Rep. Lou Lang

Filed: 5/29/2018

AMENDMENT TO SENATE BILL 1707

AMENDMENT NO. ______. Amend Senate Bill 1707 by replacing everything after the enacting clause with the following:

"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

1 must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c,
2 and 370c.1 of the Illinois Insurance Code. The Department of
3 Insurance shall enforce the requirements of this Section.
4 Rulemaking authority to implement Public Act 95-1045, if
5 any, is conditioned on the rules being adopted in accordance
6 with all provisions of the Illinois Administrative Procedure
7 Act and all rules and procedures of the Joint Committee on
8 Administrative Rules; any purported rule not so adopted, for
9 whatever reason, is unauthorized.
10 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
11 100-138, eff. 8-18-17; revised 10-3-17.)

12 Section 10. The State Finance Act is amended by changing
13 Section 5.872 as follows:

14 (30 ILCS 105/5.872)
15 Sec. 5.872. The Parity Advancement ~~Education~~ Fund.
16 (Source: P.A. 99-480, eff. 9-9-15; 99-642, eff. 7-28-16.)

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

19 (55 ILCS 5/5-1069.3)
20 Sec. 5-1069.3. Required health benefits. If a county,
21 including a home rule county, is a self-insurer for purposes of
22 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:

1 (65 ILCS 5/10-4-2.3)
2 Sec. 10-4-2.3. Required health benefits. If a
3 municipality, including a home rule municipality, is a
4 self-insurer for purposes of providing health insurance
5 coverage for its employees, the coverage shall include coverage
6 for the post-mastectomy care benefits required to be covered by
7 a policy of accident and health insurance under Section 356t
8 and the coverage required under Sections 356g, 356g.5,
9 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10,
10 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~
11 356z.25, and 356z.26 of the Illinois Insurance Code. The
12 coverage shall comply with Sections 155.22a, 355b, 356z.19, and
13 370c of the Illinois Insurance Code. The Department of
14 Insurance shall enforce the requirements of this Section. The
15 requirement that health benefits be covered as provided in this
16 is an exclusive power and function of the State and is a denial
17 and limitation under Article VII, Section 6, subsection (h) of
18 the Illinois Constitution. A home rule municipality to which
19 this Section applies must comply with every provision of this
20 Section.
21 Rulemaking authority to implement Public Act 95-1045, if
22 any, is conditioned on the rules being adopted in accordance
23 with all provisions of the Illinois Administrative Procedure
24 Act and all rules and procedures of the Joint Committee on
25 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 <u>the effective date of this amendatory Act of the 100th General Assembly</u> ~~the effective date of this amendatory Act of the 97th General Assembly~~, every insurer <u>that</u> ~~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 <u>provide</u> ~~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<u>,</u> ~~or~~ nervous<u>, or substance use</u> 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

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

23 (3) Insofar as this Section applies solely to licensed
24 clinical social workers, licensed clinical professional
25 counselors, licensed marriage and family therapists, licensed
26 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

1 or condition" means a condition or disorder that involves a
2 mental health condition or substance use disorder that falls
3 under any of the diagnostic categories listed in the mental and
4 behavioral disorders chapter of the current edition of the
5 International Classification of Disease or that is listed in
6 the most recent version of the Diagnostic and Statistical
7 Manual of Mental Disorders.

