

1 AN ACT concerning health.

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

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

6 (5 ILCS 375/6.11)

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

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

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

3 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
4 100-138, eff. 8-18-17; revised 10-3-17.)

5 Section 10. The State Finance Act is amended by changing
6 Section 5.872 as follows:

7 (30 ILCS 105/5.872)

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

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

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

12 (55 ILCS 5/5-1069.3)

13 Sec. 5-1069.3. Required health benefits. If a county,
14 including a home rule county, is a self-insurer for purposes of
15 providing health insurance coverage for its employees, the
16 coverage shall include coverage for the post-mastectomy care
17 benefits required to be covered by a policy of accident and
18 health insurance under Section 356t and the coverage required
19 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
20 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
21 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, and 356z.26 of the
22 Illinois Insurance Code. The coverage shall comply with

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

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

15 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
16 100-138, eff. 8-18-17; revised 10-5-17.)

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

19 (65 ILCS 5/10-4-2.3)

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

1 a policy of accident and health insurance under Section 356t
2 and the coverage required under Sections 356g, 356g.5,
3 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10,
4 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~
5 356z.25, and 356z.26 of the Illinois Insurance Code. The
6 coverage shall comply with Sections 155.22a, 355b, 356z.19, and
7 370c of the Illinois Insurance Code. The Department of
8 Insurance shall enforce the requirements of this Section. The
9 requirement that health benefits be covered as provided in this
10 is an exclusive power and function of the State and is a denial
11 and limitation under Article VII, Section 6, subsection (h) of
12 the Illinois Constitution. A home rule municipality to which
13 this Section applies must comply with every provision of this
14 Section.

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

21 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
22 100-138, eff. 8-18-17; revised 10-5-17.)

23 Section 25. The School Code is amended by changing Section
24 10-22.3f as follows:

1 (105 ILCS 5/10-22.3f)

2 Sec. 10-22.3f. Required health benefits. Insurance
3 protection and benefits for employees shall provide the
4 post-mastectomy care benefits required to be covered by a
5 policy of accident and health insurance under Section 356t and
6 the coverage required under Sections 356g, 356g.5, 356g.5-1,
7 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
8 356z.13, 356z.14, 356z.15, 356z.22, ~~and 356z.25,~~ and 356z.26 of
9 the Illinois Insurance Code. Insurance policies shall comply
10 with Section 356z.19 of the Illinois Insurance Code. The
11 coverage shall comply with Sections 155.22a, ~~and 355b,~~ and 370c
12 of the Illinois Insurance Code. The Department of Insurance
13 shall enforce the requirements of this Section.

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

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

22 Section 30. The Illinois Insurance Code is amended by
23 changing Sections 370c and 370c.1 as follows:

24 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

1 Sec. 370c. Mental and emotional disorders.

2 (a) (1) On and after the effective date of this amendatory
3 Act of the 100th General Assembly ~~the effective date of this~~
4 ~~amendatory Act of the 97th General Assembly~~, every insurer that
5 ~~which~~ amends, delivers, issues, or renews group accident and
6 health policies providing coverage for hospital or medical
7 treatment or services for illness on an expense-incurred basis
8 shall provide ~~offer to the applicant or group policyholder~~
9 ~~subject to the insurer's standards of insurability~~, coverage
10 for reasonable and necessary treatment and services for mental,
11 emotional, ~~or~~ nervous, or substance use disorders or
12 conditions, ~~other than serious mental illnesses as defined in~~
13 ~~item (2) of subsection (b)~~, consistent with the parity
14 requirements of Section 370c.1 of this Code.

15 (2) Each insured that is covered for mental, emotional,
16 nervous, or substance use disorders or conditions shall be free
17 to select the physician licensed to practice medicine in all
18 its branches, licensed clinical psychologist, licensed
19 clinical social worker, licensed clinical professional
20 counselor, licensed marriage and family therapist, licensed
21 speech-language pathologist, or other licensed or certified
22 professional at a program licensed pursuant to the Illinois
23 Alcoholism and Other Drug Abuse and Dependency Act of his
24 choice to treat such disorders, and the insurer shall pay the
25 covered charges of such physician licensed to practice medicine
26 in all its branches, licensed clinical psychologist, licensed

1 clinical social worker, licensed clinical professional
2 counselor, licensed marriage and family therapist, licensed
3 speech-language pathologist, or other licensed or certified
4 professional at a program licensed pursuant to the Illinois
5 Alcoholism and Other Drug Abuse and Dependency Act up to the
6 limits of coverage, provided (i) the disorder or condition
7 treated is covered by the policy, and (ii) the physician,
8 licensed psychologist, licensed clinical social worker,
9 licensed clinical professional counselor, licensed marriage
10 and family therapist, licensed speech-language pathologist, or
11 other licensed or certified professional at a program licensed
12 pursuant to the Illinois Alcoholism and Other Drug Abuse and
13 Dependency Act is authorized to provide said services under the
14 statutes of this State and in accordance with accepted
15 principles of his profession.

