



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB5498

by Rep. Deb Conroy

SYNOPSIS AS INTRODUCED:

215 ILCS 5/370c

from Ch. 73, par. 982c

Amends the Illinois Insurance Code. Provides that the Department of Insurance and the Department of Healthcare and Family Services shall each appoint a Mental Health and Substance Use Disorder Parity Compliance Officer to assist with the responsibilities of enforcing the requirements of the Illinois Insurance Code. Provides that group accident and health policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall provide specified coverage for the diagnosis and medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions. Provides criteria and standards for the types of treatment that constitute medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions. Provides that an insurer shall not limit benefits or coverage for chronic or pervasive mental, emotional, nervous, or substance use disorders or conditions to short-term treatment or to alleviating current symptoms. Provides that insurers shall perform specified actions to ensure the proper use of medical necessity criteria. Provides that if medically necessary services for mental, emotional, nervous, or substance use disorders or conditions are not available in-network within the geography and timeliness standards, the insurer must cover out-of-network services. Provides that if the Department of Insurance determines that an insurer has failed to meet the requirements of the amendatory Act, it shall impose a penalty per product line with respect to each beneficiary. Makes other changes.

LRB101 20368 BMS 69914 b

FISCAL NOTE ACT
MAY APPLY

STATE MANDATES
ACT MAY REQUIRE
REIMBURSEMENT

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 1. Reference to Act. This Act may be referred to as
5 the Ensuring Coverage of Mental Health and Substance Use
6 Disorder Care Act.

7 Section 2. Intent; purposes; findings.

8 (a) The General Assembly intends by this Act to ensure that
9 all health plan medical necessity determinations concerning
10 mental health and substance use disorder services are fully
11 consistent with the generally accepted standards of behavioral
12 healthcare.

13 (b) The U.S. District Court of the Northern District of
14 California in *Wit v. United Behavioral Health*, 2019 WL 1033730
15 (N.D.CA Mar. 5, 2019), a class-action case representing over
16 50,000 people wrongly and systematically denied coverage of
17 mental health and substance use disorder services they sought,
18 found that generally accepted standards of care require:

19 (1) effective treatment of underlying conditions,
20 rather than mere amelioration of current symptoms (such as
21 suicidality or psychosis);

22 (2) treatment of co-occurring behavioral health
23 disorders and medical conditions in a coordinated manner;

1 (3) treatment of the least intensive and restrictive
2 level of care that is safe and effective; a lower level or
3 less intensive care is appropriate only if it is safe and
4 just as effective as treatment at a higher level of service
5 intensity;

6 (4) erring on the side of caution by placing patients
7 in higher levels of care when there is ambiguity as to the
8 appropriate level of care or when the recommended level of
9 care is not available;

10 (5) treatment to maintain functioning or prevent
11 deterioration;

12 (6) treatment of mental health and substance use
13 disorders for an appropriate duration based on individual
14 patient needs rather than on specific time limits;

15 (7) accounting for the unique needs of children and
16 adolescents when making level of care decisions; and

17 (8) applying multidimensional assessments of patient
18 needs when making determinations regarding the appropriate
19 level of care.

20 (c) In *Wit v. United Behavioral Health*, the U.S. District
21 Court concluded that all parties' experts agreed that the
22 following standardized assessment tools, used for medical
23 necessity determinations and placement decisions, reflect
24 generally accepted standards of care:

25 (1) the Treatment Criteria for Addictive,
26 Substance-Related, and Co-Occurring Conditions (ASAM

1 Criteria) developed by the American Society of Addiction
2 Medicine;

3 (2) the Level of Care Utilization System (LOCUS)
4 criteria developed by the American Association of
5 Community Psychiatrists;

6 (3) the Child and Adolescent Level of Care Utilization
7 System (CALOCUS) developed by the American Association of
8 Community Psychiatrists;

9 (4) the Child and Adolescent Services Intensity
10 Instrument (CASII) developed by the American Academy of
11 Child & Adolescent Psychiatry; and

12 (5) the Early Childhood Service Intensity Instrument
13 (ECSII) developed by the American Academy Child &
14 Adolescent Psychiatry.

15 (d) Nothing in this Act is intended to be interpreted in
16 such a manner that it undermines patient self determination or
17 in a manner that limits a patient's right to choose his or her
18 preferred course of care or that is inconsistent with the
19 Medical Patient Rights Act.

