

SB1992



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB1992

Introduced 2/6/2025, by Sen. Cristina Castro

SYNOPSIS AS INTRODUCED:

215 ILCS 5/370c

from Ch. 73, par. 982c

Amends the Illinois Insurance Code. Provides that an individual or group health benefit plan shall not impose any prior authorization requirements on outpatient services for the prevention, screening, diagnosis, or treatment of mental, emotional, nervous, or substance use disorders or conditions.

LRB104 08246 BAB 18296 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Section 370c as follows:

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

7 Sec. 370c. Mental and emotional disorders.

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

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 reimbursing insurer that amends, delivers,
3 issues, or renews a group or individual policy of accident and
4 health insurance, a qualified health plan offered through the
5 health insurance marketplace, or a provider of treatment of
6 mental, emotional, nervous, or substance use disorders or
7 conditions shall furnish medical records or other necessary
8 data that substantiate that initial or continued treatment is
9 at all times medically necessary. An insurer shall provide a
10 mechanism for the timely review by a provider holding the same
11 license and practicing in the same specialty as the patient's
12 provider, who is unaffiliated with the insurer, jointly
13 selected by the patient (or the patient's next of kin or legal
14 representative if the patient is unable to act for himself or
15 herself), the patient's provider, and the insurer in the event
16 of a dispute between the insurer and patient's provider
17 regarding the medical necessity of a treatment proposed by a
18 patient's provider. If the reviewing provider determines the
19 treatment to be medically necessary, the insurer shall provide
20 reimbursement for the treatment. Future contractual or
21 employment actions by the insurer regarding the patient's
22 provider may not be based on the provider's participation in
23 this procedure. Nothing prevents the insured from agreeing in
24 writing to continue treatment at his or her expense. When
25 making a determination of the medical necessity for a
26 treatment modality for mental, emotional, nervous, or

1 substance use disorders or conditions, an insurer must make
2 the determination in a manner that is consistent with the
3 manner used to make that determination with respect to other
4 diseases or illnesses covered under the policy, including an
5 appeals process. Medical necessity determinations for
6 substance use disorders shall be made in accordance with
7 appropriate patient placement criteria established by the
8 American Society of Addiction Medicine. No additional criteria
9 may be used to make medical necessity determinations for
10 substance use disorders.

11 (4) A group health benefit plan amended, delivered,
12 issued, or renewed on or after January 1, 2019 (the effective
13 date of Public Act 100-1024) or an individual policy of
14 accident and health insurance or a qualified health plan
15 offered through the health insurance marketplace amended,
16 delivered, issued, or renewed on or after January 1, 2019 (the
17 effective date of Public Act 100-1024):

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

24 (i) 45 days of inpatient treatment; and

25 (ii) beginning on June 26, 2006 (the effective
26 date of Public Act 94-921), 60 visits for outpatient

1 treatment including group and individual outpatient
2 treatment; and

3 (iii) for plans or policies delivered, issued for
4 delivery, renewed, or modified after January 1, 2007
5 (the effective date of Public Act 94-906), 20
6 additional outpatient visits for speech therapy for
7 treatment of pervasive developmental disorders that
8 will be in addition to speech therapy provided
9 pursuant to item (ii) of this subparagraph (A); and

10 (B) may not include a lifetime limit on the number of
11 days of inpatient treatment or the number of outpatient
12 visits covered under the plan.

13 (C) (Blank).

14 (5) An issuer of a group health benefit plan or an
15 individual policy of accident and health insurance or a
16 qualified health plan offered through the health insurance
17 marketplace may not count toward the number of outpatient
18 visits required to be covered under this Section an outpatient
19 visit for the purpose of medication management and shall cover
20 the outpatient visits under the same terms and conditions as
21 it covers outpatient visits for the treatment of physical
22 illness.

23 (5.5) An individual or group health benefit plan amended,
24 delivered, issued, or renewed on or after September 9, 2015
25 (the effective date of Public Act 99-480) shall offer coverage
26 for medically necessary acute treatment services and medically

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

14 As used in this subsection:

15 "Acute treatment services" means 24-hour medically
16 supervised addiction treatment that provides evaluation and
17 withdrawal management and may include biopsychosocial
18 assessment, individual and group counseling, psychoeducational
19 groups, and discharge planning.