16 (3) Insofar as this Section applies solely to licensed
17 clinical social workers, licensed clinical professional
18 counselors, licensed marriage and family therapists, licensed
19 speech-language pathologists, and other licensed or certified
20 professionals at programs licensed pursuant to the Illinois
21 Alcoholism and Other Drug Abuse and Dependency Act, those
22 persons who may provide services to individuals shall do so
23 after the licensed clinical social worker, licensed clinical
24 professional counselor, licensed marriage and family
25 therapist, licensed speech-language pathologist, or other
26 licensed or certified professional at a program licensed

1 pursuant to the Illinois Alcoholism and Other Drug Abuse and
2 Dependency Act has informed the patient of the desirability of
3 the patient conferring with the patient's primary care
4 physician ~~and the licensed clinical social worker, licensed~~
5 ~~clinical professional counselor, licensed marriage and family~~
6 ~~therapist, licensed speech language pathologist, or other~~
7 ~~licensed or certified professional at a program licensed~~
8 ~~pursuant to the Illinois Alcoholism and Other Drug Abuse and~~
9 ~~Dependency Act has provided written notification to the~~
10 ~~patient's primary care physician, if any, that services are~~
11 ~~being provided to the patient. That notification may, however,~~
12 ~~be waived by the patient on a written form. Those forms shall~~
13 ~~be retained by the licensed clinical social worker, licensed~~
14 ~~clinical professional counselor, licensed marriage and family~~
15 ~~therapist, licensed speech language pathologist, or other~~
16 ~~licensed or certified professional at a program licensed~~
17 ~~pursuant to the Illinois Alcoholism and Other Drug Abuse and~~
18 ~~Dependency Act for a period of not less than 5 years.~~

19 (4) "Mental, emotional, nervous, or substance use disorder
20 or condition" means a condition or disorder that involves a
21 mental health condition or substance use disorder that falls
22 under any of the diagnostic categories listed in the mental and
23 behavioral disorders chapter of the current edition of the
24 International Classification of Disease or that is listed in
25 the most recent version of the Diagnostic and Statistical
26 Manual of Mental Disorders.

1 (b) (1) (Blank). ~~An insurer that provides coverage for~~
2 ~~hospital or medical expenses under a group or individual policy~~
3 ~~of accident and health insurance or health care plan amended,~~
4 ~~delivered, issued, or renewed on or after the effective date of~~
5 ~~this amendatory Act of the 100th General Assembly shall provide~~
6 ~~coverage under the policy for treatment of serious mental~~
7 ~~illness and substance use disorders consistent with the parity~~
8 ~~requirements of Section 370c.1 of this Code. This subsection~~
9 ~~does not apply to any group policy of accident and health~~
10 ~~insurance or health care plan for any plan year of a small~~
11 ~~employer as defined in Section 5 of the Illinois Health~~
12 ~~Insurance Portability and Accountability Act.~~

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

17 ~~(A) schizophrenia;~~

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

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

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

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

24 ~~(F) pervasive developmental disorders;~~

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

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

1 ~~(I) panic disorder;~~
2 ~~(J) post-traumatic stress disorders (acute, chronic,~~
3 ~~or with delayed onset); and~~
4 ~~(K) eating disorders, including, but not limited to,~~
5 ~~anorexia nervosa, bulimia nervosa, pica, rumination~~
6 ~~disorder, avoidant/restrictive food intake disorder, other~~
7 ~~specified feeding or eating disorder (OSFED), and any other~~
8 ~~eating disorder contained in the most recent version of the~~
9 ~~Diagnostic and Statistical Manual of Mental Disorders~~
10 ~~published by the American Psychiatric Association.~~

11 (2.5) (Blank). ~~"Substance use disorder" means the~~
12 ~~following mental disorders as defined in the most current~~
13 ~~edition of the Diagnostic and Statistical Manual (DSM)~~
14 ~~published by the American Psychiatric Association:~~

