AN ACT concerning regulation.

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

Section 5. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, and 356z.77 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, ~~and~~ 370c, and 370c.4 of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this

Section. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

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; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, 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; 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 10. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, and 356z.77 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, ~~and~~ 370c, and 370c.4 of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

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; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, 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; 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 15. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and

the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 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, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, and 356z.77 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, ~~and~~ 370c, and 370c.4 of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

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; 102-103, 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; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 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; 103-535, eff. 8-11-23;

103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 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 Illinois Insurance Code is amended by adding Section 370c.4 as follows:

(215 ILCS 5/370c.4 new)

Sec. 370c.4. Mental health and substance use parity.

(a) In this Section:

"Application" means a person's or facility's application to become a participating provider with an insurer in at least one of the insurer's provider networks.

"Applying provider" means a provider or facility that has submitted a completed application to become a participating provider or facility with an insurer.

"Behavioral health trainee" means any person: (1) engaged in the provision of mental health or substance use disorder clinical services as part of that person's supervised course of study while enrolled in a master's or doctoral psychology, social work, counseling, or marriage or family therapy program or as a postdoctoral graduate working toward licensure; and (2) who is working toward clinical State licensure under the clinical supervision of a fully licensed mental health or substance use disorder treatment provider.

"Completed application" means a person's or facility's

application to become a participating provider that has been submitted to the insurer and includes all the required information for the application to be considered by the insurer according to the insurer's policies and procedures for verifying a provider's or facility's credentials.

"Contracting process" means the process by which a mental health or substance use disorder treatment provider or facility makes a completed application with an insurer to become a participating provider with the insurer until the effective date of a final contract between the provider or facility and the insurer. "Contracting process" includes the process of verifying a provider's credentials.

"Participating provider" means any mental health or substance use disorder treatment provider that has a contract to provide mental health or substance use disorder services with an insurer.

(b) Consistent with the principles of the federal Mental Health Parity and Addiction Equity Act of 2008, and for the purposes of strengthening network adequacy for mental health and substance use disorder services and lowering out-of-network utilization, provider reimbursement rates subject to this Section shall comply with the reimbursement rate floors for all in-network mental health and substance use disorder services, including inpatient services, outpatient services, office visits, and residential care, delivered by Illinois providers and facilities using the Illinois data in

the Research Triangle Institute International's study, Behavioral Health Parity - Pervasive Disparities in Access to In-Network Care Continue, Mark, T.L., & Parish, W. (April 2024). The reimbursement rate floors for in-network mental health and substance use disorder services requires that reimbursement for each service, classified by Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes, Ambulatory Payment Classifications (APC), Enhanced Ambulatory Patient Groups (EAPG), Medicare Severity Diagnosis Related Groups (MS-DRG), All Patient Refined Diagnosis Related Groups (APR-DRG), and base payment rates with adjusters and applicable outliers must be equal to or greater than the dollar amounts applicable under this subsection on the date of service for the geographic location. The reimbursement rate floor for each Healthcare Common Procedure Coding System (HCPCS) code, Current Procedural Terminology (CPT) code, Ambulatory Payment Classification (APC), Enhanced Ambulatory Patient Group (EAPG), Medicare Severity Diagnosis Related Group (MS-DRG), All Patient Refined Diagnosis Related Group (APR-DRG), and base payment rate with adjusters and applicable outliers shall apply to all group or individual policies of accident and health insurance or managed care plans that are amended, delivered, issued, or renewed on or after January 1, 2027, or any contracted third party administering the behavioral health benefits for the insurer.

(1) Except as otherwise provided in this subsection, the reimbursement rate floor for each Healthcare Common Procedure Coding System (HCPCS) code, Current Procedural Terminology (CPT) code, Ambulatory Payment Classification (APC), Enhanced Ambulatory Patient Group (EAPG), Medicare Severity Diagnosis Related Group (MS-DRG), All Patient Refined Diagnosis Related Group (APR-DRG), and base payment rate with adjusters and applicable outliers for a mental health or substance use disorder service shall be equal to the following dollar amount:

(A)(i) the average reimbursement percentage for Illinois All Medical/Surgical Clinicians, as listed on the first line of Appendix C-13, page C-52 of the Research Triangle Institute International study, plus;

(ii) half of the difference between the average reimbursement percentage and the percentage at the 75th percentile for Illinois All Medical/Surgical Clinicians, as listed in the first line in Appendix C-13, page C-52, multiplied by;

(B) the same source of the benchmark rate that was used to calculate the percentages in items (i) and (ii) of subparagraph (A), using the updated benchmark rate for medical/surgical clinicians for the same Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code in effect on

the date of service for the geographic location, except that:

(i) the source of the benchmark rate for a hospital inpatient service shall follow the formula set out by the same federal health care program for the acute inpatient operating prospective payment system in effect on the date of service for the geographic location using all applicable adjusters and outliers; and

(ii) the source of the benchmark rate for a hospital outpatient service shall follow the formula set out by the same federal health care program for the hospital outpatient services prospective payment system in effect on the date of service for the geographic location using all applicable adjusters and outliers.

Calculation of the benchmark rate shall adhere to the methodologies used in the Research Triangle Institution International study using comparable benefits within the same classification.

