AN ACT concerning regulation.

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

Article 1.

Section 1-1. This Act may be referred to as the Health Care Protection Act.

Article 2.

Section 2-5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.55 as follows:

(5 ILCS 100/5-45.55 new)

Sec. 5-45.55. Emergency rulemaking; Network Adequacy and Transparency Act. To provide for the expeditious and timely implementation of the Network Adequacy and Transparency Act, emergency rules implementing federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated by the Department of Insurance and are more stringent than the State standards extant at the time the final federal standards are published may be adopted in accordance with Section 5-45 by the Department of Insurance. The adoption of emergency

rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

Section 2-10. The Network Adequacy and Transparency Act is amended by changing Sections 3, 5, 10, 15, 20, 25, and 30 and by adding Sections 35, 36, 40, 50, and 55 as follows:

(215 ILCS 124/3)

Sec. 3. Applicability of Act. This Act applies to an individual or group policy of ~~accident and~~ health insurance coverage with a network plan amended, delivered, issued, or renewed in this State on or after January 1, 2019. This Act does not apply to an individual or group policy for excepted benefits or short-term, limited-duration health insurance coverage ~~dental or vision insurance or a limited health service organization~~ with a network plan amended, delivered, issued, or renewed in this State on or after January 1, 2019, except to the extent that federal law establishes network adequacy and transparency standards for stand-alone dental plans, which the Department shall enforce for plans amended, delivered, issued, or renewed on or after January 1, 2025.

(Source: P.A. 100-502, eff. 9-15-17; 100-601, eff. 6-29-18.)

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a

beneficiary has given express written consent to represent the beneficiary; a person authorized by law to provide substituted consent for a beneficiary; or the beneficiary's treating provider only when the beneficiary or his or her family member is unable to provide consent.

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an issuer ~~insurer~~.

"Department" means the Department of Insurance.

"Essential community provider" has the meaning ascribed to that term in 45 CFR 156.235.

"Excepted benefits" has the meaning ascribed to that term in 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted benefits" includes individual, group, or blanket coverage.

"Exchange" has the meaning ascribed to that term in 45 CFR 155.20.

"Director" means the Director of Insurance.

"Family caregiver" means a relative, partner, friend, or neighbor who has a significant relationship with the patient and administers or assists the patient with activities of daily living, instrumental activities of daily living, or

other medical or nursing tasks for the quality and welfare of that patient.

"Group health plan" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance coverage" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Health insurance coverage" does not include any coverage or benefits under Medicare or under the medical assistance program established under Article V of the Illinois Public Aid Code.

"Issuer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

~~"Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers compensation insurance, and pharmacy benefit managers.~~

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers within any county, the removal of a major

health system that causes a network to be significantly different within any county from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

"Network" means the group or groups of preferred providers providing services to a network plan.

"Network plan" means an individual or group policy of ~~accident and~~ health insurance coverage that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the issuer or by a third party contracted to arrange, contract for, or administer such provider-related incentives for the issuer ~~insurer~~.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, ~~or~~ post-operative visits, or a serious and complex condition as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of treatment for a health condition that a treating provider

attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; ~~or~~ (4) the third trimester of pregnancy through the post-partum period; (5) undergoing a course of institutional or inpatient care from the provider within the meaning of 42 U.S.C. 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective surgery from the provider, including receipt of preoperative or postoperative care from such provider with respect to such a surgery; (7) being determined to be terminally ill, as determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving treatment for such illness from such provider; or (8) any other treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a provider because of the potential for changes in the therapeutic regimen or because of the potential for a recurrence of symptoms.

"Preferred provider" means any provider who has entered, either directly or indirectly, into an agreement with an employer or risk-bearing entity relating to health care services that may be rendered to beneficiaries under a network plan.

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions or facilities that provide health care services.

"Short-term, limited-duration insurance" means any type of

accident and health insurance offered or provided within this State pursuant to a group or individual policy or individual certificate by a company, regardless of the situs state of the delivery of the policy, that has an expiration date specified in the contract that is fewer than 365 days after the original effective date. Regardless of the duration of coverage, "short-term, limited-duration insurance" does not include excepted benefits or any student health insurance coverage.

"Stand-alone dental plan" has the meaning ascribed to that term in 45 CFR 156.400.

"Telehealth" has the meaning given to that term in Section 356z.22 of the Illinois Insurance Code.

"Telemedicine" has the meaning given to that term in Section 49.5 of the Medical Practice Act of 1987.

"Tiered network" means a network that identifies and groups some or all types of provider and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

"Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology, or family practice.

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

(215 ILCS 124/10)

Sec. 10. Network adequacy.

(a) Before issuing, delivering, or renewing a network plan, an issuer ~~An insurer~~ providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An issuer ~~insurer~~ shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the issuer ~~insurer~~ in accordance with any rights or remedies available under applicable State or federal law.

(b) Before issuing, delivering, or renewing a network plan, an issuer ~~Insurers~~ must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers <u>in each plan</u>, additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the issuer ~~insurer~~ shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances,

the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost sharing provisions.

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

(c) The issuer ~~network plan~~ shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department for each network plan.

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established ~~annually~~ by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; and

(CC) HIV.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an

assessment of additional specialties to be included in the list under this subsection (c).

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

(d) The network plan shall demonstrate to the Director maximum travel and distance standards and appointment wait time standards for plan beneficiaries, which shall be established ~~annually~~ by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as

large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment wait time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

If the federal area designations for the maximum time or

distance or appointment wait time standards required are changed by the most recent Letter to Issuers in the Federally-facilitated Marketplaces, the Department shall post on its website notice of such changes and may amend its rules to conform to those designations if the Director deems appropriate.

(d-5)(1) Every issuer ~~insurer~~ shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Issuers ~~Insurers~~ shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and

proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of

this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential

treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the issuer ~~insurer~~ shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under

this Section.

(g) Except for the requirements set forth in subsection (d-5), issuers ~~insurers~~ who are not able to comply with the provider ratios and time and distance or appointment wait time standards established under this Act or federal law ~~by the Department~~ may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the issuer ~~insurer~~ (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the issuer ~~insurer~~ provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the

Department consistent with the requirements of this Act.

(h) Issuers ~~Insurers~~ are required to report to the Director any material change to an approved network plan within 15 business days after the change occurs and any change that would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer ~~insurer~~, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 business days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of $5,000 per day.

(i) If a network plan is inadequate under this Act with respect to a provider type in a county, and if the network plan does not have an approved exception for that provider type in that county pursuant to subsection (g), an issuer shall cover out-of-network claims for covered health care services received from that provider type within that county at the in-network benefit level and shall retroactively adjudicate and reimburse beneficiaries to achieve that objective if their claims were processed at the out-of-network level contrary to this subsection. Nothing in this subsection shall be construed

to supersede Section 356z.3a of the Illinois Insurance Code.

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection may subject the issuer to a civil penalty of $5,000 per policy.

(k) For the Department to enforce any new or modified federal standard before the Department adopts the standard by rule, the Department must, no later than May 15 before the start of the plan year, give public notice to the affected health insurance issuers through a bulletin.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23.)

(215 ILCS 124/15)

Sec. 15. Notice of nonrenewal or termination.

(a) A network plan must give at least 60 days' notice of nonrenewal or termination of a provider to the provider and to the beneficiaries served by the provider. The notice shall include a name and address to which a beneficiary or provider may direct comments and concerns regarding the nonrenewal or termination and the telephone number maintained by the Department for consumer complaints. Immediate written notice may be provided without 60 days' notice when a provider's license has been disciplined by a State licensing board or when the network plan reasonably believes direct imminent physical harm to patients under the provider's ~~providers~~ care may occur. The notice to the beneficiary shall provide the individual with an opportunity to notify the issuer of the individual's need for transitional care.

(b) Primary care providers must notify active affected patients of nonrenewal or termination of the provider from the network plan, except in the case of incapacitation.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/20)

Sec. 20. Transition of services.

(a) A network plan shall provide for continuity of care for its beneficiaries as follows:

(1) If a beneficiary's ~~physician or hospital~~ provider leaves the network plan's network of providers for reasons

other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider remains within the network plan's service area, if benefits provided under such network plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan, or if a contract between a group health plan and a health insurance issuer offering a network plan in connection with the group health plan is terminated and results in a loss of benefits provided under such plan with respect to such provider, then the network plan shall permit the beneficiary to continue an ongoing course of treatment with that provider during a transitional period for the following duration:

(A) 90 days from the date of the notice to the beneficiary of the provider's disaffiliation from the network plan if the beneficiary has an ongoing course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the time of the provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

(2) Notwithstanding the provisions of paragraph (1) of this subsection (a), such care shall be authorized by the network plan during the transitional period in accordance

with the following:

(A) the provider receives continued reimbursement from the network plan at the rates and terms and conditions applicable under the terminated contract prior to the start of the transitional period;

(B) the provider adheres to the network plan's quality assurance requirements, including provision to the network plan of necessary medical information related to such care; and

(C) the provider otherwise adheres to the network plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorizations for treatment.

(3) The provisions of this Section governing health care provided during the transition period do not apply if the beneficiary has successfully transitioned to another provider participating in the network plan, if the beneficiary has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary.

(b) A network plan shall provide for continuity of care for new beneficiaries as follows:

(1) If a new beneficiary whose provider is not a member of the network plan's provider network, but is within the network plan's service area, enrolls in the network plan, the network plan shall permit the

beneficiary to continue an ongoing course of treatment with the beneficiary's current physician during a transitional period:

(A) of 90 days from the effective date of enrollment if the beneficiary has an ongoing course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.

