



## 102ND GENERAL ASSEMBLY

### State of Illinois

2021 and 2022

SB0697

Introduced 2/25/2021, by Sen. Laura Fine

#### SYNOPSIS AS INTRODUCED:

215 ILCS 5/370c  
215 ILCS 180/35  
215 ILCS 180/40

from Ch. 73, par. 982c

Amends the Illinois Insurance Code. Provides that every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in the State and Medicaid managed care organizations providing coverage for hospital or medical treatment shall provide coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions. Provides that an insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public program. Provides that an insurer shall base any medical necessity determination or the utilization review criteria on current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care. Provides that in conducting utilization review of covered health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, and nervous disorders or conditions in children, adolescents, and adults, an insurer shall exclusively apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Provides that an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in the treatment criteria. Provides that the Director may, after appropriate notice and opportunity for hearing, assess a civil penalty between \$5,000 and \$20,000 for each violation. Amends the Health Carrier External Review Act. Provides that independent review organization shall comply with specified requirements for an adverse determination or final adverse determination involving mental, emotional, nervous, or substance use disorders or conditions. Makes other changes. Effective immediately.

LRB102 17144 BMS 22576 b

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 the U.S. Center for Disease Control and  
8 Prevention, children with adverse childhood experiences  
9 are more likely to experience negative outcomes like  
10 post-traumatic stress disorder, increased anxiety and  
11 depression, suicide, and substance use. A 2020 report from  
12 Mental Health America shows that 62.1% of Illinois youth  
13 with severe depression do not receive any mental health  
14 treatment. Survey results found that 80% of college  
15 students report that COVID-19 has negatively impacted  
16 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 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 Section 370c 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. Changes in terminology,  
12 organization, or classification of mental, emotional, nervous,  
13 or substance use disorder or condition in future versions of  
14 the American Psychiatric Association's Diagnostic and  
15 Statistical Manual of Mental Disorders or the World Health  
16 Organization's International Statistical Classification of  
17 Diseases and Related Health Problems shall not affect the  
18 conditions covered by this Section as long as a condition is  
19 commonly understood to be a mental, emotional, nervous, or  
20 substance use disorder or condition by health care providers  
21 practicing in relevant clinical specialties. "Mental,  
22 emotional, nervous, or substance use disorder or condition"  
23 includes any mental health condition that occurs during  
24 pregnancy or during the postpartum period and includes, but is  
25 not limited to, postpartum depression.

26 (5) Medically necessary treatment and medical necessity

1 determinations shall be interpreted and made in a manner that  
2 is consistent with and pursuant to subsections (h) through  
3 (t).

4 (b) (1) (Blank).

5 (2) (Blank).

6 (2.5) (Blank).

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

1 reimbursement for the treatment. Future contractual or  
2 employment actions by the insurer regarding the patient's  
3 provider may not be based on the provider's participation in  
4 this procedure. Nothing prevents the insured from agreeing in  
5 writing to continue treatment at his or her expense. When  
6 making a determination of the medical necessity for a  
7 treatment modality for mental, emotional, nervous, or  
8 substance use disorders or conditions, an insurer must make  
9 the determination in a manner that is consistent with the  
10 manner used to make that determination with respect to other  
11 diseases or illnesses covered under the policy, including an  
12 appeals process. Medical necessity determinations for  
13 substance use disorders shall be made in accordance with  
14 appropriate patient placement criteria established by the  
15 American Society of Addiction Medicine. No additional criteria  
16 may be used to make medical necessity determinations for  
17 substance use disorders.

18 (4) A group health benefit plan amended, delivered,  
19 issued, or renewed on or after January 1, 2019 (the effective  
20 date of Public Act 100-1024) or an individual policy of  
21 accident and health insurance or a qualified health plan  
22 offered through the health insurance marketplace amended,  
23 delivered, issued, or renewed on or after January 1, 2019 (the  
24 effective date of Public Act 100-1024):

25 (A) shall provide coverage based upon medical  
26 necessity for the treatment of a mental, emotional,

1 nervous, or substance use disorder or condition consistent  
2 with the parity requirements of Section 370c.1 of this  
3 Code; provided, however, that in each calendar year  
4 coverage shall not be less than the following:

5 (i) 45 days of inpatient treatment; and

6 (ii) beginning on June 26, 2006 (the effective  
7 date of Public Act 94-921), 60 visits for outpatient  
8 treatment including group and individual outpatient  
9 treatment; and

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

17 (B) may not include a lifetime limit on the number of  
18 days of inpatient treatment or the number of outpatient  
19 visits covered under the plan.