15 ~~(A) substance abuse disorders;~~
16 ~~(B) substance dependence disorders; and~~
17 ~~(C) substance induced disorders.~~

18 (3) Unless otherwise prohibited by federal law and
19 consistent with the parity requirements of Section 370c.1 of
20 this Code, the reimbursing insurer that amends, delivers,
21 issues, or renews a group or individual policy of accident and
22 health insurance, a qualified health plan offered through the
23 health insurance marketplace, or, a provider of treatment of
24 mental, emotional, nervous, ~~serious mental illness~~ or
25 substance use disorders or conditions ~~disorder~~ shall furnish
26 medical records or other necessary data that substantiate that

1 initial or continued treatment is at all times medically
2 necessary. An insurer shall provide a mechanism for the timely
3 review by a provider holding the same license and practicing in
4 the same specialty as the patient's provider, who is
5 unaffiliated with the insurer, jointly selected by the patient
6 (or the patient's next of kin or legal representative if the
7 patient is unable to act for himself or herself), the patient's
8 provider, and the insurer in the event of a dispute between the
9 insurer and patient's provider regarding the medical necessity
10 of a treatment proposed by a patient's provider. If the
11 reviewing provider determines the treatment to be medically
12 necessary, the insurer shall provide reimbursement for the
13 treatment. Future contractual or employment actions by the
14 insurer regarding the patient's provider may not be based on
15 the provider's participation in this procedure. Nothing
16 prevents the insured from agreeing in writing to continue
17 treatment at his or her expense. When making a determination of
18 the medical necessity for a treatment modality for mental,
19 emotional, nervous, ~~serious mental illness~~ or substance use
20 disorders or conditions ~~disorder~~, an insurer must make the
21 determination in a manner that is consistent with the manner
22 used to make that determination with respect to other diseases
23 or illnesses covered under the policy, including an appeals
24 process. Medical necessity determinations for substance use
25 disorders shall be made in accordance with appropriate patient
26 placement criteria established by the American Society of

1 Addiction Medicine. No additional criteria may be used to make
2 medical necessity determinations for substance use disorders.

3 (4) A group health benefit plan amended, delivered, issued,
4 or renewed on or after the effective date of this amendatory
5 Act of the 100th General Assembly or an individual policy of
6 accident and health insurance or a qualified health plan
7 offered through the health insurance marketplace amended,
8 delivered, issued, or renewed on or after the effective date of
9 this amendatory Act of the 100th General Assembly ~~the effective~~
10 ~~date of this amendatory Act of the 97th General Assembly:~~

11 (A) shall provide coverage based upon medical
12 necessity for the treatment of a mental, emotional,
13 nervous, or ~~mental illness and~~ substance use disorder or
14 condition ~~disorders~~ consistent with the parity
15 requirements of Section 370c.1 of this Code; provided,
16 however, that in each calendar year coverage shall not be
17 less than the following:

18 (i) 45 days of inpatient treatment; and

19 (ii) beginning on June 26, 2006 (the effective date
20 of Public Act 94-921), 60 visits for outpatient
21 treatment including group and individual outpatient
22 treatment; and

23 (iii) for plans or policies delivered, issued for
24 delivery, renewed, or modified after January 1, 2007
25 (the effective date of Public Act 94-906), 20
26 additional outpatient visits for speech therapy for

1 treatment of pervasive developmental disorders that
2 will be in addition to speech therapy provided pursuant
3 to item (ii) of this subparagraph (A); and

4 (B) may not include a lifetime limit on the number of
5 days of inpatient treatment or the number of outpatient
6 visits covered under the plan.

7 (C) (Blank).

8 (5) An issuer of a group health benefit plan or an
9 individual policy of accident and health insurance or a
10 qualified health plan offered through the health insurance
11 marketplace may not count toward the number of outpatient
12 visits required to be covered under this Section an outpatient
13 visit for the purpose of medication management and shall cover
14 the outpatient visits under the same terms and conditions as it
15 covers outpatient visits for the treatment of physical illness.