(2) If a beneficiary, or a beneficiary's authorized representative, elects in writing to continue to receive care from such provider pursuant to paragraph (1) of this subsection (b), such care shall be authorized by the network plan for the transitional period in accordance with the following:

(A) the provider receives reimbursement from the network plan at rates established by the network plan;

(B) the provider adheres to the network plan's quality assurance requirements, including provision to the network plan of necessary medical information related to such care; and

(C) the provider otherwise adheres to the network plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorization for treatment.

(3) The provisions of this Section governing health care provided during the transition period do not apply if the beneficiary has successfully transitioned to another provider participating in the network plan, if the beneficiary has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary.

(c) In no event shall this Section be construed to require a network plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the beneficiary's contract.

(d) A provider shall comply with the requirements of 42 U.S.C. 300gg-138.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/25)

Sec. 25. Network transparency.

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or

contract number.

(2) An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of $5,000 per month. ~~The network plan shall update the online provider directory at least monthly.~~ Providers shall notify the network plan electronically or in writing within 10 business days of any changes to their information as listed in the provider directory, including the information required in subsections (b), (c), and (d) ~~subparagraph (K) of paragraph (1) of subsection (b)~~. With regard to subparagraph (I) of paragraph (1) of subsection (b), the provider must give notice to the issuer within 20 business days of deciding to cease accepting new patients covered by the plan if the new patient limitation is expected to last 40 business days or longer. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 2 ~~10~~ business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) At least once every 90 days, the issuer shall self-audit each network plan's ~~The network plan shall audit periodically at least 25% of its~~ provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The issuer shall

submit the self-audit and a summary to the Department, and the Department shall make the summary of each self-audit publicly available. The Department shall specify the requirements of the summary, which shall be statistical in nature except for a high-level narrative evaluating the impact of internal and external factors on the accuracy of the directory and the timeliness of updates. ~~The network plan shall submit the audit to the Director upon request.~~ As part of these self-audits ~~audits~~, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network. The self-audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

(4) A network plan shall provide a print copy of a current provider directory or a print copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. Except when an issuer's print copies use the same provider information as the electronic provider directory on each print copy's date of printing, print ~~Print~~ copies must be updated at least every 90 days ~~quarterly~~ and ~~an~~ errata that reflects changes in the provider network must be included in each update ~~updated quarterly~~.

(5) For each network plan, a network plan shall include, in plain language in both the electronic and print directory, the following general information:

(A) in plain language, a description of the criteria the plan has used to build its provider network;

(B) if applicable, in plain language, a description of the criteria the issuer ~~insurer~~ or network plan has used to create tiered networks;

(C) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a beneficiary-covered person or a prospective beneficiary-covered person to be able to identify the provider tier; ~~and~~

(D) if applicable, a notation that authorization or referral may be required to access some providers; ~~.~~

(E) a telephone number and email address for a customer service representative to whom directory inaccuracies may be reported; and

(F) a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed

as in-network prior to the provision of care and a telephone number and email address to dispute such charges.

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) patient population served (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients;

(J) board certifications, if applicable; ~~and~~

(K) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(L) whether the health care professional accepts

appointment requests from patients; and

(M) the anticipated date the provider will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms that the provider is scheduled to leave the network;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer);

(C) participating hospital location; ~~and~~

(D) hospital accreditation status; and

(E) the anticipated date the hospital will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the hospital is scheduled to leave the network; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; ~~and~~

(D) participating facility location or locations; and~~.~~

(E) the anticipated date the facility will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the facility is scheduled to leave the network.

(c) For the electronic provider directories, for each

network plan, a network plan shall make available all of the following information in addition to the searchable information required in this Section:

(1) for health care professionals:

(A) contact information, including both a telephone number and digital contact information if the provider has supplied digital contact information; and

(B) languages spoken other than English by clinical staff, if applicable;

(2) for hospitals, telephone number and digital contact information; and

(3) for facilities other than hospitals, telephone number.

(d) The issuer ~~insurer~~ or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) for health care professionals:

(A) name;

(B) contact information, including a telephone number and digital contact information if the provider has supplied digital contact information;

(C) participating office location or locations;

(D) patient population (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) languages spoken other than English, if applicable;

(F) whether accepting new patients; ~~and~~

(G) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent; and

(H) whether the health care professional accepts appointment requests from patients.

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer); and

(C) participating hospital location, ~~and~~ telephone number, and digital contact information; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) patient population (such as pediatric, adult, elderly, or women) served, if applicable, and types of services performed; and

(D) participating facility location or locations, ~~and~~ telephone numbers, and digital contact information for each location.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the issuer's ~~insurer's~~ electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number and email address in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information or report provider directory inaccuracies. The printed provider directory shall include a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute those charges.

(f) The Director may conduct periodic audits of the

accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(g) To the extent not otherwise provided in this Act, an issuer shall comply with the requirements of 42 U.S.C. 300qq-115, except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Section.

(h) If the issuer or the Department identifies a provider incorrectly listed in the provider directory, the issuer shall check each of the issuer's network plan provider directories for the provider within 2 business days to ascertain whether the provider is a preferred provider in that network plan and, if the provider is incorrectly listed in the provider directory, remove the provider from the provider directory without delay.

(i) If the Director determines that an issuer violated this Section, the Director may assess a fine up to $5,000 per violation, except for inaccurate information given by a provider to the issuer. If an issuer, or any entity or person acting on the issuer's behalf, knew or reasonably should have known that a provider was incorrectly included in a provider directory, the Director may assess a fine of up to $25,000 per violation against the issuer.

(j) This Section applies to network plans not otherwise

exempt under Section 3, including stand-alone dental plans.

(Source: P.A. 102-92, eff. 7-9-21; revised 9-26-23.)

(215 ILCS 124/30)

Sec. 30. Administration and enforcement.

(a) Issuers ~~Insurers~~, as defined in this Act, have a continuing obligation to comply with the requirements of this Act. Other than the duties specifically created in this Act, nothing in this Act is intended to preclude, prevent, or require the adoption, modification, or termination of any utilization management, quality management, or claims processing methodologies of an issuer ~~insurer~~.

(b) Nothing in this Act precludes, prevents, or requires the adoption, modification, or termination of any network plan term, benefit, coverage or eligibility provision, or payment methodology.

(c) The Director shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law.

(d) The Department shall adopt rules to enforce compliance with this Act to the extent necessary.

(e) In accordance with Section 5-45 of the Illinois Administrative Procedure Act, the Department may adopt emergency rules to implement federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated by the Department and are more stringent than the State

standards extant at the time the final federal standards are published.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/35 new)

Sec. 35. Provider requirements. Providers shall comply with 42 U.S.C. 300gg-138 and 300gg-139 and the regulations promulgated thereunder, as well as Section 20, paragraph (2) of subsection (a) of Section 25, subsections (h) and (j) of Section 25, and Section 36 of this Act, except that "provider directory information" includes all information required to be included in a provider directory pursuant to Section 25 of this Act.

(215 ILCS 124/36 new)

Sec. 36. Complaint of incorrect charges.

(a) A beneficiary who, taking into account the reimbursement, if any, by the issuer, incurs a cost in excess of the in-network cost-sharing for a covered service from a provider, facility, or hospital that was listed as in-network in the plan's provider directory prior to or at the time of the provision of services may file a complaint with the Department. The Department shall investigate the complaint and determine if the provider was incorrectly included in the plan's provider directory when the beneficiary made the appointment or received the service.

(b) Upon the Department's confirmation of the allegations in the complaint that the beneficiary incurred a cost in excess of the in-network cost-sharing for covered services provided by an incorrectly included provider when the appointment was made or service was provided, the issuer shall reimburse the beneficiary for all costs incurred in excess of the in-network cost-sharing. However, if the issuer has paid the claim to the provider directly, the issuer shall notify the beneficiary and the provider of the beneficiary's right to reimbursement from the provider for any payments in excess of the in-network cost-sharing amount pursuant to 42 U.S.C. 300gg-139(b), and the issuer's notice shall specify the in-network cost-sharing amount for the covered services. The amounts paid by the beneficiary within the in-network cost-sharing amount shall apply towards the in-network deductible and out-of-pocket maximum, if any.

(215 ILCS 124/40 new)

Sec. 40. Confidentiality.

(a) All records in the custody or possession of the Department are presumed to be open to public inspection or copying unless exempt from disclosure by Section 7 or 7.5 of the Freedom of Information Act. Except as otherwise provided in this Section or other applicable law, the filings required under this Act shall be open to public inspection or copying.

(b) The following information shall not be deemed

confidential:

(1) actual or projected ratios of providers to beneficiaries;

(2) actual or projected time and distance between network providers and beneficiaries or actual or projected waiting times for a beneficiary to see a network provider;

(3) geographic maps of network providers;

(4) requests for exceptions under subsection (g) of Section 10, except with respect to any discussion of ongoing or planned contractual negotiations with providers that the issuer requests to be treated as confidential;

(5) provider directories and provider lists;

(6) self-audit summaries required under paragraph (3) of subsection (a) of Section 25 of this Act; and

(7) issuer or Department statements of determination as to whether a network plan has satisfied this Act's requirements regarding the information described in this subsection.

(c) An issuer's work papers and reports on the results of a self-audit of its provider directories, including any communications between the issuer and the Department, shall remain confidential unless expressly waived by the issuer or unless deemed public information under federal law.

(d) The filings required under Section 10 of this Act shall be confidential while they remain under the Department's review but shall become open to public inspection and copying

upon completion of the review, except as provided in this Section or under other applicable law.

(e) Nothing in this Section shall supersede the statutory requirement that work papers obtained during a market conduct examination be deemed confidential.

(215 ILCS 124/50 new)

Sec. 50. Funds for enforcement. Moneys from fines and penalties collected from issuers for violations of this Act shall be deposited into the Insurance Producer Administration Fund for appropriation by the General Assembly to the Department to be used for providing financial support of the Department's enforcement of this Act.

(215 ILCS 124/55 new)

Sec. 55. Uniform electronic provider directory information notification forms.

