



Rep. Lou Lang

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1 AMENDMENT TO HOUSE BILL 68

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 68 by replacing  
3 everything after the enacting clause with the following:

4 "Section 5. The State Finance Act is amended by changing  
5 Section 5.872 as follows:

6 (30 ILCS 105/5.872)

7 Sec. 5.872. The Parity Advancement ~~Education~~ Fund.

8 (Source: P.A. 99-480, eff. 9-9-15; 99-642, eff. 7-28-16.)

9 Section 10. The Illinois Insurance Code is amended by  
10 changing Sections 370c and 370c.1 as follows:

11 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

12 Sec. 370c. Mental and emotional disorders.

13 (a) (1) On and after the effective date of this amendatory  
14 Act of the 100th General Assembly ~~the effective date of this~~

1 ~~amendatory Act of the 97th General Assembly~~, every insurer that  
2 ~~which~~ amends, delivers, issues, or renews group accident and  
3 health policies providing coverage for hospital or medical  
4 treatment or services for illness on an expense-incurred basis  
5 shall provide ~~offer to the applicant or group policyholder~~  
6 ~~subject to the insurer's standards of insurability~~, coverage  
7 for reasonable and necessary treatment and services for mental,  
8 emotional, ~~or~~ nervous, or substance use disorders or  
9 conditions, ~~other than serious mental illnesses as defined in~~  
10 ~~item (2) of subsection (b)~~, consistent with the parity  
11 requirements of Section 370c.1 of this Code.

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

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

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

1 ~~physician and the licensed clinical social worker, licensed~~  
2 ~~clinical professional counselor, licensed marriage and family~~  
3 ~~therapist, licensed speech language pathologist, or other~~  
4 ~~licensed or certified professional at a program licensed~~  
5 ~~pursuant to the Illinois Alcoholism and Other Drug Abuse and~~  
6 ~~Dependency Act has provided written notification to the~~  
7 ~~patient's primary care physician, if any, that services are~~  
8 ~~being provided to the patient. That notification may, however,~~  
9 ~~be waived by the patient on a written form. Those forms shall~~  
10 ~~be retained by the licensed clinical social worker, licensed~~  
11 ~~clinical professional counselor, licensed marriage and family~~  
12 ~~therapist, licensed speech language pathologist, or other~~  
13 ~~licensed or certified professional at a program licensed~~  
14 ~~pursuant to the Illinois Alcoholism and Other Drug Abuse and~~  
15 ~~Dependency Act for a period of not less than 5 years.~~

16 (4) "Mental, emotional, nervous, or substance use disorder  
17 or condition" means a condition or disorder that involves a  
18 mental health condition or substance use disorder that falls  
19 under any of the diagnostic categories listed in the mental and  
20 behavioral disorders chapter of the current edition of the  
21 International Classification of Disease or that is listed in  
22 the most recent version of the Diagnostic and Statistical  
23 Manual of Mental Disorders.

24 (b) (1) (Blank). ~~An insurer that provides coverage for~~  
25 ~~hospital or medical expenses under a group policy of accident~~  
26 ~~and health insurance or health care plan amended, delivered,~~

1 ~~issued, or renewed on or after the effective date of this~~  
2 ~~amendatory Act of the 97th General Assembly shall provide~~  
3 ~~coverage under the policy for treatment of serious mental~~  
4 ~~illness and substance use disorders consistent with the parity~~  
5 ~~requirements of Section 370c.1 of this Code. This subsection~~  
6 ~~does not apply to any group policy of accident and health~~  
7 ~~insurance or health care plan for any plan year of a small~~  
8 ~~employer as defined in Section 5 of the Illinois Health~~  
9 ~~Insurance Portability and Accountability Act.~~

10 (2) (Blank). ~~"Serious mental illness" means the following~~  
11 ~~psychiatric illnesses as defined in the most current edition of~~  
12 ~~the Diagnostic and Statistical Manual (DSM) published by the~~  
13 ~~American Psychiatric Association:~~

