Rep. Lindsey LaPointe

Filed: 4/14/2026

1 AMENDMENT TO HOUSE BILL 4585

2 AMENDMENT NO. ______. Amend House Bill 4585 by replacing
3 everything after the enacting clause with the following:

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,

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

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

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

26 (5) Medically necessary treatment and medical necessity

1 determinations shall be interpreted and made in a manner that
2 is consistent with and pursuant to subsections (h) through
3 (y).

4 (b)(1) (Blank).

5 (2) (Blank).

6 (2.5) (Blank).

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

1 or illnesses covered under the policy, including an appeals
2 process. Medical necessity determinations for substance use
3 disorders shall be made in accordance with appropriate patient
4 placement criteria established by the American Society of
5 Addiction Medicine. No additional criteria may be used to make
6 medical necessity determinations for substance use disorders.
7 (4) A group health benefit plan amended, delivered,
8 issued, or renewed on or after January 1, 2019 (the effective
9 date of Public Act 100-1024) or an individual policy of
10 accident and health insurance or a qualified health plan
11 offered through the health insurance marketplace amended,
12 delivered, issued, or renewed on or after January 1, 2019 (the
13 effective date of Public Act 100-1024):
14 (A) shall provide coverage based upon medical
15 necessity for the treatment of a mental, emotional,
16 nervous, or substance use disorder or condition consistent
17 with the parity requirements of Section 370c.1 of this
18 Code; provided, however, that in each calendar year
19 coverage shall not be less than the following:
20 (i) 45 days of inpatient treatment; and
21 (ii) beginning on June 26, 2006 (the effective
22 date of Public Act 94-921), 60 visits for outpatient
23 treatment including group and individual outpatient
24 treatment; and
25 (iii) for plans or policies delivered, issued for
26 delivery, renewed, or modified after January 1, 2007

1 (the effective date of Public Act 94-906), 20
2 additional outpatient visits for speech therapy for
3 treatment of pervasive developmental disorders that
4 will be in addition to speech therapy provided
5 pursuant to item (ii) of this subparagraph (A); and
6 (B) may not include a lifetime limit on the number of
7 days of inpatient treatment or the number of outpatient
8 visits covered under the plan.
9 (C) (Blank).
10 (5) An issuer of a group health benefit plan or an
11 individual policy of accident and health insurance or a
12 qualified health plan offered through the health insurance
13 marketplace may not count toward the number of outpatient
14 visits required to be covered under this Section an outpatient
15 visit for the purpose of medication management and shall cover
16 the outpatient visits under the same terms and conditions as
17 it covers outpatient visits for the treatment of physical
18 illness.
19 (5.5) An individual or group health benefit plan amended,
20 delivered, issued, or renewed on or after September 9, 2015
21 (the effective date of Public Act 99-480) shall offer coverage
22 for medically necessary acute treatment services and medically
23 necessary clinical stabilization services. The treating
24 provider shall base all treatment recommendations and the
25 health benefit plan shall base all medical necessity
26 determinations for substance use disorders in accordance with

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

10 As used in this subsection:

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

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

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

25 (6) An issuer of a group health benefit plan may provide or
26 offer coverage required under this Section through a managed

care plan.

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

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

(B) shall not impose any step therapy requirements;

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

(D) shall not exclude coverage for a prescription medication approved by the United States Food and Drug Administration for the treatment of substance use

1 disorders and any associated counseling or wraparound
2 services on the grounds that such medications and services
3 were court ordered.
4 (7) (Blank).
5 (8) (Blank).
6 (9) With respect to all mental, emotional, nervous, or
7 substance use disorders or conditions, coverage for inpatient
8 treatment shall include coverage for treatment in a
9 residential treatment center certified or licensed by the
10 Department of Public Health or the Department of Human
11 Services.
12 (A) Coverage for treatment in a residential treatment
13 center shall include residential coverage for the
14 diagnosis and treatment of substance use disorders,
15 including at American Society of Addiction Medicine levels
16 of treatment 3.5 (Clinically Managed High-Intensity
17 Residential) and 3.7 (Medically Managed Residential). This
18 coverage shall include medically necessary treatment for
19 substance use disorder treatment services provided in
20 residential settings. This coverage shall not apply
21 financial requirements or treatment limitations, including
22 concurrent or utilization review requirements, to
23 residential substance use disorder benefits that are more
24 restrictive than the predominant financial requirements
25 and treatment limitations applied to other medical and
26 surgical benefits covered by the policy.

