



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB2362

Introduced 2/10/2023, by Sen. Rachel Ventura

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.11
215 ILCS 5/356z.61 new
215 ILCS 5/370c from Ch. 73, par. 982c
215 ILCS 5/370c.1
215 ILCS 5/370c.3 new
305 ILCS 5/5-16.8
720 ILCS 5/49-7 new

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 on or after January 1, 2024 shall provide coverage for medically necessary treatment of vision, hearing, and dental disorders or conditions. Sets forth provisions concerning availability of plan information, notification, external review, limitations on benefits for medically necessary services, and medical necessity determinations. Provides that if the Director of Insurance determines that an insurer has violated the provisions, the Director may assess a civil penalty between \$1,000 and \$5,000 for each violation. Sets forth provisions concerning vision, hearing, and dental disorder or condition parity. Makes other changes. Makes conforming changes in the State Employees Group Insurance Act of 1971 and the Medical Assistance Article of the Illinois Public Aid Code. Amends the Criminal Code of 2012. Establishes the offense of criminal violation of health benefit parity.

LRB103 29039 BMS 55425 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 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Section 6.11 as follows:

6 (5 ILCS 375/6.11)

7 (Text of Section before amendment by P.A. 102-768)

8 Sec. 6.11. Required health benefits; Illinois Insurance
9 Code requirements. The program of health benefits shall
10 provide the post-mastectomy care benefits required to be
11 covered by a policy of accident and health insurance under
12 Section 356t of the Illinois Insurance Code. The program of
13 health benefits shall provide the coverage required under
14 Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356w, 356x,
15 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10,
16 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22,
17 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33,
18 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51,
19 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, and 356z.60 of
20 the Illinois Insurance Code. The program of health benefits
21 must comply with Sections 155.22a, 155.37, 355b, 356z.19,
22 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance
23 Code. The Department of Insurance shall enforce the

1 requirements of this Section with respect to Sections 370c and
2 370c.1 of the Illinois Insurance Code; all other requirements
3 of this Section shall be enforced by the Department of Central
4 Management Services.

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

11 (Source: P.A. 101-13, eff. 6-12-19; 101-281, eff. 1-1-20;
12 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff.
13 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103,
14 eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22;
15 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff.
16 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816,
17 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;
18 revised 12-13-22.)

19 (Text of Section after amendment by P.A. 102-768)

20 Sec. 6.11. Required health benefits; Illinois Insurance
21 Code requirements. The program of health benefits shall
22 provide the post-mastectomy care benefits required to be
23 covered by a policy of accident and health insurance under
24 Section 356t of the Illinois Insurance Code. The program of
25 health benefits shall provide the coverage required under

1 Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356w, 356x,
2 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10,
3 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22,
4 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33,
5 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51,
6 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59, ~~and~~
7 356z.60, and 356z.61 of the Illinois Insurance Code. The
8 program of health benefits must comply with Sections 155.22a,
9 155.37, 355b, 356z.19, 370c, ~~and~~ 370c.1, and 370c.3 and
10 Article XXXIIB of the Illinois Insurance Code. The Department
11 of Insurance shall enforce the requirements of this Section
12 with respect to Sections 370c and 370c.1 of the Illinois
13 Insurance Code; all other requirements of this Section shall
14 be enforced by the Department of Central Management Services.

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

21 (Source: P.A. 101-13, eff. 6-12-19; 101-281, eff. 1-1-20;
22 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff.
23 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103,
24 eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22;
25 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff.
26 1-1-23; 102-768, eff. 1-1-24; 102-804, eff. 1-1-23; 102-813,

1 eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23;
2 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23.)

3 Section 10. The Illinois Insurance Code is amended by
4 changing Sections 370c and 370c.1 and by adding Sections
5 356z.61 and 370c.3 as follows:

6 (215 ILCS 5/356z.61 new)

7 Sec. 356z.61. Vision, hearing, and dental disorders.

8 (a) As used in this Section:

9 "Group policy of accident and health insurance" and "group
10 health benefit plan" includes (1) State-regulated
11 employer-sponsored group health insurance plans written in
12 Illinois or which purport to provide coverage for a resident
13 of this State; and (2) State employee health plans.

14 "Medically necessary treatment of vision, hearing, and
15 dental disorders or conditions" means a service or product
16 addressing the specific needs of that patient for the purpose
17 of screening, preventing, diagnosing, managing, or treating an
18 illness, injury, or condition or its symptoms and
19 comorbidities, including minimizing the progression of an
20 illness, injury, or condition or its symptoms and
21 comorbidities in a manner that is all of the following:

22 (1) in accordance with the generally accepted
23 standards of care; and

24 (2) not primarily for the economic benefit of the

1 insurer, purchaser, or for the convenience of the patient,
2 treating physician, or other health care provider.

3 "Utilization review" means either of the following:

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

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

18 "Utilization review criteria" means patient placement
19 criteria or any criteria, standards, protocols, or guidelines
20 used by an insurer to conduct utilization review.

21 (b) (1) On and after the effective date of this amendatory
22 Act of the 103rd General Assembly, every insurer that amends,
23 delivers, issues, or renews group accident and health policies
24 providing coverage for hospital or medical treatment or
25 services for illness on an expense-incurred basis shall
26 provide coverage for the medically necessary treatment of

1 vision, hearing, and dental disorders or conditions consistent
2 with the parity requirements of Section 370c.3.

3 (2) Each insured that is covered for vision, hearing,
4 and dental disorders or conditions shall be free to select
5 the physician licensed to practice medicine in all of its
6 branches of his or her choice to treat such disorders or
7 conditions, and the insurer shall pay the covered charges
8 of such physician licensed to practice medicine in all of
9 its branches up to the limits of coverage, so long as (i)
10 the disorder or condition treated is covered by the
11 policy, and (ii) the physician is authorized to provide
12 said services under the laws of this State and in
13 accordance with accepted principles of his or her
14 profession.