- 14 ~~(A) schizophrenia;~~  
15 ~~(B) paranoid and other psychotic disorders;~~  
16 ~~(C) bipolar disorders (hypomanic, manic, depressive,~~  
17 ~~and mixed);~~  
18 ~~(D) major depressive disorders (single episode or~~  
19 ~~recurrent);~~  
20 ~~(E) schizoaffective disorders (bipolar or depressive);~~  
21 ~~(F) pervasive developmental disorders;~~  
22 ~~(G) obsessive compulsive disorders;~~  
23 ~~(H) depression in childhood and adolescence;~~  
24 ~~(I) panic disorder;~~  
25 ~~(J) post traumatic stress disorders (acute, chronic,~~  
26 ~~or with delayed onset); and~~

1 ~~(K) anorexia nervosa and bulimia nervosa.~~

2 (2.5) (Blank). ~~"Substance use disorder" means the~~  
3 ~~following mental disorders as defined in the most current~~  
4 ~~edition of the Diagnostic and Statistical Manual (DSM)~~  
5 ~~published by the American Psychiatric Association:~~

6 ~~(A) substance abuse disorders;~~

7 ~~(B) substance dependence disorders; and~~

8 ~~(C) substance induced disorders.~~

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

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

20 (4) A group health benefit plan amended, delivered, issued,  
21 or renewed on or after the effective date of this amendatory  
22 Act of the 100th General Assembly or an individual policy of  
23 accident and health insurance or a qualified health plan  
24 offered through the health insurance marketplace amended,  
25 delivered, issued, or renewed on or after the effective date of  
26 this amendatory Act of the 100th General Assembly ~~the effective~~

1 ~~date of this amendatory Act of the 97th General Assembly :~~

2 (A) shall provide coverage based upon medical  
3 necessity for the treatment of a mental, emotional,  
4 nervous, or ~~mental illness and~~ substance use disorder or  
5 condition ~~disorders~~ consistent with the parity  
6 requirements of Section 370c.1 of this Code; provided,  
7 however, that in each calendar year coverage shall not be  
8 less than the following:

9 (i) 45 days of inpatient treatment; and

10 (ii) beginning on June 26, 2006 (the effective date  
11 of Public Act 94-921), 60 visits for outpatient  
12 treatment including group and individual outpatient  
13 treatment; and

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

21 (B) may not include a lifetime limit on the number of  
22 days of inpatient treatment or the number of outpatient  
23 visits covered under the plan.

24 (C) (Blank).

25 (5) An issuer of a group health benefit plan or an  
26 individual policy of accident and health insurance or a



1 qualified health plan offered through the health insurance  
2 marketplace may not count toward the number of outpatient  
3 visits required to be covered under this Section an outpatient  
4 visit for the purpose of medication management and shall cover  
5 the outpatient visits under the same terms and conditions as it  
6 covers outpatient visits for the treatment of physical illness.

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

25 As used in this subsection:

26 "Acute treatment services" means 24-hour medically

1 supervised addiction treatment that provides evaluation and  
2 withdrawal management and may include biopsychosocial  
3 assessment, individual and group counseling, psychoeducational  
4 groups, and discharge planning.

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

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

15 (7) (Blank).

16 (8) (Blank).

17 (9) With respect to all mental, emotional, nervous, or  
18 substance use disorders or conditions, coverage for inpatient  
19 treatment shall include coverage for treatment in a residential  
20 treatment center certified or licensed by the Department of  
21 Public Health or the Department of Human Services.

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

25 (d) With respect to a group or individual policy of  
26 accident and health insurance or a qualified health plan

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

18 (1) ensuring compliance by individual and group  
19 policies;

20 (2) detecting violations of the law by individual and  
21 group policies ~~proactively monitoring discriminatory~~  
22 practices;

23 (3) accepting, evaluating, and responding to  
24 complaints regarding such violations;

25 (4) maintaining and regularly reviewing for possible  
26 parity violations a publicly available consumer complaint

1 log regarding mental, emotional, nervous, or substance use  
2 disorders or conditions coverage;

3 (5) performing parity compliance pre-market and  
4 post-market conduct examinations of individual and group  
5 plans and policies, including, but not limited to, reviews  
6 of:

7 (A) network adequacy using established criteria as  
8 set forth in federal and State requirements for medical  
9 assistance and individual or group health policies;

10 (B) reimbursement rates;

11 (C) denials of authorization, payment, and  
12 coverage;

13 (D) prior authorization requirements; and

14 (E) other specific criteria as shall be set forth  
15 in rules adopted by the Department.

