

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. This Act may be referred to as the Generally
5 Accepted Standards of Behavioral Health Care Act of 2021.

6 Section 2. The General Assembly finds and declares the
7 following:

8 (a) The State of Illinois and the entire country faces a
9 mental health and addiction crisis.

10 (1) One in 5 adults experience a mental health
11 disorder, and data from 2017 shows that one in 12 had a
12 substance use disorder. The COVID-19 pandemic has
13 exacerbated the nation's mental health and addiction
14 crisis. According the U.S. Center for Disease Control and
15 Prevention, since the start of the COVID-19 pandemic,
16 Americans have experienced higher rates of depression,
17 anxiety, and trauma, and rates of substance use and
18 suicidal ideation have increased.

19 (2) Nationally, the suicide rate has increased 35% in
20 the past 20 years. According to the Illinois Department of
21 Public Health, more than 1,000 Illinoisans die by suicide
22 every year, including 1,439 deaths in 2019, and it is the
23 third leading cause of death among young adults aged 15 to

1 34.

2 (3) Between 2013 and 2019, Illinois saw a 1,861%
3 increase in synthetic opioid overdose deaths and a 68%
4 increase in heroin overdose deaths. In 2019 alone, there
5 were 2.3 and 2 times as many opioid deaths as homicides and
6 car crash deaths, respectively.

7 (4) Communities of color are disproportionately
8 impacted by lack of access to and inequities in mental
9 health and substance use disorder care.

10 (A) According to the Substance Abuse and Mental
11 Health Services Administration, two-thirds of Black
12 and Hispanic Americans with a mental illness and
13 nearly 90% with a substance use disorder do not
14 receive medically necessary treatment.

15 (B) Data from the U.S. Census Bureau demonstrates
16 that Black Americans saw the highest increases in
17 rates of anxiety and depression in 2020.

18 (C) Data from the Illinois Department of Public
19 Health reveals that Black Illinoisans are hospitalized
20 for opioid overdoses at a rate 6 times higher than
21 white Illinoisans.

22 (D) In the first half of 2020, the number of
23 suicides among Black Chicagoans had increased 106%
24 from the previous year. Nationally, from 2001 to 2017,
25 suicide rates doubled among Black girls aged 13 to 19
26 and increased 60% for Black boys of the same age.

1 (E) According to the Substance Abuse and Mental
2 Health Services Administration, between 2008 and 2018
3 there were significant increases in serious mental
4 illness and suicide ideation in Hispanics aged 18 to
5 25 and there remains a large gap in treatment need
6 among Hispanics.

7 (5) According to the U.S. Center for Disease Control
8 and Prevention, children with adverse childhood
9 experiences are more likely to experience negative
10 outcomes like post-traumatic stress disorder, increased
11 anxiety and depression, suicide, and substance use. A 2020
12 report from Mental Health America shows that 62.1% of
13 Illinois youth with severe depression do not receive any
14 mental health treatment. Survey results found that 80% of
15 college students report that COVID-19 has negatively
16 impacted their mental health.

17 (6) In rural communities, between 2001 and 2015, the
18 suicide rate increased by 27%, and between 1999 and 2015
19 the overdose rate increased 325%.

20 (7) According to the U.S. Department of Veterans
21 Affairs, 154 veterans died by suicide in 2018, which
22 accounts for more than 10% of all suicide deaths reported
23 by the Illinois Department of Public Health in the same
24 year, despite only accounting for approximately 5.7% of
25 the State's total population. Nationally, between 2008 and
26 2017, more than 6,000 veterans died by suicide each year.

1 (8) According to the National Alliance on Mental
2 Illness, 2,000,000 people with mental illness are
3 incarcerated every year, where they do not receive the
4 treatment they need.

5 (b) A recent landmark federal court ruling offers a
6 concrete demonstration of how the mental health and addiction
7 crisis described in subsection (a) is worsened through the
8 denial of medically necessary mental health and substance use
9 disorder treatment.

10 (1) In March 2019, the United States District Court of
11 the Northern District of California ruled in *Wit v. United*
12 *Behavioral Health*, 2019 WL 1033730 (*Wit*; N.D.CA Mar. 5,
13 2019), that United Behavioral Health created flawed level
14 of care placement criteria that were inconsistent with
15 generally accepted standards of mental health and
16 substance use disorder care in order to "mitigate" the
17 requirements of the federal Mental Health Parity and
18 Addiction Equity Act of 2008.

19 (2) As described by the federal court in *Wit*, the 8
20 generally accepted standards of mental health and
21 substance use disorder care require all of the following:

22 (A) Effective treatment of underlying conditions,
23 rather than mere amelioration of current symptoms,
24 such as suicidality or psychosis.

25 (B) Treatment of co-occurring behavioral health
26 disorders or medical conditions in a coordinated

1 manner.

2 (C) Treatment at the least intensive and
3 restrictive level of care that is safe and effective
4 and meets the needs of the patient's condition; a
5 lower level or less intensive care is appropriate only
6 if it is safe and just as effective as treatment at a
7 higher level or service intensity.

8 (D) Erring on the side of caution, by placing
9 patients in higher levels of care when there is
10 ambiguity as to the appropriate level of care, or when
11 the recommended level of care is not available.

12 (E) Treatment to maintain functioning or prevent
13 deterioration.

14 (F) Treatment of mental health and substance use
15 disorders for an appropriate duration based on
16 individual patient needs rather than on specific time
17 limits.

18 (G) Accounting for the unique needs of children
19 and adolescents when making level of care decisions.

20 (H) Applying multidimensional assessments of
21 patient needs when making determinations regarding the
22 appropriate level of care.

23 (3) The court in Wit found that all parties' expert
24 witnesses regarded the American Society of Addiction
25 Medicine (ASAM) criteria for substance use disorders and
26 Level of Care Utilization System (LOCUS), Child and

1 Adolescent Level of Care Utilization System (CALOCUS),
2 Child and Adolescent Service Intensity Instrument (CASII),
3 and Early Childhood Service Intensity Instrument (ECSII)
4 criteria for mental health disorders as prime examples of
5 level of care criteria that are fully consistent with
6 generally accepted standards of mental health and
7 substance use care.

8 (4) In particular, the coverage of intermediate levels
9 of care, such as residential treatment, which are
10 essential components of the level of care continuum called
11 for by nonprofit, and clinical specialty associations such
12 as the American Society of Addiction Medicine, are often
13 denied through overly restrictive medical necessity
14 determinations.

15 (5) On November 3, 2020, the court issued a remedies
16 order requiring United Behavioral Health to reprocess
17 67,000 mental health and substance use disorder claims and
18 mandating that, for the next decade, United Behavioral
19 Health must use the relevant nonprofit clinical society
20 guidelines for its medical necessity determinations.

21 (6) The court's findings also demonstrated how United
22 Behavioral Health was in violation of Section 370c of the
23 Illinois Insurance Code for its failure to use the
24 American Society of Addiction Medicine Criteria for
25 substance use disorders. The results of market conduct
26 examinations released by the Illinois Department of

1 Insurance on July 15, 2020 confirmed these findings citing
2 United Healthcare and CIGNA for their failure to use the
3 American Society of Addiction Medicine Criteria when
4 making medical necessity determinations for substance use
5 disorders as required by Illinois law.

6 (c) Insurers should not be permitted to deny medically
7 necessary mental health and substance use disorder care
8 through the use of utilization review practices and criteria
9 that are inconsistent with generally accepted standards of
10 mental health and substance use disorder care.

11 (1) Illinois parity law (Sections 370c and 370c.1 of
12 the Illinois Insurance Code) requires that health plans
13 treat illnesses of the brain, such as addiction and
14 depression, the same way they treat illness of other parts
15 of the body, such as cancer and diabetes. The Illinois
16 General Assembly significantly strengthened Illinois'
17 parity law, which incorporates provisions of the federal
18 Paul Wellstone and Pete Domenici Mental Health Parity and
19 Addiction Equity Act of 2008, in both 2015 and 2018.

