SENATE JOURNAL

STATE OF ILLINOIS

ONE HUNDRED THIRD GENERAL ASSEMBLY

116TH LEGISLATIVE DAY

WEDNESDAY, MAY 22, 2024

12:11 O'CLOCK P.M.

NO. 116
[May 22, 2024]

SENATE
Daily Journal Index
116th Legislative Day

The Senate met pursuant to adjournment.
Senator Omar Aquino, Chicago, Illinois, presiding.
Prayer by Dr. Driss El-Akrich, Islamic Society of Greater Springfield, Springfield, Illinois.
Senator Johnson led the Senate in the Pledge of Allegiance.

Senator Hunter moved that reading and approval of the Journal of Tuesday, May 21, 2024, be postponed, pending arrival of the printed Journal.
The motion prevailed.

REPORT RECEIVED

The Secretary placed before the Senate the following report:

Reporting Requirement of 50 ILCS 707/20 (Law Enforcement Camera Grant Act), submitted by the Moraine Valley Police Department.

The foregoing report was ordered received and placed on file in the Secretary's Office.

LEGISLATIVE MEASURE FILED

The following Committee amendment to the Senate Bill listed below has been filed with the Secretary and referred to the Committee on Assignments:

Amendment No. 2 to Senate Bill 3591

MESSAGE FROM THE PRESIDENT

OFFICE OF THE SENATE PRESIDENT
DON HARMON
STATE OF ILLINOIS

327 STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
217-782-2728

160 N. LASALLE ST., STE. 720
CHICAGO, ILLINOIS 60601
312-814-2075

May 22, 2024

Mr. Tim Anderson
Secretary of the Senate
Room 058 State House
Springfield, IL 62706

Dear Mr. Secretary:

Pursuant to the Senate Rule 2-10, I am extending the 3rd Reading deadline to May 24, 2024, for the following bills: SB0863

Sincerely,
s/Don Harmon
Don Harmon
Senate President

cc: Senate Republican Leader John F. Curran

PRESENTATION OF CELEBRATION OF LIFE RESOLUTIONS

SENATE RESOLUTION NO. 1019
Offered by Senator Fowler and all Senators:
Mourns the death of Bill Springer of Equality.

SENATE RESOLUTION NO. 1020
Offered by Senator Anderson and all Senators:
Mourns the death of Craig A. Meeske, formerly of East Moline.

SENATE RESOLUTION NO. 1021
Offered by Senator Anderson and all Senators:
Mourns the death of Jan Christensen of East Moline.

SENATE RESOLUTION NO. 1022
Offered by Senator Anderson and all Senators:
Mourns the death of Harold Junior Land of Topeka.

SENATE RESOLUTION NO. 1023
Offered by Senator McClure and all Senators:
Mourns the death of Rev. Dr. Dan Smith of New Haven, Missouri.

SENATE RESOLUTION NO. 1024
Offered by Senator McClure and all Senators:
Mourns the passing of Kenneth D. Bryan of Teutopolis.

SENATE RESOLUTION NO. 1025
Offered by Senator McClure and all Senators:
Mourns the passing of Walker Lee Bryan of Beecher City.

SENATE RESOLUTION NO. 1026
Offered by Senator McClure and all Senators:
Mourns the passing of Rose Tennery "Rosie" Bryan of Beecher City.

SENATE RESOLUTION NO. 1027
Offered by Senator McClure and all Senators:
Mourns the death of Vasile Cricovan of Twinsburg, Ohio.

SENATE RESOLUTION NO. 1028
Offered by Senator McClure and all Senators:
Mourns the death of Robert Eugene "Bob" Trainor.

SENATE RESOLUTION NO. 1029
Offered by Senator McClure and all Senators:
Mourns the passing of Gerald "Jerry" Peters of Petersburg.

SENATE RESOLUTION NO. 1030
Offered by Senator McClure and all Senators:
Mourns the death of David Daniels of Springfield.

SENATE RESOLUTION NO. 1031
Offered by Senator McClure and all Senators:
Mourns the death of Patricia Graves of Springfield.

SENATE RESOLUTION NO. 1032
Offered by Senator McClure and all Senators:

Mourns the death of Stacks the Library Cat of Litchfield.

By unanimous consent, the foregoing resolutions were referred to the Resolutions Consent Calendar.

REPORT FROM STANDING COMMITTEE

Senator Peters, Chair of the Committee on Labor, to which was referred **House Bill No. 5324**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

MESSAGES FROM THE HOUSE

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3686

A bill for AN ACT concerning safety.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 2 to SENATE BILL NO. 3686

Passed the House, as amended, May 21, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 2 TO SENATE BILL 3686

AMENDMENT NO. 2 . Amend Senate Bill 3686 on page 2, immediately below line 11, by inserting the following:

""Agency-sponsored household battery recycling program" means a household battery recycling program sponsored by the Agency where the Agency provides for the transport, processing, recycling, and other end-of-life management for household-generated batteries collected by Agency collection partners under grant funding provided by the U.S. Department of Energy on or after January 1, 2024."; and

on page 2, immediately below line 22, by inserting the following:

""Battery Stewardship Program" means a program implemented by a battery stewardship organization consistent with an approved battery stewardship plan."; and

on page 3, line 20, by deleting "and"; and

on page 3, line 23, by replacing "product." with "product; and"; and

on page 3, immediately below line 23, by inserting the following:

"(6) a battery that is a component of a motor vehicle or intended for use exclusively in motor vehicles."; and

on page 4, immediately below line 8, by inserting the following:

""Motor vehicle" includes automobiles, vans, trucks, tractors, motorcycles, and motorboats as defined in subsection (h) of Section 22.23 of the Environmental Protection Act. For purposes of this Act, "motor vehicle" also includes all-terrain vehicles as defined in Section 1-101.8 of the Illinois Vehicle Code and watercraft as defined in Section 1-2 of the Boat Registration and Safety Act."; and

on page 7, by deleting lines 21 through 23; and

on page 13, line 14, after "sites", by inserting "supported by the battery stewardship program"; and

on page 13, line 15, after "sites", by inserting "supported by the battery stewardship program"; and

on page 15, line 10, by replacing "plan", with "plan, or the addition or removal of a collection location to the battery stewardship program because of changes to an Agency-sponsored household battery recycling program"; and

on page 22, immediately below line 2, by inserting the following:

"(4) The collection location requirements set forth in paragraphs (2) and (3) of this subsection may be satisfied by collection locations participating in an Agency-sponsored household battery recycling program."; and

on page 22, lines 5 through 7, by replacing "December 31, 2026 for portable batteries and by no later than December 31, 2028 for medium-format batteries" with "December 31, 2028"; and

on page 39, immediately below line 2, by inserting the following:

"Section 95. Agency-sponsored household battery recycling program. If the Agency receives funding to support an Agency-sponsored household battery recycling program that operates concurrently with the Battery Stewardship Program that is the subject of this Act, the costs of collecting and managing batteries through the Agency-sponsored household battery recycling program shall not be the responsibility of the battery stewardship organization.".

Under the rules, the foregoing **Senate Bill No. 3686**, with House Amendment No. 2, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has passed bills of the following titles, in the passage of which I am instructed to ask the concurrence of the Senate, to-wit:

HOUSE BILL NO. 814

A bill for AN ACT concerning State government.

HOUSE BILL NO. 4567

A bill for AN ACT concerning criminal law.

Passed the House, May 21, 2024.

JOHN W. HOLLMAN, Clerk of the House

The foregoing **House Bills Numbered 814 and 4567** were taken up, ordered printed and placed on first reading.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has adopted the following joint resolution, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

HOUSE JOINT RESOLUTION NO. 69

WHEREAS, On June 30, 2022, the U.S. Supreme Court affirmed that U.S. immigration law expressly authorizes the Department of Homeland Security (DHS) to grant "parole", permission to temporarily remain in the United States and apply for a work permit to certain people who are undocumented without Congressional approval for "urgent humanitarian reasons or significant public benefit" so long as the exercise of such discretion is "reasonable and reasonably explained" on a case by case basis per Biden v. Texas, 142 S. Ct. 2528 (2022); and

WHEREAS, The U.S. government has exercised its parole authority in a wide variety of ways for humanitarian reasons and significant public benefit; and

WHEREAS, A program known as Military Parole in Place already exists for spouses, parents, or children, who are undocumented, of active-duty or former active duty members of the U.S. Armed Forces and the Selected Reserve of the Ready Reserve; and

WHEREAS, Amidst Congressional inaction on immigration reform, President Biden has utilized parole more than any other U.S. president in history, extending the program to more than 1 million people who are undocumented over the past two years; and

WHEREAS, The U.S. is experiencing an unprecedented labor shortage across multiple sectors of our economy that are vital to our national well-being; and

WHEREAS, In the State of Illinois, the fifth largest economy in the United States, critical industries, such as manufacturing, transportation, warehousing, agriculture, healthcare, childcare, senior/home care, hospitality, construction, and education, are experiencing a prolonged staffing shortage that is harming their growth and competitiveness; and

WHEREAS, According to the Bureau of Labor Statistics, as analyzed by the U.S. Chamber of Commerce, Illinois has, on average, 76 available workers for every 100 jobs; and

WHEREAS, The Illinois Department of Employment Security (IDES) reports that the largest number of high-demand, high-wage job openings through 2030 are in occupations that require short-term or moderate-term on-the-job training, including over 56,000 annual openings in the restaurant sector, over 41,000 annual openings for laborers, assemblers, and maintenance workers, over 59,000 annual openings for cashiers and retail sales and customer service representatives, and over 15,000 annual openings in home health and personal care aides; and

WHEREAS, The Illinois Farm Bureau has indicated that local worker shortages are among the top current challenges for Illinois farmers, suppliers, and processors, including locating qualified truck drivers to haul grain and sourcing enough hands to pick vegetables or manage livestock, and furthermore, that this shortage in the agricultural supply chains continues to not only undermine the financial health of farms in Illinois but, more importantly, threaten food security, and, ultimately, our national security; and

WHEREAS, The Illinois State Board of Education's (ISBE) 2023 Unfilled Positions Report shows that school districts in Illinois reported more unfilled positions in FY23 than they did in FY22, and there continues to be a high demand for paraprofessionals and teachers, particularly in the City of Chicago, the Northeast region, and the East Central region, and the demand for paraprofessionals, who often serve special education and bilingual students, outweighs the supply; and

WHEREAS, The Illinois Nursing Workforce Center reports the State is facing an estimated shortfall of nearly 15,000 nurses by 2025 and a deficit of 6,200 physicians by 2030, fueled in part by pandemic burnout and by providers leaving the profession or retiring, as 52% of the almost 195,000 RNs in Illinois are over the age of 55 with 27% planning to retire in the next five years and less than 8,000 nurses graduating each year; and

WHEREAS, The Migration Policy Institute estimates that there are more than 12,000 Illinois residents with international healthcare degrees who are prohibited from providing care due to licensing or worker authorization; and

WHEREAS, The Service Employees International Union (SEIU) reports that many seniors in the Illinois Community Cares Program (CCP) are already going without the care they should receive due to a severe workforce shortage, and the number of authorized CCP hours not serviced has increased by 46%; much of the increased need for home care is associated with the increasing number of senior Illinoisans, a strong preference for in-home rather than nursing facility services, and a strong preference for culturally competent care; IDES projects that Illinois will need an additional 9,000 home care workers annually for each of the next ten years; and

WHEREAS, Despite the State's critical need for labor, nearly half a million Illinoisans who are undocumented are still unable to legally work; and

WHEREAS, Nearly 30% of Illinoisans who are undocumented have been residing and contributing to the workforce in the U.S. for over 20 years; and

WHEREAS, The majority of residents in Illinois who are undocumented reside in mixed status families with U.S. citizen and lawful permanent resident family members; and

WHEREAS, Long-term immigrant workers in Illinois who are undocumented empower key sectors of the economy, including manufacturing, farming, food production, senior/home care, child care, healthcare, education, construction, hospitality, and warehousing, contributing to our State's prosperity and also contributing approximately $1.5 billion in taxes per year; and

WHEREAS, Granting work permits will provide a significant public benefit to Illinois' economy by expanding the formal workforce to include all who have the eligibility to work, while increasing taxes paid to the State; and

WHEREAS, In the education sector alone, Illinois school districts report a high number of unfilled teaching and paraprofessional positions; and

WHEREAS, Teachers and paraprofessionals are essential for primary and secondary school students in our State, particularly for special education and bilingual students; and

WHEREAS, The existing worker shortage is so great that many school districts have been forced to contract workers directly from abroad, even though long-term immigrants are well-suited to fill these positions; and

WHEREAS, The exclusion from federal benefits leaves long-term immigrant workers who are undocumented and their families vulnerable and forces the State of Illinois to spend our tax dollars to provide critical health care and other benefits; and

WHEREAS, Granting work permits would allow workers to earn a fair wage and secure benefits, including health insurance; and

WHEREAS, Granting work permits would aid in the enforcement of existing labor laws, thereby reducing the exploitation of our lowest wage workers, the majority of whom are workers of color and immigrants; and

WHEREAS, Work permits would protect from deportation tens of thousands of students in Illinois who are undocumented and without the protection of Deferred Action for Childhood Arrivals (DACA) and would ensure that youth who are undocumented get the education they need to support themselves and their families and contribute to the State and national economies; and

WHEREAS, Illinois provides limited benefits and resources for individuals who are undocumented, including limited healthcare coverage for low-income qualifying immigrants, much of which would be unnecessary if the undocumented had work permits and could secure such benefits through their employment; and

WHEREAS, Despite the protections Illinois has enacted to protect long-term immigrant workers who are undocumented, they continue to be at risk of deportation, family separation, exploitation at work, and exclusion from health care and other benefits due to their immigration status, all of which negatively affects Illinois' economy and public safety and the quality-of-life in our communities; and

WHEREAS, For all these reasons, work permits for long-term immigrant workers would be a significant public benefit to the State of Illinois; and

WHEREAS, Only the federal government can issue work permits to people who are undocumented under its parole authority; therefore, be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE ONE HUNDRED THIRD GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, THE SENATE CONCURRING HEREIN, that we urge the President of the United States to authorize the DHS Secretary to establish a program to evaluate parole and work authorization on a case-by-case basis for long-term immigrant workers who are undocumented and residing in Illinois to address this State's critical need for labor and to secure the family life for tens of thousands of mixed status families in Illinois; and be it further

RESOLVED, That we urge the Governor to work with federal partners to urge, by all possible means, the establishment of such a parole and work authorization program for the long-term immigrant population who are undocumented and residing in Illinois; and be it further

RESOLVED, That suitable copies of this resolution be delivered to the Office of the President of the United States and to all members of the Illinois Congressional Delegation.

Adopted by the House, May 17, 2024.

JOHN W. HOLLMAN, Clerk of the House

The foregoing message from the House of Representatives reporting House Joint Resolution No. 69 was referred to the Committee on Assignments.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A FIRST TIME

House Bill No. 814, sponsored by Senator Harmon, was taken up, read by title a first time and referred to the Committee on Assignments.

House Bill No. 4567, sponsored by Senator Murphy, was taken up, read by title a first time and referred to the Committee on Assignments.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A SECOND TIME

On motion of Senator Bennett, **House Bill No. 4179** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Revenue, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 4179

AMENDMENT NO. 1 . Amend House Bill 4179 by replacing everything after the enacting clause with the following:

"Section 5. The Emergency Services Districts Act is amended by changing Sections 2.5, 4, 11, 11.3, 11.4, and 11.5 as follows:

(70 ILCS 2005/2.5)

Sec. 2.5. Rescue squad district continuance. A rescue squad district organized under this Act before January 1, 2024 (the effective date of Public Act 103-134) ~~this amendatory Act of the 103rd General Assembly~~ may (i) continue to be named a rescue squad district or be renamed an emergency services district by ordinance of the board of trustees of the district, (ii) operate under the provisions of this Act as if it was ~~they were~~ organized as an emergency services district, ~~and~~ (iii) continue exercising taxing authority granted to it that was approved before January 1, 2024, and (iv) for a district in counties other than Cook County, DuPage County, Kane County, Lake County, McHenry County, or Will County, increase, by referendum, the tax rate authorized by its organizational proposition under Section 4 by up to an additional 0.20%. However, the aggregate tax authorized to be levied for any one year under Section 4, including the amount levied under the organizational proposition, shall not exceed 0.20% of value for a district in Cook County, DuPage County, Kane County, Lake County, McHenry County, or Will County or 0.40% of value for a district in counties other than Cook County, DuPage County, Kane County, Lake County, McHenry County, or Will County, as equalized or assessed by the Department of Revenue. The taxes authorized under this Section may be used for any purpose allowed under this Act, including, but not limited to, ambulance service. ~~the~~

~~effective date of this amendatory Act of the 103rd General Assembly and the taxes may be used for any purpose allowed under this Act.~~

(Source: P.A. 103-134, eff. 1-1-24.)

(70 ILCS 2005/4) (from Ch. 85, par. 6854)

Sec. 4. The determination of the court as to the necessity for the organization of the proposed emergency services district, together with the description of the boundaries of the district as fixed by the court, shall be entered of record in the court. Thereupon the court shall certify the question of the organization of the territory included within the boundaries fixed by it as an emergency services district to the proper election officials, who shall submit the question to the legal voters resident within the territory at an election to be held in the district. Notice of the referendum shall be given and the referendum conducted in the manner provided by the general election law. The notice of the election shall state the purpose of the referendum, describe the territory proposed to be organized as an emergency services district, and state the time of the election.

The proposition shall be in substantially the following form:

Shall this territory (describing it) be organized as The ..... Emergency Services District and shall the District be authorized to levy and collect a property tax not to exceed [0.20%/0.40%, as applicable] ~~.20%~~ on the property situated in the District?	YES --- NO

The court shall cause a statement of the result to be entered of record in the court.

(Source: P.A. 103-134, eff. 1-1-24.)

(70 ILCS 2005/11)

Sec. 11. Property tax; fees.

(a) An emergency services district organized under this Act may levy and collect a general tax on the property situated in the district, but the aggregate amount of taxes levied for any one year under this Act shall not exceed the rate of 0.20% ~~.20%~~ of value for a district in Cook County, DuPage County, Kane County, Lake County, McHenry County, or Will County or 0.80% of value for a district in counties other than Cook County, DuPage County, Kane County, Lake County, McHenry County, or Will County, as equalized or assessed by the Department of Revenue. For a district in a county other than Cook County, DuPage County, Kane County, Lake County, McHenry County, or Will County, no more than half of the rate (0.40%) may be authorized under paragraph (iv) of Section 2.5, Section 4, or both and half of the rate (0.40%) under Section 11.5. The board of trustees shall determine and certify the amount to be levied and shall return the same to the county clerk. The limitation upon the tax rate may be increased or decreased under the referendum provisions of the General Revenue Law of Illinois.

In case the district is located in more than one county, the board of trustees shall determine and certify the amount to be levied upon the taxable property lying in each county and return the same to the respective county clerks of the counties in which the amount is to be levied. In order to determine the amount to be levied upon the taxable property of that part of the district lying in each county, the board shall ascertain from the county clerk of the respective counties in which the district lies the last ascertained equalized value of the taxable property of the district lying in their respective counties, then shall ascertain the rate per cent required and shall, accordingly, apportion the whole amount to be raised between the several parts of the district so lying in the different counties. The tax provided for in this Section shall be levied at the same time and in the same manner as nearly as practicable as taxes are now levied for municipal purposes under the laws of this State.

All general taxes under this Act, when collected, shall be paid over to the treasurer of the board of trustees, who is authorized to receive and receipt for the same.

(b) An emergency services ~~A rescue squad~~ district organized under this Act may fix, charge, and collect fees for district ~~rescue squad~~ services and ambulance services within or outside of the ~~rescue squad~~ district not exceeding the reasonable cost of the service.

(Source: P.A. 103-134, eff. 1-1-24; 103-174, eff. 6-30-23; revised 12-12-23.)

(70 ILCS 2005/11.3)

Sec. 11.3. Ambulance service.

(a) The board of trustees may provide ambulance service to or from points within or without the district, contract with providers of ambulance service, combine with other units of local government for the purpose of providing ambulance service, and adopt rules and regulations relating to ambulance service within the board's jurisdiction.

(b) The board of trustees may:

(1) contract with a private person, hospital, corporation, or another governmental unit for the provision and operation of ambulance service or subsidize the ambulance service;

(2) limit the number of ambulance services by referendum;

(3) within its jurisdiction, fix, charge, and collect fees for ambulance service within or outside of the ~~fire protection~~ district not exceeding the reasonable cost of the service; and

(4) establish necessary regulations not inconsistent with the statutes or regulations of the Department of Public Health relating to ambulance service.

The board of trustees may limit the number of ambulances under paragraph (2) or establish regulations under paragraph (4) if a referendum under Section 11.5 has been approved.

(Source: P.A. 103-134, eff. 1-1-24.)

(70 ILCS 2005/11.4)

Sec. 11.4. Charge for ambulance service.

(a) The board of trustees of a district may fix, charge, and collect fees not exceeding the reasonable cost of the service for ambulance services rendered by the district within or outside of the district ~~against persons who are not residents of the district and against businesses and other entities that are not located within the district~~.

(b) A fee charged to an individual patient under subsection (a) shall be computed at a rate not to exceed $250 per hour and not to exceed $70 per hour per ambulance worker responding to a call for assistance. This limitation does not apply to a third-party payer, and the third-party payer shall pay the charges set in subsection (a). An additional fee may be charged to reimburse the district for documented extraordinary expenses ~~of materials used~~ in rendering ambulance services up to the reasonable cost of the materials, personnel, and operating costs. No charge shall be made for services for which the total charge would be less than $50.

As used in this subsection, "third-party payer" means an entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier, and any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for health care services or products.

(c) All revenue from the fees charged under this Section shall be deposited to the district's general fund.

(Source: P.A. 103-134, eff. 1-1-24.)

(70 ILCS 2005/11.5)

Sec. 11.5. Ambulance service tax. Whenever the board of trustees of an emergency services district desires to levy a special tax to provide an ambulance service or support an existing ambulance service, it shall certify the question to the proper election officials, who shall submit that question at an election to the voters of the district. The result of the referendum shall be entered upon the records of the district. If a majority of the votes on the question are in favor of the question, the board of trustees may then levy a special tax at a rate not to exceed 0.40% of the value of all taxable property within the district as equalized or assessed by the Department of Revenue. The question shall be in substantially the following form:

Shall the .... Emergency Services District levy a special tax at a rate not to exceed 0.40% of the value of all taxable property within the district as equalized or assessed by the Department of Revenue for the purpose of providing or supporting an ambulance service?

YES

NO

The ~~A~~ tax levied under Section 4 ~~11~~ may be used for ambulance services as well as a tax levied under this Section. The aggregate percentage of all tax levies that a district may levy under this Act may not exceed the aggregate percentage limitation under Section 11.
(Source: P.A. 103-134, eff. 1-1-24.)

Section 99. Effective date. This Act takes effect upon becoming law.".

Floor Amendment Nos. 2 and 3 were held in the Committee on Revenue.
There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Porfirio, **House Bill No. 4426** was taken up, read by title a second time.
Committee Amendment No. 1 was held in the Committee on Judiciary.
Committee Amendment No. 2 was held in the Committee on Assignments.
Committee Amendment No. 3 was held in the Committee on Judiciary.
There being no further amendments, the bill was ordered to a third reading.

On motion of Senator Johnson, **House Bill No. 4491** having been printed, was taken up and read by title a second time.
The following amendment was offered in the Committee on Health and Human Services, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 4491

AMENDMENT NO. 1 . Amend House Bill 4491, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Child Care Act of 1969 is amended by changing Section 3 as follows:
(225 ILCS 10/3) (from Ch. 23, par. 2213)
Sec. 3. (a) No person, group of persons or corporation may operate or conduct any facility for child care, as defined in this Act, without a license or permit issued by the Department or without being approved by the Department as meeting the standards established for such licensing, with the exception of facilities for whom standards are established by the Department of Corrections under Section 3-15-2 of the Unified Code of Corrections and with the exception of facilities defined in Section 2.10 of this Act, and with the exception of programs or facilities licensed by the Department of Human Services under the Substance Use Disorder Act.
(b) No part day child care facility as described in Section 2.10 may operate without written notification to the Department or without complying with Section 7.1. Notification shall include a notarized statement by the facility that the facility complies with state or local health standards and state fire safety standards, and shall be filed with the department every 2 years.
(c) The Director of the Department shall establish policies and coordinate activities relating to child care licensing, licensing of day care homes and day care centers.
(d) Any facility or agency which is exempt from licensing may apply for licensing if licensing is required for some government benefit.
(e) A provider of day care described in items (a) through (j) of Section 2.09 of this Act is exempt from licensure. The Department shall provide written verification of exemption and description of compliance with standards for the health, safety, and development of the children who receive the services upon submission by the provider of, in addition to any other documentation required by the Department, a notarized statement that the facility complies with: (1) the standards of the Department of Public Health or local health department, (2) the fire safety standards of the State Fire Marshal, and (3) if operated in a public school building, the health and safety standards of the State Board of Education.
(f) Through June 30, 2029, either a qualified child care director, as described in 89 Ill. Adm. Code 407.130, or a qualified early childhood teacher, as described in 89 Ill. Adm. Code 407.140, with a minimum of 2,880 hours of experience as an early childhood teacher at the early childhood teacher's current facility must be present for the first and last hour of the workday and at the open or close of the facility. The Department shall adopt rules to implement this subsection. Such rules must be filed with the Joint Committee on Administrative Rules no later than January 1, 2025.
(Source: P.A. 99-699, eff. 7-29-16; 100-759, eff. 1-1-19.)

Section 99. Effective date. This Act takes effect upon becoming law.".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Martwick, **House Bill No. 4588** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Judiciary, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 4588

AMENDMENT NO. 1 . Amend House Bill 4588 by replacing everything after the enacting clause with the following:

"Section 5. The Regulatory Sunset Act is amended by changing Section 4.37 as follows:

(5 ILCS 80/4.37)

Sec. 4.37. Acts and Articles repealed on January 1, 2027. The following are repealed on January 1, 2027:

The Clinical Psychologist Licensing Act.

The Illinois Optometric Practice Act of 1987.

Articles II, III, IV, V, VI, VIIA, ~~VIIB,~~ VIIC, XVII, XXXI, and XXXI 1/4 of the Illinois Insurance Code.

The Boiler and Pressure Vessel Repairer Regulation Act.

The Marriage and Family Therapy Licensing Act.

The Boxing and Full-contact Martial Arts Act.

The Cemetery Oversight Act.

The Community Association Manager Licensing and Disciplinary Act.

The Detection of Deception Examiners Act.

The Home Inspector License Act.

The Massage Licensing Act.

The Medical Practice Act of 1987.

The Petroleum Equipment Contractors Licensing Act.

The Radiation Protection Act of 1990.

The Real Estate Appraiser Licensing Act of 2002.

The Registered Interior Designers Act.

The Landscape Architecture Registration Act.

The Water Well and Pump Installation Contractor's License Act.

The Licensed Certified Professional Midwife Practice Act.

(Source: P.A. 102-20, eff. 6-25-21; 102-284, eff. 8-6-21; 102-437, eff. 8-20-21; 102-656, eff. 8-27-21; 102-683, eff. 10-1-22; 102-813, eff. 5-13-22; 103-371, eff. 1-1-24.)

Section 10. The Illinois Insurance Code is amended by adding Section 123B-15 as follows:

(215 ILCS 5/123B-15 new)

Sec. 123B-15. Article repeal. This Article is repealed on January 1, 2057.

