



Rep. Lou Lang

Filed: 5/28/2018

10000HB0068ham005

LRB100 03757 SMS 40938 a

1 AMENDMENT TO HOUSE BILL 68

2 AMENDMENT NO. _____. Amend House Bill 68, AS AMENDED, by
3 replacing everything after the enacting clause with the
4 following:

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

7 (5 ILCS 375/6.11)

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

1 the Illinois Insurance Code. The program of health benefits
2 must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c,
3 and 370c.1 of the Illinois Insurance Code. The Department of
4 Insurance shall enforce the requirements of this Section.

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

11 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
12 100-138, eff. 8-18-17; revised 10-3-17.)

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

15 (30 ILCS 105/5.872)

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

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

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

20 (55 ILCS 5/5-1069.3)

21 Sec. 5-1069.3. Required health benefits. If a county,
22 including a home rule county, is a self-insurer for purposes of

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

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

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

25 Section 20. The Illinois Municipal Code is amended by

1 changing Section 10-4-2.3 as follows:

2 (65 ILCS 5/10-4-2.3)

3 Sec. 10-4-2.3. Required health benefits. If a
4 municipality, including a home rule municipality, is a
5 self-insurer for purposes of providing health insurance
6 coverage for its employees, the coverage shall include coverage
7 for the post-mastectomy care benefits required to be covered by
8 a policy of accident and health insurance under Section 356t
9 and the coverage required under Sections 356g, 356g.5,
10 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10,
11 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~
12 356z.25, and 356z.26 of the Illinois Insurance Code. The
13 coverage shall comply with Sections 155.22a, 355b, 356z.19, and
14 370c of the Illinois Insurance Code. The Department of
15 Insurance shall enforce the requirements of this Section. The
16 requirement that health benefits be covered as provided in this
17 is an exclusive power and function of the State and is a denial
18 and limitation under Article VII, Section 6, subsection (h) of
19 the Illinois Constitution. A home rule municipality to which
20 this Section applies must comply with every provision of this
21 Section.

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

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

3 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
4 100-138, eff. 8-18-17; revised 10-5-17.)

5 Section 25. The School Code is amended by changing Section
6 10-22.3f as follows:

7 (105 ILCS 5/10-22.3f)

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

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

1 whatever reason, is unauthorized.

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

4 Section 30. The Illinois Insurance Code is amended by
5 changing Sections 370c and 370c.1 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 100th General Assembly ~~the effective date of this~~
10 ~~amendatory Act of the 97th General Assembly~~, every insurer that
11 ~~which~~ amends, delivers, issues, or renews group accident and
12 health policies providing coverage for hospital or medical
13 treatment or services for illness on an expense-incurred basis
14 shall provide ~~offer to the applicant or group policyholder~~
15 ~~subject to the insurer's standards of insurability~~, coverage
16 for reasonable and necessary treatment and services for mental,
17 emotional, ~~or~~ nervous, or substance use disorders or
18 conditions, ~~other than serious mental illnesses as defined in~~
19 ~~item (2) of subsection (b)~~, consistent with the parity
20 requirements of Section 370c.1 of this Code.

21 (2) Each insured that is covered for mental, emotional,
22 nervous, or substance use disorders or conditions shall be free
23 to select the physician licensed to practice medicine in all
24 its branches, licensed clinical psychologist, licensed

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

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

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

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

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

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

25 ~~(A) schizophrenia;~~

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

1 ~~(C) bipolar disorders (hypomanic, manic, depressive,~~
2 ~~and mixed);~~

3 ~~(D) major depressive disorders (single episode or~~
4 ~~recurrent);~~

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

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

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

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

9 ~~(I) panic disorder;~~

10 ~~(J) post-traumatic stress disorders (acute, chronic,~~
11 ~~or with delayed onset); and~~

12 ~~(K) eating disorders, including, but not limited to,~~
13 ~~anorexia nervosa, bulimia nervosa, pica, rumination~~
14 ~~disorder, avoidant/restrictive food intake disorder, other~~
15 ~~specified feeding or eating disorder (OSFED), and any other~~
16 ~~eating disorder contained in the most recent version of the~~
17 ~~Diagnostic and Statistical Manual of Mental Disorders~~
18 ~~published by the American Psychiatric Association.~~

19 (2.5) (Blank). ~~"Substance use disorder" means the~~
20 ~~following mental disorders as defined in the most current~~
21 ~~edition of the Diagnostic and Statistical Manual (DSM)~~
22 ~~published by the American Psychiatric Association:~~