1 (B) Coverage for treatment in a residential treatment
2 center may be subject to annual deductibles, coinsurance,
3 or other cost sharing that is consistent with those
4 imposed on other benefits covered by the policy.
5 (C) This paragraph (9) shall apply to facilities in
6 this State that are licensed, certified, or otherwise
7 authorized and participating in a provider network.
8 Coverage for treatment in a residential treatment center
9 shall not be subject to prior authorization and shall not
10 be subject to concurrent utilization review during the
11 first 3 days of American Society of Addiction Medicine
12 Level 3.7 and the first 28 days of American Society of
13 Addiction Medicine Level 3.5 residential admission, so
14 long as the facility notifies the insurer of both the
15 admission and the initial treatment plan within the
16 notification periods set forth in subsection (g). The
17 facility shall perform clinical review of the patient,
18 including consultation with the insurer at or just prior
19 to the 14th day of treatment to ensure that the facility is
20 using the American Society of Addiction Medicine patient
21 placement criteria to ensure that the residential
22 treatment is medically necessary for the patient.
23 (D) Prior to discharge, in addition to the notice
24 required under subsection (g), the facility shall provide
25 the patient and the insurer with a written discharge plan,
26 which shall describe arrangements for additional services

1 needed following discharge from the residential facility,
2 as determined using the American Society of Addiction
3 Medicine patient placement criteria used by the insurer
4 and designated by the relevant Illinois State agencies.
5 Prior to discharge, the facility shall indicate to the
6 insurer whether services included in the discharge plan
7 are secured or determined to be reasonably available.
8 (E) An insured shall not have any financial obligation
9 to the facility for any services provided during
10 residential treatment, including all services provided
11 during the first 35 days of residential treatment, other
12 than any copayment, coinsurance, or deductible otherwise
13 required under the policy. The American Society of
14 Addiction Medicine patient placement criteria for medical
15 necessity determinations under the policy with respect to
16 residential substance use disorder benefits shall be made
17 available by the insurer to any insured, prospective
18 insured, or in-network provider upon request.
19 (c) This Section shall not be interpreted to require
20 coverage for speech therapy or other habilitative services for
21 those individuals covered under Section 356z.15 of this Code.
22 (d) With respect to a group or individual policy of
23 accident and health insurance or a qualified health plan
24 offered through the health insurance marketplace, the
25 Department and, with respect to medical assistance, the
26 Department of Healthcare and Family Services shall each

1 enforce the requirements of this Section and Sections 356z.23
2 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
3 Mental Health Parity and Addiction Equity Act of 2008, 42
4 U.S.C. 18031(j), and any amendments to, and federal guidance
5 or regulations issued under, those Acts, including, but not
6 limited to, final regulations issued under the Paul Wellstone
7 and Pete Domenici Mental Health Parity and Addiction Equity
8 Act of 2008 and final regulations applying the Paul Wellstone
9 and Pete Domenici Mental Health Parity and Addiction Equity
10 Act of 2008 to Medicaid managed care organizations, the
11 Children's Health Insurance Program, and alternative benefit
12 plans. Specifically, the Department and the Department of
13 Healthcare and Family Services shall take action:

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

24 (2) evaluating all consumer or provider complaints
25 regarding mental, emotional, nervous, or substance use
26 disorder or condition coverage for possible parity

1 violations;
2 (3) performing parity compliance market conduct
3 examinations or, in the case of the Department of
4 Healthcare and Family Services, parity compliance audits
5 of individual and group plans and policies, including, but
6 not limited to, reviews of:
7 (A) nonquantitative treatment limitations,
8 including, but not limited to, prior authorization
9 requirements, concurrent review, retrospective review,
10 step therapy, network admission standards,
11 reimbursement rates, and geographic restrictions;
12 (B) denials of authorization, payment, and
13 coverage; and
14 (C) other specific criteria as may be determined
15 by the Department.
16 The findings and the conclusions of the parity compliance
17 market conduct examinations and audits shall be made public.
18 The Director may adopt rules to effectuate any provisions
19 of the Paul Wellstone and Pete Domenici Mental Health Parity
20 and Addiction Equity Act of 2008 that relate to the business of
21 insurance.
22 (e) Availability of plan information.
23 (1) The criteria for medical necessity determinations
24 made under a group health plan, an individual policy of
25 accident and health insurance, or a qualified health plan
26 offered through the health insurance marketplace with