20 (C) (Blank).

21 (5) An issuer of a group health benefit plan or an  
22 individual policy of accident and health insurance or a  
23 qualified health plan offered through the health insurance  
24 marketplace may not count toward the number of outpatient  
25 visits required to be covered under this Section an outpatient  
26 visit for the purpose of medication management and shall cover

1 the outpatient visits under the same terms and conditions as  
2 it covers outpatient visits for the treatment of physical  
3 illness.

4 (5.5) An individual or group health benefit plan amended,  
5 delivered, issued, or renewed on or after September 9, 2015  
6 (the effective date of Public Act 99-480) shall offer coverage  
7 for medically necessary acute treatment services and medically  
8 necessary clinical stabilization services. The treating  
9 provider shall base all treatment recommendations and the  
10 health benefit plan shall base all medical necessity  
11 determinations for substance use disorders in accordance with  
12 the most current edition of the Treatment Criteria for  
13 Addictive, Substance-Related, and Co-Occurring Conditions  
14 established by the American Society of Addiction Medicine. The  
15 treating provider shall base all treatment recommendations and  
16 the health benefit plan shall base all medical necessity  
17 determinations for medication-assisted treatment in accordance  
18 with the most current Treatment Criteria for Addictive,  
19 Substance-Related, and Co-Occurring Conditions established by  
20 the American Society of Addiction Medicine.

21 As used in this subsection:

22 "Acute treatment services" means 24-hour medically  
23 supervised addiction treatment that provides evaluation and  
24 withdrawal management and may include biopsychosocial  
25 assessment, individual and group counseling, psychoeducational  
26 groups, and discharge planning.



1 "Clinical stabilization services" means 24-hour treatment,  
2 usually following acute treatment services for substance  
3 abuse, which may include intensive education and counseling  
4 regarding the nature of addiction and its consequences,  
5 relapse prevention, outreach to families and significant  
6 others, and aftercare planning for individuals beginning to  
7 engage in recovery from addiction.

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

11 (6.5) An individual or group health benefit plan amended,  
12 delivered, issued, or renewed on or after January 1, 2019 (the  
13 effective date of Public Act 100-1024):

14 (A) shall not impose prior authorization requirements,  
15 other than those established under the Treatment Criteria  
16 for Addictive, Substance-Related, and Co-Occurring  
17 Conditions established by the American Society of  
18 Addiction Medicine, on a prescription medication approved  
19 by the United States Food and Drug Administration that is  
20 prescribed or administered for the treatment of substance  
21 use disorders;

22 (B) shall not impose any step therapy requirements,  
23 other than those established under the Treatment Criteria  
24 for Addictive, Substance-Related, and Co-Occurring  
25 Conditions established by the American Society of  
26 Addiction Medicine, before authorizing coverage for a

1 prescription medication approved by the United States Food  
2 and Drug Administration that is prescribed or administered  
3 for the treatment of substance use disorders;

4 (C) shall place all prescription medications approved  
5 by the United States Food and Drug Administration  
6 prescribed or administered for the treatment of substance  
7 use disorders on, for brand medications, the lowest tier  
8 of the drug formulary developed and maintained by the  
9 individual or group health benefit plan that covers brand  
10 medications and, for generic medications, the lowest tier  
11 of the drug formulary developed and maintained by the  
12 individual or group health benefit plan that covers  
13 generic medications; and

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

20 (7) (Blank).

21 (8) (Blank).

