HB2847

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB2847

Introduced 2/16/2023, by Rep. Lindsey LaPointe

SYNOPSIS AS INTRODUCED:

20 ILCS 2310/2310-720 new
215 ILCS 5/356z.61 new
215 ILCS 5/356z.62 new
215 ILCS 5/356z.63 new
215 ILCS 5/367n new

Provides that the Act may be referred to as the Mental Health Equity Access and Prevention Act. Amends the Department of Public Health Powers and Duties Law. Provides that subject to appropriation, the Department of Public Health shall undertake a public educational campaign to bring broad public awareness to communities across the State on the importance of mental health and wellness. Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall cover all medically necessary out-of-network mental health visits, treatment, and services provided by a mental health provider or facility. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for 2 annual mental health prevention and wellness visits for children and for adults. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall not require the diagnosis of a mental, emotional, or nervous disorder or condition to establish medical necessity for mental health care, services, or treatment. Provides that the Department of Insurance shall contract with an independent third party with expertise in analyzing commercial insurance premiums and costs to perform an independent analysis of the impact of the coverage of services pursuant to the provisions has had on insurance premiums. Provides that the Department shall adopt any rules necessary to implement the provisions by no later than October 31, 2024. Makes other changes. Effective immediately.

LRB103 26943 BMS 53308 b

A BILL FOR

1 AN ACT concerning regulation.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. References to Act; purpose.
5 (a) References to Act. This Act may be referred to as the
6 Mental Health Equity Access and Prevention Act.
7 (b) Purpose. This Act is intended to address Illinois'
8 skyrocketing mental health needs for children, youth, and
9 adults following the COVID-19 pandemic, cover preventive
10 mental health care to address symptoms early, increase access
11 to affordable care, and maximize the full mental health
12 workforce.

13 Section 5. Findings. The General Assembly finds that:
14 (1) According to a recent U.S. Surgeon General's
15 Advisory on Protecting Youth Mental Health, the proportion
16 of high school students reporting persistent feelings of
17 hopelessness and sadness increased by 40% between 2009 and
18 2019, and rates of depression and anxiety doubled during
19 the COVID-19 pandemic.
20 (2) Death by suicide is alarmingly high, particularly
21 among Black children. Black children under 13 are now
22 nearly twice as likely to die by suicide than White
23 children.

(3) According to a bipartisan United States Senate Finance Committee report on Mental Health Care in the United States, symptoms for depression and anxiety in adults increased nearly fourfold during the COVID-19 pandemic.

(4) At the same time of unprecedented demand for treatment and support, the mental health workforce crisis is causing severe mental health care access challenges.

(5) Private insurance does not cover preventive mental health care. Preventive mental health care can address mental health issues before symptoms worsen or before a mental health crisis occurs.

(6) Commercial insurance networks that include mental health providers are severely restrictive, meaning a small percentage of the mental health workforce is contracted as in-network providers. This forces individuals and patients to seek costly treatment through out-of-network care.

(7) The cost of mental health treatment is inaccessible and unaffordable for many Illinoisans for these reasons.

(8) A recent Milliman research report that analyzed insurance claims for 37 million Americans, including Illinois residents, found major disparities in insurance contracting with in-network mental health providers and contracting with medical/surgical providers. The report's findings include the following:

(A) Illinois out-of-network mental health utilization was 18.2% for outpatient services in 2017 compared to just 3.9% for medical/surgical services.

(B) Illinois out-of-network mental health utilization was 12.1% in 2017 for inpatient care compared to just 2.8% for medical/surgical services.

(C) The disparity between out-of-network usage for mental health compared to medical/surgical services grew significantly between 2013 and 2017: out-of-network mental health utilization for outpatient visits grew by 44% while out-of-network utilization for medical/surgical services decreased by 42% over the same period in Illinois.

(D) Nearly 14% of mental health office visits for individuals with a PPO plan were out-of-network in Illinois.

(9) According to a report in JAMA Psychiatry, 26% of psychiatrists see patients who do not use their insurance to pay for their visit because it is an out-of-network visit; according to a 2015 American Psychological Association Survey of Psychology Health Service Providers, 21% of psychologists report that most of their patients pay out-of-pocket because their visit is out-of-network.

(10) Illinois must maximize its full mental health workforce to address the mental health crisis the state is experiencing post-COVID-19 and improve access to

1 affordable, timely care.

2 Section 10. The Department of Public Health Powers and
3 Duties Law of the Civil Administrative Code of Illinois is
4 amended by adding Section 2310-720 as follows:

5 (20 ILCS 2310/2310-720 new)
6 Sec. 2310-720. Public educational effort on mental health
7 and wellness. Subject to appropriation, the Department shall
8 undertake a public educational campaign to bring broad public
9 awareness to communities across this State on the importance
10 of mental health and wellness, including the expanded coverage
11 of mental health treatment, and consistent with the
12 recommendations of the Illinois Children's Mental Health
13 Partnership's Children's Mental Health Plan of 2022 and Public
14 Act 102-899. The Department shall look to other successful
15 public educational campaigns to guide this effort, such as the
16 public educational campaign related to Get Covered Illinois.
17 Additionally, the Department shall work with the Department of
18 Insurance, the Illinois State Board of Education, the
19 Department of Human Services, the Department of Healthcare and
20 Family Services, the Department of Juvenile Justice, the
21 Department of Children and Family Services, and other State
22 agencies as necessary to promote consistency in messaging and
23 distribution methods between this campaign and other
24 concurrent public educational campaigns related to mental

1 health and mental wellness. Public messaging for this campaign
2 shall be simple, easy to understand, and shall include
3 culturally competent messaging for different communities and
4 regions throughout this State.

