Rep. Lou Lang

Filed: 3/16/2017

AMENDMENT TO HOUSE BILL 68

AMENDMENT NO. _____. Amend House Bill 68 by replacing everything after the enacting clause with the following:

"Section 5. The State Finance Act is amended by changing Section 5.872 as follows:

(30 ILCS 105/5.872)

Sec. 5.872. The Parity Advancement ~~Education~~ Fund.

(Source: P.A. 99-480, eff. 9-9-15; 99-642, eff. 7-28-16.)

Section 10. The Illinois Insurance Code is amended by changing Sections 370c and 370c.1 as follows:

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this amendatory Act of the 100th General Assembly ~~the effective date of this~~

~~amendatory Act of the 97th General Assembly~~, every insurer that ~~which~~ 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 ~~offer to the applicant or group policyholder subject to the insurer's standards of insurability,~~ coverage for reasonable and necessary treatment and services for mental, emotional, ~~or~~ nervous, or substance use disorders or conditions~~, other than serious mental illnesses as defined in item (2) of subsection (b),~~ 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 Illinois Alcoholism and Other Drug Abuse and Dependency Act of his 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 Illinois Alcoholism and Other Drug Abuse and Dependency 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 Illinois Alcoholism and Other Drug Abuse and Dependency Act is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his 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 Illinois Alcoholism and Other Drug Abuse and Dependency 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 Illinois Alcoholism and Other Drug Abuse and Dependency Act has informed the patient of the desirability of the patient conferring with the patient's primary care

physician ~~and 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 Illinois Alcoholism and Other Drug Abuse and Dependency Act has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by 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 Illinois Alcoholism and Other Drug Abuse and Dependency Act for a period of not less than 5 years~~.

(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 International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(b) (1) (Blank). ~~An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered,~~

~~issued, or renewed on or after the effective date of this amendatory Act of the 97th General Assembly shall provide coverage under the policy for treatment of serious mental illness and substance use disorders consistent with the parity requirements of Section 370c.1 of this Code. This subsection does not apply to any group policy of accident and health insurance or health care plan for any plan year of a small employer as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act.~~

(2) (Blank). ~~"Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:~~

~~(A) schizophrenia;~~

~~(B) paranoid and other psychotic disorders;~~

~~(C) bipolar disorders (hypomanic, manic, depressive, and mixed);~~

~~(D) major depressive disorders (single episode or recurrent);~~

~~(E) schizoaffective disorders (bipolar or depressive);~~

~~(F) pervasive developmental disorders;~~

~~(G) obsessive-compulsive disorders;~~

~~(H) depression in childhood and adolescence;~~

~~(I) panic disorder;~~

~~(J) post traumatic stress disorders (acute, chronic, or with delayed onset); and~~

~~(K) anorexia nervosa and bulimia nervosa.~~

(2.5) (Blank). ~~"Substance use disorder" means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:~~

~~(A) substance abuse disorders;~~

~~(B) substance dependence disorders; and~~

~~(C) substance induced disorders.~~

(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 ~~serious mental illness or~~ substance use disorders or conditions ~~disorder~~ 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 ~~serious mental illness or~~ substance use disorders or conditions ~~disorder~~, 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 the effective date of this amendatory Act of the 100th General Assembly 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 the effective date of this amendatory Act of the 100th General Assembly ~~the effective~~

~~date of this amendatory Act of the 97th General Assembly~~ :

(A) shall provide coverage based upon medical necessity for the treatment of a mental, emotional, nervous, or ~~mental illness and~~ substance use disorder or condition ~~disorders~~ 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 the effective date of this amendatory Act of the 99th General Assembly 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 ~~Patient Placement Criteria~~. 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.

(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 ~~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: ~~State and federal parity law, which includes~~

(1) ensuring compliance by individual and group policies;

(2) detecting violations of the law by individual and group policies ~~proactively monitoring discriminatory practices~~;

(3) accepting, evaluating, and responding to complaints regarding such violations;

(4) maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint

log regarding mental, emotional, nervous, or substance use disorders or conditions coverage;

(5) performing parity compliance pre-market and post-market conduct examinations of individual and group plans and policies, including, but not limited to, reviews of:

(A) network adequacy using established criteria as set forth in federal and State requirements for medical assistance and individual or group health policies;

(B) reimbursement rates;

(C) denials of authorization, payment, and coverage;

(D) prior authorization requirements; and

(E) other specific criteria as shall be set forth in rules adopted by the Department.

The findings and conclusions of the parity compliance market conduct examinations shall be made public and shall be reported to the General Assembly.

The Director shall 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. ~~and ensuring violations are appropriately remedied and deterred.~~

(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, ~~health~~ or substance use disorders or conditions ~~disorder~~ 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.