23 ~~(A) substance abuse disorders;~~

24 ~~(B) substance dependence disorders; and~~

25 ~~(C) substance induced disorders.~~

26 (3) Unless otherwise prohibited by federal law and

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

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

11 (4) A group health benefit plan amended, delivered, issued,
12 or renewed on or after the effective date of this amendatory
13 Act of the 100th General Assembly or an individual policy of
14 accident and health insurance or a qualified health plan
15 offered through the health insurance marketplace amended,
16 delivered, issued, or renewed on or after the effective date of
17 this amendatory Act of the 100th General Assembly ~~the effective~~
18 ~~date of this amendatory Act of the 97th General Assembly:~~

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

26 (i) 45 days of inpatient treatment; and

1 (ii) beginning on June 26, 2006 (the effective date
2 of Public Act 94-921), 60 visits for outpatient
3 treatment including group and individual outpatient
4 treatment; and

5 (iii) for plans or policies delivered, issued for
6 delivery, renewed, or modified after January 1, 2007
7 (the effective date of Public Act 94-906), 20
8 additional outpatient visits for speech therapy for
9 treatment of pervasive developmental disorders that
10 will be in addition to speech therapy provided pursuant
11 to item (ii) of this subparagraph (A); and

12 (B) may not include a lifetime limit on the number of
13 days of inpatient treatment or the number of outpatient
14 visits covered under the plan.

15 (C) (Blank).

16 (5) An issuer of a group health benefit plan or an
17 individual policy of accident and health insurance or a
18 qualified health plan offered through the health insurance
19 marketplace may not count toward the number of outpatient
20 visits required to be covered under this Section an outpatient
21 visit for the purpose of medication management and shall cover
22 the outpatient visits under the same terms and conditions as it
23 covers outpatient visits for the treatment of physical illness.

24 (5.5) An individual or group health benefit plan amended,
25 delivered, issued, or renewed on or after the effective date of
26 this amendatory Act of the 99th General Assembly shall offer

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

16 As used in this subsection:

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

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

1 aftercare planning for individuals beginning to engage in
2 recovery from addiction.

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

6 (6.5) An individual or group health benefit plan amended,
7 delivered, issued, or renewed on or after the effective date of
8 this amendatory Act of 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 habilitative 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 ~~(d) The Department shall enforce the requirements of State~~
26 ~~and federal parity law, which includes ensuring compliance by~~

1 ~~individual and group policies; detecting violations of the law~~
2 ~~by individual and group policies proactively monitoring~~
3 ~~discriminatory practices; accepting, evaluating, and~~
4 ~~responding to complaints regarding such violations; and~~
5 ~~ensuring violations are appropriately remedied and deterred.~~

6 (e) Availability of plan information.

7 (1) The criteria for medical necessity determinations
8 made under a group health plan, an individual policy of
9 accident and health insurance, or a qualified health plan
10 offered through the health insurance marketplace with
11 respect to mental health or substance use disorder benefits
12 (or health insurance coverage offered in connection with
13 the plan with respect to such benefits) must be made
14 available by the plan administrator (or the health
15 insurance issuer offering such coverage) to any current or
16 potential participant, beneficiary, or contracting
17 provider upon request.

18 (2) The reason for any denial under a group health
19 benefit plan, an individual policy of accident and health
20 insurance, or a qualified health plan offered through the
21 health insurance marketplace (or health insurance coverage
22 offered in connection with such plan or policy) of
23 reimbursement or payment for services with respect to
24 mental, emotional, nervous, health or substance use
25 disorders or conditions ~~disorder~~ benefits in the case of
26 any participant or beneficiary must be made available

1 within a reasonable time and in a reasonable manner and in
2 readily understandable language by the plan administrator
3 (or the health insurance issuer offering such coverage) to
4 the participant or beneficiary upon request.

5 (f) As used in this Section, "group policy of accident and
6 health insurance" and "group health benefit plan" includes (1)
7 State-regulated employer-sponsored group health insurance
8 plans written in Illinois or which purport to provide coverage
9 for a resident of this State; and (2) State employee health
10 plans.

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

12 (215 ILCS 5/370c.1)

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

15 (a) On and after the effective date of this amendatory Act
16 of the 99th General Assembly, every insurer that amends,
17 delivers, issues, or renews a group or individual policy of
18 accident and health insurance or a qualified health plan
19 offered through the Health Insurance Marketplace in this State
20 providing coverage for hospital or medical treatment and for
21 the treatment of mental, emotional, nervous, or substance use
22 disorders or conditions shall ensure that:

23 (1) the financial requirements applicable to such
24 mental, emotional, nervous, or substance use disorder or
25 condition benefits are no more restrictive than the

1 predominant financial requirements applied to
2 substantially all hospital and medical benefits covered by
3 the policy and that there are no separate cost-sharing
4 requirements that are applicable only with respect to
5 mental, emotional, nervous, or substance use disorder or
6 condition benefits; and

7 (2) the treatment limitations applicable to such
8 mental, emotional, nervous, or substance use disorder or
9 condition benefits are no more restrictive than the
10 predominant treatment limitations applied to substantially
11 all hospital and medical benefits covered by the policy and
12 that there are no separate treatment limitations that are
13 applicable only with respect to mental, emotional,
14 nervous, or substance use disorder or condition benefits.