22 (9) With respect to all mental, emotional, nervous, or  
23 substance use disorders or conditions, coverage for inpatient  
24 treatment shall include coverage for treatment in a  
25 residential treatment center certified or licensed by the  
26 Department of Public Health or the Department of Human

1 Services.

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

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

23 (1) proactively ensuring compliance by individual and  
24 group policies, including by requiring that insurers  
25 submit comparative analyses, as set forth in paragraph (6)  
26 of subsection (k) of Section 370c.1, demonstrating how

1           they design and apply nonquantitative treatment  
2           limitations, both as written and in operation, for mental,  
3           emotional, nervous, or substance use disorder or condition  
4           benefits as compared to how they design and apply  
5           nonquantitative treatment limitations, as written and in  
6           operation, for medical and surgical benefits;

7           (2) evaluating all consumer or provider complaints  
8           regarding mental, emotional, nervous, or substance use  
9           disorder or condition coverage for possible parity  
10          violations;

11          (3) performing parity compliance market conduct  
12          examinations or, in the case of the Department of  
13          Healthcare and Family Services, parity compliance audits  
14          of individual and group plans and policies, including, but  
15          not limited to, reviews of:

16                (A) nonquantitative treatment limitations,  
17                including, but not limited to, prior authorization  
18                requirements, concurrent review, retrospective review,  
19                step therapy, network admission standards,  
20                reimbursement rates, and geographic restrictions;

21                (B) denials of authorization, payment, and  
22                coverage; and

23                (C) other specific criteria as may be determined  
24                by the Department.

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

1           The Director may adopt rules to effectuate any provisions  
2 of the Paul Wellstone and Pete Domenici Mental Health Parity  
3 and Addiction Equity Act of 2008 that relate to the business of  
4 insurance.

5           (e) Availability of plan information.

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

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

1 understandable language by the plan administrator (or the  
2 health insurance issuer offering such coverage) to the  
3 participant or beneficiary upon request.

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

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

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

21 "Benefits", with respect to managed care organizations,  
22 means the benefits provided for treatment services for  
23 inpatient and outpatient treatment of substance use disorders  
24 or conditions at American Society of Addiction Medicine levels  
25 of treatment 2.1 (Intensive Outpatient), 2.5 (Partial  
26 Hospitalization), 3.5 (Clinically Managed High-Intensity

1 Residential), and 3.7 (Medically Monitored Intensive  
2 Inpatient) and OMT (Opioid Maintenance Therapy) services.

3 "Substance use disorder treatment provider or facility"  
4 means a licensed physician, licensed psychologist, licensed  
5 psychiatrist, licensed advanced practice registered nurse, or  
6 licensed, certified, or otherwise State-approved facility or  
7 provider of substance use disorder treatment.

8 (2) A group health insurance policy, an individual health  
9 benefit plan, or qualified health plan that is offered through  
10 the health insurance marketplace, small employer group health  
11 plan, and large employer group health plan that is amended,  
12 delivered, issued, executed, or renewed in this State, or  
13 approved for issuance or renewal in this State, on or after  
14 January 1, 2019 (the effective date of Public Act 100-1023)  
15 shall comply with the requirements of this Section and Section  
16 370c.1. The services for the treatment and the ongoing  
17 assessment of the patient's progress in treatment shall follow  
18 the requirements of 77 Ill. Adm. Code 2060.

19 (3) Prior authorization shall not be utilized for the  
20 benefits under this subsection. The substance use disorder  
21 treatment provider or facility shall notify the insurer of the  
22 initiation of treatment. For an insurer that is not a managed  
23 care organization, the substance use disorder treatment  
24 provider or facility notification shall occur for the  
25 initiation of treatment of the covered person within 2  
26 business days. For managed care organizations, the substance

1 use disorder treatment provider or facility notification shall  
2 occur in accordance with the protocol set forth in the  
3 provider agreement for initiation of treatment within 24  
4 hours. If the managed care organization is not capable of  
5 accepting the notification in accordance with the contractual  
6 protocol during the 24-hour period following admission, the  
7 substance use disorder treatment provider or facility shall  
8 have one additional business day to provide the notification  
9 to the appropriate managed care organization. Treatment plans  
10 shall be developed in accordance with the requirements and  
11 timeframes established in 77 Ill. Adm. Code 2060. If the  
12 substance use disorder treatment provider or facility fails to  
13 notify the insurer of the initiation of treatment in  
14 accordance with these provisions, the insurer may follow its  
15 normal prior authorization processes.