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

22 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

23 Sec. 370c. Mental and emotional disorders.

24 (a)(1) On and after August 16, 2019 ~~January 1, 2019~~ (the

1 effective date of Public Act 101-386 ~~this amendatory Act of the~~
2 ~~101st General Assembly Public Act 100-1024~~), every insurer that
3 amends, delivers, issues, or renews group accident and health
4 policies providing coverage for hospital or medical treatment
5 or services for illness on an expense-incurred basis shall,
6 pursuant to subsections (h) through (m), provide coverage for
7 the diagnosis and medically necessary treatment of ~~reasonable~~
8 ~~and necessary treatment and services for~~ mental, emotional,
9 nervous, or substance use disorders or conditions consistent
10 with the parity requirements of Section 370c.1 of this Code.

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

1 coverage, provided (i) the disorder or condition treated is
2 covered by the policy, and (ii) the physician, licensed
3 psychologist, licensed clinical social worker, licensed
4 clinical professional counselor, licensed marriage and family
5 therapist, licensed speech-language pathologist, or other
6 licensed or certified professional at a program licensed
7 pursuant to the Substance Use Disorder Act is authorized to
8 provide said services under the statutes of this State and in
9 accordance with accepted principles of his profession.

10 (3) Insofar as this Section applies solely to licensed
11 clinical social workers, licensed clinical professional
12 counselors, licensed marriage and family therapists, licensed
13 speech-language pathologists, and other licensed or certified
14 professionals at programs licensed pursuant to the Substance
15 Use Disorder Act, those persons who may provide services to
16 individuals shall do so after the licensed clinical social
17 worker, licensed clinical professional counselor, licensed
18 marriage and family therapist, licensed speech-language
19 pathologist, or other licensed or certified professional at a
20 program licensed pursuant to the Substance Use Disorder Act has
21 informed the patient of the desirability of the patient
22 conferring with the patient's primary care physician.

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

1 behavioral disorders chapter of the current edition of the
2 International Classification of Disease or that is listed in
3 the most recent version of the Diagnostic and Statistical
4 Manual of Mental Disorders. "Mental, emotional, nervous, or
5 substance use disorder or condition" includes any mental health
6 condition that occurs during pregnancy or during the postpartum
7 period and includes, but is not limited to, postpartum
8 depression.

9 (b) (1) (Blank).

10 (2) (Blank).

11 (2.5) (Blank).

12 (3) Unless otherwise prohibited by federal law and
13 consistent with the parity requirements of Section 370c.1 of
14 this Code, the reimbursing insurer that amends, delivers,
15 issues, or renews a group or individual policy of accident and
16 health insurance, a qualified health plan offered through the
17 health insurance marketplace, or a provider of treatment of
18 mental, emotional, nervous, or substance use disorders or
19 conditions shall furnish medical records or other necessary
20 data that substantiate that initial or continued treatment is
21 at all times medically necessary. An insurer shall provide a
22 mechanism for the timely review by a provider holding the same
23 license and practicing in the same specialty as the patient's
24 provider, who is unaffiliated with the insurer, jointly
25 selected by the patient (or the patient's next of kin or legal
26 representative if the patient is unable to act for himself or

1 herself), the patient's provider, and the insurer in the event
2 of a dispute between the insurer and patient's provider
3 regarding the medical necessity, made pursuant to subsections
4 (h) through (m), of a treatment proposed by a patient's
5 provider. If the reviewing provider determines the treatment to
6 be medically necessary, the insurer shall provide
7 reimbursement for the treatment. Future contractual or
8 employment actions by the insurer regarding the patient's
9 provider may not be based on the provider's participation in
10 this procedure. Nothing prevents the insured from agreeing in
11 writing to continue treatment at his or her expense. When
12 making a determination of the medical necessity pursuant to
13 subsections (h) through (m) for a treatment modality for
14 mental, emotional, nervous, or substance use disorders or
15 conditions, an insurer must make the determination in a manner
16 that is consistent with the manner used to make that
17 determination with respect to other diseases or illnesses
18 covered under the policy, including an appeals process. Medical
19 necessity determinations made pursuant to subsections (h)
20 through (m) for substance use disorders shall be made in
21 accordance with appropriate patient placement criteria
22 established by the American Society of Addiction Medicine. No
23 additional criteria may be used to make medical necessity
24 determinations, pursuant to subsections (h) through (m), for
25 substance use disorders.

