department of  
8 Healthcare and Family Services shall take action:

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

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

23 (3) performing parity compliance market conduct  
24 examinations or, in the case of the Department of  
25 Healthcare and Family Services, parity compliance audits  
26 of individual and group plans and policies, including, but

1 not limited to, reviews of:

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

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

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

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

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

17 (e) Availability of plan information.

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

1 current or potential participant, beneficiary, or  
2 contracting provider upon request.

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

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

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

25 "Benefits", with respect to insurers that are not Medicaid  
26 managed care organizations, means the benefits provided for

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

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

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

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

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

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

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

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

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

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

24 (D) upon determination that a service was excluded  
25 under the terms of coverage. For situations that qualify  
26 under this subparagraph (D), the limitation to billing for

1 a copayment, coinsurance, or deductible shall not apply;

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

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

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

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

24 If an expedited external review request meets the criteria  
25 of the Health Carrier External Review Act, an independent  
26 review organization shall make a final determination of

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

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

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

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

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

25 (h) As used in this Section:

26 "Generally accepted standards of mental, emotional,

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

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

- 25 (1) in accordance with the generally accepted  
26 standards of mental, emotional, nervous, or substance use

1 disorder or condition care;

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

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

7 "Utilization review" means either of the following:

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

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

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

25 (i)(1) Every insurer that amends, delivers, issues, or  
26 renews a group or individual policy of accident and health

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

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

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

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

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

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

26 (k) An insurer shall base any medical necessity

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

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

1     Addiction Medicine.

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

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

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

1 subsection (k).

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

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

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

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

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

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

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

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

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

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

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

26 (8) Maintain documentation of interrater reliability

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

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

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

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

1 Advancement Fund established in subsection (i) of Section  
2 370c.1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (E) for outpatient treatment or partial  
26 hospitalization programs only, upon determination that

1 a service was not medically necessary consistent with  
2 subsections (h) through (n); or

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

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

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

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

16 (x) Notwithstanding any provision of this Section, nothing  
17 shall require the medical assistance program under Article V  
18 of the Illinois Public Aid Code or the Children's Health  
19 Insurance Program Act to violate any applicable federal laws,  
20 regulations, or grant requirements, including requirements for  
21 utilization management, or any State or federal consent  
22 decrees. Nothing in subsection (g) or (w) shall prevent the  
23 Department of Healthcare and Family Services from requiring a  
24 health care provider to use specified level of care,  
25 admission, continued stay, or discharge criteria, including,  
26 but not limited to, those under Section 5-5.23 of the Illinois

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

1 limited to, the Children's Mental Health Act and the Mental  
2 Health and Developmental Disabilities Administrative Act.

3 (y) (Blank).

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

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