15 (b) The following provisions shall apply concerning
16 aggregate lifetime limits:

17 (1) In the case of a group or individual policy of
18 accident and health insurance or a qualified health plan
19 offered through the Health Insurance Marketplace amended,
20 delivered, issued, or renewed in this State on or after the
21 effective date of this amendatory Act of the 99th General
22 Assembly that provides coverage for hospital or medical
23 treatment and for the treatment of mental, emotional,
24 nervous, or substance use disorders or conditions the
25 following provisions shall apply:

26 (A) if the policy does not include an aggregate

1 lifetime limit on substantially all hospital and
2 medical benefits, then the policy may not impose any
3 aggregate lifetime limit on mental, emotional,
4 nervous, or substance use disorder or condition
5 benefits; or

6 (B) if the policy includes an aggregate lifetime
7 limit on substantially all hospital and medical
8 benefits (in this subsection referred to as the
9 "applicable lifetime limit"), then the policy shall
10 either:

11 (i) apply the applicable lifetime limit both
12 to the hospital and medical benefits to which it
13 otherwise would apply and to mental, emotional,
14 nervous, or substance use disorder or condition
15 benefits and not distinguish in the application of
16 the limit between the hospital and medical
17 benefits and mental, emotional, nervous, or
18 substance use disorder or condition benefits; or

19 (ii) not include any aggregate lifetime limit
20 on mental, emotional, nervous, or substance use
21 disorder or condition benefits that is less than
22 the applicable lifetime limit.

23 (2) In the case of a policy that is not described in
24 paragraph (1) of subsection (b) of this Section and that
25 includes no or different aggregate lifetime limits on
26 different categories of hospital and medical benefits, the

1 Director shall establish rules under which subparagraph
2 (B) of paragraph (1) of subsection (b) of this Section is
3 applied to such policy with respect to mental, emotional,
4 nervous, or substance use disorder or condition benefits by
5 substituting for the applicable lifetime limit an average
6 aggregate lifetime limit that is computed taking into
7 account the weighted average of the aggregate lifetime
8 limits applicable to such categories.

9 (c) The following provisions shall apply concerning annual
10 limits:

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

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

25 (B) if the policy includes an annual limit on
26 substantially all hospital and medical benefits (in

1 this subsection referred to as the "applicable annual
2 limit"), then the policy shall either:

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

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

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

1 (d) With respect to mental, emotional, nervous, or
2 substance use disorders or conditions, an insurer shall use
3 policies and procedures for the election and placement of
4 mental, emotional, nervous, or substance use disorder or
5 condition ~~substance abuse~~ treatment drugs on their formulary
6 that are no less favorable to the insured as those policies and
7 procedures the insurer uses for the selection and placement of
8 ~~other~~ drugs for medical or surgical conditions and shall follow
9 the expedited coverage determination requirements for
10 substance abuse treatment drugs set forth in Section 45.2 of
11 the Managed Care Reform and Patient Rights Act.

12 (e) This Section shall be interpreted in a manner
13 consistent with all applicable federal parity regulations
14 including, but not limited to, the Paul Wellstone and Pete
15 Domenici Mental Health Parity and Addiction Equity Act of 2008,
16 final regulations issued under the Paul Wellstone and Pete
17 Domenici Mental Health Parity and Addiction Equity Act of 2008
18 and final regulations applying the Paul Wellstone and Pete
19 Domenici Mental Health Parity and Addiction Equity Act of 2008
20 to Medicaid managed care organizations, the Children's Health
21 Insurance Program, and alternative benefit plans ~~at 78 FR~~
22 ~~68240~~.

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

26 (g) As used in this Section:

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

5 "Mental, emotional, nervous, or substance use disorder or
6 condition" means a condition or disorder that involves a mental
7 health condition or substance use disorder that falls under any
8 of the diagnostic categories listed in the mental and
9 behavioral disorders chapter of the current edition of the
10 International Classification of Disease or that is listed in
11 the most recent version of the Diagnostic and Statistical
12 Manual of Mental Disorders.

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

1 2590.712, and 45 CFR 146.136.