5 Section 15. The Illinois Insurance Code is amended by
6 adding Sections 356z.61, 356z.62, 356z.63, and 367n as
7 follows:

8 (215 ILCS 5/356z.61 new)
9 Sec. 356z.61. Coverage of out-of-network mental health
10 care.
11 (a) A group or individual policy of accident and health
12 insurance or a managed care plan that is amended, delivered,
13 issued, or renewed on or after January 1, 2025 shall cover all
14 medically necessary out-of-network mental health visits,
15 including prevention and wellness visits, mental health
16 treatment, and mental health services provided by a mental
17 health provider or facility.
18 (b) For purposes of insured cost sharing, the insured
19 shall pay no more for the out-of-network services and visits
20 than the insured would have paid for in-network services and
21 visits.
22 (c) No action shall be required by the insured to use
23 out-of-network mental health services covered pursuant to this
24 Section. The insured has the right to select the provider of

1 their choice and the modality, in-person visit or telehealth,
2 for medically necessary care.
3 (d) The insurer shall reimburse the out-of-network mental
4 health provider or facility at the provider's usual and
5 customary in-network charges for medically necessary patient
6 care.
7 (e) This Section shall apply to each plan until the plan
8 reduces by 50% the annual disparity between out-of-network
9 mental health utilization and out-of-network medical/surgical
10 utilization for both out-patient mental health visits and
11 inpatient mental health visits from the Base Year by
12 increasing the number of in-network mental health providers
13 and facilities. Outpatient mental health visits and inpatient
14 mental health visits shall be measured separately. The Base
15 Year shall be calendar year 2017 for purposes of measuring the
16 disparity against future years. A plan is exempt from this
17 Section for inpatient care or outpatient care, or both, once
18 the 50% reduction in the disparity between mental health and
19 medical/surgical out-of-network utilization is met.
20 (f) The Department or a contracted third party shall
21 monitor annually the metrics established in this Section for
22 each plan. If a plan becomes exempt from this Section in a
23 given year but fails to maintain the 50% reduction in the
24 disparity between mental health and medical/surgical
25 out-of-network utilization in a future plan year, the
26 exemption lapses for the following plan year and shall be

1 reinstated once the plan meets the 50% reduction in disparity.
2 Plan beneficiaries shall be notified when there is any change
3 in benefit coverage.
4 (g) The Department or a contracted third party shall
5 monitor annually whether there are increases in in-network
6 contracts with mental health providers and facilities for a
7 plan, and shall also monitor whether there is a mental health
8 industry-wide pattern that indicates that mental health
9 providers and facilities are unwilling to contract with a plan
10 for in-network services at a reimbursement rate that is at
11 least at parity with medical/surgical and primary care
12 providers. This analysis shall be applied separately to
13 inpatient mental health services and to outpatient mental
14 health services. If such a pattern is found with respect to a
15 plan for inpatient mental health services or for outpatient
16 mental health services, then the plan is exempt from this
17 Section for inpatient or outpatient services in the following
18 plan year. The plan must notify plan beneficiaries that the
19 coverage for out-of-network services pursuant to this Section
20 no longer applies to their coverage. In the plan year
21 following the plan exemption, the plan must comply with the
22 out-of-network coverage requirements of this Section. Plan
23 beneficiaries shall be notified when there is any change in
24 benefit coverage.
25 (h) If, at any time, the Secretary of the United States
26 Department of Health and Human Services, or its successor

1 agency, adopts rules or regulations to be published in the
2 Federal Register or publishes a comment in the Federal
3 Register or issues an opinion, guidance, or other action that
4 would require the State, under any provision of the Patient
5 Protection and Affordable Care Act (P.L. 111-148), including,
6 but not limited to, 42 U.S.C. 18031(d)(3)(b), or any successor
7 provision, to defray the cost of any service covered pursuant
8 to this Section, then the requirement that a group or
9 individual policy of accident and health insurance or managed
10 care plan cover such service is inoperative other than any
11 such coverage authorized under Section 1902 of the Social
12 Security Act, 42 U.S.C. 1396a, and the State shall not assume
13 any obligation for the cost of the coverage.

14 (i) The Department shall adopt a rule to define "mental
15 health industry-wide pattern" with meaningful input from
16 mental health provider associations and insurers.

17 (j) The Department shall adopt any rules necessary to
18 implement this Section by no later than October 31, 2023.

