



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4650

Introduced 2/3/2026, by Rep. Lindsey LaPointe

SYNOPSIS AS INTRODUCED:

215 ILCS 5/370c

from Ch. 73, par. 982c

Amends the Illinois Insurance Code. Provides that, in conducting utilization review of all covered health care services for the diagnosis, prevention, and treatment of mental, emotional, and nervous disorders or conditions, an insurer shall apply the criteria and guidelines set forth in the most recent version of the treatment criteria developed by an unaffiliated professional organization (instead of an unaffiliated nonprofit professional association) for the relevant clinical specialty or, for Medicaid managed care organizations, criteria and guidelines determined by the Department of Healthcare and Family Services that are consistent with generally accepted standards of mental, emotional, nervous or substance use disorder or condition care. Provides that insurers may not apply utilization review criteria developed by any entity that has a financial stake in the outcome of the utilization review decisions. Makes changes to provisions concerning utilization review relating to level of care placement, continued stay, transfer, discharge, or any other patient care decisions that are within the scope of the specified sources.

LRB104 18397 BAB 31839 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 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 (c) This Section shall not be interpreted to require
6 coverage for speech therapy or other rehabilitative services for
7 those individuals covered under Section 356z.15 of this Code.

8 (d) With respect to a group or individual policy of
9 accident and health insurance or a qualified health plan
10 offered through the health insurance marketplace, the
11 Department and, with respect to medical assistance, the
12 Department of Healthcare and Family Services shall each
13 enforce the requirements of this Section and Sections 356z.23
14 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
15 Mental Health Parity and Addiction Equity Act of 2008, 42
16 U.S.C. 18031(j), and any amendments to, and federal guidance
17 or regulations issued under, those Acts, including, but not
18 limited to, final regulations issued under the Paul Wellstone
19 and Pete Domenici Mental Health Parity and Addiction Equity
20 Act of 2008 and final regulations applying the Paul Wellstone
21 and Pete Domenici Mental Health Parity and Addiction Equity
22 Act of 2008 to Medicaid managed care organizations, the
23 Children's Health Insurance Program, and alternative benefit
24 plans. Specifically, the Department and the Department of
25 Healthcare and Family Services shall take action:

26 (1) proactively ensuring compliance by individual and

1 group policies, including by requiring that insurers
2 submit comparative analyses, as set forth in paragraph (6)
3 of subsection (k) of Section 370c.1, demonstrating how
4 they design and apply nonquantitative treatment
5 limitations, both as written and in operation, for mental,
6 emotional, nervous, or substance use disorder or condition
7 benefits as compared to how they design and apply
8 nonquantitative treatment limitations, as written and in
9 operation, for medical and surgical benefits;

10 (2) evaluating all consumer or provider complaints
11 regarding mental, emotional, nervous, or substance use
12 disorder or condition coverage for possible parity
13 violations;

14 (3) performing parity compliance market conduct
15 examinations or, in the case of the Department of
16 Healthcare and Family Services, parity compliance audits
17 of individual and group plans and policies, including, but
18 not limited to, reviews of:

19 (A) nonquantitative treatment limitations,
20 including, but not limited to, prior authorization
21 requirements, concurrent review, retrospective review,
22 step therapy, network admission standards,
23 reimbursement rates, and geographic restrictions;

24 (B) denials of authorization, payment, and
25 coverage; and

26 (C) other specific criteria as may be determined

1 by the Department.

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

4 The Director may adopt rules to effectuate any provisions
5 of the Paul Wellstone and Pete Domenici Mental Health Parity
6 and Addiction Equity Act of 2008 that relate to the business of
7 insurance.

8 (e) Availability of plan information.

9 (1) The criteria for medical necessity determinations
10 made under a group health plan, an individual policy of
11 accident and health insurance, or a qualified health plan
12 offered through the health insurance marketplace with
13 respect to mental health or substance use disorder
14 benefits (or health insurance coverage offered in
15 connection with the plan with respect to such benefits)
16 must be made available by the plan administrator (or the
17 health insurance issuer offering such coverage) to any
18 current or potential participant, beneficiary, or
19 contracting provider upon request.

20 (2) The reason for any denial under a group health
21 benefit plan, an individual policy of accident and health
22 insurance, or a qualified health plan offered through the
23 health insurance marketplace (or health insurance coverage
24 offered in connection with such plan or policy) of
25 reimbursement or payment for services with respect to
26 mental, emotional, nervous, or substance use disorders or

1 conditions benefits in the case of any participant or
2 beneficiary must be made available within a reasonable
3 time and in a reasonable manner and in readily
4 understandable language by the plan administrator (or the
5 health insurance issuer offering such coverage) to the
6 participant or beneficiary upon request.