(a) On or before January 1, 2026, the Department shall develop and publish a uniform electronic provider directory information form that issuers shall make available to onboarding, current, and former preferred providers to notify the issuer of the provider's currently accurate provider directory information under Section 25 of this Act and 42 U.S.C. 300gg-139. The form shall address information needed from newly onboarding preferred providers, updates to previously supplied provider directory information, reporting

an inaccurate directory entry of previously supplied information, contract terminations, and differences in information for specific network plans offered by an issuer, such as whether the provider is a preferred provider for the network plan or is accepting new patients under that plan. The Department shall allow issuers to implement this form through either a PDF or a web portal that requests the same information.

(b) Notwithstanding any other provision of law to the contrary, beginning 6 months after the Department publishes the uniform electronic provider directory information form and no later than July 1, 2026, every provider must use the uniform electronic provider directory information form to notify issuers of their provider directory information as required under Section 25 of this Act and 42 U.S.C. 300gg-139. Issuers shall accept this form as sufficient to update their provider directories. Issuers shall not accept paper or fax submissions of provider directory information from providers.

(c) The Uniform Electronic Provider Directory Information Form Task Force is created. The purpose of this task force is to provide input and advice to the Department of Insurance in the development of a uniform electronic provider directory information form. The task force shall include at least the following individuals:

(1) the Director of Insurance or a designee, as chair;

(2) the Marketplace Director or a designee;

(3) the Director of the Division of Professional Regulation or a designee;

(4) the Director of Public Health or a designee;

(5) the Secretary of Innovation and Technology or a designee;

(6) the Director of Healthcare and Family Services or a designee;

(7) the following individuals appointed by the Director:

(A) one representative of a statewide association representing physicians;

(B) one representative of a statewide association representing nurses;

(C) one representative of a statewide organization representing a majority of Illinois hospitals;

(D) one representative of a statewide organization representing Illinois pharmacies;

(E) one representative of a statewide organization representing mental health care providers;

(F) one representative of a statewide organization representing substance use disorder health care providers;

(G) 2 representatives of health insurance issuers doing business in this State or issuer trade associations, at least one of which represents a State-domiciled mutual health insurance company, with

a demonstrated expertise in the business of health insurance or health benefits administration; and

(H) 2 representatives of a health insurance consumer advocacy group.

(d) The Department shall convene the task force described in this Section no later than April 1, 2025.

(e) The Department, in development of the uniform electronic provider directory information form, and the task force, in offering input, shall take into consideration the following:

(1) readability and user experience;

(2) interoperability;

(3) existing regulations established by the federal Centers for Medicare and Medicaid Services, the Department of Insurance, the Department of Healthcare and Family Service, the Department of Financial and Professional Regulation, and the Department of Public Health;

(4) potential opportunities to avoid duplication of data collection efforts, including, but not limited to, opportunities related to:

(A) integrating any provider reporting required under Section 25 of this Act and 42 U.S.C. 300gg-139 with the provider reporting required under the Health Care Professional Credentials Data Collection Act;

(B) furnishing information to any national provider directory established by the federal Centers

for Medicare and Medicaid Services or another federal agency with jurisdiction over health care providers; and

(C) furnishing information in compliance with the Patients' Right to Know Act;

(5) compatibility with the Illinois Health Benefits Exchange;

(6) provider licensing requirements and forms; and

(7) information needed to classify a provider under any specialty type for which a network adequacy standard may be established under this Act when a specialty board certification or State license does not currently exist.

Section 2-15. The Managed Care Reform and Patient Rights Act is amended by changing Sections 20 and 25 as follows:

(215 ILCS 134/20)

Sec. 20. Notice of nonrenewal or termination. A health care plan must give at least 60 days notice of nonrenewal or termination of a health care provider to the health care provider and to the enrollees served by the health care provider. The notice shall include a name and address to which an enrollee or health care provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days notice when a health care provider's license has been disciplined by a State

licensing board. The notice to the enrollee shall provide the individual with an opportunity to notify the health care plan of the individual's need for transitional care.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 134/25)

Sec. 25. Transition of services.

(a) A health care plan shall provide for continuity of care for its enrollees as follows:

(1) If an enrollee's health care provider ~~physician~~ leaves the health care plan's network of health care providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider ~~physician~~ remains within the health care plan's service area, or if benefits provided under such health care plan with respect to such provider are terminated because of a change in the terms of the participation of such provider in such plan, or if a contract between a group health plan, as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act, and a health care plan offered in connection with the group health plan is terminated and results in a loss of benefits provided under such plan with respect to such provider, the health care plan shall permit the enrollee to continue an ongoing course of

treatment with that provider ~~physician~~ during a transitional period:

(A) of 90 days from the date of the notice of provider's ~~physician's~~ termination from the health care plan to the enrollee of the provider's ~~physician's~~ disaffiliation from the health care plan if the enrollee has an ongoing course of treatment; or

(B) if the enrollee has entered the third trimester of pregnancy at the time of the provider's ~~physician's~~ disaffiliation, that includes the provision of post-partum care directly related to the delivery.

(2) Notwithstanding the provisions in item (1) of this subsection, such care shall be authorized by the health care plan during the transitional period only if the provider ~~physician~~ agrees:

(A) to continue to accept reimbursement from the health care plan at the rates applicable prior to the start of the transitional period;

(B) to adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to such care; and

(C) to otherwise adhere to the health care plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining

preauthorizations for treatment.

(3) During an enrollee's plan year, a health care plan shall not remove a drug from its formulary or negatively change its preferred or cost-tier sharing unless, at least 60 days before making the formulary change, the health care plan:

(A) provides general notification of the change in its formulary to current and prospective enrollees;

(B) directly notifies enrollees currently receiving coverage for the drug, including information on the specific drugs involved and the steps they may take to request coverage determinations and exceptions, including a statement that a certification of medical necessity by the enrollee's prescribing provider will result in continuation of coverage at the existing level; and

(C) directly notifies in writing ~~by first class mail and~~ through an electronic transmission~~, if available,~~ the prescribing provider of all health care plan enrollees currently prescribed the drug affected by the proposed change; the notice shall include a one-page form by which the prescribing provider can notify the health care plan in writing or electronically ~~by first class mail~~ that coverage of the drug for the enrollee is medically necessary.

The notification in paragraph (C) may direct the

prescribing provider to an electronic portal through which the prescribing provider may electronically file a certification to the health care plan that coverage of the drug for the enrollee is medically necessary. The prescribing provider may make a secure electronic signature beside the words "certification of medical necessity", and this certification shall authorize continuation of coverage for the drug.

If the prescribing provider certifies to the health care plan either in writing or electronically that the drug is medically necessary for the enrollee as provided in paragraph (C), a health care plan shall authorize coverage for the drug prescribed based solely on the prescribing provider's assertion that coverage is medically necessary, and the health care plan is prohibited from making modifications to the coverage related to the covered drug, including, but not limited to:

(i) increasing the out-of-pocket costs for the covered drug;

(ii) moving the covered drug to a more restrictive tier; or

(iii) denying an enrollee coverage of the drug for which the enrollee has been previously approved for coverage by the health care plan.

Nothing in this item (3) prevents a health care plan

from removing a drug from its formulary or denying an enrollee coverage if the United States Food and Drug Administration has issued a statement about the drug that calls into question the clinical safety of the drug, the drug manufacturer has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by Section 506C of the Federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. 356c, or the drug manufacturer has removed the drug from the market.

Nothing in this item (3) prohibits a health care plan, by contract, written policy or procedure, or any other agreement or course of conduct, from requiring a pharmacist to effect substitutions of prescription drugs consistent with Section 19.5 of the Pharmacy Practice Act, under which a pharmacist may substitute an interchangeable biologic for a prescribed biologic product, and Section 25 of the Pharmacy Practice Act, under which a pharmacist may select a generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration and in accordance with the Illinois Food, Drug and Cosmetic Act.

This item (3) applies to a policy or contract that is amended, delivered, issued, or renewed on or after January 1, 2019. This item (3) does not apply to a health plan as defined in the State Employees Group Insurance Act of 1971

or medical assistance under Article V of the Illinois Public Aid Code.

(b) A health care plan shall provide for continuity of care for new enrollees as follows:

(1) If a new enrollee whose physician is not a member of the health care plan's provider network, but is within the health care plan's service area, enrolls in the health care plan, the health care plan shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current physician during a transitional period:

(A) of 90 days from the effective date of enrollment if the enrollee has an ongoing course of treatment; or

(B) if the enrollee has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.

(2) If an enrollee elects to continue to receive care from such physician pursuant to item (1) of this subsection, such care shall be authorized by the health care plan for the transitional period only if the physician agrees:

(A) to accept reimbursement from the health care plan at rates established by the health care plan; such rates shall be the level of reimbursement applicable to similar physicians within the health

care plan for such services;

(B) to adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to such care; and

(C) to otherwise adhere to the health care plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining preauthorization for treatment.

(c) In no event shall this Section be construed to require a health care plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the enrollee's contract. In no event shall this Section be construed to prohibit the addition of prescription drugs to a health care plan's list of covered drugs during the coverage year.

(d) In this Section, "ongoing course of treatment" has the meaning ascribed to that term in Section 5 of the Network Adequacy and Transparency Act.

(Source: P.A. 100-1052, eff. 8-24-18.)

Article 3.

Section 3-5. The Illinois Insurance Code is amended by changing Section 355 as follows:

(215 ILCS 5/355) (from Ch. 73, par. 967)

Sec. 355. Accident and health policies; provisions.

(a) As used in this Section:

"Inadequate rate" means a rate:

(1) that is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) the continued use of which endangers the solvency of an insurer using that rate.

"Large employer" has the meaning provided in the Illinois Health Insurance Portability and Accountability Act.

"Plain language" has the meaning provided in the federal Plain Writing Act of 2010 and subsequent guidance documents, including the Federal Plain Language Guidelines.

