AN ACT concerning health.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, ~~and~~ 356z.25, and 356z.26 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on

Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-3-17.)

Section 10. 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 15. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, and 356z.26 of the Illinois Insurance Code. The coverage shall comply with

Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

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

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

Section 20. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by

a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, and 356z.26 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

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

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

Section 25. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, and 356z.26 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, ~~and~~ 355b, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 9-25-17.)

Section 30. 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 or individual 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 100th 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) eating disorders, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.~~

(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, ~~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, ~~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.

(6.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 100th General Assembly:

(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.

~~(d) The Department shall enforce the requirements of State and federal parity law, which includes ensuring compliance by individual and group policies; detecting violations of the law by individual and group policies proactively monitoring discriminatory practices; accepting, evaluating, and responding to complaints regarding such violations; 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.

(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.

(Source: P.A. 99-480, eff. 9-9-15; 100-305, eff. 8-24-17.)

(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, those limitations described under federal regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(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 market conduct examinations or, in

the case of the Department of Healthcare and Family Services, audits 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 and audits. This shall include:

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

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

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

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

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.

(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.

(j) The Department of Insurance and the Department of Healthcare and Family Services shall convene and provide technical support to a workgroup of 11 members that shall be comprised of 3 mental health parity experts recommended by an organization advocating on behalf of mental health parity appointed by the President of the Senate; 3 behavioral health providers recommended by an organization that represents behavioral health providers appointed by the Speaker of the House of Representatives; 2 representing Medicaid managed care organizations recommended by an organization that represents

Medicaid managed care plans appointed by the Minority Leader of the House of Representatives; 2 representing commercial insurers recommended by an organization that represents insurers appointed by the Minority Leader of the Senate; and a representative of an organization that represents Medicaid managed care plans appointed by the Governor.

The workgroup shall provide recommendations to the General Assembly on health plan data reporting requirements that separately break out data on mental, emotional, nervous, or substance use disorder or condition benefits and data on other medical benefits, including physical health and related health services no later than December 31, 2019. The recommendations to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct. This workgroup shall take into account federal requirements and recommendations on mental health parity reporting for the Medicaid program. This workgroup shall also develop the format and provide any needed definitions for reporting requirements in subsection (k). The research and evaluation of the working group shall include, but not be limited to:

(1) claims denials due to benefit limits, if applicable;

(2) administrative denials for no prior authorization;

(3) denials due to not meeting medical necessity;

(4) denials that went to external review and whether they were upheld or overturned for medical necessity;

(5) out-of-network claims;

(6) emergency care claims;

(7) network directory providers in the outpatient benefits classification who filed no claims in the last 6 months, if applicable;

(8) the impact of existing and pertinent limitations and restrictions related to approved services, licensed providers, reimbursement levels, and reimbursement methodologies within the Division of Mental Health, the Division of Substance Use Prevention and Recovery programs, the Department of Healthcare and Family Services, and, to the extent possible, federal regulations and law; and

(9) when reporting and publishing should begin.

Representatives from the Department of Healthcare and Family Services, representatives from the Division of Mental Health, and representatives from the Division of Substance Use Prevention and Recovery shall provide technical advice to the workgroup.

(k) 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, the format and definitions for which will be developed by the workgroup in subsection (j), to the Department, or, with respect to medical assistance, the Department of Healthcare and Family Services starting on or before July 1, 2020 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) 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.

(2) 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.

(3) 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.

(4) A description of the process used to develop or

select the medical necessity criteria for mental, emotional, nervous, or substance use disorder or condition benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(5) Identification of all nonquantitative treatment limitations that are applied to both mental, emotional, nervous, or substance use disorder or condition benefits and medical and surgical benefits within each classification of benefits.

(6) The results of an analysis that demonstrates that for the medical necessity criteria described in subparagraph (A) and for each nonquantitative treatment limitation identified in subparagraph (B), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental, emotional, nervous, or substance use disorder or condition benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a nonquantitative treatment limitation applies 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 evidence relied upon in designing each nonquantitative treatment limitation;

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and applied no more stringently 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 described in subparagraphs (C) and (D) 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 42 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(7) 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, under the requirements of Section 30 of the Viatical Settlements Act of 2009.

(l) 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 on or after the effective date of this amendatory Act of the 100th General Assembly shall, in advance of the plan year, make available to the Department or, with respect to medical assistance, the Department of Healthcare and Family Services and to all plan

participants and beneficiaries the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k). For plan participants and medical assistance beneficiaries, the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k) shall be made available on a publicly-available website whose web address is prominently displayed in plan and managed care organization informational and marketing materials.

(m) In conjunction with its compliance examination program conducted in accordance with the Illinois State Auditing Act, the Auditor General shall undertake a review of compliance by the Department and the Department of Healthcare and Family Services with Section 370c and this Section. Any findings resulting from the review conducted under this Section shall be included in the applicable State agency's compliance examination report. Each compliance examination report shall be issued in accordance with Section 3-14 of the Illinois State Auditing Act. A copy of each report shall also be delivered to the head of the applicable State agency and posted on the Auditor General's website.

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

Section 99. Effective date. This Act takes effect January 1, 2019.