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

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

24 ~~(A) schizophrenia;~~

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

26 ~~(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

1 this Code, the reimbursing insurer that amends, delivers,
2 issues, or renews a group or individual policy of accident and
3 health insurance, a qualified health plan offered through the
4 health insurance marketplace, or, a provider of treatment of
5 mental, emotional, nervous, serious mental illness or
6 substance use disorders or conditions disorder shall furnish
7 medical records or other necessary data that substantiate that
8 initial or continued treatment is at all times medically
9 necessary. An insurer shall provide a mechanism for the timely
10 review by a provider holding the same license and practicing in
11 the same specialty as the patient's provider, who is
12 unaffiliated with the insurer, jointly selected by the patient
13 (or the patient's next of kin or legal representative if the
14 patient is unable to act for himself or herself), the patient's
15 provider, and the insurer in the event of a dispute between the
16 insurer and patient's provider regarding the medical necessity
17 of a treatment proposed by a patient's provider. If the
18 reviewing provider determines the treatment to be medically
19 necessary, the insurer shall provide reimbursement for the
20 treatment. Future contractual or employment actions by the
21 insurer regarding the patient's provider may not be based on
22 the provider's participation in this procedure. Nothing
23 prevents the insured from agreeing in writing to continue
24 treatment at his or her expense. When making a determination of
25 the medical necessity for a treatment modality for mental,
26 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

1 of Public Act 94-921), 60 visits for outpatient
2 treatment including group and individual outpatient
3 treatment; and
4 (iii) for plans or policies delivered, issued for
5 delivery, renewed, or modified after January 1, 2007
6 (the effective date of Public Act 94-906), 20
7 additional outpatient visits for speech therapy for
8 treatment of pervasive developmental disorders that
9 will be in addition to speech therapy provided pursuant
10 to item (ii) of this subparagraph (A); and
11 (B) may not include a lifetime limit on the number of
12 days of inpatient treatment or the number of outpatient
13 visits covered under the plan.
14 (C) (Blank).
15 (5) An issuer of a group health benefit plan or an
16 individual policy of accident and health insurance or a
17 qualified health plan offered through the health insurance
18 marketplace may not count toward the number of outpatient
19 visits required to be covered under this Section an outpatient
20 visit for the purpose of medication management and shall cover
21 the outpatient visits under the same terms and conditions as it
22 covers outpatient visits for the treatment of physical illness.
23 (5.5) An individual or group health benefit plan amended,
24 delivered, issued, or renewed on or after the effective date of
25 this amendatory Act of the 99th General Assembly shall offer
26 coverage for medically necessary acute treatment services and

1 medically necessary clinical stabilization services. The
2 treating provider shall base all treatment recommendations and
3 the health benefit plan shall base all medical necessity
4 determinations for substance use disorders in accordance with
5 the most current edition of the Treatment Criteria for
6 Addictive, Substance-Related, and Co-Occurring Conditions
7 established by the American Society of Addiction Medicine
8 ~~Patient Placement Criteria~~. The treating provider shall base
9 all treatment recommendations and the health benefit plan shall
10 base all medical necessity determinations for
11 medication-assisted treatment in accordance with the most
12 current Treatment Criteria for Addictive, Substance-Related,
13 and Co-Occurring Conditions established by the American
14 Society of Addiction Medicine.

15 As used in this subsection:

16 "Acute treatment services" means 24-hour medically
17 supervised addiction treatment that provides evaluation and
18 withdrawal management and may include biopsychosocial
19 assessment, individual and group counseling, psychoeducational
20 groups, and discharge planning.

21 "Clinical stabilization services" means 24-hour treatment,
22 usually following acute treatment services for substance
23 abuse, which may include intensive education and counseling
24 regarding the nature of addiction and its consequences, relapse
25 prevention, outreach to families and significant others, and
26 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

1 Department and, with respect to medical assistance, the
2 Department of Healthcare and Family Services shall each enforce
3 the requirements of this Section and Sections 356z.23 and
4 370c.1 of this Code, the Paul Wellstone and Pete Domenici
5 Mental Health Parity and Addiction Equity Act of 2008, 42
6 U.S.C. 18031(j), and any amendments to, and federal guidance or
7 regulations issued under, those Acts, including, but not
8 limited to, final regulations issued under the Paul Wellstone
9 and Pete Domenici Mental Health Parity and Addiction Equity Act
10 of 2008 and final regulations applying the Paul Wellstone and
11 Pete Domenici Mental Health Parity and Addiction Equity Act of
12 2008 to Medicaid managed care organizations, the Children's
13 Health Insurance Program, and alternative benefit plans.
14 Specifically, the Department and the Department of Healthcare
15 and Family Services shall take action:
16 (1) proactively ensuring compliance by individual and
17 group policies, including by requiring that insurers
18 submit comparative analyses, as set forth in paragraph (6)
19 of subsection (k) of Section 370c.1, demonstrating how they
20 design and apply nonquantitative treatment limitations,
21 both as written and in operation, for mental, emotional,
22 nervous, or substance use disorder or condition benefits as
23 compared to how they design and apply nonquantitative
24 treatment limitations, as written and in operation, for
25 medical and surgical benefits;
26 (2) evaluating all consumer or provider complaints

