



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4500

Introduced 1/20/2026, by Rep. Margaret Croke

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.40

Amends the Illinois Insurance Code. Provides that, for policies of accident and health insurance amended, delivered, issued, or renewed on or after January 1, 2027, coverage for pregnancy and postpartum care shall include medically necessary blood pressure monitors for pregnant or postpartum insured persons or beneficiaries. Effective immediately.

LRB104 17655 BAB 31086 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 25. The Illinois Insurance Code is amended by
5 adding Section 356z.40 as follows:

6 (215 ILCS 5/356z.40)

7 Sec. 356z.40. Pregnancy and postpartum coverage.

8 (a) An individual or group policy of accident and health
9 insurance or managed care plan amended, delivered, issued, or
10 renewed on or after October 8, 2021 (the effective date of
11 Public Act 102-665) shall provide coverage for pregnancy and
12 newborn care in accordance with 42 U.S.C. 18022(b) regarding
13 essential health benefits. For policies amended, delivered,
14 issued, or renewed on or after January 1, 2026, this
15 subsection also applies to coverage for postpartum care.

16 (b) Benefits under this Section shall be as follows:

17 (1) An individual who has been identified as
18 experiencing a high-risk pregnancy by the individual's
19 treating provider shall have access to clinically
20 appropriate case management programs. As used in this
21 subsection, "case management" means a mechanism to
22 coordinate and assure continuity of services, including,
23 but not limited to, health services, social services, and

1 educational services necessary for the individual. "Case
2 management" involves individualized assessment of needs,
3 planning of services, referral, monitoring, and advocacy
4 to assist an individual in gaining access to appropriate
5 services and closure when services are no longer required.
6 "Case management" is an active and collaborative process
7 involving a single qualified case manager, the individual,
8 the individual's family, the providers, and the community.
9 This includes close coordination and involvement with all
10 service providers in the management plan for that
11 individual or family, including assuring that the
12 individual receives the services. As used in this
13 subsection, "high-risk pregnancy" means a pregnancy in
14 which the pregnant or postpartum individual or baby is at
15 an increased risk for poor health or complications during
16 pregnancy or childbirth, including, but not limited to,
17 hypertension disorders, gestational diabetes, and
18 hemorrhage.

19 (2) An individual shall have access to medically
20 necessary treatment of a mental, emotional, nervous, or
21 substance use disorder or condition consistent with the
22 requirements set forth in this Section and in Sections
23 370c and 370c.1 of this Code. Prior authorization
24 requirements are prohibited to the extent provided in
25 Section 370c.

26 (3) The benefits provided for inpatient and outpatient

1 services for the medically necessary treatment of a
2 mental, emotional, nervous, or substance use disorder or
3 condition related to pregnancy or postpartum complications
4 shall be provided consistent with the requirements of
5 Sections 370c and 370c.1 of this Code. The facility or
6 provider shall notify the insurer of both the admission
7 and the initial treatment plan within 48 hours after
8 admission or initiation of treatment. Subject to the
9 requirements of Sections 370c and 370c.1 of this Code,
10 nothing in this paragraph shall prevent an insurer from
11 applying concurrent and post-service utilization review of
12 health care services, including review of medical
13 necessity, case management, experimental and
14 investigational treatments, managed care provisions, and
15 other terms and conditions of the insurance policy.

16 (4) The benefits for the first 48 hours of initiation
17 of services for an inpatient admission, detoxification or
18 withdrawal management program, or partial hospitalization
19 admission for the treatment of a mental, emotional,
20 nervous, or substance use disorder or condition related to
21 pregnancy or postpartum complications shall be provided
22 without post-service or concurrent review of medical
23 necessity, as the medical necessity for the first 48 hours
24 of such services shall be determined solely by the covered
25 pregnant or postpartum individual's provider. Subject to
26 Sections 370c and 370c.1 of this Code, nothing in this

1 paragraph shall prevent an insurer from applying
2 concurrent and post-service utilization review, including
3 the review of medical necessity, case management,
4 experimental and investigational treatments, managed care
5 provisions, and other terms and conditions of the
6 insurance policy, of any inpatient admission,
7 detoxification or withdrawal management program admission,
8 or partial hospitalization admission services for the
9 treatment of a mental, emotional, nervous, or substance
10 use disorder or condition related to pregnancy or
11 postpartum complications received 48 hours after the
12 initiation of such services. If an insurer determines that
13 the services are no longer medically necessary, then the
14 covered person shall have the right to external review
15 pursuant to the requirements of the Health Carrier
16 External Review Act.