(2) If the rate benchmark set by this subsection is tied to a federal health care program, a rate floor dollar amount shall take effect on the date the federal health care program's benchmark rate takes effect. However, for any year that the benchmark rate decreases for any Healthcare Common Procedure Coding System (HCPCS) code,

Current Procedural Terminology (CPT) code, Ambulatory Payment Classification (APC), Enhanced Ambulatory Patient Group (EAPG), Medicare Severity Diagnosis Related Group (MS-DRG), All Patient Refined Diagnosis Related Group (APR-DRG), and base payment rate with adjusters and applicable outliers, the reimbursement rate floor for the purposes of this Section shall remain at the level it was the previous year. Notwithstanding any other provision of this Section, all rate floor dollar amounts in effect on January 1, 2027 shall be equal to the amount described in paragraph (1). The Department has the authority to enforce and monitor the reimbursement rate floor set pursuant to this Section.

(c) A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2027, or any contracted third party administering the behavioral health benefits for the insurer, shall cover all medically necessary mental health or substance use disorder services received by the same insured on the same day from the same or different mental health or substance use provider or facility for both outpatient and inpatient care.

(d) A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2027, or any contracted third party administering the behavioral health

benefits for the insurer, shall cover any medically necessary mental health or substance use disorder service provided by a behavioral health trainee when the trainee is working toward clinical State licensure and is under the supervision of a fully licensed mental health or substance use disorder treatment provider who is a 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 who is engaged in treating mental, emotional, nervous, or substance use disorders or conditions. Services provided by the trainee must be billed under the supervising clinician's rendering National Provider Identifier.

(e) A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2027, or any contracted third party administering the behavioral health benefits for the insurer, shall:

(1) cover medically necessary 60-minute psychotherapy billed using the Current Procedural Terminology Code 90837 for Individual Therapy;

(2) not impose more onerous documentation requirements on the provider than is required for other psychotherapy

Current Procedural Terminology (CPT) codes; and

(3) not audit the use of Current Procedural Terminology Code 90837 any more frequently than audits for the use of other psychotherapy Current Procedural Terminology (CPT) codes.

(f)(1) Any group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2027, or any contracted third party administering the behavioral health benefits for the insurer, shall complete the contracting process with a mental health or substance use disorder treatment provider or facility for becoming a participating provider in the insurer's network, including the verification of the provider's credentials, within 60 days from the date of a completed application to the insurer to become a participating provider. Nothing in this paragraph (1), however, presumes or establishes a contract between an insurer and a provider.

(2) Any group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2027, or any contracted third party administering the behavioral health benefits for the insurer, shall reimburse a participating mental health or substance use disorder treatment provider or facility at the contracted reimbursement rate for any medically necessary services provided to an insured from the

date of submission of the provider's or facility's completed application to become a participating provider with the insurer up to the effective date of the provider's contract. The provider's claims for such services shall be reimbursed only when submitted after the effective date of the provider's contract with the insurer. This paragraph (2) does not apply to a provider that does not have a completed contract with an insurer. If a provider opts to submit claims for medically necessary mental health or substance use disorder services pursuant to this paragraph (2), the provider must notify the insured following submission of the claims to the insurer that the services provided to the insured may be treated as in-network services.

(3) Any group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2027, or any contracted third party administering the behavioral health benefits for the insurer, shall cover any medically necessary mental health or substance use disorder service provided by a fully licensed mental health or substance use disorder treatment provider affiliated with a mental health or substance use disorder treatment group practice who has submitted a completed application to become a participating provider with an insurer who is delivering services under the supervision of another fully licensed participating mental health or substance use disorder treatment provider within the

same group practice up to the effective date of the applying provider's contract with the insurer as a participating provider. Services provided by the applying provider must be billed under the supervising licensed provider's rendering National Provider Identifier.

(4) Upon request, an insurer, or any contracted third party administering the behavioral health benefits for the insurer, shall provide an applying provider with the insurer's credentialing policies and procedures. An insurer, or any contracted third party administering the behavioral health benefits for the insurer, shall post the following nonproprietary information on its website and make that information available to all applicants:

(A) a list of the information required to be included in an application;

(B) a checklist of the materials that must be submitted in the credentialing process; and

(C) designated contact information of a network representative, including a designated point of contact, an email address, and a telephone number, to which an applicant may address any credentialing inquiries.

(g) The Department has the same authority to enforce this Section as it has to enforce compliance with Sections 370c and 370c.1. Additionally, if the Department determines that an insurer or any contracted third party administering the behavioral health benefits for the insurer has violated this

Section, the Department shall, after appropriate notice and opportunity for hearing in accordance with Section 402, by order assess a civil penalty of $1,000 for each violation. The Department shall establish any processes or procedures necessary to monitor compliance with this Section.

(h) At the end of 2 years, 7 years, and 12 years following the implementation of subsection (b) of this Section, the Department shall review the impact of this Section on network adequacy for mental health and substance use disorder treatment and access to affordable mental health and substance use care. By no later than December 31, 2030, December 31, 2035, and December 31, 2040, the Department shall submit a report in each of those years to the General Assembly that includes its analyses and findings. For the purpose of evaluating trends in network adequacy, the Department is granted the authority to examine out-of-network utilization and out-of-pocket costs for insureds for mental health and substance use disorder treatment and services for all plans to compare with in-network utilization for purposes of evaluating access to care. The Department shall conduct an analysis of the impact, if any, of the reimbursement rate floor for mental health and substance use disorder services on health insurance premiums across the State-regulated health insurance markets, taking into consideration the need to expand network adequacy to improve access to care.

(i) The Department of Insurance shall adopt any rules

necessary to implement this Section by no later than September 1, 2026.

(j) This Section does not apply to a health care plan serving Medicaid populations that provides, arranges for, pays for, or reimburses the cost of any health care service for persons who are enrolled under the Illinois Public Aid Code or under the Children's Health Insurance Program Act.

Section 99. Effective date. This Act takes effect June 1, 2026.