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

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

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

1 and mental health physician groups for the purpose of
2 discussing issues related to the treatment and coverage of
3 mental, emotional, nervous, or substance use ~~abuse~~
4 disorders or conditions and compliance with parity
5 obligations under State and federal law. Compliance shall
6 be measured, tracked, and shared during the meetings of the
7 working group ~~and mental illness~~. The working group shall
8 meet once before January 1, 2016 and shall meet
9 semiannually thereafter. The Department shall issue an
10 annual report to the General Assembly that includes a list
11 of the health care insurance carriers, mental health
12 advocacy groups, substance abuse patient advocacy groups,
13 and mental health physician groups that participated in the
14 working group meetings, details on the issues and topics
15 covered, and any legislative recommendations developed by
16 the working group.

17 (3) Not later than August 1 of each year, the
18 Department, in conjunction with the Department of
19 Healthcare and Family Services, shall issue a joint report
20 to the General Assembly and provide an educational
21 presentation to the General Assembly. The report and
22 presentation shall:

23 (A) Cover the methodology the Departments use to
24 check for compliance with the federal Paul Wellstone
25 and Pete Domenici Mental Health Parity and Addiction
26 Equity Act of 2008, 42 U.S.C. 18031(j), and any federal

1 regulations or guidance relating to the compliance and
2 oversight of the federal Paul Wellstone and Pete
3 Domenici Mental Health Parity and Addiction Equity Act
4 of 2008 and 42 U.S.C. 18031(j).

5 (B) Cover the methodology the Departments use to
6 check for compliance with this Section and Sections
7 356z.23 and 370c of this Code.

8 (C) Identify market conduct examinations or, in
9 the case of the Department of Healthcare and Family
10 Services, audits conducted or completed during the
11 preceding 12-month period regarding compliance with
12 parity in mental, emotional, nervous, and substance
13 use disorder or condition benefits under State and
14 federal laws and summarize the results of such market
15 conduct examinations and audits. This shall include:

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

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

20 (iii) the subject matter of each market
21 conduct examination and audit, including
22 quantitative and non-quantitative treatment
23 limitations; and

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

1 Individually identifiable information shall be
2 excluded from the reports consistent with federal
3 privacy protections.

4 (D) Detail any educational or corrective actions
5 the Departments have taken to ensure compliance with
6 the federal Paul Wellstone and Pete Domenici Mental
7 Health Parity and Addiction Equity Act of 2008, 42
8 U.S.C. 18031(j), this Section, and Sections 356z.23
9 and 370c of this Code.

10 (E) The report must be written in non-technical,
11 readily understandable language and shall be made
12 available to the public by, among such other means as
13 the Departments find appropriate, posting the report
14 on the Departments' websites.

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

25 (j) The Department of Insurance and the Department of
26 Healthcare and Family Services shall convene and provide

1 technical support to a workgroup of 11 members that shall be
2 comprised of 3 mental health parity experts recommended by an
3 organization advocating on behalf of mental health parity
4 appointed by the President of the Senate; 3 behavioral health
5 providers recommended by an organization that represents
6 behavioral health providers appointed by the Speaker of the
7 House of Representatives; 2 representing Medicaid managed care
8 organizations recommended by an organization that represents
9 Medicaid managed care plans appointed by the Minority Leader of
10 the House of Representatives; 2 representing commercial
11 insurers recommended by an organization that represents
12 insurers appointed by the Minority Leader of the Senate; and a
13 representative of an organization that represents Medicaid
14 managed care plans appointed by the Governor.

15 The workgroup shall provide recommendations to the General
16 Assembly on health plan data reporting requirements that
17 separately break out data on mental, emotional, nervous, or
18 substance use disorder or condition benefits and data on other
19 medical benefits, including physical health and related health
20 services no later than December 31, 2019. The recommendations
21 to the General Assembly shall be filed with the Clerk of the
22 House of Representatives and the Secretary of the Senate in
23 electronic form only, in the manner that the Clerk and the
24 Secretary shall direct. This workgroup shall take into account
25 federal requirements and recommendations on mental health
26 parity reporting for the Medicaid program. This workgroup shall

1 also develop the format and provide any needed definitions for
2 reporting requirements in subsection (k). The research and
3 evaluation of the working group shall include, but not be
4 limited to:

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

7 (2) administrative denials for no prior authorization;

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

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

11 (5) out-of-network claims;

12 (6) emergency care claims;

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

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

24 (9) when reporting and publishing should begin.

25 Representatives from the Department of Healthcare and
26 Family Services, representatives from the Division of Mental

1 Health, and representatives from the Division of Substance Use
2 Prevention and Recovery shall provide technical advice to the
3 workgroup.