15 (c)(1) Unless otherwise prohibited by federal law and
16 consistent with the parity requirements of Section 370c.3, the
17 reimbursing insurer that amends, delivers, issues, or renews a
18 group or individual policy of accident and health insurance, a
19 qualified health plan offered through the health insurance
20 marketplace, or a provider of treatment of vision, hearing,
21 and dental disorders or conditions shall furnish medical
22 records or other necessary data that substantiate that initial
23 or continued treatment is at all times medically necessary. An
24 insurer shall provide a mechanism for the timely review by a
25 provider holding the same license and practicing in the same
26 specialty as the patient's provider who is unaffiliated with

1 the insurer, jointly selected by the patient or the patient's
2 next of kin or legal representative if the patient is unable to
3 act for himself or herself, the patient's provider, and the
4 insurer if there is a dispute between the insurer and
5 patient's provider regarding the medical necessity of a
6 treatment proposed by a patient's provider. If the reviewing
7 provider determines the treatment to be medically necessary,
8 then the insurer shall provide reimbursement for the
9 treatment. Future contractual or employment actions by the
10 insurer regarding the patient's provider may not be based on
11 the provider's participation in this procedure. Nothing
12 prevents the insured from agreeing in writing to continue
13 treatment at his or her expense. When making a determination
14 of the medical necessity for a treatment modality for vision,
15 hearing, and dental disorders or conditions an insurer must
16 make the determination in a manner that is consistent with the
17 manner used to make that determination with respect to other
18 diseases or illnesses covered under the policy, including an
19 appeals process.

20 (2) A group health benefit plan, an individual policy
21 of accident and health insurance, or a qualified health
22 plan offered through the health insurance marketplace that
23 is amended, delivered, issued, or renewed on or after the
24 effective date of this amendatory Act of the 103rd General
25 Assembly shall provide coverage based upon medical
26 necessity for the treatment of vision, hearing, and dental

1 disorders or conditions consistent with the parity
2 requirements of Section 370c.3.

3 (3) An issuer of a group health benefit plan, an
4 individual policy of accident and health insurance, or a
5 qualified health plan offered through the health insurance
6 marketplace shall cover the outpatient visits for vision,
7 hearing, and dental disorders or conditions under the same
8 terms and conditions as it covers outpatient visits for
9 the treatment of other physical illness.

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

13 (d) Availability of plan information.

14 (1) The criteria for medical necessity determinations
15 made under a group health plan, an individual policy of
16 accident and health insurance, or a qualified health plan
17 offered through the health insurance marketplace with
18 respect to vision, hearing, and dental disorders or
19 conditions, or health insurance coverage offered in
20 connection with the plan, with respect to such benefits
21 must be made available by the plan administrator, or the
22 health insurance issuer offering such coverage, to any
23 current or potential participant, beneficiary, or
24 contracting provider upon request.

25 (2) The reason for any denial under a group health
26 benefit plan, an individual policy of accident and health

1 insurance, or a qualified health plan offered through the
2 health insurance marketplace, or health insurance coverage
3 offered in connection with such plan or policy, of
4 reimbursement or payment for services with respect to
5 vision, hearing, and dental disorders or conditions
6 benefits in the case of any participant or beneficiary
7 must be made available within a reasonable time and in a
8 reasonable manner and in readily understandable language
9 by the plan administrator, or the health insurance issuer
10 offering such coverage, to the participant or beneficiary
11 upon request.

12 (e)(1) If an insurer determines that treatment is no
13 longer medically necessary, the insurer shall notify the
14 covered person, the covered person's authorized
15 representative, if any, and the covered person's health care
16 provider in writing of the covered person's right to request
17 an external review pursuant to the Health Carrier External
18 Review Act. The notification shall occur within 24 hours
19 following the adverse determination.

20 (2) Pursuant to the requirements of the Health Carrier
21 External Review Act, the covered person or the covered
22 person's authorized representative may request an
23 expedited external review. Under this subsection, a
24 request for expedited external review must be initiated
25 within 24 hours following the adverse determination
26 notification by the insurer. Failure to request an

1 expedited external review within 24 hours shall preclude a
2 covered person or a covered person's authorized
3 representative from requesting an expedited external
4 review.

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

15 (f)(1) Every insurer that amends, delivers, issues, or
16 renews a group or individual policy of accident and health
17 insurance or a qualified health plan offered through the
18 health insurance marketplace in this State and Medicaid
19 managed care organizations providing coverage for hospital or
20 medical treatment on or after January 1, 2024 shall provide
21 coverage for medically necessary treatment of vision, hearing,
22 and dental disorders or conditions.

23 (2) An insurer shall not set a specific limit on the
24 duration of benefits or coverage of medically necessary
25 treatment of vision, hearing, and dental disorders or
26 conditions or limit coverage only to alleviation of the

1 insured's current symptoms.

2 (3) An insurer that authorizes a specific type of
3 treatment by a provider pursuant to this Section shall not
4 rescind or modify the authorization after that provider
5 renders the health care service in good faith and pursuant
6 to this authorization for any reason, including, but not
7 limited to, the insurer's subsequent cancellation or
8 modification of the insured's or policyholder's contract
9 or the insured's or policyholder's eligibility. Nothing in
10 this Section shall require the insurer to cover a
11 treatment when the authorization was granted based on a
12 material misrepresentation by the insured, the
13 policyholder, or the provider. Nothing in this Section
14 shall require Medicaid managed care organizations to pay
15 for services if the individual was not eligible for
16 Medicaid at the time the service was rendered. Nothing in
17 this Section shall require an insurer to pay for services
18 if the individual was not the insurer's enrollee at the
19 time services were rendered. As used in this paragraph,
20 "material" means a fact or situation that is not merely
21 technical in nature and results in or could result in a
22 substantial change in the situation.

23 (g) An insurer shall not limit benefits or coverage for
24 medically necessary services on the basis that those services
25 should be or could be covered by a public entitlement program,
26 including, but not limited to, special education or an

1 individualized education program, Medicaid, Medicare,
2 supplemental security income, or social security disability
3 insurance, and shall not include or enforce a contract term
4 that excludes otherwise covered benefits on the basis that
5 those services should be or could be covered by a public
6 entitlement program. Nothing in this subsection shall be
7 construed to require an insurer to cover benefits that have
8 been authorized and provided for a covered person by a public
9 entitlement program. Medicaid managed care organizations are
10 not subject to this subsection.