1 regarding mental, emotional, nervous, or substance use
2 disorder or condition coverage for possible parity
3 violations;
4 (3) performing parity compliance market conduct
5 examinations or, in the case of the Department of
6 Healthcare and Family Services, parity compliance audits
7 of individual and group plans and policies, including, but
8 not limited to, reviews of:
9 (A) nonquantitative treatment limitations,
10 including, but not limited to, prior authorization
11 requirements, concurrent review, retrospective review,
12 step therapy, network admission standards,
13 reimbursement rates, and geographic restrictions;
14 (B) denials of authorization, payment, and
15 coverage; and
16 (C) other specific criteria as may be determined by
17 the Department.
18 The findings and the conclusions of the parity compliance
19 market conduct examinations and audits shall be made public.
20 The Director may adopt rules to effectuate any provisions
21 of the Paul Wellstone and Pete Domenici Mental Health Parity
22 and Addiction Equity Act of 2008 that relate to the business of
23 insurance.
24 ~~(d) The Department shall enforce the requirements of State~~
25 ~~and federal parity law, which includes ensuring compliance by~~
26 ~~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

1 readily understandable language by the plan administrator
2 (or the health insurance issuer offering such coverage) to
3 the participant or beneficiary upon request.
4 (f) As used in this Section, "group policy of accident and
5 health insurance" and "group health benefit plan" includes (1)
6 State-regulated employer-sponsored group health insurance
7 plans written in Illinois or which purport to provide coverage
8 for a resident of this State; and (2) State employee health
9 plans.
10 (Source: P.A. 99-480, eff. 9-9-15; 100-305, eff. 8-24-17.)

11 (215 ILCS 5/370c.1)
12 Sec. 370c.1. Mental, emotional, nervous, or substance use
13 disorder or condition ~~health and addiction~~ parity.
14 (a) On and after the effective date of this amendatory Act
15 of the 99th General Assembly, every insurer that amends,
16 delivers, issues, or renews a group or individual policy of
17 accident and health insurance or a qualified health plan
18 offered through the Health Insurance Marketplace in this State
19 providing coverage for hospital or medical treatment and for
20 the treatment of mental, emotional, nervous, or substance use
21 disorders or conditions shall ensure that:
22 (1) the financial requirements applicable to such
23 mental, emotional, nervous, or substance use disorder or
24 condition benefits are no more restrictive than the
25 predominant financial requirements applied to

1 substantially all hospital and medical benefits covered by
2 the policy and that there are no separate cost-sharing
3 requirements that are applicable only with respect to
4 mental, emotional, nervous, or substance use disorder or
5 condition benefits; and
6 (2) the treatment limitations applicable to such
7 mental, emotional, nervous, or substance use disorder or
8 condition benefits are no more restrictive than the
9 predominant treatment limitations applied to substantially
10 all hospital and medical benefits covered by the policy and
11 that there are no separate treatment limitations that are
12 applicable only with respect to mental, emotional,
13 nervous, or substance use disorder or condition benefits.
14 (b) The following provisions shall apply concerning
15 aggregate lifetime limits:
16 (1) In the case of a group or individual policy of
17 accident and health insurance or a qualified health plan
18 offered through the Health Insurance Marketplace amended,
19 delivered, issued, or renewed in this State on or after the
20 effective date of this amendatory Act of the 99th General
21 Assembly that provides coverage for hospital or medical
22 treatment and for the treatment of mental, emotional,
23 nervous, or substance use disorders or conditions the
24 following provisions shall apply:
25 (A) if the policy does not include an aggregate
26 lifetime limit on substantially all hospital and