"Unreasonable rate increase" means a rate increase that the Director determines to be excessive, unjustified, or unfairly discriminatory in accordance with 45 CFR 154.205.

(b) No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143. If the Director disapproves the policy form, he or she shall make a written decision stating the respects in which such form does

not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form. On and after January 1, 2025, any form filing submitted for large employer group accident and health insurance shall be automatically deemed approved within 90 days of the submission date unless the Director extends by not more than an additional 30 days the period within which the form shall be approved or disapproved by giving written notice to the insurer of such extension before the expiration of the 90 days. Any form in receipt of such an extension shall be automatically deemed approved within 120 days of the submission date. The Director may toll the filing due to a conflict in legal interpretation of federal or State law as long as the tolling is applied uniformly to all applicable forms, written notification is provided to the insurer prior to the tolling, the duration of the tolling is provided within the notice to the insurer, and justification for the tolling is posted to the Department's website. The Director may disapprove the filing if the insurer fails to respond to an objection or request for additional information within the timeframe identified for response. As used in this subsection, "large employer" has the meaning given in Section 5 of the federal Health Insurance Portability and Accountability Act.

(c) For plan year 2026 and thereafter, premium rates for all individual and small group accident and health insurance

policies must be filed with the Department for approval. Unreasonable rate increases or inadequate rates shall be modified or disapproved. For any plan year during which the Illinois Health Benefits Exchange operates as a full State-based exchange, the Department shall provide insurers at least 30 days' notice of the deadline to submit rate filings.

(c-5) Unless prohibited under federal law, for plan year 2026 and thereafter, each insurer proposing to offer a qualified health plan issued in the individual market through the Illinois Health Benefits Exchange must incorporate the following approach in its rate filing under this Section:

(1) The rate filing must apply a cost-sharing reduction defunding adjustment factor within a range that:

(A) is uniform across all insurers;

(B) is consistent with the total adjustment expected to be needed to cover actual cost-sharing reduction costs across all silver plans on the Illinois Health Benefits Exchange statewide, provided that such costs are calculated assuming utilization by the State's full individual-market risk pool; and

(C) assumes that the only on-Exchange silver plans that will be purchased are the 87% and 94% cost-sharing reduction variations.

(2) The rate filing must apply an induced demand factor based on the following formula: $(\text{Plan Actuarial Value})^2 - (\text{Plan Actuarial Value}) + 1.24$.

In the annual notice to insurers described in subsection (c), the Department must include the specific numerical range calculated for the applicable plan year under paragraph (1) of this subsection (c-5) and the formula in paragraph (2) of this subsection (c-5).

(d) For plan year 2025 and thereafter, the Department shall post all insurers' rate filings and summaries on the Department's website 5 business days after the rate filing deadline set by the Department in annual guidance. The rate filings and summaries posted to the Department's website shall exclude information that is proprietary or trade secret information protected under paragraph (g) of subsection (1) of Section 7 of the Freedom of Information Act or confidential or privileged under any applicable insurance law or rule. All summaries shall include a brief justification of any rate increase or decrease requested, including the number of individual members, the medical loss ratio, medical trend, administrative costs, and any other information required by rule. The plain writing summary shall include notification of the public comment period established in subsection (e).

(e) The Department shall open a 30-day public comment period on the rate filings beginning on the date that all of the rate filings are posted on the Department's website. The Department shall post all of the comments received to the Department's website within 5 business days after the comment period ends.

(f) After the close of the public comment period described in subsection (e), the Department, beginning for plan year 2026, shall issue a decision to approve, disapprove, or modify a rate filing within 60 days. Any rate filing or any rates within a filing on which the Director does not issue a decision within 60 days shall automatically be deemed approved. The Director's decision shall take into account the actuarial justifications and public comments. The Department shall notify the insurer of the decision, make the decision available to the public by posting it on the Department's website, and include an explanation of the findings, actuarial justifications, and rationale that are the basis for the decision. Any company whose rate has been modified or disapproved shall be allowed to request a hearing within 10 days after the action taken. The action of the Director in disapproving a rate shall be subject to judicial review under the Administrative Review Law.

(g) If, following the issuance of a decision but before the effective date of the premium rates approved by the decision, an event occurs that materially affects the Director's decision to approve, deny, or modify the rates, the Director may consider supplemental facts or data reasonably related to the event.

(h) The Department shall adopt rules implementing the procedures described in subsections (d) through (g) by March 31, 2024.

(i) Subsection (a) and subsections (c) through (h) of this Section do not apply to grandfathered health plans as defined in 45 CFR 147.140; excepted benefits as defined in 42 U.S.C. 300gg-91; student health insurance coverage as defined in 45 CFR 147.145; the large group market as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act; or short-term, limited-duration health insurance coverage as defined in Section 5 of the Short-Term, Limited-Duration Health Insurance Coverage Act. For a filing of premium rates or classifications of risk for any of these types of coverage, the Director's initial review period shall not exceed 60 days to issue informal objections to the company that request additional clarification, explanation, substantiating documentation, or correction of concerns identified in the filing before the company implements the premium rates, classifications, or related rate-setting methodologies described in the filing, except that the Director may extend by not more than an additional 30 days the period of initial review by giving written notice to the company of such extension before the expiration of the initial 60-day period. Nothing in this subsection shall confer authority upon the Director to approve, modify, or disapprove rates where that authority is not provided by other law. Nothing in this subsection shall prohibit the Director from conducting any investigation, examination, hearing, or other formal administrative or enforcement proceeding with respect to a

company's rate filing or implementation thereof under applicable law at any time, including after the period of initial review.

(Source: P.A. 103-106, eff. 1-1-24.)

Section 3-10. The Illinois Health Benefits Exchange Law is amended by changing Section 5-5 as follows:

(215 ILCS 122/5-5)

Sec. 5-5. State health benefits exchange. It is declared that this State, beginning October 1, 2013, in accordance with Section 1311 of the federal Patient Protection and Affordable Care Act, shall establish a State health benefits exchange to be known as the Illinois Health Benefits Exchange in order to help individuals and small employers with no more than 50 employees shop for, select, and enroll in qualified, affordable private health plans that fit their needs at competitive prices. The Exchange shall separate coverage pools for individuals and small employers and shall supplement and not supplant any existing private health insurance market for individuals and small employers. The Department of Insurance shall operate the Illinois Health Benefits Exchange as a State-based exchange using the federal platform by plan year 2025 and as a State-based exchange by plan year 2026. The Director of Insurance may require that all plans in the individual and small group markets, other than grandfathered

health plans, be made available for comparison on the Illinois Health Benefits Exchange, but may not require that all plans in the individual and small group markets be purchased exclusively on the Illinois Health Benefits Exchange. Through the adoption of rules, the Director of Insurance may require that plans offered on the exchange conform with standardized plan designs that provide for standardized cost sharing for covered health services. Except when it is inconsistent with State law, the Department of Insurance shall enforce the coverage requirements under the federal Patient Protection and Affordable Care Act, including the coverage of all United States Preventive Services Task Force Grade A and B preventive services without cost sharing notwithstanding any federal overturning or repeal of 42 U.S.C. 300gg-13(a)(1), that apply to the individual and small group markets. Beginning for plan year 2026, if a health insurance issuer offers a product as defined under 45 CFR 144.103 at the gold or silver level through the Illinois Health Benefits Exchange, the issuer must offer that product at both the gold and silver levels. The Director of Insurance may elect to add a small business health options program to the Illinois Health Benefits Exchange to help small employers enroll their employees in qualified health plans in the small group market. The General Assembly shall appropriate funds to establish the Illinois Health Benefits Exchange.

(Source: P.A. 103-103, eff. 6-27-23.)

Article 4.

Section 4-5. The Illinois Insurance Code is amended by changing Section 355 as follows:

(215 ILCS 5/355) (from Ch. 73, par. 967)

Sec. 355. Accident and health policies; provisions.

(a) As used in this Section:

"Inadequate rate" means a rate:

(1) that is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) the continued use of which endangers the solvency of an insurer using that rate.

"Large employer" has the meaning provided in the Illinois Health Insurance Portability and Accountability Act.

"Plain language" has the meaning provided in the federal Plain Writing Act of 2010 and subsequent guidance documents, including the Federal Plain Language Guidelines.

"Unreasonable rate increase" means a rate increase that the Director determines to be excessive, unjustified, or unfairly discriminatory in accordance with 45 CFR 154.205.

(b) No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the

classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143. If the Director disapproves the policy form, he or she shall make a written decision stating the respects in which such form does not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form. On and after January 1, 2025, any form filing submitted for large employer group accident and health insurance shall be automatically deemed approved within 90 days of the submission date unless the Director extends by not more than an additional 30 days the period within which the form shall be approved or disapproved by giving written notice to the insurer of such extension before the expiration of the 90 days. Any form in receipt of such an extension shall be automatically deemed approved within 120 days of the submission date. The Director may toll the filing due to a conflict in legal interpretation of federal or State law as long as the tolling is applied uniformly to all applicable forms, written notification is provided to the insurer prior to the tolling, the duration of the tolling is provided within the notice to the insurer, and justification for the tolling is posted to the Department's website. The Director may disapprove the filing if the insurer fails to respond to an

objection or request for additional information within the timeframe identified for response. As used in this subsection, "large employer" has the meaning given in Section 5 of the federal Health Insurance Portability and Accountability Act.

(c) For plan year 2026 and thereafter, premium rates for all individual and small group accident and health insurance policies must be filed with the Department for approval. Unreasonable rate increases or inadequate rates shall be modified or disapproved. For any plan year during which the Illinois Health Benefits Exchange operates as a full State-based exchange, the Department shall provide insurers at least 30 days' notice of the deadline to submit rate filings.