11 (h) An insurer shall base any medical necessity
12 determination or the utilization review criteria that the
13 insurer and any entity acting on the insurer's behalf applies
14 to determine the medical necessity of health care services and
15 benefits for the diagnosis, prevention, and treatment of
16 vision, hearing, and dental disorders or conditions on current
17 generally accepted standards of vision, hearing, and dental
18 disorders or conditions care. All denials and appeals shall be
19 reviewed by a professional with experience or expertise
20 comparable to the provider requesting the authorization.

21 (i) This Section does not in any way limit the rights of a
22 patient under the Medical Patient Rights Act.

23 (j) This Section does not in any way limit early and
24 periodic screening, diagnostic, and treatment benefits as
25 defined under 42 U.S.C. 1396d(r).

26 (k) Every insurer shall do all of the following:

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

5 (2) Make the educational program available to other
6 stakeholders, including the insurer's participating or
7 contracted providers and potential participants,
8 beneficiaries, or covered lives. The education program
9 must be provided at least once a year, in-person or
10 digitally, or recordings of the education program must be
11 made available to the aforementioned stakeholders.

12 (3) Provide, at no cost, the utilization review
13 criteria and any training material or resources to
14 providers and insured patients upon request. No
15 restrictions shall be placed upon the insured's or
16 treating provider's access right to utilization review
17 criteria obtained under this paragraph at any point in
18 time, including before an initial request for
19 authorization.

20 (4) Track, identify, and analyze how the utilization
21 review criteria are used to certify care, deny care, and
22 support the appeals process.

23 (5) Conduct interrater reliability testing to ensure
24 consistency in utilization review decision making that
25 covers how medical necessity decisions are made; this
26 assessment shall cover all aspects of utilization review.

1 (6) Run interrater reliability reports about how the
2 clinical guidelines are used in conjunction with the
3 utilization review process and parity compliance
4 activities.

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

11 (8) Maintain documentation of interrater reliability
12 testing and the remediation actions taken for those with
13 pass rates lower than 90% and submit to the Department or,
14 in the case of Medicaid managed care organizations, the
15 Department of Healthcare and Family Services the testing
16 results and a summary of remedial actions as part of
17 parity compliance reporting set forth in Section 370c.3.

18 (1) This Section applies to all health care services and
19 benefits for the diagnosis, prevention, and treatment of
20 vision, hearing, and dental disorders or conditions covered by
21 an insurance policy, including prescription drugs.

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

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

5 (n) If the Director determines that an insurer has
6 violated this Section, the Director may, after appropriate
7 notice and opportunity for hearing, by order, assess a civil
8 penalty between \$1,000 and \$5,000 for each violation. Moneys
9 collected from penalties shall be deposited into the Parity
10 Advancement Fund. Nothing in this Section shall be construed
11 to limit criminal liability.

12 (o) If an insurer commits a violation of this Section, the
13 insurer shall be given 30 days' notice to rectify that
14 violation. Failure to rectify the violation within the 30-day
15 notice period and any subsequent violation of this Section by
16 the insurer shall constitute a Class A misdemeanor and result
17 in criminal liability pursuant to Section 49-7 of the Criminal
18 Code of 2012.

19 (p) An insurer shall not adopt, impose, or enforce terms
20 in its policies or provider agreements, in writing or in
21 operation, that undermine, alter, or conflict with the
22 requirements of this Section.

23 (q) The provisions of this Section are severable. If any
24 provision of this Section or its application to any person or
25 circumstance is held invalid, the invalidity of that provision
26 or application does not affect other provisions or

1 applications of this Section that can be given effect without
2 the invalid provision or application.

3 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

4 Sec. 370c. Mental and emotional disorders.

5 (a) (1) On and after January 1, 2022 (the effective date of
6 Public Act 102-579), every insurer that amends, delivers,
7 issues, or renews group accident and health policies providing
8 coverage for hospital or medical treatment or services for
9 illness on an expense-incurred basis shall provide coverage
10 for the medically necessary treatment of mental, emotional,
11 nervous, or substance use disorders or conditions consistent
12 with the parity requirements of Section 370c.1 of this Code.

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

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

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

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

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

18 (b) (1) (Blank).

19 (2) (Blank).

20 (2.5) (Blank).

21 (3) Unless otherwise prohibited by federal law and
22 consistent with the parity requirements of Section 370c.1 of
23 this Code, the reimbursing insurer that amends, delivers,
24 issues, or renews a group or individual policy of accident and
25 health insurance, a qualified health plan offered through the
26 health insurance marketplace, or a provider of treatment of

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

1 substance use disorders shall be made in accordance with
2 appropriate patient placement criteria established by the
3 American Society of Addiction Medicine. No additional criteria
4 may be used to make medical necessity determinations for
5 substance use disorders.

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

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

19 (i) 45 days of inpatient treatment; and

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

24 (iii) for plans or policies delivered, issued for
25 delivery, renewed, or modified after January 1, 2007
26 (the effective date of Public Act 94-906), 20

1 additional outpatient visits for speech therapy for
2 treatment of pervasive developmental disorders that
3 will be in addition to speech therapy provided
4 pursuant to item (ii) of this subparagraph (A); and

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

8 (C) (Blank).

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

18 (5.5) An individual or group health benefit plan amended,
19 delivered, issued, or renewed on or after September 9, 2015
20 (the effective date of Public Act 99-480) shall offer coverage
21 for medically necessary acute treatment services and medically
22 necessary clinical stabilization services. The treating
23 provider shall base all treatment recommendations and the
24 health benefit plan shall base all medical necessity
25 determinations for substance use disorders in accordance with
26 the most current edition of the Treatment Criteria for

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

9 As used in this subsection:

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

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

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

25 (6.5) An individual or group health benefit plan amended,
26 delivered, issued, or renewed on or after January 1, 2019 (the

1 effective date of Public Act 100-1024):

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

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

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

1 generic medications; and

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

8 (7) (Blank).

9 (8) (Blank).

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

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

19 (d) With respect to a group or individual policy of
20 accident and health insurance or a qualified health plan
21 offered through the health insurance marketplace, the
22 Department and, with respect to medical assistance, the
23 Department of Healthcare and Family Services shall each
24 enforce the requirements of this Section and Sections 356z.23
25 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
26 Mental Health Parity and Addiction Equity Act of 2008, 42

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

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

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

25 (3) performing parity compliance market conduct
26 examinations or, in the case of the Department of

1 Healthcare and Family Services, parity compliance audits
2 of individual and group plans and policies, including, but
3 not limited to, reviews of:

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

9 (B) denials of authorization, payment, and
10 coverage; and

11 (C) other specific criteria as may be determined
12 by the Department.

