Sen. Laura Fine

Filed: 5/26/2025

AMENDMENT TO SENATE BILL 708

AMENDMENT NO. _____. Amend Senate Bill 708 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 356z.14, 356z.40, and 370c and by adding Section 355.7 as follows:

(215 ILCS 5/355.7 new)

Sec. 355.7. Medical loss ratio report and premium rebate.

(a) A health insurance issuer offering group or individual health insurance coverage, including a grandfathered health plan, shall, with respect to each plan year, submit to the Director a report concerning the ratio of the incurred loss or incurred claims plus the loss adjustment expense or change in contract reserves to earned premiums. The report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors

and payments of reinsurance, that such coverage expends:

(1) on reimbursement for clinical services provided to enrollees under such coverage;

(2) for activities that improve health care quality; and

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding federal and State taxes and licensing or regulatory fees.

(b) A health insurance issuer shall comply with subsection (a) by filing with the Director a copy of the report submitted to the United States Department of Health and Human Services under 42 U.S.C. 300gg-18, which must comply with federal regulations promulgated thereunder. The Department shall make the reports received under this Section available to the public on its website.

(c) If 42 U.S.C. 300gg-18 or the federal regulations promulgated thereunder are amended after January 15, 2025 to repeal the reporting or rebate requirements, reduce the amount or types of information required to be reported, or adopt a calculation method that reduces the amount of rebates in this State, a health insurance issuer shall file a supplemental report with the Director or make supplemental rebate payments, as applicable, for group or individual health insurance coverage regulated by this State to ensure that the same total information is filed with the Director and the same total rebates are remitted to enrollees as before the federal

repeal, reduction, or recalculation took effect.

(d) Notwithstanding any other provision of this Section, under no circumstances may the costs described in paragraphs (1) and (2) of subsection (a) include:

(1) executive compensation beyond base salary;

(2) entity surplus or accumulated profit; or

(3) costs attendant with an application for lifestyle management, weight loss, or wellness when the application falls outside the scope of 45 CFR 158.140 through 158.160.

(e) This Section does not apply with respect to any policy of excepted benefits as defined under 42 U.S.C. 300gg-91.

(f) Notwithstanding anything in this Section to the contrary, this Section does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(215 ILCS 5/356z.14)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after December 12, 2008 (the effective date of Public Act 95-1005) must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders

are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section shall be subject to a maximum benefit of $36,000 per year~~,~~ but shall not be subject to any limits on the number of visits to a service provider. The ~~After December 30, 2009, the~~ Director of ~~the Division of~~ Insurance shall, on an annual basis, adjust the maximum benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance

provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or the individual's ~~their~~ dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits in this Section.

(e-5) An insurer may not deny or refuse to provide otherwise covered services under a group or individual policy of accident and health insurance or a managed care plan solely because of the location wherein the clinically appropriate services are provided.

(f) Upon request of the ~~reimbursing~~ insurer, a provider of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated. Nothing

in this subsection supersedes the prohibition on prior authorization for mental health treatment under subsection (w) of Section 370c.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, 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. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders.

(h) Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill. Adm. Code 500 and any subsequent amendments thereto.

(h-5) If an individual has been diagnosed as having an autism spectrum disorder, meeting the diagnostic criteria in place at the time of diagnosis, and treatment is determined medically necessary, then that individual shall remain eligible for coverage under this Section even if subsequent changes to the diagnostic criteria are adopted by the American Psychiatric Association. If no changes to the diagnostic criteria are adopted after April 1, 2012, and before December 31, 2014, then this subsection (h-5) shall be of no further

force and effect.

(h-10) An insurer may not deny or refuse to provide covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract, for a person diagnosed with an autism spectrum disorder on the basis that the individual declined an alternative medication or covered service when the individual's health care provider has determined that such medication or covered service may exacerbate clinical symptomatology and is medically contraindicated for the individual and the individual has requested and received a medical exception as provided for under Section 45.1 of the Managed Care Reform and Patient Rights Act. For the purposes of this subsection (h-10), "clinical symptomatology" means any indication of disorder or disease when experienced by an individual as a change from normal function, sensation, or appearance.

