AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Sections 356z.4a and 356z.40 as follows:

(215 ILCS 5/356z.4a)

Sec. 356z.4a. Coverage for abortion.

(a) Except as otherwise provided in this Section, no individual or group policy of accident and health insurance that provides pregnancy-related benefits may be issued, amended, delivered, or renewed in this State after the effective date of this amendatory Act of the 101st General Assembly unless the policy provides a covered person with coverage for abortion care. Regardless of whether the policy otherwise provides prescription drug benefits, abortion care coverage must include medications that are obtained through a prescription and used to terminate a pregnancy, regardless of whether there is proof of a pregnancy.

(b) Coverage for abortion care may not impose any deductible, coinsurance, waiting period, or other cost-sharing limitation ~~that is greater than that required for other pregnancy-related benefits covered by the policy~~. This subsection does not apply to the extent that 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.

(c) Except as otherwise authorized under this Section, a policy shall not impose any restrictions or delays on the coverage required under this Section.

(d) This Section does not, pursuant to 42 U.S.C. 18054(a)(6), apply to a multistate plan that does not provide coverage for abortion.

(e) If the Department concludes that enforcement of this Section may adversely affect the allocation of federal funds to this State, the Department may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

(Source: P.A. 101-13, eff. 6-12-19; 102-1117, eff. 1-13-23.)

(215 ILCS 5/356z.40)

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

(a) An individual or group policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after 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. 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.

(3) The benefits provided for inpatient and outpatient services for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications shall be provided if determined to be medically necessary, consistent with the requirements of Sections 370c and 370c.1 of this Code. The facility or provider shall notify the insurer of both the admission and the initial treatment plan within 48 hours after admission or initiation of treatment. 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. Nothing in this paragraph shall prevent an insurer from applying concurrent and post-service utilization review, including the review of medical necessity, case management, experimental and investigational treatments, managed care provisions, and other terms and conditions of the insurance policy, of any inpatient admission, detoxification or withdrawal management program admission, or partial hospitalization admission services for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications received 48 hours after the initiation of such services. If an insurer determines that the services are no longer medically necessary, then the covered person shall have the right to external review pursuant to the requirements of the Health Carrier External Review Act.

(5) If an insurer determines that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment in a facility is no longer medically necessary, the insurer shall, within 24 hours, provide

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

stay through that date as applicable under the policy. The covered pregnant or postpartum individual shall not be discharged or released from the inpatient facility, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment until all internal appeals and independent utilization review organization appeals are exhausted. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(6) Except as otherwise stated in this subsection (b) 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 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).

(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.)

Section 10. The Illinois Public Aid Code is amended by

changing Sections 5-16.7 and 5-18.5 as follows:

(305 ILCS 5/5-16.7)

Sec. 5-16.7. Post-parturition care. The medical assistance program shall provide the post-parturition care benefits required to be covered by a policy of accident and health insurance under Section 356s of the Illinois Insurance Code.

~~On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.~~

(Source: P.A. 97-689, eff. 6-14-12.)

(305 ILCS 5/5-18.5)

Sec. 5-18.5. Perinatal doula and evidence-based home visiting services.

(a) As used in this Section:

"Home visiting" means a voluntary, evidence-based strategy used to support pregnant people, infants, and young children and their caregivers to promote infant, child, and maternal health, to foster educational development and school readiness, and to help prevent child abuse and neglect. Home visitors are trained professionals whose visits and activities focus on promoting strong parent-child attachment to foster healthy child development.

"Perinatal doula" means a trained provider who provides regular, voluntary physical, emotional, and educational support, but not medical or midwife care, to pregnant and birthing persons before, during, and after childbirth, otherwise known as the perinatal period.

"Perinatal doula training" means any doula training that focuses on providing support throughout the prenatal, labor and delivery, or postpartum period, and reflects the type of doula care that the doula seeks to provide.

(b) Notwithstanding any other provision of this Article, perinatal doula services and evidence-based home visiting services shall be covered under the medical assistance program, subject to appropriation, for persons who are otherwise eligible for medical assistance under this Article. Perinatal doula services include regular visits beginning in the prenatal period and continuing into the postnatal period, inclusive of continuous support during labor and delivery, that support healthy pregnancies and positive birth outcomes. Perinatal doula services may be embedded in an existing program, such as evidence-based home visiting. Perinatal doula services provided during the prenatal period may be provided weekly, services provided during the labor and delivery period may be provided for the entire duration of labor and the time immediately following birth, and services provided during the postpartum period may be provided up to 12 months postpartum.

(b-5) Notwithstanding any other provision of this Article,

beginning January 1, 2023, licensed certified professional midwife services and, beginning January 1, 2025, certified professional midwife services shall be covered under the medical assistance program, subject to appropriation, for persons who are otherwise eligible for medical assistance under this Article. The Department shall consult with midwives on reimbursement rates for midwifery services.

(c) The Department of Healthcare and Family Services shall adopt rules to administer this Section. In this rulemaking, the Department shall consider the expertise of and consult with doula program experts, doula training providers, practicing doulas, and home visiting experts, along with State agencies implementing perinatal doula services and relevant bodies under the Illinois Early Learning Council. This body of experts shall inform the Department on the credentials necessary for perinatal doula and home visiting services to be eligible for Medicaid reimbursement and the rate of reimbursement for home visiting and perinatal doula services in the prenatal, labor and delivery, and postpartum periods. Every 2 years, the Department shall assess the rates of reimbursement for perinatal doula and home visiting services and adjust rates accordingly.

(d) The Department shall seek such State plan amendments or waivers as may be necessary to implement this Section and shall secure federal financial participation for expenditures made by the Department in accordance with this Section.

(Source: P.A. 102-4, eff. 4-27-21; 102-1037, eff. 6-2-22.)

Section 99. Effective date. This Act takes effect January 1, 2026, except that this Section and the changes to Section 5-18.5 of the Illinois Public Aid Code take effect January 1, 2025.