Section 99. Effective date. This Act takes effect upon becoming law.".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Loughran Cappel, **House Bill No. 5057** was taken up, read by title a second time.

Committee Amendment No. 1 was held in the Committee on Education.

Committee Amendment No. 2 was held in the Committee on Assignments.

The following amendment was offered in the Committee on Education, adopted and ordered printed:

AMENDMENT NO. 3 TO HOUSE BILL 5057

AMENDMENT NO. 3 . Amend House Bill 5057 by replacing everything after the enacting clause with the following:

"Section 5. The School Code is amended by changing Section 21B-30 as follows:

(105 ILCS 5/21B-30)

Sec. 21B-30. Educator testing.

(a) (Blank).

(b) The State Board of Education, in consultation with the State Educator Preparation and Licensure Board, shall design and implement a system of examinations, which shall be required prior to the issuance of educator licenses. These examinations and indicators must be based on national and State professional teaching standards, as determined by the State Board of Education, in consultation with the State Educator Preparation and Licensure Board. The State Board of Education may adopt such rules as may be necessary to implement and administer this Section.

(c) (Blank).

(c-5) The State Board must adopt rules to implement a paraprofessional competency test. This test would allow an applicant seeking an Educator License with Stipulations with a paraprofessional educator endorsement to obtain the endorsement if he or she passes the test and meets the other requirements of subparagraph (J) of paragraph (2) of Section 21B-20 other than the higher education requirements.

(d) All applicants seeking a State license shall be required to pass a test of content area knowledge for each area of endorsement for which there is an applicable test. There shall be no exception to this requirement. ~~No candidate shall be allowed to student teach or serve as the teacher of record until he or she has passed the applicable content area test.~~

(d-5) The State Board shall consult with any applicable vendors within 90 days after July 28, 2023 (the effective date of Public Act 103-402) ~~this amendatory Act of the 103rd General Assembly~~ to develop a plan to transition the test of content area knowledge in the endorsement area of elementary education, grades one through 6, by July 1, 2026 to a content area test that contains testing elements that cover bilingualism, biliteracy, oral language development, foundational literacy skills, and developmentally appropriate higher-order comprehension and on which a valid and reliable language and literacy subscore can be determined. The State Board shall base its rules concerning the passing subscore on the language and literacy portion of the test on the recommended cut-score determined in the formal standard-setting process. Candidates need not achieve a particular subscore in the area of language and literacy. The State Board shall aggregate and publish the number of candidates in each preparation program who take the test and the number who pass the language and literacy portion.

(e) (Blank).

(f) Beginning on August 4, 2023 (the effective date of Public Act 103-488) ~~this amendatory Act of the 103rd General Assembly~~ through August 31, 2025, no candidate completing a teacher preparation program in this State or candidate subject to Section 21B-35 of this Code is required to pass a teacher performance assessment. Except as otherwise provided in this Article, beginning on September 1, 2015 until August 4, 2023 (the effective date of Public Act 103-488) ~~this amendatory Act of the 103rd General Assembly~~ and beginning again on September 1, 2025, all candidates completing teacher preparation programs in this State and all candidates subject to Section 21B-35 of this Code are required to pass a teacher performance assessment approved by the State Board of Education, in consultation with the State Educator Preparation and Licensure Board. A candidate may not be required to submit test materials by video submission. Subject to appropriation, an individual who holds a Professional Educator License and is employed for a minimum of one school year by a school district designated as Tier 1 under Section 18-8.15 may, after application to the State Board, receive from the State Board a refund for any costs associated with completing the teacher performance assessment under this subsection.

(f-5) The Teacher Performance Assessment Task Force is created to evaluate potential performance-based and objective teacher performance assessment systems for implementation across all educator preparation programs in this State, with the intention of ensuring consistency across programs and supporting a thoughtful and well-rounded licensure system. Members appointed to the Task Force must reflect the racial, ethnic, and geographic diversity of this State. The Task Force shall consist of all of the following members:

(1) One member of the Senate, appointed by the President of the Senate.

(2) One member of the Senate, appointed by the Minority Leader of the Senate.

(3) One member of the House of Representatives, appointed by the Speaker of the House of Representatives.

(4) One member of the House of Representatives, appointed by the Minority Leader of the House of Representatives.

(5) One member who represents a statewide professional teachers' organization, appointed by the State Superintendent of Education.

(6) One member who represents a different statewide professional teachers' organization, appointed by the State Superintendent of Education.

(7) One member from a statewide organization representing school principals, appointed by the State Superintendent of Education.

(8) One member from a statewide organization representing regional superintendents of schools, appointed by the State Superintendent of Education.

(9) One member from a statewide organization representing school administrators, appointed by the State Superintendent of Education.

(10) One member representing a school district organized under Article 34 of this Code, appointed by the State Superintendent of Education.

(11) One member of an association representing rural and small schools, appointed by the State Superintendent of Education.

(12) One member representing a suburban school district, appointed by the State Superintendent of Education.

(13) One member from a statewide organization representing school districts in the southern suburbs of the City of Chicago, appointed by the State Superintendent of Education.

(14) One member from a statewide organization representing large unit school districts, appointed by the State Superintendent of Education.

(15) One member from a statewide organization representing school districts in the collar counties of the City of Chicago, appointed by the State Superintendent of Education.

(16) Three members, each representing a different public university in this State and each a current member of the faculty of an approved educator preparation program, appointed by the State Superintendent of Education.

(17) Three members, each representing a different 4-year nonpublic university or college in this State and each a current member of the faculty of an approved educator preparation program, appointed by the State Superintendent of Education.

(18) One member of the Board of Higher Education, appointed by the State Superintendent of Education.

(19) One member representing a statewide policy organization advocating on behalf of multilingual students and families, appointed by the State Superintendent of Education.

(20) One member representing a statewide organization focused on research-based education policy to support a school system that prepares all students for college, a career, and democratic citizenship, appointed by the State Superintendent of Education.

(21) Two members representing an early childhood advocacy organization, appointed by the State Superintendent of Education.

(22) One member representing a statewide organization that partners with educator preparation programs and school districts to support the growth and development of preservice teachers, appointed by the State Superintendent of Education.

(23) One member representing a statewide organization that advocates for educational equity and racial justice in schools, appointed by the State Superintendent of Education.

(24) One member representing a statewide organization that represents school boards, appointed by the State Superintendent of Education.

(25) One member who has, within the last 5 years, served as a cooperating teacher, appointed by the State Superintendent of Education.

Members of the Task Force shall serve without compensation. The Task Force shall first meet at the call of the State Superintendent of Education, and each subsequent meeting shall be called by the chairperson of the Task Force, who shall be designated by the State Superintendent of Education. The State Board of Education shall provide administrative and other support to the Task Force.

On or before October 31 ~~August 1~~, 2024, the Task Force shall report on its work, including recommendations on a teacher performance assessment system in this State, to the State Board of Education and the General Assembly. The Task Force is dissolved upon submission of this report.

(g) The content area knowledge test and the teacher performance assessment shall be the tests that from time to time are designated by the State Board of Education, in consultation with the State Educator Preparation and Licensure Board, and may be tests prepared by an educational testing organization or tests designed by the State Board of Education, in consultation with the State Educator Preparation and Licensure Board. The test of content area knowledge shall assess content knowledge in a specific subject field. The tests must be designed to be racially neutral to ensure that no person taking the tests is discriminated against on the basis of race, color, national origin, or other factors unrelated to the person's ability to perform as a licensed employee. The score required to pass the tests shall be fixed by the State Board of Education, in consultation with the State Educator Preparation and Licensure Board. The State Board of Education's rules for scoring the content area knowledge test may include scoring and retaking of each test section separately and independently. The tests shall be administered not fewer than 3 times a year at such time and place as may be designated by the State Board of Education, in consultation with the State Educator Preparation and Licensure Board.

The State Board shall implement a test or tests to assess the speaking, reading, writing, and grammar skills of applicants for an endorsement or a license issued under subdivision (G) of paragraph (2) of Section 21B-20 of this Code in the English language and in the language of the transitional bilingual education program requested by the applicant.

(h) Except as provided in Section 34-6 of this Code, the provisions of this Section shall apply equally in any school district subject to Article 34 of this Code.

(i) The rules developed to implement and enforce the testing requirements under this Section shall include, without limitation, provisions governing test selection, test validation, and determination of a passing score, administration of the tests, frequency of administration, applicant fees, frequency of applicants taking the tests, the years for which a score is valid, and appropriate special accommodations. The State Board of Education shall develop such rules as may be needed to ensure uniformity from year to year in the level of difficulty for each form of an assessment.

(Source: P.A. 102-301, eff. 8-26-21; 103-402, eff. 7-28-23; 103-488, eff. 8-4-23; revised 9-1-23.)

Section 99. Effective date. This Act takes effect upon becoming law.".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Halpin, **House Bill No. 5086** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Collins, **House Bill No. 5142** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Insurance, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 5142

AMENDMENT NO. 1 . Amend House Bill 5142 on page 12, by replacing lines 1 and 2 with "beginning January 1, 2023, licensed certified professional midwife services and, beginning January 1, 2025, certified professional midwife services shall be covered under the".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Peters, **House Bill No. 5395** was taken up, read by title a second time.

Committee Amendment No. 1 was held in the Committee on Insurance.

The following amendment was offered in the Committee on Insurance, adopted and ordered printed:

AMENDMENT NO. 2 TO HOUSE BILL 5395

AMENDMENT NO. 2 . Amend House Bill 5395 by replacing everything after the enacting clause with the following:

"Article 1.

Section 1-1. This Act may be referred to as the Health Care Protection Act.

Article 2.

Section 2-5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.55 as follows:

(5 ILCS 100/5-45.55 new)

Sec. 5-45.55. Emergency rulemaking; Network Adequacy and Transparency Act. To provide for the expeditious and timely implementation of the Network Adequacy and Transparency Act, emergency rules implementing federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated by the Department of Insurance and are more stringent than the State standards extant at the time the final federal standards are published may be adopted in accordance with Section 5-45 by the Department of Insurance. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

Section 2-10. The Network Adequacy and Transparency Act is amended by changing Sections 3, 5, 10, 15, 20, 25, and 30 and by adding Sections 35, 36, 40, 50, and 55 as follows:

(215 ILCS 124/3)

Sec. 3. Applicability of Act. This Act applies to an individual or group policy of ~~accident and~~ health insurance coverage with a network plan amended, delivered, issued, or renewed in this State on or after January 1, 2019. This Act does not apply to an individual or group policy for excepted benefits or short-term, limited-duration health insurance coverage ~~dental or vision insurance or a limited health service organization~~ with a network plan amended, delivered, issued, or renewed in this State on or after January 1, 2019, except to the extent that federal law establishes network adequacy and transparency standards for stand-alone dental plans, which the Department shall enforce for plans amended, delivered, issued, or renewed on or after January 1, 2025.

(Source: P.A. 100-502, eff. 9-15-17; 100-601, eff. 6-29-18.)

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a beneficiary has given express written consent to represent the beneficiary; a person authorized by law to provide substituted consent for a beneficiary; or the beneficiary's treating provider only when the beneficiary or his or her family member is unable to provide consent.

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an issuer ~~insurer~~.

"Department" means the Department of Insurance.

"Essential community provider" has the meaning ascribed to that term in 45 CFR 156.235.

"Excepted benefits" has the meaning ascribed to that term in 42 U.S.C. 300gg-91(c) and implementing regulations. "Excepted benefits" includes individual, group, or blanket coverage.

"Exchange" has the meaning ascribed to that term in 45 CFR 155.20.

"Director" means the Director of Insurance.

"Family caregiver" means a relative, partner, friend, or neighbor who has a significant relationship with the patient and administers or assists the patient with activities of daily living, instrumental activities of daily living, or other medical or nursing tasks for the quality and welfare of that patient.

"Group health plan" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance coverage" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Health insurance coverage" does not include any coverage or benefits under Medicare or under the medical assistance program established under Article V of the Illinois Public Aid Code.

"Issuer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

~~"Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers compensation insurance, and pharmacy benefit managers.~~

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers within any county, the removal of a major health system that causes a network to be significantly different within any county from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

"Network" means the group or groups of preferred providers providing services to a network plan.

"Network plan" means an individual or group policy of ~~accident and~~ health insurance coverage that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the issuer or by a third party contracted to arrange, contract for, or administer such provider-related incentives for the issuer ~~insurer~~.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, ~~or~~ post-operative visits, or a serious and complex condition as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of treatment for a health condition that a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; ~~or~~ (4) the third trimester of pregnancy through the post-partum period; (5) undergoing a course of institutional or inpatient care from the provider within the meaning of 42 U.S.C. 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective surgery from the provider, including receipt of preoperative or postoperative care from such provider with respect to such a surgery; (7) being determined to be terminally ill, as determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving treatment for such illness from such provider; or (8) any other treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a provider because of the potential for changes in the therapeutic regimen or because of the potential for a recurrence of symptoms.

"Preferred provider" means any provider who has entered, either directly or indirectly, into an agreement with an employer or risk-bearing entity relating to health care services that may be rendered to beneficiaries under a network plan.

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions or facilities that provide health care services.

"Short-term, limited-duration insurance" means any type of accident and health insurance offered or provided within this State pursuant to a group or individual policy or individual certificate by a company, regardless of the situs state of the delivery of the policy, that has an expiration date specified in the contract that is fewer than 365 days after the original effective date. Regardless of the duration of coverage, "short-term, limited-duration insurance" does not include excepted benefits or any student health insurance coverage.

"Stand-alone dental plan" has the meaning ascribed to that term in 45 CFR 156.400.

"Telehealth" has the meaning given to that term in Section 356z.22 of the Illinois Insurance Code.

"Telemedicine" has the meaning given to that term in Section 49.5 of the Medical Practice Act of 1987.

"Tiered network" means a network that identifies and groups some or all types of provider and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

"Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology, or family practice.

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

(215 ILCS 124/10)

Sec. 10. Network adequacy.

(a) Before issuing, delivering, or renewing a network plan, an issuer ~~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 issuer ~~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 issuer ~~insurer~~ 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 ~~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 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 ~~insurer~~ 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. 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 ~~network plan~~ 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 ~~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) 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 ~~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).

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 ~~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. Issuers ~~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 issuer ~~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.

(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 ~~insurers~~ 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 ~~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 issuer ~~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 issuer ~~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) Issuers ~~Insurers~~ 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 ~~insurer~~, 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.)

(215 ILCS 124/15)

Sec. 15. Notice of nonrenewal or termination.

(a) A network plan must give at least 60 days' notice of nonrenewal or termination of a provider to the provider and to the beneficiaries served by the provider. The notice shall include a name and address to which a beneficiary or provider may direct comments and concerns regarding the nonrenewal or termination and the telephone number maintained by the Department for consumer complaints. Immediate written notice may be provided without 60 days' notice when a provider's license has been disciplined by a State licensing board or when the network plan reasonably believes direct imminent physical harm to patients under the provider's ~~providers~~ care may occur. The notice to the beneficiary shall provide the individual with an opportunity to notify the issuer of the individual's need for transitional care.

(b) Primary care providers must notify active affected patients of nonrenewal or termination of the provider from the network plan, except in the case of incapacitation.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/20)

Sec. 20. Transition of services.

(a) A network plan shall provide for continuity of care for its beneficiaries as follows:

(1) If a beneficiary's ~~physician or hospital~~ provider leaves the network plan's network of providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider remains within the network plan's service area, if benefits provided under such network plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan, or if a contract between a group health plan and a health insurance issuer offering a network plan in connection with the group health plan is terminated and results in a loss of benefits provided under such plan with respect to such provider, then the network plan shall permit the beneficiary to continue an ongoing course of treatment with that provider during a transitional period for the following duration:

(A) 90 days from the date of the notice to the beneficiary of the provider's disaffiliation from the network plan if the beneficiary has an ongoing course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the time of the provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

(2) Notwithstanding the provisions of paragraph (1) of this subsection (a), such care shall be authorized by the network plan during the transitional period in accordance with the following:

(A) the provider receives continued reimbursement from the network plan at the rates and terms and conditions applicable under the terminated contract prior to the start of the transitional period;

(B) the provider adheres to the network plan's quality assurance requirements, including provision to the network plan of necessary medical information related to such care; and

(C) the provider otherwise adheres to the network plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorizations for treatment.

(3) The provisions of this Section governing health care provided during the transition period do not apply if the beneficiary has successfully transitioned to another provider participating in the network plan, if the beneficiary has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary.

(b) A network plan shall provide for continuity of care for new beneficiaries as follows:

(1) If a new beneficiary whose provider is not a member of the network plan's provider network, but is within the network plan's service area, enrolls in the network plan, the network plan shall permit the beneficiary to continue an ongoing course of treatment with the beneficiary's current physician during a transitional period:

(A) of 90 days from the effective date of enrollment if the beneficiary has an ongoing course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.

(2) If a beneficiary, or a beneficiary's authorized representative, elects in writing to continue to receive care from such provider pursuant to paragraph (1) of this subsection (b), such care shall be authorized by the network plan for the transitional period in accordance with the following:

(A) the provider receives reimbursement from the network plan at rates established by the network plan;

(B) the provider adheres to the network plan's quality assurance requirements, including provision to the network plan of necessary medical information related to such care; and

(C) the provider otherwise adheres to the network plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorization for treatment.

(3) The provisions of this Section governing health care provided during the transition period do not apply if the beneficiary has successfully transitioned to another provider participating in the network plan, if the beneficiary has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary.

(c) In no event shall this Section be construed to require a network plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the beneficiary's contract.

(d) A provider shall comply with the requirements of 42 U.S.C. 300gg-138.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/25)

Sec. 25. Network transparency.

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of $5,000 per month. ~~The network plan shall update the online provider directory at least monthly.~~ Providers shall notify the network plan electronically or in writing within 10 business days of any changes to their information as listed in the provider directory, including the information required in subsections (b), (c), and (d) ~~subparagraph (K) of paragraph (1) of subsection (b)~~. With regard to subparagraph (I) of paragraph (1) of subsection (b), the provider must give notice to the issuer within 20 business days of deciding to cease accepting new patients covered by the plan if the new patient limitation is expected to last 40 business days or longer. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 2 ~~10~~ business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) At least once every 90 days, the issuer shall self-audit each network plan's ~~The network plan shall audit periodically at least 25% of its~~ provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The issuer shall submit the self-audit and a summary

to the Department, and the Department shall make the summary of each self-audit publicly available. The Department shall specify the requirements of the summary, which shall be statistical in nature except for a high-level narrative evaluating the impact of internal and external factors on the accuracy of the directory and the timeliness of updates. ~~The network plan shall submit the audit to the Director upon request.~~ As part of these self-audits ~~audits~~, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network. The self-audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

(4) A network plan shall provide a print copy of a current provider directory or a print copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. Except when an issuer's print copies use the same provider information as the electronic provider directory on each print copy's date of printing, print ~~Print~~ copies must be updated at least every 90 days ~~quarterly~~ and ~~an~~ errata that reflects changes in the provider network must be included in each update ~~updated quarterly~~.

(5) For each network plan, a network plan shall include, in plain language in both the electronic and print directory, the following general information:

(A) in plain language, a description of the criteria the plan has used to build its provider network;

(B) if applicable, in plain language, a description of the criteria the issuer ~~insurer~~ or network plan has used to create tiered networks;

(C) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a beneficiary-covered person or a prospective beneficiary-covered person to be able to identify the provider tier; ~~and~~

(D) if applicable, a notation that authorization or referral may be required to access some providers;~~.~~

(E) a telephone number and email address for a customer service representative to whom directory inaccuracies may be reported; and

(F) a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute such charges.

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) patient population served (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients;

(J) board certifications, if applicable; ~~and~~

(K) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(L) whether the health care professional accepts appointment requests from patients; and

(M) the anticipated date the provider will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms that the provider is scheduled to leave the network;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer);

(C) participating hospital location; ~~and~~

(D) hospital accreditation status; and

(E) the anticipated date the hospital will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the hospital is scheduled to leave the network; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; ~~and~~

(D) participating facility location or locations; and~~.~~

(E) the anticipated date the facility will leave the network, if applicable, which shall be included no more than 10 days after the issuer confirms the facility is scheduled to leave the network.

(c) For the electronic provider directories, for each network plan, a network plan shall make available all of the following information in addition to the searchable information required in this Section:

(1) for health care professionals:

(A) contact information, including both a telephone number and digital contact information if the provider has supplied digital contact information; and

(B) languages spoken other than English by clinical staff, if applicable;

(2) for hospitals, telephone number and digital contact information; and

(3) for facilities other than hospitals, telephone number.

(d) The issuer ~~insurer~~ or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) for health care professionals:

(A) name;

(B) contact information, including a telephone number and digital contact information if the provider has supplied digital contact information;

(C) participating office location or locations;

(D) patient population (such as pediatric, adult, elderly, or women) and specialty or subspecialty, if applicable;

(E) languages spoken other than English, if applicable;

(F) whether accepting new patients; ~~and~~

(G) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent; and

(H) whether the health care professional accepts appointment requests from patients.

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer); and

(C) participating hospital location, ~~and~~ telephone number, and digital contact information; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) patient population (such as pediatric, adult, elderly, or women) served, if applicable, and types of services performed; and

(D) participating facility location or locations, ~~and~~ telephone numbers, and digital contact information for each location.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the issuer's ~~insurer's~~ electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number and email address in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information or report provider directory inaccuracies. The printed provider directory shall include a detailed description of the process to dispute charges for out-of-network providers, hospitals, or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute those charges.

(f) The Director may conduct periodic audits of the accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(g) To the extent not otherwise provided in this Act, an issuer shall comply with the requirements of 42 U.S.C. 300gg-115, except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Section.

(h) If the issuer or the Department identifies a provider incorrectly listed in the provider directory, the issuer shall check each of the issuer's network plan provider directories for the provider within 2 business days to ascertain whether the provider is a preferred provider in that network plan and, if the provider is incorrectly listed in the provider directory, remove the provider from the provider directory without delay.

(i) If the Director determines that an issuer violated this Section, the Director may assess a fine up to $5,000 per violation, except for inaccurate information given by a provider to the issuer. If an issuer, or any entity or person acting on the issuer's behalf, knew or reasonably should have known that a provider was incorrectly included in a provider directory, the Director may assess a fine of up to $25,000 per violation against the issuer.

(j) This Section applies to network plans not otherwise exempt under Section 3, including stand-alone dental plans.

(Source: P.A. 102-92, eff. 7-9-21; revised 9-26-23.)

(215 ILCS 124/30)

Sec. 30. Administration and enforcement.

(a) Issuers ~~Insurers~~, as defined in this Act, have a continuing obligation to comply with the requirements of this Act. Other than the duties specifically created in this Act, nothing in this Act is intended to preclude, prevent, or require the adoption, modification, or termination of any utilization management, quality management, or claims processing methodologies of an issuer ~~insurer~~.

(b) Nothing in this Act precludes, prevents, or requires the adoption, modification, or termination of any network plan term, benefit, coverage or eligibility provision, or payment methodology.

(c) The Director shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law.

(d) The Department shall adopt rules to enforce compliance with this Act to the extent necessary.

(e) In accordance with Section 5-45 of the Illinois Administrative Procedure Act, the Department may adopt emergency rules to implement federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated by the Department and are more stringent than the State standards extant at the time the final federal standards are published.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/35 new)

Sec. 35. Provider requirements. Providers shall comply with 42 U.S.C. 300gg-138 and 300gg-139 and the regulations promulgated thereunder, as well as Section 20, paragraph (2) of subsection (a) of Section 25, subsections (h) and (j) of Section 25, and Section 36 of this Act, except that "provider directory information" includes all information required to be included in a provider directory pursuant to Section 25 of this Act.

(215 ILCS 124/36 new)

Sec. 36. Complaint of incorrect charges.

(a) A beneficiary who, taking into account the reimbursement, if any, by the issuer, incurs a cost in excess of the in-network cost-sharing for a covered service from a provider, facility, or hospital that was listed as in-network in the plan's provider directory prior to or at the time of the provision of services may file a complaint with the Department. The Department shall investigate the complaint and determine if the provider was incorrectly included in the plan's provider directory when the beneficiary made the appointment or received the service.

(b) Upon the Department's confirmation of the allegations in the complaint that the beneficiary incurred a cost in excess of the in-network cost-sharing for covered services provided by an incorrectly included provider when the appointment was made or service was provided, the issuer shall reimburse the beneficiary for all costs incurred in excess of the in-network cost-sharing. However, if the issuer has paid the claim to the provider directly, the issuer shall notify the beneficiary and the provider of the beneficiary's right to reimbursement from the provider for any payments in excess of the in-network cost-sharing amount pursuant to 42 U.S.C. 300gg-139(b), and the issuer's notice shall specify the in-network cost-sharing amount for the covered services. The amounts paid by the beneficiary within the in-network cost-sharing amount shall apply towards the in-network deductible and out-of-pocket maximum, if any.

(215 ILCS 124/40 new)

Sec. 40. Confidentiality.

(a) All records in the custody or possession of the Department are presumed to be open to public inspection or copying unless exempt from disclosure by Section 7 or 7.5 of the Freedom of Information Act. Except as otherwise provided in this Section or other applicable law, the filings required under this Act shall be open to public inspection or copying.

(b) The following information shall not be deemed confidential:

(1) actual or projected ratios of providers to beneficiaries;

(2) actual or projected time and distance between network providers and beneficiaries or actual or projected waiting times for a beneficiary to see a network provider;

(3) geographic maps of network providers;

(4) requests for exceptions under subsection (g) of Section 10, except with respect to any discussion of ongoing or planned contractual negotiations with providers that the issuer requests to be treated as confidential;

(5) provider directories and provider lists;

(6) self-audit summaries required under paragraph (3) of subsection (a) of Section 25 of this Act; and

(7) issuer or Department statements of determination as to whether a network plan has satisfied this Act's requirements regarding the information described in this subsection.

(c) An issuer's work papers and reports on the results of a self-audit of its provider directories, including any communications between the issuer and the Department, shall remain confidential unless expressly waived by the issuer or unless deemed public information under federal law.

(d) The filings required under Section 10 of this Act shall be confidential while they remain under the Department's review but shall become open to public inspection and copying upon completion of the review, except as provided in this Section or under other applicable law.

(e) Nothing in this Section shall supersede the statutory requirement that work papers obtained during a market conduct examination be deemed confidential.

(215 ILCS 124/50 new)

Sec. 50. Funds for enforcement. Moneys from fines and penalties collected from issuers for violations of this Act shall be deposited into the Insurance Producer Administration Fund for appropriation by the General Assembly to the Department to be used for providing financial support of the Department's enforcement of this Act.

(215 ILCS 124/55 new)

Sec. 55. Uniform electronic provider directory information notification forms.

(a) On or before January 1, 2026, the Department shall develop and publish a uniform electronic provider directory information form that issuers shall make available to onboarding, current, and former preferred providers to notify the issuer of the provider's currently accurate provider directory information under Section 25 of this Act and 42 U.S.C. 300gg-139. The form shall address information needed from newly onboarding preferred providers, updates to previously supplied provider directory information, reporting an inaccurate directory entry of previously supplied information, contract terminations, and differences in information for specific network plans offered by an issuer, such as whether the provider is a preferred provider for the network plan or is accepting new patients under that plan. The Department shall allow issuers to implement this form through either a PDF or a web portal that requests the same information.