7 (f) As used in this Section, "group policy of accident and
8 health insurance" and "group health benefit plan" includes (1)
9 State-regulated employer-sponsored group health insurance
10 plans written in Illinois or which purport to provide coverage
11 for a resident of this State; and (2) State, county,
12 municipal, or school district employee health plans.
13 References to an insurer include all plans described in this
14 subsection.

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

16 "Benefits", with respect to insurers that are not Medicaid
17 managed care organizations, means the benefits provided for
18 treatment services for inpatient and outpatient treatment of
19 substance use disorders or conditions at American Society of
20 Addiction Medicine levels of treatment 2.1 (Intensive
21 Outpatient), 2.5 (High-Intensity Outpatient), 3.1 (Clinically
22 Managed Low-Intensity Residential), 3.5 (Clinically Managed
23 High-Intensity Residential), and 3.7 (Medically Managed
24 Residential) and OMT (Opioid Maintenance Therapy) services.

25 "Benefits", with respect to Medicaid managed care
26 organizations, means the benefits provided for treatment

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

7 "Substance use disorder treatment provider or facility"
8 means a licensed physician, licensed psychologist, licensed
9 psychiatrist, licensed advanced practice registered nurse, or
10 licensed, certified, or otherwise State-approved facility or
11 provider of substance use disorder treatment.

12 (2) A group health insurance policy, an individual health
13 benefit plan, or qualified health plan that is offered through
14 the health insurance marketplace, small employer group health
15 plan, and large employer group health plan that is amended,
16 delivered, issued, executed, or renewed in this State, or
17 approved for issuance or renewal in this State, on or after
18 January 1, 2019 (the effective date of Public Act 100-1023)
19 shall comply with the requirements of this Section and Section
20 370c.1. The services for the treatment and the ongoing
21 assessment of the patient's progress in treatment shall follow
22 the requirements of 77 Ill. Adm. Code 2060.

23 (3) Prior authorization shall not be utilized for the
24 benefits under this subsection. Except to the extent
25 prohibited by Section 370c.1 with respect to treatment
26 limitations in a benefit classification or subclassification,

1 the insurer may require the substance use disorder treatment
2 provider or facility to notify the insurer of the initiation
3 of treatment. For an insurer that is not a Medicaid managed
4 care organization, the substance use disorder treatment
5 provider or facility may be required to give notification for
6 the initiation of treatment of the covered person within 2
7 business days. For Medicaid managed care organizations, the
8 substance use disorder treatment provider or facility may be
9 required to give notification in accordance with the protocol
10 set forth in the provider agreement for initiation of
11 treatment within 24 hours. If the Medicaid managed care
12 organization is not capable of accepting the notification in
13 accordance with the contractual protocol during the 24-hour
14 period following admission, the substance use disorder
15 treatment provider or facility shall have one additional
16 business day to provide the notification to the appropriate
17 managed care organization. Treatment plans shall be developed
18 in accordance with the requirements and timeframes established
19 in 77 Ill. Adm. Code 2060. No such coverage shall be subject to
20 concurrent review prior to the applicable notification
21 deadline. If coverage is denied retrospectively, neither the
22 provider or facility nor the insurer shall bill, and the
23 covered individual shall not be liable, for any treatment
24 under this subsection through the date the adverse
25 determination is issued, other than any copayment,
26 coinsurance, or deductible for the treatment or stay through

1 that date as applicable under the policy. Coverage shall not
2 be retrospectively denied for benefits that were furnished at
3 a participating substance use disorder facility prior to the
4 applicable notification deadline except for the following:

5 (A) upon reasonable determination that the benefits
6 were not provided;

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

10 (C) upon material misrepresentation by the patient or
11 provider. As used in this subparagraph (C), "material"
12 means a fact or situation that is not merely technical in
13 nature and results or could result in a substantial change
14 in the situation;

15 (D) upon determination that a service was excluded
16 under the terms of coverage. For situations that qualify
17 under this subparagraph (D), the limitation to billing for
18 a copayment, coinsurance, or deductible shall not apply;

19 (E) upon determination that a service was not
20 medically necessary consistent with subsections (h)
21 through (n); or

22 (F) upon determination that the patient did not
23 consent to the treatment and that there was no court order
24 mandating the treatment.