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

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

19 (e) Availability of plan information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 If an expedited external review request meets the criteria
26 of the Health Carrier External Review Act, an independent

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

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

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

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

23 (h) As used in this Section:

24 "Generally accepted standards of mental, emotional,
25 nervous, or substance use disorder or condition care" means
26 standards of care and clinical practice that are generally

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

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

23 (1) in accordance with the generally accepted
24 standards of mental, emotional, nervous, or substance use
25 disorder or condition care;

26 (2) clinically appropriate in terms of type,

1 frequency, extent, site, and duration; and

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

5 "Utilization review" means either of the following:

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

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

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

23 (i)(1) Every insurer that amends, delivers, issues, or
24 renews a group or individual policy of accident and health
25 insurance or a qualified health plan offered through the
26 health insurance marketplace in this State and Medicaid

1 managed care organizations providing coverage for hospital or
2 medical treatment on or after January 1, 2023 shall, pursuant
3 to subsections (h) through (s), provide coverage for medically
4 necessary treatment of mental, emotional, nervous, or
5 substance use disorders or conditions.

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

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

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

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

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

25 (k) An insurer shall base any medical necessity
26 determination or the utilization review criteria that the

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

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

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

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

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

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

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

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

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

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

26 (3) Provide, at no cost, the utilization review

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

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

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

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

26 (7) Achieve interrater reliability pass rates of at

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

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

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

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

1 utilization management functions on an insurer's behalf.

2 (t) If the Director determines that an insurer has
3 violated this Section, the Director may, after appropriate
4 notice and opportunity for hearing, by order, assess a civil
5 penalty between \$1,000 and \$5,000 for each violation. Moneys
6 collected from penalties shall be deposited into the Parity
7 Advancement Fund established in subsection (i) of Section
8 370c.1. Nothing in this Section shall be construed to limit
9 criminal liability.

10 (u) If an insurer commits a violation of this Section, the
11 insurer shall be given 30 days' notice to rectify that
12 violation. Failure to rectify the violation within the 30-day
13 notice period and any subsequent violation of this Section by
14 the insurer shall constitute a Class A misdemeanor and shall
15 result in criminal liability pursuant to Section 49-7 of the
16 Criminal Code of 2012.

17 (v) ~~(u)~~ An insurer shall not adopt, impose, or enforce
18 terms in its policies or provider agreements, in writing or in
19 operation, that undermine, alter, or conflict with the
20 requirements of this Section.

21 (w) ~~(v)~~ The provisions of this Section are severable. If
22 any provision of this Section or its application is held
23 invalid, that invalidity shall not affect other provisions or
24 applications that can be given effect without the invalid
25 provision or application.

26 (Source: P.A. 101-81, eff. 7-12-19; 101-386, eff. 8-16-19;

1 102-558, eff. 8-20-21; 102-579, eff. 1-1-22; 102-813, eff.
2 5-13-22.)

3 (215 ILCS 5/370c.1)

4 Sec. 370c.1. Mental, emotional, nervous, or substance use
5 disorder or condition parity.

6 (a) On and after July 23, 2021 (the effective date of
7 Public Act 102-135), every insurer that amends, delivers,
8 issues, or renews a group or individual policy of accident and
9 health insurance or a qualified health plan offered through
10 the Health Insurance Marketplace in this State providing
11 coverage for hospital or medical treatment and for the
12 treatment of mental, emotional, nervous, or substance use
13 disorders or conditions shall ensure prior to policy issuance
14 that:

15 (1) the financial requirements applicable to such
16 mental, emotional, nervous, or substance use disorder or
17 condition benefits are no more restrictive than the
18 predominant financial requirements applied to
19 substantially all hospital and medical benefits covered by
20 the policy and that there are no separate cost-sharing
21 requirements that are applicable only with respect to
22 mental, emotional, nervous, or substance use disorder or
23 condition benefits; and

24 (2) the treatment limitations applicable to such
25 mental, emotional, nervous, or substance use disorder or

1 condition benefits are no more restrictive than the
2 predominant treatment limitations applied to substantially
3 all hospital and medical benefits covered by the policy
4 and that there are no separate treatment limitations that
5 are applicable only with respect to mental, emotional,
6 nervous, or substance use disorder or condition benefits.

7 (b) The following provisions shall apply concerning
8 aggregate lifetime limits:

9 (1) In the case of a group or individual policy of
10 accident and health insurance or a qualified health plan
11 offered through the Health Insurance Marketplace amended,
12 delivered, issued, or renewed in this State on or after
13 September 9, 2015 (the effective date of Public Act
14 99-480) that provides coverage for hospital or medical
15 treatment and for the treatment of mental, emotional,
16 nervous, or substance use disorders or conditions the
17 following provisions shall apply:

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

24 (B) if the policy includes an aggregate lifetime
25 limit on substantially all hospital and medical
26 benefits (in this subsection referred to as the

1 "applicable lifetime limit"), then the policy shall
2 either:

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

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

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

1 (c) The following provisions shall apply concerning annual
2 limits:

3 (1) In the case of a group or individual policy of
4 accident and health insurance or a qualified health plan
5 offered through the Health Insurance Marketplace amended,
6 delivered, issued, or renewed in this State on or after
7 September 9, 2015 (the effective date of Public Act
8 99-480) that provides coverage for hospital or medical
9 treatment and for the treatment of mental, emotional,
10 nervous, or substance use disorders or conditions the
11 following provisions shall apply:

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

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

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

1 benefits and mental, emotional, nervous, or
2 substance use disorder or condition benefits; or

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

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

19 (d) With respect to mental, emotional, nervous, or
20 substance use disorders or conditions, an insurer shall use
21 policies and procedures for the election and placement of
22 mental, emotional, nervous, or substance use disorder or
23 condition treatment drugs on their formulary that are no less
24 favorable to the insured as those policies and procedures the
25 insurer uses for the selection and placement of drugs for
26 medical or surgical conditions and shall follow the expedited

1 coverage determination requirements for substance abuse
2 treatment drugs set forth in Section 45.2 of the Managed Care
3 Reform and Patient Rights Act.