20 (2) While the federal Patient Protection and
21 Affordable Care Act includes mental health and addiction
22 coverage as one of the 10 essential health benefits, it
23 does not contain a definition for medical necessity, and
24 despite the Patient Protection and Affordable Care Act,
25 needed mental health and addiction coverage can be denied
26 through overly restrictive medical necessity

1 determinations.

2 (3) Despite the strong actions taken by the Illinois
3 General Assembly, the court in *Wit v. United Behavioral*
4 *Health* demonstrated how insurers can mitigate compliance
5 with parity laws due by denying medically necessary mental
6 health and treatment by using flawed medical necessity
7 criteria.

8 (4) When medically necessary mental health and
9 substance use disorder care is denied, the manifestations
10 of the mental health and addiction crisis described in
11 subsection (a) are severely exacerbated. Individuals with
12 mental health and substance use disorders often have their
13 conditions worsen, sometimes ending up in the criminal
14 justice system or on the streets, resulting in increased
15 emergency hospitalizations, harm to individuals and
16 communities, and higher costs to taxpayers.

17 (5) In order to realize the promise of mental health
18 and addiction parity and remove barriers to mental health
19 and substance use disorder care for all Illinoisans,
20 insurers must be required to cover medically necessary
21 mental health and substance use disorder care and follow
22 generally accepted standards of mental health and
23 substance use disorder care.

24 Section 5. The Illinois Insurance Code is amended by
25 changing Sections 370c and 370c.1 as follows:

1 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

2 Sec. 370c. Mental and emotional disorders.

3 (a) (1) On and after the effective date of this amendatory
4 Act of the 102nd General Assembly January 1, 2019 ~~(the~~
5 ~~effective date of this amendatory Act of the 101st General~~
6 ~~Assembly Public Act 100-1024)~~, every insurer that amends,
7 delivers, issues, or renews group accident and health policies
8 providing coverage for hospital or medical treatment or
9 services for illness on an expense-incurred basis shall
10 provide coverage for the medically necessary treatment of
11 ~~reasonable and necessary treatment and services for~~ mental,
12 emotional, nervous, or substance use disorders or conditions
13 consistent with the parity requirements of Section 370c.1 of
14 this Code.

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

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

16 (3) Insofar as this Section applies solely to licensed
17 clinical social workers, licensed clinical professional
18 counselors, licensed marriage and family therapists, licensed
19 speech-language pathologists, and other licensed or certified
20 professionals at programs licensed pursuant to the Substance
21 Use Disorder Act, those persons who may provide services to
22 individuals shall do so after the licensed clinical social
23 worker, licensed clinical professional counselor, licensed
24 marriage and family therapist, licensed speech-language
25 pathologist, or other licensed or certified professional at a
26 program licensed pursuant to the Substance Use Disorder Act

1 has informed the patient of the desirability of the patient
2 conferring with the patient's primary care physician.

3 (4) "Mental, emotional, nervous, or substance use disorder
4 or condition" means a condition or disorder that involves a
5 mental health condition or substance use disorder that falls
6 under any of the diagnostic categories listed in the mental
7 and behavioral disorders chapter of the current edition of the
8 World Health Organization's International Classification of
9 Disease or that is listed in the most recent version of the
10 American Psychiatric Association's Diagnostic and Statistical
11 Manual of Mental Disorders. "Mental, emotional, nervous, or
12 substance use disorder or condition" includes any mental
13 health condition that occurs during pregnancy or during the
14 postpartum period and includes, but is not limited to,
15 postpartum depression.

16 (5) Medically necessary treatment and medical necessity
17 determinations shall be interpreted and made in a manner that
18 is consistent with and pursuant to subsections (h) through
19 (t).

20 (b) (1) (Blank).

21 (2) (Blank).

22 (2.5) (Blank).

23 (3) Unless otherwise prohibited by federal law and
24 consistent with the parity requirements of Section 370c.1 of
25 this Code, the reimbursing insurer that amends, delivers,
26 issues, or renews a group or individual policy of accident and

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

1 diseases or illnesses covered under the policy, including an
2 appeals process. Medical necessity determinations for
3 substance use disorders shall be made in accordance with
4 appropriate patient placement criteria established by the
5 American Society of Addiction Medicine. No additional criteria
6 may be used to make medical necessity determinations for
7 substance use disorders.

8 (4) A group health benefit plan amended, delivered,
9 issued, or renewed on or after January 1, 2019 (the effective
10 date of Public Act 100-1024) or an individual policy of
11 accident and health insurance or a qualified health plan
12 offered through the health insurance marketplace amended,
13 delivered, issued, or renewed on or after January 1, 2019 (the
14 effective date of Public Act 100-1024):

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

21 (i) 45 days of inpatient treatment; and

22 (ii) beginning on June 26, 2006 (the effective
23 date of Public Act 94-921), 60 visits for outpatient
24 treatment including group and individual outpatient
25 treatment; and

26 (iii) for plans or policies delivered, issued for

1 delivery, renewed, or modified after January 1, 2007
2 (the effective date of Public Act 94-906), 20
3 additional outpatient visits for speech therapy for
4 treatment of pervasive developmental disorders that
5 will be in addition to speech therapy provided
6 pursuant to item (ii) of this subparagraph (A); and

7 (B) may not include a lifetime limit on the number of
8 days of inpatient treatment or the number of outpatient
9 visits covered under the plan.

10 (C) (Blank).

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

20 (5.5) An individual or group health benefit plan amended,
21 delivered, issued, or renewed on or after September 9, 2015
22 (the effective date of Public Act 99-480) shall offer coverage
23 for medically necessary acute treatment services and medically
24 necessary clinical stabilization services. The treating
25 provider shall base all treatment recommendations and the
26 health benefit plan shall base all medical necessity

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

11 As used in this subsection:

12 "Acute treatment services" means 24-hour medically
13 supervised addiction treatment that provides evaluation and
14 withdrawal management and may include biopsychosocial
15 assessment, individual and group counseling, psychoeducational
16 groups, and discharge planning.

17 "Clinical stabilization services" means 24-hour treatment,
18 usually following acute treatment services for substance
19 abuse, which may include intensive education and counseling
20 regarding the nature of addiction and its consequences,
21 relapse prevention, outreach to families and significant
22 others, and aftercare planning for individuals beginning to
23 engage in recovery from addiction.

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

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

4 (A) shall not impose prior authorization requirements,
5 other than those established under the Treatment Criteria
6 for Addictive, Substance-Related, and Co-Occurring
7 Conditions established by the American Society of
8 Addiction Medicine, on a prescription medication approved
9 by the United States Food and Drug Administration that is
10 prescribed or administered for the treatment of substance
11 use disorders;

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

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

1 of the drug formulary developed and maintained by the
2 individual or group health benefit plan that covers
3 generic medications; and

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

10 (7) (Blank).

11 (8) (Blank).

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

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

21 (d) With respect to a group or individual policy of
22 accident and health insurance or a qualified health plan
23 offered through the health insurance marketplace, the
24 Department and, with respect to medical assistance, the
25 Department of Healthcare and Family Services shall each
26 enforce the requirements of this Section and Sections 356z.23

1 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
2 Mental Health Parity and Addiction Equity Act of 2008, 42
3 U.S.C. 18031(j), and any amendments to, and federal guidance
4 or regulations issued under, those Acts, including, but not
5 limited to, final regulations issued under the Paul Wellstone
6 and Pete Domenici Mental Health Parity and Addiction Equity
7 Act of 2008 and final regulations applying the Paul Wellstone
8 and Pete Domenici Mental Health Parity and Addiction Equity
9 Act of 2008 to Medicaid managed care organizations, the
10 Children's Health Insurance Program, and alternative benefit
11 plans. Specifically, the Department and the Department of
12 Healthcare and Family Services shall take action:

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

23 (2) evaluating all consumer or provider complaints
24 regarding mental, emotional, nervous, or substance use
25 disorder or condition coverage for possible parity
26 violations;

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

6 (A) nonquantitative treatment limitations,
7 including, but not limited to, prior authorization
8 requirements, concurrent review, retrospective review,
9 step therapy, network admission standards,
10 reimbursement rates, and geographic restrictions;

11 (B) denials of authorization, payment, and
12 coverage; and

13 (C) other specific criteria as may be determined
14 by the Department.