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

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

4 (6.5) An individual or group health benefit plan amended,
5 delivered, issued, or renewed on or after the effective date
6 of this amendatory Act of the 104th General Assembly January
7 1, 2019 (the effective date of Public Act 100-1024):

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

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

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

1 (D) shall not exclude coverage for a prescription
2 medication approved by the United States Food and Drug
3 Administration for the treatment of substance use
4 disorders and any associated counseling or wraparound
5 services on the grounds that such medications and services
6 were court ordered; ~~and-~~

7 (E) shall not impose any prior authorization
8 requirements on outpatient services for the prevention,
9 screening, diagnosis, or treatment of mental, emotional,
10 nervous, or substance use disorders or conditions.

11 (7) (Blank).

12 (8) (Blank).

13 (9) With respect to all mental, emotional, nervous, or
14 substance use disorders or conditions, coverage for inpatient
15 treatment shall include coverage for treatment in a
16 residential treatment center certified or licensed by the
17 Department of Public Health or the Department of Human
18 Services.

19 (c) This Section shall not be interpreted to require
20 coverage for speech therapy or other rehabilitative 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 employee health
26 plans.

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

2 "Benefits", with respect to insurers, means the benefits
3 provided for treatment services for inpatient and outpatient
4 treatment of substance use disorders or conditions at American
5 Society of Addiction Medicine levels of treatment 2.1
6 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1
7 (Clinically Managed Low-Intensity Residential), 3.3
8 (Clinically Managed Population-Specific High-Intensity
9 Residential), 3.5 (Clinically Managed High-Intensity
10 Residential), and 3.7 (Medically Monitored Intensive
11 Inpatient) and OMT (Opioid Maintenance Therapy) services.

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

20 "Substance use disorder treatment provider or facility"
21 means a licensed physician, licensed psychologist, licensed
22 psychiatrist, licensed advanced practice registered nurse, or
23 licensed, certified, or otherwise State-approved facility or
24 provider of substance use disorder treatment.

25 (2) A group health insurance policy, an individual health
26 benefit plan, or qualified health plan that is offered through

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

10 (3) Prior authorization shall not be utilized for the
11 benefits under this subsection. The substance use disorder
12 treatment provider or facility shall notify the insurer of the
13 initiation of treatment. For an insurer that is not a managed
14 care organization, the substance use disorder treatment
15 provider or facility notification shall occur for the
16 initiation of treatment of the covered person within 2
17 business days. For managed care organizations, the substance
18 use disorder treatment provider or facility notification shall
19 occur in accordance with the protocol set forth in the
20 provider agreement for initiation of treatment within 24
21 hours. If the managed care organization is not capable of
22 accepting the notification in accordance with the contractual
23 protocol during the 24-hour period following admission, the
24 substance use disorder treatment provider or facility shall
25 have one additional business day to provide the notification
26 to the appropriate managed care organization. Treatment plans

1 shall be developed in accordance with the requirements and
2 timeframes established in 77 Ill. Adm. Code 2060. If the
3 substance use disorder treatment provider or facility fails to
4 notify the insurer of the initiation of treatment in
5 accordance with these provisions, the insurer may follow its
6 normal prior authorization processes.

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

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

23 If an expedited external review request meets the criteria
24 of the Health Carrier External Review Act, an independent
25 review organization shall make a final determination of
26 medical necessity within 72 hours. If an independent review

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

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

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

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

21 (h) As used in this Section:

22 "Generally accepted standards of mental, emotional,
23 nervous, or substance use disorder or condition care" means
24 standards of care and clinical practice that are generally
25 recognized by health care providers practicing in relevant
26 clinical specialties such as psychiatry, psychology, clinical

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

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

21 (1) in accordance with the generally accepted
22 standards of mental, emotional, nervous, or substance use
23 disorder or condition care;

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

26 (3) not primarily for the economic benefit of the

1 insurer, purchaser, or for the convenience of the patient,
2 treating physician, or other health care provider.

3 "Utilization review" means either of the following:

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

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

18 "Utilization review criteria" means patient placement
19 criteria or any criteria, standards, protocols, or guidelines
20 used by an insurer to conduct utilization review.

21 (i)(1) Every insurer that amends, delivers, issues, or
22 renews a group or individual policy of accident and health
23 insurance or a qualified health plan offered through the
24 health insurance marketplace in this State and Medicaid
25 managed care organizations providing coverage for hospital or
26 medical treatment on or after January 1, 2023 shall, pursuant

1 to subsections (h) through (s), provide coverage for medically
2 necessary treatment of mental, emotional, nervous, or
3 substance use disorders or conditions.

