Illinois Health and Hospital Association

December 16, 2025

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: **Commercial Behavioral Health Reform Bills – Hospital Impact**

Over the past two years, IHA has successfully supported and amended three new laws that establish substantial behavioral health coverage and reimbursement reforms for state-regulated commercial insurers. Throughout the negotiation process, IHA's Behavioral Health Advisory Forum provided strategic input. This memo will outline key changes for healthcare providers and payers within the following legislation, with provider requirements in **bold**:

- Governor Pritzker's Health Care Protection Act (HPA, HB 5395/PA 103-0650) and the Health Care Protection Expansion Act (HPEA, HB 3019/PA 104-0028) take effect Jan. 1, 2026.
- Passed during veto session and signed by Gov. JB Pritzker on Dec. 12, 2025, HB 1085/PA 104-0446 reforms take effect on July 1, 2026 and Jan. 1, 2027.

Healthcare Protection Act and Healthcare Protection Expansion Act (HB 5395/HB 3019)
This year, the HPEA modified requirements made law by the HPA, its 2024 predecessor. Below is a detailed, combined summary of new protections and requirements within both laws, impacting providers, beneficiaries, and state-regulated commercial insurers.

Following successful negotiations with the sponsors, prohibitions on prior authorization and concurrent review for the first 72 hours of hospital inpatient behavioral health are maintained, while additional protections are broadened to partial hospitalization and outpatient services, with conditions.

Network Adequacy (Only Appliable to Commercial Insurers)

- Expands continuity of care eligibility for an ongoing course of treatment when a provider leaves an insurer's network. Individuals are now eligible for continuity of care if they are:
  - Undergoing a course of institutional or inpatient care;
  - Scheduled to undergo nonelective surgery, including preoperative and postoperative care;
  - Determined to be terminally ill and receiving treatment for that illness; and
  - Receiving any other treatment of a condition or disease that requires repeated healthcare services pursuant to a plan of treatment.
- Strengthens requirement for insurers to cover services at no greater cost than preferred providers, if they are inaccessible for specified reasons, by clarifying that

beneficiaries must be given a network exception. Health maintenance organizations (HMOs) are no longer exempt and must also notify the beneficiary of an approved referral as a network exception when applicable access deficiencies are identified.

- Requires insurers to demonstrate evidence that network plans offered on the Exchange in the individual or small group market, and any off-Exchange plans that mirror these plans, include essential community providers, in line with rules established by the Exchange.
- Requires insurers to provide reasonable reimbursement to beneficiaries for food, lodging and travel if in-network mental health facilities or providers do not meet network adequacy standards for policy years beginning Jan. 1, 2026.
- Requires insurers meet at least the federal minimum ratios, maximum time, distance and appointment wait time standards pertaining to network adequacy established for plans on the federally facilitated exchange. Provides the Illinois Dept. of Insurance (DOI) greater oversight to ensure insurers follow network adequacy requirements.
- Requires insurers to cover out-of-network claims at the in-network rate if a network is deemed inadequate for a specific provider type and the insurer does not have an exemption from the DOI.
- **Requires providers to give notice to an insurer within 20 business days** if the provider decides to stop accepting new patients for a period of 40 business days or longer.
- Addresses insurers' use of "ghost networks" by requiring insurers to audit their provider directories for accuracy at least every 90 days and make necessary corrections.
- Requires DOI to develop and publish a uniform electronic provider directory information form by Jan. 1, 2026, in consultation with the Uniform Directory Task Force that met throughout this year, and requires providers to begin using this form by July 1, 2026.

Prior Authorization, Concurrent and Retrospective Review (Applicable to Commercial Insurers and Medicaid MCOs)

- Prohibits prior authorization for inpatient mental health admission to any participating hospital, including for individuals with autism spectrum disorder, during pregnancy and postpartum.
- Prohibits concurrent review for 72 hours after hospital admission **if the provider notifies the insurer of the admission and treatment plan within 48 hours of admission**.
- Prohibits prior authorization for outpatient and partial hospitalization mental health services provided by a facility or licensed physician, clinical psychologist, clinical social worker, clinical professional counselor, marriage and family therapist, speech language pathologist, or any other licensed, certified, or legally authorized provider, including trainees working under supervision of

