LRB094 13838 LJB 48711 b

94TH GENERAL ASSEMBLY

State of Illinois

2005 and 2006

HB4125

Introduced 10/14/05, by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.11	
55 ILCS 5/5-1069.3	
65 ILCS 5/10-4-2.3	
105 ILCS 5/10-22.3f	
215 ILCS 5/356z.7 new	
215 ILCS 5/370c	from Ch. 73, par. 982c
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 165/10	from Ch. 32, par. 604
305 ILCS 5/5-16.8	

Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the Health Maintenance Organization Act, the Voluntary Health Services Plans Act, and the Illinois Public Aid Code to require coverage for the treatment of pervasive developmental disorders. Amends the Illinois Insurance Code to provide that certain mental health coverages apply to health maintenance organizations and individual policies of accident and health insurance. Effective immediately.

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FISCAL NOTE ACT MAY APPLY

STATE MANDATES ACT MAY REQUIRE REIMBURSEMENT

A BILL FOR

AN ACT concerning insurance.

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

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

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356u, 356w, 356x, 356z.2, 356z.4, ~~and~~ 356z.6, and 356z.7 of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 92-440, eff. 8-17-01; 92-764, eff. 1-1-03; 93-102, eff. 1-1-04; 93-853, eff. 1-1-05.)

Section 10. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356u, 356w, 356x, ~~and~~ 356z.6, and 356z.7 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under

Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

(Source: P.A. 93-853, eff. 1-1-05.)

Section 15. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356u, 356w, 356x, ~~and~~ 356z.6, and 356z.7 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

(Source: P.A. 93-853, eff. 1-1-05.)

Section 20. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356u, 356w, 356x, ~~and~~ 356z.6, and 356z.7 of the Illinois Insurance Code.

(Source: P.A. 93-853, eff. 1-1-05.)

Section 25. The Illinois Insurance Code is amended by adding Section 356z.7 and by changing Section 370c as follows:

(215 ILCS 5/356z.7 new)

Sec. 356z.7. Pervasive developmental disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 94th General Assembly shall provide coverage for the treatment of pervasive developmental disorders. The coverage required by this Section is limited to treatment that is prescribed by the insured's or the insured's immediate family member's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, reissue, or otherwise terminate or restrict coverage to an individual under an insurance policy solely because the individual is diagnosed with a pervasive developmental disorder.

Coverage required under this Section may not impose any deductible, coinsurance, waiting period, or other cost-sharing or limitation that is greater than that required for any physical illness generally under the insurance policy.

(b) As used in this Section:

"Immediate family member" means the insured, any children of the insured covered by the insurance policy, including, but not limited to, children by birth, marriage, or adoption, and any spouse of the insured covered by the insurance policy.

"Pervasive developmental disorder" means a neurological condition, including, but not limited to, Asperger's Syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this Section, every insurer and health maintenance organization which delivers, issues for delivery or renews or modifies group or individual A&H policies or health care plans providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b), up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit. The changes made to this item (1) by this amendatory Act of the 94th General Assembly apply on and after the effective date of this amendatory Act of the 94th General Assembly.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, or licensed clinical professional counselor is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed

clinical social workers and licensed clinical professional counselors, those persons who may provide services to individuals shall do so after the licensed clinical social worker or licensed clinical professional counselor has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker or licensed clinical professional counselor has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker or licensed clinical professional counselor for a period of not less than 5 years.

(b) (1) An insurer or health maintenance organization that provides coverage for hospital or medical expenses under a group or individual policy of accident and health insurance or health care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees. The changes made to this item (1) by this amendatory Act of the 94th General Assembly apply on and after the effective date of this amendatory Act of the 94th General Assembly.

(2) "Serious mental illness" means the following 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;

(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) (Blank).

(Source: P.A. 94-402, eff. 8-2-05; P.A. 94-584, eff. 8-15-05; revised 8-19-05.)

Section 30. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.7, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not

apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to

be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used

to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 92-764, eff. 1-1-03; 93-102, eff. 1-1-04; 93-261, eff. 1-1-04; 93-477, eff. 8-8-03; 93-529, eff. 8-14-03; 93-853, eff. 1-1-05; 93-1000, eff. 1-1-05; revised 10-14-04.)

Section 35. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.7, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 92-130, eff. 7-20-01; 92-440, eff. 8-17-01; 92-651, eff. 7-11-02; 92-764, eff. 1-1-03; 93-102, eff. 1-1-04; 93-529, eff. 8-14-03; 93-853, eff. 1-1-05; 93-1000, eff. 1-1-05; revised 10-14-04.)

Section 40. The Illinois Public Aid Code is amended by changing Section 5-16.8 as follows:

(305 ILCS 5/5-16.8)

Sec. 5-16.8. Required health benefits. The medical assistance program shall (i) provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356u, 356w, 356x, ~~and~~ 356z.6, and 356z.7 of the Illinois Insurance Code and (ii) be subject to the provisions of Section 364.01 of the Illinois Insurance Code.

(Source: P.A. 93-853, eff. 1-1-05; 93-1000, eff. 1-1-05; revised 10-14-04.)

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