26 (4) A group health benefit plan amended, delivered, issued,

1 or renewed on or after January 1, 2019 (the effective date of
2 Public Act 100-1024) or an individual policy of accident and
3 health insurance or a qualified health plan offered through the
4 health insurance marketplace amended, delivered, issued, or
5 renewed on or after January 1, 2019 (the effective date of
6 Public Act 100-1024):

7 (A) shall provide coverage based upon medical
8 necessity, pursuant to subsections (h) through (m), for the
9 treatment of a mental, emotional, nervous, or substance use
10 disorder or condition consistent with the parity
11 requirements of Section 370c.1 of this Code; provided,
12 however, that in each calendar year coverage shall not be
13 less than the following:

14 (i) 45 days of inpatient treatment; and

15 (ii) beginning on June 26, 2006 (the effective date
16 of Public Act 94-921), 60 visits for outpatient
17 treatment including group and individual outpatient
18 treatment; and

19 (iii) for plans or policies delivered, issued for
20 delivery, renewed, or modified after January 1, 2007
21 (the effective date of Public Act 94-906), 20
22 additional outpatient visits for speech therapy for
23 treatment of pervasive developmental disorders that
24 will be in addition to speech therapy provided pursuant
25 to item (ii) of this subparagraph (A); and

26 (B) may not include a lifetime limit on the number of

1 days of inpatient treatment or the number of outpatient
2 visits covered under the plan.

3 (C) (Blank).

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

12 (5.5) An individual or group health benefit plan amended,
13 delivered, issued, or renewed on or after September 9, 2015
14 (the effective date of Public Act 99-480) shall offer coverage
15 for medically necessary acute treatment services and medically
16 necessary clinical stabilization services. The treating
17 provider shall base all treatment recommendations and the
18 health benefit plan shall base all medical necessity
19 determinations, pursuant to subsections (h) through (m), for
20 substance use disorders in accordance with the most current
21 edition of the Treatment Criteria for Addictive,
22 Substance-Related, and Co-Occurring Conditions established by
23 the American Society of Addiction Medicine. The treating
24 provider shall base all treatment recommendations and the
25 health benefit plan shall base all medical necessity
26 determinations, pursuant to subsections (h) through (m), for

1 medication-assisted treatment in accordance with the most
2 current Treatment Criteria for Addictive, Substance-Related,
3 and Co-Occurring Conditions established by the American
4 Society of Addiction Medicine.

5 As used in this subsection:

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

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

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

21 (6.5) An individual or group health benefit plan amended,
22 delivered, issued, or renewed on or after January 1, 2019 (the
23 effective date of Public Act 100-1024):

24 (A) shall not impose prior authorization requirements,
25 other than those established under the Treatment Criteria
26 for Addictive, Substance-Related, and Co-Occurring

1 Conditions established by the American Society of
2 Addiction Medicine, on a prescription medication approved
3 by the United States Food and Drug Administration that is
4 prescribed or administered for the treatment of substance
5 use disorders;

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

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

24 (D) shall not exclude coverage for a prescription
25 medication approved by the United States Food and Drug
26 Administration for the treatment of substance use

1 disorders and any associated counseling or wraparound
2 services on the grounds that such medications and services
3 were court ordered.

4 (7) (Blank).

5 (8) (Blank).

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

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

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

1 Pete Domenici Mental Health Parity and Addiction Equity Act of
2 2008 to Medicaid managed care organizations, the Children's
3 Health Insurance Program, and alternative benefit plans.
4 Specifically, the Department and the Department of Healthcare
5 and Family Services shall take action:

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

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

20 (3) performing parity compliance market conduct
21 examinations or, in the case of the Department of
22 Healthcare and Family Services, parity compliance audits
23 of individual and group plans and policies, including, but
24 not limited to, reviews of:

25 (A) nonquantitative treatment limitations,
26 including, but not limited to, prior authorization

1 requirements, concurrent review, retrospective review,
2 step therapy, network admission standards,
3 reimbursement rates, and geographic restrictions;

4 (B) denials of authorization, payment, and
5 coverage; and

6 (C) other specific criteria as may be determined by
7 the Department.

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

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

14 (d-1) The Department of Insurance and the Department of
15 Healthcare and Family Services shall each appoint a Mental
16 Health and Substance Use Disorder Parity Compliance Officer to
17 assist the departments with the responsibilities of enforcing
18 the requirements of this Section and Section 370c.1.

19 (e) Availability of plan information.