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

17 The Director may adopt rules to effectuate any provisions
18 of the Paul Wellstone and Pete Domenici Mental Health Parity
19 and Addiction Equity Act of 2008 that relate to the business of
20 insurance.

21 (e) Availability of plan information.

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

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

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

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

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

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

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

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

24 (2) A group health insurance policy, an individual health
25 benefit plan, or qualified health plan that is offered through
26 the health insurance marketplace, small employer group health

1 plan, and large employer group health plan that is amended,
2 delivered, issued, executed, or renewed in this State, or
3 approved for issuance or renewal in this State, on or after
4 January 1, 2019 (the effective date of Public Act 100-1023)
5 shall comply with the requirements of this Section and Section
6 370c.1. The services for the treatment and the ongoing
7 assessment of the patient's progress in treatment shall follow
8 the requirements of 77 Ill. Adm. Code 2060.

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

1 timeframes established in 77 Ill. Adm. Code 2060. If the
2 substance use disorder treatment provider or facility fails to
3 notify the insurer of the initiation of treatment in
4 accordance with these provisions, the insurer may follow its
5 normal prior authorization processes.

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

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

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

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

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

22 (7) Nothing in this subsection shall be construed to
23 require an insurer to provide coverage for any of the benefits
24 in this subsection.

25 (h) As used in this Section:

26 "Generally accepted standards of mental, emotional,

1 nervous, or substance use disorder or condition care" means
2 standards of care and clinical practice that are generally
3 recognized by health care providers practicing in relevant
4 clinical specialties such as psychiatry, psychology, clinical
5 sociology, social work, addiction medicine and counseling, and
6 behavioral health treatment. Valid, evidence-based sources
7 reflecting generally accepted standards of mental, emotional,
8 nervous, or substance use disorder or condition care include
9 peer-reviewed scientific studies and medical literature,
10 recommendations of nonprofit health care provider professional
11 associations and specialty societies, including, but not
12 limited to, patient placement criteria and clinical practice
13 guidelines, recommendations of federal government agencies,
14 and drug labeling approved by the United States Food and Drug
15 Administration.

16 "Medically necessary treatment of mental, emotional,
17 nervous, or substance use disorders or conditions" means a
18 service or product addressing the specific needs of that
19 patient, for the purpose of screening, preventing, diagnosing,
20 managing, or treating an illness, injury, or condition or its
21 symptoms and comorbidities, including minimizing the
22 progression of an illness, injury, or condition or its
23 symptoms and comorbidities in a manner that is all of the
24 following:

25 (1) in accordance with the generally accepted
26 standards of mental, emotional, nervous, or substance use

1 disorder or condition care;

2 (2) clinically appropriate in terms of type,
3 frequency, extent, site, and duration; and

4 (3) not primarily for the economic benefit of the
5 insurer, purchaser, or for the convenience of the patient,
6 treating physician, or other health care provider.

7 "Utilization review" means either of the following:

8 (1) prospectively, retrospectively, or concurrently
9 reviewing and approving, modifying, delaying, or denying,
10 based in whole or in part on medical necessity, requests
11 by health care providers, insureds, or their authorized
12 representatives for coverage of health care services
13 before, retrospectively, or concurrently with the
14 provision of health care services to insureds.

15 (2) evaluating the medical necessity, appropriateness,
16 level of care, service intensity, efficacy, or efficiency
17 of health care services, benefits, procedures, or
18 settings, under any circumstances, to determine whether a
19 health care service or benefit subject to a medical
20 necessity coverage requirement in an insurance policy is
21 covered as medically necessary for an insured.

22 "Utilization review criteria" means patient placement
23 criteria or any criteria, standards, protocols, or guidelines
24 used by an insurer to conduct utilization review.

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

1 insurance or a qualified health plan offered through the
2 health insurance marketplace in this State and Medicaid
3 managed care organizations providing coverage for hospital or
4 medical treatment on or after January 1, 2023 shall, pursuant
5 to subsections (h) through (s), provide coverage for medically
6 necessary treatment of mental, emotional, nervous, or
7 substance use disorders or conditions.

8 (2) An insurer shall not set a specific limit on the
9 duration of benefits or coverage of medically necessary
10 treatment of mental, emotional, nervous, or substance use
11 disorders or conditions or limit coverage only to alleviation
12 of the insured's current symptoms.

13 (3) All medical necessity determinations made by the
14 insurer concerning service intensity, level of care placement,
15 continued stay, and transfer or discharge of insureds
16 diagnosed with mental, emotional, nervous, or substance use
17 disorders or conditions shall be conducted in accordance with
18 the requirements of subsections (k) through (u).

19 (4) An insurer that authorizes a specific type of
20 treatment by a provider pursuant to this Section shall not
21 rescind or modify the authorization after that provider
22 renders the health care service in good faith and pursuant to
23 this authorization for any reason, including, but not limited
24 to, the insurer's subsequent cancellation or modification of
25 the insured's or policyholder's contract, or the insured's or
26 policyholder's eligibility. Nothing in this Section shall

1 require the insurer to cover a treatment when the
2 authorization was granted based on a material
3 misrepresentation by the insured, the policyholder, or the
4 provider. Nothing in this Section shall require Medicaid
5 managed care organizations to pay for services if the
6 individual was not eligible for Medicaid at the time the
7 service was rendered. Nothing in this Section shall require an
8 insurer to pay for services if the individual was not the
9 insurer's enrollee at the time services were rendered. As used
10 in this paragraph, "material" means a fact or situation that
11 is not merely technical in nature and results in or could
12 result in a substantial change in the situation.

13 (j) An insurer shall not limit benefits or coverage for
14 medically necessary services on the basis that those services
15 should be or could be covered by a public entitlement program,
16 including, but not limited to, special education or an
17 individualized education program, Medicaid, Medicare,
18 Supplemental Security Income, or Social Security Disability
19 Insurance, and shall not include or enforce a contract term
20 that excludes otherwise covered benefits on the basis that
21 those services should be or could be covered by a public
22 entitlement program. Nothing in this subsection shall be
23 construed to require an insurer to cover benefits that have
24 been authorized and provided for a covered person by a public
25 entitlement program. Medicaid managed care organizations are
26 not subject to this subsection.

1 (k) An insurer shall base any medical necessity
2 determination or the utilization review criteria that the
3 insurer, and any entity acting on the insurer's behalf,
4 applies to determine the medical necessity of health care
5 services and benefits for the diagnosis, prevention, and
6 treatment of mental, emotional, nervous, or substance use
7 disorders or conditions on current generally accepted
8 standards of mental, emotional, nervous, or substance use
9 disorder or condition care. All denials and appeals shall be
10 reviewed by a professional with experience or expertise
11 comparable to the provider requesting the authorization.

12 (l) For medical necessity determinations relating to level
13 of care placement, continued stay, and transfer or discharge
14 of insureds diagnosed with mental, emotional, and nervous
15 disorders or conditions, an insurer shall apply the patient
16 placement criteria set forth in the most recent version of the
17 treatment criteria developed by an unaffiliated nonprofit
18 professional association for the relevant clinical specialty
19 or, for Medicaid managed care organizations, patient placement
20 criteria determined by the Department of Healthcare and Family
21 Services that are consistent with generally accepted standards
22 of mental, emotional, nervous or substance use disorder or
23 condition care. Pursuant to subsection (b), in conducting
24 utilization review of all covered services and benefits for
25 the diagnosis, prevention, and treatment of substance use
26 disorders an insurer shall use the most recent edition of the

1 patient placement criteria established by the American Society
2 of Addiction Medicine.