(d) For plan year 2025 and thereafter, the Department shall post all insurers' rate filings and summaries on the Department's website 5 business days after the rate filing deadline set by the Department in annual guidance. The rate filings and summaries posted to the Department's website shall exclude information that is proprietary or trade secret information protected under paragraph (g) of subsection (1) of Section 7 of the Freedom of Information Act or confidential or privileged under any applicable insurance law or rule. All summaries shall include a brief justification of any rate increase or decrease requested, including the number of individual members, the medical loss ratio, medical trend, administrative costs, and any other information required by rule. The plain writing summary shall include notification of

the public comment period established in subsection (e).

(e) The Department shall open a 30-day public comment period on the rate filings beginning on the date that all of the rate filings are posted on the Department's website. The Department shall post all of the comments received to the Department's website within 5 business days after the comment period ends.

(f) After the close of the public comment period described in subsection (e), the Department, beginning for plan year 2026, shall issue a decision to approve, disapprove, or modify a rate filing within 60 days. Any rate filing or any rates within a filing on which the Director does not issue a decision within 60 days shall automatically be deemed approved. The Director's decision shall take into account the actuarial justifications and public comments. The Department shall notify the insurer of the decision, make the decision available to the public by posting it on the Department's website, and include an explanation of the findings, actuarial justifications, and rationale that are the basis for the decision. Any company whose rate has been modified or disapproved shall be allowed to request a hearing within 10 days after the action taken. The action of the Director in disapproving a rate shall be subject to judicial review under the Administrative Review Law.

(g) If, following the issuance of a decision but before the effective date of the premium rates approved by the

decision, an event occurs that materially affects the Director's decision to approve, deny, or modify the rates, the Director may consider supplemental facts or data reasonably related to the event.

(h) The Department shall adopt rules implementing the procedures described in subsections (d) through (g) by March 31, 2024.

(i) Subsection (a), ~~and~~ subsections (c) through (h), and subsection (j) of this Section do not apply to grandfathered health plans as defined in 45 CFR 147.140; excepted benefits as defined in 42 U.S.C. 300gg-91; or student health insurance coverage as defined in 45 CFR 147.145~~; the large group market as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act; or short-term, limited-duration health insurance coverage as defined in Section 5 of the Short Term, Limited Duration Health Insurance Coverage Act~~. For a filing of premium rates or classifications of risk for any of these types of coverage, the Director's initial review period shall not exceed 60 days to issue informal objections to the company that request additional clarification, explanation, substantiating documentation, or correction of concerns identified in the filing before the company implements the premium rates, classifications, or related rate-setting methodologies described in the filing, except that the Director may extend by not more than an additional 30 days the period of initial review by giving

written notice to the company of such extension before the expiration of the initial 60-day period. Nothing in this subsection shall confer authority upon the Director to approve, modify, or disapprove rates where that authority is not provided by other law. Nothing in this subsection shall prohibit the Director from conducting any investigation, examination, hearing, or other formal administrative or enforcement proceeding with respect to a company's rate filing or implementation thereof under applicable law at any time, including after the period of initial review.

(j) Subsection (a) and subsections (c) through (h) do not apply to group policies issued in the large group market as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act. For large group policies issued, delivered, amended, or renewed on or after January 1, 2026 that are not described in subsection (i), the premium rates and risk classifications, including any rate manuals and rules used to arrive at the rates, must be filed with the Department annually for approval at least 120 days before the rates are intended to take effect.

(1) A rate filing shall be modified or disapproved if the premiums are unreasonable in relation to the benefits because the rates were not calculated in accordance with sound actuarial principles.

(2) Within 60 days of receipt of the rate filing, the Director shall issue a decision to approve, disapprove, or

modify the filing along with the reasons and actuarial justification for the decision. Any rate filing or rates within a filing on which the Director does not issue a decision within 60 days shall be automatically deemed approved.

(3) Any company whose rate or rate filing has been modified or disapproved shall be allowed to request a hearing within 10 days after the action taken. The action of the Director in disapproving a rate or rate filing shall be subject to judicial review under the Administrative Review Law.

(4) Nothing in this subsection requires a company to file a large group policy's final premium rates for prior approval if the company negotiates the final rates or rate adjustments with the plan sponsor or its administrator in accordance with the rate manual and rules of the currently approved rate filing for the policy.

In this subsection, "administrator" and "plan sponsor" have the meaning given to those terms in 29 U.S.C. 1002(16).

(Source: P.A. 103-106, eff. 1-1-24.)

Section 4-10. The Health Maintenance Organization Act is amended by changing Section 4-12 as follows:

(215 ILCS 125/4-12) (from Ch. 111 1/2, par. 1409.5)

Sec. 4-12. Changes in rate methodology and benefits,

material modifications. A health maintenance organization shall file with the Director, prior to use, a notice of any change in rate methodology, or benefits and of any material modification of any matter or document furnished pursuant to Section 2-1, together with such supporting documents as are necessary to fully explain the change or modification.

(a) Contract modifications described in subsections (c)(5), (c)(6) and (c)(7) of Section 2-1 shall include all form agreements between the organization and enrollees, providers, administrators of services and insurers of health maintenance organizations.

(b) Material transactions or series of transactions other than those described in subsection (a) of this Section, the total annual value of which exceeds the greater of $100,000 or 5% of net earned subscription revenue for the most current 12-month period as determined from filed financial statements.

(c) Any agreement between the organization and an insurer shall be subject to the provisions of the laws of this State regarding reinsurance as provided in Article XI of the Illinois Insurance Code. All reinsurance agreements must be filed. Approval of the Director is required for all agreements except the following: individual stop loss, aggregate excess, hospitalization benefits or out-of-area of the participating providers unless 20% or more of the organization's total risk is reinsured, in which case all reinsurance agreements require approval.

(d) In addition to any applicable provisions of this Act, premium rate filings shall be subject to subsections (a) and (c) through (j) ~~(i)~~ of Section 355 of the Illinois Insurance Code.

(Source: P.A. 103-106, eff. 1-1-24.)

Section 4-15. The Limited Health Service Organization Act is amended by changing Section 3006 as follows:

(215 ILCS 130/3006) (from Ch. 73, par. 1503-6)

Sec. 3006. Changes in rate methodology and benefits; material modifications; addition of limited health services.

(a) A limited health service organization shall file with the Director prior to use, a notice of any change in rate methodology, charges, or benefits and of any material modification of any matter or document furnished pursuant to Section 2001, together with such supporting documents as are necessary to fully explain the change or modification.

(1) Contract modifications described in paragraphs (5) and (6) of subsection (c) of Section 2001 shall include all agreements between the organization and enrollees, providers, administrators of services, and insurers of limited health services; also other material transactions or series of transactions, the total annual value of which exceeds the greater of $100,000 or 5% of net earned subscription revenue for the most current 12-month ~~12~~

~~month~~ period as determined from filed financial statements.

(2) Contract modification for reinsurance. Any agreement between the organization and an insurer shall be subject to the provisions of Article XI of the Illinois Insurance Code, as now or hereafter amended. All reinsurance agreements must be filed with the Director. Approval of the Director in required agreements must be filed. Approval of the director is required for all agreements except individual stop loss, aggregate excess, hospitalization benefits, or out-of-area of the participating providers, unless 20% or more of the organization's total risk is reinsured, in which case all reinsurance agreements shall require approval.

(b) If a limited health service organization desires to add one or more additional limited health services, it shall file a notice with the Director and, at the same time, submit the information required by Section 2001 if different from that filed with the prepaid limited health service organization's application. Issuance of such an amended certificate of authority shall be subject to the conditions of Section 2002 of this Act.

(c) In addition to any applicable provisions of this Act, premium rate filings shall be subject to subsection (i) and, for pharmaceutical policies, subsection (j) of Section 355 of the Illinois Insurance Code.

(Source: P.A. 103-106, eff. 1-1-24; revised 1-2-24.)

Article 6.

Section 6-5. The Illinois Insurance Code is amended by changing Sections 155.36, 155.37, 356z.40, and 370c as follows:

(215 ILCS 5/155.36)

Sec. 155.36. Managed Care Reform and Patient Rights Act. Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code shall comply with Sections 25, 45, 45.1, 45.2, 45.3, 65, 70, ~~and~~ 85, and 87, subsection (d) of Section 30, and the definitions ~~definition~~ of the term "emergency medical condition" and any other term in Section 10 of the Managed Care Reform and Patient Rights Act that is used in the other Sections listed in this Section.

(Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

(215 ILCS 5/155.37)

Sec. 155.37. Drug formulary; notice.

(a) Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code and provide coverage for prescription drugs through the use of a drug formulary must notify insureds of any

change in the formulary. A company may comply with this Section by posting changes in the formulary on its website.

(b) No later than October 1, 2025, insurance companies that use a drug formulary shall post the formulary on their websites in a manner that is searchable and accessible to the general public without requiring an individual to create any account. This formulary shall adhere to a template developed by the Department by March 31, 2025, which shall take into consideration existing requirements for reporting of information established by the federal Centers for Medicare and Medicaid Services as well as display of cost-sharing information. This template and all formularies also shall do all the following:

(1) include information on cost-sharing tiers and utilization controls, such as prior authorization, for each covered drug;

(2) indicate any drugs on the formulary that are preferred over other drugs on the formulary;

(3) include information to educate insureds about the differences between drugs administered or provided under a policy's medical benefit and drugs covered under a drug benefit and how to obtain coverage information about drugs that are not covered under the drug benefit;

(4) include information to educate insureds that policies that provide drug benefits are required to have a method for enrollees to obtain drugs not listed in the

formulary if they are deemed medically necessary by a clinician under Section 45.1 of the Managed Care Reform and Patient Rights Act;

(5) include information on which medications are covered, including both generic and brand name; and

(6) include information on what tier of the plan's drug formulary each medication is in.

(c) No formulary may establish a step therapy requirement as prohibited by Section 87 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 92-440, eff. 8-17-01; 92-651, eff. 7-11-02.)