20 (1) The criteria for medical necessity determinations,
21 pursuant to subsections (h) through (m), made under a group
22 health plan, an individual policy of accident and health
23 insurance, or a qualified health plan offered through the
24 health insurance marketplace with respect to mental health
25 or substance use disorder benefits (or health insurance
26 coverage offered in connection with the plan with respect

1 to such benefits) must be made available by the plan
2 administrator (or the health insurance issuer offering
3 such coverage) to any current or potential participant,
4 beneficiary, or contracting provider upon request.

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

18 (f) As used in this Section, "group policy of accident and
19 health insurance" and "group health benefit plan" includes (1)
20 State-regulated employer-sponsored group health insurance
21 plans written in Illinois or which purport to provide coverage
22 for a resident of this State; and (2) State employee health
23 plans.

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

25 "Benefits", with respect to insurers, means the benefits
26 provided for treatment services for inpatient and outpatient

1 treatment of substance use disorders or conditions at American
2 Society of Addiction Medicine levels of treatment 2.1
3 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1
4 (Clinically Managed Low-Intensity Residential), 3.3
5 (Clinically Managed Population-Specific High-Intensity
6 Residential), 3.5 (Clinically Managed High-Intensity
7 Residential), and 3.7 (Medically Monitored Intensive
8 Inpatient) and OMT (Opioid Maintenance Therapy) services.

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

17 "Substance use disorder treatment provider or facility"
18 means a licensed physician, licensed psychologist, licensed
19 psychiatrist, licensed advanced practice registered nurse, or
20 licensed, certified, or otherwise State-approved facility or
21 provider of substance use disorder treatment.

22 (2) A group health insurance policy, an individual health
23 benefit plan, or qualified health plan that is offered through
24 the health insurance marketplace, small employer group health
25 plan, and large employer group health plan that is amended,
26 delivered, issued, executed, or renewed in this State, or

1 approved for issuance or renewal in this State, on or after
2 January 1, 2019 (the effective date of Public Act 100-1023)
3 shall comply with the requirements of this Section and Section
4 370c.1. The services for the treatment and the ongoing
5 assessment of the patient's progress in treatment shall follow
6 the requirements of 77 Ill. Adm. Code 2060.

7 (3) Prior authorization shall not be utilized for the
8 benefits under this subsection. The substance use disorder
9 treatment provider or facility shall notify the insurer of the
10 initiation of treatment. For an insurer that is not a managed
11 care organization, the substance use disorder treatment
12 provider or facility notification shall occur for the
13 initiation of treatment of the covered person within 2 business
14 days. For managed care organizations, the substance use
15 disorder treatment provider or facility notification shall
16 occur in accordance with the protocol set forth in the provider
17 agreement for initiation of treatment within 24 hours. If the
18 managed care organization is not capable of accepting the
19 notification in accordance with the contractual protocol
20 during the 24-hour period following admission, the substance
21 use disorder treatment provider or facility shall have one
22 additional business day to provide the notification to the
23 appropriate managed care organization. Treatment plans shall
24 be developed in accordance with the requirements and timeframes
25 established in 77 Ill. Adm. Code 2060. If the substance use
26 disorder treatment provider or facility fails to notify the

1 insurer of the initiation of treatment in accordance with these
2 provisions, the insurer may follow its normal prior
3 authorization processes.

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

12 Pursuant to the requirements of the Health Carrier External
13 Review Act, the covered person or the covered person's
14 authorized representative may request an expedited external
15 review. An expedited external review may not occur if the
16 substance use disorder treatment provider or facility
17 determines that continued treatment is no longer medically
18 necessary. Under this subsection, a request for expedited
19 external review must be initiated within 24 hours following the
20 adverse determination notification by the insurer. Failure to
21 request an expedited external review within 24 hours shall
22 preclude a covered person or a covered person's authorized
23 representative from requesting an expedited external review.

24 If an expedited external review request meets the criteria
25 of the Health Carrier External Review Act, an independent
26 review organization shall make a final determination of medical

1 necessity, pursuant to subsections (h) through (m), within 72
2 hours. If an independent review organization upholds an adverse
3 determination, an insurer shall remain responsible to provide
4 coverage of benefits through the day following the
5 determination of the independent review organization. A
6 decision to reverse an adverse determination shall comply with
7 the Health Carrier External Review Act.