3 (m) For medical necessity determinations relating to level
4 of care placement, continued stay, and transfer or discharge
5 that are within the scope of the sources specified in
6 subsection (l), an insurer shall not apply different,
7 additional, conflicting, or more restrictive utilization
8 review criteria than the criteria set forth in those sources.
9 For all level of care placement decisions, the insurer shall
10 authorize placement at the level of care consistent with the
11 assessment of the insured using the relevant patient placement
12 criteria as specified in subsection (l). If that level of
13 placement is not available, the insurer shall authorize the
14 next higher level of care. In the event of disagreement, the
15 insurer shall provide full detail of its assessment using the
16 relevant criteria as specified in subsection (l) to the
17 provider of the service and the patient.

18 Nothing in this subsection or subsection (l) prohibits an
19 insurer from applying utilization review criteria that were
20 developed in accordance with subsection (k) to health care
21 services and benefits for mental, emotional, and nervous
22 disorders or conditions that are not related to medical
23 necessity determinations for level of care placement,
24 continued stay, and transfer or discharge. If an insurer
25 purchases or licenses utilization review criteria pursuant to
26 this subsection, the insurer shall verify and document before

1 use that the criteria were developed in accordance with
2 subsection (k).

3 (n) In conducting utilization review that is outside the
4 scope of the criteria as specified in subsection (l) or
5 relates to the advancements in technology or in the types or
6 levels of care that are not addressed in the most recent
7 versions of the sources specified in subsection (l), an
8 insurer shall conduct utilization review in accordance with
9 subsection (k).

10 (o) This Section does not in any way limit the rights of a
11 patient under the Medical Patient Rights Act.

12 (p) This Section does not in any way limit early and
13 periodic screening, diagnostic, and treatment benefits as
14 defined under 42 U.S.C. 1396d(r).

15 (q) To ensure the proper use of the criteria described in
16 subsection (l), every insurer shall do all of the following:

17 (1) Educate the insurer's staff, including any third
18 parties contracted with the insurer to review claims,
19 conduct utilization reviews, or make medical necessity
20 determinations about the utilization review criteria.

21 (2) Make the educational program available to other
22 stakeholders, including the insurer's participating or
23 contracted providers and potential participants,
24 beneficiaries, or covered lives. The education program
25 must be provided at least once a year, in-person or
26 digitally, or recordings of the education program must be

1 made available to the aforementioned stakeholders.

2 (3) Provide, at no cost, the utilization review
3 criteria and any training material or resources to
4 providers and insured patients upon request. For
5 utilization review criteria not concerning level of care
6 placement, continued stay, and transfer or discharge used
7 by the insurer pursuant to subsection (m), the insurer may
8 place the criteria on a secure, password-protected website
9 so long as the access requirements of the website do not
10 unreasonably restrict access to insureds or their
11 providers. No restrictions shall be placed upon the
12 insured's or treating provider's access right to
13 utilization review criteria obtained under this paragraph
14 at any point in time, including before an initial request
15 for authorization.

16 (4) Track, identify, and analyze how the utilization
17 review criteria are used to certify care, deny care, and
18 support the appeals process.

19 (5) Conduct interrater reliability testing to ensure
20 consistency in utilization review decision making that
21 covers how medical necessity decisions are made; this
22 assessment shall cover all aspects of utilization review
23 as defined in subsection (h).

24 (6) Run interrater reliability reports about how the
25 clinical guidelines are used in conjunction with the
26 utilization review process and parity compliance

1 activities.

2 (7) Achieve interrater reliability pass rates of at
3 least 90% and, if this threshold is not met, immediately
4 provide for the remediation of poor interrater reliability
5 and interrater reliability testing for all new staff
6 before they can conduct utilization review without
7 supervision.

8 (8) Maintain documentation of interrater reliability
9 testing and the remediation actions taken for those with
10 pass rates lower than 90% and submit to the Department of
11 Insurance or, in the case of Medicaid managed care
12 organizations, the Department of Healthcare and Family
13 Services the testing results and a summary of remedial
14 actions as part of parity compliance reporting set forth
15 in subsection (k) of Section 370c.1.

16 (r) This Section applies to all health care services and
17 benefits for the diagnosis, prevention, and treatment of
18 mental, emotional, nervous, or substance use disorders or
19 conditions covered by an insurance policy, including
20 prescription drugs.

21 (s) This Section applies to an insurer that amends,
22 delivers, issues, or renews a group or individual policy of
23 accident and health insurance or a qualified health plan
24 offered through the health insurance marketplace in this State
25 providing coverage for hospital or medical treatment and
26 conducts utilization review as defined in this Section,

1 including Medicaid managed care organizations, and any entity
2 or contracting provider that performs utilization review or
3 utilization management functions on an insurer's behalf.

4 (t) If the Director determines that an insurer has
5 violated this Section, the Director may, after appropriate
6 notice and opportunity for hearing, by order, assess a civil
7 penalty between \$1,000 and \$5,000 for each violation. Moneys
8 collected from penalties shall be deposited into the Parity
9 Advancement Fund established in subsection (i) of Section
10 370c.1.

11 (u) An insurer shall not adopt, impose, or enforce terms
12 in its policies or provider agreements, in writing or in
13 operation, that undermine, alter, or conflict with the
14 requirements of this Section.

15 (v) The provisions of this Section are severable. If any
16 provision of this Section or its application is held invalid,
17 that invalidity shall not affect other provisions or
18 applications that can be given effect without the invalid
19 provision or application.

20 (Source: P.A. 100-305, eff. 8-24-17; 100-1023, eff. 1-1-19;
21 100-1024, eff. 1-1-19; 101-81, eff. 7-12-19; 101-386, eff.
22 8-16-19; revised 9-20-19.)

23 (215 ILCS 5/370c.1)

24 Sec. 370c.1. Mental, emotional, nervous, or substance use
25 disorder or condition parity.

1 (a) On and after the effective date of this amendatory Act
2 of the 99th General Assembly, every insurer that amends,
3 delivers, issues, or renews a group or individual policy of
4 accident and health insurance or a qualified health plan
5 offered through the Health Insurance Marketplace in this State
6 providing coverage for hospital or medical treatment and for
7 the treatment of mental, emotional, nervous, or substance use
8 disorders or conditions shall ensure that:

9 (1) the financial requirements applicable to such
10 mental, emotional, nervous, or substance use disorder or
11 condition benefits are no more restrictive than the
12 predominant financial requirements applied to
13 substantially all hospital and medical benefits covered by
14 the policy and that there are no separate cost-sharing
15 requirements that are applicable only with respect to
16 mental, emotional, nervous, or substance use disorder or
17 condition benefits; and

18 (2) the treatment limitations applicable to such
19 mental, emotional, nervous, or substance use disorder or
20 condition benefits are no more restrictive than the
21 predominant treatment limitations applied to substantially
22 all hospital and medical benefits covered by the policy
23 and that there are no separate treatment limitations that
24 are applicable only with respect to mental, emotional,
25 nervous, or substance use disorder or condition benefits.

26 (b) The following provisions shall apply concerning

1 aggregate lifetime limits:

2 (1) In the case of a group or individual policy of
3 accident and health insurance or a qualified health plan
4 offered through the Health Insurance Marketplace amended,
5 delivered, issued, or renewed in this State on or after
6 the effective date of this amendatory Act of the 99th
7 General Assembly that provides coverage for hospital or
8 medical treatment and for the treatment of mental,
9 emotional, nervous, or substance use disorders or
10 conditions the following provisions shall apply:

11 (A) if the policy does not include an aggregate
12 lifetime limit on substantially all hospital and
13 medical benefits, then the policy may not impose any
14 aggregate lifetime limit on mental, emotional,
15 nervous, or substance use disorder or condition
16 benefits; or

17 (B) if the policy includes an aggregate lifetime
18 limit on substantially all hospital and medical
19 benefits (in this subsection referred to as the
20 "applicable lifetime limit"), then the policy shall
21 either:

22 (i) apply the applicable lifetime limit both
23 to the hospital and medical benefits to which it
24 otherwise would apply and to mental, emotional,
25 nervous, or substance use disorder or condition
26 benefits and not distinguish in the application of

1 the limit between the hospital and medical
2 benefits and mental, emotional, nervous, or
3 substance use disorder or condition benefits; or

4 (ii) not include any aggregate lifetime limit
5 on mental, emotional, nervous, or substance use
6 disorder or condition benefits that is less than
7 the applicable lifetime limit.