(215 ILCS 5/356z.40)

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

(a) An individual or group policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall provide coverage for pregnancy and newborn care in accordance with 42 U.S.C. 18022(b) regarding essential health benefits.

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

(1) An individual who has been identified as experiencing a high-risk pregnancy by the individual's treating provider shall have access to clinically appropriate case management programs. As used in this subsection, "case management" means a mechanism to

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

(2) An individual shall have access to medically necessary treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the requirements set forth in this Section and in Sections 370c and 370c.1 of this Code.

(3) The benefits provided for inpatient and outpatient

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

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

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

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

respect to the internal appeal within 24 hours and communicate such determination to the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider. If the determination is to uphold the denial, the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider have the right to file an expedited external appeal. An independent ~~utilization~~ review organization shall make a determination within 72 hours. If the insurer's determination is upheld and it is determined that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment is not medically necessary, the insurer shall remain responsible for providing benefits for the inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment through the day following the date the determination is made, and the covered pregnant or postpartum individual shall only be responsible for any applicable copayment, deductible, and coinsurance for the stay through that date as applicable under the policy. The covered pregnant or postpartum individual shall not be discharged or released from the inpatient facility, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or

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

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

(7) The benefits required by paragraphs (2) and (6) of this subsection (b) are to be provided to all covered pregnant or postpartum individuals with a diagnosis of a mental, emotional, nervous, or substance use disorder or condition. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection (b).

(Source: P.A. 102-665, eff. 10-8-21.)

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

Sec. 370c. Mental and emotional disorders.

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

with the parity requirements of Section 370c.1 of this Code.

(2) Each insured that is covered for mental, emotional, nervous, or substance use disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act of his or her choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his or her

profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, licensed marriage and family therapists, licensed speech-language pathologists, and other licensed or certified professionals at programs licensed pursuant to the Substance Use Disorder Act, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act has informed the patient of the desirability of the patient conferring with the patient's primary care physician.

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

postpartum depression.

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

(b)(1) (Blank).

(2) (Blank).

(2.5) (Blank).

(3) Unless otherwise prohibited by federal law and consistent with the parity requirements of Section 370c.1 of this Code, the reimbursing insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance, a qualified health plan offered through the health insurance marketplace, or a provider of treatment of mental, emotional, nervous, or substance use disorders or conditions shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a

patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for mental, emotional, nervous, or substance use disorders or conditions, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders.

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

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

(i) 45 days of inpatient treatment; and

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

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

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

(C) (Blank).

(5) An issuer of a group health benefit plan or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace may not count toward the number of outpatient

visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

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

As used in this subsection:

"Acute treatment services" means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial

assessment, individual and group counseling, psychoeducational groups, and discharge planning.

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

(6) An issuer of a group health benefit plan may provide or 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, 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~~, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring~~

~~Conditions established by the American Society of Addiction Medicine, before authorizing coverage for a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders~~;

(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 disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

(7) (Blank).

(8) (Blank).

(9) With respect to all mental, emotional, nervous, or substance use disorders or conditions, coverage for inpatient treatment shall include coverage for treatment in a

residential treatment center certified or licensed by the Department of Public Health or the Department of Human Services.

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

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

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers

submit comparative analyses, as set forth in paragraph (6) of subsection (k) of Section 370c.1, demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits;

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

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

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

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

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

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

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

(e) Availability of plan information.

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

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

beneficiary must be made available within a reasonable time and in a reasonable manner and in readily understandable language by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary upon request.

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

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

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

"Benefits", with respect to managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels

of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

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

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

(3) Prior authorization shall not be utilized for the benefits under this subsection. The substance use disorder treatment provider or facility shall notify the insurer of the initiation of treatment. For an insurer that is not a managed care organization, the substance use disorder treatment provider or facility notification shall occur for the

initiation of treatment of the covered person within 2 business days. For managed care organizations, the substance use disorder treatment provider or facility notification shall occur in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization. Treatment plans shall be developed in accordance with the requirements and timeframes established in 77 Ill. Adm. Code 2060. If the substance use disorder treatment provider or facility fails to notify the insurer of the initiation of treatment in accordance with these provisions, the insurer may follow its normal prior authorization processes.

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

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

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

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

(6) The benefits required by this subsection shall be provided to all covered persons with a diagnosis of substance use disorder or conditions. The presence of additional related

or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection.

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

(h) As used in this Section:

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

"Medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing,

managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities in a manner that is all of the following:

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

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

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

"Utilization review" means either of the following:

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

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical

necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

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

(i)(1) Every 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 and Medicaid managed care organizations providing coverage for hospital or medical treatment on or after January 1, 2023 shall, pursuant to subsections (h) through (s), provide coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions.

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

(3) All utilization review conducted ~~medical necessity determinations made~~ by the insurer concerning diagnosis, prevention, and treatment ~~service intensity, level of care placement, continued stay, and transfer or discharge~~ of insureds diagnosed with mental, emotional, nervous, or substance use disorders or conditions shall be conducted in accordance with the requirements of subsections (k) through

(w) ~~(u)~~.

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this Section shall not rescind or modify the authorization after that provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent cancellation or modification of the insured's or policyholder's contract, or the insured's or policyholder's eligibility. Nothing in this Section shall require the insurer to cover a treatment when the authorization was granted based on a material misrepresentation by the insured, the policyholder, or the provider. Nothing in this Section shall require Medicaid managed care organizations to pay for services if the individual was not eligible for Medicaid at the time the service was rendered. Nothing in this Section shall require an insurer to pay for services if the individual was not the insurer's enrollee at the time services were rendered. As used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results in or could result in a substantial change in the situation.

(j) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare,

Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program. Nothing in this subsection shall be construed to require an insurer to cover benefits that have been authorized and provided for a covered person by a public entitlement program. Medicaid managed care organizations are not subject to this subsection.

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

(l) In conducting utilization review of all covered health care services for the diagnosis, prevention, and treatment of ~~For medical necessity determinations relating to level of care placement, continued stay, and transfer or discharge of insureds diagnosed with~~ mental, emotional, and nervous disorders or conditions, an insurer shall apply the ~~patient~~

~~placement~~ criteria and guidelines set forth in the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty or, for Medicaid managed care organizations, ~~patient placement~~ 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. Pursuant to subsection (b), in conducting utilization review of all covered services and benefits for the diagnosis, prevention, and treatment of substance use disorders an insurer shall use the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine.

(m) In conducting utilization review ~~For medical necessity determinations~~ relating to level of care placement, continued stay, ~~and~~ transfer, ~~or~~ discharge, or any other patient care decisions that are within the scope of the sources specified in subsection (l), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the assessment of the insured using the relevant patient placement criteria as specified in subsection (l). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the

insurer shall provide full detail of its assessment using the relevant criteria as specified in subsection (l) to the provider of the service and the patient.

~~Nothing in this subsection or subsection (l) prohibits an insurer from applying utilization review criteria that were developed in accordance with subsection (k) to health care services and benefits for mental, emotional, and nervous disorders or conditions that are not related to medical necessity determinations for level of care placement, continued stay, and transfer or discharge.~~ If an insurer purchases or licenses utilization review criteria pursuant to this subsection, the insurer shall verify and document before use that the criteria were developed in accordance with subsection (k).

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

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

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

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

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

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

(3) Provide, at no cost, the utilization review criteria and any training material or resources to providers and insured patients upon request. For utilization review criteria not concerning level of care placement, continued stay, ~~and~~ transfer, ~~or~~ discharge, or other patient care decisions used by the insurer pursuant to subsection (m), the insurer may place the criteria on a secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access to insureds or their providers. No restrictions shall be placed upon the insured's or treating provider's access right to utilization review criteria obtained under this paragraph at any point in time, including before an

initial request for authorization.

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

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

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

(7) Achieve interrater reliability pass rates of at 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, 2026, coverage for inpatient mental health treatment at participating hospitals shall comply with the following requirements:

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

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

(3) Treatment provided under this subsection may be reviewed retrospectively. If coverage is denied retrospectively, neither the insurer nor the participating

hospital 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 treatment at a participating hospital 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; or

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

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

(x) Notwithstanding any provision of this Section, nothing shall require the medical assistance program under Article V

of the Illinois Public Aid Code to violate any applicable federal laws, regulations, or grant requirements or any State or federal consent decrees. Nothing in subsection (w) shall prevent the Department of Healthcare and Family Services from requiring a health care provider to use specified level of care, admission, continued stay, or discharge criteria, including, but not limited to, those under Section 5-5.23 of the Illinois Public Aid Code, as long as the Department of Healthcare and Family Services does not require a health care provider to seek prior authorization or concurrent review from the Department of Healthcare and Family Services, a Medicaid managed care organization, or a utilization review organization under the circumstances expressly prohibited by subsection (w). Nothing in this Section prohibits a health plan, including a Medicaid managed care organization, from conducting reviews for fraud, waste, or abuse and reporting suspected fraud, waste, or abuse according to State and federal requirements.

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

(Source: P.A. 102-558, eff. 8-20-21; 102-579, eff. 1-1-22; 102-813, eff. 5-13-22; 103-426, eff. 8-4-23.)

Section 6-10. The Managed Care Reform and Patient Rights Act is amended by changing Sections 10, 45.1, and 85 and by adding Section 87 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions. In this Act:

"Adverse determination" means a determination by a health care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary.

"Clinical peer" means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to another hospital before delivery; or

(B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches, or to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

"Generally accepted standards of care" means standards of care and clinical practice that are generally recognized by

health care providers practicing in relevant clinical specialties for the illness, injury, or condition or its symptoms and comorbidities. Valid, evidence-based sources reflecting generally accepted standards of care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Health care plan" means a plan, including, but not limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services, that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that

subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall not include the following:

(1) indemnity health insurance policies including those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) except with respect to subsections (a) and (b) of Section 65 and subsection (a-5) of Section 70, not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health care professional" means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing in this Act shall be construed to define Independent Practice Associations or Physician-Hospital Organizations as health care providers.