4 (e) This Section shall be interpreted in a manner
5 consistent with all applicable federal parity regulations
6 including, but not limited to, the Paul Wellstone and Pete
7 Domenici Mental Health Parity and Addiction Equity Act of
8 2008, final regulations issued under the Paul Wellstone and
9 Pete Domenici Mental Health Parity and Addiction Equity Act of
10 2008 and final regulations applying the Paul Wellstone and
11 Pete Domenici Mental Health Parity and Addiction Equity Act of
12 2008 to Medicaid managed care organizations, the Children's
13 Health Insurance Program, and alternative benefit plans.

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

17 (g) As used in this Section:

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

22 "Mental, emotional, nervous, or substance use disorder or
23 condition" means a condition or disorder that involves a
24 mental health condition or substance use disorder that falls
25 under any of the diagnostic categories listed in the mental
26 and behavioral disorders chapter of the current edition of the

1 International Classification of Disease or that is listed in
2 the most recent version of the Diagnostic and Statistical
3 Manual of Mental Disorders.

4 "Treatment limitation" includes limits on benefits based
5 on the frequency of treatment, number of visits, days of
6 coverage, days in a waiting period, or other similar limits on
7 the scope or duration of treatment. "Treatment limitation"
8 includes both quantitative treatment limitations, which are
9 expressed numerically (such as 50 outpatient visits per year),
10 and nonquantitative treatment limitations, which otherwise
11 limit the scope or duration of treatment. A permanent
12 exclusion of all benefits for a particular condition or
13 disorder shall not be considered a treatment limitation.
14 "Nonquantitative treatment" means those limitations as
15 described under federal regulations (26 CFR 54.9812-1).
16 "Nonquantitative treatment limitations" include, but are not
17 limited to, those limitations described under federal
18 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
19 146.136.

20 (h) The Department of Insurance shall implement the
21 following education initiatives:

22 (1) By January 1, 2016, the Department shall develop a
23 plan for a Consumer Education Campaign on parity. The
24 Consumer Education Campaign shall focus its efforts
25 throughout the State and include trainings in the
26 northern, southern, and central regions of the State, as

1 defined by the Department, as well as each of the 5 managed
2 care regions of the State as identified by the Department
3 of Healthcare and Family Services. Under this Consumer
4 Education Campaign, the Department shall: (1) by January
5 1, 2017, provide at least one live training in each region
6 on parity for consumers and providers and one webinar
7 training to be posted on the Department website and (2)
8 establish a consumer hotline to assist consumers in
9 navigating the parity process by March 1, 2017. By January
10 1, 2018 the Department shall issue a report to the General
11 Assembly on the success of the Consumer Education
12 Campaign, which shall indicate whether additional training
13 is necessary or would be recommended.

14 (2) The Department, in coordination with the
15 Department of Human Services and the Department of
16 Healthcare and Family Services, shall convene a working
17 group of health care insurance carriers, mental health
18 advocacy groups, substance abuse patient advocacy groups,
19 and mental health physician groups for the purpose of
20 discussing issues related to the treatment and coverage of
21 mental, emotional, nervous, or substance use disorders or
22 conditions and compliance with parity obligations under
23 State and federal law. Compliance shall be measured,
24 tracked, and shared during the meetings of the working
25 group. The working group shall meet once before January 1,
26 2016 and shall meet semiannually thereafter. The

1 Department shall issue an annual report to the General
2 Assembly that includes a list of the health care insurance
3 carriers, mental health advocacy groups, substance abuse
4 patient advocacy groups, and mental health physician
5 groups that participated in the working group meetings,
6 details on the issues and topics covered, and any
7 legislative recommendations developed by the working
8 group.

9 (3) Not later than January 1 of each year, the
10 Department, in conjunction with the Department of
11 Healthcare and Family Services, shall issue a joint report
12 to the General Assembly and provide an educational
13 presentation to the General Assembly. The report and
14 presentation shall:

15 (A) Cover the methodology the Departments use to
16 check for compliance with the federal Paul Wellstone
17 and Pete Domenici Mental Health Parity and Addiction
18 Equity Act of 2008, 42 U.S.C. 18031(j), and any
19 federal regulations or guidance relating to the
20 compliance and oversight of the federal Paul Wellstone
21 and Pete Domenici Mental Health Parity and Addiction
22 Equity Act of 2008 and 42 U.S.C. 18031(j).

23 (B) Cover the methodology the Departments use to
24 check for compliance with this Section and Sections
25 356z.23, ~~and~~ 370c, and 370c.3 of this Code.

26 (C) Identify market conduct examinations or, in

1 the case of the Department of Healthcare and Family
2 Services, audits conducted or completed during the
3 preceding 12-month period regarding compliance with
4 parity in mental, emotional, nervous, and substance
5 use disorder or condition benefits and parity in
6 vision, hearing, and dental disorder or condition
7 benefits under State and federal laws and summarize
8 the results of such market conduct examinations and
9 audits. This shall include:

10 (i) the number of market conduct examinations
11 and audits initiated and completed;

12 (ii) the benefit classifications examined by
13 each market conduct examination and audit;

14 (iii) the subject matter of each market
15 conduct examination and audit, including
16 quantitative and nonquantitative treatment
17 limitations; and

18 (iv) a summary of the basis for the final
19 decision rendered in each market conduct
20 examination and audit.

21 Individually identifiable information shall be
22 excluded from the reports consistent with federal
23 privacy protections.

24 (D) Detail any educational or corrective actions
25 the Departments have taken to ensure compliance with
26 the federal Paul Wellstone and Pete Domenici Mental

1 Health Parity and Addiction Equity Act of 2008, 42
2 U.S.C. 18031(j), this Section, and Sections 356z.23,
3 ~~and 370c,~~ and 370c.3 of this Code.

4 (E) The report must be written in non-technical,
5 readily understandable language and shall be made
6 available to the public by, among such other means as
7 the Departments find appropriate, posting the report
8 on the Departments' websites.