16 (5.5) An individual or group health benefit plan amended,
17 delivered, issued, or renewed on or after the effective date of
18 this amendatory Act of the 99th General Assembly shall offer
19 coverage for medically necessary acute treatment services and
20 medically necessary clinical stabilization services. The
21 treating provider shall base all treatment recommendations and
22 the health benefit plan shall base all medical necessity
23 determinations for substance use disorders in accordance with
24 the most current edition of the Treatment Criteria for
25 Addictive, Substance-Related, and Co-Occurring Conditions
26 established by the American Society of Addiction Medicine

1 ~~Patient Placement Criteria.~~ The treating provider shall base
2 all treatment recommendations and the health benefit plan shall
3 base all medical necessity determinations for
4 medication-assisted treatment in accordance with the most
5 current Treatment Criteria for Addictive, Substance-Related,
6 and Co-Occurring Conditions established by the American
7 Society of Addiction Medicine.

8 As used in this subsection:

9 "Acute treatment services" means 24-hour medically
10 supervised addiction treatment that provides evaluation and
11 withdrawal management and may include biopsychosocial
12 assessment, individual and group counseling, psychoeducational
13 groups, and discharge planning.

14 "Clinical stabilization services" means 24-hour treatment,
15 usually following acute treatment services for substance
16 abuse, which may include intensive education and counseling
17 regarding the nature of addiction and its consequences, relapse
18 prevention, outreach to families and significant others, and
19 aftercare planning for individuals beginning to engage in
20 recovery from addiction.

21 (6) An issuer of a group health benefit plan may provide or
22 offer coverage required under this Section through a managed
23 care plan.

24 (6.5) An individual or group health benefit plan amended,
25 delivered, issued, or renewed on or after the effective date of
26 this amendatory Act of the 100th General Assembly:

1 (A) shall not impose prior authorization requirements,
2 other than those established under the Treatment Criteria
3 for Addictive, Substance-Related, and Co-Occurring
4 Conditions established by the American Society of
5 Addiction Medicine, on a prescription medication approved
6 by the United States Food and Drug Administration that is
7 prescribed or administered for the treatment of substance
8 use disorders;

9 (B) shall not impose any step therapy requirements,
10 other than those established under the Treatment Criteria
11 for Addictive, Substance-Related, and Co-Occurring
12 Conditions established by the American Society of
13 Addiction Medicine, before authorizing coverage for a
14 prescription medication approved by the United States Food
15 and Drug Administration that is prescribed or administered
16 for the treatment of substance use disorders;

17 (C) shall place all prescription medications approved
18 by the United States Food and Drug Administration
19 prescribed or administered for the treatment of substance
20 use disorders on, for brand medications, the lowest tier of
21 the drug formulary developed and maintained by the
22 individual or group health benefit plan that covers brand
23 medications and, for generic medications, the lowest tier
24 of the drug formulary developed and maintained by the
25 individual or group health benefit plan that covers generic
26 medications; and

1 (D) shall not exclude coverage for a prescription
2 medication approved by the United States Food and Drug
3 Administration for the treatment of substance use
4 disorders and any associated counseling or wraparound
5 services on the grounds that such medications and services
6 were court ordered.

7 (7) (Blank).

8 (8) (Blank).

9 (9) With respect to all mental, emotional, nervous, or
10 substance use disorders or conditions, coverage for inpatient
11 treatment shall include coverage for treatment in a residential
12 treatment center certified or licensed by the Department of
13 Public Health or the Department of Human Services.

14 (c) This Section shall not be interpreted to require
15 coverage for speech therapy or other habilitative services for
16 those individuals covered under Section 356z.15 of this Code.

17 (d) With respect to a group or individual policy of
18 accident and health insurance or a qualified health plan
19 offered through the health insurance marketplace, the
20 Department and, with respect to medical assistance, the
21 Department of Healthcare and Family Services shall each enforce
22 the requirements of this Section and Sections 356z.23 and
23 370c.1 of this Code, the Paul Wellstone and Pete Domenici
24 Mental Health Parity and Addiction Equity Act of 2008, 42
25 U.S.C. 18031(j), and any amendments to, and federal guidance or
26 regulations issued under, those Acts, including, but not

1 limited to, final regulations issued under the Paul Wellstone
2 and Pete Domenici Mental Health Parity and Addiction Equity Act
3 of 2008 and final regulations applying the Paul Wellstone and
4 Pete Domenici Mental Health Parity and Addiction Equity Act of
5 2008 to Medicaid managed care organizations, the Children's
6 Health Insurance Program, and alternative benefit plans.
7 Specifically, the Department and the Department of Healthcare
8 and Family Services shall take action:

