

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 as follows:

6 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

7 Sec. 370c. Mental and emotional disorders.

8 (a)(1) On and after the effective date of this amendatory
9 Act of the 101st General Assembly ~~this amendatory Act of the~~
10 ~~100th General Assembly~~, every insurer that amends, delivers,
11 issues, or renews group accident and health policies providing
12 coverage for hospital or medical treatment or services for
13 illness on an expense-incurred basis shall provide coverage for
14 reasonable and necessary treatment and services for mental,
15 emotional, nervous, or substance use disorders or conditions
16 consistent with the parity requirements of Section 370c.1 of
17 this Code.

18 (2) Each insured that is covered for mental, emotional,
19 nervous, or substance use disorders or conditions shall be free
20 to select the physician licensed to practice medicine in all
21 its branches, licensed clinical psychologist, licensed
22 clinical social worker, licensed clinical professional
23 counselor, licensed marriage and family therapist, licensed

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

1 professionals at programs licensed pursuant to the Substance
2 Use Disorder ~~Illinois Alcoholism and Other Drug Abuse and~~
3 ~~Dependency~~ Act, those persons who may provide services to
4 individuals shall do so after the licensed clinical social
5 worker, licensed clinical professional counselor, licensed
6 marriage and family therapist, licensed speech-language
7 pathologist, or other licensed or certified professional at a
8 program licensed pursuant to the Substance Use Disorder
9 ~~Illinois Alcoholism and Other Drug Abuse and Dependency~~ Act has
10 informed the patient of the desirability of the patient
11 conferring with the patient's primary care physician.

12 (4) "Mental, emotional, nervous, or substance use disorder
13 or condition" means a condition or disorder that involves a
14 mental health condition or substance use disorder that falls
15 under any of the diagnostic categories listed in the mental and
16 behavioral disorders chapter of the current edition of the
17 International Classification of Disease or that is listed in
18 the most recent version of the Diagnostic and Statistical
19 Manual of Mental Disorders. "Mental, emotional, nervous, or
20 substance use disorder or condition" includes any mental health
21 condition that occurs during pregnancy or during the postpartum
22 period and includes, but is not limited to, postpartum
23 depression.

24 (b) (1) (Blank).

25 (2) (Blank).

26 (2.5) (Blank).

1 (3) Unless otherwise prohibited by federal law and
2 consistent with the parity requirements of Section 370c.1 of
3 this Code, the reimbursing insurer that amends, delivers,
4 issues, or renews a group or individual policy of accident and
5 health insurance, a qualified health plan offered through the
6 health insurance marketplace, or a provider of treatment of
7 mental, emotional, nervous, or substance use disorders or
8 conditions shall furnish medical records or other necessary
9 data that substantiate that initial or continued treatment is
10 at all times medically necessary. An insurer shall provide a
11 mechanism for the timely review by a provider holding the same
12 license and practicing in the same specialty as the patient's
13 provider, who is unaffiliated with the insurer, jointly
14 selected by the patient (or the patient's next of kin or legal
15 representative if the patient is unable to act for himself or
16 herself), the patient's provider, and the insurer in the event
17 of a dispute between the insurer and patient's provider
18 regarding the medical necessity of a treatment proposed by a
19 patient's provider. If the reviewing provider determines the
20 treatment to be medically necessary, the insurer shall provide
21 reimbursement for the treatment. Future contractual or
22 employment actions by the insurer regarding the patient's
23 provider may not be based on the provider's participation in
24 this procedure. Nothing prevents the insured from agreeing in
25 writing to continue treatment at his or her expense. When
26 making a determination of the medical necessity for a treatment

1 modality for mental, emotional, nervous, or substance use
2 disorders or conditions, an insurer must make the determination
3 in a manner that is consistent with the manner used to make
4 that determination with respect to other diseases or illnesses
5 covered under the policy, including an appeals process. Medical
6 necessity determinations for substance use disorders shall be
7 made in accordance with appropriate patient placement criteria
8 established by the American Society of Addiction Medicine. No
9 additional criteria may be used to make medical necessity
10 determinations for substance use disorders.

11 (4) A group health benefit plan amended, delivered, issued,
12 or renewed on or after January 1, 2019 (the effective date of
13 Public Act 100-1024) ~~this amendatory Act of the 100th General~~
14 ~~Assembly~~ or an individual policy of accident and health
15 insurance or a qualified health plan offered through the health
16 insurance marketplace amended, delivered, issued, or renewed
17 on or after January 1, 2019 (the effective date of Public Act
18 100-1024) ~~this amendatory Act of the 100th General Assembly:~~

19 (A) shall provide coverage based upon medical
20 necessity for the treatment of a mental, emotional,
21 nervous, or substance use disorder or condition consistent
22 with the parity requirements of Section 370c.1 of this
23 Code; provided, however, that in each calendar year
24 coverage shall not be less than the following:

25 (i) 45 days of inpatient treatment; and

26 (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 September 9, 2015
25 (the effective date of Public Act 99-480) ~~this amendatory Act~~
26 ~~of the 99th General Assembly~~ shall offer coverage for medically

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

1 recovery from addiction.