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including behavioral health, mental health, home health, and pharmaceutical services and products.

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

"Medically necessary" means that a service or product addresses the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities, in a manner that is all of the following:

(1) in accordance with generally accepted standards of care;

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

(3) not primarily for the economic benefit of the health care plan, purchaser, or utilization review organization, or for the convenience of the patient, treating physician, or other health care provider.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Physician" means a person licensed under the Medical Practice Act of 1987.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

"Stabilization" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

"Step therapy requirement" means a utilization review or formulary requirement that specifies, as a condition of

coverage under a health care plan, the order in which certain health care services must be used to treat or manage an enrollee's health condition.

"Step therapy requirement" does not include:

(1) utilization review to identify when a treatment or health care service is contraindicated or clinically appropriate or to limit quantity or dosage for an enrollee based on utilization review criteria consistent with generally accepted standards of care developed in accordance with Section 87 of this Act;

(2) the removal of a drug from a formulary or changing the drug's preferred or cost-sharing tier to higher cost sharing;

(3) use of the medical exceptions process under Section 45.1 of this Act; any decision during a medical exceptions process based on cost is step therapy and prohibited;

(4) a requirement to obtain prior authorization for the requested treatment; or

(5) for health care plans operated or overseen by the Department of Healthcare and Family Services, including Medicaid managed care plans, any utilization controls mandated by 42 CFR 456.703 or a preferred drug list as described in Section 5-30.14 of the Illinois Public Aid Code.

"Utilization review" means the evaluation of the medical

necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review" includes either of the following:

(1) prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based, in whole or in part, on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to enrollees; or

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care plan is covered as medically necessary for an enrollee.

"Utilization review criteria" means criteria, standards, protocols, or guidelines used by a utilization review program to conduct utilization review to ensure that a patient's care is aligned with generally accepted standards of care and consistent with State law.

"Utilization review program" means a program established by a person to perform utilization review.

(Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

(215 ILCS 134/45.1)

Sec. 45.1. Medical exceptions procedures required.

(a) Notwithstanding any other provision of law, on or after January 1, 2018 (the effective date of Public Act 99-761), every insurer licensed in this State to sell a policy of group or individual accident and health insurance or a health benefits plan shall establish and maintain a medical exceptions process that allows covered persons or their authorized representatives to request any clinically appropriate prescription drug when (1) the drug is not covered based on the health benefit plan's formulary; (2) the health benefit plan is discontinuing coverage of the drug on the plan's formulary for reasons other than safety or other than because the prescription drug has been withdrawn from the market by the drug's manufacturer; (3) (blank) ~~the prescription drug alternatives required to be used in accordance with a step therapy requirement (A) has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance or (B) has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to the enrollee~~; or (4) the number of doses available

under a dose restriction for the prescription drug (A) has been ineffective in the treatment of the enrollee's disease or medical condition or (B) based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.

(b) The health carrier's established medical exceptions procedures must require, at a minimum, the following:

(1) Any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals.

(2) The health carrier must, within 72 hours after receipt of a request made under subsection (a) of this Section, either approve or deny the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial. A health carrier shall not use the authorization of alternative covered medications under this Section in a manner that effectively creates a step therapy requirement.

(3) In the case of an expedited coverage determination, the health carrier must either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(c) An off-formulary ~~A step therapy requirement~~ exception request shall not be denied ~~be approved~~ if:

(1) the formulary ~~required~~ prescription drug is contraindicated;

(2) the patient has tried the formulary ~~required~~ prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or

(3) the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

(d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug

prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy or contract up to the quantity covered.

(e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan.

(f) Notwithstanding any other provision of this Section, nothing in this Section shall be interpreted or implemented in a manner not consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those Acts.

(g) Nothing in this Section shall require or authorize the State agency responsible for the administration of the medical assistance program established under the Illinois Public Aid Code to approve, supply, or cover prescription drugs pursuant to the procedure established in this Section.

(Source: P.A. 103-154, eff. 6-30-23.)

(215 ILCS 134/85)

Sec. 85. Utilization review program registration.

(a) No person may conduct a utilization review program in this State unless once every 2 years the person registers the utilization review program with the Department and certifies

compliance with the Health Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health Utilization Management Standards. Nothing in this Act shall be construed to require a health care plan or its subcontractors to become American Accreditation Healthcare Commission (URAC) accredited.

(b) In addition, the Director of the Department, in consultation with the Director of the Department of Public Health, may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (a).

(b-5) The Department shall recognize the Accreditation Association for Ambulatory Health Care among the list of accreditors from which utilization organizations may receive accreditation and qualify for reduced registration and renewal fees.

(c) The provisions of this Section do not apply to:

(1) persons providing utilization review program services only to the federal government;

(2) self-insured health plans under the federal Employee Retirement Income Security Act of 1974, however,

this Section does apply to persons conducting a utilization review program on behalf of these health plans;

(3) hospitals and medical groups performing utilization review activities for internal purposes unless the utilization review program is conducted for another person.

Nothing in this Act prohibits a health care plan or other entity from contractually requiring an entity designated in item (3) of this subsection to adhere to the utilization review program requirements of this Act.

(d) This registration shall include submission of all of the following information regarding utilization review program activities:

(1) The name, address, and telephone number of the utilization review programs.

(2) The organization and governing structure of the utilization review programs.

(3) The number of lives for which utilization review is conducted by each utilization review program.

(4) Hours of operation of each utilization review program.

(5) Description of the grievance process for each utilization review program.

(6) Number of covered lives for which utilization review was conducted for the previous calendar year for

each utilization review program.

(7) Written policies and procedures for protecting confidential information according to applicable State and federal laws for each utilization review program.

(e) (1) A utilization review program shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

(A) kept confidential in accordance with applicable State and federal laws; and

(B) shared only with the enrollee, the enrollee's designee, the enrollee's health care provider, and those who are authorized by law to receive the information.

Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.

(2) Only a clinical peer ~~health care professional~~ may make adverse determinations regarding the medical necessity of health care services during the course of utilization review. Either a health care professional or an accredited algorithmic automated process, or both in combination, may certify the medical necessity of a health care service in accordance with accreditation standards. Nothing in this subsection prohibits an accredited algorithmic automated process from being used to refer a case to a clinical peer for a potential adverse determination.

(3) When making retrospective reviews, utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided.

(4) When making prospective, concurrent, and retrospective determinations, utilization review programs shall collect only information that is necessary to make the determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification, unless required under State or federal Medicare or Medicaid rules or regulations, but may request such code if available, or routinely request copies of medical records of all enrollees reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to review are medically necessary. In these cases, only the necessary or relevant sections of the medical record shall be required.

(f) If the Department finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing

a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.

(g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.

(h) Any adverse determination made by a health care plan or its subcontractors may be appealed in accordance with subsection (f) of Section 45.

(i) The Director may by rule establish a registration fee for each person conducting a utilization review program. All fees paid to and collected by the Director under this Section shall be deposited into the Insurance Producer Administration Fund.

(Source: P.A. 99-111, eff. 1-1-16.)

(215 ILCS 134/87 new)

Sec. 87. General standards for use of utilization review criteria.

(a) Beginning January 1, 2026, all utilization review programs shall make medical necessity determinations in

accordance with the requirements of this Section. No policy, contract, certificate, formulary, or evidence of coverage issued to any enrollee may contain terms or conditions to the contrary.

(b) All utilization review programs shall determine medical necessity by using the most recent treatment criteria developed by:

(1) an unaffiliated, nonprofit professional association for the relevant clinical specialty;

(2) a third-party entity that develops treatment criteria that: (i) are updated annually; (ii) are not paid for clinical care decision outcomes; (iii) do not offer different treatment criteria for the same health care service unless otherwise required by State or federal law; and (iv) are consistent with current generally accepted standards of care; or

(3) the Department of Healthcare and Family Services if the criteria are consistent with current generally accepted standards of care.

(c) For all level of care placement decisions, the utilization review program shall authorize placement at the level of care at or above the level ordered by the provider using the relevant treatment criteria as specified in subsection (b). If there is a disagreement between the health care plan and the provider or patient, the health care plan or utilization review program shall provide its complete

assessment to the provider and the patient.

(d) If a utilization review program purchases or licenses utilization review criteria pursuant to this Section, the utilization review program shall, before using the criteria, verify and document that the criteria were developed in accordance with subsection (b).

(e) All health care plans and utilization review programs must:

(1) make an educational program on the chosen treatment criteria available to all staff and contracted entities performing utilization review;

(2) provide, at no cost, the treatment criteria and any related training material to providers and enrollees upon request; enrollees and treating providers shall be able to access treatment criteria at any point in time, including before an initial request for authorization;

(3) track, identify, and analyze how the treatment criteria are used to certify care, deny care, and support the appeals process;

(4) conduct interrater reliability testing to ensure consistency in utilization review decision-making; this testing shall cover all aspects of utilization review criteria as defined in Section 10;

(5) achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, initiate remediation of poor interrater reliability within 3

business days after the finding and conduct interrater reliability testing for all new staff before they can conduct utilization review supervision; and

(6) maintain documentation of interrater reliability testing and any remediation 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 de-identified of patient or employee personal information and a summary of remedial actions.

(f) Beginning January 1, 2026, no utilization review program or any policy, contract, certificate, evidence of coverage, or formulary shall impose step therapy requirements. Nothing in this subsection prohibits a health care plan, by contract, written policy, procedure, or any other agreement or course of conduct, from requiring a pharmacist to effect substitutions of prescription drugs consistent with Section 19.5 of the Pharmacy Practice Act, under which a pharmacist may substitute an interchangeable biologic for a prescribed biologic product, and Section 25 of the Pharmacy Practice Act, under which a pharmacist may select a generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration and in accordance with the Illinois Food, Drug and Cosmetic Act. For health care plans operated or overseen by the Department of Healthcare and Family Services, including Medicaid managed care plans, the prohibition in this

subsection does not apply to step therapy requirements for drugs that do not appear on the most recent Preferred Drug List published by the Department of Healthcare and Family Services.