(3) The following information 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) must be made available upon request:

(A) a Summary Plan Description, or similar summary information;

(B) the specific plan or policy language regarding the imposition of a nonquantitative treatment limitation (such as a preauthorization requirement);

(C) the specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan or policy (including factors that were relied upon and were rejected) in determining that a nonquantitative treatment limitation applies to any particular mental health or substance use disorder benefit;

(D) information regarding the application of a nonquantitative treatment limitation to any medical or surgical benefits within any benefit classification at issue;

(E) the specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan or policy (including factors that were relied upon and were rejected) in determining the extent to which a nonquantitative treatment limitation applies to a particular medical or surgical benefit within a

benefit classification at issue; and

(F) any analyses performed by the plan or under the policy as to how any nonquantitative treatment limitation complies with 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.

(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) The General Assembly decrees that it is the public policy of the State of Illinois to allow for private enforcement of mental, emotional, nervous, or substance use disorder or condition parity protections in a court of

competent jurisdiction, without administrative exhaustion or arbitration, even if otherwise required by an insurance policy.

Members, patients, subscribers, enrollees, and providers (in-network and out-of-network) on behalf of members, patients, subscribers, and enrollees have the right to commence a civil action against any group health plan, an issuer of 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) that violates the provisions of this Section, such that any member of a group health plan or an individual covered under a 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) authorized representative of such plan or related entity, advocacy organization representing the interests of members of a health plan carrier or related entity, health care providers, or organization representing the interests of providers reimbursed by a health plan carrier or related entity, against which the violation is alleged, shall have standing to commence a civil action in a court of competent jurisdiction.

The remedy under this Section is limited to a $5,000 penalty for each act or offense; injunctive relief; general and special damages, which may be trebled; restitution of premium; and attorney's fees and costs.

A violation consists of any violation of this Section or Section 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, Children's Health Insurance Programs (CHIP), and Alternative Benefit Plans.

A violation of this Section shall not be contingent upon the plaintiff proving the medical necessity of any prescribed procedure, service, or medication.

(Source: P.A. 99-480, eff. 9-9-15.)

(215 ILCS 5/370c.1)

Sec. 370c.1. Mental, emotional, nervous, or substance use disorder or condition ~~health and addiction~~ parity.

(a) On and after the effective date of this amendatory Act of the 99th General Assembly, 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 providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use

disorders or conditions shall ensure that:

(1) the financial requirements applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant financial requirements applied to substantially all hospital and medical benefits covered by the policy and that there are no separate cost-sharing requirements that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits; and

(2) the treatment limitations applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy and that there are no separate treatment limitations that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits.

(b) The following provisions shall apply concerning aggregate lifetime limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after the effective date of this amendatory Act of the 99th General Assembly that provides coverage for hospital or medical

treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an aggregate lifetime limit on substantially all hospital and medical benefits, then the policy may not impose any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an aggregate lifetime limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable lifetime limit"), then the policy shall either:

(i) apply the applicable lifetime limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable lifetime limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (b) of this Section and that includes no or different aggregate lifetime limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (b) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(c) The following provisions shall apply concerning annual limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after the effective date of this amendatory Act of the 99th General Assembly that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an annual limit on substantially all hospital and medical benefits, then the policy may not impose any annual limits on

mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an annual limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable annual limit"), then the policy shall either:

(i) apply the applicable annual limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any annual limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable annual limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (c) of this Section and that includes no or different annual limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (c) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by

substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(d) With respect to mental, emotional, nervous, or substance use disorders or conditions, an insurer shall use policies and procedures for the election and placement of mental, emotional, nervous, or substance use disorder or condition ~~substance abuse~~ treatment drugs on their formulary that are no less favorable to the insured as those policies and procedures the insurer uses for the selection and placement of ~~other~~ drugs for medical or surgical conditions and shall follow the expedited coverage determination requirements for substance abuse treatment drugs set forth in Section 45.2 of the Managed Care Reform and Patient Rights Act.

(e) This Section shall be interpreted in a manner consistent with all applicable federal parity regulations including, but not limited to, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 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 ~~at 78 FR 68240~~.

(f) The provisions of subsections (b) and (c) of this Section shall not be interpreted to allow the use of lifetime or annual limits otherwise prohibited by State or federal law.

(g) As used in this Section:

"Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket maximums, but does not include an aggregate lifetime limit or an annual limit subject to subsections (b) and (c).