8 (5) The substance use disorder treatment provider or
9 facility shall provide the insurer with 7 business days'
10 advance notice of the planned discharge of the patient from the
11 substance use disorder treatment provider or facility and
12 notice on the day that the patient is discharged from the
13 substance use disorder treatment provider or facility.

14 (6) The benefits required by this subsection shall be
15 provided to all covered persons with a diagnosis of substance
16 use disorder or conditions. The presence of additional related
17 or unrelated diagnoses shall not be a basis to reduce or deny
18 the benefits required by this subsection.

19 (7) Nothing in this subsection shall be construed to
20 require an insurer to provide coverage for any of the benefits
21 in this subsection.

22 (h)(1) Every insurer that amends, delivers, issues, or
23 renews group accident and health policies providing coverage
24 for hospital or medical treatment or services for illness on an
25 expense-incurred basis on or after July 1, 2020 shall, pursuant
26 to this Section, provide coverage for the diagnosis and

1 medically necessary treatment of mental, emotional, nervous,
2 or substance use disorders or conditions.

3 (2) Medically necessary treatment of mental, emotional,
4 nervous, or substance use disorders or conditions shall be an
5 item or service that is:

6 (A) recommended by the patient's treatment provider;

7 (B) furnished in the manner and setting that can most
8 effectively and comprehensively address patients'
9 conditions, including, but not limited to, functional
10 impairments, lack of coping skills, symptoms, and the
11 underlying bio-psycho-social determinants of mental
12 health, substance use, medical disorders, and any
13 combination thereof;

14 (C) provided in sufficient amount, duration, and scope
15 to:

16 (i) prevent, diagnose, or treat a disorder;

17 (ii) achieve age-appropriate growth and
18 development;

19 (iii) manage the progression of disability; or

20 (iv) attain, maintain, or regain full functional
21 capacity.

22 (D) consistent with generally accepted standards of
23 practice, which shall be based on:

24 (i) scientific evidence published in peer-reviewed
25 medical or scientific literature generally recognized
26 by the relevant clinical community; or

1 (ii) clinical specialty society recommendations,
2 professional standards, or consensus statements.

3 (3) An insurer shall not limit benefits or coverage for
4 chronic or pervasive mental, emotional, nervous, or substance
5 use disorders or conditions to short-term treatment or to
6 alleviating current symptoms.

7 (4) Consistent with paragraph (2), for all medical
8 necessity determinations concerning level of care placement,
9 continued stay, and transfer and discharge, to the extent
10 applicable services are described therein, an insurer must
11 exclusively rely on the most recent editions of:

12 (A) the Treatment Criteria for Addictive,
13 Substance-Related, and Co-Occurring Conditions (ASAM
14 Criteria) developed by the American Society of Addiction
15 Medicine for substance use disorders for patients of any
16 age;

17 (B) the Level of Care Utilization System (LOCUS)
18 criteria developed by the American Association of
19 Community Psychiatrists for mental health disorders for
20 patients ages 18 years and over;

21 (C) the Child and Adolescent Level of Care Utilization
22 System (CALOCUS) developed by the American Association of
23 Community Psychiatrists or the Child and Adolescent
24 Services Intensity Instrument (CASII) developed by the
25 American Academy of Child & Adolescent Psychiatry for
26 mental health disorders for patients ages 6 to 17;

1 (D) the Early Childhood Service Intensity Instrument
2 (ECSII) developed by the American Academy Child &
3 Adolescent Psychiatry for mental health disorders for
4 patients ages 0 to 5 years; or

5 (E) the American Psychiatric Association criteria for
6 eating disorders for a primary diagnosis of an eating
7 disorder for patients of any age.

8 (5) To ensure the proper use of criteria described in
9 paragraph (4), insurers shall:

10 (A) track, identify, and analyze how the clinical
11 guidelines are used to certify care, deny care, and support
12 the appeals process and submit the results of this analysis
13 to the Department or, in the case of Medicaid managed care
14 organizations, to the Department of Healthcare and Family
15 Services on July 1 of every year. The Departments are to
16 submit a joint report summarizing the submitted analyses to
17 the General Assembly by January 1 of every year;

18 (B) apply the criteria to the level of treatment
19 proposed by the insured patient's treatment provider and
20 not impose criteria for a different or higher level of
21 treatment;

22 (C) run inter-rater reliability reports about how the
23 clinical guidelines are used in conjunction with the
24 utilization management process and parity compliance
25 activities;

26 (D) achieve inter-rater reliability pass rates of at

1 least 90% and, whenever this threshold is not met,
2 immediately provide for the remediation of poor
3 inter-rater reliability and inter-reliability testing for
4 all new staff before they can conduct utilization review
5 without supervision; and

6 (E) report the activities in this subsection to the
7 plan's quality assurance committee.