(h-15) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost

of any coverage outlined in subsection (h-10), then subsection (h-10) is inoperative with respect to all coverage outlined in subsection (h-10) other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage set forth in subsection (h-10).

(i) As used in this Section:

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

"Medically necessary" means any care, treatment, intervention, service, or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, disease, or disability; or (iii) assist to achieve or maintain maximum

functional activity in performing daily activities.

"Treatment for autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

(1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.

(2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

(3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-322, eff. 1-1-22; 103-154, eff. 6-30-23; revised 7-23-24.)

(215 ILCS 5/356z.40)

(Text of Section before amendment by P.A. 103-701 and 103-720)

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 October 8, 2021 (the effective date of Public Act 102-665) ~~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. Prior authorization requirements are prohibited to the extent provided in Section 370c.

(3) The benefits provided for inpatient and outpatient services for the medically necessary 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 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 Sections ~~Section~~ 370c and 370c.1 of this Code, 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 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, or if the insurer's determination is not appealed, 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; 103-650, eff. 1-1-25; revised 9-10-24.)

(Text of Section after amendment by P.A. 103-701 and 103-720)

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 October 8, 2021 (the effective date of Public Act 102-665) shall provide coverage for pregnancy and newborn care in accordance with 42 U.S.C. 18022(b) regarding essential health benefits. For policies amended, delivered, issued, or renewed on or after January 1, 2026, this subsection also applies to coverage for postpartum care.

(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. Prior authorization requirements are prohibited to the extent provided in Section 370c.

(3) The benefits provided for inpatient and outpatient services for the medically necessary 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 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 Sections ~~Section~~ 370c and 370c.1 of this Code, 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 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, or if the insurer's determination is not appealed, 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) and subsection (c), 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 (i) all covered pregnant or postpartum individuals with a diagnosis of a mental, emotional, nervous, or substance use disorder or condition and (ii) all individuals who have experienced a miscarriage or stillbirth. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection (b).

(8) Insurers shall cover all services for pregnancy, postpartum, and newborn care that are rendered by perinatal doulas or licensed certified professional midwives, including home births, home visits, and support during labor, abortion, or miscarriage. Coverage shall include the necessary equipment and medical supplies for a home birth. For home visits by a perinatal doula, not counting any home birth, the policy may limit coverage to 16 visits before and 16 visits after a birth, miscarriage, or abortion, provided that the policy shall not be

required to cover more than $8,000 for doula visits for each pregnancy and subsequent postpartum period. As used in this paragraph (8), "perinatal doula" has the meaning given in subsection (a) of Section 5-18.5 of the Illinois Public Aid Code.

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

(10) Coverage for postpartum services shall apply for all covered services rendered within the first 12 months after the end of pregnancy, subject to any policy limitation on home visits by a perinatal doula allowed under paragraph (8) of this subsection (b). Nothing in this paragraph (10) shall be construed to require a policy to cover services for an individual who is no longer insured or enrolled under the policy. If an individual becomes insured or enrolled under a new policy, the new

policy shall cover the individual consistent with the time period and limitations allowed under this paragraph (10). This paragraph (10) is subject to the requirements of Section 25 of the Managed Care Reform and Patient Rights Act, Section 20 of the Network Adequacy and Transparency Act, and 42 U.S.C. 300gg-113.

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

(Source: P.A. 102-665, eff. 10-8-21; 103-650, eff. 1-1-25; 103-701, eff. 1-1-26; 103-720, eff. 1-1-26; revised 11-26-24.)

(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 (y) ~~(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. Nothing in this paragraph (3) supersedes the prohibition on prior authorization requirements to the extent provided under subsections (g) and (w) and subparagraph (A) of paragraph (6.5) of this

subsection. ~~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.