"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 International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

"Treatment limitation" includes limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. "Treatment limitation" includes both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of treatment. A permanent exclusion of all benefits for a particular condition or disorder shall not be considered a treatment limitation. "Nonquantitative

treatment" means those limitations as described under federal regulations (26 CFR 54.9812-1). Nonquantitative treatment limitations include, but are not limited to:

(1) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) for plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(4) standards for provider admission to participate in a network, including reimbursement rates;

(5) plan methods for determining usual, customary, and reasonable charges;

(6) refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(7) exclusions based on failure to complete a course of treatment;

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(9) in-network and out-of-network geographic

limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the participant is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers, physicians, licensed psychologists, licensed clinical professional counselors, licensed marriage and family therapists, licensed speech-language pathologists, or other licensed or certified professionals at a program licensed pursuant to the Illinois Alcoholism and Other Drug Abuse and Dependency Act;

(16) network adequacy as set forth in federal and State requirements for medical assistance and individual or group health policies; and

(17) provider reimbursement rates, including reimbursement rates for mental, emotional, nervous, or substance use disorder or condition screenings or diagnostic tests performed in primary care and integrated settings.

(h) The Department of Insurance shall implement the following education initiatives:

(1) By January 1, 2016, the Department shall develop a plan for a Consumer Education Campaign on parity. The Consumer Education Campaign shall focus its efforts throughout the State and include trainings in the northern, southern, and central regions of the State, as defined by the Department, as well as each of the 5 managed care regions of the State as identified by the Department of Healthcare and Family Services. Under this Consumer Education Campaign, the Department shall: (1) by January 1, 2017, provide at least one live training in each region on parity for consumers and providers and one webinar training to be posted on the Department website and (2) establish a consumer hotline to assist consumers in navigating the parity process by March 1, 2017 ~~2016~~. By January 1, 2018 the Department shall issue a report to the General Assembly on the success of the Consumer Education Campaign, which shall indicate whether additional training is necessary or would be recommended.

(2) The Department, in coordination with the Department of Human Services and the Department of Healthcare and Family Services, shall convene a working group of health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups for the purpose of discussing issues related to the treatment and coverage of mental, emotional, nervous, or substance use ~~abuse~~

disorders or conditions and compliance with parity obligations under State and federal law. Compliance shall be measured, tracked, and shared during the meetings of the working group ~~and mental illness~~. The working group shall meet once before January 1, 2016 and shall meet semiannually thereafter. The Department shall issue an annual report to the General Assembly that includes a list of the health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups that participated in the working group meetings, details on the issues and topics covered, and any legislative recommendations developed by the working group.

(3) Not later than August 1 of each year, the Department, in conjunction with the Department of Healthcare and Family Services, shall issue a joint report to the General Assembly and provide an educational presentation to the General Assembly. The report and presentation shall:

(A) Cover the methodology the Departments use to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

of 2008 and 42 U.S.C. 18031(j).

(B) Cover the methodology the Departments use to check for compliance with this Section and Sections 356z.23 and 370c of this Code.

(C) Identify pre-market and post-market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental, emotional, nervous, and substance use disorder or condition benefits under State and federal laws and summarize the results of such market conduct examinations. This shall include:

(i) the number of market conduct examinations initiated and completed;

(ii) the benefit classifications examined by each market conduct examination;

(iii) the subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations; and

(iv) a summary of the basis for the final decision rendered in each market conduct examination.

Individually identifiable information shall be excluded from the reports consistent with federal privacy protections.

(D) Detail any educational or corrective actions the Departments have taken to ensure compliance with

the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), this Section, and Sections 356z.23 and 370c of this Code.

(E) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the Departments find appropriate, posting the report on the Departments' websites.

(4) In the event of uncertainty or disagreement with respect to the application, interpretation, implementation, or enforcement of the federal 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, 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, Section 370c of this Code, and this Section, the Department and the Department of Healthcare and Family Services may request a formal written opinion from the Attorney General. The requests and opinions shall be issued

in accordance with State law and policies of the Attorney General. The Departments shall inform the public on their websites and in writing that any aggrieved beneficiary may ask the Departments to request a formal written opinion from the Attorney General.

(i) The Parity Advancement ~~Education~~ Fund is created as a special fund in the State treasury. Moneys from fines and penalties collected from insurers for violations of this Section shall be deposited into the Fund. Moneys deposited into the Fund for appropriation by the General Assembly to the Department ~~of Insurance~~ shall be used for the purpose of providing financial support of the Consumer Education Campaign, parity compliance advocacy, and other initiatives that support parity implementation and enforcement on behalf of consumers and to the Department of Human Services for treatment grants.

(j) 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 for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall submit an annual report to the Department, or with respect to medical assistance the Department of Healthcare and Family Services, on or before March 1 that contains the following information separately for inpatient in-network benefits, inpatient

out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits in the case of accident and health insurance or qualified health plans, or inpatient, outpatient, emergency care, and prescription drug benefits in the case of medical assistance:

(1) The number and percentage of times a benefit limit is exceeded for a mental, emotional, nervous, or substance use disorder or condition benefit and the number and percentage of times a benefit limit is exceeded for other medical benefits.

(2) The number and percentage of times a co-pay or co-insurance limit for a mental, emotional, nervous, or substance use disorder or condition benefit is different from other medical benefits.