1 respect to mental health or substance use disorder
2 benefits (or health insurance coverage offered in
3 connection with the plan with respect to such benefits)
4 must be made available by the plan administrator (or the
5 health insurance issuer offering such coverage) to any
6 current or potential participant, beneficiary, or
7 contracting provider upon request.

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

21 (f) As used in this Section, "group policy of accident and
22 health insurance" and "group health benefit plan" includes (1)
23 State-regulated employer-sponsored group health insurance
24 plans written in Illinois or which purport to provide coverage
25 for a resident of this State; and (2) State, county,
26 municipal, or school district employee health plans.

1 References to an insurer include all plans described in this
2 subsection.
3 (g) (1) As used in this subsection:
4 "Benefits", with respect to insurers that are not Medicaid
5 managed care organizations, means the benefits provided for
6 treatment services for inpatient and outpatient treatment of
7 substance use disorders or conditions at American Society of
8 Addiction Medicine levels of treatment 2.1 (Intensive
9 Outpatient), 2.5 (High-Intensity Outpatient), 3.1 (Clinically
10 Managed Low-Intensity Residential), 3.5 (Clinically Managed
11 High-Intensity Residential), and 3.7 (Medically Managed
12 Residential) and OMT (Opioid Maintenance Therapy) services.
13 "Benefits", with respect to Medicaid managed care
14 organizations, means the benefits provided for treatment
15 services for inpatient and outpatient treatment of substance
16 use disorders or conditions at American Society of Addiction
17 Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5
18 (High-Intensity Outpatient), 3.5 (Clinically Managed
19 High-Intensity Residential), and 3.7 (Medically Managed
20 Residential) and OMT (Opioid Maintenance Therapy) services.
21 "Substance use disorder treatment provider or facility"
22 means a licensed physician, licensed psychologist, licensed
23 psychiatrist, licensed advanced practice registered nurse, or
24 licensed, certified, or otherwise State-approved facility or
25 provider of substance use disorder treatment.
26 (2) A group health insurance policy, an individual health

1 benefit plan, or qualified health plan that is offered through
2 the health insurance marketplace, small employer group health
3 plan, and large employer group health plan that is amended,
4 delivered, issued, executed, or renewed in this State, or
5 approved for issuance or renewal in this State, on or after
6 January 1, 2019 (the effective date of Public Act 100-1023)
7 shall comply with the requirements of this Section and Section
8 370c.1. The services for the treatment and the ongoing
9 assessment of the patient's progress in treatment shall follow
10 the requirements of 77 Ill. Adm. Code 2060.

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

1 accordance with the contractual protocol during the 24-hour
2 period following admission, the substance use disorder
3 treatment provider or facility shall have one additional
4 business day to provide the notification to the appropriate
5 managed care organization. Treatment plans shall be developed
6 in accordance with the requirements and timeframes established
7 in 77 Ill. Adm. Code 2060. No such coverage shall be subject to
8 concurrent review prior to the applicable notification
9 deadline. If coverage is denied retrospectively, neither the
10 provider or facility nor the insurer shall bill, and the
11 covered individual shall not be liable, for any treatment
12 under this subsection through the date the adverse
13 determination is issued, other than any copayment,
14 coinsurance, or deductible for the treatment or stay through
15 that date as applicable under the policy. Coverage shall not
16 be retrospectively denied for benefits that were furnished at
17 a participating substance use disorder facility prior to the
18 applicable notification deadline except for the following:
19 (A) upon reasonable determination that the benefits
20 were not provided;
21 (B) upon determination that the patient receiving the
22 treatment was not an insured, enrollee, or beneficiary
23 under the policy;
24 (C) upon material misrepresentation by the patient or
25 provider. As used in this subparagraph (C), "material"
26 means a fact or situation that is not merely technical in