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

(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, including limitations on dosage, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine, on a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(B) shall not impose any step therapy requirements;

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

(D) shall not exclude coverage for a prescription medication approved by the United States Food and Drug Administration for the treatment of substance use 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, county, municipal, or school district employee health plans. References to an insurer include all plans described in this subsection.

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

"Benefits", with respect to insurers that are not Medicaid 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 (High-Intensity Outpatient) ~~(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 Managed Residential ~~Monitored Intensive Inpatient~~) and OMT (Opioid Maintenance Therapy) services.

"Benefits", with respect to Medicaid 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 (High-Intensity Outpatient) ~~(Partial Hospitalization)~~, 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Managed Residential ~~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. Except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification, the insurer may require the ~~The~~ substance use disorder treatment provider or facility to ~~shall~~ notify the insurer of the initiation of treatment. For an insurer that is not a Medicaid managed care organization, the substance use disorder treatment provider or facility may be required to give notification ~~shall occur~~ for the initiation of treatment of the covered person within 2 business days. For Medicaid managed care organizations, the substance use disorder treatment provider or facility may be required to give notification ~~shall occur~~ in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following 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. No such coverage shall be subject to concurrent review prior to the applicable notification deadline. If coverage is denied retrospectively, neither the provider or facility nor the insurer shall bill, and the covered individual 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 treatment or stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for benefits that were furnished at a participating substance use disorder facility prior to the applicable notification deadline except for the following: ~~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.~~

(A) upon reasonable determination that the benefits were 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 provider. As used in this subparagraph (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;

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

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

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

(4) For an insurer that is not a Medicaid 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.

(8) Any concurrent or retrospective review permitted by this subsection must be consistent with the utilization review

provisions in subsections (h) through (n).

(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 by the insurer concerning diagnosis, prevention, and treatment 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).

(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 mental, emotional, and nervous disorders or conditions, an insurer shall apply the criteria and guidelines set forth in the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty or, for Medicaid managed care organizations, criteria and guidelines determined by the Department of Healthcare and Family Services that are consistent with generally accepted standards of mental, emotional, nervous or substance use disorder or condition care. 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 relating to level of care placement, continued stay, transfer, 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.

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, transfer, 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 medically necessary treatment of mental, emotional, or nervous disorders or conditions ~~for inpatient mental health treatment at participating hospitals~~ shall comply with the following requirements:

(1) No ~~Subject to paragraphs (2) and (3) of this subsection, no~~ policy shall require prior authorization for outpatient or partial hospitalization services for treatment of mental, emotional, or nervous disorders or conditions provided by a physician licensed to practice medicine in all branches, a licensed clinical psychologist, a licensed clinical social worker, a

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

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

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

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

(2) No policy shall require prior authorization for inpatient treatment at a hospital for mental, emotional, or nervous disorders or conditions at a participating provider. Additionally, no such coverage shall ~~Coverage provided under this subsection also shall not~~ be subject to concurrent review for the first 72 hours after admission, provided that the provider ~~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~~ Recommended level of care placements identified in the discharge plan shall comply with generally accepted standards of care, as defined in subsection (h).

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

(B) 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 or facility.

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

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

(3) Treatment provided under this subsection may be reviewed retrospectively. If coverage is denied retrospectively, neither the insurer nor the participating provider ~~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 admission to inpatient hospitalization for treatment of mental, emotional, or nervous disorders or conditions, or before the applicable deadline under paragraph (1) of this subsection for outpatient treatment or partial hospitalization programs, ~~treatment~~ at a participating provider ~~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;~~.~~

