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 Illinois Insurance Code is amended by
5 changing Section 370c as follows:

6 (215 ILCS 5/370c) (from Ch. 73, par. 982c)
7 Sec. 370c. Mental and emotional disorders.
8 (a) (1) On and after the effective date of this Section,
9 every insurer which delivers, issues for delivery or renews or
10 modifies group A&H policies providing coverage for hospital or
11 medical treatment or services for illness on an
12 expense-incurred basis shall offer to the applicant or group
13 policyholder subject to the insurers standards of
14 insurability, coverage for reasonable and necessary treatment
15 and services for mental, emotional or nervous disorders or
16 conditions, other than serious mental illnesses as defined in
17 item (2) of subsection (b), up to the limits provided in the
18 policy for other disorders or conditions, except (i) the
19 insured may be required to pay up to 50% of expenses incurred
20 as a result of the treatment or services, and (ii) the annual
21 benefit limit may be limited to the lesser of $10,000 or 25% of
22 the lifetime policy limit.
23 (2) Each insured that is covered for mental, emotional or
24 nervous disorders or conditions shall be free to select the
25 physician licensed to practice medicine in all its branches,
26 licensed clinical psychologist, licensed clinical social
27 worker, or licensed clinical professional counselor of his
28 choice to treat such disorders, and the insurer shall pay the
29 covered charges of such physician licensed to practice medicine
30 in all its branches, licensed clinical psychologist, licensed
31 clinical social worker, or licensed clinical professional
32 counselor up to the limits of coverage, provided (i) the

1 disorder or condition treated is covered by the policy, and
2 (ii) the physician, licensed psychologist, licensed clinical
3 social worker, or licensed clinical professional counselor is
4 authorized to provide said services under the statutes of this
5 State and in accordance with accepted principles of his
6 profession.
7 (3) Insofar as this Section applies solely to licensed
8 clinical social workers and licensed clinical professional
9 counselors, those persons who may provide services to
10 individuals shall do so after the licensed clinical social
11 worker or licensed clinical professional counselor has
12 informed the patient of the desirability of the patient
13 conferring with the patient's primary care physician and the
14 licensed clinical social worker or licensed clinical
15 professional counselor has provided written notification to
16 the patient's primary care physician, if any, that services are
17 being provided to the patient. That notification may, however,
18 be waived by the patient on a written form. Those forms shall
19 be retained by the licensed clinical social worker or licensed
20 clinical professional counselor for a period of not less than 5
21 years.
22 (b) (1) An insurer that provides coverage for hospital or
23 medical expenses under a group policy of accident and health
24 insurance or health care plan amended, delivered, issued, or
25 renewed after the effective date of this amendatory Act of the
26 92nd General Assembly shall provide coverage under the policy
27 for treatment of serious mental illness under the same terms
28 and conditions as coverage for hospital or medical expenses
29 related to other illnesses and diseases. The coverage required
30 under this Section must provide for same durational limits,
31 amount limits, deductibles, and co-insurance requirements for
32 serious mental illness as are provided for other illnesses and
33 diseases. This subsection does not apply to coverage provided
34 to employees by employers who have 50 or fewer employees.
35 (2) "Serious mental illness" means the following
36 psychiatric illnesses as defined in the most current edition of

the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence; ~~and~~

(I) panic disorder; and~~.~~

(J) post-traumatic stress disorders (acute, chronic, or with delayed onset).

(3) Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness,

an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year;

(i) 45 days of inpatient treatment; and

(ii) 35 visits for outpatient treatment including group and individual outpatient treatment;

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

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

(7) This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(A) an addiction to a controlled substance or cannabis that is used in violation of law; or

(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.

(8) This subsection (b) is inoperative after December 31, 2005.

(Source: P.A. 92-182, eff. 7-27-01; 92-185, eff. 1-1-02; 92-651, eff. 7-11-02.)

1 Section 99. Effective date. This Act takes effect upon
2 becoming law.