16 The findings and conclusions of the parity compliance  
17 market conduct examinations shall be made public and shall be  
18 reported to the General Assembly.

19 The Director shall adopt rules to effectuate any provisions  
20 of the Paul Wellstone and Pete Domenici Mental Health Parity  
21 and Addiction Equity Act of 2008 that relate to the business of  
22 insurance. and ensuring violations are appropriately remedied  
23 and deterred.

24 (e) Availability of plan information.

25 (1) The criteria for medical necessity determinations  
26 made under a group health plan, an individual policy of

1       accident and health insurance, or a qualified health plan  
2       offered through the health insurance marketplace with  
3       respect to mental health or substance use disorder benefits  
4       (or health insurance coverage offered in connection with  
5       the plan with respect to such benefits) must be made  
6       available by the plan administrator (or the health  
7       insurance issuer offering such coverage) to any current or  
8       potential participant, beneficiary, or contracting  
9       provider upon request.

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

23       (3) The following information under a group health  
24       benefit plan, an individual policy of accident and health  
25       insurance, or a qualified health plan offered through the  
26       health insurance marketplace (or health insurance coverage

1       offered in connection with such plan or policy) must be  
2       made available upon request:

3               (A) a Summary Plan Description, or similar summary  
4               information;

5               (B) the specific plan or policy language regarding  
6               the imposition of a nonquantitative treatment  
7               limitation (such as a preauthorization requirement);

8               (C) the specific underlying processes, strategies,  
9               evidentiary standards, and other factors (including,  
10              but not limited to, all evidence) considered by the  
11              plan or policy (including factors that were relied upon  
12              and were rejected) in determining that a  
13              nonquantitative treatment limitation applies to any  
14              particular mental health or substance use disorder  
15              benefit;

16              (D) information regarding the application of a  
17              nonquantitative treatment limitation to any medical or  
18              surgical benefits within any benefit classification at  
19              issue;

20              (E) the specific underlying processes, strategies,  
21              evidentiary standards, and other factors (including,  
22              but not limited to, all evidence) considered by the  
23              plan or policy (including factors that were relied upon  
24              and were rejected) in determining the extent to which a  
25              nonquantitative treatment limitation applies to a  
26              particular medical or surgical benefit within a

1 benefit classification at issue; and

2 (F) any analyses performed by the plan or under the  
3 policy as to how any nonquantitative treatment  
4 limitation complies with this Section and Sections  
5 356z.23 and 370c.1 of this Code, the Paul Wellstone and  
6 Pete Domenici Mental Health Parity and Addiction  
7 Equity Act of 2008, 42 U.S.C. 18031(j), and any  
8 amendments to, and federal guidance or regulations  
9 issued under, those Acts, including, but not limited  
10 to, final regulations issued under the Paul Wellstone  
11 and Pete Domenici Mental Health Parity and Addiction  
12 Equity Act of 2008 and final regulations applying the  
13 Paul Wellstone and Pete Domenici Mental Health Parity  
14 and Addiction Equity Act of 2008 to Medicaid managed  
15 care organizations, the Children's Health Insurance  
16 Program, and alternative benefit plans.

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

23 (g) The General Assembly decrees that it is the public  
24 policy of the State of Illinois to allow for private  
25 enforcement of mental, emotional, nervous, or substance use  
26 disorder or condition parity protections in a court of

1 competent jurisdiction, without administrative exhaustion or  
2 arbitration, even if otherwise required by an insurance policy.