(g) Except for subsection (f), this Section does not apply to utilization review concerning diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions, which shall be governed by Section 370c of the Illinois Insurance Code.

(h) Nothing in this Section supersedes or waives requirements provided under any other State or federal law or federal regulation that any coverage subject to this Section comply with specific utilization review criteria for a specific illness, level of care placement, injury, or condition or its symptoms and comorbidities.

Section 6-15. The Health Carrier External Review Act is amended by changing Section 10 as follows:

(215 ILCS 180/10)

Sec. 10. Definitions. For the purposes of this Act:

"Adverse determination" means:

(1) a determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the

health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

(2) the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or

(3) a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

"Authorized representative" means:

(1) a person to whom a covered person has given express written consent to represent the covered person for purposes of this Law;

(2) a person authorized by law to provide substituted consent for a covered person;

(3) a family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) a health care provider when the covered person's

health benefit plan requires that a request for a benefit under the plan be initiated by the health care provider; or

(5) in the case of an urgent care request, a health care provider with knowledge of the covered person's medical condition.

"Best evidence" means evidence based on:

(1) randomized clinical trials;

(2) if randomized clinical trials are not available, then cohort studies or case-control studies;

(3) if items (1) and (2) are not available, then case-series; or

(4) if items (1), (2), and (3) are not available, then expert opinion.

"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services. <u>"Clinical review criteria" includes all utilization review criteria as defined in Section 10 of the Managed Care Reform and Patient Rights Act.</u>

"Cohort study" means a prospective evaluation of 2 groups of patients with only one group of patients receiving specific intervention.

"Concurrent review" means a review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Director" means the Director of the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on an overall systematic review of the research in making decisions about the care of individual patients.

"Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

"Facility" means an institution providing health care services or a health care setting.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act.

"Health benefit plan" means a policy, contract, certificate, plan, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care provider" or "provider" means a physician, hospital facility, or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with State law, responsible for recommending health care services on behalf of a covered person.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, or any other entity providing a plan of health insurance, health benefits, or health care services. "Health carrier" also means Limited Health Service Organizations (LHSO) and Voluntary Health Service Plans.

"Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to:

(1) the past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) the provision of health care services to an individual; or

(3) payment for the provision of health care services to an individual.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"Medical or scientific evidence" means evidence found in the following sources:

(1) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) the following standard reference compendia:

(a) The American Hospital Formulary Service-Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia-Drug

Information;

(5) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) the federal Agency for Healthcare Research and Quality;

(b) the National Institutes of Health;

(c) the National Cancer Institute;

(d) the National Academy of Sciences;

(e) the Centers for Medicare & Medicaid Services;

(f) the federal Food and Drug Administration; and

(g) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) any other medical or scientific evidence that is comparable to the sources listed in items (1) through (5).

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Prospective review" means a review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

"Protected health information" means health information (i) that identifies an individual who is the subject of the information; or (ii) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"Randomized clinical trial" means a controlled prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" means any review of a request for a benefit that is not a concurrent or prospective review request. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

"Utilization review" has the meaning provided by the Managed Care Reform and Patient Rights Act.

"Utilization review organization" means a utilization review program as defined in the Managed Care Reform and Patient Rights Act.

(Source: P.A. 97-574, eff. 8-26-11; 97-813, eff. 7-13-12; 98-756, eff. 7-16-14.)

Section 6-20. The Prior Authorization Reform Act is amended by changing Sections 15 and 20 as follows:

(215 ILCS 200/15)

Sec. 15. Definitions. As used in this Act:

"Adverse determination" has the meaning given to that term in Section 10 of the Health Carrier External Review Act.

"Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination.

"Approval" means a determination by a health insurance issuer or its contracted utilization review organization that a health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's or its contracted utilization review organization's requirements for medical necessity and appropriateness.

"Clinical review criteria" has the meaning given to that term in Section 10 of the Health Carrier External Review Act.

"Department" means the Department of Insurance.

"Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Emergency services" has the meaning given to that term in federal health insurance reform requirements for the group and individual health insurance markets, 45 CFR 147.138.

"Enrollee" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Health care professional" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient

Rights Act.

"Health care provider" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act, except that facilities licensed under the Nursing Home Care Act and long-term care facilities as defined in Section 1-113 of the Nursing Home Care Act are excluded from this Act.

"Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health, and pharmaceutical services and products.

"Health insurance issuer" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Medically necessary" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act. ~~means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered~~

~~effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party, but focused on what is best for the patient's health outcome.~~

"Physician" means a person licensed under the Medical Practice Act of 1987 or licensed under the laws of another state to practice medicine in all its branches.

"Prior authorization" means the process by which health insurance issuers or their contracted utilization review organizations determine the medical necessity and medical appropriateness of otherwise covered health care services before the rendering of such health care services. "Prior authorization" includes any health insurance issuer's or its contracted utilization review organization's requirement that an enrollee, health care professional, or health care provider notify the health insurance issuer or its contracted utilization review organization before, at the time of, or concurrent to providing a health care service.

"Urgent health care service" means a health care service with respect to which the application of the time periods for making a non-expedited prior authorization that in the opinion of a health care professional with knowledge of the enrollee's medical condition:

(1) could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain

maximum function; or

(2) could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

"Urgent health care service" does not include emergency services.

"Utilization review organization" has the meaning given to that term in 50 Ill. Adm. Code 4520.30.

(Source: P.A. 102-409, eff. 1-1-22.)

(215 ILCS 200/20)

Sec. 20. Disclosure and review of prior authorization requirements.

(a) A health insurance issuer shall maintain a complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the health insurance issuer. The health insurance issuer shall publish this list on its public website without requiring a member of the general public to create any account or enter any credentials to access it. The list described in this subsection is not required to contain the clinical review criteria applicable to these services.

(b) A health insurance issuer shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and

conspicuously posted on its website to enrollees, health care professionals, and health care providers. Content published by a third party and licensed for use by a health insurance issuer or its contracted utilization review organization may be made available through the health insurance issuer's or its contracted utilization review organization's secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall indicate for each service subject to prior authorization:

(1) when prior authorization became required for policies issued or delivered in Illinois, including the effective date or dates and the termination date or dates, if applicable, in Illinois;

(2) the date the Illinois-specific requirement was listed on the health insurance issuer's or its contracted utilization review organization's website;

(3) where applicable, the date that prior authorization was removed for Illinois; and

(4) where applicable, access to a standardized electronic prior authorization request transaction process.

(c) The clinical review criteria must:

(1) be based on nationally recognized, generally accepted standards except where State law provides its own standard;

(2) be developed in accordance with the current standards of a national medical accreditation entity;

(3) ensure quality of care and access to needed health care services;

(4) be evidence-based;

(5) be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and

(6) be evaluated and updated, if necessary, at least annually.

(d) A health insurance issuer shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim.

(e) A health insurance issuer or its contracted utilization review organization shall not deem as incidental or deny supplies or health care services that are routinely used as part of a health care service when:

(1) an associated health care service has received prior authorization; or

(2) prior authorization for the health care service is not required.

(f) If a health insurance issuer intends either to implement a new prior authorization requirement or restriction

or amend an existing requirement or restriction, the health insurance issuer shall provide contracted health care professionals and contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. The written notice may be provided in an electronic format, including email or facsimile, if the health care professional or health care provider has agreed in advance to receive notices electronically. The health insurance issuer shall ensure that the new or amended requirement is not implemented unless the health insurance issuer's or its contracted utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

(g) Entities using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. The statistics must be updated annually and include all of the following information:

(1) a list of all health care services, including medications, that are subject to prior authorization;

(2) the total number of prior authorization requests received;

(3) the number of prior authorization requests denied during the previous plan year by the health insurance issuer or its contracted utilization review organization

with respect to each service described in paragraph (1) and the top 5 reasons for denial;

(4) the number of requests described in paragraph (3) that were appealed, the number of the appealed requests that upheld the adverse determination, and the number of appealed requests that reversed the adverse determination;

(5) the average time between submission and response; and

(6) any other information as the Director determines appropriate.

(Source: P.A. 102-409, eff. 1-1-22.)

Section 6-25. The Illinois Public Aid Code is amended by changing Section 5-16.12 as follows:

(305 ILCS 5/5-16.12)

Sec. 5-16.12. Managed Care Reform and Patient Rights Act. The medical assistance program and other programs administered by the Department are subject to the provisions of the Managed Care Reform and Patient Rights Act. The Department may adopt rules to implement those provisions. These rules shall require compliance with that Act in the medical assistance managed care programs and other programs administered by the Department. The medical assistance fee-for-service program is not subject to the provisions of the Managed Care Reform and Patient Rights Act<u>, except for Sections 85 and 87 of the</u>

Managed Care Reform and Patient Rights Act and for any definition in Section 10 of the Managed Care Reform and Patient Rights Act that applies to Sections 85 and 87 of the Managed Care Reform and Patient Rights Act.

Nothing in the Managed Care Reform and Patient Rights Act shall be construed to mean that the Department is a health care plan as defined in that Act simply because the Department enters into contractual relationships with health care plans; provided that this clause shall not defeat the applicability of Sections 10, 85, and 87 of the Managed Care Reform and Patient Rights Act to the fee-for-service program.

(Source: P.A. 91-617, eff. 1-1-00.)

Article 99.

Section 99-95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 99-99. Effective date. This Act takes effect January 1, 2025, except that the changes to Section 45.1 of the Managed Care Reform and Patient Rights Act take effect January 1, 2026.