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

5 (6.5) An individual or group health benefit plan amended,
6 delivered, issued, or renewed on or after January 1, 2019 (the
7 effective date of Public Act 100-1024) ~~this amendatory Act of~~
8 ~~the 100th General Assembly:~~

9 (A) shall not impose prior authorization 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, on a prescription medication approved
14 by the United States Food and Drug Administration that is
15 prescribed or administered for the treatment of substance
16 use disorders;

17 (B) shall not impose any step therapy requirements,
18 other than those established under the Treatment Criteria
19 for Addictive, Substance-Related, and Co-Occurring
20 Conditions established by the American Society of
21 Addiction Medicine, before authorizing coverage for a
22 prescription medication approved by the United States Food
23 and Drug Administration that is prescribed or administered
24 for the treatment of substance use disorders;

25 (C) shall place all prescription medications approved
26 by the United States Food and Drug Administration

1 prescribed or administered for the treatment of substance
2 use disorders on, for brand medications, the lowest tier of
3 the drug formulary developed and maintained by the
4 individual or group health benefit plan that covers brand
5 medications and, for generic medications, the lowest tier
6 of the drug formulary developed and maintained by the
7 individual or group health benefit plan that covers generic
8 medications; and

9 (D) shall not exclude coverage for a prescription
10 medication approved by the United States Food and Drug
11 Administration for the treatment of substance use
12 disorders and any associated counseling or wraparound
13 services on the grounds that such medications and services
14 were court ordered.

15 (7) (Blank).

16 (8) (Blank).

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

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

25 (d) With respect to a group or individual policy of
26 accident and health insurance or a qualified health plan

1 offered through the health insurance marketplace, the
2 Department and, with respect to medical assistance, the
3 Department of Healthcare and Family Services shall each enforce
4 the requirements of this Section and Sections 356z.23 and
5 370c.1 of this Code, the Paul Wellstone and Pete Domenici
6 Mental Health Parity and Addiction Equity Act of 2008, 42
7 U.S.C. 18031(j), and any amendments to, and federal guidance or
8 regulations issued under, those Acts, including, but not
9 limited to, final regulations issued under the Paul Wellstone
10 and Pete Domenici Mental Health Parity and Addiction Equity Act
11 of 2008 and final regulations applying the Paul Wellstone and
12 Pete Domenici Mental Health Parity and Addiction Equity Act of
13 2008 to Medicaid managed care organizations, the Children's
14 Health Insurance Program, and alternative benefit plans.
15 Specifically, the Department and the Department of Healthcare
16 and Family Services shall take action:

17 (1) proactively ensuring compliance by individual and
18 group policies, including by requiring that insurers
19 submit comparative analyses, as set forth in paragraph (6)
20 of subsection (k) of Section 370c.1, demonstrating how they
21 design and apply nonquantitative treatment limitations,
22 both as written and in operation, for mental, emotional,
23 nervous, or substance use disorder or condition benefits as
24 compared to how they design and apply nonquantitative
25 treatment limitations, as written and in operation, for
26 medical and surgical benefits;

1 (2) evaluating all consumer or provider complaints
2 regarding mental, emotional, nervous, or substance use
3 disorder or condition coverage for possible parity
4 violations;

5 (3) performing parity compliance market conduct
6 examinations or, in the case of the Department of
7 Healthcare and Family Services, parity compliance audits
8 of individual and group plans and policies, including, but
9 not limited to, reviews of:

10 (A) nonquantitative treatment limitations,
11 including, but not limited to, prior authorization
12 requirements, concurrent review, retrospective review,
13 step therapy, network admission standards,
14 reimbursement rates, and geographic restrictions;

15 (B) denials of authorization, payment, and
16 coverage; and

17 (C) other specific criteria as may be determined by
18 the Department.

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

21 The Director may adopt rules to effectuate any provisions
22 of the Paul Wellstone and Pete Domenici Mental Health Parity
23 and Addiction Equity Act of 2008 that relate to the business of
24 insurance.

25 (e) Availability of plan information.

26 (1) The criteria for medical necessity determinations

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

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

24 (f) As used in this Section, "group policy of accident and
25 health insurance" and "group health benefit plan" includes (1)
26 State-regulated employer-sponsored group health insurance

1 plans written in Illinois or which purport to provide coverage
2 for a resident of this State; and (2) State employee health
3 plans.

4 (g) (1) As used in this subsection:

5 "Benefits", with respect to insurers, means the benefits
6 provided for treatment services for inpatient and outpatient
7 treatment of substance use disorders or conditions at American
8 Society of Addiction Medicine levels of treatment 2.1
9 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1
10 (Clinically Managed Low-Intensity Residential), 3.3
11 (Clinically Managed Population-Specific High-Intensity
12 Residential), 3.5 (Clinically Managed High-Intensity
13 Residential), and 3.7 (Medically Monitored Intensive
14 Inpatient) and OMT (Opioid Maintenance Therapy) services.