one of the above licensed professionals.
    - Coverage may be subject to concurrent and retrospective review.
    - HMOs are still permitted to require service referrals for non-participating providers.
    - **Facility or provider may be required to notify the insurer of treatment initiation**.
    - Coverage cannot be subject to concurrent review **until the following notification deadlines after the initiation of treatment**:
        - Commercial insurers may require a deadline of two business days for outpatient treatment and 48 hours for partial hospitalization.
        - Medicaid managed care organizations (MCOs) may require a deadline of 24 hours for outpatient treatment or partial hospitalization. If the MCO cannot accept the notification within that period, the provider will have one additional business day to provide the notification.
- In addition to the existing prohibition on prior authorization for SUD treatment, prohibits concurrent review for two business days after treatment initiation for commercial health plans and 24 hours for Medicaid MCOs, and permits these as notification deadlines the insurer may require.
- Prohibits retrospective review for the first 72 hours of an inpatient mental health admission and before notification deadlines that align with concurrent review requirements for outpatient MH services, partial hospitalization MH services, and SUD services, unless the insurer:
    - Reasonably determines that inpatient mental health treatment was not provided;
    - Determines the patient was not insured under the policy;
    - Discovers material misrepresentation by the patient or healthcare provider;
    - Determines that the service was excluded under the terms of the policy;
    - Determines the patient did not consent to treatment and no court order mandated treatment; or
    - Determines an outpatient or partial hospitalization service was not medically necessary (**not** applicable to inpatient services).
- **If coverage is retrospectively denied, the patient cannot be held liable for payment for inpatient, outpatient, or partial hospitalization mental health services, or SUD services** through the date the adverse determination is made, other than any copayment, coinsurance, or deductible.
- Removes insurer requirement to provide timely review of a service denial by a provider holding the same license and specialty as the patient's provider, who is unaffiliated with the insurer, in the event of a dispute with the patient's provider over a treatment's medical necessity. Also, removes required insurer payment if the reviewer finds the service medically necessary.
    - The Prior Authorization Reform Act (215 ILCS 200/35, 45) maintains provisions that require insurers to use qualified personnel when making adverse

determinations of prior authorization, concurrent review and appeal review.

- Prior authorization, concurrent and retrospective review provisions:
    - Do not apply to coverage for prescription and over-the-counter drugs;
    - Cannot require Medicaid to reimburse for services not covered under the Public Aid Code or the Children's Health Insurance Program Act;
    - IL. Dept. of Healthcare and Family Services (HFS), another state agency, or a Medicaid MCO on a state agency's behalf may implement or require programs, services, screenings, assessments, tools, or reviews to comply with state or federal requirements, state or federal consent decrees or court orders, or any applicable case law; and
    - Do not prohibit reviews for medical necessity, clinical appropriateness, safety, fraud, waste, and abuse in line with state and federal requirements.
- This provision is effective Jan. 1, 2026.

Discharge Planning and Placement (Applicable to Commercial Insurers and Medicaid MCOs)

- Language states a fully developed hospital discharge plan and prepared continuity services must meet patient's needs and preferences upon release.
- Requires recommended level of care placements for discharge planning to comply with generally accepted standards of care.
- **If a hospital meets standards outlined in the previous two bullets <u>and</u> notifies the insurer of the admission and treatment plan within 48 hours of admission**, the insurer shall approve coverage of the recommended level of care upon discharge, subject to concurrent review.
    - HMOs are still permitted to require service referrals for non-participating providers upon discharge.
- This provision is effective Jan. 1, 2026.

Coverage Requirements

- Expands existing mental health and substance use disorder (MHSUD) insurer coverage requirements to include county, municipal and school district employee health plans, in addition to employer-sponsored and state employee plans, including:
    - Prior authorization, concurrent, and retrospective review requirements;
    - Minimum treatment requirements (e.g., 45 days inpatient, 60 outpatient visits, no lifetime limits);
    - Parity with treatment for physical illnesses;
    - Medically necessary acute treatment services and medically necessary clinical stabilization services; and
    - Prior authorization and dosage limitations for SUD prescription medications only as established by the American Society of Addiction Medicine, with these drugs on the lowest tier of the drug formularies.

Utilization Review Organization Standards (Applicable to Commercial Insurers and Medicaid MCOs)

- For an insurer's utilization review program, requires the insurer to use either:
    - Treatment criteria developed by an unaffiliated nonprofit professional association. For SUDs specifically, criteria must be established by the American Society of Addiction Medicine; or
    - Nationally recognized, evidence-based treatment criteria reflecting generally accepted standards of care, when certain requirements are met.
    - For Medicaid, treatment criteria developed by HFS are acceptable if the criteria are consistent with generally accepted standards of care.
- Requires utilization review programs to authorize level of care placement decisions at the level of care at or above the level ordered by the provider using relevant treatment criteria specified above. If there is a disagreement, provide a complete assessment to the provider and patient.
- Requires insurers to run interrater reliability reports and based on that rate, take action to remediate and report remediation actions to either DOI or HFS.
- This provision is effective Jan. 1, 2026.