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

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

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

1 individual was not eligible for Medicaid at the time the
2 service was rendered. Nothing in this Section shall require an
3 insurer to pay for services if the individual was not the
4 insurer's enrollee at the time services were rendered. As used
5 in this paragraph, "material" means a fact or situation that
6 is not merely technical in nature and results in or could
7 result in a substantial change in the situation.

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

22 (k) An insurer shall base any medical necessity
23 determination or the utilization review criteria that the
24 insurer, and any entity acting on the insurer's behalf,
25 applies to determine the medical necessity of health care
26 services and benefits for the diagnosis, prevention, and

1 treatment of mental, emotional, nervous, or substance use
2 disorders or conditions on current generally accepted
3 standards of mental, emotional, nervous, or substance use
4 disorder or condition care. All denials and appeals shall be
5 reviewed by a professional with experience or expertise
6 comparable to the provider requesting the authorization.

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

24 (m) In conducting utilization review relating to level of
25 care placement, continued stay, transfer, discharge, or any
26 other patient care decisions that are within the scope of the

1 sources specified in subsection (l), an insurer shall not
2 apply different, additional, conflicting, or more restrictive
3 utilization review criteria than the criteria set forth in
4 those sources. For all level of care placement decisions, the
5 insurer shall authorize placement at the level of care
6 consistent with the assessment of the insured using the
7 relevant patient placement criteria as specified in subsection
8 (l). If that level of placement is not available, the insurer
9 shall authorize the next higher level of care. In the event of
10 disagreement, the insurer shall provide full detail of its
11 assessment using the relevant criteria as specified in
12 subsection (l) to the provider of the 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 inpatient
9 mental health treatment at participating hospitals shall
10 comply with the following requirements:

11 (1) Subject to paragraphs (2) and (3) of this
12 subsection, no policy shall require prior authorization
13 for admission for such treatment at any participating
14 hospital.

15 (2) Coverage provided under this subsection also shall
16 not be subject to concurrent review for the first 72
17 hours, provided that the hospital must notify the insurer
18 of both the admission and the initial treatment plan
19 within 48 hours of admission. A discharge plan must be
20 fully developed and continuity services prepared to meet
21 the patient's needs and the patient's community preference
22 upon release. Nothing in this paragraph supersedes a
23 health maintenance organization's referral requirement for
24 services from nonparticipating providers upon a patient's
25 discharge from a hospital.

26 (3) Treatment provided under this subsection may be

1 reviewed retrospectively. If coverage is denied
2 retrospectively, neither the insurer nor the participating
3 hospital shall bill, and the insured shall not be liable,
4 for any treatment under this subsection through the date
5 the adverse determination is issued, other than any
6 copayment, coinsurance, or deductible for the stay through
7 that date as applicable under the policy. Coverage shall
8 not be retrospectively denied for the first 72 hours of
9 treatment at a participating hospital except:

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

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

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

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

24 (4) Nothing in this subsection shall be construed to
25 require a policy to cover any health care service excluded
26 under the terms of coverage.

1 (x) Notwithstanding any provision of this Section, nothing
2 shall require the medical assistance program under Article V
3 of the Illinois Public Aid Code to violate any applicable
4 federal laws, regulations, or grant requirements or any State
5 or federal consent decrees. Nothing in subsection (w) shall
6 prevent the Department of Healthcare and Family Services from
7 requiring a health care provider to use specified level of
8 care, admission, continued stay, or discharge criteria,
9 including, but not limited to, those under Section 5-5.23 of
10 the Illinois Public Aid Code, as long as the Department of
11 Healthcare and Family Services does not require a health care
12 provider to seek prior authorization or concurrent review from
13 the Department of Healthcare and Family Services, a Medicaid
14 managed care organization, or a utilization review
15 organization under the circumstances expressly prohibited by
16 subsection (w). Nothing in this Section prohibits a health
17 plan, including a Medicaid managed care organization, from
18 conducting reviews for fraud, waste, or abuse and reporting
19 suspected fraud, waste, or abuse according to State and
20 federal requirements.

21 (y) Children's Mental Health. Nothing in this Section
22 shall suspend the screening and assessment requirements for
23 mental health services for children participating in the
24 State's medical assistance program as required in Section
25 5-5.23 of the Illinois Public Aid Code.

26 (Source: P.A. 102-558, eff. 8-20-21; 102-579, eff. 1-1-22;

1 102-813, eff. 5-13-22; 103-426, eff. 8-4-23; 103-650, eff.
2 1-1-25; 103-1040, eff. 8-9-24; revised 11-26-24.)