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

18 (j) The Department of Insurance and the Department of
19 Healthcare and Family Services shall convene and provide
20 technical support to a workgroup of 11 members that shall be
21 comprised of 3 mental health parity experts recommended by an
22 organization advocating on behalf of mental health parity
23 appointed by the President of the Senate; 3 behavioral health
24 providers recommended by an organization that represents
25 behavioral health providers appointed by the Speaker of the
26 House of Representatives; 2 representing Medicaid managed care

1 organizations recommended by an organization that represents
2 Medicaid managed care plans appointed by the Minority Leader
3 of the House of Representatives; 2 representing commercial
4 insurers recommended by an organization that represents
5 insurers appointed by the Minority Leader of the Senate; and a
6 representative of an organization that represents Medicaid
7 managed care plans appointed by the Governor.

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

24 (1) claims denials due to benefit limits, if
25 applicable;

26 (2) administrative denials for no prior authorization;

- 1 (3) denials due to not meeting medical necessity;
- 2 (4) denials that went to external review and whether
- 3 they were upheld or overturned for medical necessity;
- 4 (5) out-of-network claims;
- 5 (6) emergency care claims;
- 6 (7) network directory providers in the outpatient
- 7 benefits classification who filed no claims in the last 6
- 8 months, if applicable;
- 9 (8) the impact of existing and pertinent limitations
- 10 and restrictions related to approved services, licensed
- 11 providers, reimbursement levels, and reimbursement
- 12 methodologies within the Division of Mental Health, the
- 13 Division of Substance Use Prevention and Recovery
- 14 programs, the Department of Healthcare and Family
- 15 Services, and, to the extent possible, federal regulations
- 16 and law; and
- 17 (9) when reporting and publishing should begin.

18 Representatives from the Department of Healthcare and
19 Family Services, representatives from the Division of Mental
20 Health, and representatives from the Division of Substance Use
21 Prevention and Recovery shall provide technical advice to the
22 workgroup.

23 (k) An insurer that amends, delivers, issues, or renews a
24 group or individual policy of accident and health insurance or
25 a qualified health plan offered through the health insurance
26 marketplace in this State providing coverage for hospital or

1 medical treatment and for the treatment of mental, emotional,
2 nervous, or substance use disorders or conditions shall submit
3 an annual report, the format and definitions for which will be
4 developed by the workgroup in subsection (j), to the
5 Department, or, with respect to medical assistance, the
6 Department of Healthcare and Family Services starting on or
7 before July 1, 2020 that contains the following information
8 separately for inpatient in-network benefits, inpatient
9 out-of-network benefits, outpatient in-network benefits,
10 outpatient out-of-network benefits, emergency care benefits,
11 and prescription drug benefits in the case of accident and
12 health insurance or qualified health plans, or inpatient,
13 outpatient, emergency care, and prescription drug benefits in
14 the case of medical assistance:

15 (1) A summary of the plan's pharmacy management
16 processes for mental, emotional, nervous, or substance use
17 disorder or condition benefits compared to those for other
18 medical benefits.

19 (2) A summary of the internal processes of review for
20 experimental benefits and unproven technology for mental,
21 emotional, nervous, or substance use disorder or condition
22 benefits and those for other medical benefits.

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

1 (4) A description of the process used to develop or
2 select the medical necessity criteria for mental,
3 emotional, nervous, or substance use disorder or condition
4 benefits and the process used to develop or select the
5 medical necessity criteria for medical and surgical
6 benefits.

7 (5) Identification of all nonquantitative treatment
8 limitations that are applied to both mental, emotional,
9 nervous, or substance use disorder or condition benefits
10 and medical and surgical benefits within each
11 classification of benefits.

12 (6) The results of an analysis that demonstrates that
13 for the medical necessity criteria described in
14 subparagraph (A) and for each nonquantitative treatment
15 limitation identified in subparagraph (B), as written and
16 in operation, the processes, strategies, evidentiary
17 standards, or other factors used in applying the medical
18 necessity criteria and each nonquantitative treatment
19 limitation to mental, emotional, nervous, or substance use
20 disorder or condition benefits within each classification
21 of benefits are comparable to, and are applied no more
22 stringently than, the processes, strategies, evidentiary
23 standards, or other factors used in applying the medical
24 necessity criteria and each nonquantitative treatment
25 limitation to medical and surgical benefits within the
26 corresponding classification of benefits; at a minimum,

1 the results of the analysis shall:

2 (A) identify the factors used to determine that a
3 nonquantitative treatment limitation applies to a
4 benefit, including factors that were considered but
5 rejected;

6 (B) identify and define the specific evidentiary
7 standards used to define the factors and any other
8 evidence relied upon in designing each nonquantitative
9 treatment limitation;

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

20 (D) provide the comparative analyses, including
21 the results of the analyses, performed to determine
22 that the processes and strategies used to apply each
23 nonquantitative treatment limitation, in operation,
24 for mental, emotional, nervous, or substance use
25 disorder or condition benefits are comparable to, and
26 applied no more stringently than, the processes or

1 strategies used to apply each nonquantitative
2 treatment limitation, in operation, for medical and
3 surgical benefits; and

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

13 (7) Any other information necessary to clarify data
14 provided in accordance with this Section requested by the
15 Director, including information that may be proprietary or
16 have commercial value, under the requirements of Section
17 30 of the Viatical Settlements Act of 2009.

18 (1) An insurer that amends, delivers, issues, or renews a
19 group or individual policy of accident and health insurance or
20 a qualified health plan offered through the health insurance
21 marketplace in this State providing coverage for hospital or
22 medical treatment and for the treatment of mental, emotional,
23 nervous, or substance use disorders or conditions on or after
24 January 1, 2019 (the effective date of Public Act 100-1024)
25 shall, in advance of the plan year, make available to the
26 Department or, with respect to medical assistance, the

1 Department of Healthcare and Family Services and to all plan
2 participants and beneficiaries the information required in
3 subparagraphs (C) through (E) of paragraph (6) of subsection
4 (k). For plan participants and medical assistance
5 beneficiaries, the information required in subparagraphs (C)
6 through (E) of paragraph (6) of subsection (k) shall be made
7 available on a publicly-available website whose web address is
8 prominently displayed in plan and managed care organization
9 informational and marketing materials.

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

22 (Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21;
23 102-813, eff. 5-13-22.)

24 (215 ILCS 5/370c.3 new)

25 Sec. 370c.3. Vision, hearing, and dental disorder or

1 condition parity.