15 "Benefits", with respect to managed care organizations,
16 means the benefits provided for treatment services for
17 inpatient and outpatient treatment of substance use disorders
18 or conditions at American Society of Addiction Medicine levels
19 of treatment 2.1 (Intensive Outpatient), 2.5 (Partial
20 Hospitalization), 3.5 (Clinically Managed High-Intensity
21 Residential), and 3.7 (Medically Monitored Intensive
22 Inpatient) and OMT (Opioid Maintenance Therapy) services.

23 "Substance use disorder treatment provider or facility"
24 means a licensed physician, licensed psychologist, licensed
25 psychiatrist, licensed advanced practice registered nurse, or
26 licensed, certified, or otherwise State-approved facility or

1 provider of substance use disorder treatment.

2 (2) A group health insurance policy, an individual health
3 benefit plan, or qualified health plan that is offered through
4 the health insurance marketplace, small employer group health
5 plan, and large employer group health plan that is amended,
6 delivered, issued, executed, or renewed in this State, or
7 approved for issuance or renewal in this State, on or after
8 January 1, 2019 (the effective date of Public Act 100-1023)
9 ~~this amendatory Act of the 100th General Assembly~~ shall comply
10 with the requirements of this Section and Section 370c.1. The
11 services for the treatment and the ongoing assessment of the
12 patient's progress in treatment shall follow the requirements
13 of 77 Ill. Adm. Code 2060.

14 (3) Prior authorization shall not be utilized for the
15 benefits under this subsection. The substance use disorder
16 treatment provider or facility shall notify the insurer of the
17 initiation of treatment. For an insurer that is not a managed
18 care organization, the substance use disorder treatment
19 provider or facility notification shall occur for the
20 initiation of treatment of the covered person within 2 business
21 days. For managed care organizations, the substance use
22 disorder treatment provider or facility notification shall
23 occur in accordance with the protocol set forth in the provider
24 agreement for initiation of treatment within 24 hours. If the
25 managed care organization is not capable of accepting the
26 notification in accordance with the contractual protocol

1 during the 24-hour period following admission, the substance
2 use disorder treatment provider or facility shall have one
3 additional business day to provide the notification to the
4 appropriate managed care organization. Treatment plans shall
5 be developed in accordance with the requirements and timeframes
6 established in 77 Ill. Adm. Code 2060. If the substance use
7 disorder treatment provider or facility fails to notify the
8 insurer of the initiation of treatment in accordance with these
9 provisions, the insurer may follow its normal prior
10 authorization processes.

11 (4) For an insurer that is not a managed care organization,
12 if an insurer determines that benefits are no longer medically
13 necessary, the insurer shall notify the covered person, the
14 covered person's authorized representative, if any, and the
15 covered person's health care provider in writing of the covered
16 person's right to request an external review pursuant to the
17 Health Carrier External Review Act. The notification shall
18 occur within 24 hours following the adverse determination.

19 Pursuant to the requirements of the Health Carrier External
20 Review Act, the covered person or the covered person's
21 authorized representative may request an expedited external
22 review. An expedited external review may not occur if the
23 substance use disorder treatment provider or facility
24 determines that continued treatment is no longer medically
25 necessary. Under this subsection, a request for expedited
26 external review must be initiated within 24 hours following the

1 adverse determination notification by the insurer. Failure to
2 request an expedited external review within 24 hours shall
3 preclude a covered person or a covered person's authorized
4 representative from requesting an expedited external review.

5 If an expedited external review request meets the criteria
6 of the Health Carrier External Review Act, an independent
7 review organization shall make a final determination of medical
8 necessity within 72 hours. If an independent review
9 organization upholds an adverse determination, an insurer
10 shall remain responsible to provide coverage of benefits
11 through the day following the determination of the independent
12 review organization. A decision to reverse an adverse
13 determination shall comply with the Health Carrier External
14 Review Act.

15 (5) The substance use disorder treatment provider or
16 facility shall provide the insurer with 7 business days'
17 advance notice of the planned discharge of the patient from the
18 substance use disorder treatment provider or facility and
19 notice on the day that the patient is discharged from the
20 substance use disorder treatment provider or facility.

21 (6) The benefits required by this subsection shall be
22 provided to all covered persons with a diagnosis of substance
23 use disorder or conditions. The presence of additional related
24 or unrelated diagnoses shall not be a basis to reduce or deny
25 the benefits required by this subsection.

26 (7) Nothing in this subsection shall be construed to

1 require an insurer to provide coverage for any of the benefits
2 in this subsection.

3 (Source: P.A. 99-480, eff. 9-9-15; 100-305, eff. 8-24-17;
4 100-1023, eff. 1-1-19; 100-1024, eff. 1-1-19; revised
5 10-18-18.)

6 Section 99. Effective date. This Act takes effect upon
7 becoming law.