SB2440

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB2440

Introduced 1/30/2018, by Sen. Julie A. Morrison

SYNOPSIS AS INTRODUCED:

215 ILCS 5/370c.1

Amends the Illinois Insurance Code. Provides than an insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan that provides coverage for hospital or medical treatment and for treatment of a mental, emotional, nervous, or substance use disorder or condition shall submit an annual report to the Department of Insurance or, with respect to medical assistance, the Department of Healthcare and Family Services on or before March 1 containing specific information. Provides that the Director of Insurance cannot certify an insurer's policy if the insurer fails to submit all specific information required.

LRB100 16053 SMS 31172 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Section 370c.1 as follows:

6 (215 ILCS 5/370c.1)
7 Sec. 370c.1. Mental health and addiction parity.
8 (a) On and after the effective date of this amendatory Act
9 of the 99th General Assembly, every insurer that amends,
10 delivers, issues, or renews a group or individual policy of
11 accident and health insurance or a qualified health plan
12 offered through the Health Insurance Marketplace in this State
13 providing coverage for hospital or medical treatment and for
14 the treatment of mental, emotional, nervous, or substance use
15 disorders or conditions shall ensure that:
16 (1) the financial requirements applicable to such
17 mental, emotional, nervous, or substance use disorder or
18 condition benefits are no more restrictive than the
19 predominant financial requirements applied to
20 substantially all hospital and medical benefits covered by
21 the policy and that there are no separate cost-sharing
22 requirements that are applicable only with respect to
23 mental, emotional, nervous, or substance use disorder or

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

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

1 aggregate lifetime limit that is computed taking into
2 account the weighted average of the aggregate lifetime
3 limits applicable to such categories.
4 (c) The following provisions shall apply concerning annual
5 limits:
6 (1) In the case of a group or individual policy of
7 accident and health insurance or a qualified health plan
8 offered through the Health Insurance Marketplace amended,
9 delivered, issued, or renewed in this State on or after the
10 effective date of this amendatory Act of the 99th General
11 Assembly that provides coverage for hospital or medical
12 treatment and for the treatment of mental, emotional,
13 nervous, or substance use disorders or conditions the
14 following provisions shall apply:
15 (A) if the policy does not include an annual limit
16 on substantially all hospital and medical benefits,
17 then the policy may not impose any annual limits on
18 mental, emotional, nervous, or substance use disorder
19 or condition benefits; or
20 (B) if the policy includes an annual limit on
21 substantially all hospital and medical benefits (in
22 this subsection referred to as the "applicable annual
23 limit"), then the policy shall either:
24 (i) apply the applicable annual limit both to
25 the hospital and medical benefits to which it
26 otherwise would apply and to mental, emotional,

nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

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

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

(d) With respect to substance use disorders, an insurer shall use policies and procedures for the election and placement of 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 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 Mental Health Parity and Addiction Equity Act of 2008 at 78 FR 68240.

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

(g) As used in this Section:

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

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

1 treatment" means those limitations as described under federal
2 regulations (26 CFR 54.9812-1).

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

5 (1) By January 1, 2016, the Department shall develop a
6 plan for a Consumer Education Campaign on parity. The
7 Consumer Education Campaign shall focus its efforts
8 throughout the State and include trainings in the northern,
9 southern, and central regions of the State, as defined by
10 the Department, as well as each of the 5 managed care
11 regions of the State as identified by the Department of
12 Healthcare and Family Services. Under this Consumer
13 Education Campaign, the Department shall: (1) by January 1,
14 2017, provide at least one live training in each region on
15 parity for consumers and providers and one webinar training
16 to be posted on the Department website and (2) establish a
17 consumer hotline to assist consumers in navigating the
18 parity process by March 1, 2016. By January 1, 2018 the
19 Department shall issue a report to the General Assembly on
20 the success of the Consumer Education Campaign, which shall
21 indicate whether additional training is necessary or would
22 be recommended.