4 (k) An insurer that amends, delivers, issues, or renews a
5 group or individual policy of accident and health insurance or
6 a qualified health plan offered through the health insurance
7 marketplace in this State providing coverage for hospital or
8 medical treatment and for the treatment of mental, emotional,
9 nervous, or substance use disorders or conditions shall submit
10 an annual report, the format and definitions for which will be
11 developed by the workgroup in subsection (j), to the
12 Department, or, with respect to medical assistance, the
13 Department of Healthcare and Family Services starting on or
14 before July 1, 2020 that contains the following information
15 separately for inpatient in-network benefits, inpatient
16 out-of-network benefits, outpatient in-network benefits,
17 outpatient out-of-network benefits, emergency care benefits,
18 and prescription drug benefits in the case of accident and
19 health insurance or qualified health plans, or inpatient,
20 outpatient, emergency care, and prescription drug benefits in
21 the case of medical assistance:

22 (1) A summary of the plan's pharmacy management
23 processes for mental, emotional, nervous, or substance use
24 disorder or condition benefits compared to those for other
25 medical benefits.

26 (2) A summary of the internal processes of review for

1 experimental benefits and unproven technology for mental,
2 emotional, nervous, or substance use disorder or condition
3 benefits and those for other medical benefits.

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

8 (4) A description of the process used to develop or
9 select the medical necessity criteria for mental,
10 emotional, nervous, or substance use disorder or condition
11 benefits and the process used to develop or select the
12 medical necessity criteria for medical and surgical
13 benefits.

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

19 (6) The results of an analysis that demonstrates that
20 for the medical necessity criteria described in
21 subparagraph (A) and for each nonquantitative treatment
22 limitation identified in subparagraph (B), as written and
23 in operation, the processes, strategies, evidentiary
24 standards, or other factors used in applying the medical
25 necessity criteria and each nonquantitative treatment
26 limitation to mental, emotional, nervous, or substance use

1 disorder or condition benefits within each classification
2 of benefits are comparable to, and are applied no more
3 stringently than, the processes, strategies, evidentiary
4 standards, or other factors used in applying the medical
5 necessity criteria and each nonquantitative treatment
6 limitation to medical and surgical benefits within the
7 corresponding classification of benefits; at a minimum,
8 the results of the analysis shall:

9 (A) identify the factors used to determine that a
10 nonquantitative treatment limitation applies to a
11 benefit, including factors that were considered but
12 rejected;

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

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

1 (D) provide the comparative analyses, including
2 the results of the analyses, performed to determine
3 that the processes and strategies used to apply each
4 nonquantitative treatment limitation, in operation,
5 for mental, emotional, nervous, or substance use
6 disorder or condition benefits are comparable to, and
7 applied no more stringently than, the processes or
8 strategies used to apply each nonquantitative
9 treatment limitation, in operation, for medical and
10 surgical benefits; and

11 (E) disclose the specific findings and conclusions
12 reached by the insurer that the results of the analyses
13 described in subparagraphs (C) and (D) indicate that
14 the insurer is in compliance with this Section and the
15 Mental Health Parity and Addiction Equity Act of 2008
16 and its implementing regulations, which includes 42
17 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any
18 other related federal regulations found in the Code of
19 Federal Regulations.

20 (7) Any other information necessary to clarify data
21 provided in accordance with this Section requested by the
22 Director, including information that may be proprietary or
23 have commercial value, under the requirements of Section 30
24 of the Viatical Settlements Act of 2009.

25 (1) An insurer that amends, delivers, issues, or renews a
26 group or individual policy of accident and health insurance or

1 a qualified health plan offered through the health insurance
2 marketplace in this State providing coverage for hospital or
3 medical treatment and for the treatment of mental, emotional,
4 nervous, or substance use disorders or conditions on or after
5 the effective date of this amendatory Act of the 100th General
6 Assembly shall, in advance of the plan year, make available to
7 the Department or, with respect to medical assistance, the
8 Department of Healthcare and Family Services and to all plan
9 participants and beneficiaries the information required in
10 subparagraphs (C) through (E) of paragraph (6) of subsection
11 (k). For plan participants and medical assistance
12 beneficiaries, the information required in subparagraphs (C)
13 through (E) of paragraph (6) of subsection (k) shall be made
14 available on a publicly-available website whose web address is
15 prominently displayed in plan and managed care organization
16 informational and marketing materials.

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

1 the head of the applicable State agency and posted on the
2 Auditor General's website.

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

4 Section 99. Effective date. This Act takes effect January
5 1, 2019.".