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

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

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

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

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

(x) Notwithstanding any provision of this Section, nothing shall require the medical assistance program under Article V of the Illinois Public Aid Code or the Children's Health Insurance Program Act to violate any applicable federal laws, regulations, or grant requirements, including requirements for utilization management, or any State or federal consent decrees. Nothing in subsection (g) or ~~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, subject to applicable federal laws, regulations, or grant requirements, including requirements for utilization management, 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 subsections (g) and ~~subsection~~ (w). Nothing in this Section prohibits a health plan, including a Medicaid managed care organization, from conducting reviews for medical necessity, clinical appropriateness, safety, fraud, waste, or abuse and reporting suspected fraud, waste, or abuse according to State and federal requirements. Nothing in this Section limits the authority of the Department of Healthcare and Family Services

or another State agency, or a Medicaid managed care organization on the State agency's behalf, to (i) implement or require programs, services, screenings, assessments, tools, or reviews to comply with applicable federal law, federal regulation, federal grant requirements, any State or federal consent decrees or court orders, or any applicable case law, such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii) administer or require programs, services, screenings, assessments, tools, or reviews established under State or federal laws, rules, or regulations in compliance with State or federal laws, rules, or regulations, including, but not limited to, the Children's Mental Health Act and the Mental Health and Developmental Disabilities Administrative Act.

(y) (Blank). ~~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; 103-650, eff. 1-1-25; 103-1040, eff. 8-9-24; revised 11-26-24.)

Section 10. The Network Adequacy and Transparency Act is amended by changing Section 10 as follows:

(215 ILCS 124/10)

(Text of Section from P.A. 103-650)

Sec. 10. Network adequacy.

(a) Before issuing, delivering, or renewing a network plan, an issuer 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 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 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 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 in each plan, 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 shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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 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 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 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 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 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 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 <u>at the in-network benefit level</u>.

<u>(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.</u>

<u>(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect,</u>

as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the

beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days after a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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 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 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 (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 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 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, 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; 103-650, eff. 1-1-25.)

(Text of Section from P.A. 103-656)

Sec. 10. Network adequacy.

(a) 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 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) 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, 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 insurer shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when

a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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 complies with subsections (d)

and (e) of Section 55 of the Prior Authorization Reform Act.

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

(1) The 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. 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).

(d) The network plan shall demonstrate to the Director maximum travel and distance 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).

(d-5)(1) Every 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. 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 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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue

Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically

necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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), insurers who are not able to comply with the provider ratios and time and distance standards established 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-656, eff. 1-1-25.)

(Text of Section from P.A. 103-718)

Sec. 10. Network adequacy.

(a) 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 obstetrical and gynecological health care professionals.

An 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) 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, 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 insurer shall give the beneficiary a network exception and 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, except that the health

maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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.

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

(1) The 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. 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).

(d) The network plan shall demonstrate to the Director maximum travel and distance 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).

(d-5)(1) Every 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. 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 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 <u>at the in-network benefit level</u>.

<u>(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.</u>

<u>(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect,</u>

as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the

beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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), insurers who are not able to comply with the provider ratios and time and distance standards established 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-718, eff. 7-19-24.)

(Text of Section from P.A. 103-777)

Sec. 10. Network adequacy.

(a) 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 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) 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, 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 insurer shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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.

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

(1) The 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) If the federal Centers for Medicare and Medicaid Services establishes minimum provider ratios for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year.

(d) The network plan shall demonstrate to the Director maximum travel and distance 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).

If the federal Centers for Medicare and Medicaid Services establishes appointment wait-time standards for qualified

health plans, including stand-alone dental plans, in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for the same types of qualified health plans for that plan year. If the federal Centers for Medicare and Medicaid Services establishes time and distance standards for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year.

(d-5)(1) Every 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. 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 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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(4) If the federal Centers for Medicare and Medicaid Services establishes a more stringent standard in any county than specified in paragraph (1) or (2) of this subsection (d-5) for qualified health plans in the type of exchange in use in this State for a given plan year, the federal standard shall apply in lieu of the standard in paragraph (1) or (2) of this subsection (d-5) for qualified health plans for that plan year.

(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), insurers who are not able to comply with the provider ratios, time and distance standards, and appointment wait-time standards established under this Act or federal law 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's

compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-777, eff. 1-1-25.)