19 (215 ILCS 5/356z.62 new)

20 Sec. 356z.62. Coverage of no-cost mental health prevention
21 and wellness visits.

22 (a) A group or individual policy of accident and health
23 insurance or managed care plan that is amended, delivered,
24 issued, or renewed on or after January 1, 2025 shall provide
25 coverage for 2 annual mental health prevention and wellness

visits for children and for adults.

(b) Mental health prevention and wellness visits shall include any age-appropriate screening recommended by the United States Preventive Services Task Force or by the American Academy of Pediatrics' Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents for purposes of identifying a mental health issue, including trauma, mental health condition, or mental health disorder; discussion of any mental health symptoms that might be present, including discussion of a previously diagnosed mental health condition or disorder and symptoms; an evaluation of adverse childhood experiences; discussion of mental health and wellness; and, when necessary, assistance with a needed connection to any further recommended or medically necessary mental health assessment, treatment, or peer support.

(c) A mental health prevention and wellness visit shall be up to 60 minutes and may be performed by a physician licensed to practice medicine in all of its branches, a licensed clinical psychologist, a licensed clinical social worker, a licensed clinical professional counselor, a licensed marriage and family therapist, a licensed social worker, or a licensed professional counselor.

(d) No cost sharing shall be imposed and no prior authorization shall be required for mental health prevention and wellness visits.

(e) A mental health prevention and wellness visit shall

not replace a Well Child visit or a general health or medical visit.

(f) A mental health prevention and wellness visit shall be reimbursed through the following American Medical Association current procedural terminology codes and at the same rate that current procedural terminology codes are reimbursed for the provision of other medical care: 99381-88387 and 99391-99397.

(g) Reimbursement of any of the current procedural terminology codes listed in this Section shall comply with the following:

(1) Reimbursement may be adjusted for payment of claims that are billed by a nonphysician clinician so long as the methodology to determine the adjustments are comparable to and applied no more stringently than the methodology for adjustments made for reimbursement of claims billed by nonphysician clinicians for other medical care, in accordance with 45 CFR 146.136(c)(4);

(2) for the purpose of covering a mental health prevention and wellness visit, reimbursement shall not be denied because the code was already reimbursed for the purpose of covering a service other than such visit;

(3) for the purpose of covering a service other than a mental health prevention and wellness visit, reimbursement shall not be denied because the code was already reimbursed for the purpose of covering a mental health prevention and wellness visit; and

1 (4) for a mental health prevention and wellness visit
2 and for a service other than a mental health prevention
3 and wellness visit, reimbursement shall not be denied if
4 they occur on the same date by the same provider and the
5 provider is a primary care provider.
6 (h) If, at any time, the Secretary of the United States
7 Department of Health and Human Services, or its successor
8 agency, adopts rules or regulations to be published in the
9 Federal Register or publishes a comment in the Federal
10 Register or issues an opinion, guidance, or other action that
11 would require the State, under any provision of the Patient
12 Protection and Affordable Care Act (P.L. 111-148), including,
13 but not limited to, 42 U.S.C. 18031(d)(3)(b), or any successor
14 provision, to defray the cost of any service covered pursuant
15 to this Section, then the requirement that a group or
16 individual policy of accident and health insurance or managed
17 care plan cover such service is inoperative other than any
18 such coverage authorized under Section 1902 of the Social
19 Security Act, 42 U.S.C. 1396a, and the State shall not assume
20 any obligation for the cost of the coverage.
21 (i) The Department shall adopt any rules necessary to
22 implement this Section by no later than October 31, 2023.

23 (215 ILCS 5/356z.63 new)
24 Sec. 356z.63. Coverage of medically necessary mental
25 health care for individuals not diagnosed with a mental health

1 disorder.
2 (a) A group or individual policy of accident and health
3 insurance or managed care plan that is amended, delivered,
4 issued, or renewed on or after January 1, 2025 shall not
5 require the diagnosis of a mental, emotional, or nervous
6 disorder or condition to establish medical necessity for
7 mental health care, services, or treatment.
8 (b) The Department shall adopt any rules necessary to
9 implement this Section by no later than October 31, 2024.

10 (215 ILCS 5/367n new)
11 Sec. 367n. Analysis of mental health care coverage on
12 insurance premiums.
13 (a) After 5 years following the effective date of this
14 Act, if requested by an insurer, the Department shall contract
15 with an independent third party with expertise in analyzing
16 commercial insurance premiums and costs to perform an
17 independent analysis of the impact of the coverage of services
18 pursuant to this Act has had on insurance premiums in
19 Illinois. If the premiums increased by more than 2% annually
20 solely due to coverage pursuant to Sections 356z.61, 356z.62,
21 and 356z.63, a plan is exempt from those provisions for one
22 policy year following the year the cost was incurred.
23 Compliance with Sections 356z.61, 356z.62, and 356z.63 is
24 required in the succeeding year and following years. The plan
25 must notify plan beneficiaries of any changes pursuant to this

1 Section.

2 (b) The Department shall adopt any rules necessary to
3 implement this Section by no later than October 31, 2024.

4 Section 99. Effective date. This Act takes effect upon
5 becoming law.