23 (2) The Department, in coordination with the
24 Department of Human Services and the Department of
25 Healthcare and Family Services, shall convene a working
26 group of health care insurance carriers, mental health

1 advocacy groups, substance abuse patient advocacy groups,
2 and mental health physician groups for the purpose of
3 discussing issues related to the treatment and coverage of
4 substance abuse disorders and mental illness. The working
5 group shall meet once before January 1, 2016 and shall meet
6 semiannually thereafter. The Department shall issue an
7 annual report to the General Assembly that includes a list
8 of the health care insurance carriers, mental health
9 advocacy groups, substance abuse patient advocacy groups,
10 and mental health physician groups that participated in the
11 working group meetings, details on the issues and topics
12 covered, and any legislative recommendations.
13 (i) The Parity Education Fund is created as a special fund
14 in the State treasury. Moneys deposited into the Fund for
15 appropriation by the General Assembly to the Department of
16 Insurance shall be used for the purpose of providing financial
17 support of the Consumer Education Campaign.
18 (j) An insurer that amends, delivers, issues, or renews a
19 group or individual policy of accident and health insurance or
20 a qualified health plan offered through the health insurance
21 marketplace in this State providing coverage for hospital or
22 medical treatment and for the treatment of mental, emotional,
23 nervous, or substance use disorders or conditions shall submit
24 an annual report to the Department or, with respect to medical
25 assistance, the Department of Healthcare and Family Services on
26 or before March 1 that contains the following information

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

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

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

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

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

1 for other medical benefits.
2 (5) The number and percentage of administrative
3 denials for no prior authorization for a mental, emotional,
4 nervous, or substance use disorder or condition benefit and
5 the number and percentage of administrative denials for no
6 prior authorization for other medical benefits.
7 (6) The number and percentage of denials due to a
8 mental, emotional, nervous, or substance use disorder or
9 condition benefit not being a covered benefit and the
10 number and percentage of denials for other medical benefits
11 not being a covered benefit.
12 (7) The number and percentage of denials due to a
13 mental, emotional, nervous, or substance use disorder or
14 condition benefit not meeting medical necessity and the
15 number and percentage of denials for other medical benefits
16 not meeting medical necessity.
17 (8) The number and percentage of denials upheld on
18 appeal for a mental, emotional, nervous, or substance use
19 disorder or condition benefit for not meeting medical
20 necessity and the number and percentage of those for other
21 medical benefits.
22 (9) The number and percentage of denials due to a
23 mental, emotional, nervous, or substance use disorder or
24 condition benefit being denied administratively or any
25 reason other than medical necessity.
26 (10) The number and percentage of denials of mental,

1 emotional, nervous, or substance use disorder or condition
2 benefits that went to the plan's external quality review
3 organization, or similar reviewing body and were upheld and
4 those that were overturned for medical necessity.

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

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

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

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

1 non-doctoral level non-MD/DO practitioners; and inpatient,
2 residential, and ambulatory provider organizations.

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

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

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

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

(A) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

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

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

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

1 limitation in operation for medical and surgical
2 benefits; and
3 (E) disclose the specific findings and conclusions
4 reached by the insurer that the results of the analyses
5 above indicate that the insurer is in compliance with
6 this Section and the Mental Health Parity and Addiction
7 Equity Act of 2008 and its implementing regulations,
8 which includes 45 CFR 146.136 and any other relevant
9 current or future regulations.
10 (19) A certification signed by the insurer's chief
11 executive officer and chief medical officer that states
12 that the insurer has completed a comprehensive review of
13 the administrative practices of the insurer for the prior
14 calendar year for compliance with the necessary provisions
15 of this Section and Sections 356z.23 and 370c of this Code,
16 the federal Paul Wellstone and Pete Domenici Mental Health
17 Parity and Addiction Equity Act of 2008, 42 U.S.C.
18 18031(j), and any amendments to, and federal guidance or
19 regulations issued under, those Acts, including, but not
20 limited to, final regulations issued under the Paul
21 Wellstone and Pete Domenici Mental Health Parity and
22 Addiction Equity Act of 2008 and final regulations applying
23 the Paul Wellstone and Pete Domenici Mental Health Parity
24 and Addiction Equity Act of 2008 to Medicaid managed care
25 organizations, the Children's Health Insurance Program,
26 and alternative benefit plans.

1 (20) Any other information necessary to clarify data
2 provided in accordance with this Section requested by the
3 Director, including information that may be proprietary or
4 have commercial value.
5 The Director shall not certify any policy of an insurer
6 that fails to submit all data as required by this Section.
7 (Source: P.A. 99-480, eff. 9-9-15.)