3 Members, patients, subscribers, enrollees, and providers  
4 (in-network and out-of-network) on behalf of members,  
5 patients, subscribers, and enrollees have the right to commence  
6 a civil action against any group health plan, an issuer of an  
7 individual policy of accident and health insurance, or a  
8 qualified health plan offered through the health insurance  
9 marketplace (or health insurance coverage offered in  
10 connection with such plan or policy) that violates the  
11 provisions of this Section, such that any member of a group  
12 health plan or an individual covered under a policy of accident  
13 and health insurance or a qualified health plan offered through  
14 the health insurance marketplace (or health insurance coverage  
15 offered in connection with such plan or policy) authorized  
16 representative of such plan or related entity, advocacy  
17 organization representing the interests of members of a health  
18 plan carrier or related entity, health care providers, or  
19 organization representing the interests of providers  
20 reimbursed by a health plan carrier or related entity, against  
21 which the violation is alleged, shall have standing to commence  
22 a civil action in a court of competent jurisdiction.

23 The remedy under this Section is limited to a \$5,000  
24 penalty for each act or offense; injunctive relief; general and  
25 special damages, which may be trebled; restitution of premium;  
26 and attorney's fees and costs.



1       A violation consists of any violation of this Section or  
2 Section 370c.1 of this Code, the Paul Wellstone and Pete  
3 Domenici Mental Health Parity and Addiction Equity Act of 2008,  
4 42 U.S.C. 18031(j), and any amendments to, and federal guidance  
5 or regulations issued under, those acts, including, but not  
6 limited to, final regulations issued under the Paul Wellstone  
7 and Pete Domenici Mental Health Parity and Addiction Equity Act  
8 of 2008 and final regulations applying the Paul Wellstone and  
9 Pete Domenici Mental Health Parity and Addiction Equity Act of  
10 2008 to Medicaid Managed Care Organizations, Children's Health  
11 Insurance Programs (CHIP), and Alternative Benefit Plans.

12       A violation of this Section shall not be contingent upon  
13 the plaintiff proving the medical necessity of any prescribed  
14 procedure, service, or medication.

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

16       (215 ILCS 5/370c.1)

17       Sec. 370c.1. Mental, emotional, nervous, or substance use  
18 disorder or condition ~~health and addiction~~ parity.

19       (a) On and after the effective date of this amendatory Act  
20 of the 99th General Assembly, every insurer that amends,  
21 delivers, issues, or renews a group or individual policy of  
22 accident and health insurance or a qualified health plan  
23 offered through the Health Insurance Marketplace in this State  
24 providing coverage for hospital or medical treatment and for  
25 the treatment of mental, emotional, nervous, or substance use

1 disorders or conditions shall ensure that:

2 (1) the financial requirements applicable to such  
3 mental, emotional, nervous, or substance use disorder or  
4 condition benefits are no more restrictive than the  
5 predominant financial requirements applied to  
6 substantially all hospital and medical benefits covered by  
7 the policy and that there are no separate cost-sharing  
8 requirements that are applicable only with respect to  
9 mental, emotional, nervous, or substance use disorder or  
10 condition benefits; and

11 (2) the treatment limitations applicable to such  
12 mental, emotional, nervous, or substance use disorder or  
13 condition benefits are no more restrictive than the  
14 predominant treatment limitations applied to substantially  
15 all hospital and medical benefits covered by the policy and  
16 that there are no separate treatment limitations that are  
17 applicable only with respect to mental, emotional,  
18 nervous, or substance use disorder or condition benefits.

19 (b) The following provisions shall apply concerning  
20 aggregate lifetime limits:

21 (1) In the case of a group or individual policy of  
22 accident and health insurance or a qualified health plan  
23 offered through the Health Insurance Marketplace amended,  
24 delivered, issued, or renewed in this State on or after the  
25 effective date of this amendatory Act of the 99th General  
26 Assembly that provides coverage for hospital or medical

1 treatment and for the treatment of mental, emotional,  
2 nervous, or substance use disorders or conditions the  
3 following provisions shall apply:

4 (A) if the policy does not include an aggregate  
5 lifetime limit on substantially all hospital and  
6 medical benefits, then the policy may not impose any  
7 aggregate lifetime limit on mental, emotional,  
8 nervous, or substance use disorder or condition  
9 benefits; or

10 (B) if the policy includes an aggregate lifetime  
11 limit on substantially all hospital and medical  
12 benefits (in this subsection referred to as the  
13 "applicable lifetime limit"), then the policy shall  
14 either:

15 (i) apply the applicable lifetime limit both  
16 to the hospital and medical benefits to which it  
17 otherwise would apply and to mental, emotional,  
18 nervous, or substance use disorder or condition  
19 benefits and not distinguish in the application of  
20 the limit between the hospital and medical  
21 benefits and mental, emotional, nervous, or  
22 substance use disorder or condition benefits; or

23 (ii) not include any aggregate lifetime limit  
24 on mental, emotional, nervous, or substance use  
25 disorder or condition benefits that is less than  
26 the applicable lifetime limit.

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

13           (c) The following provisions shall apply concerning annual  
14 limits:

15           (1) In the case of a group or individual policy of  
16 accident and health insurance or a qualified health plan  
17 offered through the Health Insurance Marketplace amended,  
18 delivered, issued, or renewed in this State on or after the  
19 effective date of this amendatory Act of the 99th General  
20 Assembly that provides coverage for hospital or medical  
21 treatment and for the treatment of mental, emotional,  
22 nervous, or substance use disorders or conditions the  
23 following provisions shall apply:

24           (A) if the policy does not include an annual limit  
25 on substantially all hospital and medical benefits,  
26 then the policy may not impose any annual limits on

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

3           (B) if the policy includes an annual limit on  
4           substantially all hospital and medical benefits (in  
5           this subsection referred to as the "applicable annual  
6           limit"), then the policy shall either:

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

15          (ii) not include any annual limit on mental,  
16          emotional, nervous, or substance use disorder or  
17          condition benefits that is less than the  
18          applicable annual limit.

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

1 substituting for the applicable annual limit an average  
2 annual limit that is computed taking into account the  
3 weighted average of the annual limits applicable to such  
4 categories.

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

16 (e) This Section shall be interpreted in a manner  
17 consistent with all applicable federal parity regulations  
18 including, but not limited to, the Paul Wellstone and Pete  
19 Domenici Mental Health Parity and Addiction Equity Act of 2008,  
20 final regulations issued under the Paul Wellstone and Pete  
21 Domenici Mental Health Parity and Addiction Equity Act of 2008  
22 and final regulations applying the Paul Wellstone and Pete  
23 Domenici Mental Health Parity and Addiction Equity Act of 2008  
24 to Medicaid managed care organizations, the Children's Health  
25 Insurance Program, and alternative benefit plans ~~at 78 FR~~  
26 ~~68240~~.

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

4 (g) As used in this Section:

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

9 "Mental, emotional, nervous, or substance use disorder or  
10 condition" means a condition or disorder that involves a mental  
11 health condition or substance use disorder that falls under any  
12 of the diagnostic categories listed in the mental and  
13 behavioral disorders chapter of the current edition of the  
14 International Classification of Disease or that is listed in  
15 the most recent version of the Diagnostic and Statistical  
16 Manual of Mental Disorders.

17 "Treatment limitation" includes limits on benefits based  
18 on the frequency of treatment, number of visits, days of  
19 coverage, days in a waiting period, or other similar limits on  
20 the scope or duration of treatment. "Treatment limitation"  
21 includes both quantitative treatment limitations, which are  
22 expressed numerically (such as 50 outpatient visits per year),  
23 and nonquantitative treatment limitations, which otherwise  
24 limit the scope or duration of treatment. A permanent exclusion  
25 of all benefits for a particular condition or disorder shall  
26 not be considered a treatment limitation. "Nonquantitative

1 treatment" means those limitations as described under federal  
2 regulations (26 CFR 54.9812-1). Nonquantitative treatment  
3 limitations include, but are not limited to:

4 (1) medical management standards limiting or excluding  
5 benefits based on medical necessity or medical  
6 appropriateness, or based on whether the treatment is  
7 experimental or investigative;