1 medical benefits, then the policy may not impose any
2 aggregate lifetime limit on mental, emotional,
3 nervous, or substance use disorder or condition
4 benefits; or
5 (B) if the policy includes an aggregate lifetime
6 limit on substantially all hospital and medical
7 benefits (in this subsection referred to as the
8 "applicable lifetime limit"), then the policy shall
9 either:
10 (i) apply the applicable lifetime limit both
11 to the hospital and medical benefits to which it
12 otherwise would apply and to mental, emotional,
13 nervous, or substance use disorder or condition
14 benefits and not distinguish in the application of
15 the limit between the hospital and medical
16 benefits and mental, emotional, nervous, or
17 substance use disorder or condition benefits; or
18 (ii) not include any aggregate lifetime limit
19 on mental, emotional, nervous, or substance use
20 disorder or condition benefits that is less than
21 the applicable lifetime limit.
22 (2) In the case of a policy that is not described in
23 paragraph (1) of subsection (b) of this Section and that
24 includes no or different aggregate lifetime limits on
25 different categories of hospital and medical benefits, the
26 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

1 limit"), then the policy shall either:
2 (i) apply the applicable annual limit both to
3 the hospital and medical benefits to which it
4 otherwise would apply and to mental, emotional,
5 nervous, or substance use disorder or condition
6 benefits and not distinguish in the application of
7 the limit between the hospital and medical
8 benefits and mental, emotional, nervous, or
9 substance use disorder or condition benefits; or
10 (ii) not include any annual limit on mental,
11 emotional, nervous, or substance use disorder or
12 condition benefits that is less than the
13 applicable annual limit.
14 (2) In the case of a policy that is not described in
15 paragraph (1) of subsection (c) of this Section and that
16 includes no or different annual limits on different
17 categories of hospital and medical benefits, the Director
18 shall establish rules under which subparagraph (B) of
19 paragraph (1) of subsection (c) of this Section is applied
20 to such policy with respect to mental, emotional, nervous,
21 or substance use disorder or condition benefits by
22 substituting for the applicable annual limit an average
23 annual limit that is computed taking into account the
24 weighted average of the annual limits applicable to such
25 categories.
26 (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,

1 coinsurance, and out-of-pocket maximums, but does not include
2 an aggregate lifetime limit or an annual limit subject to
3 subsections (b) and (c).
4 "Mental, emotional, nervous, or substance use disorder or
5 condition" means a condition or disorder that involves a mental
6 health condition or substance use disorder that falls under any
7 of the diagnostic categories listed in the mental and
8 behavioral disorders chapter of the current edition of the
9 International Classification of Disease or that is listed in
10 the most recent version of the Diagnostic and Statistical
11 Manual of Mental Disorders.
12 "Treatment limitation" includes limits on benefits based
13 on the frequency of treatment, number of visits, days of
14 coverage, days in a waiting period, or other similar limits on
15 the scope or duration of treatment. "Treatment limitation"
16 includes both quantitative treatment limitations, which are
17 expressed numerically (such as 50 outpatient visits per year),
18 and nonquantitative treatment limitations, which otherwise
19 limit the scope or duration of treatment. A permanent exclusion
20 of all benefits for a particular condition or disorder shall
21 not be considered a treatment limitation. "Nonquantitative
22 treatment" means those limitations as described under federal
23 regulations (26 CFR 54.9812-1). "Nonquantitative treatment
24 limitations" include, but are not limited to, those limitations
25 described under federal regulations 26 CFR 54.9812-1, 29 CFR
26 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