8 (2) In the case of a policy that is not described in
9 paragraph (1) of subsection (b) of this Section and that
10 includes no or different aggregate lifetime limits on
11 different categories of hospital and medical benefits, the
12 Director shall establish rules under which subparagraph
13 (B) of paragraph (1) of subsection (b) of this Section is
14 applied to such policy with respect to mental, emotional,
15 nervous, or substance use disorder or condition benefits
16 by substituting for the applicable lifetime limit an
17 average aggregate lifetime limit that is computed taking
18 into account the weighted average of the aggregate
19 lifetime limits applicable to such categories.

20 (c) The following provisions shall apply concerning annual
21 limits:

22 (1) In the case of a group or individual policy of
23 accident and health insurance or a qualified health plan
24 offered through the Health Insurance Marketplace amended,
25 delivered, issued, or renewed in this State on or after
26 the effective date of this amendatory Act of the 99th

1 General Assembly that provides coverage for hospital or
2 medical treatment and for the treatment of mental,
3 emotional, nervous, or substance use disorders or
4 conditions the following provisions shall apply:

5 (A) if the policy does not include an annual limit
6 on substantially all hospital and medical benefits,
7 then the policy may not impose any annual limits on
8 mental, emotional, nervous, or substance use disorder
9 or condition benefits; or

10 (B) if the policy includes an annual limit on
11 substantially all hospital and medical benefits (in
12 this subsection referred to as the "applicable annual
13 limit"), then the policy shall either:

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

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

26 (2) In the case of a policy that is not described in

1 paragraph (1) of subsection (c) of this Section and that
2 includes no or different annual limits on different
3 categories of hospital and medical benefits, the Director
4 shall establish rules under which subparagraph (B) of
5 paragraph (1) of subsection (c) of this Section is applied
6 to such policy with respect to mental, emotional, nervous,
7 or substance use disorder or condition benefits by
8 substituting for the applicable annual limit an average
9 annual limit that is computed taking into account the
10 weighted average of the annual limits applicable to such
11 categories.

12 (d) With respect to mental, emotional, nervous, or
13 substance use disorders or conditions, an insurer shall use
14 policies and procedures for the election and placement of
15 mental, emotional, nervous, or substance use disorder or
16 condition treatment drugs on their formulary that are no less
17 favorable to the insured as those policies and procedures the
18 insurer uses for the selection and placement of drugs for
19 medical or surgical conditions and shall follow the expedited
20 coverage determination requirements for substance abuse
21 treatment drugs set forth in Section 45.2 of the Managed Care
22 Reform and Patient Rights Act.

23 (e) This Section shall be interpreted in a manner
24 consistent with all applicable federal parity regulations
25 including, but not limited to, the Paul Wellstone and Pete
26 Domenici Mental Health Parity and Addiction Equity Act of

1 2008, final regulations issued under the Paul Wellstone and
2 Pete Domenici Mental Health Parity and Addiction Equity Act of
3 2008 and final regulations applying the Paul Wellstone and
4 Pete Domenici Mental Health Parity and Addiction Equity Act of
5 2008 to Medicaid managed care organizations, the Children's
6 Health Insurance Program, and alternative benefit plans.

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

10 (g) As used in this Section:

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

15 "Mental, emotional, nervous, or substance use disorder or
16 condition" means a condition or disorder that involves a
17 mental health condition or substance use disorder that falls
18 under any of the diagnostic categories listed in the mental
19 and behavioral disorders chapter of the current edition of the
20 International Classification of Disease or that is listed in
21 the most recent version of the Diagnostic and Statistical
22 Manual of Mental Disorders.

23 "Treatment limitation" includes limits on benefits based
24 on the frequency of treatment, number of visits, days of
25 coverage, days in a waiting period, or other similar limits on
26 the scope or duration of treatment. "Treatment limitation"

1 includes both quantitative treatment limitations, which are
2 expressed numerically (such as 50 outpatient visits per year),
3 and nonquantitative treatment limitations, which otherwise
4 limit the scope or duration of treatment. A permanent
5 exclusion of all benefits for a particular condition or
6 disorder shall not be considered a treatment limitation.
7 "Nonquantitative treatment" means those limitations as
8 described under federal regulations (26 CFR 54.9812-1).
9 "Nonquantitative treatment limitations" include, but are not
10 limited to, those limitations described under federal
11 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
12 146.136.

13 (h) The Department of Insurance shall implement the
14 following education initiatives:

15 (1) By January 1, 2016, the Department shall develop a
16 plan for a Consumer Education Campaign on parity. The
17 Consumer Education Campaign shall focus its efforts
18 throughout the State and include trainings in the
19 northern, southern, and central regions of the State, as
20 defined by the Department, as well as each of the 5 managed
21 care regions of the State as identified by the Department
22 of Healthcare and Family Services. Under this Consumer
23 Education Campaign, the Department shall: (1) by January
24 1, 2017, provide at least one live training in each region
25 on parity for consumers and providers and one webinar
26 training to be posted on the Department website and (2)

1 establish a consumer hotline to assist consumers in
2 navigating the parity process by March 1, 2017. By January
3 1, 2018 the Department shall issue a report to the General
4 Assembly on the success of the Consumer Education
5 Campaign, which shall indicate whether additional training
6 is necessary or would be recommended.

7 (2) The Department, in coordination with the
8 Department of Human Services and the Department of
9 Healthcare and Family Services, shall convene a working
10 group of health care insurance carriers, mental health
11 advocacy groups, substance abuse patient advocacy groups,
12 and mental health physician groups for the purpose of
13 discussing issues related to the treatment and coverage of
14 mental, emotional, nervous, or substance use disorders or
15 conditions and compliance with parity obligations under
16 State and federal law. Compliance shall be measured,
17 tracked, and shared during the meetings of the working
18 group. The working group shall meet once before January 1,
19 2016 and shall meet semiannually thereafter. The
20 Department shall issue an annual report to the General
21 Assembly that includes a list of the health care insurance
22 carriers, mental health advocacy groups, substance abuse
23 patient advocacy groups, and mental health physician
24 groups that participated in the working group meetings,
25 details on the issues and topics covered, and any
26 legislative recommendations developed by the working

1 group.

2 (3) Not later than January ~~August~~ 1 of each year, the
3 Department, in conjunction with the Department of
4 Healthcare and Family Services, shall issue a joint report
5 to the General Assembly and provide an educational
6 presentation to the General Assembly. The report and
7 presentation shall:

8 (A) Cover the methodology the Departments use to
9 check for compliance with the federal Paul Wellstone
10 and Pete Domenici Mental Health Parity and Addiction
11 Equity Act of 2008, 42 U.S.C. 18031(j), and any
12 federal regulations or guidance relating to the
13 compliance and oversight of the federal Paul Wellstone
14 and Pete Domenici Mental Health Parity and Addiction
15 Equity Act of 2008 and 42 U.S.C. 18031(j).

16 (B) Cover the methodology the Departments use to
17 check for compliance with this Section and Sections
18 356z.23 and 370c of this Code.

19 (C) Identify market conduct examinations or, in
20 the case of the Department of Healthcare and Family
21 Services, audits conducted or completed during the
22 preceding 12-month period regarding compliance with
23 parity in mental, emotional, nervous, and substance
24 use disorder or condition benefits under State and
25 federal laws and summarize the results of such market
26 conduct examinations and audits. This shall include:

1 (i) the number of market conduct examinations
2 and audits initiated and completed;

3 (ii) the benefit classifications examined by
4 each market conduct examination and audit;

5 (iii) the subject matter of each market
6 conduct examination and audit, including
7 quantitative and nonquantitative treatment
8 limitations; and

9 (iv) a summary of the basis for the final
10 decision rendered in each market conduct
11 examination and audit.