(3) The number and percentage of claim denials for mental, emotional, nervous, or substance use disorder or condition benefits due to benefit limits and the number and percentage of claim denials for other medical benefits due to benefit limits.

(4) The number and percentage of denials for experimental benefits or the use of unproven technology for a mental, emotional, nervous, or substance use disorder or condition benefit and the number and percentage of denials for experimental benefits or the use of unproven technology for other medical benefits.

(5) The number and percentage of administrative denials for no prior authorization for a mental, emotional, nervous, or substance use disorder or condition benefit and the number and percentage of administrative denials for no prior authorization for other medical benefits.

(6) The number and percentage of denials due to a mental, emotional, nervous, or substance use disorder or condition benefit not being a covered benefit and the number and percentage of denials for other medical benefits not being a covered benefit.

(7) The number and percentage of denials due to a mental, emotional, nervous, or substance use disorder or condition benefit not meeting medical necessity and the number and percentage of denials for other medical benefits not meeting medical necessity.

(8) The number and percentage of denials upheld on appeal for a mental, emotional, nervous, or substance use disorder or condition benefit for not meeting medical necessity and the number and percentage of those for other medical benefits.

(9) The number and percentage of denials due to a mental, emotional, nervous, or substance use disorder or condition benefit being denied administratively or any reason other than medical necessity.

(10) The number and percentage of denials of mental, emotional, nervous, or substance use disorder or condition

benefits that went to the plan's external quality review organization, or similar reviewing body and were upheld and those that were overturned for medical necessity.

(11) The number and percentage of continued stay review denials for mental, emotional, nervous, or substance use disorder or condition benefits.

(12) The number and percentage of out-of-network claims for mental, emotional, nervous, or substance use disorder or condition benefits in each classification of benefits and the number and percentage of out-of-network claims for other medical benefits in each classification of benefits.

(13) The number and percentage of emergency care claims for mental, emotional, nervous, or substance use disorder or condition benefits in each classification of benefits and the number and percentage of emergency care claims for other medical benefits in each classification of benefits.

(14) The number and percentage of network directory providers in the outpatient benefits classification who filed no claims in the last 6 months of the plan's claims reporting period and all pertinent summary information and results respecting the tests and metrics the insurer used to assess the availability of each of the following types of mental, emotional, nervous, or substance use disorder or condition providers: MD/DO; doctoral level non-MD/DO and non-doctoral level non-MD/DO practitioners; and inpatient,

residential, and ambulatory provider organizations.

(15) A summary of the plan's pharmacy management processes for mental, emotional, nervous, or substance use disorder or condition benefits compared to those for other medical benefits.

(16) A summary of the internal processes of review for experimental benefits and unproven technology for mental, emotional, nervous, or substance use disorder or condition benefits and those for other medical benefits.

(17) A summary of how the plan's policies and procedures for utilization management for mental, emotional, nervous, or substance use disorder or condition benefits compare to those for other medical benefits.

(18) The results of an analysis that demonstrates that for each nonquantitative treatment limitation, as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply each nonquantitative treatment limitation to mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply each nonquantitative treatment limitation, as written and in operation, to medical and surgical benefits; at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a

nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(B) identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each nonquantitative treatment limitation;

(C) identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each nonquantitative treatment limitation as written for mental, emotional, nervous, or substance use disorders or conditions benefits are comparable to and no more stringent than the processes and strategies used to design each nonquantitative treatment limitation as written for medical and surgical benefits;

(D) identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to apply each nonquantitative treatment limitation in operation for mental, emotional, nervous, or substance use disorders or conditions benefits are comparable to and no more stringent than the processes or strategies used to apply each nonquantitative treatment limitation in operation for medical and surgical

benefits; and

(E) disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the insurer is in compliance with this Section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations, which includes 45 CFR 146.136 and any other relevant current or future regulations.

(19) A certification signed by the insurer's chief executive officer and chief medical officer that states that the insurer has completed a comprehensive review of the administrative practices of the insurer for the prior calendar year for compliance with the necessary provisions of this Section and Sections 356z.23 and 370c of this Code, the federal 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.

(20) Any other information necessary to clarify data

provided in accordance with this Section requested by the Director, including information that may be proprietary or have commercial value.

The Director shall not certify any policy of an insurer that fails to submit all data as required by this Section.

(k) There is created within the Office of the Attorney General an Office of Consumer Advocate, which shall assist consumers, insureds, health care providers, and recipients in:

(1) ensuring compliance with the requirements of this Section;

(2) addressing issues related to insurance availability;

(3) identifying and rectifying claims processing issues;

(4) clarifying and resolving coverage questions; and

(5) addressing other matters related to insurance consumer education and assistance.

(Source: P.A. 99-480, eff. 9-9-15.)".