1 oversight of the federal Paul Wellstone and Pete
2 Domenici Mental Health Parity and Addiction Equity Act
3 of 2008 and 42 U.S.C. 18031(j).
4 (B) Cover the methodology the Departments use to
5 check for compliance with this Section and Sections
6 356z.23 and 370c of this Code.
7 (C) Identify market conduct examinations or, in
8 the case of the Department of Healthcare and Family
9 Services, audits conducted or completed during the
10 preceding 12-month period regarding compliance with
11 parity in mental, emotional, nervous, and substance
12 use disorder or condition benefits under State and
13 federal laws and summarize the results of such market
14 conduct examinations and audits. This shall include:
15 (i) the number of market conduct examinations
16 and audits initiated and completed;
17 (ii) the benefit classifications examined by
18 each market conduct examination and audit;
19 (iii) the subject matter of each market
20 conduct examination and audit, including
21 quantitative and non-quantitative treatment
22 limitations; and
23 (iv) a summary of the basis for the final
24 decision rendered in each market conduct
25 examination and audit.
26 Individually identifiable information shall be

1 excluded from the reports consistent with federal
2 privacy protections.
3 (D) Detail any educational or corrective actions
4 the Departments have taken to ensure compliance with
5 the federal Paul Wellstone and Pete Domenici Mental
6 Health Parity and Addiction Equity Act of 2008, 42
7 U.S.C. 18031(j), this Section, and Sections 356z.23
8 and 370c of this Code.
9 (E) The report must be written in non-technical,
10 readily understandable language and shall be made
11 available to the public by, among such other means as
12 the Departments find appropriate, posting the report
13 on the Departments' websites.
14 (i) The Parity Advancement ~~Education~~ Fund is created as a
15 special fund in the State treasury. Moneys from fines and
16 penalties collected from insurers for violations of this
17 Section shall be deposited into the Fund. Moneys deposited into
18 the Fund for appropriation by the General Assembly to the
19 Department ~~of Insurance~~ shall be used for the purpose of
20 providing financial support of the Consumer Education
21 Campaign, parity compliance advocacy, and other initiatives
22 that support parity implementation and enforcement on behalf of
23 consumers.
24 (j) The Department of Insurance and the Department of
25 Healthcare and Family Services shall convene and provide
26 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

1 Prevention and Recovery shall provide technical advice to the
2 workgroup.
3 (k) An insurer that amends, delivers, issues, or renews a
4 group or individual policy of accident and health insurance or
5 a qualified health plan offered through the health insurance
6 marketplace in this State providing coverage for hospital or
7 medical treatment and for the treatment of mental, emotional,
8 nervous, or substance use disorders or conditions shall submit
9 an annual report, the format and definitions for which will be
10 developed by the workgroup in subsection (j), to the
11 Department, or, with respect to medical assistance, the
12 Department of Healthcare and Family Services starting on or
13 before July 1, 2020 that contains the following information
14 separately for inpatient in-network benefits, inpatient
15 out-of-network benefits, outpatient in-network benefits,
16 outpatient out-of-network benefits, emergency care benefits,
17 and prescription drug benefits in the case of accident and
18 health insurance or qualified health plans, or inpatient,
19 outpatient, emergency care, and prescription drug benefits in
20 the case of medical assistance:
21 (1) A summary of the plan's pharmacy management
22 processes for mental, emotional, nervous, or substance use
23 disorder or condition benefits compared to those for other
24 medical benefits.
25 (2) A summary of the internal processes of review for
26 experimental benefits and unproven technology for mental,

1 emotional, nervous, or substance use disorder or condition
2 benefits and those for other medical benefits.
3 (3) A summary of how the plan's policies and procedures
4 for utilization management for mental, emotional, nervous,
5 or substance use disorder or condition benefits compare to
6 those for other medical benefits.
7 (4) A description of the process used to develop or
8 select the medical necessity criteria for mental,
9 emotional, nervous, or substance use disorder or condition
10 benefits and the process used to develop or select the
11 medical necessity criteria for medical and surgical
12 benefits.
13 (5) Identification of all nonquantitative treatment
14 limitations that are applied to both mental, emotional,
15 nervous, or substance use disorder or condition benefits
16 and medical and surgical benefits within each
17 classification of benefits.
18 (6) The results of an analysis that demonstrates that
19 for the medical necessity criteria described in
20 subparagraph (A) and for each nonquantitative treatment
21 limitation identified in subparagraph (B), as written and
22 in operation, the processes, strategies, evidentiary
23 standards, or other factors used in applying the medical
24 necessity criteria and each nonquantitative treatment
25 limitation to mental, emotional, nervous, or substance use
26 disorder or condition benefits within each classification