Step Therapy Requirements Prohibition (Applicable to Commercial Insurers and Medicaid MCOs)

- Defines step therapy requirements as a utilization review or formulary requirement that, as a condition of coverage, determine the order in which certain services must be used to treat or manage a health condition.
- Prohibits fail first step therapy requirements, effective Jan. 1, 2026 for commercial insurance and Medicaid.
- The Medicaid prohibition does not include step therapy requirements for drugs that do not appear on the HFS Preferred Drug List.
- This prohibition does not include a pharmacist substituting prescription drugs with an interchangeable biologic from a prescribed biologic product.
- This prohibition also does not include:
    - The use of utilization review to identify when a treatment is contraindicated or to limit quantity or dosage;
    - The removal of a drug from a formulary;
    - Requiring use of the medical exceptions process to obtain coverage for a drug that is not concurrently listed on the formulary;
    - Requirements to obtain prior authorization for the requested treatment;
    - The HFS requirement that Medicaid MCOs comply with the Preferred Drug List utilization control process; and
    - The use of utilization review criteria for any healthcare service other than prescription drugs.

Plan Oversight (Applicable to Commercial Insurers and Medicaid MCOs When Indicated)

- Requires commercial insurers, including grandfathered plans, to submit the medical loss ratio (MLR) report filed with the U.S. Dept. of Health and Human Services (under 45 CFR Part 158) to the DOI Director for each plan year.
- If federal law or rule repeals or reduces the MLR report or premium rebate requirements, the commercial insurer must continue to submit this information to DOI and provide premium rebates to enrollees.
- Permits HFS to adopt rules to implement applicable provisions of the HPEA for Medicaid MCOs.

Commercial Behavioral Health Reform (HB 1085)

Coverage and Reimbursement Reforms

Beginning Jan. 1, 2027, HB 1085 requires most state-regulated commercial insurers to implement **key reforms for MHSUD services**, including:

- The establishment of a rate floor for in-network inpatient services, outpatient services, office visits, and residential care that must be at least **141.7%** of Medicare rates effective on the date of service for the geographic location. **IHA encourages member feedback on the new commercial rate floor following implementation.**
    - Hospital inpatient and outpatient services are multiplied by the Medicare hospital inpatient and outpatient prospective payment systems, using **all** applicable adjusters and outliers.
    - For any year the Medicare benchmark rate decreases, the rate floor remains at the level it was the previous year.
- Coverage of medically necessary (MN) services received on the same day, whether from the same provider/facility or multiple providers/facilities for both outpatient and inpatient care.
- Coverage of trainees working toward clinical state licensure for all MN services, when under supervision and billing under a licensed MHSUD treatment provider.
- Coverage of MN 60-minute individual psychotherapy (Current Procedural Terminology Code 90837) with no additional documentation requirements for that service, and without more frequent audits than audits for other psychotherapy codes.
- Reimbursement of a participating provider/facility and trainees billing under a supervisor at the contracted rate for MN services from the date a contract was submitted up to the contract's effective date.
    - Claims must be submitted after the contract's effective date. This provision is not applicable to providers without a completed and fully executed contract in place.
    - **Providers must notify beneficiaries following claim submission that the services may be treated as in-network services.**

Contracting and Credentialing

Beginning June 1, 2026, HB 1085 requires insurers to provide applicants with a list of credentialing policies and procedures, upon request, with all application information, a

checklist of materials required for submission, and network representative contact information available to applicants on its website.

Beginning Jan. 1, 2027, insurers must complete the contracting process with providers/facilities to become a participating in-network provider within 60 days from the date of a completed application, including provider credentialing. This is not intended to presume or establish a contract between an insurer and provider.

Monitoring and Enforcement
DOI has enforcement authority for all requirements, permitting a civil penalty of $1000 for each violation, and:

- Must submit a report to the General Assembly at the end of 2030, 2035 and 2040 on the impact of the legislation on network adequacy and affordable access to care.
- Has authority to examine out-of-network utilization and out-of-pocket costs for insureds for MHSUD treatment for all plans to compare it to in-network utilization.
- Must conduct an analysis of the impact of the commercial rate floor on premiums across state-regulated health insurance markets.
- Must use rulemaking authority to implement provisions of the legislation by Sept. 1, 2026.

Beneficiary Application
Covered beneficiaries for these reforms include individuals with group or individual policies of accident and health insurance or managed care plans and third-party behavioral health benefit contractors that administer benefits under the Insurance Code (215 ILCS 5/), Counties Code (55 ILCS 5/), Municipal Code (65 ILCS 5/), and School Code (105 ILCS 5/). These reforms **do not apply** to beneficiaries covered by Medicaid under the Public Aid Code (305 ILCS 5/) or Children's Health Insurance Program Act (215 ILCS 106/) or state employees under the State Employees Group Insurance Act (5 ILCS 375/).

As these laws become effective, we **encourage members to provide questions or feedback on any implementation barriers *here***. For more information on other state behavioral health legislation successfully amended and/or passed with IHA support this year, see IHA's **2025 End of Session Report**.