(Text of Section from P.A. 103-906)

Sec. 10. Network adequacy.

(a) 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 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 insurer in accordance

with any rights or remedies available under applicable State or federal law.

(b) 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, 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 insurer shall give the beneficiary a network exception and 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, except that the health maintenance organization must notify the beneficiary when a referral has been granted as a network exception based on any preferred provider access deficiency described in this paragraph or under the circumstances applicable in paragraph (3) of subsection (d-5). 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.

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

(1) The 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. 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.

(1.5) Beginning January 1, 2026, every insurer shall demonstrate to the Director that each in-network hospital has at least one radiologist, pathologist, anesthesiologist, and emergency room physician as a preferred provider in a network plan. The Department may, by rule, require additional types of hospital-based medical specialists to be included as preferred providers in each in-network hospital in a network plan.

(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).

(d) The network plan shall demonstrate to the Director maximum travel and distance 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).

(d-5)(1) Every 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. 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 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 at the in-network benefit level.

(A) For plan or policy years beginning on or after January 1, 2026, the issuer also shall provide reasonable reimbursement to a beneficiary who has received an exception as outlined in this paragraph (3) for costs including food, lodging, and travel.

(i) Reimbursement for food and lodging shall be at the prevailing federal per diem rates then in effect, as set by the United States General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses.

(ii) At the time an issuer grants an exception under this paragraph (3), the issuer shall give written notification to the beneficiary of potential eligibility for reimbursement under this subparagraph (A) and instructions on how to file a claim for such reimbursement, including a link to the claim form on the issuer's public website and a phone number for a

beneficiary to request that the issuer send a hard copy of the claim form by postal mail. The Department shall create the template for the reimbursement notification form, which issuers shall fill in and post on their public website.

(iii) An issuer may require a beneficiary to submit a claim for food, travel, or lodging reimbursement within 60 days of the last date of the health care service for which travel was undertaken, and the beneficiary may appeal any denial of reimbursement claims.

(iv) An issuer may deny reimbursement for food, lodging, and travel if the provider's site of care is neither within this State nor within 100 miles of the beneficiary's residence unless, after a good faith effort, no provider can be found who is available within those parameters to provide the medically necessary health care service within 10 business days of a request for appointment.

(B) Notwithstanding any other provision of this Section to the contrary, subparagraph (A) of this paragraph (3) does not apply to policies issued or delivered in this State that provide medical assistance under the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(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), insurers who are not able to comply with the provider ratios and time and distance standards established 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 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 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) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23; 103-906, eff. 1-1-25.)

Section 15. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

(Text of Section before amendment by P.A. 103-808)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f,

356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents

of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and

the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service

agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable

or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;

102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 9-26-24.)

(Text of Section after amendment by P.A. 103-808)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f, 356g, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,

356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68, 356z.69, 356z.70, 356z.71, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected

combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as

defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a

statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.

1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25; 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24; 103-808, eff. 1-1-26; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 20. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355.7, 355b, 355d, 356g, 356g.5, 356g.5-1, 356m, 356q, 356r, 356t, 356u, 356u.10, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,

356z.32, 356z.32a, 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.71, 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-656, eff. 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753, eff. 8-2-24; 103-758, eff. 1-1-25; 103-832, eff. 1-1-25; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 25. The Illinois Public Aid Code is amended by

changing Section 5-5.28 as follows:

(305 ILCS 5/5-5.28 new)

Sec. 5-5.28. Rulemaking authority. The Department of Healthcare and Family Services may adopt rules to implement the applicable provisions of this amendatory Act of the 104th General Assembly to managed care organizations, managed care community networks, and, at the Department's discretion, any other managed care entity described in subsection (i) of Section 5-30 of the Illinois Public Aid Code and the medical assistance fee-for-service program.

Section 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. Effective date. This Act takes effect January 1, 2026.".