25 (4) For an insurer that is not a Medicaid managed care
26 organization, if an insurer determines that benefits are no

1 longer medically necessary, the insurer shall notify the
2 covered person, the covered person's authorized
3 representative, if any, and the covered person's health care
4 provider in writing of the covered person's right to request
5 an external review pursuant to the Health Carrier External
6 Review Act. The notification shall occur within 24 hours
7 following the adverse determination.

8 Pursuant to the requirements of the Health Carrier
9 External Review Act, the covered person or the covered
10 person's authorized representative may request an expedited
11 external review. An expedited external review may not occur if
12 the substance use disorder treatment provider or facility
13 determines that continued treatment is no longer medically
14 necessary.

15 If an expedited external review request meets the criteria
16 of the Health Carrier External Review Act, an independent
17 review organization shall make a final determination of
18 medical necessity within 72 hours. If an independent review
19 organization upholds an adverse determination, an insurer
20 shall remain responsible to provide coverage of benefits
21 through the day following the determination of the independent
22 review organization. A decision to reverse an adverse
23 determination shall comply with the Health Carrier External
24 Review Act.

25 (5) The substance use disorder treatment provider or
26 facility shall provide the insurer with 7 business days'

1 advance notice of the planned discharge of the patient from
2 the substance use disorder treatment provider or facility and
3 notice on the day that the patient is discharged from the
4 substance use disorder treatment provider or facility.

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

10 (7) Nothing in this subsection shall be construed to
11 require an insurer to provide coverage for any of the benefits
12 in this subsection.

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

16 (h) As used in this Section:

17 "Generally accepted standards of mental, emotional,
18 nervous, or substance use disorder or condition care" means
19 standards of care and clinical practice that are generally
20 recognized by health care providers practicing in relevant
21 clinical specialties such as psychiatry, psychology, clinical
22 sociology, social work, addiction medicine and counseling, and
23 behavioral health treatment. Valid, evidence-based sources
24 reflecting generally accepted standards of mental, emotional,
25 nervous, or substance use disorder or condition care include
26 peer-reviewed scientific studies and medical literature,

1 recommendations of nonprofit health care provider professional
2 associations and specialty societies, including, but not
3 limited to, patient placement criteria and clinical practice
4 guidelines, recommendations of federal government agencies,
5 and drug labeling approved by the United States Food and Drug
6 Administration.

7 "Medically necessary treatment of mental, emotional,
8 nervous, or substance use disorders or conditions" means a
9 service or product addressing the specific needs of that
10 patient, for the purpose of screening, preventing, diagnosing,
11 managing, or treating an illness, injury, or condition or its
12 symptoms and comorbidities, including minimizing the
13 progression of an illness, injury, or condition or its
14 symptoms and comorbidities in a manner that is all of the
15 following:

16 (1) in accordance with the generally accepted
17 standards of mental, emotional, nervous, or substance use
18 disorder or condition care;

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

21 (3) not primarily for the economic benefit of the
22 insurer, purchaser, or for the convenience of the patient,
23 treating physician, or other health care provider.

24 "Utilization review" means either of the following:

25 (1) prospectively, retrospectively, or concurrently
26 reviewing and approving, modifying, delaying, or denying,

1 based in whole or in part on medical necessity, requests
2 by health care providers, insureds, or their authorized
3 representatives for coverage of health care services
4 before, retrospectively, or concurrently with the
5 provision of health care services to insureds.

6 (2) evaluating the medical necessity, appropriateness,
7 level of care, service intensity, efficacy, or efficiency
8 of health care services, benefits, procedures, or
9 settings, under any circumstances, to determine whether a
10 health care service or benefit subject to a medical
11 necessity coverage requirement in an insurance policy is
12 covered as medically necessary for an insured.

13 "Utilization review criteria" means patient placement
14 criteria or any criteria, standards, protocols, or guidelines
15 used by an insurer to conduct utilization review.

16 (i)(1) Every insurer that amends, delivers, issues, or
17 renews a group or individual policy of accident and health
18 insurance or a qualified health plan offered through the
19 health insurance marketplace in this State and Medicaid
20 managed care organizations providing coverage for hospital or
21 medical treatment on or after January 1, 2023 shall, pursuant
22 to subsections (h) through (s), provide coverage for medically
23 necessary treatment of mental, emotional, nervous, or
24 substance use disorders or conditions.

25 (2) An insurer shall not set a specific limit on the
26 duration of benefits or coverage of medically necessary

1 treatment of mental, emotional, nervous, or substance use
2 disorders or conditions or limit coverage only to alleviation
3 of the insured's current symptoms.

4 (3) All utilization review conducted by the insurer
5 concerning diagnosis, prevention, and treatment of insureds
6 diagnosed with mental, emotional, nervous, or substance use
7 disorders or conditions shall be conducted in accordance with
8 the requirements of subsections (k) through (w).