(b) Notwithstanding any other provision of law to the contrary, beginning 6 months after the Department publishes the uniform electronic provider directory information form and no later than July 1, 2026, every provider must use the uniform electronic provider directory information form to notify issuers of their provider directory information as required under Section 25 of this Act and 42 U.S.C. 300gg-139. Issuers shall accept this form as sufficient to update their provider directories. Issuers shall not accept paper or fax submissions of provider directory information from providers.

(c) The Uniform Electronic Provider Directory Information Form Task Force is created. The purpose of this task force is to provide input and advice to the Department of Insurance in the development of a uniform electronic provider directory information form. The task force shall include at least the following individuals:

(1) the Director of Insurance or a designee, as chair;

(2) the Marketplace Director or a designee;

(3) the Director of the Division of Professional Regulation or a designee;

(4) the Director of Public Health or a designee;

(5) the Secretary of Innovation and Technology or a designee;

(6) the Director of Healthcare and Family Services or a designee;

(7) the following individuals appointed by the Director:

(A) one representative of a statewide association representing physicians;

(B) one representative of a statewide association representing nurses;

(C) one representative of a statewide organization representing a majority of Illinois hospitals;

(D) one representative of a statewide organization representing Illinois pharmacies;

(E) one representative of a statewide organization representing mental health care providers;

(F) one representative of a statewide organization representing substance use disorder health care providers;

(G) 2 representatives of health insurance issuers doing business in this State or issuer trade associations, at least one of which represents a State-domiciled mutual health insurance company, with a demonstrated expertise in the business of health insurance or health benefits administration; and

(H) 2 representatives of a health insurance consumer advocacy group.

(d) The Department shall convene the task force described in this Section no later than April 1, 2025.

(e) The Department, in development of the uniform electronic provider directory information form, and the task force, in offering input, shall take into consideration the following:

(1) readability and user experience;

(2) interoperability;

(3) existing regulations established by the federal Centers for Medicare and Medicaid Services, the Department of Insurance, the Department of Healthcare and Family Service, the Department of Financial and Professional Regulation, and the Department of Public Health;

(4) potential opportunities to avoid duplication of data collection efforts, including, but not limited to, opportunities related to:

(A) integrating any provider reporting required under Section 25 of this Act and 42 U.S.C. 300gg-139 with the provider reporting required under the Health Care Professional Credentials Data Collection Act;

(B) furnishing information to any national provider directory established by the federal Centers for Medicare and Medicaid Services or another federal agency with jurisdiction over health care providers; and

(C) furnishing information in compliance with the Patients' Right to Know Act;

(5) compatibility with the Illinois Health Benefits Exchange;

(6) provider licensing requirements and forms; and

(7) information needed to classify a provider under any specialty type for which a network adequacy standard may be established under this Act when a specialty board certification or State license does not currently exist.

Section 2-15. The Managed Care Reform and Patient Rights Act is amended by changing Sections 20 and 25 as follows:

(215 ILCS 134/20)

Sec. 20. Notice of nonrenewal or termination. A health care plan must give at least 60 days notice of nonrenewal or termination of a health care provider to the health care provider and to the enrollees served by the health care provider. The notice shall include a name and address to which an enrollee or health care provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days notice when a health care provider's license has been disciplined by a State licensing board. The notice to the enrollee shall provide the individual with an opportunity to notify the health care plan of the individual's need for transitional care.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 134/25)

Sec. 25. Transition of services.

(a) A health care plan shall provide for continuity of care for its enrollees as follows:

(1) If an enrollee's health care provider ~~physician~~ leaves the health care plan's network of health care providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider ~~physician~~ remains within the health care plan's service area, or if benefits provided under such health care plan with respect to such provider are terminated because of a change in the terms of the participation of such provider in such plan, or if a contract between a group health plan, as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act, and a health care plan offered in connection with the group health plan is terminated and results in a loss of benefits provided under such plan with respect to such provider, the health care plan shall permit the enrollee to continue an ongoing course of treatment with that provider ~~physician~~ during a transitional period:

(A) of 90 days from the date of the notice of provider's ~~physician's~~ termination from the health care plan to the enrollee of the provider's ~~physician's~~ disaffiliation from the health care plan if the enrollee has an ongoing course of treatment; or

(B) if the enrollee has entered the third trimester of pregnancy at the time of the provider's ~~physician's~~ disaffiliation, that includes the provision of post-partum care directly related to the delivery.

(2) Notwithstanding the provisions in item (1) of this subsection, such care shall be authorized by the health care plan during the transitional period only if the provider ~~physician~~ agrees:

(A) to continue to accept reimbursement from the health care plan at the rates applicable prior to the start of the transitional period;

(B) to adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to such care; and

(C) to otherwise adhere to the health care plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorizations for treatment.

(3) During an enrollee's plan year, a health care plan shall not remove a drug from its formulary or negatively change its preferred or cost-tier sharing unless, at least 60 days before making the formulary change, the health care plan:

(A) provides general notification of the change in its formulary to current and prospective enrollees;

(B) directly notifies enrollees currently receiving coverage for the drug, including information on the specific drugs involved and the steps they may take to request coverage determinations and exceptions, including a statement that a certification of medical necessity by

the enrollee's prescribing provider will result in continuation of coverage at the existing level; and

(C) directly notifies in writing ~~by first class mail and~~ through an electronic transmission~~, if available,~~ the prescribing provider of all health care plan enrollees currently prescribed the drug affected by the proposed change; the notice shall include a one-page form by which the prescribing provider can notify the health care plan in writing or electronically ~~by first class mail~~ that coverage of the drug for the enrollee is medically necessary.

The notification in paragraph (C) may direct the prescribing provider to an electronic portal through which the prescribing provider may electronically file a certification to the health care plan that coverage of the drug for the enrollee is medically necessary. The prescribing provider may make a secure electronic signature beside the words "certification of medical necessity", and this certification shall authorize continuation of coverage for the drug.

If the prescribing provider certifies to the health care plan either in writing or electronically that the drug is medically necessary for the enrollee as provided in paragraph (C), a health care plan shall authorize coverage for the drug prescribed based solely on the prescribing provider's assertion that coverage is medically necessary, and the health care plan is prohibited from making modifications to the coverage related to the covered drug, including, but not limited to:

(i) increasing the out-of-pocket costs for the covered drug;

(ii) moving the covered drug to a more restrictive tier; or

(iii) denying an enrollee coverage of the drug for which the enrollee has been previously approved for coverage by the health care plan.

Nothing in this item (3) prevents a health care plan from removing a drug from its formulary or denying an enrollee coverage if the United States Food and Drug Administration has issued a statement about the drug that calls into question the clinical safety of the drug, the drug manufacturer has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by Section 506C of the Federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. 356c, or the drug manufacturer has removed the drug from the market.

Nothing in this item (3) prohibits a health care plan, by contract, written policy or procedure, or any other agreement or course of conduct, from requiring a pharmacist to effect substitutions of prescription drugs consistent with Section 19.5 of the Pharmacy Practice Act, under which a pharmacist may substitute an interchangeable biologic for a prescribed biologic product, and Section 25 of the Pharmacy Practice Act, under which a pharmacist may select a generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration and in accordance with the Illinois Food, Drug and Cosmetic Act.

This item (3) applies to a policy or contract that is amended, delivered, issued, or renewed on or after January 1, 2019. This item (3) does not apply to a health plan as defined in the State Employees Group Insurance Act of 1971 or medical assistance under Article V of the Illinois Public Aid Code.

(b) A health care plan shall provide for continuity of care for new enrollees as follows:

(1) If a new enrollee whose physician is not a member of the health care plan's provider network, but is within the health care plan's service area, enrolls in the health care plan, the health care plan shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current physician during a transitional period:

(A) of 90 days from the effective date of enrollment if the enrollee has an ongoing course of treatment; or

(B) if the enrollee has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.

(2) If an enrollee elects to continue to receive care from such physician pursuant to item (1) of this subsection, such care shall be authorized by the health care plan for the transitional period only if the physician agrees:

(A) to accept reimbursement from the health care plan at rates established by the health care plan; such rates shall be the level of reimbursement applicable to similar physicians within the health care plan for such services;

(B) to adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to such care; and

(C) to otherwise adhere to the health care plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining preauthorization for treatment.

(c) In no event shall this Section be construed to require a health care plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the enrollee's contract. In no event shall this Section be construed to prohibit the addition of prescription drugs to a health care plan's list of covered drugs during the coverage year.

(d) In this Section, "ongoing course of treatment" has the meaning ascribed to that term in Section 5 of the Network Adequacy and Transparency Act.

(Source: P.A. 100-1052, eff. 8-24-18.)

Article 3.

Section 3-5. The Illinois Insurance Code is amended by changing Section 355 as follows:

(215 ILCS 5/355) (from Ch. 73, par. 967)

Sec. 355. Accident and health policies; provisions.

(a) As used in this Section:

"Inadequate rate" means a rate:

(1) that is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) the continued use of which endangers the solvency of an insurer using that rate.

"Large employer" has the meaning provided in the Illinois Health Insurance Portability and Accountability Act.

"Plain language" has the meaning provided in the federal Plain Writing Act of 2010 and subsequent guidance documents, including the Federal Plain Language Guidelines.

"Unreasonable rate increase" means a rate increase that the Director determines to be excessive, unjustified, or unfairly discriminatory in accordance with 45 CFR 154.205.

(b) No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143. If the Director disapproves the policy form, he or she shall make a written decision stating the respects in which such form does not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form. On and after January 1, 2025, any form filing submitted for large employer group accident and health insurance shall be automatically deemed approved within 90 days of the submission date unless the Director extends by not more than an additional 30 days the period within which the form shall be approved or disapproved by giving written notice to the insurer of such extension before the expiration of the 90 days. Any form in receipt of such an extension shall be automatically deemed approved within 120 days of the submission date. The Director may toll the filing due to a conflict in legal interpretation of federal or State law as long as the tolling is applied uniformly to all applicable forms, written notification is provided to the insurer prior to the tolling, the duration of the tolling is provided within the notice to the insurer, and justification for the tolling is posted to the Department's website. The Director may disapprove the filing if the insurer fails to respond to an objection or request for additional information within the timeframe identified for response. As used in this subsection, "large employer" has the meaning given in Section 5 of the federal Health Insurance Portability and Accountability Act.

(c) For plan year 2026 and thereafter, premium rates for all individual and small group accident and health insurance policies must be filed with the Department for approval. Unreasonable rate increases or inadequate rates shall be modified or disapproved. For any plan year during which the Illinois Health Benefits Exchange operates as a full State-based exchange, the Department shall provide insurers at least 30 days' notice of the deadline to submit rate filings.

(c-5) Unless prohibited under federal law, for plan year 2026 and thereafter, each insurer proposing to offer a qualified health plan issued in the individual market through the Illinois Health Benefits Exchange must incorporate the following approach in its rate filing under this Section:

(1) The rate filing must apply a cost-sharing reduction defunding adjustment factor within a range that:

(A) is uniform across all insurers;

(B) is consistent with the total adjustment expected to be needed to cover actual cost-sharing reduction costs across all silver plans on the Illinois Health Benefits Exchange statewide, provided that such costs are calculated assuming utilization by the State's full individual-market risk pool; and

(C) assumes that the only on-Exchange silver plans that will be purchased are the 87% and 94% cost-sharing reduction variations.

(2) The rate filing must apply an induced demand factor based on the following formula: (Plan Actuarial Value)^2 - (Plan Actuarial Value) + 1.24.

In the annual notice to insurers described in subsection (c), the Department must include the specific numerical range calculated for the applicable plan year under paragraph (1) of this subsection (c-5) and the formula in paragraph (2) of this subsection (c-5).

(d) For plan year 2025 and thereafter, the Department shall post all insurers' rate filings and summaries on the Department's website 5 business days after the rate filing deadline set by the Department in annual guidance. The rate filings and summaries posted to the Department's website shall exclude information that is proprietary or trade secret information protected under paragraph (g) of subsection (1) of Section 7 of the Freedom of Information Act or confidential or privileged under any applicable insurance law or rule. All summaries shall include a brief justification of any rate increase or decrease requested, including the number of individual members, the medical loss ratio, medical trend, administrative costs, and any other information required by rule. The plain writing summary shall include notification of the public comment period established in subsection (e).

(e) The Department shall open a 30-day public comment period on the rate filings beginning on the date that all of the rate filings are posted on the Department's website. The Department shall post all of the comments received to the Department's website within 5 business days after the comment period ends.

(f) After the close of the public comment period described in subsection (e), the Department, beginning for plan year 2026, shall issue a decision to approve, disapprove, or modify a rate filing within 60 days. Any rate filing or any rates within a filing on which the Director does not issue a decision within 60 days shall automatically be deemed approved. The Director's decision shall take into account the actuarial justifications and public comments. The Department shall notify the insurer of the decision, make the decision available to the public by posting it on the Department's website, and include an explanation of the findings, actuarial justifications, and rationale that are the basis for the decision. Any company whose rate has been modified or disapproved shall be allowed to request a hearing within 10 days after the action taken. The action of the Director in disapproving a rate shall be subject to judicial review under the Administrative Review Law.

(g) If, following the issuance of a decision but before the effective date of the premium rates approved by the decision, an event occurs that materially affects the Director's decision to approve, deny, or modify the rates, the Director may consider supplemental facts or data reasonably related to the event.

(h) The Department shall adopt rules implementing the procedures described in subsections (d) through (g) by March 31, 2024.

(i) Subsection (a) and subsections (c) through (h) of this Section do not apply to grandfathered health plans as defined in 45 CFR 147.140; excepted benefits as defined in 42 U.S.C. 300gg-91; student health insurance coverage as defined in 45 CFR 147.145; the large group market as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act; or short-term, limited-duration health insurance coverage as defined in Section 5 of the Short-Term, Limited-Duration Health Insurance Coverage Act. For a filing of premium rates or classifications of risk for any of these types of coverage, the Director's initial review period shall not exceed 60 days to issue informal objections to the company that request additional clarification, explanation, substantiating documentation, or correction of concerns identified in the filing before the company implements the premium rates, classifications, or related rate-setting methodologies described in the filing, except that the Director may extend by not more than an additional 30 days the period of initial review by giving written notice to the company of such extension before the expiration of the initial 60-day period. Nothing in this subsection shall confer authority upon the Director to approve, modify, or disapprove rates where that authority is not provided by other law. Nothing in this subsection shall prohibit the Director from conducting any investigation, examination, hearing, or other formal administrative or enforcement proceeding with respect to a company's rate filing or implementation thereof under applicable law at any time, including after the period of initial review.

(Source: P.A. 103-106, eff. 1-1-24.)

Section 3-10. The Illinois Health Benefits Exchange Law is amended by changing Section 5-5 as follows:

(215 ILCS 122/5-5)

Sec. 5-5. State health benefits exchange. It is declared that this State, beginning October 1, 2013, in accordance with Section 1311 of the federal Patient Protection and Affordable Care Act, shall establish a State health benefits exchange to be known as the Illinois Health Benefits Exchange in order to help individuals and small employers with no more than 50 employees shop for, select, and enroll in qualified, affordable private health plans that fit their needs at competitive prices. The Exchange shall separate coverage pools for individuals and small employers and shall supplement and not supplant any existing private health insurance market for individuals and small employers. The Department of Insurance shall operate the Illinois Health Benefits Exchange as a State-based exchange using the federal platform by plan year 2025 and as a State-based exchange by plan year 2026. The Director of Insurance may require that all plans in the individual and small group markets, other than grandfathered health plans, be made available for comparison on the Illinois Health Benefits Exchange, but may not require that all plans in the individual and small group markets be purchased exclusively on the Illinois Health Benefits Exchange. Through the adoption of rules, the Director of Insurance may require that plans offered on the exchange conform with standardized plan designs that provide for standardized cost sharing for covered health services. Except when it is inconsistent with State law, the Department of Insurance shall enforce the coverage requirements under the federal Patient Protection and Affordable Care Act, including the coverage of all United States Preventive Services Task Force Grade A and B preventive services without cost sharing notwithstanding any federal overturning or repeal of 42 U.S.C. 300gg-13(a)(1), that apply to the individual and small group markets. Beginning for plan year 2026, if a health insurance issuer offers a product as defined under 45 CFR 144.103 at the gold or silver level through the Illinois Health Benefits Exchange, the issuer must offer that product at both the gold and silver levels. The Director of Insurance may elect to add a small business health options program to the Illinois Health Benefits Exchange to help small employers enroll their employees in qualified health plans in the small group market. The General Assembly shall appropriate funds to establish the Illinois Health Benefits Exchange.

(Source: P.A. 103-103, eff. 6-27-23.)

Article 4.

Section 4-5. The Illinois Insurance Code is amended by changing Section 355 as follows:

(215 ILCS 5/355) (from Ch. 73, par. 967)

Sec. 355. Accident and health policies; provisions.

(a) As used in this Section:

"Inadequate rate" means a rate:

(1) that is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) the continued use of which endangers the solvency of an insurer using that rate.

"Large employer" has the meaning provided in the Illinois Health Insurance Portability and Accountability Act.

"Plain language" has the meaning provided in the federal Plain Writing Act of 2010 and subsequent guidance documents, including the Federal Plain Language Guidelines.

"Unreasonable rate increase" means a rate increase that the Director determines to be excessive, unjustified, or unfairly discriminatory in accordance with 45 CFR 154.205.

(b) No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143. If the Director disapproves the policy form, he or she shall make a written decision stating the respects in which such form does not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form. On and after January 1, 2025, any form filing submitted for large employer group accident and health insurance shall be automatically deemed approved within 90 days of the submission date unless the Director extends by not more than an additional 30 days the period within which the form shall be approved or disapproved by giving written notice to the insurer of such extension before the expiration of the 90 days. Any form in receipt of such an extension shall be automatically deemed approved within 120

days of the submission date. The Director may toll the filing due to a conflict in legal interpretation of federal or State law as long as the tolling is applied uniformly to all applicable forms, written notification is provided to the insurer prior to the tolling, the duration of the tolling is provided within the notice to the insurer, and justification for the tolling is posted to the Department's website. The Director may disapprove the filing if the insurer fails to respond to an objection or request for additional information within the timeframe identified for response. As used in this subsection, "large employer" has the meaning given in Section 5 of the federal Health Insurance Portability and Accountability Act.

(c) For plan year 2026 and thereafter, premium rates for all individual and small group accident and health insurance policies must be filed with the Department for approval. Unreasonable rate increases or inadequate rates shall be modified or disapproved. For any plan year during which the Illinois Health Benefits Exchange operates as a full State-based exchange, the Department shall provide insurers at least 30 days' notice of the deadline to submit rate filings.

(d) For plan year 2025 and thereafter, the Department shall post all insurers' rate filings and summaries on the Department's website 5 business days after the rate filing deadline set by the Department in annual guidance. The rate filings and summaries posted to the Department's website shall exclude information that is proprietary or trade secret information protected under paragraph (g) of subsection (1) of Section 7 of the Freedom of Information Act or confidential or privileged under any applicable insurance law or rule. All summaries shall include a brief justification of any rate increase or decrease requested, including the number of individual members, the medical loss ratio, medical trend, administrative costs, and any other information required by rule. The plain writing summary shall include notification of the public comment period established in subsection (e).

(e) The Department shall open a 30-day public comment period on the rate filings beginning on the date that all of the rate filings are posted on the Department's website. The Department shall post all of the comments received to the Department's website within 5 business days after the comment period ends.

(f) After the close of the public comment period described in subsection (e), the Department, beginning for plan year 2026, shall issue a decision to approve, disapprove, or modify a rate filing within 60 days. Any rate filing or any rates within a filing on which the Director does not issue a decision within 60 days shall automatically be deemed approved. The Director's decision shall take into account the actuarial justifications and public comments. The Department shall notify the insurer of the decision, make the decision available to the public by posting it on the Department's website, and include an explanation of the findings, actuarial justifications, and rationale that are the basis for the decision. Any company whose rate has been modified or disapproved shall be allowed to request a hearing within 10 days after the action taken. The action of the Director in disapproving a rate shall be subject to judicial review under the Administrative Review Law.

(g) If, following the issuance of a decision but before the effective date of the premium rates approved by the decision, an event occurs that materially affects the Director's decision to approve, deny, or modify the rates, the Director may consider supplemental facts or data reasonably related to the event.

(h) The Department shall adopt rules implementing the procedures described in subsections (d) through (g) by March 31, 2024.

(i) Subsection (a), ~~and~~ subsections (c) through (h), and subsection (j) of this Section do not apply to grandfathered health plans as defined in 45 CFR 147.140; excepted benefits as defined in 42 U.S.C. 300gg-91; or student health insurance coverage as defined in 45 CFR 147.145~~; the large group market as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act; or short-term, limited-duration health insurance coverage as defined in Section 5 of the Short-Term, Limited-Duration Health Insurance Coverage Act~~. For a filing of premium rates or classifications of risk for any of these types of coverage, the Director's initial review period shall not exceed 60 days to issue informal objections to the company that request additional clarification, explanation, substantiating documentation, or correction of concerns identified in the filing before the company implements the premium rates, classifications, or related rate-setting methodologies described in the filing, except that the Director may extend by not more than an additional 30 days the period of initial review by giving written notice to the company of such extension before the expiration of the initial 60-day period. Nothing in this subsection shall confer authority upon the Director to approve, modify, or disapprove rates where that authority is not provided by other law. Nothing in this subsection shall prohibit the Director from conducting any investigation, examination, hearing, or other formal administrative or enforcement proceeding with respect to a company's rate filing or implementation thereof under applicable law at any time, including after the period of initial review.

(j) Subsections (c) through (h) do not apply to group policies issued to large employers. For large employer group policies issued, delivered, amended, or renewed on or after January 1, 2026 that are not described in subsection (i), the premium rates and risk classifications, including any rate manuals and rules used to arrive at the rates, must be filed with the Department annually for approval at least 120 days before the rates are intended to take effect.

(1) A rate filing shall be modified or disapproved if the premiums are unreasonable in relation to the benefits because the rates were not calculated in accordance with sound actuarial principles.

(2) Within 60 days of receipt of the rate filing, the Director shall issue a decision to approve, disapprove, or modify the filing along with the reasons and actuarial justification for the decision. Any rate filing or rates within a filing on which the Director does not issue a decision within 60 days shall be automatically deemed approved.

(3) Any company whose rate or rate filing has been modified or disapproved shall be allowed to request a hearing within 10 days after the action taken. The action of the Director in disapproving a rate or rate filing shall be subject to judicial review under the Administrative Review Law.

(4) Nothing in this subsection requires a company to file a large employer group policy's final premium rates for prior approval if the company negotiates the final rates or rate adjustments with the large employer in accordance with the rate manual and rules of the currently approved rate filing for the policy.

(Source: P.A. 103-106, eff. 1-1-24.)

Section 4-10. The Health Maintenance Organization Act is amended by changing Section 4-12 as follows:

(215 ILCS 125/4-12) (from Ch. 111 1/2, par. 1409.5)

Sec. 4-12. Changes in rate methodology and benefits, material modifications. A health maintenance organization shall file with the Director, prior to use, a notice of any change in rate methodology, or benefits and of any material modification of any matter or document furnished pursuant to Section 2-1, together with such supporting documents as are necessary to fully explain the change or modification.

(a) Contract modifications described in subsections (c)(5), (c)(6) and (c)(7) of Section 2-1 shall include all form agreements between the organization and enrollees, providers, administrators of services and insurers of health maintenance organizations.

(b) Material transactions or series of transactions other than those described in subsection (a) of this Section, the total annual value of which exceeds the greater of $100,000 or 5% of net earned subscription revenue for the most current 12-month period as determined from filed financial statements.

(c) Any agreement between the organization and an insurer shall be subject to the provisions of the laws of this State regarding reinsurance as provided in Article XI of the Illinois Insurance Code. All reinsurance agreements must be filed. Approval of the Director is required for all agreements except the following: individual stop loss, aggregate excess, hospitalization benefits or out-of-area of the participating providers unless 20% or more of the organization's total risk is reinsured, in which case all reinsurance agreements require approval.

(d) In addition to any applicable provisions of this Act, premium rate filings shall be subject to subsections (a) and (c) through (j) ~~(i)~~ of Section 355 of the Illinois Insurance Code.

(Source: P.A. 103-106, eff. 1-1-24.)

Section 4-15. The Limited Health Service Organization Act is amended by changing Section 3006 as follows:

(215 ILCS 130/3006) (from Ch. 73, par. 1503-6)

Sec. 3006. Changes in rate methodology and benefits; material modifications; addition of limited health services.

(a) A limited health service organization shall file with the Director prior to use, a notice of any change in rate methodology, charges, or benefits and of any material modification of any matter or document furnished pursuant to Section 2001, together with such supporting documents as are necessary to fully explain the change or modification.

(1) Contract modifications described in paragraphs (5) and (6) of subsection (c) of Section 2001 shall include all agreements between the organization and enrollees, providers, administrators of services, and insurers of limited health services; also other material transactions or series of transactions, the total annual value of which exceeds the greater of $100,000 or 5% of net earned

subscription revenue for the most current 12-month ~~12 month~~ period as determined from filed financial statements.

(2) Contract modification for reinsurance. Any agreement between the organization and an insurer shall be subject to the provisions of Article XI of the Illinois Insurance Code, as now or hereafter amended. All reinsurance agreements must be filed with the Director. Approval of the Director in required agreements must be filed. Approval of the director is required for all agreements except individual stop loss, aggregate excess, hospitalization benefits, or out-of-area of the participating providers, unless 20% or more of the organization's total risk is reinsured, in which case all reinsurance agreements shall require approval.

(b) If a limited health service organization desires to add one or more additional limited health services, it shall file a notice with the Director and, at the same time, submit the information required by Section 2001 if different from that filed with the prepaid limited health service organization's application. Issuance of such an amended certificate of authority shall be subject to the conditions of Section 2002 of this Act.

(c) In addition to any applicable provisions of this Act, premium rate filings shall be subject to subsection (i) and, for pharmaceutical policies, subsection (j) of Section 355 of the Illinois Insurance Code.
(Source: P.A. 103-106, eff. 1-1-24; revised 1-2-24.)

Article 6.

Section 6-5. The Illinois Insurance Code is amended by changing Sections 155.36, 155.37, 356z.40, and 370c as follows:

(215 ILCS 5/155.36)

Sec. 155.36. Managed Care Reform and Patient Rights Act. Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code shall comply with Sections 25, 45, 45.1, 45.2, 45.3, 65, 70, ~~and~~ 85, and 87, subsection (d) of Section 30, and the definitions ~~definition~~ of the term "emergency medical condition" and any other term in Section 10 of the Managed Care Reform and Patient Rights Act that is used in the other Sections listed in this Section.
(Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

(215 ILCS 5/155.37)

Sec. 155.37. Drug formulary; notice.

(a) Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code and provide coverage for prescription drugs through the use of a drug formulary must notify insureds of any change in the formulary. A company may comply with this Section by posting changes in the formulary on its website.