9 (1) proactively ensuring compliance by individual and
10 group policies, including by requiring that insurers
11 submit comparative analyses, as set forth in paragraph (6)
12 of subsection (k) of Section 370c.1, demonstrating how they
13 design and apply nonquantitative treatment limitations,
14 both as written and in operation, for mental, emotional,
15 nervous, or substance use disorder or condition benefits as
16 compared to how they design and apply nonquantitative
17 treatment limitations, as written and in operation, for
18 medical and surgical benefits;

19 (2) evaluating all consumer or provider complaints
20 regarding mental, emotional, nervous, or substance use
21 disorder or condition coverage for possible parity
22 violations;

23 (3) performing parity compliance market conduct
24 examinations or, in the case of the Department of
25 Healthcare and Family Services, parity compliance audits
26 of individual and group plans and policies, including, but

1 not limited to, reviews of:

2 (A) nonquantitative treatment limitations,
3 including, but not limited to, prior authorization
4 requirements, concurrent review, retrospective review,
5 step therapy, network admission standards,
6 reimbursement rates, and geographic restrictions;

7 (B) denials of authorization, payment, and
8 coverage; and

9 (C) other specific criteria as may be determined by
10 the Department.

11 The findings and the conclusions of the parity compliance
12 market conduct examinations and audits shall be made public.

13 The Director may adopt rules to effectuate any provisions
14 of the Paul Wellstone and Pete Domenici Mental Health Parity
15 and Addiction Equity Act of 2008 that relate to the business of
16 insurance.

17 ~~(d) The Department shall enforce the requirements of State~~
18 ~~and federal parity law, which includes ensuring compliance by~~
19 ~~individual and group policies; detecting violations of the law~~
20 ~~by individual and group policies proactively monitoring~~
21 ~~discriminatory practices; accepting, evaluating, and~~
22 ~~responding to complaints regarding such violations; and~~
23 ~~ensuring violations are appropriately remedied and deterred.~~

24 (e) Availability of plan information.

25 (1) The criteria for medical necessity determinations
26 made under a group health plan, an individual policy of

1 accident and health insurance, or a qualified health plan
2 offered through the health insurance marketplace with
3 respect to mental health or substance use disorder benefits
4 (or health insurance coverage offered in connection with
5 the plan with respect to such benefits) must be made
6 available by the plan administrator (or the health
7 insurance issuer offering such coverage) to any current or
8 potential participant, beneficiary, or contracting
9 provider upon request.

10 (2) The reason for any denial under a group health
11 benefit plan, an individual policy of accident and health
12 insurance, or a qualified health plan offered through the
13 health insurance marketplace (or health insurance coverage
14 offered in connection with such plan or policy) of
15 reimbursement or payment for services with respect to
16 mental, emotional, nervous, ~~health~~ or substance use
17 disorders or conditions ~~disorder~~ benefits in the case of
18 any participant or beneficiary must be made available
19 within a reasonable time and in a reasonable manner and in
20 readily understandable language by the plan administrator
21 (or the health insurance issuer offering such coverage) to
22 the participant or beneficiary upon request.

23 (f) As used in this Section, "group policy of accident and
24 health insurance" and "group health benefit plan" includes (1)
25 State-regulated employer-sponsored group health insurance
26 plans written in Illinois or which purport to provide coverage

1 for a resident of this State; and (2) State employee health
2 plans.

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

4 (215 ILCS 5/370c.1)

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

7 (a) On and after the effective date of this amendatory Act
8 of the 99th General Assembly, every insurer that amends,
9 delivers, issues, or renews a group or individual policy of
10 accident and health insurance or a qualified health plan
11 offered through the Health Insurance Marketplace in this State
12 providing coverage for hospital or medical treatment and for
13 the treatment of mental, emotional, nervous, or substance use
14 disorders or conditions shall ensure that:

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

24 (2) the treatment limitations applicable to such
25 mental, emotional, nervous, or substance use disorder or

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

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

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

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

24 (B) if the policy includes an aggregate lifetime
25 limit on substantially all hospital and medical
26 benefits (in this subsection referred to as the

1 "applicable lifetime limit"), then the policy shall
2 either:

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

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

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

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

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

12 (A) if the policy does not include an annual limit
13 on substantially all hospital and medical benefits,
14 then the policy may not impose any annual limits on
15 mental, emotional, nervous, or substance use disorder
16 or condition benefits; or

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

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

1 benefits and mental, emotional, nervous, or
2 substance use disorder or condition benefits; or

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

7 (2) In the case of a policy that is not described in
8 paragraph (1) of subsection (c) of this Section and that
9 includes no or different annual limits on different
10 categories of hospital and medical benefits, the Director
11 shall establish rules under which subparagraph (B) of
12 paragraph (1) of subsection (c) of this Section is applied
13 to such policy with respect to mental, emotional, nervous,
14 or substance use disorder or condition benefits by
15 substituting for the applicable annual limit an average
16 annual limit that is computed taking into account the
17 weighted average of the annual limits applicable to such
18 categories.