1 nature and results or could result in a substantial change
2 in the situation;
3 (D) upon determination that a service was excluded
4 under the terms of coverage. For situations that qualify
5 under this subparagraph (D), the limitation to billing for
6 a copayment, coinsurance, or deductible shall not apply;
7 (E) upon determination that a service was not
8 medically necessary consistent with subsections (h)
9 through (n); or
10 (F) upon determination that the patient did not
11 consent to the treatment and that there was no court order
12 mandating the treatment.
13 (4) For an insurer that is not a Medicaid managed care
14 organization, if an insurer determines that benefits are no
15 longer medically necessary, the insurer shall notify the
16 covered person, the covered person's authorized
17 representative, if any, and the covered person's health care
18 provider in writing of the covered person's right to request
19 an external review pursuant to the Health Carrier External
20 Review Act. The notification shall occur within 24 hours
21 following the adverse determination.
22 Pursuant to the requirements of the Health Carrier
23 External Review Act, the covered person or the covered
24 person's authorized representative may request an expedited
25 external review. An expedited external review may not occur if
26 the substance use disorder treatment provider or facility

1 determines that continued treatment is no longer medically
2 necessary.
3 If an expedited external review request meets the criteria
4 of the Health Carrier External Review Act, an independent
5 review organization shall make a final determination of
6 medical necessity within 72 hours. If an independent review
7 organization upholds an adverse determination, an insurer
8 shall remain responsible to provide coverage of benefits
9 through the day following the determination of the independent
10 review organization. A decision to reverse an adverse
11 determination shall comply with the Health Carrier External
12 Review Act.
13 (5) The substance use disorder treatment provider or
14 facility shall provide the insurer with 7 business days'
15 advance notice of the planned discharge of the patient from
16 the substance use disorder treatment provider or facility and
17 notice on the day that the patient is discharged from the
18 substance use disorder treatment provider or facility.
19 (6) The benefits required by this subsection shall be
20 provided to all covered persons with a diagnosis of substance
21 use disorder or conditions. The presence of additional related
22 or unrelated diagnoses shall not be a basis to reduce or deny
23 the benefits required by this subsection.
24 (7) Nothing in this subsection shall be construed to
25 require an insurer to provide coverage for any of the benefits
26 in this subsection.

1 (8) Any concurrent or retrospective review permitted by
2 this subsection must be consistent with the utilization review
3 provisions in subsections (h) through (n).
4 (h) As used in this Section:
5 "Generally accepted standards of mental, emotional,
6 nervous, or substance use disorder or condition care" means
7 standards of care and clinical practice that are generally
8 recognized by health care providers practicing in relevant
9 clinical specialties such as psychiatry, psychology, clinical
10 sociology, social work, addiction medicine and counseling, and
11 behavioral health treatment. Valid, evidence-based sources
12 reflecting generally accepted standards of mental, emotional,
13 nervous, or substance use disorder or condition care include
14 peer-reviewed scientific studies and medical literature,
15 recommendations of nonprofit health care provider professional
16 associations and specialty societies, including, but not
17 limited to, patient placement criteria and clinical practice
18 guidelines, recommendations of federal government agencies,
19 and drug labeling approved by the United States Food and Drug
20 Administration.
21 "Medically necessary treatment of mental, emotional,
22 nervous, or substance use disorders or conditions" means a
23 service or product addressing the specific needs of that
24 patient, for the purpose of screening, preventing, diagnosing,
25 managing, or treating an illness, injury, or condition or its
26 symptoms and comorbidities, including minimizing the

1 progression of an illness, injury, or condition or its
2 symptoms and comorbidities in a manner that is all of the
3 following:
4 (1) in accordance with the generally accepted
5 standards of mental, emotional, nervous, or substance use
6 disorder or condition care;
7 (2) clinically appropriate in terms of type,
8 frequency, extent, site, and duration; and
9 (3) not primarily for the economic benefit of the
10 insurer, purchaser, or for the convenience of the patient,
11 treating physician, or other health care provider.
12 "Utilization review" means either of the following:
13 (1) prospectively, retrospectively, or concurrently
14 reviewing and approving, modifying, delaying, or denying,
15 based in whole or in part on medical necessity, requests
16 by health care providers, insureds, or their authorized
17 representatives for coverage of health care services
18 before, retrospectively, or concurrently with the
19 provision of health care services to insureds.
20 (2) evaluating the medical necessity, appropriateness,
21 level of care, service intensity, efficacy, or efficiency
22 of health care services, benefits, procedures, or
23 settings, under any circumstances, to determine whether a
24 health care service or benefit subject to a medical
25 necessity coverage requirement in an insurance policy is
26 covered as medically necessary for an insured.