8 (i) Every insurer that amends, delivers, issues, or renews
9 group accident and health policies providing coverage for
10 hospital or medical treatment or services for illness on an
11 expense-incurred basis shall, at minimum, include the
12 following services as covered benefits for mental, emotional,
13 nervous, or substance use disorders or conditions:

14 (1) outpatient services;

15 (2) inpatient services;

16 (3) intermediate services, including the full range of
17 levels of care in the most recent edition of the ASAM
18 criteria, LOCUS, CALOCUS, ECSII, and CASII (including, but
19 not limited to, partial hospitalization, intensive
20 outpatient, psycho-social treatment models, and
21 coordinated specialty care);

22 (4) emergency and urgent care services, both inpatient
23 and outpatient;

24 (5) all medications approved by the United States Food
25 and Drug Administration for the treatment of substance use
26 disorders; and

1 (6) emergency medication without prior authorization.

2 (j) If any medically necessary services for mental,
3 emotional, nervous, or substance use disorders or conditions
4 are not available in-network within the geography and
5 timeliness standards set by law or regulation, the insurer must
6 immediately cover out-of-network services, whether secured by
7 the patient or insurer, at an in-network benefit level and
8 reimburse out-of-network providers for such services at full
9 billed charges. An insurer may not interrupt a course of
10 treatment initiated out-of-network due to inadequacy if
11 in-network services subsequently become available.

12 (k) An insurer shall not limit the benefits or coverage for
13 medically necessary services on the basis that those services
14 should be or could be covered by a public entitlement program,
15 including, but not limited to, special education or an
16 individualized education program, Medicaid, Medicare,
17 Supplemental Security Income, or Social Security Disability
18 Insurance, and shall not include or enforce a contract term
19 that excludes otherwise covered benefits on the basis that
20 those services should be or could be covered by a public
21 entitlement program.

22 (l) An insurer shall only engage applicable qualified
23 physicians who specialize in the treatment of mental,
24 emotional, nervous, or substance use disorders or conditions or
25 the appropriate subspecialty therein and who possess an active
26 professional license or certificate, to review, approve, or

1 deny services.

2 (m) An insurer shall not adopt, impose, or enforce any
3 terms in its policies or provider agreements, in writing or in
4 operation, that undermine or alter the requirements in this
5 Section.

6 (n) If the Department determines that an insurer has failed
7 to meet any requirement of this Section or Section 370c.1, the
8 Department shall impose a penalty per product line with respect
9 to each participant or beneficiary to whom such failure
10 relates.

11 (1) The amount of the penalty imposed shall be as
12 follows:

13 (A) for violations in which it is established that
14 the insurer did not know and, by exercising reasonable
15 diligence, would not have known that the insurer
16 violated a provision, an amount not less than \$100 or
17 more than \$50,000 for each violation;

18 (B) for a violation in which it is established that
19 the violation was due to reasonable cause and not to
20 willful neglect, an amount not less than \$1,000 or more
21 than \$50,000 for each violation;

22 (C) for a violation in which it is established that
23 the violation was due to willful neglect and was timely
24 corrected, an amount not less than \$10,000 or more than
25 \$50,000 for each violation; and

26 (D) for a violation in which it is established that

1 the violation was due to willful neglect and was not
2 timely corrected, an amount not less than \$50,000 for
3 each violation.

4 (2) Except that a penalty for violations of the same
5 requirement or prohibition under any of these categories
6 may not exceed \$3,000,000 in a calendar year.

7 (3) With respect to parity, violations of different
8 State or federal requirements or prohibitions shall be
9 considered a unique violation for the purposes of paragraph
10 (2).

11 (4) The amounts in this subsection shall be annually
12 adjusted for inflation in accordance with 26 U.S.C.
13 1(f)(3).

14 (5) Notwithstanding paragraph (3) of Section 403A,
15 penalties under this Section and Section 370c.1 shall not
16 be subject to time limits.

17 (Source: P.A. 100-305, eff. 8-24-17; 100-1023, eff. 1-1-19;
18 100-1024, eff. 1-1-19; 101-81, eff. 7-12-19; 101-386, eff.
19 8-16-19; revised 9-20-19.)