9 (4) An insurer that authorizes a specific type of
10 treatment by a provider pursuant to this Section shall not
11 rescind or modify the authorization after that provider
12 renders the health care service in good faith and pursuant to
13 this authorization for any reason, including, but not limited
14 to, the insurer's subsequent cancellation or modification of
15 the insured's or policyholder's contract, or the insured's or
16 policyholder's eligibility. Nothing in this Section shall
17 require the insurer to cover a treatment when the
18 authorization was granted based on a material
19 misrepresentation by the insured, the policyholder, or the
20 provider. Nothing in this Section shall require Medicaid
21 managed care organizations to pay for services if the
22 individual was not eligible for Medicaid at the time the
23 service was rendered. Nothing in this Section shall require an
24 insurer to pay for services if the individual was not the
25 insurer's enrollee at the time services were rendered. As used
26 in this paragraph, "material" means a fact or situation that

1 is not merely technical in nature and results in or could
2 result in a substantial change in the situation.

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

17 (k) An insurer shall base any medical necessity
18 determination or the utilization review criteria that the
19 insurer, and any entity acting on the insurer's behalf,
20 applies to determine the medical necessity of health care
21 services and benefits for the diagnosis, prevention, and
22 treatment of mental, emotional, nervous, or substance use
23 disorders or conditions on current generally accepted
24 standards of mental, emotional, nervous, or substance use
25 disorder or condition care. All denials and appeals shall be
26 reviewed by a professional with experience or expertise

1 comparable to the provider requesting the authorization.

2 (l) In conducting utilization review of all covered health
3 care services for the diagnosis, prevention, and treatment of
4 mental, emotional, and nervous disorders or conditions, an
5 insurer shall apply the criteria and guidelines set forth in
6 the most recent version of the treatment criteria developed by
7 an unaffiliated ~~nonprofit~~ professional organization
8 ~~association~~ for the relevant clinical specialty or, for
9 Medicaid managed care organizations, criteria and guidelines
10 determined by the Department of Healthcare and Family Services
11 that are consistent with generally accepted standards of
12 mental, emotional, nervous or substance use disorder or
13 condition care. Insurers may not apply utilization review
14 criteria developed by any entity that has a financial stake in
15 the outcome of the utilization review decisions. Pursuant to
16 subsection (b), in conducting utilization review of all
17 covered services and benefits for the diagnosis, prevention,
18 and treatment of substance use disorders an insurer shall use
19 the most recent edition of the patient placement criteria
20 established by the American Society of Addiction Medicine.

21 (m) In conducting utilization review relating to level of
22 care placement, continued stay, transfer, discharge, or any
23 other patient care decisions that are within the scope of the
24 sources specified in subsection (l), an insurer shall not
25 apply ~~different, additional,~~ conflicting, or more restrictive
26 utilization review criteria than the criteria set forth in

1 those sources, and shall not apply utilization review criteria
2 created by any entity that has a financial stake in the outcome
3 of the utilization review decisions. For all level of care
4 placement decisions, the insurer shall authorize placement at
5 the level of care consistent with the assessment of the
6 insured using the relevant patient placement criteria as
7 specified in subsection (l). If that level of placement is not
8 available, the insurer shall authorize the next higher level
9 of care. In the event of disagreement, the insurer shall
10 provide full detail of its assessment using the relevant
11 criteria as specified in subsection (l) to the provider of the
12 service and the patient.

13 If an insurer purchases or licenses utilization review
14 criteria pursuant to this subsection, the insurer shall verify
15 and document before use that the criteria were developed in
16 accordance with subsection (k).

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

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

26 (p) This Section does not in any way limit early and

1 periodic screening, diagnostic, and treatment benefits as
2 defined under 42 U.S.C. 1396d(r).

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

5 (1) Educate the insurer's staff, including any third
6 parties contracted with the insurer to review claims,
7 conduct utilization reviews, or make medical necessity
8 determinations about the utilization review criteria.

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

16 (3) Provide, at no cost, the utilization review
17 criteria and any training material or resources to
18 providers and insured patients upon request. For
19 utilization review criteria not concerning level of care
20 placement, continued stay, transfer, discharge, or other
21 patient care decisions used by the insurer pursuant to
22 subsection (m), the insurer may place the criteria on a
23 secure, password-protected website so long as the access
24 requirements of the website do not unreasonably restrict
25 access to insureds or their providers. No restrictions
26 shall be placed upon the insured's or treating provider's

1 access right to utilization review criteria obtained under
2 this paragraph at any point in time, including before an
3 initial request for authorization.