1 "Utilization review criteria" means patient placement
2 criteria or any criteria, standards, protocols, or guidelines
3 used by an insurer to conduct utilization review.

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

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

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

23 (4) An insurer that authorizes a specific type of
24 treatment by a provider pursuant to this Section shall not
25 rescind or modify the authorization after that provider
26 renders the health care service in good faith and pursuant to

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

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

1 construed to require an insurer to cover benefits that have
2 been authorized and provided for a covered person by a public
3 entitlement program. Medicaid managed care organizations are
4 not subject to this subsection.

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

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

1 care. Pursuant to subsection (b), in conducting utilization
2 review of all covered services and benefits for the diagnosis,
3 prevention, and treatment of substance use disorders an
4 insurer shall use the most recent edition of the patient
5 placement criteria established by the American Society of
6 Addiction Medicine.

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

22 If an insurer purchases or licenses utilization review
23 criteria pursuant to this subsection, the insurer shall verify
24 and document before use that the criteria were developed in
25 accordance with subsection (k).

26 (n) In conducting utilization review that is outside the

1 scope of the criteria as specified in subsection (l) or
2 relates to the advancements in technology or in the types or
3 levels of care that are not addressed in the most recent
4 versions of the sources specified in subsection (l), an
5 insurer shall conduct utilization review in accordance with
6 subsection (k).

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

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

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

14 (1) Educate the insurer's staff, including any third
15 parties contracted with the insurer to review claims,
16 conduct utilization reviews, or make medical necessity
17 determinations about the utilization review criteria.

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

25 (3) Provide, at no cost, the utilization review
26 criteria and any training material or resources to

1 providers and insured patients upon request. For
2 utilization review criteria not concerning level of care
3 placement, continued stay, transfer, discharge, or other
4 patient care decisions used by the insurer pursuant to
5 subsection (m), the insurer may place the criteria on a
6 secure, password-protected website so long as the access
7 requirements of the website do not unreasonably restrict
8 access to insureds or their providers. No restrictions
9 shall be placed upon the insured's or treating provider's
10 access right to utilization review criteria obtained under
11 this paragraph at any point in time, including before an
12 initial request for authorization.

13 (4) Track, identify, and analyze how the utilization
14 review criteria are used to certify care, deny care, and
15 support the appeals process.

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

21 (6) Run interrater reliability reports about how the
22 clinical guidelines are used in conjunction with the
23 utilization review process and parity compliance
24 activities.

25 (7) Achieve interrater reliability pass rates of at
26 least 90% and, if this threshold is not met, immediately

provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

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

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

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

(t) If the Director determines that an insurer has violated this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty between $1,000 and $5,000 for each violation. Moneys collected from penalties shall be deposited into the Parity Advancement Fund established in subsection (i) of Section 370c.1.

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

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

(w) Beginning January 1, 2027 ~~2026~~, coverage for medically necessary treatment of mental, emotional, ~~or~~ nervous, or substance use disorders or conditions shall comply with the following requirements:

(1) No policy shall require prior authorization for outpatient or partial hospitalization services for treatment of mental, emotional, ~~or~~ nervous, or substance use disorders or conditions provided by a physician licensed to practice medicine in all branches, a licensed clinical psychologist, a licensed clinical social worker,

a licensed clinical professional counselor, a licensed marriage and family therapist, a licensed speech-language pathologist, or any other type of licensed, certified, or legally authorized provider, including trainees working under the supervision of a licensed health care professional listed under this subsection, or facility whose outpatient or partial hospitalization services the policy covers for treatment of mental, emotional, ~~or~~ nervous, or substance use disorders or conditions. Such coverage may be subject to concurrent and retrospective review consistent with the utilization review provisions in subsection (b), subsections (h) through (n), and Section 370c.1. Nothing in this paragraph (1) supersedes a health maintenance organization's referral requirement for services from nonparticipating providers. An insurer may require providers or facilities to notify the insurer of the initiation of treatment as specified in this subsection, except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification. No such coverage shall be subject to concurrent review for any services furnished before an applicable notification deadline, subject to the following:

(A) In the case of outpatient treatment, for an insurer that is not a Medicaid managed care organization, the insurer may set a notification

deadline of 2 business days after the initiation of the covered person's treatment. A Medicaid managed care organization may set a deadline of 24 hours after the initiation of treatment. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol within the 24-hour period following initiation, the treatment provider or facility shall have one additional business day to provide the notification to the Medicaid managed care organization.