2 (a) As used in this Section:

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

7 "Treatment limitation" includes limits on benefits based
8 on the frequency of treatment, number of visits, days of
9 coverage, days in a waiting period, or other similar limits on
10 the scope or duration of treatment. "Treatment limitation"
11 includes both quantitative treatment limitations, which are
12 expressed numerically (such as 50 outpatient visits per year),
13 and nonquantitative treatment limitations, which otherwise
14 limit the scope or duration of treatment. A permanent
15 exclusion of all benefits for a particular condition or
16 disorder shall not be considered a treatment limitation.
17 "Nonquantitative treatment" means those limitations as
18 described under federal regulations (26 CFR 54.9812-1).
19 "Nonquantitative treatment limitations" include, but are not
20 limited to, those limitations described under federal
21 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
22 146.136.

23 (b) On and after the effective date of this amendatory Act
24 of the 103rd General Assembly, every insurer that amends,
25 delivers, issues, or renews a group or individual policy of
26 accident and health insurance or a qualified health plan

1 offered through the health insurance marketplace in this State
2 providing coverage for hospital or medical treatment and for
3 the treatment of a vision, hearing, or dental disorder or
4 condition shall ensure before policy issuance that:

5 (1) the financial requirements applicable to such
6 vision, hearing, or dental disorder or condition benefits
7 are no more restrictive than the predominant financial
8 requirements applied to substantially all hospital and
9 medical benefits covered by the policy and that there are
10 no separate cost-sharing requirements that are applicable
11 only with respect to vision, hearing, or dental disorder
12 or condition benefits; and

13 (2) the treatment limitations applicable to such
14 vision, hearing, or dental disorder or condition benefits
15 are no more restrictive than the predominant treatment
16 limitations applied to substantially all hospital and
17 medical benefits covered by the policy and that there are
18 no separate treatment limitations that are applicable only
19 with respect to vision, hearing, or dental disorder or
20 condition benefits.

21 (c) The following provisions shall apply concerning
22 aggregate lifetime limits:

23 (1) In the case of a group or individual policy of
24 accident and health insurance or a qualified health plan
25 offered through the health insurance marketplace amended,
26 delivered, issued, or renewed in this State on or after

1 the effective date of this amendatory Act of the 103rd
2 General Assembly that provides coverage for hospital or
3 medical treatment and for the treatment of a vision,
4 hearing, or dental disorder or condition, the following
5 provisions shall apply:

6 (A) if the policy does not include an aggregate
7 lifetime limit on substantially all hospital and
8 medical benefits, then the policy may not impose any
9 aggregate lifetime limit on vision, hearing, dental
10 disorder or condition benefits; or

11 (B) if the policy includes an aggregate lifetime
12 limit on substantially all hospital and medical
13 benefits, then the policy shall either:

14 (i) apply the aggregate lifetime limit both to
15 the hospital and medical benefits to which it
16 otherwise would apply and to vision, hearing, and
17 dental disorder or condition benefits and not
18 distinguish in the application of the limit
19 between the hospital and medical benefits and
20 vision, hearing, and dental disorder or condition
21 benefits; or

22 (ii) not include any aggregate lifetime limit
23 on vision, hearing, and dental disorder or
24 condition benefits that is less than the aggregate
25 lifetime limit on substantially all hospital and
26 medical benefits.

1 (2) In the case of a policy that is not described in
2 paragraph (1) of subsection (b) and that includes no or
3 different aggregate lifetime limits on different
4 categories of hospital and medical benefits, the
5 Department shall adopt rules under which subparagraph (B)
6 of paragraph (1) of subsection (b) is applied to such
7 policy with respect to vision, hearing, and dental
8 disorder or condition benefits by substituting the
9 aggregate lifetime limit on substantially all hospital and
10 medical benefits with an average aggregate lifetime limit
11 that is computed taking into account the weighted average
12 of the aggregate lifetime limits applicable to such
13 categories.

14 (d) The following provisions shall apply concerning annual
15 limits:

16 (1) In the case of a group or individual policy of
17 accident and health insurance or a qualified health plan
18 offered through the health insurance marketplace amended,
19 delivered, issued, or renewed in this State on or after
20 the effective date of this amendatory Act of the 103rd
21 General Assembly that provides coverage for hospital or
22 medical treatment and for the treatment of a vision,
23 hearing, or dental disorder or condition, the following
24 provisions shall apply:

25 (A) if the policy does not include an annual limit
26 on substantially all hospital and medical benefits,

1 then the policy may not impose any annual limits on
2 vision, hearing, or dental disorder or condition
3 benefits; or

4 (B) if the policy includes an annual limit on
5 substantially all hospital and medical benefits, then
6 the policy shall either:

7 (i) apply the annual limit on substantially
8 all hospital and medical benefits both to the
9 hospital and medical benefits to which it
10 otherwise would apply and to mental, emotional,
11 nervous, or substance use disorder or condition
12 benefits and not distinguish in the application of
13 the limit between the hospital and medical
14 benefits and vision, hearing, and dental disorder
15 or condition benefits; or

16 (ii) not include any annual limit on vision,
17 hearing, and dental disorder or condition benefits
18 that is less than the annual limit on
19 substantially all hospital and medical benefits.

20 (2) In the case of a policy that is not described in
21 paragraph (1) of subsection (c) and that includes no or
22 different annual limits on different categories of
23 hospital and medical benefits, the Director shall
24 establish rules under which subparagraph (B) of paragraph
25 (1) of subsection (c) is applied to such policy with
26 respect to vision, hearing, and dental disorder or

1 condition benefits by substituting the annual limit on
2 substantially all hospital and medical benefits with an
3 average annual limit that is computed taking into account
4 the weighted average of the annual limits applicable to
5 such categories.

6 (e) With respect to a vision, hearing, and dental disorder
7 or condition, an insurer shall use policies and procedures for
8 the election and placement of vision, hearing, and dental
9 disorder or condition treatment drugs on their formulary that
10 are no less favorable to the insured as those policies and
11 procedures the insurer uses for the selection and placement of
12 drugs for medical or surgical conditions and shall follow the
13 expedited coverage determination requirements for substance
14 abuse treatment drugs set forth in Section 45.2 of the Managed
15 Care Reform and Patient Rights Act.

16 (f) The provisions of subsections (c) and (d) shall not be
17 interpreted to allow the use of lifetime or annual limits
18 otherwise prohibited by State or federal law.