17 (5) If an insurer determines that continued inpatient
18 care, detoxification or withdrawal management, partial
19 hospitalization, intensive outpatient treatment, or
20 outpatient treatment in a facility is no longer medically
21 necessary, the insurer shall, within 24 hours, provide
22 written notice to the covered pregnant or postpartum
23 individual and the covered pregnant or postpartum
24 individual's provider of its decision and the right to
25 file an expedited internal appeal of the determination.
26 The insurer shall review and make a determination with

1 respect to the internal appeal within 24 hours and
2 communicate such determination to the covered pregnant or
3 postpartum individual and the covered pregnant or
4 postpartum individual's provider. If the determination is
5 to uphold the denial, the covered pregnant or postpartum
6 individual and the covered pregnant or postpartum
7 individual's provider have the right to file an expedited
8 external appeal. An independent review organization shall
9 make a determination within 72 hours. If the insurer's
10 determination is upheld and it is determined that
11 continued inpatient care, detoxification or withdrawal
12 management, partial hospitalization, intensive outpatient
13 treatment, or outpatient treatment is not medically
14 necessary, or if the insurer's determination is not
15 appealed, the insurer shall remain responsible for
16 providing benefits for the inpatient care, detoxification
17 or withdrawal management, partial hospitalization,
18 intensive outpatient treatment, or outpatient treatment
19 through the day following the date the determination is
20 made, and the covered pregnant or postpartum individual
21 shall only be responsible for any applicable copayment,
22 deductible, and coinsurance for the stay through that date
23 as applicable under the policy. The covered pregnant or
24 postpartum individual shall not be discharged or released
25 from the inpatient facility, detoxification or withdrawal
26 management, partial hospitalization, intensive outpatient

1 treatment, or outpatient treatment until all internal
2 appeals and independent utilization review organization
3 appeals are exhausted. A decision to reverse an adverse
4 determination shall comply with the Health Carrier
5 External Review Act.

6 (6) Except as otherwise stated in this subsection (b)
7 and subsection (c), the benefits and cost-sharing shall be
8 provided to the same extent as for any other medical
9 condition covered under the policy.

10 (7) The benefits required by paragraphs (2) and (6) of
11 this subsection (b) are to be provided to (i) all covered
12 pregnant or postpartum individuals with a diagnosis of a
13 mental, emotional, nervous, or substance use disorder or
14 condition and (ii) all individuals who have experienced a
15 miscarriage or stillbirth. The presence of additional
16 related or unrelated diagnoses shall not be a basis to
17 reduce or deny the benefits required by this subsection
18 (b).

19 (8) Insurers shall cover all services for pregnancy,
20 postpartum, and newborn care that are rendered by
21 perinatal doulas or licensed certified professional
22 midwives, including home births, home visits, and support
23 during labor, abortion, or miscarriage. Coverage shall
24 include the necessary equipment and medical supplies for a
25 home birth. For home visits by a perinatal doula, not
26 counting any home birth, the policy may limit coverage to

1 16 visits before and 16 visits after a birth, miscarriage,
2 or abortion, provided that the policy shall not be
3 required to cover more than \$8,000 for doula visits for
4 each pregnancy and subsequent postpartum period. As used
5 in this paragraph (8), "perinatal doula" has the meaning
6 given in subsection (a) of Section 5-18.5 of the Illinois
7 Public Aid Code.

8 (9) Coverage for pregnancy, postpartum, and newborn
9 care shall include home visits by lactation consultants
10 and the purchase of breast pumps and breast pump supplies,
11 including such breast pumps, breast pump supplies,
12 breastfeeding supplies, and feeding aids as recommended by
13 the lactation consultant. As used in this paragraph (9),
14 "lactation consultant" means an International
15 Board-Certified Lactation Consultant, a certified
16 lactation specialist with a certification from Lactation
17 Education Consultants, or a certified lactation counselor
18 as defined in subsection (a) of Section 5-18.10 of the
19 Illinois Public Aid Code.

20 (9.5) For policies of accident and health insurance
21 amended, delivered, issued, or renewed on or after January
22 1, 2027, coverage for pregnancy and postpartum care shall
23 include medically necessary blood pressure monitors for
24 pregnant or postpartum insured persons or beneficiaries.

25 (10) Coverage for postpartum services shall apply for
26 all covered services rendered within the first 12 months

1 after the end of pregnancy, subject to any policy
2 limitation on home visits by a perinatal doula allowed
3 under paragraph (8) of this subsection (b). Nothing in
4 this paragraph (10) shall be construed to require a policy
5 to cover services for an individual who is no longer
6 insured or enrolled under the policy. If an individual
7 becomes insured or enrolled under a new policy, the new
8 policy shall cover the individual consistent with the time
9 period and limitations allowed under this paragraph (10).
10 This paragraph (10) is subject to the requirements of
11 Section 25 of the Managed Care Reform and Patient Rights
12 Act, Section 20 of the Network Adequacy and Transparency
13 Act, and 42 U.S.C. 300gg-113.

14 (c) All coverage described in subsection (b), other than
15 health care services for home births, shall be provided
16 without cost-sharing, except that, for mental health services,
17 the cost-sharing prohibition does not apply to inpatient or
18 residential services, and, for substance use disorder
19 services, the cost-sharing prohibition applies only to levels
20 of treatment below and not including Level 3.1 (Clinically
21 Managed Low-Intensity Residential), as established by the
22 American Society for Addiction Medicine. This subsection does
23 not apply to the extent such coverage would disqualify a
24 high-deductible health plan from eligibility for a health
25 savings account pursuant to Section 223 of the Internal
26 Revenue Code.

1 (Source: P.A. 103-650, eff. 1-1-25; 103-701, eff. 1-1-26;
2 103-720, eff. 1-1-26; 104-28, eff. 1-1-26; 104-417, eff.
3 8-15-25.)

4 Section 99. Effective date. This Act takes effect upon
5 becoming law.