12 Individually identifiable information shall be
13 excluded from the reports consistent with federal
14 privacy protections.

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

21 (E) The report must be written in non-technical,
22 readily understandable language and shall be made
23 available to the public by, among such other means as
24 the Departments find appropriate, posting the report
25 on the Departments' websites.

26 (i) The Parity Advancement Fund is created as a special

1 fund in the State treasury. Moneys from fines and penalties
2 collected from insurers for violations of this Section shall
3 be deposited into the Fund. Moneys deposited into the Fund for
4 appropriation by the General Assembly to the Department shall
5 be used for the purpose of providing financial support of the
6 Consumer Education Campaign, parity compliance advocacy, and
7 other initiatives that support parity implementation and
8 enforcement on behalf of consumers.

9 (j) The Department of Insurance and the Department of
10 Healthcare and Family Services shall convene and provide
11 technical support to a workgroup of 11 members that shall be
12 comprised of 3 mental health parity experts recommended by an
13 organization advocating on behalf of mental health parity
14 appointed by the President of the Senate; 3 behavioral health
15 providers recommended by an organization that represents
16 behavioral health providers appointed by the Speaker of the
17 House of Representatives; 2 representing Medicaid managed care
18 organizations recommended by an organization that represents
19 Medicaid managed care plans appointed by the Minority Leader
20 of the House of Representatives; 2 representing commercial
21 insurers recommended by an organization that represents
22 insurers appointed by the Minority Leader of the Senate; and a
23 representative of an organization that represents Medicaid
24 managed care plans appointed by the Governor.

25 The workgroup shall provide recommendations to the General
26 Assembly on health plan data reporting requirements that

1 separately break out data on mental, emotional, nervous, or
2 substance use disorder or condition benefits and data on other
3 medical benefits, including physical health and related health
4 services no later than December 31, 2019. The recommendations
5 to the General Assembly shall be filed with the Clerk of the
6 House of Representatives and the Secretary of the Senate in
7 electronic form only, in the manner that the Clerk and the
8 Secretary shall direct. This workgroup shall take into account
9 federal requirements and recommendations on mental health
10 parity reporting for the Medicaid program. This workgroup
11 shall also develop the format and provide any needed
12 definitions for reporting requirements in subsection (k). The
13 research and evaluation of the working group shall include,
14 but not be limited to:

15 (1) claims denials due to benefit limits, if
16 applicable;

17 (2) administrative denials for no prior authorization;

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

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

21 (5) out-of-network claims;

22 (6) emergency care claims;

23 (7) network directory providers in the outpatient
24 benefits classification who filed no claims in the last 6
25 months, if applicable;

26 (8) the impact of existing and pertinent limitations

1 and restrictions related to approved services, licensed
2 providers, reimbursement levels, and reimbursement
3 methodologies within the Division of Mental Health, the
4 Division of Substance Use Prevention and Recovery
5 programs, the Department of Healthcare and Family
6 Services, and, to the extent possible, federal regulations
7 and law; and

8 (9) when reporting and publishing should begin.

9 Representatives from the Department of Healthcare and
10 Family Services, representatives from the Division of Mental
11 Health, and representatives from the Division of Substance Use
12 Prevention and Recovery shall provide technical advice to the
13 workgroup.

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

1 outpatient out-of-network benefits, emergency care benefits,
2 and prescription drug benefits in the case of accident and
3 health insurance or qualified health plans, or inpatient,
4 outpatient, emergency care, and prescription drug benefits in
5 the case of medical assistance:

6 (1) A summary of the plan's pharmacy management
7 processes for mental, emotional, nervous, or substance use
8 disorder or condition benefits compared to those for other
9 medical benefits.

10 (2) A summary of the internal processes of review for
11 experimental benefits and unproven technology for mental,
12 emotional, nervous, or substance use disorder or condition
13 benefits and those for other medical benefits.

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

18 (4) A description of the process used to develop or
19 select the medical necessity criteria for mental,
20 emotional, nervous, or substance use disorder or condition
21 benefits and the process used to develop or select the
22 medical necessity criteria for medical and surgical
23 benefits.

24 (5) Identification of all nonquantitative treatment
25 limitations that are applied to both mental, emotional,
26 nervous, or substance use disorder or condition benefits

1 and medical and surgical benefits within each
2 classification of benefits.

3 (6) The results of an analysis that demonstrates that
4 for the medical necessity criteria described in
5 subparagraph (A) and for each nonquantitative treatment
6 limitation identified in subparagraph (B), as written and
7 in operation, the processes, strategies, evidentiary
8 standards, or other factors used in applying the medical
9 necessity criteria and each nonquantitative treatment
10 limitation to mental, emotional, nervous, or substance use
11 disorder or condition benefits within each classification
12 of benefits are comparable to, and are applied no more
13 stringently than, the processes, strategies, evidentiary
14 standards, or other factors used in applying the medical
15 necessity criteria and each nonquantitative treatment
16 limitation to medical and surgical benefits within the
17 corresponding classification of benefits; at a minimum,
18 the results of the analysis shall:

19 (A) identify the factors used to determine that a
20 nonquantitative treatment limitation applies to a
21 benefit, including factors that were considered but
22 rejected;

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

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

11 (D) provide the comparative analyses, including
12 the results of the analyses, performed to determine
13 that the processes and strategies used to apply each
14 nonquantitative treatment limitation, in operation,
15 for mental, emotional, nervous, or substance use
16 disorder or condition benefits are comparable to, and
17 applied no more stringently than, the processes or
18 strategies used to apply each nonquantitative
19 treatment limitation, in operation, for medical and
20 surgical benefits; and

21 (E) disclose the specific findings and conclusions
22 reached by the insurer that the results of the
23 analyses described in subparagraphs (C) and (D)
24 indicate that the insurer is in compliance with this
25 Section and the Mental Health Parity and Addiction
26 Equity Act of 2008 and its implementing regulations,

1 which includes 42 CFR Parts 438, 440, and 457 and 45
2 CFR 146.136 and any other related federal regulations
3 found in the Code of Federal Regulations.

4 (7) Any other information necessary to clarify data
5 provided in accordance with this Section requested by the
6 Director, including information that may be proprietary or
7 have commercial value, under the requirements of Section
8 30 of the Viatical Settlements Act of 2009.

9 (1) An insurer that amends, delivers, issues, or renews a
10 group or individual policy of accident and health insurance or
11 a qualified health plan offered through the health insurance
12 marketplace in this State providing coverage for hospital or
13 medical treatment and for the treatment of mental, emotional,
14 nervous, or substance use disorders or conditions on or after
15 the effective date of this amendatory Act of the 100th General
16 Assembly shall, in advance of the plan year, make available to
17 the Department or, with respect to medical assistance, the
18 Department of Healthcare and Family Services and to all plan
19 participants and beneficiaries the information required in
20 subparagraphs (C) through (E) of paragraph (6) of subsection
21 (k). For plan participants and medical assistance
22 beneficiaries, the information required in subparagraphs (C)
23 through (E) of paragraph (6) of subsection (k) shall be made
24 available on a publicly-available website whose web address is
25 prominently displayed in plan and managed care organization
26 informational and marketing materials.

1 (m) In conjunction with its compliance examination program
2 conducted in accordance with the Illinois State Auditing Act,
3 the Auditor General shall undertake a review of compliance by
4 the Department and the Department of Healthcare and Family
5 Services with Section 370c and this Section. Any findings
6 resulting from the review conducted under this Section shall
7 be included in the applicable State agency's compliance
8 examination report. Each compliance examination report shall
9 be issued in accordance with Section 3-14 of the Illinois
10 State Auditing Act. A copy of each report shall also be
11 delivered to the head of the applicable State agency and
12 posted on the Auditor General's website.

13 (Source: P.A. 99-480, eff. 9-9-15; 100-1024, eff. 1-1-19.)

