

1 AN ACT concerning regulation.

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

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

6 (55 ILCS 5/5-1069.3)

7 Sec. 5-1069.3. Required health benefits. If a county,  
8 including a home rule county, is a self-insurer for purposes  
9 of providing health insurance coverage for its employees, the  
10 coverage shall include coverage for the post-mastectomy care  
11 benefits required to be covered by a policy of accident and  
12 health insurance under Section 356t and the coverage required  
13 under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u,  
14 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9,  
15 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,  
16 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36,  
17 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51,  
18 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61,  
19 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71,  
20 356z.74, and 356z.77 of the Illinois Insurance Code. The  
21 coverage shall comply with Sections 155.22a, 355b, 356z.19,  
22 ~~and~~ 370c, and 370c.4 of the Illinois Insurance Code. The  
23 Department of Insurance shall enforce the requirements of this

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

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

13 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;  
14 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.  
15 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,  
16 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;  
17 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.  
18 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,  
19 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;  
20 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff.  
21 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914,  
22 eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25;  
23 revised 11-26-24.)

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

1 (65 ILCS 5/10-4-2.3)

2 Sec. 10-4-2.3. Required health benefits. If a  
3 municipality, including a home rule municipality, is a  
4 self-insurer for purposes of providing health insurance  
5 coverage for its employees, the coverage shall include  
6 coverage for the post-mastectomy care benefits required to be  
7 covered by a policy of accident and health insurance under  
8 Section 356t and the coverage required under Sections 356g,  
9 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x,  
10 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11,  
11 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26,  
12 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41,  
13 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54,  
14 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64,  
15 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, and  
16 356z.77 of the Illinois Insurance Code. The coverage shall  
17 comply with Sections 155.22a, 355b, 356z.19, ~~and~~ 370c, and  
18 370c.4 of the Illinois Insurance Code. The Department of  
19 Insurance shall enforce the requirements of this Section. The  
20 requirement that health benefits be covered as provided in  
21 this is an exclusive power and function of the State and is a  
22 denial and limitation under Article VII, Section 6, subsection  
23 (h) of the Illinois Constitution. A home rule municipality to  
24 which this Section applies must comply with every provision of  
25 this Section.

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

7 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;  
8 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.  
9 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731,  
10 eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22;  
11 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff.  
12 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,  
13 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;  
14 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff.  
15 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914,  
16 eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25;  
17 revised 11-26-24.)

18 Section 15. The School Code is amended by changing Section  
19 10-22.3f as follows:

20 (105 ILCS 5/10-22.3f)

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

1 the coverage required under Sections 356g, 356g.5, 356g.5-1,  
2 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a,  
3 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14,  
4 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32,  
5 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,  
6 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60,  
7 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~  
8 356z.71, 356z.74, and 356z.77 of the Illinois Insurance Code.  
9 Insurance policies shall comply with Section 356z.19 of the  
10 Illinois Insurance Code. The coverage shall comply with  
11 Sections 155.22a, 355b, ~~and~~ 370c, and 370c.4 of the Illinois  
12 Insurance Code. The Department of Insurance shall enforce the  
13 requirements of this Section.

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

20 (Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;  
21 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff.  
22 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804,  
23 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;  
24 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff.  
25 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420,  
26 eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23;

1 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff.  
2 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918,  
3 eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

4 Section 20. The Illinois Insurance Code is amended by  
5 adding Section 370c.4 as follows:

6 (215 ILCS 5/370c.4 new)

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

8 (a) In this Section:

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

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

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

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

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

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

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

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

1 the Research Triangle Institute International's study,  
2 Behavioral Health Parity - Pervasive Disparities in Access to  
3 In-Network Care Continue, Mark, T.L., & Parish, W. (April  
4 2024). The reimbursement rate floors for in-network mental  
5 health and substance use disorder services requires that  
6 reimbursement for each service, classified by Healthcare  
7 Common Procedure Coding System (HCPCS) codes, Current  
8 Procedural Terminology (CPT) codes, Ambulatory Payment  
9 Classifications (APC), Enhanced Ambulatory Patient Groups  
10 (EAPG), Medicare Severity Diagnosis Related Groups (MS-DRG),  
11 All Patient Refined Diagnosis Related Groups (APR-DRG), and  
12 base payment rates with adjusters and applicable outliers must  
13 be equal to or greater than the dollar amounts applicable  
14 under this subsection on the date of service for the  
15 geographic location. The reimbursement rate floor for each  
16 Healthcare Common Procedure Coding System (HCPCS) code,  
17 Current Procedural Terminology (CPT) code, Ambulatory Payment  
18 Classification (APC), Enhanced Ambulatory Patient Group  
19 (EAPG), Medicare Severity Diagnosis Related Group (MS-DRG),  
20 All Patient Refined Diagnosis Related Group (APR-DRG), and  
21 base payment rate with adjusters and applicable outliers shall  
22 apply to all group or individual policies of accident and  
23 health insurance or managed care plans that are amended,  
24 delivered, issued, or renewed on or after January 1, 2027, or  
25 any contracted third party administering the behavioral health  
26 benefits for the insurer.

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

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

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

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

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

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

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

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

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

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

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

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

1 benefits for the insurer, shall cover any medically necessary  
2 mental health or substance use disorder service provided by a  
3 behavioral health trainee when the trainee is working toward  
4 clinical State licensure and is under the supervision of a  
5 fully licensed mental health or substance use disorder  
6 treatment provider who is a physician licensed to practice  
7 medicine in all its branches, licensed clinical psychologist,  
8 licensed clinical social worker, licensed clinical  
9 professional counselor, licensed marriage and family  
10 therapist, licensed speech-language pathologist, or other  
11 licensed or certified professional at a program licensed  
12 pursuant to the Substance Use Disorder Act who is engaged in  
13 treating mental, emotional, nervous, or substance use  
14 disorders or conditions. Services provided by the trainee must  
15 be billed under the supervising clinician's rendering National  
16 Provider Identifier.

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

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

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

1 Current Procedural Terminology (CPT) codes; and

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

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

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

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

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

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

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

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

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

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

22 (g) The Department has the same authority to enforce this  
23 Section as it has to enforce compliance with Sections 370c and  
24 370c.1. Additionally, if the Department determines that an  
25 insurer or any contracted third party administering the  
26 behavioral health benefits for the insurer has violated this

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

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

26 (i) The Department of Insurance shall adopt any rules

1 necessary to implement this Section by no later than September  
2 1, 2026.

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

8 Section 99. Effective date. This Act takes effect June 1,  
9 2026.