(b) No later than October 1, 2025, insurance companies that use a drug formulary shall post the formulary on their websites in a manner that is searchable and accessible to the general public without requiring an individual to create any account. This formulary shall adhere to a template developed by the Department by March 31, 2025, which shall take into consideration existing requirements for reporting of information established by the federal Centers for Medicare and Medicaid Services as well as display of cost-sharing information. This template and all formularies also shall do all the following:

(1) include information on cost-sharing tiers and utilization controls, such as prior authorization, for each covered drug;

(2) indicate any drugs on the formulary that are preferred over other drugs on the formulary;

(3) include information to educate insureds about the differences between drugs administered or provided under a policy's medical benefit and drugs covered under a drug benefit and how to obtain coverage information about drugs that are not covered under the drug benefit;

(4) include information to educate insureds that policies that provide drug benefits are required to have a method for enrollees to obtain drugs not listed in the formulary if they are deemed medically necessary by a clinician under Section 45.1 of the Managed Care Reform and Patient Rights Act;

(5) include information on which medications are covered, including both generic and brand name; and

(6) include information on what tier of the plan's drug formulary each medication is in.

(c) No formulary may establish a step therapy requirement as prohibited by Section 87 of the Managed Care Reform and Patient Rights Act.
(Source: P.A. 92-440, eff. 8-17-01; 92-651, eff. 7-11-02.)

(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 the effective date of 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.

(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. Subject to the requirements of Sections 370c and 370c.1 of this Code, nothing ~~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 Section 370c and 370c.1 of this Code, nothing ~~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), 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.)

(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 (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. 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.

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

(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 employee health plans.

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

"Benefits", with respect to insurers, 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 (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 Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

"Benefits", with respect to 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 (Partial Hospitalization), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically 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. The substance use disorder treatment provider or facility shall notify the insurer of the initiation of treatment. For an insurer that is not a managed care organization, the substance use disorder treatment provider or facility notification shall occur for the initiation of treatment of the covered person within 2 business days. For managed care organizations, the substance use disorder treatment provider or facility notification shall occur in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the 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. 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.

(4) For an insurer that is not a 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.

(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 ~~medical necessity determinations made~~ by the insurer concerning diagnosis, prevention, and treatment ~~service intensity, level of care placement, continued stay, and transfer or discharge~~ 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) ~~(u)~~.

(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 ~~For medical necessity determinations relating to level of care placement, continued stay, and transfer or discharge of insureds diagnosed with~~ mental, emotional, and nervous disorders or conditions, an insurer shall apply the ~~patient placement~~ 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, ~~patient placement~~ 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 ~~For medical necessity determinations~~ relating to level of care placement, continued stay, ~~and~~ transfer, ~~or~~ 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.

~~Nothing in this subsection or subsection (l) prohibits an insurer from applying utilization review criteria that were developed in accordance with subsection (k) to health care services and benefits for mental, emotional, and nervous disorders or conditions that are not related to medical necessity determinations for level of care placement, continued stay, and transfer or discharge.~~ 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, ~~and~~ transfer, ~~or~~ 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 inpatient mental health treatment at participating hospitals shall comply with the following requirements:

(1) Subject to paragraphs (2) and (3) of this subsection, no policy shall require prior authorization for admission for such treatment at any participating hospital.

(2) Coverage provided under this subsection also shall not be subject to concurrent review for the first 72 hours, provided that the 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.

(3) Treatment provided under this subsection may be reviewed retrospectively. If coverage is denied retrospectively, neither the insurer nor the participating 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 treatment at a participating 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.

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

(x) Notwithstanding any provision of this Section, nothing shall require the medical assistance program under Article V of the Illinois Public Aid Code to violate any applicable federal laws, regulations, or grant requirements or any State or federal consent decrees. Nothing in 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 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 subsection (w). Nothing in this Section prohibits a health plan, including a Medicaid managed care organization, from conducting reviews for fraud, waste, or abuse and reporting suspected fraud, waste, or abuse according to State and federal requirements.

(y) 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.)

Section 6-10. The Managed Care Reform and Patient Rights Act is amended by changing Sections 10, 45.1, and 85 and by adding Section 87 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions. In this Act:

"Adverse determination" means a determination by a health care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary.

"Clinical peer" means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to another hospital before delivery; or

(B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches, or to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

"Generally accepted standards of care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties for the illness, injury, or condition or its symptoms and comorbidities. Valid, evidence-based sources reflecting generally accepted standards of 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.

"Health care plan" means a plan, including, but not limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services, that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for

services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall not include the following:

(1) indemnity health insurance policies including those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) except with respect to subsections (a) and (b) of Section 65 and subsection (a-5) of Section 70, not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health care professional" means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing in this Act shall be construed to define Independent Practice Associations or Physician-Hospital Organizations as health care providers.

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including behavioral health, mental health, home health, and pharmaceutical services and products.

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

"Medically necessary" means that a service or product addresses the specific needs of a 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 generally accepted standards of care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the health care plan, purchaser, or utilization review organization, or for the convenience of the patient, treating physician, or other health care provider.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Physician" means a person licensed under the Medical Practice Act of 1987.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

"Stabilization" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

"Step therapy requirement" means a utilization review or formulary requirement that specifies, as a condition of coverage under a health care plan, the order in which certain health care services must be used to treat or manage an enrollee's health condition.

"Step therapy requirement" does not include:

(1) utilization review to identify when a treatment or health care service is contraindicated or clinically appropriate or to limit quantity or dosage for an enrollee based on utilization review criteria consistent with generally accepted standards of care developed in accordance with Section 87 of this Act;

(2) the removal of a drug from a formulary or changing the drug's preferred or cost-sharing tier to higher cost sharing;

(3) use of the medical exceptions process under Section 45.1 of this Act; any decision during a medical exceptions process based on cost is step therapy and prohibited;

(4) a requirement to obtain prior authorization for the requested treatment; or

(5) for health care plans operated or overseen by the Department of Healthcare and Family Services, including Medicaid managed care plans, any utilization controls mandated by 42 CFR 456.703 or a preferred drug list as described in Section 5-30.14 of the Illinois Public Aid Code.

"Utilization review" means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review" includes 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, enrollees, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to enrollees; or

(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 a health care plan is covered as medically necessary for an enrollee.

"Utilization review criteria" means criteria, standards, protocols, or guidelines used by a utilization review program to conduct utilization review to ensure that a patient's care is aligned with generally accepted standards of care and consistent with State law.

"Utilization review program" means a program established by a person to perform utilization review.
(Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

(215 ILCS 134/45.1)

Sec. 45.1. Medical exceptions procedures required.

(a) Notwithstanding any other provision of law, on or after January 1, 2018 (the effective date of Public Act 99-761), every insurer licensed in this State to sell a policy of group or individual accident and health insurance or a health benefits plan shall establish and maintain a medical exceptions process that allows covered persons or their authorized representatives to request any clinically appropriate prescription drug when (1) the drug is not covered based on the health benefit plan's formulary; (2) the health benefit plan is discontinuing coverage of the drug on the plan's formulary for reasons other than safety or other than because the prescription drug has been withdrawn from the market by the drug's manufacturer; (3) (blank) ~~the prescription drug alternatives required to be used in accordance with a step therapy requirement (A) has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance or (B) has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to the enrollee~~; or (4) the number of doses available under a dose restriction for the prescription drug (A) has been ineffective in the treatment of the enrollee's disease or medical condition or (B) based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.

(b) The health carrier's established medical exceptions procedures must require, at a minimum, the following:

(1) Any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals.

(2) The health carrier must, within 72 hours after receipt of a request made under subsection (a) of this Section, either approve or deny the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial. A health carrier shall not use the authorization of alternative covered medications under this Section in a manner that effectively creates a step therapy requirement.

(3) In the case of an expedited coverage determination, the health carrier must either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(c) An off-formulary ~~A step therapy requirement~~ exception request shall not be denied ~~be approved~~ if:

(1) the formulary ~~required~~ prescription drug is contraindicated;

(2) the patient has tried the formulary ~~required~~ prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or

(3) the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

(d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy or contract up to the quantity covered.

(e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan.

(f) Notwithstanding any other provision of this Section, nothing in this Section shall be interpreted or implemented in a manner not consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those Acts.

(g) Nothing in this Section shall require or authorize the State agency responsible for the administration of the medical assistance program established under the Illinois Public Aid Code to approve, supply, or cover prescription drugs pursuant to the procedure established in this Section.

(Source: P.A. 103-154, eff. 6-30-23.)

(215 ILCS 134/85)

Sec. 85. Utilization review program registration.

(a) No person may conduct a utilization review program in this State unless once every 2 years the person registers the utilization review program with the Department and certifies compliance with the Health Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health Utilization Management Standards. Nothing in this Act shall be construed to require a health care plan or its subcontractors to become American Accreditation Healthcare Commission (URAC) accredited.

(b) In addition, the Director of the Department, in consultation with the Director of the Department of Public Health, may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (a).

(b-5) The Department shall recognize the Accreditation Association for Ambulatory Health Care among the list of accreditors from which utilization organizations may receive accreditation and qualify for reduced registration and renewal fees.

(c) The provisions of this Section do not apply to:

(1) persons providing utilization review program services only to the federal government;

(2) self-insured health plans under the federal Employee Retirement Income Security Act of 1974, however, this Section does apply to persons conducting a utilization review program on behalf of these health plans;

(3) hospitals and medical groups performing utilization review activities for internal purposes unless the utilization review program is conducted for another person.

Nothing in this Act prohibits a health care plan or other entity from contractually requiring an entity designated in item (3) of this subsection to adhere to the utilization review program requirements of this Act.

(d) This registration shall include submission of all of the following information regarding utilization review program activities:

(1) The name, address, and telephone number of the utilization review programs.

(2) The organization and governing structure of the utilization review programs.

(3) The number of lives for which utilization review is conducted by each utilization review program.

(4) Hours of operation of each utilization review program.

(5) Description of the grievance process for each utilization review program.

(6) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.

(7) Written policies and procedures for protecting confidential information according to applicable State and federal laws for each utilization review program.

(e) (1) A utilization review program shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

(A) kept confidential in accordance with applicable State and federal laws; and

(B) shared only with the enrollee, the enrollee's designee, the enrollee's health care provider, and those who are authorized by law to receive the information.

Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.

(2) Only a clinical peer ~~health care professional~~ may make adverse determinations regarding the medical necessity of health care services during the course of utilization review. Either a health care professional or an accredited algorithmic automated process, or both in combination, may certify the medical necessity of a health care service in accordance with accreditation standards. Nothing in this subsection prohibits an accredited algorithmic automated process from being used to refer a case to a clinical peer for a potential adverse determination.

(3) When making retrospective reviews, utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided.

(4) When making prospective, concurrent, and retrospective determinations, utilization review programs shall collect only information that is necessary to make the determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification, unless required under State or federal Medicare or Medicaid rules or regulations, but may request such code if available, or routinely request copies of medical records of all enrollees reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to review are medically necessary. In these cases, only the necessary or relevant sections of the medical record shall be required.

(f) If the Department finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.

(g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.

(h) Any adverse determination made by a health care plan or its subcontractors may be appealed in accordance with subsection (f) of Section 45.

(i) The Director may by rule establish a registration fee for each person conducting a utilization review program. All fees paid to and collected by the Director under this Section shall be deposited into the Insurance Producer Administration Fund.

(Source: P.A. 99-111, eff. 1-1-16.)

(215 ILCS 134/87 new)

Sec. 87. General standards for use of utilization review criteria.

(a) Beginning January 1, 2026, all utilization review programs shall make medical necessity determinations in accordance with the requirements of this Section. No policy, contract, certificate, formulary, or evidence of coverage issued to any enrollee may contain terms or conditions to the contrary.

(b) All utilization review programs shall determine medical necessity by using the most recent treatment criteria developed by:

(1) an unaffiliated, nonprofit professional association for the relevant clinical specialty;

(2) a third-party entity that develops treatment criteria that: (i) are updated annually; (ii) are not paid for clinical care decision outcomes; (iii) do not offer different treatment criteria for the same health care service unless otherwise required by State or federal law; and (iv) are consistent with current generally accepted standards of care; or

(3) the Department of Healthcare and Family Services if the criteria are consistent with current generally accepted standards of care.

(c) For all level of care placement decisions, the utilization review program shall authorize placement at the level of care at or above the level ordered by the provider using the relevant treatment criteria as specified in subsection (b). If there is a disagreement between the health care plan and the provider or patient, the health care plan or utilization review program shall provide its complete assessment to the provider and the patient.

(d) If a utilization review program purchases or licenses utilization review criteria pursuant to this Section, the utilization review program shall, before using the criteria, verify and document that the criteria were developed in accordance with subsection (b).

(e) All health care plans and utilization review programs must:

(1) make an educational program on the chosen treatment criteria available to all staff and contracted entities performing utilization review;

(2) provide, at no cost, the treatment criteria and any related training material to providers and enrollees upon request; enrollees and treating providers shall be able to access treatment criteria at any point in time, including before an initial request for authorization;

(3) track, identify, and analyze how the treatment criteria are used to certify care, deny care, and support the appeals process;

(4) conduct interrater reliability testing to ensure consistency in utilization review decision-making; this testing shall cover all aspects of utilization review criteria as defined in Section 10;

(5) achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, initiate remediation of poor interrater reliability within 3 business days after the finding and conduct interrater reliability testing for all new staff before they can conduct utilization review supervision; and

(6) maintain documentation of interrater reliability testing and any remediation 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 de-identified of patient or employee personal information and a summary of remedial actions.

(f) Beginning January 1, 2026, no utilization review program or any policy, contract, certificate, evidence of coverage, or formulary shall impose step therapy requirements. Nothing in this subsection prohibits a health care plan, by contract, written policy, procedure, or any other agreement or course of conduct, from requiring a pharmacist to effect substitutions of prescription drugs consistent with Section 19.5 of the Pharmacy Practice Act, under which a pharmacist may substitute an interchangeable biologic for a prescribed biologic product, and Section 25 of the Pharmacy Practice Act, under which a pharmacist may select a generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration and in accordance with the Illinois Food, Drug and Cosmetic Act. For health care plans operated or overseen by the Department of Healthcare and Family Services, including Medicaid managed care plans, the prohibition in this subsection does not apply to step therapy requirements for drugs that do not appear on the most recent Preferred Drug List published by the Department of Healthcare and Family Services.

(g) Except for subsection (f), this Section does not apply to utilization review concerning diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions, which shall be governed by Section 370c of the Illinois Insurance Code.

(h) Nothing in this Section supersedes or waives requirements provided under any other State or federal law or federal regulation that any coverage subject to this Section comply with specific utilization review criteria for a specific illness, level of care placement, injury, or condition or its symptoms and comorbidities.

Section 6-15. The Health Carrier External Review Act is amended by changing Section 10 as follows: (215 ILCS 180/10)

Sec. 10. Definitions. For the purposes of this Act:

"Adverse determination" means:

(1) a determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

(2) the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or

(3) a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

"Authorized representative" means:

(1) a person to whom a covered person has given express written consent to represent the covered person for purposes of this Law;

(2) a person authorized by law to provide substituted consent for a covered person;

(3) a family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) a health care provider when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care provider; or

(5) in the case of an urgent care request, a health care provider with knowledge of the covered person's medical condition.

"Best evidence" means evidence based on:

(1) randomized clinical trials;

(2) if randomized clinical trials are not available, then cohort studies or case-control studies;

(3) if items (1) and (2) are not available, then case-series; or

(4) if items (1), (2), and (3) are not available, then expert opinion.

"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services. "Clinical review criteria" includes all utilization review criteria as defined in Section 10 of the Managed Care Reform and Patient Rights Act.

"Cohort study" means a prospective evaluation of 2 groups of patients with only one group of patients receiving specific intervention.

"Concurrent review" means a review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Director" means the Director of the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on an overall systematic review of the research in making decisions about the care of individual patients.

"Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

"Facility" means an institution providing health care services or a health care setting.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act.

"Health benefit plan" means a policy, contract, certificate, plan, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care provider" or "provider" means a physician, hospital facility, or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with State law, responsible for recommending health care services on behalf of a covered person.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, or any other entity providing a plan of health insurance, health benefits, or health care services. "Health carrier" also means Limited Health Service Organizations (LHSO) and Voluntary Health Service Plans.

"Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to:

(1) the past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) the provision of health care services to an individual; or

(3) payment for the provision of health care services to an individual.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"Medical or scientific evidence" means evidence found in the following sources:

(1) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) the following standard reference compendia:

(a) The American Hospital Formulary Service-Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia-Drug Information;

(5) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) the federal Agency for Healthcare Research and Quality;

(b) the National Institutes of Health;

(c) the National Cancer Institute;

(d) the National Academy of Sciences;

(e) the Centers for Medicare & Medicaid Services;

(f) the federal Food and Drug Administration; and

(g) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) any other medical or scientific evidence that is comparable to the sources listed in items (1) through (5).

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Prospective review" means a review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

"Protected health information" means health information (i) that identifies an individual who is the subject of the information; or (ii) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"Randomized clinical trial" means a controlled prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" means any review of a request for a benefit that is not a concurrent or prospective review request. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

"Utilization review" has the meaning provided by the Managed Care Reform and Patient Rights Act.

"Utilization review organization" means a utilization review program as defined in the Managed Care Reform and Patient Rights Act.

(Source: P.A. 97-574, eff. 8-26-11; 97-813, eff. 7-13-12; 98-756, eff. 7-16-14.)

Section 6-20. The Prior Authorization Reform Act is amended by changing Sections 15 and 20 as follows:

(215 ILCS 200/15)

Sec. 15. Definitions. As used in this Act:

"Adverse determination" has the meaning given to that term in Section 10 of the Health Carrier External Review Act.

"Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination.

"Approval" means a determination by a health insurance issuer or its contracted utilization review organization that a health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's or its contracted utilization review organization's requirements for medical necessity and appropriateness.

"Clinical review criteria" has the meaning given to that term in Section 10 of the Health Carrier External Review Act.

"Department" means the Department of Insurance.

"Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Emergency services" has the meaning given to that term in federal health insurance reform requirements for the group and individual health insurance markets, 45 CFR 147.138.

"Enrollee" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Health care professional" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Health care provider" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act, except that facilities licensed under the Nursing Home Care Act and long-term care facilities as defined in Section 1-113 of the Nursing Home Care Act are excluded from this Act.

"Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health, and pharmaceutical services and products.

"Health insurance issuer" has the meaning given to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Medically necessary" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act. ~~means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party, but focused on what is best for the patient's health outcome.~~

"Physician" means a person licensed under the Medical Practice Act of 1987 or licensed under the laws of another state to practice medicine in all its branches.

"Prior authorization" means the process by which health insurance issuers or their contracted utilization review organizations determine the medical necessity and medical appropriateness of otherwise covered health care services before the rendering of such health care services. "Prior authorization" includes any health insurance issuer's or its contracted utilization review organization's requirement that an enrollee, health care professional, or health care provider notify the health insurance issuer or its contracted utilization review organization before, at the time of, or concurrent to providing a health care service.

"Urgent health care service" means a health care service with respect to which the application of the time periods for making a non-expedited prior authorization that in the opinion of a health care professional with knowledge of the enrollee's medical condition:

(1) could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(2) could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

"Urgent health care service" does not include emergency services.

"Utilization review organization" has the meaning given to that term in 50 Ill. Adm. Code 4520.30.

(Source: P.A. 102-409, eff. 1-1-22.)

(215 ILCS 200/20)

Sec. 20. Disclosure and review of prior authorization requirements.

(a) A health insurance issuer shall maintain a complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the health insurance issuer. The health insurance issuer shall publish this list on its public website without requiring a member of the general public to create any account or enter any credentials to access it. The list described in this subsection is not required to contain the clinical review criteria applicable to these services.

(b) A health insurance issuer shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals, and health care providers. Content published by a third party and licensed for use by a health insurance issuer or its contracted utilization review organization may be made available through the health insurance issuer's or its contracted utilization review organization's secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall indicate for each service subject to prior authorization:

(1) when prior authorization became required for policies issued or delivered in Illinois, including the effective date or dates and the termination date or dates, if applicable, in Illinois;

(2) the date the Illinois-specific requirement was listed on the health insurance issuer's or its contracted utilization review organization's website;

(3) where applicable, the date that prior authorization was removed for Illinois; and

(4) where applicable, access to a standardized electronic prior authorization request transaction process.

(c) The clinical review criteria must:

(1) be based on nationally recognized, generally accepted standards except where State law provides its own standard;

(2) be developed in accordance with the current standards of a national medical accreditation entity;

(3) ensure quality of care and access to needed health care services;

(4) be evidence-based;

(5) be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and

(6) be evaluated and updated, if necessary, at least annually.

(d) A health insurance issuer shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim.

(e) A health insurance issuer or its contracted utilization review organization shall not deem as incidental or deny supplies or health care services that are routinely used as part of a health care service when:

(1) an associated health care service has received prior authorization; or

(2) prior authorization for the health care service is not required.

(f) If a health insurance issuer intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the health insurance issuer shall provide contracted health care professionals and contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. The written notice may be provided in an electronic format, including email or facsimile, if the health care professional or health care provider has agreed in advance to receive notices electronically. The health insurance issuer shall ensure that the new or amended requirement is not implemented unless the health insurance issuer's or its contracted utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

(g) Entities using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. The statistics must be updated annually and include all of the following information:

(1) a list of all health care services, including medications, that are subject to prior authorization;

(2) the total number of prior authorization requests received;

(3) the number of prior authorization requests denied during the previous plan year by the health insurance issuer or its contracted utilization review organization with respect to each service described in paragraph (1) and the top 5 reasons for denial;

(4) the number of requests described in paragraph (3) that were appealed, the number of the appealed requests that upheld the adverse determination, and the number of appealed requests that reversed the adverse determination;

(5) the average time between submission and response; and

(6) any other information as the Director determines appropriate.

(Source: P.A. 102-409, eff. 1-1-22.)

Section 6-25. The Illinois Public Aid Code is amended by changing Section 5-16.12 as follows:

(305 ILCS 5/5-16.12)

Sec. 5-16.12. Managed Care Reform and Patient Rights Act. The medical assistance program and other programs administered by the Department are subject to the provisions of the Managed Care Reform and Patient Rights Act. The Department may adopt rules to implement those provisions. These rules shall require compliance with that Act in the medical assistance managed care programs and other programs administered by the Department. The medical assistance fee-for-service program is not subject to the provisions of the Managed Care Reform and Patient Rights Act, except for Sections 85 and 87 of the Managed Care Reform and Patient Rights Act and for any definition in Section 10 of the Managed Care Reform and Patient Rights Act that applies to Sections 85 and 87 of the Managed Care Reform and Patient Rights Act.

Nothing in the Managed Care Reform and Patient Rights Act shall be construed to mean that the Department is a health care plan as defined in that Act simply because the Department enters into contractual relationships with health care plans; provided that this clause shall not defeat the applicability of Sections 10, 85, and 87 of the Managed Care Reform and Patient Rights Act to the fee-for-service program.

(Source: P.A. 91-617, eff. 1-1-00.)

Article 99.

Section 99-95. 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 99-99. Effective date. This Act takes effect January 1, 2025, except that the changes to Section 45.1 of the Managed Care Reform and Patient Rights Act take effect January 1, 2026.".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Harmon, **House Bill No. 303** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Ellman, **House Bill No. 4276** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Judiciary, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 4276

AMENDMENT NO. 1 . Amend House Bill 4276 by replacing everything after the enacting clause with the following:

"Section 5. The Life Care Facilities Act is amended by adding Sections 5.1 and 5.2 as follows:

(210 ILCS 40/5.1 new)

Sec. 5.1. Pre-sale disclosures.

(a) Prior to the execution of a refundable life care contract and the transfer of any money or other property to a provider or escrow agent, the provider shall deliver to the consumer a pre-sale disclosure printed on paper. The pre-sale disclosure shall be signed by the consumer prior to executing the life care contract. The pre-sale disclosure shall include:

(1) the caption, "ENTRY FEE REFUNDS: CONSUMER NOTICE", in at least 28-point font and the remaining portion in at least 12-point font;

(2) the caption, "The timing of refunds for past residents may not be indicative of your refund experience. Your ability to collect on the full amount of the calculated refund may be modified or nullified pending market conditions, any future sale of this organization, or in the event of bankruptcy. Current residents, former residents awaiting refunds, and the estates of former residents awaiting refunds shall be provided with the most recent entry fee refund data disclosure upon request.";

(3) for refunds returned by the provider in the most recently completed calendar year:

(A) the average number of months passed before the refund of an entry fee by the provider; and

(B) the median number of months passed before the refund of an entry fee by the provider;

(4) the percentage of entry fee contracts awaiting refunds from the provider with wait times exceeding 24 months as of the end of the most recently completed calendar year;

(5) the percentage of entry fee contracts awaiting refunds from the provider with wait times exceeding 36 months as of the end of the most recently completed calendar year;

(6) the percentage of entry fee contracts awaiting refunds from the provider with wait times exceeding 60 months as of the end of the most recently completed calendar year;

(7) the number of entry fee contracts awaiting refunds from the provider as of the last day of the most recently completed calendar year; and

(8) the number of entry fee refunds returned by the provider in the most recently completed calendar year.

(b) For the purpose of determining the time a refund is due, the start time of the refund begins after the unit has been permanently vacated, returned to resalable condition, and the outgoing resident has a zero balance due, excluding outstanding balances to be payable by outside payors, including, but not limited to, Medicare, Medicaid, Managed Medicare, or within 30 days of the unit being permanently vacated and the outgoing resident has a zero balance due, whichever is shorter. Refund delays due to estate factors outside of

the community's control, including, but not limited to, probate challenges, estate challenges, or an inability to confirm next of kin, are not included in the outstanding refunds to be disclosed.

(c) Pre-sale disclosures may include additional data by calendar year.

(d) If a payee for an entry fee refund cannot be determined, for purposes of calculating the data in subsection (a), a refund shall be considered complete when a new resident occupies the specified living unit.

(e) The most current pre-sale disclosure data detailed in subsection (a) shall be made available, upon request, to current residents that have refundable entry fee contracts, former residents who have not yet received refunds for their refundable entry fees, and the estates of former residents who have not yet received refunds for their refundable entry fees.

(210 ILCS 40/5.2 new)

Sec. 5.2. Living unit reappropriation. If an unoccupied living unit is contemplated for use for a purpose other than as a living unit, including, but not limited to, an exam room or a storage room, and if there exist beneficiaries awaiting an entry fee refund, the beneficiaries of the entry fee refund must provide a signed acknowledgment of, and agreement to, the reappropriation that may be in effect up to a specific date. The reappropriation acknowledgment shall include:

(1) the caption, "ENTRY FEE REFUND DELAYS: CONSUMER NOTICE" in at least 28-point font and the remaining portion in at least a 12-point font;

(2) the caption, "Your agreement to this arrangement may result in the delayed sale of the living unit as well as the delayed return of the entry fee."; and

(3) a statement that the rights provided under this Section may not be waived.".

Floor Amendment No. 2 was held in the Committee on Assignments.

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator N. Harris, **House Bill No. 4367** was taken up, read by title a second time.

Committee Amendment No. 1 was held in the Committee on Insurance.

The following amendment was offered in the Committee on Insurance, adopted and ordered printed:

AMENDMENT NO. 2 TO HOUSE BILL 4367

AMENDMENT NO. 2 . Amend House Bill 4367 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Section 534.4 as follows:

(215 ILCS 5/534.4) (from Ch. 73, par. 1065.84-4)

Sec. 534.4. "Insolvent company" means a company organized as a stock company, mutual company, reciprocal or Lloyds (a) which holds a certificate of authority to transact insurance in this State either at the time the policy was issued or when the insured event occurred, or any company which has assumed or has been allocated such policy obligation through merger, division, insurance business transfer, consolidation, or reinsurance, whether or not such assuming company held a certificate of authority to transact insurance in this State at the time such policy was issued or when the insured event occurred; and (b) against which a final Order of Liquidation with a finding of insolvency to which there is no further right of appeal has been entered by a court of competent jurisdiction in the company's State of domicile after the effective date of this Article. When a policy obligation is assumed or allocated through merger, division, insurance business transfer, consolidation, or reinsurance, nothing in this Section shall be construed to create Fund coverage if none existed at the time of assumption or allocation or to destroy Fund coverage if it existed at the time of assumption or allocation.