14 Section 10. The Health Carrier External Review Act is
15 amended by changing Sections 35 and 40 as follows:

16 (215 ILCS 180/35)

17 Sec. 35. Standard external review.

18 (a) Within 4 months after the date of receipt of a notice
19 of an adverse determination or final adverse determination, a
20 covered person or the covered person's authorized
21 representative may file a request for an external review with
22 the Director. Within one business day after the date of
23 receipt of a request for external review, the Director shall
24 send a copy of the request to the health carrier.

1 (b) Within 5 business days following the date of receipt
2 of the external review request, the health carrier shall
3 complete a preliminary review of the request to determine
4 whether:

5 (1) the individual is or was a covered person in the
6 health benefit plan at the time the health care service
7 was requested or at the time the health care service was
8 provided;

9 (2) the health care service that is the subject of the
10 adverse determination or the final adverse determination
11 is a covered service under the covered person's health
12 benefit plan, but the health carrier has determined that
13 the health care service is not covered;

14 (3) the covered person has exhausted the health
15 carrier's internal appeal process unless the covered
16 person is not required to exhaust the health carrier's
17 internal appeal process pursuant to this Act;

18 (4) (blank); and

19 (5) the covered person has provided all the
20 information and forms required to process an external
21 review, as specified in this Act.

22 (c) Within one business day after completion of the
23 preliminary review, the health carrier shall notify the
24 Director and covered person and, if applicable, the covered
25 person's authorized representative in writing whether the
26 request is complete and eligible for external review. If the

1 request:

2 (1) is not complete, the health carrier shall inform
3 the Director and covered person and, if applicable, the
4 covered person's authorized representative in writing and
5 include in the notice what information or materials are
6 required by this Act to make the request complete; or

7 (2) is not eligible for external review, the health
8 carrier shall inform the Director and covered person and,
9 if applicable, the covered person's authorized
10 representative in writing and include in the notice the
11 reasons for its ineligibility.

12 The Department may specify the form for the health
13 carrier's notice of initial determination under this
14 subsection (c) and any supporting information to be included
15 in the notice.

16 The notice of initial determination of ineligibility shall
17 include a statement informing the covered person and, if
18 applicable, the covered person's authorized representative
19 that a health carrier's initial determination that the
20 external review request is ineligible for review may be
21 appealed to the Director by filing a complaint with the
22 Director.

23 Notwithstanding a health carrier's initial determination
24 that the request is ineligible for external review, the
25 Director may determine that a request is eligible for external
26 review and require that it be referred for external review. In

1 making such determination, the Director's decision shall be in
2 accordance with the terms of the covered person's health
3 benefit plan, unless such terms are inconsistent with
4 applicable law, and shall be subject to all applicable
5 provisions of this Act.

6 (d) Whenever the Director receives notice that a request
7 is eligible for external review following the preliminary
8 review conducted pursuant to this Section, within one business
9 day after the date of receipt of the notice, the Director
10 shall:

11 (1) assign an independent review organization from the
12 list of approved independent review organizations compiled
13 and maintained by the Director pursuant to this Act and
14 notify the health carrier of the name of the assigned
15 independent review organization; and

16 (2) notify in writing the covered person and, if
17 applicable, the covered person's authorized representative
18 of the request's eligibility and acceptance for external
19 review and the name of the independent review
20 organization.

21 The Director shall include in the notice provided to the
22 covered person and, if applicable, the covered person's
23 authorized representative a statement that the covered person
24 or the covered person's authorized representative may, within
25 5 business days following the date of receipt of the notice
26 provided pursuant to item (2) of this subsection (d), submit

1 in writing to the assigned independent review organization
2 additional information that the independent review
3 organization shall consider when conducting the external
4 review. The independent review organization is not required
5 to, but may, accept and consider additional information
6 submitted after 5 business days.

7 (e) The assignment by the Director of an approved
8 independent review organization to conduct an external review
9 in accordance with this Section shall be done on a random basis
10 among those independent review organizations approved by the
11 Director pursuant to this Act.

12 (f) Within 5 business days after the date of receipt of the
13 notice provided pursuant to item (1) of subsection (d) of this
14 Section, the health carrier or its designee utilization review
15 organization shall provide to the assigned independent review
16 organization the documents and any information considered in
17 making the adverse determination or final adverse
18 determination; in such cases, the following provisions shall
19 apply:

20 (1) Except as provided in item (2) of this subsection
21 (f), failure by the health carrier or its utilization
22 review organization to provide the documents and
23 information within the specified time frame shall not
24 delay the conduct of the external review.

25 (2) If the health carrier or its utilization review
26 organization fails to provide the documents and

1 information within the specified time frame, the assigned
2 independent review organization may terminate the external
3 review and make a decision to reverse the adverse
4 determination or final adverse determination.

5 (3) Within one business day after making the decision
6 to terminate the external review and make a decision to
7 reverse the adverse determination or final adverse
8 determination under item (2) of this subsection (f), the
9 independent review organization shall notify the Director,
10 the health carrier, the covered person and, if applicable,
11 the covered person's authorized representative, of its
12 decision to reverse the adverse determination.

13 (g) Upon receipt of the information from the health
14 carrier or its utilization review organization, the assigned
15 independent review organization shall review all of the
16 information and documents and any other information submitted
17 in writing to the independent review organization by the
18 covered person and the covered person's authorized
19 representative.

20 (h) Upon receipt of any information submitted by the
21 covered person or the covered person's authorized
22 representative, the independent review organization shall
23 forward the information to the health carrier within 1
24 business day.

25 (1) Upon receipt of the information, if any, the
26 health carrier may reconsider its adverse determination or

1 final adverse determination that is the subject of the
2 external review.

3 (2) Reconsideration by the health carrier of its
4 adverse determination or final adverse determination shall
5 not delay or terminate the external review.

6 (3) The external review may only be terminated if the
7 health carrier decides, upon completion of its
8 reconsideration, to reverse its adverse determination or
9 final adverse determination and provide coverage or
10 payment for the health care service that is the subject of
11 the adverse determination or final adverse determination.
12 In such cases, the following provisions shall apply:

13 (A) Within one business day after making the
14 decision to reverse its adverse determination or final
15 adverse determination, the health carrier shall notify
16 the Director, the covered person and, if applicable,
17 the covered person's authorized representative, and
18 the assigned independent review organization in
19 writing of its decision.

20 (B) Upon notice from the health carrier that the
21 health carrier has made a decision to reverse its
22 adverse determination or final adverse determination,
23 the assigned independent review organization shall
24 terminate the external review.

25 (i) In addition to the documents and information provided
26 by the health carrier or its utilization review organization

1 and the covered person and the covered person's authorized
2 representative, if any, the independent review organization,
3 to the extent the information or documents are available and
4 the independent review organization considers them
5 appropriate, shall consider the following in reaching a
6 decision:

7 (1) the covered person's pertinent medical records;

8 (2) the covered person's health care provider's
9 recommendation;

10 (3) consulting reports from appropriate health care
11 providers and other documents submitted by the health
12 carrier or its designee utilization review organization,
13 the covered person, the covered person's authorized
14 representative, or the covered person's treating provider;

15 (4) the terms of coverage under the covered person's
16 health benefit plan with the health carrier to ensure that
17 the independent review organization's decision is not
18 contrary to the terms of coverage under the covered
19 person's health benefit plan with the health carrier,
20 unless the terms are inconsistent with applicable law;

21 (5) the most appropriate practice guidelines, which
22 shall include applicable evidence-based standards and may
23 include any other practice guidelines developed by the
24 federal government, national or professional medical
25 societies, boards, and associations;

26 (6) any applicable clinical review criteria developed

1 and used by the health carrier or its designee utilization
2 review organization;

3 (7) the opinion of the independent review
4 organization's clinical reviewer or reviewers after
5 considering items (1) through (6) of this subsection (i)
6 to the extent the information or documents are available
7 and the clinical reviewer or reviewers considers the
8 information or documents appropriate;

9 (8) (blank); and

10 (9) in the case of medically necessary determinations
11 for substance use disorders, the patient placement
12 criteria established by the American Society of Addiction
13 Medicine.