1 of benefits are comparable to, and are applied no more
2 stringently than, the processes, strategies, evidentiary
3 standards, or other factors used in applying the medical
4 necessity criteria and each nonquantitative treatment
5 limitation to medical and surgical benefits within the
6 corresponding classification of benefits; at a minimum,
7 the results of the analysis shall:
8 (A) identify the factors used to determine that a
9 nonquantitative treatment limitation applies to a
10 benefit, including factors that were considered but
11 rejected;
12 (B) identify and define the specific evidentiary
13 standards used to define the factors and any other
14 evidence relied upon in designing each nonquantitative
15 treatment limitation;
16 (C) provide the comparative analyses, including
17 the results of the analyses, performed to determine
18 that the processes and strategies used to design each
19 nonquantitative treatment limitation, as written, for
20 mental, emotional, nervous, or substance use disorder
21 or condition benefits are comparable to, and are
22 applied no more stringently than, the processes and
23 strategies used to design each nonquantitative
24 treatment limitation, as written, for medical and
25 surgical benefits;
26 (D) provide the comparative analyses, including

1 the results of the analyses, performed to determine
2 that the processes and strategies used to apply each
3 nonquantitative treatment limitation, in operation,
4 for mental, emotional, nervous, or substance use
5 disorder or condition benefits are comparable to, and
6 applied no more stringently than, the processes or
7 strategies used to apply each nonquantitative
8 treatment limitation, in operation, for medical and
9 surgical benefits; and
10 (E) disclose the specific findings and conclusions
11 reached by the insurer that the results of the analyses
12 described in subparagraphs (C) and (D) indicate that
13 the insurer is in compliance with this Section and the
14 Mental Health Parity and Addiction Equity Act of 2008
15 and its implementing regulations, which includes 42
16 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any
17 other related federal regulations found in the Code of
18 Federal Regulations.
19 (7) Any other information necessary to clarify data
20 provided in accordance with this Section requested by the
21 Director, including information that may be proprietary or
22 have commercial value, under the requirements of Section 30
23 of the Viatical Settlements Act of 2009.
24 (l) An insurer that amends, delivers, issues, or renews a
25 group or individual policy of accident and health insurance or
26 a qualified health plan offered through the health insurance

1 marketplace in this State providing coverage for hospital or
2 medical treatment and for the treatment of mental, emotional,
3 nervous, or substance use disorders or conditions on or after
4 the effective date of this amendatory Act of the 100th General
5 Assembly shall, in advance of the plan year, make available to
6 the Department or, with respect to medical assistance, the
7 Department of Healthcare and Family Services and to all plan
8 participants and beneficiaries the information required in
9 subparagraphs (C) through (E) of paragraph (6) of subsection
10 (k). For plan participants and medical assistance
11 beneficiaries, the information required in subparagraphs (C)
12 through (E) of paragraph (6) of subsection (k) shall be made
13 available on a publicly-available website whose web address is
14 prominently displayed in plan and managed care organization
15 informational and marketing materials.
16 (m) In conjunction with its compliance examination program
17 conducted in accordance with the Illinois State Auditing Act,
18 the Auditor General shall undertake a review of compliance by
19 the Department and the Department of Healthcare and Family
20 Services with Section 370c and this Section. Any findings
21 resulting from the review conducted under this Section shall be
22 included in the applicable State agency's compliance
23 examination report. Each compliance examination report shall
24 be issued in accordance with Section 3-14 of the Illinois State
25 Auditing Act. A copy of each report shall also be delivered to
26 the head of the applicable State agency and posted on the

1 Auditor General's website.
2 (Source: P.A. 99-480, eff. 9-9-15.)

3 Section 99. Effective date. This Act takes effect January
4 1, 2019.".