(Source: P.A. 103-75, eff. 6-9-23.)

Section 99. Effective date. This Act takes effect upon becoming law.".

There being no further amendments, the bill, as amended, was ordered to a third reading.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Johnson, **House Bill No. 4175** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 51; NAYS 8.

The following voted in the affirmative:

Aquino	Glowiak Hilton	Loughran Cappel	Stadelman
Belt	Halpin	Martwick	Toro
Castro	Harris, N.	McClure	Tracy
Cervantes	Harriss, E.	McConchie	Turner, D.
Collins	Hastings	Morrison	Turner, S.
Cunningham	Holmes	Murphy	Ventura
Curran	Hunter	Peters	Villa
DeWitte	Johnson	Plummer	Villanueva
Edly-Allen	Jones, E.	Porfirio	Villivalam
Ellman	Joyce	Preston	Walker
Faraci	Koehler	Rezin	Wilcox
Feigenholtz	Lewis	Simmons	Mr. President
Fine	Lightford	Sims	

The following voted in the negative:

Anderson	Chesney	Stoller
Bennett	Fowler	Syverson
Bryant	Rose	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof.

On motion of Senator Loughran Cappel, **House Bill No. 4412** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 59; NAYS None.

The following voted in the affirmative:

Anderson	Feigenholtz	Lightford	Stadelman
Aquino	Fine	Loughran Cappel	Stoller
Belt	Fowler	Martwick	Syverson
Bennett	Glowiak Hilton	McClure	Toro
Bryant	Halpin	McConchie	Tracy
Castro	Harris, N.	Morrison	Turner, D.
Cervantes	Harriss, E.	Murphy	Turner, S.
Chesney	Hastings	Peters	Ventura
Collins	Holmes	Plummer	Villa
Cunningham	Hunter	Porfirio	Villanueva
Curran	Johnson	Preston	Villivalam
DeWitte	Jones, E.	Rezin	Walker

Edly-Allen	Joyce	Rose	Wilcox
Ellman	Koehler	Simmons	Mr. President
Faraci	Lewis	Sims	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence in the Senate Amendments adopted thereto.

On motion of Senator Cervantes, **House Bill No. 4500** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 59; NAYS None.

The following voted in the affirmative:

Anderson	Feigenholtz	Lightford	Stadelman
Aquino	Fine	Loughran Cappel	Stoller
Belt	Fowler	Martwick	Syverson
Bennett	Glowiak Hilton	McClure	Toro
Bryant	Halpin	McConchie	Tracy
Castro	Harris, N.	Morrison	Turner, D.
Cervantes	Harriss, E.	Murphy	Turner, S.
Chesney	Hastings	Peters	Ventura
Collins	Holmes	Plummer	Villa
Cunningham	Hunter	Porfirio	Villanueva
Curran	Johnson	Preston	Villivalam
DeWitte	Jones, E.	Rezin	Walker
Edly-Allen	Joyce	Rose	Wilcox
Ellman	Koehler	Simmons	Mr. President
Faraci	Lewis	Sims	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence in the Senate Amendment adopted thereto.

On motion of Senator Stadelman, **House Bill No. 4634** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 59; NAYS None.

The following voted in the affirmative:

Anderson	Feigenholtz	Lightford	Stadelman
Aquino	Fine	Loughran Cappel	Stoller
Belt	Fowler	Martwick	Syverson
Bennett	Glowiak Hilton	McClure	Toro
Bryant	Halpin	McConchie	Tracy
Castro	Harris, N.	Morrison	Turner, D.
Cervantes	Harriss, E.	Murphy	Turner, S.
Chesney	Hastings	Peters	Ventura

Collins	Holmes	Plummer	Villa
Cunningham	Hunter	Porfirio	Villanueva
Curran	Johnson	Preston	Villivalam
DeWitte	Jones, E.	Rezin	Walker
Edly-Allen	Joyce	Rose	Wilcox
Ellman	Koehler	Simmons	Mr. President
Faraci	Lewis	Sims	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof.

On motion of Senator Castro, **House Bill No. 4467** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, was taken up and read by title a third time.

And the question being, "Shall this bill pass?" it was decided in the affirmative by the following vote:

YEAS 47; NAYS 12.

The following voted in the affirmative:

Aquino	Feigenholtz	Lewis	Simmons
Belt	Fine	Lightford	Sims
Bennett	Glowiak Hilton	Loughran Cappel	Stadelman
Castro	Halpin	Martwick	Toro
Cervantes	Harris, N.	McConchie	Turner, D.
Collins	Hastings	Morrison	Ventura
Cunningham	Holmes	Murphy	Villa
Curran	Hunter	Peters	Villanueva
DeWitte	Johnson	Porfirio	Villivalam
Edly-Allen	Jones, E.	Preston	Walker
Ellman	Joyce	Rezin	Mr. President
Faraci	Koehler	Rose	

The following voted in the negative:

Anderson	Harriss, E.	Syverson
Bryant	McClure	Tracy
Chesney	Plummer	Turner, S.
Fowler	Stoller	Wilcox

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof.

At the hour of 12:58 o'clock p.m., the Chair announced that the Senate stands at ease.

AT EASE

At the hour of 1:03 o'clock p.m., the Senate resumed consideration of business.

Senator Aquino, presiding.

REPORT FROM COMMITTEE ON ASSIGNMENTS

Senator Lightford, Chair of the Committee on Assignments, during its May 22, 2024 meeting, reported the following Legislative Measures have been assigned to the indicated Standing Committees of the Senate:

Executive: **Floor Amendment No. 1 to Senate Bill 496; Floor Amendment No. 1 to Senate Bill 497; Committee Amendment No. 2 to Senate Bill 3527; Committee Amendment No. 1 to Senate Bill 3591; Committee Amendment No. 2 to Senate Bill 3591; Committee Amendment No. 1 to Senate Bill 3737; Committee Amendment No. 2 to House Bill 4209**.

Senator Lightford, Chair of the Committee on Assignments, during its May 22, 2024 meeting, to which was referred **Senate Bill No. 863** on March 31, 2023, pursuant to Rule 3-9(a), reported that the Committee recommends that the bill be approved for consideration and returned to the calendar in its former position.

The report of the Committee was concurred in.

And **Senate Bill No. 863** was returned to the order of third reading.

Senator Lightford, Chair of the Committee on Assignments, during its May 22, 2024 meeting, to which was referred **House Bill No. 341**, reported the same back with the recommendation that the bill be placed on the order of second reading without recommendation to committee.

Pursuant to Senate Rule 3-8 (b-1), the following amendment will remain in the Committee on Assignments: **Committee Amendment No. 3 to Senate Bill 3736**.

LEGISLATIVE MEASURE FILED

The following Floor amendment to the Senate Bill listed below has been filed with the Secretary and referred to the Committee on Assignments:

Amendment No. 1 to Senate Bill 863

REPORT FROM COMMITTEE ON ASSIGNMENTS

Senator Lightford, Chair of the Committee on Assignments, during its May 22, 2024 meeting, reported the following Legislative Measure has been assigned to the indicated Standing Committee of the Senate:

Executive: **Floor Amendment No. 1 to Senate Bill 863**.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A THIRD TIME

On motion of Senator Villa, **House Bill No. 4720** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, was taken up and read by title a third time.

And the question being, “Shall this bill pass?” it was decided in the affirmative by the following vote:

YEAS 38; NAYS 18.

The following voted in the affirmative:

Aquino	Fine	Loughran Cappel	Toro
Belt	Glowiak Hilton	Martwick	Turner, D.
Castro	Halpin	Morrison	Ventura

Cervantes	Harris, N.	Murphy	Villa
Collins	Hastings	Peters	Villanueva
Cunningham	Hunter	Porfirio	Villivalam
Edly-Allen	Johnson	Preston	Walker
Ellman	Jones, E.	Simmons	Mr. President
Faraci	Koehler	Sims	
Feigenholtz	Lightford	Stadelman	

The following voted in the negative:

Anderson	Fowler	Plummer	Tracy
Bennett	Harriss, E.	Rezin	Turner, S.
Bryant	Lewis	Rose	Wilcox
Chesney	McClure	Stoller	
DeWitte	McConchie	Syverson	

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence in the Senate Amendment adopted thereto.

On motion of Senator Villa, **House Bill No. 4768** having been printed as received from the House of Representatives, together with all Senate Amendments adopted thereto, was taken up and read by title a third time.

And the question being, “Shall this bill pass?” it was decided in the affirmative by the following vote:

YEAS 34; NAYS 19; Present 2.

The following voted in the affirmative:

Aquino	Feigenholtz	Martwick	Turner, D.
Belt	Fine	Morrison	Ventura
Castro	Halpin	Murphy	Villa
Cervantes	Harris, N.	Peters	Villanueva
Collins	Hunter	Porfirio	Villivalam
Cunningham	Johnson	Preston	Walker
Edly-Allen	Jones, E.	Simmons	Mr. President
Ellman	Koehler	Sims	
Faraci	Lightford	Toro	

The following voted in the negative:

Anderson	DeWitte	McClure	Syverson
Bennett	Fowler	McConchie	Tracy
Bryant	Harriss, E.	Plummer	Turner, S.
Chesney	Joyce	Rezin	Wilcox
Curran	Lewis	Stoller	

The following voted present:

Hastings
Rose

This bill, having received the vote of a constitutional majority of the members elected, was declared passed, and all amendments not adopted were tabled pursuant to Senate Rule No. 5-4(a).

Ordered that the Secretary inform the House of Representatives thereof and ask their concurrence in the Senate Amendment adopted thereto.

POSTING NOTICES WAIVED

Senator Castro moved to waive the six-day posting requirement on **House Bills numbered 307, 2363, 5496 and 5561** so that the measures may be heard in the Committee on Executive that is scheduled to meet May 22, 2024.

The motion prevailed.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A SECOND TIME

On motion of Senator Harmon, **House Bill No. 341** having been printed, was taken up, read by title a second time and ordered to a third reading.

At the hour of 1:32 o'clock p.m., the Honorable Don Harmon, President of the Senate, presiding.

On motion of Senator Aquino, **House Bill No. 5324** having been printed, was taken up, read by title a second time and ordered to a third reading.

COMMITTEE MEETING ANNOUNCEMENTS

The Chair announced the following committees to meet after caucus:

Executive in Room 212
Licensed Activities in Room 400
State Government in Room 409

The Chair announced the following committee to meet at 3:30 o'clock p.m.:

Special Committee on Criminal Law and Public Safety in Room 409

The Chair announced the following committees to meet at 4:30 o'clock p.m.:

Revenue in Room 400
Local Government in Room 409

Senator Aquino asked and obtained unanimous consent to recess for the purpose of a Democrat caucus.

PRESENTATION OF CONGRATULATORY RESOLUTION

SENATE RESOLUTION NO. 1033

Offered by Senator Simmons:

Recognizes the Black and African American communities of the 7th Senate District and expresses our deep appreciation and respect for the myriad of Black communities that currently reside in and have lived in the 7th District. Celebrates the history, achievements, culture, activism, and countless other contributions that Black people from a vast and beautiful diaspora have made to the 7th Senate District of Illinois on the far north side of Chicago.

Under the Rules, the foregoing resolution was referred to the Committee on Assignments.

At the hour of 1:34 o'clock p.m., the Chair announced that the Senate stands at recess subject to the call of the Chair.

AFTER RECESS

At the hour of 7:01 o'clock p.m., the Senate resumed consideration of business.
Senator Aquino, presiding.

PRESENTATION OF CONGRATULATORY RESOLUTIONS

SENATE RESOLUTION NO. 1034

Offered by Senator Feigenholtz:
Congratulates Teresa A. Hubka, D.O. on her election as national president of the American Osteopathic Association (AOA).

SENATE RESOLUTION NO. 1035

Offered by Senator Ellman:
Congratulates Brian W. Caputo, Ph.D. on the occasion of his retirement as president of College of DuPage. Wishes him the best in all his future endeavors.

Under the Rules, the foregoing resolutions were referred to the Committee on Assignments.

REPORTS FROM STANDING COMMITTEES

Senator Castro, Chair of the Committee on Executive, to which was referred **Senate Bill No. 3591**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.
Under the rules, the bill was ordered to a second reading.

Senator Castro, Chair of the Committee on Executive, to which was referred the following Senate floor amendments, reported that the Committee recommends do adopt:

Senate Amendment No. 1 to Senate Bill 496
Senate Amendment No. 1 to Senate Bill 497
Senate Amendment No. 1 to Senate Bill 863

Under the rules, the foregoing floor amendments are eligible for consideration on second reading.

Senator Castro, Chair of the Committee on Executive, to which was referred **House Bills Numbered 307, 2363, 4284, 4772, 4867, 5229, 5496, 5511 and 5561**, reported the same back with the recommendation that the bills do pass.
Under the rules, the bills were ordered to a second reading.

Senator Castro, Chair of the Committee on Executive, to which was referred **House Bill No. 5371**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.
Under the rules, the bill was ordered to a second reading.

Senator Glowiak Hilton, Chair of the Committee on Licensed Activities, to which was referred **House Bill No. 4357**, reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

Senator Joyce, Chair of the Committee on State Government, to which was referred **House Bills Numbered 4819, 4838 and 5028**, reported the same back with the recommendation that the bills do pass.

Under the rules, the bills were ordered to a second reading.

Senator Joyce, Chair of the Committee on State Government, to which was referred **House Joint Resolution No. 58**, reported the same back with the recommendation that the resolution be adopted.

Under the rules, **House Joint Resolution No. 58** was placed on the Secretary's Desk.

Senator Sims, Chair of the Special Committee on Criminal Law and Public Safety, to which was referred the following Senate floor amendment, reported that the Committee recommends do adopt:

Senate Amendment No. 3 to House Bill 277

Under the rules, the foregoing floor amendment is eligible for consideration on second reading.

Senator Holmes, Chair of the Committee on Local Government, to which was referred **Senate Resolution No. 957**, reported the same back with the recommendation that the resolution be adopted.

Under the rules, **Senate Resolution No. 957** was placed on the Secretary's Desk.

Senator Villanueva, Chair of the Committee on Revenue, to which was referred **House Bill No. 612**, reported the same back with the recommendation that the bill do pass.

Under the rules, the bill was ordered to a second reading.

Senator Villanueva, Chair of the Committee on Revenue, to which was referred the following Senate floor amendment, reported that the Committee recommends do adopt:

Senate Amendment No. 3 to House Bill 4179

Under the rules, the foregoing floor amendment is eligible for consideration on second reading.

MESSAGES FROM THE HOUSE

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 317

A bill for AN ACT concerning revenue.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 317

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 317

AMENDMENT NO. 1 . Amend Senate Bill 317 by replacing everything after the enacting clause with the following:

"Section 5. The Property Tax Code is amended by changing Section 21-16 as follows:

(35 ILCS 200/21-16)

Sec. 21-16. Property owned by a governmental entity ~~taxing district~~; delinquency.

(a) Notwithstanding any other provision of law, ~~in a county with more than 800,000 inhabitants but fewer than 1,000,000 inhabitants,~~ if a lessee is liable for the payment of property taxes extended against property that is owned by a governmental entity ~~taxing district~~, and those taxes remain unpaid in whole or in part 60 days after the final ~~second~~ installment due date, then the county treasurer shall promptly notify the governmental entity ~~taxing district~~ that owns the property of the delinquency in writing. The governmental entity ~~taxing district~~ shall promptly notify the county supervisor of assessments upon the execution of a new lease or the termination of a lease for property owned by the governmental entity ~~taxing district~~. The State's Attorney of the county in which the property is located may bring an action against the lessee in the circuit court in the name of the People of the State of Illinois, and, upon proof of liability, the court shall enter judgment against the lessee in a sum equal to the full amount of delinquent taxes, interest, penalties, and costs. This judgment shall be enforceable against the lessee, or any other parties provided by applicable law, in any manner permitted by law for the collection of a debt or judgment. The proceeds of any judgment under this Section shall be distributed to the taxing districts as otherwise provided in this Code.

(b) Before tax year 2024, this Section applies to property located in a county with more than 800,000 inhabitants but fewer than 1,000,000 inhabitants. For tax year 2024 and thereafter, this Section applies in all counties.

(c) As used in this Section:

"Governmental entity" means, before tax year 2024, a taxing district, as defined in Section 1-150.

"Governmental entity" means, for tax year 2024 and thereafter, a unit of federal, State, or local government, a school district, or a community college district.

(Source: P.A. 101-198, eff. 1-1-20.)

Section 99. Effective date. This Act takes effect upon becoming law.".

Under the rules, the foregoing **Senate Bill No. 317**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 1960

A bill for AN ACT concerning transportation.

Together with the following amendments which are attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 2 to SENATE BILL NO. 1960

House Amendment No. 3 to SENATE BILL NO. 1960

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 2 TO SENATE BILL 1960

AMENDMENT NO. 2 . Amend Senate Bill 1960, on page 19, by replacing lines 5 through 17 with the following:

"(j) A person may not operate a low-speed electric scooter upon any public highway in the State while under the influence of alcohol or any drug.

(k) The use of low-speed electric scooters is not permitted on State highways.

(l) Every low-speed electric scooter shall be well-maintained and in good operating condition.".

AMENDMENT NO. 3 TO SENATE BILL 1960

AMENDMENT NO. 3 . Amend Senate Bill 1960 on page 17, line 14, by replacing "right of way" with "right-of-way"; and

on page 17, immediately above line 24 by inserting the following:

"(a-5) Subject to the restrictions of this Section, the Department of Natural Resources may authorize and regulate the operation of low-speed electric scooters on any or all properties owned, managed, or leased by the Department of Natural Resources including, but not limited to, sidewalks, trails, or other public rights-of-way where the operation of bicycles is permitted. The use of low-speed electric scooters within any property that is owned, managed, or leased by the Department of Natural Resources is allowed only if authorized by the Department of Natural Resources. The Department of Natural Resources is authorized to adopt administrative rules for the regulation of low-speed electric scooters on any and all properties owned, managed, or leased by the Department of Natural Resources.".

Under the rules, the foregoing **Senate Bill No. 1960**, with House Amendments numbered 2 and 3, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 2667

A bill for AN ACT concerning transportation.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 2667

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 2667

AMENDMENT NO. 1 . Amend Senate Bill 2667 on page 1, by replacing lines 7 and 8 with the following:

"Sec. 5.1015. The Illinois USTA/Midwest Youth Tennis Foundation Fund."; and

on page 10, by replacing lines 6 through 15 with the following:

"(20) The Illinois USTA/Midwest Youth Tennis Foundation decal.

(A) Original issuance: $40; with $25 to the Illinois USTA/Midwest Youth Tennis Foundation Fund and $15 to the Secretary of State Special License Plate Fund.

(B) Renewal: $40; with $38 to the Illinois USTA/Midwest Youth Tennis Foundation Fund and $2 to the Secretary of State Special License Plate Fund."; and

on page 13, by replacing lines 6 through 11 with the following:

"(16) The Illinois USTA/Midwest Youth Tennis Foundation Fund. All money in the Illinois USTA/Midwest Youth Tennis Foundation Fund shall be paid as grants to Illinois USTA/Midwest Youth Tennis Foundation to aid USTA/Midwest districts in the State with exposing youth to the game of tennis.".

Under the rules, the foregoing **Senate Bill No. 2667**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 2682

A bill for AN ACT concerning State government.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 2682

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 2682

AMENDMENT NO. 1 . Amend Senate Bill 2682 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Increasing Representation of Women in Technology Task Force Act.

Section 5. Increasing Representation of Women in Technology Task Force; membership.

(a) The Increasing Representation of Women in Technology Task Force is hereby established within the Illinois Workforce Innovation Board.

(b) The Task Force shall consist of the following members:

(1) one member of the Senate, appointed by the President of the Senate;

(2) one member of the Senate, appointed by the Minority Leader of the Senate;

(3) one member of the House of Representatives, appointed by the Speaker of the House of Representatives;

(4) one member of the House of Representatives, appointed by the Minority Leader of the House of Representatives;

(5) the Director of the Governor's Office of Management and Budget, or the Director's designee;

(6) one member representing a statewide labor organization, appointed by the Governor;

(7) one member representing a national laboratory that is a multi-disciplinary science and engineering research center, appointed by the Governor;

(8) the Chief Equity Officer of the State of Illinois Office of Equity or the Chief Equity Officer's designee;

(9) one member representing local or State economic development interests, appointed by the Governor;

(10) one member representing women in technology, appointed by the Governor;

(11) one member representing a technology manufacturing corporation, appointed by the Governor;

(12) 4 members representing companies that have been recognized for the recruitment, advancement, and retention of women in technology positions and the corresponding management chain in the last 3 years, appointed by the Governor;

(13) one member from a community-based organization that supports women in technology, appointed by the Governor;

(14) the Vice Chancellor of Diversity, Equity & Inclusion of the University of Illinois Office of the Vice Chancellor of Diversity, Equity & Inclusion, or the Vice Chancellor's designee;

(15) the Executive Director of the Illinois Community College Board, or the Executive Director's designee;

(16) one member with knowledge of diversity, equity, and inclusion best practices from an advocacy group representing women in technology, appointed by the Governor; and

(17) A chairperson of the Illinois Workforce Innovation Board, appointed by the Illinois Workforce Innovation Board, or that chairperson's designee.

(c) The members of the Task Force shall serve without compensation.

(d) The Task Force shall meet at least quarterly to fulfill its duties under this Act. At the first meeting of the Task Force, the Task Force shall elect 2 cochairs; one chair shall be a standing member of the Illinois Workforce Innovation Board, and one chair shall be selected from among members of the Task Force.

(e) The Illinois Workforce Innovation Board shall, in consultation with an Illinois public college or university, provide administrative and other support to the Task Force.

Section 10. Duties. The Task Force shall have the following duties:

(1) subject to appropriation, collect data on the state of recruitment, advancement, and retention of women in technology positions;

(2) evaluate evidence and data on recruitment, advancement, and retention of women in technology positions and the corresponding management chain;

(3) set goals for recruitment, advancement, and retention of women in technology positions and the corresponding management chains;

(4) identify best practices for the recruitment, advancement, and retention of women in technology positions and the corresponding management chain, such as tools for data collection and analysis and techniques to improve the number of women in technology positions;

(5) recommend government policies to incentivize companies to recruit, advance, and retain women in technology positions and the corresponding management chain; and

(6) establish a plan to create an oversight body to track companies' progress year-over-year on recruitment, advancement, and retention of women in technology positions and the corresponding management chain, and manage use of the incentives for those companies with a positive track record.

Section 15. Report. The Task Force shall report to the Governor and the General Assembly by December 1 of each year on its activities and findings. The Task Force shall submit a final report to the Governor and the General Assembly by December 1, 2028 on all of its activities and final findings and recommendations.

Section 20. Repeal. This Act is repealed on January 1, 2030.

Section 99. Effective date. This Act takes effect January 1, 2025.".

Under the rules, the foregoing **Senate Bill No. 2682**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3081

A bill for AN ACT concerning education.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3081

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3081

AMENDMENT NO. 1 . Amend Senate Bill 3081 on page 3, line 26, by deleting "of Trustees".

Under the rules, the foregoing **Senate Bill No. 3081**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has passed bills of the following titles, in the passage of which I am instructed to ask the concurrence of the Senate, to-wit:

HOUSE BILL NO. 299

A bill for AN ACT concerning education.

HOUSE BILL NO. 817

A bill for AN ACT concerning State government.

HOUSE BILL NO. 3765

A bill for AN ACT concerning public employee benefits.

HOUSE BILL NO. 4799

A bill for AN ACT concerning gaming.

HOUSE BILL NO. 5430

A bill for AN ACT concerning education.

Passed the House, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

The foregoing **House Bills Numbered 299, 817, 3765, 4799 and 5430** were taken up, ordered printed and placed on first reading.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 692

A bill for AN ACT concerning local government.

Together with the following amendments which are attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 692

House Amendment No. 2 to SENATE BILL NO. 692

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 692

AMENDMENT NO. 1 . Amend Senate Bill 692 on page 3, immediately below line 19, by inserting the following:

"(9) one member representing a statewide labor organization, appointed by the Governor;"; and

on page 3, line 20, by replacing "(9)" with "(10)"; and

on page 3, line 22, by replacing "(10)" with "(11)"; and

on page 3, line 24, by replacing "(11)" with "(12)"; and

on page 3, line 26, by replacing "(12)" with "(13)"; and

on page 4, line 3, by replacing "(13)" with "(14)".

AMENDMENT NO. 2 TO SENATE BILL 692

AMENDMENT NO. 2 . Amend Senate Bill 692, AS AMENDED, in Section 5, in subsection (c) of Sec. 605-1115, by replacing paragraphs (13) and (14) with the following:

"(13) one member of the House of Representatives, appointed by the Speaker of the House of Representatives;

(14) one member of the House of Representatives, appointed by the Minority Leader of the House of Representatives; and

(15) one member representing a statewide manufacturing association, appointed by the Governor.".

Under the rules, the foregoing **Senate Bill No. 692**, with House Amendments numbered 1 and 2, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 2804

A bill for AN ACT concerning State government.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 2804
Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 2804

AMENDMENT NO. 1 . Amend Senate Bill 2804 by replacing everything after the enacting clause with the following:

"Section 5. The Department of Central Management Services Law of the Civil Administrative Code of Illinois is amended by adding Section 405-135 as follows:

(20 ILCS 405/405-135 new)

Sec. 405-135. Rulemaking for administrative hearing procedure. After consulting with affected State agencies, the Department of Central Management Services may adopt rules to facilitate electronic filing and rules governing practice and procedure in administrative hearings. Agencies that do not use the Department for administrative hearing support shall not be subject to any rulemaking or rules under this Section.

Section 99. Effective date. This Act takes effect upon becoming law.".

Under the rules, the foregoing **Senate Bill No. 2804**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3112

A bill for AN ACT concerning regulation.

Together with the following amendments which are attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 2 to SENATE BILL NO. 3112
House Amendment No. 3 to SENATE BILL NO. 3112
Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 2 TO SENATE BILL 3112

AMENDMENT NO. 2 . Amend Senate Bill 3112 on page 4, by replacing lines 3 through 7 with "rules shall be considered acted upon. In order to provide appropriate feedback, Board meetings shall be conducted within the 90-day window. If the Board does not meet within the 90 days, the 90-day window shall be extended for not more than 45 days to ensure the Board has had an opportunity to act upon the proposed rules."; and

by replacing line 24 on page 6 through line 2 on page 7 with "days, the rules shall be considered acted upon. In order to provide appropriate feedback, Board meetings shall be conducted within the 90-day window. If the Board does not meet within the 90 days, the 90-day window shall be extended for not more than 45 days to ensure the Board has had an opportunity to act upon the proposed rules.".

AMENDMENT NO. 3 TO SENATE BILL 3112

AMENDMENT NO. 3 . Amend Senate Bill 3112 on page 3, by replacing line 6 with "be a majority of appointed voting members. A member of the"; and

on page 6, by replacing line 1 with "be a majority of appointed voting members. A member of the".