14 (i-5) For an adverse determination or final adverse
15 determination involving mental, emotional, nervous, or
16 substance use disorders or conditions, the independent review
17 organization shall:

18 (1) consider the documents and information as set
19 forth in subsection (i), except that all practice
20 guidelines and clinical review criteria must be consistent
21 with the requirements set forth in Section 370c of the
22 Illinois Insurance Code; and

23 (2) make its decision, pursuant to subsection (j),
24 whether to uphold or reverse the adverse determination or
25 final adverse determination based on whether the service
26 constitutes medically necessary treatment of a mental,

1 emotional, nervous, or substance use disorders or
2 condition as defined in Section 370c of the Illinois
3 Insurance Code.

4 (j) Within 5 days after the date of receipt of all
5 necessary information, but in no event more than 45 days after
6 the date of receipt of the request for an external review, the
7 assigned independent review organization shall provide written
8 notice of its decision to uphold or reverse the adverse
9 determination or the final adverse determination to the
10 Director, the health carrier, the covered person, and, if
11 applicable, the covered person's authorized representative. In
12 reaching a decision, the assigned independent review
13 organization is not bound by any claim determinations reached
14 prior to the submission of information to the independent
15 review organization. In such cases, the following provisions
16 shall apply:

17 (1) The independent review organization shall include
18 in the notice:

19 (A) a general description of the reason for the
20 request for external review;

21 (B) the date the independent review organization
22 received the assignment from the Director to conduct
23 the external review;

24 (C) the time period during which the external
25 review was conducted;

26 (D) references to the evidence or documentation,

1 including the evidence-based standards, considered in
2 reaching its decision;

3 (E) the date of its decision;

4 (F) the principal reason or reasons for its
5 decision, including what applicable, if any,
6 evidence-based standards that were a basis for its
7 decision; and

8 (G) the rationale for its decision.

9 (2) (Blank).

10 (3) (Blank).

11 (4) Upon receipt of a notice of a decision reversing
12 the adverse determination or final adverse determination,
13 the health carrier immediately shall approve the coverage
14 that was the subject of the adverse determination or final
15 adverse determination.

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

17 (215 ILCS 180/40)

18 Sec. 40. Expedited external review.

19 (a) A covered person or a covered person's authorized
20 representative may file a request for an expedited external
21 review with the Director either orally or in writing:

22 (1) immediately after the date of receipt of a notice
23 prior to a final adverse determination as provided by
24 subsection (b) of Section 20 of this Act;

25 (2) immediately after the date of receipt of a notice

1 upon final adverse determination as provided by subsection
2 (c) of Section 20 of this Act; or

3 (3) if a health carrier fails to provide a decision on
4 request for an expedited internal appeal within 48 hours
5 as provided by item (2) of Section 30 of this Act.

6 (b) Upon receipt of a request for an expedited external
7 review, the Director shall immediately send a copy of the
8 request to the health carrier. Immediately upon receipt of the
9 request for an expedited external review, the health carrier
10 shall determine whether the request meets the reviewability
11 requirements set forth in subsection (b) of Section 35. In
12 such cases, the following provisions shall apply:

13 (1) The health carrier shall immediately notify the
14 Director, the covered person, and, if applicable, the
15 covered person's authorized representative of its
16 eligibility determination.

17 (2) The notice of initial determination shall include
18 a statement informing the covered person and, if
19 applicable, the covered person's authorized representative
20 that a health carrier's initial determination that an
21 external review request is ineligible for review may be
22 appealed to the Director.

23 (3) The Director may determine that a request is
24 eligible for expedited external review notwithstanding a
25 health carrier's initial determination that the request is
26 ineligible and require that it be referred for external

1 review.

2 (4) In making a determination under item (3) of this
3 subsection (b), the Director's decision shall be made in
4 accordance with the terms of the covered person's health
5 benefit plan, unless such terms are inconsistent with
6 applicable law, and shall be subject to all applicable
7 provisions of this Act.

8 (5) The Director may specify the form for the health
9 carrier's notice of initial determination under this
10 subsection (b) and any supporting information to be
11 included in the notice.

12 (c) Upon receipt of the notice that the request meets the
13 reviewability requirements, the Director shall immediately
14 assign an independent review organization from the list of
15 approved independent review organizations compiled and
16 maintained by the Director to conduct the expedited review. In
17 such cases, the following provisions shall apply:

18 (1) The assignment of an approved independent review
19 organization to conduct an external review in accordance
20 with this Section shall be made from those approved
21 independent review organizations qualified to conduct
22 external review as required by Sections 50 and 55 of this
23 Act.

24 (2) The Director shall immediately notify the health
25 carrier of the name of the assigned independent review
26 organization. Immediately upon receipt from the Director

1 of the name of the independent review organization
2 assigned to conduct the external review, but in no case
3 more than 24 hours after receiving such notice, the health
4 carrier or its designee utilization review organization
5 shall provide or transmit all necessary documents and
6 information considered in making the adverse determination
7 or final adverse determination to the assigned independent
8 review organization electronically or by telephone or
9 facsimile or any other available expeditious method.

10 (3) If the health carrier or its utilization review
11 organization fails to provide the documents and
12 information within the specified timeframe, the assigned
13 independent review organization may terminate the external
14 review and make a decision to reverse the adverse
15 determination or final adverse determination.

16 (4) Within one business day after making the decision
17 to terminate the external review and make a decision to
18 reverse the adverse determination or final adverse
19 determination under item (3) of this subsection (c), the
20 independent review organization shall notify the Director,
21 the health carrier, the covered person, and, if
22 applicable, the covered person's authorized representative
23 of its decision to reverse the adverse determination or
24 final adverse determination.

25 (d) In addition to the documents and information provided
26 by the health carrier or its utilization review organization

1 and any documents and information provided by the covered
2 person and the covered person's authorized representative, the
3 independent review organization, to the extent the information
4 or documents are available and the independent review
5 organization considers them appropriate, shall consider
6 information as required by subsection (i) of Section 35 of
7 this Act in reaching a decision.

8 (d-5) For expedited external reviews involving mental,
9 emotional, nervous, or substance use disorders or conditions,
10 the independent review organization shall consider documents
11 and information and shall make a decision to uphold or reverse
12 the adverse determination or final adverse determination
13 pursuant to subsection (i-5) of Section 35.

14 (e) As expeditiously as the covered person's medical
15 condition or circumstances requires, but in no event more than
16 72 hours after the date of receipt of the request for an
17 expedited external review, the assigned independent review
18 organization shall:

19 (1) make a decision to uphold or reverse the final
20 adverse determination; and

21 (2) notify the Director, the health carrier, the
22 covered person, the covered person's health care provider,
23 and, if applicable, the covered person's authorized
24 representative, of the decision.

25 (f) In reaching a decision, the assigned independent
26 review organization is not bound by any decisions or

1 conclusions reached during the health carrier's utilization
2 review process or the health carrier's internal appeal
3 process.

4 (g) Upon receipt of notice of a decision reversing the
5 adverse determination or final adverse determination, the
6 health carrier shall immediately approve the coverage that was
7 the subject of the adverse determination or final adverse
8 determination.

9 (h) If the notice provided pursuant to subsection (e) of
10 this Section was not in writing, then within 48 hours after the
11 date of providing that notice, the assigned independent review
12 organization shall provide written confirmation of the
13 decision to the Director, the health carrier, the covered
14 person, and, if applicable, the covered person's authorized
15 representative including the information set forth in
16 subsection (j) of Section 35 of this Act as applicable.

17 (i) An expedited external review may not be provided for
18 retrospective adverse or final adverse determinations.

19 (j) The assignment by the Director of an approved
20 independent review organization to conduct an external review
21 in accordance with this Section shall be done on a random basis
22 among those independent review organizations approved by the
23 Director pursuant to this Act.

24 (Source: P.A. 96-857, eff. 7-1-10; 97-333, eff. 8-12-11;
25 97-574, eff. 8-26-11.)

26 Section 99. Effective date. This Act takes effect January

1 1, 2022, except that this Section and the changes to Section
2 370c.1 of the Illinois Insurance Code take effect upon
3 becoming law.