19 (g) An insurer that amends, delivers, issues, or renews a
20 group or individual policy of accident and health insurance or
21 a qualified health plan offered through the health insurance
22 marketplace in this State providing coverage for hospital or
23 medical treatment and for the treatment of vision, hearing, or
24 dental disorders or conditions shall submit an annual report
25 that contains the following information separately for
26 inpatient in-network benefits, inpatient out-of-network

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

7 (1) A summary of the plan's pharmacy management
8 processes for vision, hearing, and dental disorder or
9 condition benefits compared to those for other medical
10 benefits.

11 (2) A summary of the internal processes of review for
12 experimental benefits and unproven technology for vision,
13 hearing, and dental disorder or condition benefits and
14 those for other medical benefits.

15 (3) A summary of how the plan's policies and
16 procedures for utilization management for vision, hearing,
17 and dental disorder or condition benefits compare to those
18 for other medical benefits.

19 (4) A description of the process used to develop or
20 select the medical necessity criteria for vision, hearing,
21 and dental disorder or condition benefits and the process
22 used to develop or select the medical necessity criteria
23 for medical and surgical benefits.

24 (5) Identification of all nonquantitative treatment
25 limitations that are applied to vision, hearing, and
26 dental disorder or condition benefits and medical and

1 surgical benefits within each classification of benefits.

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

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

19 (E) disclose the specific findings and conclusions
20 reached by the insurer that the results of the
21 analyses described in subparagraphs (C) and (D) of
22 this paragraph indicate that the insurer is in
23 compliance with this Section.

24 (7) Any other information necessary to clarify data
25 provided in accordance with this Section requested by the
26 Director, including information that may be proprietary or

1 have commercial value, under the requirements of Section
2 30 of the Viatical Settlements Act of 2009.

3 (h) An insurer that amends, delivers, issues, or renews a
4 group or individual policy of accident and health insurance or
5 a qualified health plan offered through the health insurance
6 marketplace in this State providing coverage for hospital or
7 medical treatment and for the treatment of vision, hearing, or
8 dental disorder or condition on or after the effective date of
9 this amendatory Act of the 103rd General Assembly shall, in
10 advance of the plan year, make available to the Department or,
11 with respect to medical assistance, the Department of
12 Healthcare and Family Services and to all plan participants
13 and beneficiaries the information required in subparagraphs
14 (C) through (E) of paragraph (6) of subsection (g). For plan
15 participants and medical assistance beneficiaries, the
16 information required in subparagraphs (C) through (E) of
17 paragraph (6) of subsection (g) shall be made available on a
18 publicly available website with a web address that is
19 prominently displayed in plan and managed care organization
20 informational and marketing materials.

21 (i) In conjunction with its compliance examination program
22 conducted in accordance with the Illinois State Auditing Act,
23 the Auditor General shall undertake a review of compliance by
24 the Department and the Department of Healthcare and Family
25 Services with Section 370c and this Section. Any findings
26 resulting from the review conducted under this Section shall

1 be included in the applicable State agency's compliance
2 examination report. Each compliance examination report shall
3 be issued in accordance with Section 3-14 of the Illinois
4 State Auditing Act. A copy of each report shall also be
5 delivered to the head of the applicable State agency and
6 posted on the Auditor General's website.

7 Section 15. The Illinois Public Aid Code is amended by
8 changing Section 5-16.8 as follows:

9 (305 ILCS 5/5-16.8)

10 Sec. 5-16.8. Required health benefits. The medical
11 assistance program shall (i) provide the post-mastectomy care
12 benefits required to be covered by a policy of accident and
13 health insurance under Section 356t and the coverage required
14 under Sections 356g.5, 356q, 356u, 356w, 356x, 356z.6,
15 356z.26, 356z.29, 356z.32, 356z.33, 356z.34, 356z.35, 356z.46,
16 356z.47, 356z.51, 356z.53, 356z.56, 356z.59, ~~and~~ 356z.60, and
17 356z.61 of the Illinois Insurance Code, (ii) be subject to the
18 provisions of Sections 356z.19, 356z.44, 356z.49, 364.01,
19 370c, ~~and~~ 370c.1, and 370c.3 of the Illinois Insurance Code,
20 and (iii) be subject to the provisions of subsection (d-5) of
21 Section 10 of the Network Adequacy and Transparency Act.

22 The Department, by rule, shall adopt a model similar to
23 the requirements of Section 356z.39 of the Illinois Insurance
24 Code.

1 On and after July 1, 2012, the Department shall reduce any
2 rate of reimbursement for services or other payments or alter
3 any methodologies authorized by this Code to reduce any rate
4 of reimbursement for services or other payments in accordance
5 with Section 5-5e.

6 To ensure full access to the benefits set forth in this
7 Section, on and after January 1, 2016, the Department shall
8 ensure that provider and hospital reimbursement for
9 post-mastectomy care benefits required under this Section are
10 no lower than the Medicare reimbursement rate.

11 (Source: P.A. 101-81, eff. 7-12-19; 101-218, eff. 1-1-20;
12 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-574, eff.
13 1-1-20; 101-649, eff. 7-7-20; 102-30, eff. 1-1-22; 102-144,
14 eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22;
15 102-530, eff. 1-1-22; 102-642, eff. 1-1-22; 102-804, eff.
16 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-1093,
17 eff. 1-1-23; 102-1117, eff. 1-13-23.)

18 Section 20. The Criminal Code of 2012 is amended by adding
19 Section 49-7 as follows:

20 (720 ILCS 5/49-7 new)

21 Sec. 49-7. Criminal violation of health benefit parity.

22 (a) A person commits a criminal violation of health
23 benefit parity if he or she knowingly and without legal
24 justification, by any means, causes Sections 356z.61, 370c, or

1 370c.3 of the Illinois Insurance Code to be violated.

2 (b) Criminal violation of health benefit parity is a Class
3 A misdemeanor.

4 (c) Nothing in this Section shall be construed to limit
5 further liability for civil damages or penalties resulting
6 from other negligent conduct or intentional misconduct by any
7 person.

8 Section 95. No acceleration or delay. Where this Act makes
9 changes in a statute that is represented in this Act by text
10 that is not yet or no longer in effect (for example, a Section
11 represented by multiple versions), the use of that text does
12 not accelerate or delay the taking effect of (i) the changes
13 made by this Act or (ii) provisions derived from any other
14 Public Act.