Under the rules, the foregoing **Senate Bill No. 3112**, with House Amendments numbered 2 and 3, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3136

A bill for AN ACT concerning children.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3136

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3136

AMENDMENT NO. 1 . Amend Senate Bill 3136 on page 5, by replacing lines 17 through 20 with "constitute a quorum. Two legislators appointed to the Task Force shall be elected by members of the Task Force to serve as co-chairs. The"; and

on page 6, by replacing lines 6 and 7 with "provides technical assistance or implementation support to State child welfare systems to develop and implement the family recovery plans"; and

on page 6, line 9, after "Act.", by inserting "The Task Force may coordinate with existing committees or workgroups currently engaged in the development and implementation of family recovery plan requirements of the federal Child Abuse and Prevention Treatment Act.".

Under the rules, the foregoing **Senate Bill No. 3136**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3137

A bill for AN ACT concerning health.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3137

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3137

AMENDMENT NO. 1 . Amend Senate Bill 3137 on page 1, by replacing lines 11 and 12 with the following:

"representative, if known, of the patient as specified in this Section. The facility shall attempt to provide verbal notice to the personal representative, if known, of the patient"; and

on page 2, by replacing lines 8 and 9 with the following:

"representative, if known, of the recipient of services as specified in this Section. The facility shall attempt to provide verbal notice to the personal representative, if"; and

on page 2, line 12, by inserting ", if known," after "representative".

Under the rules, the foregoing **Senate Bill No. 3137**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3238

A bill for AN ACT concerning State government.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3238

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3238

AMENDMENT NO. 1 . Amend Senate Bill 3238 on page 20, immediately below line 26, by inserting the following:

"Section 23. The Commission on Equity and Inclusion Act is amended by changing Section 40-10 as follows:

(30 ILCS 574/40-10)

Sec. 40-10. Powers and duties. In addition to the other powers and duties which may be prescribed in this Act or elsewhere, the Commission shall have the following powers and duties:

(1) The Commission shall have a role in all State and university procurement by facilitating and streamlining communications between the Business Enterprise Council for Minorities, Women, and Persons with Disabilities, the purchasing entities, the Chief Procurement Officers, and others.

(2) The Commission may create a scoring evaluation for State agency directors, public university presidents and chancellors, and public community college presidents. The scoring shall be based on the following 3 principles: (i) increasing capacity; (ii) growing revenue; and (iii) enhancing credentials. These principles should be the foundation of the agency compliance plan required under Section 6 of the Business Enterprise for Minorities, Women, and Persons with Disabilities Act.

(3) The Commission shall exercise the authority and duties provided to it under Section 5-7 of the Illinois Procurement Code.

(4) The Commission, working with State agencies, shall provide support for diversity in State hiring.

(5) The Commission shall oversee the implementation of diversity training of the State workforce.

(6) Each January, and as otherwise frequently as may be deemed necessary and appropriate by the Commission, the Commission shall propose and submit to the Governor and the General Assembly legislative changes to increase inclusion and diversity in State government.

(7) The Commission shall have oversight over the following entities:

(A) the Illinois African-American Family Commission;

(B) the Illinois Latino Family Commission;

(C) the Asian American Family Commission;

(D) the Illinois Muslim American Advisory Council;

(E) the Illinois African-American Fair Contracting Commission created under Executive Order 2018-07; and

(F) the Business Enterprise Council for Minorities, Women, and Persons with Disabilities.

(7.5) The Commission shall have oversight over the collection of supplier diversity reports by State agencies to the extent that those agencies are required to collect supplier diversity reports. This oversight shall include publishing, on the Commission's website, a copy of each such supplier diversity report submitted to a State agency and may include conducting an annual hearing with each State agency to discuss ongoing compliance with supplier diversity reporting requirements. The Commission is not responsible for ensuring compliance by the filers of supplier diversity reports to their respective agencies. The agencies subject to oversight by the Commission and the relevant voluntary supplier diversity reports include the following:

(A) the Health Facilities and Services Review Board for hospitals;

(B) the Department of Commerce and Economic Opportunity for tax credit recipients under the Economic Development for a Growing Economy Tax Credit Act;

(C) the Illinois Commerce Commission for utilities and railroads;

(D) the Illinois Gaming Board for casinos; and

(E) the Illinois Racing Board for race tracks.

(7.6) The Commission may hold public workshops focused on specific industries and reports to collaboratively connect diverse enterprises with entities that manage supplier diversity programs.

These workshops may be modeled after Illinois Commerce Commission hearings for utilities and railroads that include a collaborative discussion of filed supplier diversity reports.

(8) The Commission shall adopt any rules necessary for the implementation and administration of the requirements of this Act.

(9) The Commission shall exercise the authority and duties provided to it under Section 45-57 of the Illinois Procurement Code.

(Source: P.A. 101-657, eff. 1-1-22; 102-29, eff. 6-25-21; 102-671, eff. 11-30-21.)"; and

on page 33, by replacing lines 8 and 9 with the following:

"Section 99. Effective date. This Act takes effect upon becoming law, except that Section 23 takes effect on July 1, 2025.".

Under the rules, the foregoing **Senate Bill No. 3238**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3412

A bill for AN ACT concerning regulation.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3412

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3412

AMENDMENT NO. 1 . Amend Senate Bill 3412 on page 5, line 13, after the period, by inserting "Solely for purposes of payroll processing services, "in this State" for a transaction requested electronically or by phone, means the mailing address the person requesting the payroll processing services uses with the Internal Revenue Service is in Illinois."; and

on page 33, line 20, by replacing "delegate" with "delegates"; and

on page 35, by replacing lines 21 and 22 with "shall be nonrefundable unless otherwise indicated."; and

on page 83, by replacing lines 2 through 13 with the following:

"(e) A provider of payroll processing services that was not licensed pursuant to the Transmitters of Money Act on the effective date of this Act and transmitted no more than $50,000,000 in this State in calendar year 2023 shall not be required to be licensed and comply with this Act until January 1, 2025. A provider of payroll processing services that was not licensed pursuant to the Transmitters of Money Act on the effective date of this Act and transmitted no more than $50,000,000 in this State in calendar year 2023 shall not be penalized for providing such services before January 1, 2025 if the provider submits a completed application for licensure prior to January 1, 2025."; and

by deleting line 23 on page 102 through line 2 on page 103.

Under the rules, the foregoing **Senate Bill No. 3412**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3473

A bill for AN ACT concerning education.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 2 to SENATE BILL NO. 3473

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 2 TO SENATE BILL 3473

AMENDMENT NO. 2 . Amend Senate Bill 3473 by replacing everything after the enacting clause with the following:

"Section 5. The School Code is amended by adding Section 2-3.204 and by changing Section 27A-5 as follows:

(105 ILCS 5/2-3.204 new)

Sec. 2-3.204. Type 1 diabetes informational materials.

(a) The State Board of Education, in coordination with the Department of Public Health, shall develop type 1 diabetes informational materials for the parents and guardians of students. The informational materials shall be made available to each school district and charter school on the State Board's Internet website. Each school district and charter school shall post the informational materials on the school district's or charter school's website, if any.

(b) Information developed pursuant to this Section may include, but is not limited to, all of the following:

(1) A description of type 1 diabetes.

(2) A description of the risk factors and warning signs associated with type 1 diabetes.

(3) A recommendation regarding a student displaying warning signs associated with type 1 diabetes that the parent or guardian of the student should immediately consult with the student's primary care provider to determine if immediate screening for type 1 diabetes is appropriate.

(4) A description of the screening process for type 1 diabetes and the implications of test results.

(5) A recommendation that, following a type 1 diabetes diagnosis, the parent or guardian should consult with the student's primary care provider to develop an appropriate treatment plan, which may include consultation with and examination by a specialty care provider, including, but not limited to, a properly qualified endocrinologist.

(105 ILCS 5/27A-5)

(Text of Section before amendment by P.A. 102-466 and 103-472)

Sec. 27A-5. Charter school; legal entity; requirements.

(a) A charter school shall be a public, nonsectarian, nonreligious, non-home based, and non-profit school. A charter school shall be organized and operated as a nonprofit corporation or other discrete, legal, nonprofit entity authorized under the laws of the State of Illinois.

(b) A charter school may be established under this Article by creating a new school or by converting an existing public school or attendance center to charter school status. In all new applications to establish a charter school in a city having a population exceeding 500,000, operation of the charter school shall be limited to one campus. This limitation does not apply to charter schools existing or approved on or before April 16, 2003.

(b-5) (Blank).

(c) A charter school shall be administered and governed by its board of directors or other governing body in the manner provided in its charter. The governing body of a charter school shall be subject to the Freedom of Information Act and the Open Meetings Act. A charter school's board of directors or other governing body must include at least one parent or guardian of a pupil currently enrolled in the charter school who may be selected through the charter school or a charter network election, appointment by the charter school's board of directors or other governing body, or by the charter school's Parent Teacher Organization or its equivalent.

(c-5) No later than January 1, 2021 or within the first year of his or her first term, every voting member of a charter school's board of directors or other governing body shall complete a minimum of 4 hours of professional development leadership training to ensure that each member has sufficient familiarity with the board's or governing body's role and responsibilities, including financial oversight and accountability of the school, evaluating the principal's and school's performance, adherence to the Freedom

of Information Act and the Open Meetings Act, and compliance with education and labor law. In each subsequent year of his or her term, a voting member of a charter school's board of directors or other governing body shall complete a minimum of 2 hours of professional development training in these same areas. The training under this subsection may be provided or certified by a statewide charter school membership association or may be provided or certified by other qualified providers approved by the State Board.

(d) For purposes of this subsection (d), "non-curricular health and safety requirement" means any health and safety requirement created by statute or rule to provide, maintain, preserve, or safeguard safe or healthful conditions for students and school personnel or to eliminate, reduce, or prevent threats to the health and safety of students and school personnel. "Non-curricular health and safety requirement" does not include any course of study or specialized instructional requirement for which the State Board has established goals and learning standards or which is designed primarily to impart knowledge and skills for students to master and apply as an outcome of their education.

A charter school shall comply with all non-curricular health and safety requirements applicable to public schools under the laws of the State of Illinois. The State Board shall promulgate and post on its Internet website a list of non-curricular health and safety requirements that a charter school must meet. The list shall be updated annually no later than September 1. Any charter contract between a charter school and its authorizer must contain a provision that requires the charter school to follow the list of all non-curricular health and safety requirements promulgated by the State Board and any non-curricular health and safety requirements added by the State Board to such list during the term of the charter. Nothing in this subsection (d) precludes an authorizer from including non-curricular health and safety requirements in a charter school contract that are not contained in the list promulgated by the State Board, including non-curricular health and safety requirements of the authorizing local school board.

(e) Except as otherwise provided in the School Code, a charter school shall not charge tuition; provided that a charter school may charge reasonable fees for textbooks, instructional materials, and student activities.

(f) A charter school shall be responsible for the management and operation of its fiscal affairs, including, but not limited to, the preparation of its budget. An audit of each charter school's finances shall be conducted annually by an outside, independent contractor retained by the charter school. The contractor shall not be an employee of the charter school or affiliated with the charter school or its authorizer in any way, other than to audit the charter school's finances. To ensure financial accountability for the use of public funds, on or before December 1 of every year of operation, each charter school shall submit to its authorizer and the State Board a copy of its audit and a copy of the Form 990 the charter school filed that year with the federal Internal Revenue Service. In addition, if deemed necessary for proper financial oversight of the charter school, an authorizer may require quarterly financial statements from each charter school.

(g) A charter school shall comply with all provisions of this Article, the Illinois Educational Labor Relations Act, all federal and State laws and rules applicable to public schools that pertain to special education and the instruction of English learners, and its charter. A charter school is exempt from all other State laws and regulations in this Code governing public schools and local school board policies; however, a charter school is not exempt from the following:

(1) Sections 10-21.9 and 34-18.5 of this Code regarding criminal history records checks and checks of the Statewide Sex Offender Database and Statewide Murderer and Violent Offender Against Youth Database of applicants for employment;

(2) Sections 10-20.14, 10-22.6, 24-24, 34-19, and 34-84a of this Code regarding discipline of students;

(3) the Local Governmental and Governmental Employees Tort Immunity Act;

(4) Section 108.75 of the General Not For Profit Corporation Act of 1986 regarding indemnification of officers, directors, employees, and agents;

(5) the Abused and Neglected Child Reporting Act;

(5.5) subsection (b) of Section 10-23.12 and subsection (b) of Section 34-18.6 of this Code;

(6) the Illinois School Student Records Act;

(7) Section 10-17a of this Code regarding school report cards;

(8) the P-20 Longitudinal Education Data System Act;

(9) Section 27-23.7 of this Code regarding bullying prevention;

(10) Section 2-3.162 of this Code regarding student discipline reporting;

(11) Sections 22-80 and 27-8.1 of this Code;

(12) Sections 10-20.60 and 34-18.53 of this Code;
(13) Sections 10-20.63 and 34-18.56 of this Code;
(14) Sections 22-90 and 26-18 of this Code;
(15) Section 22-30 of this Code;
(16) Sections 24-12 and 34-85 of this Code;
(17) the Seizure Smart School Act;
(18) Section 2-3.64a-10 of this Code;
(19) Sections 10-20.73 and 34-21.9 of this Code;
(20) Section 10-22.25b of this Code;
(21) Section 27-9.1a of this Code;
(22) Section 27-9.1b of this Code;
(23) Section 34-18.8 of this Code;
(25) Section 2-3.188 of this Code;
(26) Section 22-85.5 of this Code;
(27) subsections (d-10), (d-15), and (d-20) of Section 10-20.56 of this Code;
(28) Sections 10-20.83 and 34-18.78 of this Code;
(29) Section 10-20.13 of this Code;
(30) Section 28-19.2 of this Code;
(31) Section 34-21.6 of this Code; ~~and~~
(32) Section 22-85.10 of this Code; and~~.~~
(37) Section 2-3.204 of this Code.

The change made by Public Act 96-104 to this subsection (g) is declaratory of existing law.

(h) A charter school may negotiate and contract with a school district, the governing body of a State college or university or public community college, or any other public or for-profit or nonprofit private entity for: (i) the use of a school building and grounds or any other real property or facilities that the charter school desires to use or convert for use as a charter school site, (ii) the operation and maintenance thereof, and (iii) the provision of any service, activity, or undertaking that the charter school is required to perform in order to carry out the terms of its charter. Except as provided in subsection (i) of this Section, a school district may charge a charter school reasonable rent for the use of the district's buildings, grounds, and facilities. Any services for which a charter school contracts with a school district shall be provided by the district at cost. Any services for which a charter school contracts with a local school board or with the governing body of a State college or university or public community college shall be provided by the public entity at cost.

(i) In no event shall a charter school that is established by converting an existing school or attendance center to charter school status be required to pay rent for space that is deemed available, as negotiated and provided in the charter agreement, in school district facilities. However, all other costs for the operation and maintenance of school district facilities that are used by the charter school shall be subject to negotiation between the charter school and the local school board and shall be set forth in the charter.

(j) A charter school may limit student enrollment by age or grade level.

(k) If the charter school is authorized by the State Board, then the charter school is its own local education agency.

(Source: P.A. 102-51, eff. 7-9-21; 102-157, eff. 7-1-22; 102-360, eff. 1-1-22; 102-445, eff. 8-20-21; 102-522, eff. 8-20-21; 102-558, eff. 8-20-21; 102-676, eff. 12-3-21; 102-697, eff. 4-5-22; 102-702, eff. 7-1-23; 102-805, eff. 1-1-23; 102-813, eff. 5-13-22; 103-154, eff. 6-30-23; 103-175, eff. 6-30-23.)

(Text of Section after amendment by P.A. 103-472 but before amendment by P.A. 102-466)

Sec. 27A-5. Charter school; legal entity; requirements.

(a) A charter school shall be a public, nonsectarian, nonreligious, non-home based, and non-profit school. A charter school shall be organized and operated as a nonprofit corporation or other discrete, legal, nonprofit entity authorized under the laws of the State of Illinois.

(b) A charter school may be established under this Article by creating a new school or by converting an existing public school or attendance center to charter school status. In all new applications to establish a charter school in a city having a population exceeding 500,000, operation of the charter school shall be limited to one campus. This limitation does not apply to charter schools existing or approved on or before April 16, 2003.

(b-5) (Blank).

(c) A charter school shall be administered and governed by its board of directors or other governing body in the manner provided in its charter. The governing body of a charter school shall be subject to the Freedom of Information Act and the Open Meetings Act. A charter school's board of directors or other governing body must include at least one parent or guardian of a pupil currently enrolled in the charter school who may be selected through the charter school or a charter network election, appointment by the charter school's board of directors or other governing body, or by the charter school's Parent Teacher Organization or its equivalent.

(c-5) No later than January 1, 2021 or within the first year of his or her first term, every voting member of a charter school's board of directors or other governing body shall complete a minimum of 4 hours of professional development leadership training to ensure that each member has sufficient familiarity with the board's or governing body's role and responsibilities, including financial oversight and accountability of the school, evaluating the principal's and school's performance, adherence to the Freedom of Information Act and the Open Meetings Act, and compliance with education and labor law. In each subsequent year of his or her term, a voting member of a charter school's board of directors or other governing body shall complete a minimum of 2 hours of professional development training in these same areas. The training under this subsection may be provided or certified by a statewide charter school membership association or may be provided or certified by other qualified providers approved by the State Board.

(d) For purposes of this subsection (d), "non-curricular health and safety requirement" means any health and safety requirement created by statute or rule to provide, maintain, preserve, or safeguard safe or healthful conditions for students and school personnel or to eliminate, reduce, or prevent threats to the health and safety of students and school personnel. "Non-curricular health and safety requirement" does not include any course of study or specialized instructional requirement for which the State Board has established goals and learning standards or which is designed primarily to impart knowledge and skills for students to master and apply as an outcome of their education.

A charter school shall comply with all non-curricular health and safety requirements applicable to public schools under the laws of the State of Illinois. The State Board shall promulgate and post on its Internet website a list of non-curricular health and safety requirements that a charter school must meet. The list shall be updated annually no later than September 1. Any charter contract between a charter school and its authorizer must contain a provision that requires the charter school to follow the list of all non-curricular health and safety requirements promulgated by the State Board and any non-curricular health and safety requirements added by the State Board to such list during the term of the charter. Nothing in this subsection (d) precludes an authorizer from including non-curricular health and safety requirements in a charter school contract that are not contained in the list promulgated by the State Board, including non-curricular health and safety requirements of the authorizing local school board.

(e) Except as otherwise provided in the School Code, a charter school shall not charge tuition; provided that a charter school may charge reasonable fees for textbooks, instructional materials, and student activities.

(f) A charter school shall be responsible for the management and operation of its fiscal affairs, including, but not limited to, the preparation of its budget. An audit of each charter school's finances shall be conducted annually by an outside, independent contractor retained by the charter school. The contractor shall not be an employee of the charter school or affiliated with the charter school or its authorizer in any way, other than to audit the charter school's finances. To ensure financial accountability for the use of public funds, on or before December 1 of every year of operation, each charter school shall submit to its authorizer and the State Board a copy of its audit and a copy of the Form 990 the charter school filed that year with the federal Internal Revenue Service. In addition, if deemed necessary for proper financial oversight of the charter school, an authorizer may require quarterly financial statements from each charter school.

(g) A charter school shall comply with all provisions of this Article, the Illinois Educational Labor Relations Act, all federal and State laws and rules applicable to public schools that pertain to special education and the instruction of English learners, and its charter. A charter school is exempt from all other State laws and regulations in this Code governing public schools and local school board policies; however, a charter school is not exempt from the following:

(1) Sections 10-21.9 and 34-18.5 of this Code regarding criminal history records checks and checks of the Statewide Sex Offender Database and Statewide Murderer and Violent Offender Against Youth Database of applicants for employment;

(2) Sections 10-20.14, 10-22.6, 24-24, 34-19, and 34-84a of this Code regarding discipline of students;

(3) the Local Governmental and Governmental Employees Tort Immunity Act;

(4) Section 108.75 of the General Not For Profit Corporation Act of 1986 regarding indemnification of officers, directors, employees, and agents;

(5) the Abused and Neglected Child Reporting Act;

(5.5) subsection (b) of Section 10-23.12 and subsection (b) of Section 34-18.6 of this Code;

(6) the Illinois School Student Records Act;

(7) Section 10-17a of this Code regarding school report cards;

(8) the P-20 Longitudinal Education Data System Act;

(9) Section 27-23.7 of this Code regarding bullying prevention;

(10) Section 2-3.162 of this Code regarding student discipline reporting;

(11) Sections 22-80 and 27-8.1 of this Code;

(12) Sections 10-20.60 and 34-18.53 of this Code;

(13) Sections 10-20.63 and 34-18.56 of this Code;

(14) Sections 22-90 and 26-18 of this Code;

(15) Section 22-30 of this Code;

(16) Sections 24-12 and 34-85 of this Code;

(17) the Seizure Smart School Act;

(18) Section 2-3.64a-10 of this Code;

(19) Sections 10-20.73 and 34-21.9 of this Code;

(20) Section 10-22.25b of this Code;

(21) Section 27-9.1a of this Code;

(22) Section 27-9.1b of this Code;

(23) Section 34-18.8 of this Code;

(25) Section 2-3.188 of this Code;

(26) Section 22-85.5 of this Code;

(27) subsections (d-10), (d-15), and (d-20) of Section 10-20.56 of this Code;

(28) Sections 10-20.83 and 34-18.78 of this Code;

(29) Section 10-20.13 of this Code;

(30) Section 28-19.2 of this Code;

(31) Section 34-21.6 of this Code; ~~and~~

(32) Section 22-85.10 of this Code;

(33) Section 2-3.196 of this Code;

(34) Section 22-95 of this Code;

(35) Section 34-18.62 of this Code; ~~and~~

(36) the Illinois Human Rights Act; and~~.~~

(37) Section 2-3.204 of this Code.

The change made by Public Act 96-104 to this subsection (g) is declaratory of existing law.

(h) A charter school may negotiate and contract with a school district, the governing body of a State college or university or public community college, or any other public or for-profit or nonprofit private entity for: (i) the use of a school building and grounds or any other real property or facilities that the charter school desires to use or convert for use as a charter school site, (ii) the operation and maintenance thereof, and (iii) the provision of any service, activity, or undertaking that the charter school is required to perform in order to carry out the terms of its charter. Except as provided in subsection (i) of this Section, a school district may charge a charter school reasonable rent for the use of the district's buildings, grounds, and facilities. Any services for which a charter school contracts with a school district shall be provided by the district at cost. Any services for which a charter school contracts with a local school board or with the governing body of a State college or university or public community college shall be provided by the public entity at cost.

(i) In no event shall a charter school that is established by converting an existing school or attendance center to charter school status be required to pay rent for space that is deemed available, as negotiated and provided in the charter agreement, in school district facilities. However, all other costs for the operation and maintenance of school district facilities that are used by the charter school shall be subject to negotiation between the charter school and the local school board and shall be set forth in the charter.

(j) A charter school may limit student enrollment by age or grade level.

(k) If the charter school is authorized by the State Board, then the charter school is its own local education agency.
(Source: P.A. 102-51, eff. 7-9-21; 102-157, eff. 7-1-22; 102-360, eff. 1-1-22; 102-445, eff. 8-20-21; 102-522, eff. 8-20-21; 102-558, eff. 8-20-21; 102-676, eff. 12-3-21; 102-697, eff. 4-5-22; 102-702, eff. 7-1-23; 102-805, eff. 1-1-23; 102-813, eff. 5-13-22; 103-154, eff. 6-30-23; 103-175, eff. 6-30-23; 103-472, eff. 8-1-24; revised 8-31-23.)

(Text of Section after amendment by P.A. 102-466)

Sec. 27A-5. Charter school; legal entity; requirements.

(a) A charter school shall be a public, nonsectarian, nonreligious, non-home based, and non-profit school. A charter school shall be organized and operated as a nonprofit corporation or other discrete, legal, nonprofit entity authorized under the laws of the State of Illinois.

(b) A charter school may be established under this Article by creating a new school or by converting an existing public school or attendance center to charter school status. In all new applications to establish a charter school in a city having a population exceeding 500,000, operation of the charter school shall be limited to one campus. This limitation does not apply to charter schools existing or approved on or before April 16, 2003.

(b-5) (Blank).

(c) A charter school shall be administered and governed by its board of directors or other governing body in the manner provided in its charter. The governing body of a charter school shall be subject to the Freedom of Information Act and the Open Meetings Act. A charter school's board of directors or other governing body must include at least one parent or guardian of a pupil currently enrolled in the charter school who may be selected through the charter school or a charter network election, appointment by the charter school's board of directors or other governing body, or by the charter school's Parent Teacher Organization or its equivalent.

(c-5) No later than January 1, 2021 or within the first year of his or her first term, every voting member of a charter school's board of directors or other governing body shall complete a minimum of 4 hours of professional development leadership training to ensure that each member has sufficient familiarity with the board's or governing body's role and responsibilities, including financial oversight and accountability of the school, evaluating the principal's and school's performance, adherence to the Freedom of Information Act and the Open Meetings Act, and compliance with education and labor law. In each subsequent year of his or her term, a voting member of a charter school's board of directors or other governing body shall complete a minimum of 2 hours of professional development training in these same areas. The training under this subsection may be provided or certified by a statewide charter school membership association or may be provided or certified by other qualified providers approved by the State Board.

(d) For purposes of this subsection (d), "non-curricular health and safety requirement" means any health and safety requirement created by statute or rule to provide, maintain, preserve, or safeguard safe or healthful conditions for students and school personnel or to eliminate, reduce, or prevent threats to the health and safety of students and school personnel. "Non-curricular health and safety requirement" does not include any course of study or specialized instructional requirement for which the State Board has established goals and learning standards or which is designed primarily to impart knowledge and skills for students to master and apply as an outcome of their education.

A charter school shall comply with all non-curricular health and safety requirements applicable to public schools under the laws of the State of Illinois. The State Board shall promulgate and post on its Internet website a list of non-curricular health and safety requirements that a charter school must meet. The list shall be updated annually no later than September 1. Any charter contract between a charter school and its authorizer must contain a provision that requires the charter school to follow the list of all non-curricular health and safety requirements promulgated by the State Board and any non-curricular health and safety requirements added by the State Board to such list during the term of the charter. Nothing in this subsection (d) precludes an authorizer from including non-curricular health and safety requirements in a charter school contract that are not contained in the list promulgated by the State Board, including non-curricular health and safety requirements of the authorizing local school board.

(e) Except as otherwise provided in the School Code, a charter school shall not charge tuition; provided that a charter school may charge reasonable fees for textbooks, instructional materials, and student activities.

(f) A charter school shall be responsible for the management and operation of its fiscal affairs, including, but not limited to, the preparation of its budget. An audit of each charter school's finances shall be conducted annually by an outside, independent contractor retained by the charter school. The contractor shall not be an employee of the charter school or affiliated with the charter school or its authorizer in any way, other than to audit the charter school's finances. To ensure financial accountability for the use of public funds, on or before December 1 of every year of operation, each charter school shall submit to its authorizer and the State Board a copy of its audit and a copy of the Form 990 the charter school filed that year with the federal Internal Revenue Service. In addition, if deemed necessary for proper financial oversight of the charter school, an authorizer may require quarterly financial statements from each charter school.