19 (d) With respect to mental, emotional, nervous, or
20 substance use disorders or conditions, an insurer shall use
21 policies and procedures for the election and placement of
22 mental, emotional, nervous, or substance use disorder or
23 condition ~~substance abuse~~ treatment drugs on their formulary
24 that are no less favorable to the insured as those policies and
25 procedures the insurer uses for the selection and placement of
26 ~~other~~ drugs for medical or surgical conditions and shall follow

1 the expedited coverage determination requirements for
2 substance abuse treatment drugs set forth in Section 45.2 of
3 the Managed Care Reform and Patient Rights Act.

4 (e) This Section shall be interpreted in a manner
5 consistent with all applicable federal parity regulations
6 including, but not limited to, the Paul Wellstone and Pete
7 Domenici Mental Health Parity and Addiction Equity Act of 2008,
8 final regulations issued under the Paul Wellstone and Pete
9 Domenici Mental Health Parity and Addiction Equity Act of 2008
10 and final regulations applying the Paul Wellstone and Pete
11 Domenici Mental Health Parity and Addiction Equity Act of 2008
12 to Medicaid managed care organizations, the Children's Health
13 Insurance Program, and alternative benefit plans ~~at 78 FR~~
14 ~~68240~~.

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

18 (g) As used in this Section:

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

23 "Mental, emotional, nervous, or substance use disorder or
24 condition" means a condition or disorder that involves a mental
25 health condition or substance use disorder that falls under any
26 of the diagnostic categories listed in the mental and

1 behavioral disorders chapter of the current edition of the
2 International Classification of Disease or that is listed in
3 the most recent version of the Diagnostic and Statistical
4 Manual of Mental Disorders.

5 "Treatment limitation" includes limits on benefits based
6 on the frequency of treatment, number of visits, days of
7 coverage, days in a waiting period, or other similar limits on
8 the scope or duration of treatment. "Treatment limitation"
9 includes both quantitative treatment limitations, which are
10 expressed numerically (such as 50 outpatient visits per year),
11 and nonquantitative treatment limitations, which otherwise
12 limit the scope or duration of treatment. A permanent exclusion
13 of all benefits for a particular condition or disorder shall
14 not be considered a treatment limitation. "Nonquantitative
15 treatment" means those limitations as described under federal
16 regulations (26 CFR 54.9812-1). "Nonquantitative treatment
17 limitations" include, but are not limited to, those limitations
18 described under federal regulations 26 CFR 54.9812-1, 29 CFR
19 2590.712, and 45 CFR 146.136.

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

22 (1) By January 1, 2016, the Department shall develop a
23 plan for a Consumer Education Campaign on parity. The
24 Consumer Education Campaign shall focus its efforts
25 throughout the State and include trainings in the northern,
26 southern, and central regions of the State, as defined by

1 the Department, as well as each of the 5 managed care
2 regions of the State as identified by the Department of
3 Healthcare and Family Services. Under this Consumer
4 Education Campaign, the Department shall: (1) by January 1,
5 2017, provide at least one live training in each region on
6 parity for consumers and providers and one webinar training
7 to be posted on the Department website and (2) establish a
8 consumer hotline to assist consumers in navigating the
9 parity process by March 1, 2017 ~~2016~~. By January 1, 2018
10 the Department shall issue a report to the General Assembly
11 on the success of the Consumer Education Campaign, which
12 shall indicate whether additional training is necessary or
13 would be recommended.