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

25 Pursuant to the requirements of the Health Carrier  
26 External Review Act, the covered person or the covered



1 person's authorized representative may request an expedited  
2 external review. An expedited external review may not occur if  
3 the substance use disorder treatment provider or facility  
4 determines that continued treatment is no longer medically  
5 necessary. Under this subsection, a request for expedited  
6 external review must be initiated within 24 hours following  
7 the adverse determination notification by the insurer. Failure  
8 to request an expedited external review within 24 hours shall  
9 preclude a covered person or a covered person's authorized  
10 representative from requesting an expedited external review.

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

21 (5) The substance use disorder treatment provider or  
22 facility shall provide the insurer with 7 business days'  
23 advance notice of the planned discharge of the patient from  
24 the substance use disorder treatment provider or facility and  
25 notice on the day that the patient is discharged from the  
26 substance use disorder treatment provider or facility.

1           (6) The benefits required by this subsection shall be  
2 provided to all covered persons with a diagnosis of substance  
3 use disorder or conditions. The presence of additional related  
4 or unrelated diagnoses shall not be a basis to reduce or deny  
5 the benefits required by this subsection.

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

9           (h) As used in this Section:

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

26           "Medically necessary treatment of mental, emotional,

1 nervous, or substance use disorders or conditions" means a  
2 service or product addressing the specific needs of that  
3 patient, for the purpose of screening, preventing, diagnosing,  
4 managing, or treating an illness, injury, condition, or its  
5 symptoms, including minimizing the progression of an illness,  
6 injury, condition, or its symptoms in a manner that is all of  
7 the following:

8 (1) in accordance with the generally accepted  
9 standards of mental, emotional, nervous, or substance use  
10 disorder or condition care;

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

13 (3) not primarily for the economic benefit of the  
14 insurer, purchaser, or for the convenience of the patient,  
15 treating physician, or other health care provider.

16 "Utilization review" means either of the following:

17 (1) prospectively, retrospectively, or concurrently  
18 reviewing and approving, modifying, delaying, or denying,  
19 based in whole or in part on medical necessity, requests  
20 by health care providers, insureds, or their authorized  
21 representatives for coverage of health care services  
22 before, retrospectively, or concurrently with the  
23 provision of health care services to insureds.

24 (2) evaluating the medical necessity, appropriateness,  
25 level of care, service intensity, efficacy, or efficiency  
26 of health care services, benefits, procedures, or

1 settings, under any circumstances, to determine whether a  
2 health care service or benefit subject to a medical  
3 necessity coverage requirement in an insurance policy is  
4 covered as medically necessary for an insured.

5 "Utilization review criteria" means patient placement  
6 criteria or any criteria, standards, protocols, or guidelines  
7 used by an insurer to conduct utilization review.

8 (i)(1) Every insurer that amends, delivers, issues, or  
9 renews a group or individual policy of accident and health  
10 insurance or a qualified health plan offered through the  
11 health insurance marketplace in this State and Medicaid  
12 managed care organizations providing coverage for hospital or  
13 medical treatment on or after January 1, 2022 shall, pursuant  
14 to subsections (h) through (s), provide coverage for medically  
15 necessary treatment of mental, emotional, nervous, or  
16 substance use disorders or conditions.

17 (2) An insurer shall not limit benefits or coverage for  
18 mental, emotional, nervous, or substance use disorders or  
19 conditions to short-term or acute treatment at any level of  
20 placement.

21 (3) All medical necessity determinations made by the  
22 insurer concerning service intensity, level of care placement,  
23 continued stay, and transfer or discharge of insureds  
24 diagnosed with mental, emotional, nervous, or substance use  
25 disorders or conditions shall be conducted in accordance with  
26 the requirements of subsections (k) through (u).