(g) A charter school shall comply with all provisions of this Article, the Illinois Educational Labor Relations Act, all federal and State laws and rules applicable to public schools that pertain to special education and the instruction of English learners, and its charter. A charter school is exempt from all other State laws and regulations in this Code governing public schools and local school board policies; however, a charter school is not exempt from the following:

(1) Sections 10-21.9 and 34-18.5 of this Code regarding criminal history records checks and checks of the Statewide Sex Offender Database and Statewide Murderer and Violent Offender Against Youth Database of applicants for employment;

(2) Sections 10-20.14, 10-22.6, 24-24, 34-19, and 34-84a of this Code regarding discipline of students;

(3) the Local Governmental and Governmental Employees Tort Immunity Act;

(4) Section 108.75 of the General Not For Profit Corporation Act of 1986 regarding indemnification of officers, directors, employees, and agents;

(5) the Abused and Neglected Child Reporting Act;

(5.5) subsection (b) of Section 10-23.12 and subsection (b) of Section 34-18.6 of this Code;

(6) the Illinois School Student Records Act;

(7) Section 10-17a of this Code regarding school report cards;

(8) the P-20 Longitudinal Education Data System Act;

(9) Section 27-23.7 of this Code regarding bullying prevention;

(10) Section 2-3.162 of this Code regarding student discipline reporting;

(11) Sections 22-80 and 27-8.1 of this Code;

(12) Sections 10-20.60 and 34-18.53 of this Code;

(13) Sections 10-20.63 and 34-18.56 of this Code;

(14) Sections 22-90 and 26-18 of this Code;

(15) Section 22-30 of this Code;

(16) Sections 24-12 and 34-85 of this Code;

(17) the Seizure Smart School Act;

(18) Section 2-3.64a-10 of this Code;

(19) Sections 10-20.73 and 34-21.9 of this Code;

(20) Section 10-22.25b of this Code;

(21) Section 27-9.1a of this Code;

(22) Section 27-9.1b of this Code;

(23) Section 34-18.8 of this Code;

(24) Article 26A of this Code;

(25) Section 2-3.188 of this Code;

(26) Section 22-85.5 of this Code;

(27) subsections (d-10), (d-15), and (d-20) of Section 10-20.56 of this Code;

(28) Sections 10-20.83 and 34-18.78 of this Code;

(29) Section 10-20.13 of this Code;

(30) Section 28-19.2 of this Code;

(31) Section 34-21.6 of this Code; ~~and~~

(32) Section 22-85.10 of this Code;

(33) Section 2-3.196 of this Code;

(34) Section 22-95 of this Code;

(35) Section 34-18.62 of this Code; ~~and~~

(36) the Illinois Human Rights Act; and~~.~~

(37) Section 2-3.204 of this Code.

The change made by Public Act 96-104 to this subsection (g) is declaratory of existing law.

(h) A charter school may negotiate and contract with a school district, the governing body of a State college or university or public community college, or any other public or for-profit or nonprofit private entity for: (i) the use of a school building and grounds or any other real property or facilities that the charter school desires to use or convert for use as a charter school site, (ii) the operation and maintenance thereof, and (iii) the provision of any service, activity, or undertaking that the charter school is required to perform in order to carry out the terms of its charter. Except as provided in subsection (i) of this Section, a school district may charge a charter school reasonable rent for the use of the district's buildings, grounds, and facilities. Any services for which a charter school contracts with a school district shall be provided by the district at cost. Any services for which a charter school contracts with a local school board or with the governing body of a State college or university or public community college shall be provided by the public entity at cost.

(i) In no event shall a charter school that is established by converting an existing school or attendance center to charter school status be required to pay rent for space that is deemed available, as negotiated and provided in the charter agreement, in school district facilities. However, all other costs for the operation and maintenance of school district facilities that are used by the charter school shall be subject to negotiation between the charter school and the local school board and shall be set forth in the charter.

(j) A charter school may limit student enrollment by age or grade level.

(k) If the charter school is authorized by the State Board, then the charter school is its own local education agency.

(Source: P.A. 102-51, eff. 7-9-21; 102-157, eff. 7-1-22; 102-360, eff. 1-1-22; 102-445, eff. 8-20-21; 102-466, eff. 7-1-25; 102-522, eff. 8-20-21; 102-558, eff. 8-20-21; 102-676, eff. 12-3-21; 102-697, eff. 4-5-22; 102-702, eff. 7-1-23; 102-805, eff. 1-1-23; 102-813, eff. 5-13-22; 103-154, eff. 6-30-23; 103-175, eff. 6-30-23; 103-472, eff. 8-1-24; revised 8-31-23.)

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 upon becoming law.".

Under the rules, the foregoing **Senate Bill No. 3473**, with House Amendment No. 2, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3506

A bill for AN ACT concerning safety.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3506

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3506

AMENDMENT NO. 1 . Amend Senate Bill 3506 by inserting at the end of the bill the following:

"Section 99. Effective date. This Act takes effect upon becoming law.".

Under the rules, the foregoing **Senate Bill No. 3506**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3649

A bill for AN ACT concerning employment.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3649

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3649

AMENDMENT NO. 1 . Amend Senate Bill 3649 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Worker Freedom of Speech Act.

Section 5. Findings; legislative intent.

(a) The General Assembly finds that it is in the public policy interests of the State for all working Illinoisans to have protections from mandatory participation in employer-sponsored meetings if the meeting is designed to communicate an employer's position on religious or political matters.

(b) Employees should not be subject to intimidation tactics, acts of retaliation, discipline, or discharge from their employer for choosing not to participate in employer-sponsored meetings.

Section 10. Definitions. As used in this Act:

"Department" means the Department of Labor.

"Director" means the Director of Labor.

"Employee" has the meaning given in Section 2 of the Illinois Wage Payment and Collection Act.

"Employer" has the meaning given in Section 2 of the Illinois Wage Payment and Collection Act. "Employer" includes the State or any political subdivision of the State, unit of local government, or State or local government agency.

"Interested party" means an organization that monitors or is attentive to compliance with public or worker safety laws, wage and hour requirements, or other statutory requirements.

"Political matters" means matters relating to elections for political office, political parties, proposals to change legislation, proposals to change regulations, proposals to change public policy, and the decision to join or support any political party or political, civic, community, fraternal, or labor organization.

"Religious matters" means matters relating to religious belief, affiliation, and practice and the decision to join or support any religious organization or association.

"Voluntary" means, with respect to an action, that the action is not:

(1) incentivized by a positive change in any employment condition, including, but not limited to, any form of compensation or any other benefit of employment; and

(2) taken under threat of a negative change in any employment condition for non-attendance, including, but not limited to, the provisions set forth in Section 15, any negative performance evaluation, or any other adverse change in any form of compensation or any other benefit of employment.

Section 15. Employee protections. An employer or the employer's agent, representative, or designee may not discharge, discipline, or otherwise penalize, threaten to discharge, discipline, or otherwise penalize, or take any adverse employment action against an employee:

(1) because the employee declines to attend or participate in an employer-sponsored meeting or declines to receive or listen to communications from the employer or the agent, representative, or designee of the employer if the meeting or communication is to communicate the opinion of the employer about religious matters or political matters;

(2) as a means of inducing an employee to attend or participate in meetings or receive or listen to communications described in paragraph (1); or

(3) because the employee, or a person acting on behalf of the employee, makes a good faith report, orally or in writing, of a violation or a suspected violation of this Act.

Section 20. Right of action. An aggrieved employee may bring a civil action to enforce any provision of this Act no later than one year after the date of the alleged violation. A civil action may be brought by one or more employees for and on behalf of themselves and other employees similarly situated. The court may award a prevailing employee all appropriate relief, including injunctive relief, reinstatement to the employee's former position or an equivalent position, back pay, reestablishment of any employee benefits, including seniority, to which the employee would otherwise have been eligible if the violation had not occurred, and any other appropriate relief as deemed necessary by the court to make the employee whole. The court shall award a prevailing employee reasonable attorney's fees and costs.

Section 25. Powers of the Department and civil penalties.

(a) The Department shall inquire into any alleged violations of this Act, brought to its attention by an interested party, to institute the actions for the penalties provided in this Section and to enforce the provisions of this Act. In addition to the relief set forth in Section 20, an employer shall be assessed a civil penalty of $1,000 for each violation of Section 15, payable to the Department. Each employee who is subject to a violation of Section 15 shall constitute a separate violation.

(b) Upon a reasonable belief that an employer covered by this Act is in violation of any part of this Act, an interested party may assert that a violation of this Act has occurred and bring an action for penalties in the county where the violation is alleged to have occurred or where the principal office of the employer is located, pursuant to the following sequence of events:

(1) The interested party submits to the Department a complaint describing the violation and naming the employer alleged to have violated this Act.

(2) The Department sends notice of complaint to the named party alleged to have violated this Act and the interested party. The named party may either contest the alleged violation or cure the alleged violation.

(3) The named party contests or cures the alleged violation within 30 days after the receipt of the notice of complaint or, if the named party does not respond within 30 days, the Department issues a notice of right to sue to the interested party as described in paragraph (4).

(4) The Department issues a notice of right to sue to the interested party, if one or more of the following has occurred:

(A) the named party has cured the alleged violation to the satisfaction of the Director;

(B) the Director has determined that the allegation is unjustified or that the Department does not have jurisdiction over the matter or the parties; or

(C) the Director has determined that the allegation is justified or has not made a determination, and either has decided not to exercise jurisdiction over the matter or has concluded administrative enforcement of the matter.

(c) If, within 180 days after service of the notice of complaint to the parties, the Department has not (i) resolved the contest and cure period, (ii) with the mutual agreement of the parties, extended the time for the named party to cure the violation and resolve the complaint, or (iii) issued a right to sue letter, the interested party may initiate a civil action for penalties. The parties may extend the 180-day period by mutual agreement. The limitations period for the interested party to bring an action for the alleged violation of this Act shall be tolled for the 180-day period and for the period of any mutually agreed extensions. At the end of the 180-day period, or any mutually agreed extensions, the Department shall issue a right to sue letter to the interested party.

(d) Any claim or action filed under this Section must be made within 3 years after the alleged conduct resulting in the complaint plus any period for which the limitations period has been tolled.

(e) In an action brought under this Section, an interested party may recover against the employer any statutory penalties set forth in subsection (a) and injunctive relief. An interested party who prevails in a civil action shall receive 10% of any statutory penalties assessed, plus any attorney's fees and expenses in bringing the action.

(f) Nothing in this Section shall be construed to prevent an employee from bringing a civil action for the employee's own claim for a violation of this Act as described in Section 20.

Section 30. Notice. Within 30 days after the effective date of this Act, an employer shall post and keep posted a notice of employee rights under this Act where employee notices are customarily placed.

Section 35. Exceptions. Nothing in this Act:

(1) prohibits communications of information that the employer is required by law to communicate, but only to the extent of the lawful requirement;

(2) limits the rights of an employer or its agent, representative, or designee to conduct meetings involving religious matters or political matters, so long as attendance is voluntary, or to engage in communications, so long as receipt or listening is voluntary;

(3) limits the rights of an employer or its agent, representative, or designee from communicating to its employees any information that is necessary for the employees to perform their required job duties;

(4) prohibit an employer or its agent, representative, or designee from requiring its employees to attend any training intended to foster a civil and collaborative workplace or reduce or prevent workplace harassment or discrimination;

(5) prohibits an institution of higher education, or any agent, representative, or designee of the institution, from conducting meetings or participating in any communications with its employees concerning any coursework, symposia, research, publication, or an academic program at the institution;

(6) prohibits a political organization, a political party organization, a caucus organization, a candidate's political organization, or a not-for-profit organization that is exempt from taxation under Section 501(c)(4), 501(c)(5), or 501(c)(6) of the Internal Revenue Code from requiring its staff or employees to attend an employer-sponsored meeting or participate in any communication with the employer or the employer's agent, representative or designee for the purpose of communicating the employer's political tenets or purposes;

(7) prohibits the General Assembly or a State or local legislative or regulatory body from requiring their employees to attend an employer-sponsored meeting or participate in any communication with the employer or the employer's agent, representative, or designee for the purpose of communicating the employer's proposals to change legislation, proposals to change regulations, or proposals to change public policy; or

(8) prohibits a religious organization from requiring its employees to attend an employer-sponsored meeting or participate in any communication with the employer or the employer's agent, representative or designee for the purpose of communicating the employer's religious beliefs, practices, or tenets.".

Under the rules, the foregoing **Senate Bill No. 3649**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by

Mr. Hollman, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3753

A bill for AN ACT concerning health.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 2 to SENATE BILL NO. 3753

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 2 TO SENATE BILL 3753

AMENDMENT NO. 2 . Amend Senate Bill 3753 by replacing everything after the enacting clause with the following:

"Section 5. The Mental Health and Developmental Disabilities Administrative Act is amended by adding Section 8.1 as follows:

(20 ILCS 1705/8.1 new)

Sec. 8.1. Admission to State-operated facilities for persons with developmental disabilities.

(a) For any individual or guardian, or both, if applicable, seeking admission for the individual to a State-operated facility for persons with developmental disabilities the individual must meet the following criteria in order to be approved for admission:

(1) the individual is at least 18 years of age;

(2) the individual and the individual's guardian, as applicable, have received, attempted to receive, or received education regarding community-based services and supports;

(3) the individual meets the intermediate care facility level of care definition; and

(4) the individual meets all clinical eligibility requirements including having an intellectual disability as defined in this Act.

(b) Upon admission to a State-operated facility for persons with developmental disabilities, the facility shall complete at least annual reviews of the individual's clinical need for continued services in order to determine if these needs are able to be met in a less restrictive setting. Comprehensive and integrated assessments shall be used to assist in determining the level of care and services most appropriate to meet the individual's needs.

(c) All individuals shall have the right to know their options for supports and shall be provided the opportunity to learn about the full spectrum of care, including the range of possible living environments available as provided by entities, including, but not limited to, State-operated facilities and case management agencies. If an individual indicates that the individual would like to move to a less restrictive environment, activities to explore and take steps regarding the range of options shall be provided to the individual and guardian, if applicable. The interdisciplinary team shall assist the individual and guardian, if applicable, to identify placements that are able to meet the individual's needs, excluding when there are severe safety concerns identified by the interdisciplinary team that cannot be easily mitigated with interventions that are commonly used in the community.

An individual's support plan shall include services to address identified needs if the individual is clinically determined to no longer meet the intermediate care facility level of care, or be at risk of harm to the individual or others. Thoughtful transition planning shall take place to assist with finding a less restrictive environment of the individual's choosing, and guardian's choosing, if applicable.

Section 10. The Mental Health and Developmental Disabilities Code is amended by changing Section 4-302 and by adding Article VIII to Chapter IV as follows:

(405 ILCS 5/Ch. IV Art. VIII heading new)

ARTICLE VIII. SERVICE PROVIDER SANCTIONS

(405 ILCS 5/4-302) (from Ch. 91 1/2, par. 4-302)

Sec. 4-302. A person with a developmental disability may be administratively admitted to a facility upon application if the facility director of the facility determines that the person ~~he~~ is suitable for admission. A person 18 years of age or older, if the person ~~he~~ has the capacity, or the person's ~~his~~ guardian, if ~~he is~~ authorized by the guardianship order of the Circuit Court, may execute an application for administrative admission. Application may be executed for a person under 18 years of age by the person's ~~his~~ parent, guardian, or person in loco parentis pursuant to the Intermediate Care for the Developmentally Disabled Facilities Code authorized under the ID/DD Community Care Act.

(Source: P.A. 88-380.)

(405 ILCS 5/4-800 new)

Sec. 4-800. Provider sanctions and appeals. The Department of Human Services Division of Developmental Disabilities may impose progressive sanctions on providers that fail to comply with conditions specified by rule, or contract agreement, as determined by the Department. Sanctions include, but are not limited to, payment suspension, loss of payment, enrollment limitations, admission holds, removal of individuals currently served, or other actions up to and including contract termination, certification revocation, or licensure revocation. In situations in which recipients of services are placed at imminent risk of harm, steps to ensure the safety of individuals and any provider sanctions shall be taken expeditiously and not progressively. A service provider that has received a sanction may appeal the sanction in writing to the Department of Healthcare and Family Services within 30 days of receipt of the sanction. Steps to ensure the safety of individuals may be taken regardless of a service provider appeal. The Department shall adopt rules as necessary to implement this Section.

(405 ILCS 5/4-801 new)

Sec. 4-801. Provider discharge reconsideration requests. After an informal review of a discharge by the Department of Human Services Division of Developmental Disabilities, a provider may request a

reconsideration of the decision, to the Department of Human Services Division of Developmental Disabilities. The reconsideration request must be received within 10 working days after the provider receives the written notification, following the informal review decision from the Department of Human Services Division of Developmental Disabilities. The Department of Human Services shall adopt rules as necessary to implement this Section.".

Under the rules, the foregoing **Senate Bill No. 3753**, with House Amendment No. 2, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3768

A bill for AN ACT concerning education.
Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:
House Amendment No. 2 to SENATE BILL NO. 3768
Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 2 TO SENATE BILL 3768

AMENDMENT NO. 2 . Amend Senate Bill 3768 by replacing everything after the enacting clause with the following:

"Section 5. The School Code is amended by changing Section 14-11.02 as follows:
(105 ILCS 5/14-11.02) (from Ch. 122, par. 14-11.02)
Sec. 14-11.02. The Philip J. Rock Center and School for the Deafblind. ~~Notwithstanding any other Sections of this Article, the State Board of Education shall develop and operate or contract for the operation of a service center for persons who are deaf-blind.~~

(a) For the purpose of this Section, persons who are deafblind ~~with deaf-blindness~~ are (i) individuals with concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness, (ii) individuals with solely a hearing impairment, or (iii) individuals with solely a visual impairment ~~persons who have both auditory and visual impairments, the combination of which causes such severe communication and other developmental, educational, vocational and rehabilitation problems that such persons cannot be properly accommodated in special education or vocational rehabilitation programs solely for persons with both hearing and visual disabilities~~.

(b) To be eligible for deafblind ~~deaf-blind~~ services under this Section, a person must have (i) a visual impairment, a hearing ~~and an auditory~~ impairment, or both or (ii) a condition in which there is a progressive loss of hearing, ~~or~~ vision, or both that ~~results in concomitant vision and hearing impairments and that~~ adversely affects educational performance as determined by the multidisciplinary conference. For purposes of this ~~paragraph and~~ Section:

(1) ~~(A)~~ A visual impairment shall have the same meaning as in the federal Individuals With Disabilities Education Act and its implementing regulations ~~is defined to mean one or more of the following: (i) corrected visual acuity poorer than 20/70 in the better eye; (ii) restricted visual field of 20 degrees or less in the better eye; (iii) cortical blindness; (iv) does not appear to respond to visual stimulation, which adversely affects educational performance as determined by the multidisciplinary conference~~.

(2) A hearing ~~(B) An auditory~~ impairment shall have the same meaning as in the federal Individuals With Disabilities Education Act and its implementing regulations ~~is defined to mean one or more of the following: (i) a sensorineural or ongoing or chronic conductive hearing loss with aided sensitivity of 30dB HL or poorer; (ii) functional auditory behavior that is significantly discrepant from the person's present cognitive and/or developmental levels, which adversely affects educational performance as determined by the multidisciplinary conference~~.

(c) Notwithstanding any other provision of Article 14, the ~~The~~ State Board of Education shall ~~is empowered to establish,~~ maintain and operate or contract for the operation of a permanent, statewide, residential education facility ~~state-wide service center~~ known as the Philip J. Rock Center and School that services~~. The School serves~~ eligible students ~~children~~ between the ages of 3 and 21, unless a student's 22nd birthday occurs during the school year, in which case the student is eligible for such services through the end of the school year. Subject to appropriation, the Philip J. Rock Center and School may provide additional services to ~~21; the Center serves~~ eligible deafblind persons of all ages. The State Board of Education shall include a line item in its budget to pay the costs of operating and maintaining the Philip J. Rock Center and School. If the Center and School receives appropriated funding to serve eligible deafblind persons of all ages, services ~~Services~~ provided by the Center and School shall include, but are not limited to:

(1) identifying ~~Identifying~~ and providing case management of individuals with combined vision and hearing loss ~~persons who are auditorily and visually impaired~~;

(2) providing ~~Providing~~ families with appropriate information and dissemination of information ~~counseling~~;

(3) providing information to ~~Referring~~ persons who are deafblind about the ~~deaf-blind to~~ appropriate agencies for medical and diagnostic services;

(4) referring ~~Referring~~ persons who are deafblind ~~deaf-blind~~ to appropriate agencies for educational, rehabilitation, and support ~~training and care~~ services;

(5) developing ~~Developing~~ and expanding services throughout the State to persons who are deafblind ~~deaf-blind~~. This shall ~~will~~ include ancillary services, such as transportation, so that these persons ~~the individuals~~ can take advantage of the expanded services;

(6) maintaining ~~Maintaining~~ a residential-educational training facility, with or without a day program, in the Chicago metropolitan area located near ~~in an area accessible to~~ public transportation;

(7) (blank); ~~Receiving, dispensing, and monitoring State and Federal funds to the School and Center designated for services to persons who are deaf-blind;~~

(8) coordinating ~~Coordinating~~ services to persons who are deafblind ~~deaf-blind~~ through all appropriate agencies, including the Department of Children and Family Services and the Department of Human Services;

(9) entering ~~Entering~~ into contracts with other agencies to provide services to persons who are deafblind ~~deaf-blind~~;

(10) (blank); ~~Operating on a no-reject basis. Any individual referred to the Center for service and diagnosed as deaf-blind, as defined in this Act, shall qualify for available services;~~

(11) serving ~~Serving~~ as the information ~~referral~~ clearinghouse for all persons who are deafblind ~~deaf-blind, age 21 and older~~; and

(12) (blank). ~~Providing transition services for students of Philip J. Rock School who are deaf-blind and between the ages of 14 1/2 and 21.~~

Priority of services shall be given to students referred to the Philip J. Rock Center and School who qualify as individuals with concomitant hearing and visual impairments under clause (i) of subsection (a) of this Section or who are eligible for special education services under the category of deafblind. Such a student may not be denied enrollment unless the student's placement in the Center and School would endanger the health or safety of any other student.

(d) For the purposes of employment, the Philip J. Rock Center and School shall be considered its own employer. The State Board of Education shall appoint a chief administrator of the Philip J. Rock Center and School, who shall be employed by the Center and School and shall manage the daily operations of the Center and School. The chief administrator shall have the authority on behalf of the Center and School to:

(1) hire, evaluate, discipline, and terminate staff of the Center and School;

(2) determine wages, benefits, and other conditions of employment for all Center and School employees;

(3) bargain with the exclusive bargaining representative of the employees of the Center and School;

(4) develop a budget to be submitted to the State Board of Education for review and approval;

(5) contract for any professional, legal, and educational services necessary for the operation of the Center and School;

(6) make all decisions regarding the daily operations of the Center and School; and

(7) perform any other duties as set forth in the employment contract for the chief administrator.

(e) If the State Board of Education contracts for the fiscal administration of the Philip J. Rock Center and School, then the contract shall be with a school district, special education cooperative, or regional office of education that can serve as the fiscal agent for the Center and School. To the extent possible, the fiscal agent shall be in close geographic proximity to the Center and School.

(f) Through the individualized education program process with the student's resident school district, a student who resides at the Philip J. Rock Center and School may be placed in an alternate educational program by the student's individualized education program team. Educational placement and services shall be provided free of charge to the student's resident school district, unless there is tuition associated with the educational placement and services. If the Philip J. Rock Center and School must pay tuition or provide transportation for a student's educational placement and services, such tuition or transportation shall be billed to the student's resident school district.

(g) The Advisory Board for Services for Persons who are deafblind ~~Deaf-Blind~~ shall provide advice to the State Superintendent of Education, the Governor, and the General Assembly on all matters pertaining to policy concerning persons who are deafblind ~~deaf-blind~~, including the implementation of legislation enacted on their behalf.

The ~~Regarding the maintenance, operation and education functions of the Philip J. Rock Center and School, the~~ Advisory Board shall also make recommendations pertaining to but not limited to the following matters:

(1) existing ~~Existing~~ and proposed programs of all State agencies that provide services for persons who are deafblind ~~deaf-blind~~;

(2) the ~~The~~ State program and financial plan for deafblind ~~deaf-blind~~ services and the system of priorities to be developed by the State Board of Education;

(3) standards ~~Standards~~ for services in facilities serving persons who are deafblind ~~deaf-blind~~;

(4) standards ~~Standards~~ and rates for State payments for any services purchased for persons who are deafblind ~~deaf-blind~~;

(5) services ~~Services~~ and research activities in the field of deafblindness ~~deaf-blindness~~, including the evaluation of services; and

(6) planning ~~Planning~~ for personnel or preparation ~~personnel/preparation~~, both preservice and inservice.

The Advisory Board shall consist of 3 persons appointed by the Governor; 2 persons appointed by the State Superintendent of Education; 4 persons appointed by the Secretary of Human Services; and 2 persons appointed by the Director of Children and Family Services. ~~The 3 appointments of the Governor shall consist of a senior citizen 60 years of age or older, a consumer who is deaf-blind, and a parent of a person who is deaf-blind; provided that if any gubernatorial appointee serving on the Advisory Board on the effective date of this amendatory Act of 1991 is not either a senior citizen 60 years of age or older or a consumer who is deaf-blind or a parent of a person who is deaf-blind, then whenever that appointee's term of office expires or a vacancy in that appointee's office sooner occurs, the Governor shall make the appointment to fill that office or vacancy in a manner that will result, at the earliest possible time, in the Governor's appointments to the Advisory Board being comprised of one senior citizen 60 years of age or older, one consumer who is deaf-blind, and one parent of a person who is deaf-blind.~~ One person designated by each agency other than the Department of Human Services may be an employee of that agency. Two persons appointed by the Secretary of Human Services may be employees of the Department of Human Services. The appointments of each appointing authority other than the Governor shall include at least one parent of an individual who is deafblind ~~deaf-blind~~ or a person who is deafblind ~~deaf-blind~~.

Vacancies in terms shall be filled by the original appointing authority. After the original terms, all terms shall be for 3 years.

~~Except for those members of the Advisory Board who are compensated for State service on a full-time basis, members shall be reimbursed for all actual expenses incurred in the performance of their duties. Each member who is not compensated for State service on a full-time basis shall be compensated at a rate of $50 per day which he spends on Advisory Board duties.~~ The Advisory Board shall meet at least 2 ~~4~~ times per year ~~and not more than 12 times per year~~.

The State Board of Education ~~Advisory Board~~ shall provide support to the Advisory Board ~~for its own organization~~.

~~Six members of the Advisory Board shall constitute a quorum.~~ The affirmative vote of a majority of all members of the Advisory Board shall be necessary for any action taken by the Advisory Board.

(Source: P.A. 88-670, eff. 12-2-94; 89-397, eff. 8-20-95; 89-507, eff. 7-1-97.)".

Under the rules, the foregoing **Senate Bill No. 3768**, with House Amendment No. 2, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 3771

A bill for AN ACT concerning education.

Together with the following amendment which is attached, in the adoption of which I am instructed to ask the concurrence of the Senate, to-wit:

House Amendment No. 1 to SENATE BILL NO. 3771

Passed the House, as amended, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

AMENDMENT NO. 1 TO SENATE BILL 3771

AMENDMENT NO. 1 . Amend Senate Bill 3771 on page 2, line 13, after the period, by inserting "Beginning with grants awarded for the 2025-2026 academic year, a grant under this Section may also be used at any private, not-for-profit college or university in this State that is approved to participate in the Monetary Award Program under Section 35 of this Act. A recipient attending such a private, not-for-profit college or university shall receive payment of tuition and mandatory fees in an amount not to exceed the maximum grant payable to a student enrolled in the most expensive comparable program of study at a public college or university in this State."; and

on page 8, by replacing lines 18 through 24 with the following:
"person whose records were expunged and sealed. The clerk shall post in the common areas of the courthouse a notice containing information about grants for exonerated persons and their dependents under Section 62 of the Higher Education Student Assistance Act, including the Internet address of the Illinois Student Assistance Commission. The Illinois Student Assistance Commission shall develop a uniform statewide notice and provide the format of the notice to each clerk.".