14 (2) The Department, in coordination with the
15 Department of Human Services and the Department of
16 Healthcare and Family Services, shall convene a working
17 group of health care insurance carriers, mental health
18 advocacy groups, substance abuse patient advocacy groups,
19 and mental health physician groups for the purpose of
20 discussing issues related to the treatment and coverage of
21 mental, emotional, nervous, or substance use ~~abuse~~
22 disorders or conditions and compliance with parity
23 obligations under State and federal law. Compliance shall
24 be measured, tracked, and shared during the meetings of the
25 working group ~~and mental illness~~. The working group shall
26 meet once before January 1, 2016 and shall meet

1 semiannually thereafter. The Department shall issue an
2 annual report to the General Assembly that includes a list
3 of the health care insurance carriers, mental health
4 advocacy groups, substance abuse patient advocacy groups,
5 and mental health physician groups that participated in the
6 working group meetings, details on the issues and topics
7 covered, and any legislative recommendations developed by
8 the working group.

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

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

23 (B) Cover the methodology the Departments use to
24 check for compliance with this Section and Sections
25 356z.23 and 370c of this Code.

26 (C) Identify market conduct examinations or, in

1 the case of the Department of Healthcare and Family
2 Services, audits conducted or completed during the
3 preceding 12-month period regarding compliance with
4 parity in mental, emotional, nervous, and substance
5 use disorder or condition benefits under State and
6 federal laws and summarize the results of such market
7 conduct examinations and audits. This shall include:

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

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

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

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

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

22 (D) Detail any educational or corrective actions
23 the Departments have taken to ensure compliance with
24 the federal Paul Wellstone and Pete Domenici Mental
25 Health Parity and Addiction Equity Act of 2008, 42
26 U.S.C. 18031(j), this Section, and Sections 356z.23

1 and 370c of this Code.

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

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

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

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

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

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

25 (2) administrative denials for no prior authorization;

26 (3) denials due to not meeting medical necessity;

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

3 (5) out-of-network claims;

4 (6) emergency care claims;

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

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

16 (9) when reporting and publishing should begin.

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

22 (k) An insurer that amends, delivers, issues, or renews a
23 group or individual policy of accident and health insurance or
24 a qualified health plan offered through the health insurance
25 marketplace in this State providing coverage for hospital or
26 medical treatment and for the treatment of mental, emotional,

1 nervous, or substance use disorders or conditions shall submit
2 an annual report, the format and definitions for which will be
3 developed by the workgroup in subsection (j), to the
4 Department, or, with respect to medical assistance, the
5 Department of Healthcare and Family Services starting on or
6 before July 1, 2020 that contains the following information
7 separately for inpatient in-network benefits, inpatient
8 out-of-network benefits, outpatient in-network benefits,
9 outpatient out-of-network benefits, emergency care benefits,
10 and prescription drug benefits in the case of accident and
11 health insurance or qualified health plans, or inpatient,
12 outpatient, emergency care, and prescription drug benefits in
13 the case of medical assistance:

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

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

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

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

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

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

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

1 (A) identify the factors used to determine that a
2 nonquantitative treatment limitation applies to a
3 benefit, including factors that were considered but
4 rejected;

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

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

19 (D) provide the comparative analyses, including
20 the results of the analyses, performed to determine
21 that the processes and strategies used to apply each
22 nonquantitative treatment limitation, in operation,
23 for mental, emotional, nervous, or substance use
24 disorder or condition benefits are comparable to, and
25 applied no more stringently than, the processes or
26 strategies used to apply each nonquantitative

1 treatment limitation, in operation, for medical and
2 surgical benefits; and

3 (E) disclose the specific findings and conclusions
4 reached by the insurer that the results of the analyses
5 described in subparagraphs (C) and (D) indicate that
6 the insurer is in compliance with this Section and the
7 Mental Health Parity and Addiction Equity Act of 2008
8 and its implementing regulations, which includes 42
9 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any
10 other related federal regulations found in the Code of
11 Federal Regulations.

12 (7) Any other information necessary to clarify data
13 provided in accordance with this Section requested by the
14 Director, including information that may be proprietary or
15 have commercial value, under the requirements of Section 30
16 of the Viatical Settlements Act of 2009.

17 (1) An insurer that amends, delivers, issues, or renews a
18 group or individual policy of accident and health insurance or
19 a qualified health plan offered through the health insurance
20 marketplace in this State providing coverage for hospital or
21 medical treatment and for the treatment of mental, emotional,
22 nervous, or substance use disorders or conditions on or after
23 the effective date of this amendatory Act of the 100th General
24 Assembly shall, in advance of the plan year, make available to
25 the Department or, with respect to medical assistance, the
26 Department of Healthcare and Family Services and to all plan

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

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

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

22 Section 99. Effective date. This Act takes effect January
23 1, 2019.