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

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

12 (6) Run interrater reliability reports about how the
13 clinical guidelines are used in conjunction with the
14 utilization review process and parity compliance
15 activities.

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

22 (8) Maintain documentation of interrater reliability
23 testing and the remediation actions taken for those with
24 pass rates lower than 90% and submit to the Department of
25 Insurance or, in the case of Medicaid managed care
26 organizations, the Department of Healthcare and Family

1 Services the testing results and a summary of remedial
2 actions as part of parity compliance reporting set forth
3 in subsection (k) of Section 370c.1.

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

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

18 (t) If the Director determines that an insurer has
19 violated this Section, the Director may, after appropriate
20 notice and opportunity for hearing, by order, assess a civil
21 penalty between \$1,000 and \$5,000 for each violation. Moneys
22 collected from penalties shall be deposited into the Parity
23 Advancement Fund established in subsection (i) of Section
24 370c.1.

25 (u) An insurer shall not adopt, impose, or enforce terms
26 in its policies or provider agreements, in writing or in

1 operation, that undermine, alter, or conflict with the
2 requirements of this Section.

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

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

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

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

14 (A) In the case of outpatient treatment, for an
15 insurer that is not a Medicaid managed care
16 organization, the insurer may set a notification
17 deadline of 2 business days after the initiation of
18 the covered person's treatment. A Medicaid managed
19 care organization may set a deadline of 24 hours after
20 the initiation of treatment. If the Medicaid managed
21 care organization is not capable of accepting the
22 notification in accordance with the contractual
23 protocol within the 24-hour period following
24 initiation, the treatment provider or facility shall
25 have one additional business day to provide the
26 notification to the Medicaid managed care

1 organization.

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

16 (2) No policy shall require prior authorization for
17 inpatient treatment at a hospital for mental, emotional,
18 or nervous disorders or conditions at a participating
19 provider. Additionally, no such coverage shall be subject
20 to concurrent review for the first 72 hours after
21 admission, provided that the provider must notify the
22 insurer of both the admission and the initial treatment
23 plan within 48 hours of admission. A discharge plan must
24 be fully developed and continuity services prepared to
25 meet the patient's needs and the patient's community
26 preference upon release. Recommended level of care

1 placements identified in the discharge plan shall comply
2 with generally accepted standards of care, as defined in
3 subsection (h).

4 (A) If the provider satisfies the conditions of
5 paragraph (2), then the insurer shall approve coverage
6 of the recommended level of care, if applicable, upon
7 discharge subject to concurrent review.

8 (B) Nothing in this paragraph supersedes a health
9 maintenance organization's referral requirement for
10 services from nonparticipating providers upon a
11 patient's discharge from a hospital or facility.

12 (C) Concurrent review for such coverage must be
13 consistent with the utilization review provisions in
14 subsections (h) through (n).

15 (D) In this subsection, residential treatment that
16 is not otherwise identified in the discharge plan is
17 not inpatient hospitalization.

18 (3) Treatment provided under this subsection may be
19 reviewed retrospectively. If coverage is denied
20 retrospectively, neither the insurer nor the participating
21 provider shall bill, and the insured shall not be liable,
22 for any treatment under this subsection through the date
23 the adverse determination is issued, other than any
24 copayment, coinsurance, or deductible for the stay through
25 that date as applicable under the policy. Coverage shall
26 not be retrospectively denied for the first 72 hours of

1 admission to inpatient hospitalization for treatment of
2 mental, emotional, or nervous disorders or conditions, or
3 before the applicable deadline under paragraph (1) of this
4 subsection for outpatient treatment or partial
5 hospitalization programs, at a participating provider
6 except:

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

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

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

17 (D) upon determination that a service was excluded
18 under the terms of coverage. In that case, the
19 limitation to billing for a copayment, coinsurance, or
20 deductible shall not apply;

21 (E) for outpatient treatment or partial
22 hospitalization programs only, upon determination that
23 a service was not medically necessary consistent with
24 subsections (h) through (n); or

25 (F) upon determination that the patient did not
26 consent to the treatment and that there was no court

1 order mandating the treatment.

2 Nothing in this subsection shall be construed to
3 require a policy to cover any health care service excluded
4 under the terms of coverage.

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

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

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

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

25 (y) (Blank).

26 (Source: P.A. 103-426, eff. 8-4-23; 103-650, eff. 1-1-25;

1 103-1040, eff. 8-9-24; 104-28, eff. 1-1-26; 104-417, eff.
2 8-15-25.)