1       (4) An insurer that authorizes a specific type of  
2 treatment by a provider pursuant to this Section shall not  
3 rescind or modify the authorization after that provider  
4 renders the health care service in good faith and pursuant to  
5 this authorization for any reason, including, but not limited  
6 to, the insurer's subsequent rescission, cancellation, or  
7 modification of the insured's or policyholder's contract, or  
8 the insured's or policyholder's eligibility.

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

18       (k) An insurer shall base any medical necessity  
19 determination or the utilization review criteria that the  
20 insurer, and any entity acting on the insurer's behalf,  
21 applies to determine the medical necessity of health care  
22 services and benefits for the diagnosis, prevention, and  
23 treatment of mental, emotional, nervous, or substance use  
24 disorders or conditions on current generally accepted  
25 standards of mental, emotional, nervous, or substance use  
26 disorder or condition care. All denials and appeals shall be

1 reviewed by a professional with experience or expertise  
2 comparable to the provider requesting the authorization.

3 (l) In conducting utilization review of all covered health  
4 care services and benefits for the diagnosis, prevention, and  
5 treatment of mental, emotional, and nervous disorders or  
6 conditions in children, adolescents, and adults, an insurer  
7 shall exclusively apply the criteria and guidelines set forth  
8 in the most recent versions of the treatment criteria  
9 developed by the nonprofit professional association for the  
10 relevant clinical specialty. Pursuant to subsection (b), in  
11 conducting utilization review of all covered services and  
12 benefits for the diagnosis, prevention, and treatment of  
13 substance use disorders an insurer shall use the most recent  
14 edition of the patient placement criteria established by the  
15 American Society of Addiction Medicine.

16 (m) In conducting utilization review involving level of  
17 care placement decisions or any other patient care decisions  
18 that are within the scope of the sources specified in  
19 subsection (l), an insurer shall not apply different,  
20 additional, conflicting, or more restrictive utilization  
21 review criteria than the criteria and guidelines set forth in  
22 those sources. For all level of care placement decisions, the  
23 insurer shall authorize placement at the level of care  
24 consistent with the assessment of the insured using the  
25 relevant criteria and guidelines as specified in subsection  
26 (l). If that level of placement is not available, the insurer

1 shall authorize the next higher level of care. In the event of  
2 disagreement, the insurer shall provide full detail of its  
3 assessment using the relevant criteria and guidelines as  
4 specified in subsection (l) to the provider of the service.

5 (n) An insurer shall only engage applicable qualified  
6 providers in the treatment of mental, emotional, nervous, or  
7 substance use disorders or conditions or the appropriate  
8 subspecialty therein and who possess an active professional  
9 license or certificate, to review, approve, or deny services.

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) Sponsor a formal education program by nonprofit  
18 clinical specialty associations to educate the insurer's  
19 staff, including any third parties contracted with the  
20 insurer to review claims, conduct utilization reviews, or  
21 make medical necessity determinations about the clinical  
22 review criteria.

23 (2) Make the education program available to other  
24 stakeholders, including the insurer's participating or  
25 contracted providers and potential participants,  
26 beneficiaries, or covered lives. The education program

1 must be provided, at minimum, on a quarterly basis,  
2 in-person or digitally, or recordings of the education  
3 program must be made available to the aforementioned  
4 stakeholders.

5 (3) Provide, at no cost, the clinical review criteria  
6 and any training material or resources to providers and  
7 insured patients.

8 (4) Track, identify, and analyze how the clinical  
9 review criteria are used to certify care, deny care, and  
10 support the appeals process.

11 (5) Conduct interrater reliability testing to ensure  
12 consistency in utilization review decision making that  
13 covers how medical necessity decisions are made; this  
14 assessment shall cover all aspects of utilization review  
15 as defined in subsection (h).

16 (6) Run interrater reliability reports about how the  
17 clinical guidelines are used in conjunction with the  
18 utilization review process and parity compliance  
19 activities.

20 (7) Achieve interrater reliability pass rates of at  
21 least 90% and, if this threshold is not met, immediately  
22 provide for the remediation of poor interrater reliability  
23 and interrater reliability testing for all new staff  
24 before they can conduct utilization review without  
25 supervision.