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

(2) No policy shall require prior authorization for

1 inpatient treatment at a hospital for mental, emotional,
2 ~~or~~ nervous, or substance use disorders or conditions at a
3 participating provider. Additionally, no such coverage
4 shall be subject to concurrent review for the first 72
5 hours after admission, provided that the provider must
6 notify the insurer of both the admission and the initial
7 treatment plan within 48 hours of admission. A discharge
8 plan must be fully developed and continuity services
9 prepared to meet the patient's needs and the patient's
10 community preference upon release. Recommended level of
11 care placements identified in the discharge plan shall
12 comply with generally accepted standards of care, as
13 defined in subsection (h).

14 (A) If the provider satisfies the conditions of
15 paragraph (2), then the insurer shall approve coverage
16 of the recommended level of care, if applicable, upon
17 discharge subject to concurrent review.

18 (B) Nothing in this paragraph supersedes a health
19 maintenance organization's referral requirement for
20 services from nonparticipating providers upon a
21 patient's discharge from a hospital or facility.

22 (C) Concurrent review for such coverage must be
23 consistent with the utilization review provisions in
24 subsection (b) and subsections (h) through (n).

25 (D) In this subsection, residential treatment that
26 is not otherwise identified in the discharge plan is

not inpatient hospitalization.

(3) Treatment provided under this subsection may be reviewed retrospectively. If coverage is denied retrospectively, neither the insurer nor the participating provider shall bill, and the insured shall not be liable, for any treatment under this subsection through the date the adverse determination is issued, other than any copayment, coinsurance, or deductible for the stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for the first 72 hours of admission to inpatient hospitalization for treatment of mental, emotional, ~~or~~ nervous, or substance use disorders or conditions, or before the applicable deadline under paragraph (1) of this subsection for outpatient treatment or partial hospitalization programs, at a participating provider except:

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

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

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

1 (D) upon determination that a service was excluded
2 under the terms of coverage. In that case, the
3 limitation to billing for a copayment, coinsurance, or
4 deductible shall not apply;
5 (E) for outpatient treatment or partial
6 hospitalization programs only, upon determination that
7 a service was not medically necessary consistent with
8 subsections (h) through (n); or
9 (F) upon determination that the patient did not
10 consent to the treatment and that there was no court
11 order mandating the treatment.
12 Nothing in this subsection shall be construed to
13 require a policy to cover any health care service excluded
14 under the terms of coverage.
15 This subsection does not apply to coverage for any
16 prescription or over-the-counter drug.
17 Nothing in this subsection shall be construed to
18 require the medical assistance program to reimburse for
19 services not covered by the medical assistance program as
20 authorized by the Illinois Public Aid Code or the
21 Children's Health Insurance Program Act.
22 (x) Notwithstanding any provision of this Section, nothing
23 shall require the medical assistance program under Article V
24 of the Illinois Public Aid Code or the Children's Health
25 Insurance Program Act to violate any applicable federal laws,
26 regulations, or grant requirements, including requirements for

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

1 consent decrees or court orders, or any applicable case law,
2 such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii)
3 administer or require programs, services, screenings,
4 assessments, tools, or reviews established under State or
5 federal laws, rules, or regulations in compliance with State
6 or federal laws, rules, or regulations, including, but not
7 limited to, the Children's Mental Health Act and the Mental
8 Health and Developmental Disabilities Administrative Act.
9 (y) (Blank).
10 (Source: P.A. 103-426, eff. 8-4-23; 103-650, eff. 1-1-25;
11 103-1040, eff. 8-9-24; 104-28, eff. 1-1-26; 104-417, eff.
12 8-15-25.)

13 Section 99. Effective date. This Act takes effect upon
14 becoming law.".