Under the rules, the foregoing **Senate Bill No. 3771**, with House Amendment No. 1, was referred to the Secretary's Desk.

A message from the House by
Mr. Hollman, Clerk:
Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of bills of the following titles, to-wit:

SENATE BILL NO. 275

A bill for AN ACT concerning transportation.

SENATE BILL NO. 464

A bill for AN ACT concerning education.

SENATE BILL NO. 508

A bill for AN ACT concerning employment.

Passed the House, May 22, 2024.

JOHN W. HOLLMAN, Clerk of the House

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A FIRST TIME

House Bill No. 299, sponsored by Senator Harmon, was taken up, read by title a first time and referred to the Committee on Assignments.

House Bill No. 817, sponsored by Senator Harmon, was taken up, read by title a first time and referred to the Committee on Assignments.

House Bill No. 3765, sponsored by Senator Cunningham, was taken up, read by title a first time and referred to the Committee on Assignments.

House Bill No. 4799, sponsored by Senator Hastings, was taken up, read by title a first time and referred to the Committee on Assignments.

House Bill No. 5430, sponsored by Senator N. Harris, was taken up, read by title a first time and referred to the Committee on Assignments.

READING BILL OF THE SENATE A SECOND TIME

On motion of Senator Stadelman, **Senate Bill No. 3591** having been printed, was taken up, read by title a second time.

The following amendments were offered in the Committee on Executive, adopted and ordered printed:

AMENDMENT NO. 1 TO SENATE BILL 3591

AMENDMENT NO. 1 . Amend Senate Bill 3591 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Journalism Preservation Act.

Section 5. Findings.

(a) A free and diverse fourth estate was critical in the founding of our democracy and continues to be the lifeblood for a functioning democracy.

(b) Every day, journalism plays an essential role in Illinois and in local communities, and the ability of local news organizations to continue to provide the public with critical information about their communities and enabling publishers to receive fair market value for their content that is used by others will preserve and ensure the sustainability of local and diverse news outlets.

(c) Communities without newspapers lose touch with government, business, education, and neighbors. They operate without journalists working to keep them informed, uncover truth, expose corruption, and share common goals and experiences.

(d) Over the past 10 years, newspaper advertising has decreased 66%, and newsroom staff has declined 44%.

(e) Ethnic media has long been a distinctive genre of journalism and communications, informing, engaging, and advocating on behalf of communities underserved by both the for-profit and not-for-profit general media market. It plays a unique role in upholding the fourth estate in our democracy by facilitating cross-racial and cross-ethnic communications to facilitate social integration, promote civic engagement, and address inequalities among all of the underserved communities.

(f) Given the important role of ethnic media, it is critical to advance State policy that ensures their publishers are justly compensated for the content they create and distribute. An example is the historic preamble, "We Wish to Plead Our Own Cause," a document penned by the African-American journalist and abolitionist Samuel Cornish in 1827. It marked a significant milestone in the history of the Black press as it highlighted the urgent need for African Americans to have their own platform to voice their grievances, advocate for their rights, and challenge racial inequality. This call to action spurred the establishment of numerous Black-owned newspapers and publications, solidifying the role of the Black press as a powerful tool for empowerment and social change, and laid the groundwork in our country for other ethnic media to plead their own cause.

(g) Quality local journalism is key to sustaining civic society, strengthening communal ties, and providing information at a deeper level that national outlets cannot match.

(h) When surveyed, 73% of adults in the United States say they have confidence in their local newspaper.

Section 10. Definitions. As used in this Act:

"Access" means to acquire, to crawl, or to index content.

"Advertising revenue" means revenue generated through the sale of digital advertising impressions that are served to customers in this State through an online platform, regardless of whether those impressions are served on websites or accessed through online or mobile applications.

"Covered platform" means an online platform that, at any point during a 12-month period, either:

(1) has at least 50,000,000 United States-based monthly active users or subscribers on the online platform; or

(2) is owned or controlled by a person that either has:

(A) net annual sales in the United States or a market capitalization greater than $550,000,000,000, adjusted annually for inflation on the basis of the Consumer Price Index published by the United States Bureau of Labor Statistics; or

(B) at least 1,000,000,000 worldwide monthly active users on the online platform.

"Covered platform" does not mean an organization exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986.

"Eligible broadcaster" means a person that:

(1) holds or operates under a license issued by the Federal Communications Commission under 47 U.S.C. 301 et seq.;

(2) engages professionals to create, edit, produce, and distribute original content concerning local, regional, national, or international matters of public interest through activities, including conducting interviews, observing current events, analyzing documents and other information, or fact checking through multiple firsthand or secondhand news sources;

(3) updates its content on at least a weekly basis; and

(4) uses an editorial process for error correction and clarification, including a transparent process for reporting errors or complaints to the station.

"Eligible digital journalism provider" means an eligible publisher or eligible broadcaster that discloses its ownership to the public.

"Eligible publisher" means a person that publishes a qualifying publication.

"News journalist" means a natural person who:

(1) is employed for an average of at least 30 hours per week during a calendar year by an eligible digital journalism provider; and

(2) is responsible for gathering, developing, preparing, directing the recording of, producing, collecting, photographing, recording, writing, editing, reporting, designing, presenting, distributing, or publishing original news or information that concerns local, regional, national, or international matters of public interest.

"Notifying eligible digital journalism provider" means an entity that has provided notice to a covered platform as described in Section 15 that the entity is an eligible digital journalism provider.

"Online platform" means a website, online or mobile application, digital assistant, or online service that:

(1) accesses news articles, works of journalism, or other content, or portions thereof, generated, created, produced, or owned by an eligible digital journalism provider; and

(2) aggregates, displays, provides, distributes, or directs users to content described in paragraph (1) of this definition.

"Qualifying publication" means a website, online or mobile application, or other digital service that:

(1) does not primarily display, provide, distribute, or offer content generated, created, produced, or owned by an eligible broadcaster;

(2) provides information to an audience in this State;

(3) performs a public information function comparable to that traditionally served by newspapers and other periodical news publications;

(4) engages professionals to create, edit, produce, and distribute original content concerning local, regional, national, or international matters of public interest through activities, including conducting interviews, observing current events, analyzing documents and other information, or fact checking through multiple firsthand or secondhand news sources;

(5) updates its content at least 52 weeks in a calendar year;

(6) has an editorial process for error correction and clarification, including a transparent process for reporting errors or complaints to the publication; and

(7) meets any of the following criteria:

(A) generated at least $100,000 in annual revenue from its editorial content in the previous calendar year;

(B) had an International Standard Serial Number assigned to an affiliated periodical before submitting notice to a covered platform under Section 15; or

(B) is owned or controlled by an organization exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986;

(8) has at least 25% of its editorial content consisting of information about topics of current local, regional, national, or international public interest; or

(9) is not controlled, or wholly or partially owned by, an entity that:

(A) is a foreign power or an agent of a foreign power, as those terms are defined in 50 U.S.C. 1801;

(2) is designated as a foreign terrorist organization under 8 U.S.C. 1189;

(3) is a terrorist organization, as defined in 8 U.S.C. 1182;

(4) is designated as a specially designated global terrorist organization under federal Executive Order 13224;

(5) is an affiliate of an entity described in subparagraph (1), (2), (3), or (4); and

(6) has been convicted of violating, or attempting to violate 18 U.S.C. 2331, 2332b, or 2339A.

"Representative" means a labor organization designated as the exclusive bargaining representative of news journalists or support staff for the purposes of collective bargaining in accordance with State or federal law.

"Support staff" means a natural person who performs nonexecutive functions, including payroll, human resources, fundraising and grant support, advertising and sales, community events and partnerships, technical support, sanitation, and security.

Section 15. Notice requirements for journalism usage fee payments.

(a) On or before January 1, 2025, all eligible digital journalism providers that want to receive journalism usage fee payments under this Act shall submit notice to a covered platform as described in subsection (b). All eligible digital journalism providers that submit the notice shall receive journalism usage fee payments from covered platforms as described in Section 20 beginning no later than 30 days after the end of the arbitration process described in Section 25. Digital journalism providers may provide notice to a covered platform as described in subsection (b) after the initial arbitration has concluded; however, notice received from an eligible digital journalism provider after January 1, 2025, shall not prompt any adjustment to the percentage of advertising revenue that has previously been determined under the most recent arbitration proceeding conducted as described in Section 25.

(b) The notice described in subsection (a) shall:

(1) identifies the eligible digital journalism provider and the authorized representative of the eligible digital journalism provider;

(2) certifies, not under penalty of perjury, that the eligible digital journalism provider reasonably believes that it is either an eligible broadcaster or an eligible publisher; and

(3) identifies the root uniform resource locators for the websites associated with the eligible digital journalism provider's digital content.

(c) No later than 30 days after submitting a notice described in subsection (b), the eligible digital journalism provider shall distribute a copy of the notice to the news journalists and support staff that it employs and their representatives, if any, and publish a copy of the notice online in a text-searchable format.

(d) No later than 30 days after the deadline described in subsection (a), or after receiving a notice as described in subsection (a), the covered platform shall send a reply notice to the authorized representative identified in subsection (b) to acknowledge the receipt of the notice.

(e) A covered platform that receives as described in paragraph (b) may, within 30 days after receiving the notice, challenge:

(1) the sufficiency of the notice; and

(2) the noticing party's qualification as an eligible digital journalism provider.

Section 20. Compensation methods. A covered platform shall:

(1) annually compensate digital journalism providers for accessing the websites of the digital journalism providers, with the compensation annually adjusted for increases in the Consumer Price Index for All Urban Consumers for all items published by the United States Department of Labor and annually distributed to the digital journalism providers as follows:

(A) no less than 1% of this amount shall be paid to digital journalism providers that would receive less than $25,000 under paragraph (B), to be distributed annually on a pro rate basis among those digital journalism providers, in addition to the amount those digital journalism providers would receive under to paragraph (B); and

(B) proportionally by the number of news journalists and, subject to Section 35, freelancers, who, in the previous calendar year, were employed by each qualifying publication for the purpose of producing content in Illinois that was accessed by a platform; or

(2) participate in a final arbitration process as described in Section 25 and fully pay the arbitration award, if any, within 30 days after the award.

Section 23. Distributions.

(a) A covered platform shall make distributions as described in Section 20 either by:

(1) selecting an approved claims administrator. In selecting an approved claims administrator the covered platform shall ensure that the approved claims administrator is well-qualified to perform the distribution and has administered multiple settlements in the State of Illinois that comply with complex civil litigation class action settlement guidelines in at least 2 State or federal courts in Illinois. The costs of selecting an approved claims administrator to administer the distributions shall be in addition to the amount established in Section 20.

(2) distributing payments to digital journalism providers itself, the costs of which shall be in addition to the amount specified in Section 20.

(b) A final arbitration award under Section 25 to a jointly participating group of digital journalism providers shall be distributed proportionally by the number of news journalists and, subject to Section 35, freelancers, who, in the previous calendar year, were employed by each qualifying publication for the purpose of producing content in Illinois that was accessed by a covered platform.

Section 25. Arbitration.

(a) The percentage of the covered platform's advertising revenue remitted to notifying eligible digital journalism providers shall be determined as described in this Section. Eligible digital journalism providers shall jointly participate in the final offer arbitration process described in this Section with each covered platform to determine a single percentage of advertising revenue from which the distributions described in Section 23 will be allotted.

(b) Within 10 days after the receipt of the reply notice required by subsection (d) of Section 15, an eligible digital journalism provider may initiate, under Rule R-4 of the American Arbitration Association's Commercial Arbitration Rules and Mediation Procedures, a final offer arbitration against the covered platform for an arbitration panel to determine the percentage of the covered platform's advertising revenue remitted to the notifying eligible digital journalism providers.

(c) The arbitration procedure authorized by this subsection shall commence 10 days after the receipt of the reply notice described in subsection (d) of Section 15.

(d) The arbitration procedure authorized by this subsection shall be decided by a panel of 3 arbitrators under the American Arbitration Association's Commercial Arbitration Rules and Mediation Procedures and the American Arbitration Association-International Centre for Dispute Resolution Final Offer Arbitration Supplementary Rules, except to the extent they conflict with this Section.

(e) The covered platform and the eligible digital journalism providers shall each pay one-half of the cost of administering the arbitration proceeding, including arbitrator compensation, expenses, and administrative fees.

(f) The arbitrators shall be appointed in accordance with the American Arbitration Association's Commercial Arbitration Rules and Mediation Procedures.

(g) During a final offer arbitration proceeding under this Section, all of the following shall apply:

(1) Eligible digital journalism providers and the covered platform may demand the production of documents and information that are non-privileged, reasonably necessary, and reasonably

accessible without undue expense. Documents and information shall be exchanged no later than 30 days after the date the demand is filed.

(2) Rules regarding the admissibility of evidence under the American Arbitration Association's Commercial Arbitration Rules and Mediation Procedures shall apply.

(3) Eligible digital journalism providers and the covered platform shall each submit a final offer proposal for the remuneration that the eligible digital journalism providers should receive from the covered platform for access to the content of the eligible digital journalism providers during the period under arbitration based on the value that access provides to the platform. The final offer proposals shall include backup materials sufficient to permit the other party to replicate the proffered valuation.

(4) A final offer proposal under this Section shall not address whether or how the covered platform or any eligible digital journalism provider displays, ranks, distributes, suppresses, promotes, throttles, labels, filters, or curates the content of the eligible digital journalism providers or any other person.

(h) No later than 60 days after the date proceedings begin as described in subsection (c), the arbitration panel shall determine the percentage of the covered platform's advertising revenue remitted to notifying eligible digital journalism providers from a final offer from one of the parties without modification.

(1) In making a determination, the arbitration panel shall:

(A) refrain from considering any value conferred upon any eligible digital journalism provider by the covered platform for distributing or aggregating its content as an offset to the value created by that eligible digital journalism provider, unless the covered platform does not automatically access and extract information from an eligible digital journalism provider's website;

(B) consider past incremental revenue contributions as a guide to the future incremental revenue contribution by any eligible digital journalism provider;

(C) consider the pricing, terms, and conditions of any available, comparable commercial agreements between parties granting access to digital content, including pricing, terms, and conditions relating to price, duration, territory, and the value of data generated directly or indirectly by the content accounting for any material disparities in negotiating power between the parties to those commercial agreements;

(D) if submitted with a final offer proposal, consider the eligible digital journalism provider's previous compliance with Section 40, if applicable; and

(E) issue a standard binding arbitration award of the percentage of the covered platform's advertising revenue remitted to notifying eligible digital journalism providers.

(2) Any party to the arbitration proceeding may elect to appeal the decision of the arbitration panel as described in subsection (j) on the grounds of a procedural irregularity.

(i) If the covered platform and any eligible digital journalism providers have given notice under Section 15 reach a settlement in lieu of arbitration, the settlement shall not waive the eligible digital journalism provider's obligations as described in Section 40 and shall not settle for an amount other than the final offer proposals submitted by the parties as described in paragraph (3) of subsection (g).

(j) No fewer than 24 months after the end of an arbitration proceeding, any party to the proceeding may elect to restart the arbitration process.

Section 30. Non-retaliation.

(a) A covered platform shall not retaliate against an eligible digital journalism provider for asserting its rights under this Act by refusing to index content or changing the ranking, identification, modification, branding, or placement of the content of the eligible digital journalism provider on the covered platform.

(b) An eligible digital journalism provider that is retaliated against may bring a civil action against the covered platform.

(c) This Section does not prohibit a covered platform from, and does not impose liability on a covered platform for, enforcing its terms of service against an eligible journalism provider.

Section 35. Funding for journalists and support staff.

(a) An eligible digital journalism provider shall spend at least 70% of funds received under this Act on news journalists and support staff employed by the eligible digital journalism provider, except that an

eligible digital journalism provider with 5 or fewer employees shall spend at least 50% of funds received under this Act on news journalists and support staff employed by the eligible digital journalism provider.

(b) No later than 30 days after the end of an arbitration proceeding described in Section 25 or upon reaching a settlement in lieu of an arbitration proceeding, the eligible digital journalism provider shall provide notification in writing of its plan to comply with subsection (a) to the news journalists and support staff employed by the eligible digital journalism provider and any representatives of those news journalists or support staff.

(c) The eligible digital journalism provider's plan to comply with subsection (a) shall include a good faith estimate of the number of news journalists and support staff, if any, expected to be hired, details regarding proposed compensation adjustments, if any, and a disclosure if either hiring or compensation adjustments are not expected.

Section 40. Reporting requirements.

(a) No later than one year after the end of an arbitration proceeding described in Section 25 or reaching a settlement in lieu of an arbitration proceeding, and each year thereafter, the eligible digital journalism provider shall compile a report that includes:

(1) an attestation as to whether the eligible digital journalism provider has complied with subsection (a) of Section 35;

(2) the text of the digital journalism provider's plan to comply with subsection (a) of Section 35;

(3) the total number of journalism usage fees received from covered platforms;

(4) the name of each covered platform paying the eligible digital journalism provider a journalism usage fee and a description of how the eligible digital journalism provider spent the journalism usage fee payment, including any amount of journalism usage fees remaining unspent; and

(5) the total number of news journalists and support staff employed by the eligible digital journalism provider, including the number of news journalists and support staff hired or terminated during the previous year.

(b) No later than one year after the end of an arbitration proceeding described in Section 25 or reaching a settlement in lieu of an arbitration proceeding, and each year thereafter, the eligible digital journalism provider shall publish a copy of the report described in subsection (a) online in a text-searchable format and provide a copy to the news journalists and support staff employed by the eligible digital journalism provider, any representatives of those news journalists or support staff, and the covered platforms paying journalism usage fees to the eligible digital journalism provider.

Section 45. Preservation of rights.

(a) Nothing in this Act shall be construed as amending or repealing the ability of an eligible digital journalism provider or a covered platform to seek a preliminary or permanent injunction or any other existing remedy at law or equity.

(b) This Act does not modify, impair, expand, or in any way alter rights pertaining to the federal Lanham Act (15 U.S.C. 1051 et seq).

(c) This Act does not abridge or impair rights otherwise reserved by news journalists, support staff, or their representatives according to applicable law or existing collective bargaining agreements.

Section 50. Severability. The provisions of this Act are severable. If any provision of this act 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.".

AMENDMENT NO. 2 TO SENATE BILL 3591

AMENDMENT NO. 2 . Amend Senate Bill 3591, AS AMENDED, with reference to page and line numbers of Senate Amendment No. 1, on page 7, line 5, by replacing "(B)" with "(C)"; and

on page 7, line 13, by replacing "(A)" with "(1)".

There being no further amendments, the foregoing Amendments Numbered 1 and 2 were ordered engrossed, and the bill, as amended, was ordered to a third reading.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A SECOND TIME

On motion of Senator N. Harris, **House Bill No. 307** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Morrison, **House Bill No. 612** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Johnson, **House Bill No. 2363** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator N. Harris, **House Bill No. 4284** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Villa, **House Bill No. 4357** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Licensed Activities, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 4357

AMENDMENT NO. 1 . Amend House Bill 4357 by replacing everything after the enacting clause with the following:

"Section 5. The Medical Practice Act of 1987 is amended by changing Section 54.2 as follows:

(225 ILCS 60/54.2)

(Section scheduled to be repealed on January 1, 2027)

Sec. 54.2. Physician delegation of authority.

(a) Nothing in this Act shall be construed to limit the delegation of patient care tasks or duties by a physician, to a licensed practical nurse, a registered professional nurse, or other licensed person practicing within the scope of his or her individual licensing Act. Delegation by a physician licensed to practice medicine in all its branches to physician assistants or advanced practice registered nurses is also addressed in Section 54.5 of this Act. No physician may delegate any patient care task or duty that is statutorily or by rule mandated to be performed by a physician.

(b) In an office or practice setting and within a physician-patient relationship, a physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professional's individual licensing Act, is on site to provide assistance.

(c) Any such patient care task or duty delegated to a licensed or unlicensed person must be within the scope of practice, education, training, or experience of the delegating physician and within the context of a physician-patient relationship.

(d) Nothing in this Section shall be construed to affect referrals for professional services required by law.

(e) The Department shall have the authority to adopt ~~promulgate~~ rules concerning a physician's delegation, including, but not limited to, the use of light emitting devices for patient care or treatment. An on-site physician examination prior to the performance of a non-ablative laser procedure shall not be required when:

(1) the laser hair removal facility follows a physician delegation protocol, which shall be made available to the Department upon request;

(2) the examination is performed by an advanced practice registered nurse;

(3) the procedure is delegated by a physician and performed by a registered nurse or licensed practical nurse who has received appropriate, documented training and education in the safe and effective use of each system; and

(4) a physician is available by telephone or other electronic means to respond promptly to any questions or complications that may occur.

Nothing in this Section shall be construed to limit a licensed advanced practice registered nurse with full practice authority from practicing according to the Nurse Practice Act.

(f) Nothing in this Act shall be construed to limit the method of delegation that may be authorized by any means, including, but not limited to, oral, written, electronic, standing orders, protocols, guidelines, or verbal orders.

(g) A physician licensed to practice medicine in all of its branches under this Act may delegate any and all authority prescribed to him or her by law to international medical graduate physicians, so long as the tasks or duties are within the scope of practice, education, training, or experience of the delegating physician who is on site to provide assistance. An international medical graduate working in Illinois pursuant to this subsection is subject to all statutory and regulatory requirements of this Act, as applicable, relating to the standards of care. An international medical graduate physician is limited to providing treatment under the supervision of a physician licensed to practice medicine in all of its branches. The supervising physician or employer must keep record of and make available upon request by the Department the following: (1) evidence of education certified by the Educational Commission for Foreign Medical Graduates; (2) evidence of passage of Step 1, Step 2 Clinical Knowledge, and Step 3 of the United States Medical Licensing Examination as required by this Act; and (3) evidence of an unencumbered license from another country. This subsection does not apply to any international medical graduate whose license as a physician is revoked, suspended, or otherwise encumbered. This subsection is inoperative upon the adoption of rules implementing Section 15.5.

(Source: P.A. 103-1, eff. 4-27-23; 103-102, eff. 6-16-23.)".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Castro, **House Bill No. 4772** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Johnson, **House Bill No. 4819** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Loughran Cappel, **House Bill No. 4838** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 4867** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 5028** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Cunningham, **House Bill No. 5229** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Fine, **House Bill No. 5371** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Executive, adopted and ordered printed:

AMENDMENT NO. 1 TO HOUSE BILL 5371

AMENDMENT NO. 1 . Amend House Bill 5371 as follows:

on page 19, line 9, by deleting "2-102," and "7-101,"; and

by deleting line 11 on page 19 through line 14 on page 31; and

by deleting line 20 on page 35 through line 10 on page 38; and

on page 56, below line 21, by inserting the following:

"Section 6. The Illinois Human Rights Act is amended by changing Section 7-101 as follows:
(775 ILCS 5/7-101) (from Ch. 68, par. 7-101)

Sec. 7-101. Powers and duties. In addition to other powers and duties prescribed in this Act, the Department shall have the following powers:

(A) Rules and Regulations. To adopt, promulgate, amend, and rescind rules and regulations not inconsistent with the provisions of this Act pursuant to the Illinois Administrative Procedure Act.

(B) Charges. To issue, receive, investigate, conciliate, settle, and dismiss charges filed in conformity with this Act.

(C) Compulsory Process. To request subpoenas as it deems necessary for its investigations.

(D) Complaints. To file complaints with the Commission in conformity with this Act and to intervene in complaints pending before the Commission filed under Article 2, 4, 5, 5A, or 6.

(E) Judicial Enforcement. To seek temporary relief and to enforce orders of the Commission in conformity with this Act.

(F) Equal Employment Opportunities. To take such action as may be authorized to provide for equal employment opportunities and affirmative action.

(G) Recruitment; Research; Public Communication; Advisory Councils. To engage in such recruitment, research and public communication and create such advisory councils as may be authorized to effectuate the purposes of this Act.

(H) Coordination with other Agencies. To coordinate its activities with federal, state, and local agencies in conformity with this Act.

(I) Grants; Private Gifts.

(1) To accept public grants and private gifts as may be authorized.

(2) To design grant programs and award grants to eligible recipients.

(J) Education and Training. To implement a formal and unbiased program of education and training for all employees assigned to investigate and conciliate charges under Articles 7A and 7B. The training program shall include the following:

(1) substantive and procedural aspects of the investigation and conciliation positions;

(2) current issues in human rights law and practice;

(3) lectures by specialists in substantive areas related to human rights matters;

(4) orientation to each operational unit of the Department and Commission;

(5) observation of experienced Department investigators and attorneys conducting conciliation conferences, combined with the opportunity to discuss evidence presented and rulings made;

(6) the use of hypothetical cases requiring the Department investigator and conciliation conference attorney to issue judgments as a means to evaluating knowledge and writing ability;

(7) writing skills;

(8) computer skills, including but not limited to word processing and document management.

A formal, unbiased and ongoing professional development program including, but not limited to, the above-noted areas shall be implemented to keep Department investigators and attorneys informed of recent developments and issues and to assist them in maintaining and enhancing their professional competence.

(K) Hotlines. To establish and maintain hotlines and helplines to aid in effectuating the purposes of this Act including the confidential reporting of discrimination, harassment, and bias incidents. All communications received or sent via the hotlines and helplines are exempt from disclosure under the Freedom of Information Act.

(Source: P.A. 102-1115, eff. 1-9-23; 103-335, eff. 1-1-24.)"; and

on page 57, below line 7, by inserting the following:

"Section 99. Effective date. This Act takes effect upon becoming law except that Sections 5 and 10 take effect January 1, 2025.".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator N. Harris, **House Bill No. 5496** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Castro, **House Bill No. 5511** having been printed, was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Castro, **House Bill No. 5561** having been printed, was taken up, read by title a second time and ordered to a third reading.

LEGISLATIVE MEASURES FILED

The following Floor amendments to the House Bills listed below have been filed with the Secretary and referred to the Committee on Assignments:

Amendment No. 2 to House Bill 2911
Amendment No. 2 to House Bill 4293
Amendment No. 3 to House Bill 5395

The following Committee amendment to the Senate Bill listed below has been filed with the Secretary and referred to the Committee on Assignments:

Amendment No. 3 to Senate Bill 3527

JOINT ACTION MOTIONS FILED

The following Joint Action Motions to the Senate Bills listed below have been filed with the Secretary and referred to the Committee on Assignments:

Motion to Concur in House Amendment No. 5 to Senate Bill 774
Motion to Concur in House Amendment No. 1 to Senate Bill 2737
Motion to Concur in House Amendment No. 2 to Senate Bill 2740
Motion to Concur in House Amendment No. 1 to Senate Bill 2907
Motion to Concur in House Amendment No. 2 to Senate Bill 3282
Motion to Concur in House Amendment No. 1 to Senate Bill 3342
Motion to Concur in House Amendment No. 2 to Senate Bill 3481

At the hour of 7:11 o'clock p.m., the Chair announced that the Senate stands adjourned until Thursday, May 23, 2024, at 9:30 o'clock a.m.