26 (8) Submit to the Department of Insurance or, in the



1 case of Medicaid managed care organizations, the  
2 Department of Healthcare and Family Services every year on  
3 or before July 1 results of interrater reliability reports  
4 and a summary of the remediation actions taken for those  
5 with pass rates lower than 90%.

6 (r) This Section applies to all health care services and  
7 benefits for the diagnosis, prevention, and treatment of  
8 mental, emotional, nervous, or substance use disorders or  
9 conditions covered by an insurance policy, including  
10 prescription drugs.

11 (s) This Section applies to an insurer that amends,  
12 delivers, issues, or renews a group or individual policy of  
13 accident and health insurance or a qualified health plan  
14 offered through the health insurance marketplace in this State  
15 providing coverage for hospital or medical treatment and  
16 conducts utilization review as defined in this Section,  
17 including Medicaid managed care organizations, and any entity  
18 or contracting provider that performs utilization review or  
19 utilization management functions on an insurer's behalf.

20 (t) If the Director determines that an insurer has  
21 violated this Section, the Director may, after appropriate  
22 notice and opportunity for hearing in accordance with Section  
23 1016 of this Code, by order, assess a civil penalty between  
24 \$5,000 and \$20,000 for each violation. Moneys collected from  
25 penalties shall be deposited into the Parity Advancement Fund  
26 established in subsection (i) of Section 370c.1.

1       (u) An insurer shall not adopt, impose, or enforce terms  
2       in its policies or provider agreements, in writing or in  
3       operation, that undermine, alter, or conflict with the  
4       requirements of this Section.

5       (v) The provisions of this Section are severable. If any  
6       provision of this Section or its application is held invalid,  
7       that invalidity shall not affect other provisions or  
8       applications that can be given effect without the invalid  
9       provision or application.

10       (Source: P.A. 100-305, eff. 8-24-17; 100-1023, eff. 1-1-19;  
11       100-1024, eff. 1-1-19; 101-81, eff. 7-12-19; 101-386, eff.  
12       8-16-19; revised 9-20-19.)

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

15       (215 ILCS 180/35)

16       Sec. 35. Standard external review.

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

24       (b) Within 5 business days following the date of receipt

1 of the external review request, the health carrier shall  
2 complete a preliminary review of the request to determine  
3 whether:

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

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

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

17 (4) (blank); and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (2) If the health carrier or its utilization review  
25 organization fails to provide the documents and  
26 information within the specified time frame, the assigned

1 independent review organization may terminate the external  
2 review and make a decision to reverse the adverse  
3 determination or final adverse determination.

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

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

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

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

1 external review.

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

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

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

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

24 (i) In addition to the documents and information provided  
25 by the health carrier or its utilization review organization  
26 and the covered person and the covered person's authorized



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

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

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

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

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

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

25 (6) any applicable clinical review criteria developed  
26 and used by the health carrier or its designee utilization

1 review organization;

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

8 (8) (blank); and

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

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

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

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

1 condition as defined in Section 370c of the Illinois  
2 Insurance Code.

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

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

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

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

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

25 (D) references to the evidence or documentation,  
26 including the evidence-based standards, considered in

1 reaching its decision;

2 (E) the date of its decision;

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

7 (G) the rationale for its decision.

8 (2) (Blank).

9 (3) (Blank).

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

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

16 (215 ILCS 180/40)

17 Sec. 40. Expedited external review.

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

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

24 (2) immediately after the date of receipt of a notice  
25 upon final adverse determination as provided by subsection

1 (c) of Section 20 of this Act; or

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

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

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

16 (2) The notice of initial determination shall include  
17 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 an  
20 external review request is ineligible for review may be  
21 appealed to the Director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (f) In reaching a decision, the assigned independent  
25 review organization is not bound by any decisions or  
26 conclusions reached during the health carrier's utilization



1 review process or the health carrier's internal appeal  
2 process.

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

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

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

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

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

25 Section 99. Effective date. This Act takes effect upon  
26 becoming law.