8 (2) formulary design for prescription drugs;

9 (3) for plans with multiple network tiers (such as  
10 preferred providers and participating providers), network  
11 tier design;

12 (4) standards for provider admission to participate in  
13 a network, including reimbursement rates;

14 (5) plan methods for determining usual, customary, and  
15 reasonable charges;

16 (6) refusal to pay for higher-cost therapies until it  
17 can be shown that a lower-cost therapy is not effective  
18 (also known as fail-first policies or step therapy  
19 protocols);

20 (7) exclusions based on failure to complete a course of  
21 treatment;

22 (8) restrictions based on geographic location,  
23 facility type, provider specialty, and other criteria that  
24 limit the scope or duration of benefits for services  
25 provided under the plan or coverage;

26 (9) in-network and out-of-network geographic



1 limitations;

2 (10) standards for providing access to out-of-network  
3 providers;

4 (11) limitations on inpatient services for situations  
5 where the participant is a threat to self or others;

6 (12) exclusions for court-ordered and involuntary  
7 holds;

8 (13) experimental treatment limitations;

9 (14) service coding;

10 (15) exclusions for services provided by clinical  
11 social workers, physicians, licensed psychologists,  
12 licensed clinical professional counselors, licensed  
13 marriage and family therapists, licensed speech-language  
14 pathologists, or other licensed or certified professionals  
15 at a program licensed pursuant to the Illinois Alcoholism  
16 and Other Drug Abuse and Dependency Act;

17 (16) network adequacy as set forth in federal and State  
18 requirements for medical assistance and individual or  
19 group health policies; and

20 (17) provider reimbursement rates, including  
21 reimbursement rates for mental, emotional, nervous, or  
22 substance use disorder or condition screenings or  
23 diagnostic tests performed in primary care and integrated  
24 settings.

25 (h) The Department of Insurance shall implement the  
26 following education initiatives:

1           (1) By January 1, 2016, the Department shall develop a  
2 plan for a Consumer Education Campaign on parity. The  
3 Consumer Education Campaign shall focus its efforts  
4 throughout the State and include trainings in the northern,  
5 southern, and central regions of the State, as defined by  
6 the Department, as well as each of the 5 managed care  
7 regions of the State as identified by the Department of  
8 Healthcare and Family Services. Under this Consumer  
9 Education Campaign, the Department shall: (1) by January 1,  
10 2017, provide at least one live training in each region on  
11 parity for consumers and providers and one webinar training  
12 to be posted on the Department website and (2) establish a  
13 consumer hotline to assist consumers in navigating the  
14 parity process by March 1, 2017 ~~2016~~. By January 1, 2018  
15 the Department shall issue a report to the General Assembly  
16 on the success of the Consumer Education Campaign, which  
17 shall indicate whether additional training is necessary or  
18 would be recommended.

19           (2) The Department, in coordination with the  
20 Department of Human Services and the Department of  
21 Healthcare and Family Services, shall convene a working  
22 group of health care insurance carriers, mental health  
23 advocacy groups, substance abuse patient advocacy groups,  
24 and mental health physician groups for the purpose of  
25 discussing issues related to the treatment and coverage of  
26 mental, emotional, nervous, or substance use ~~abuse~~

1 disorders or conditions and compliance with parity  
2 obligations under State and federal law. Compliance shall  
3 be measured, tracked, and shared during the meetings of the  
4 working group and mental illness. The working group shall  
5 meet once before January 1, 2016 and shall meet  
6 semiannually thereafter. The Department shall issue an  
7 annual report to the General Assembly that includes a list  
8 of the health care insurance carriers, mental health  
9 advocacy groups, substance abuse patient advocacy groups,  
10 and mental health physician groups that participated in the  
11 working group meetings, details on the issues and topics  
12 covered, and any legislative recommendations developed by  
13 the working group.

14 (3) Not later than August 1 of each year, the  
15 Department, in conjunction with the Department of  
16 Healthcare and Family Services, shall issue a joint report  
17 to the General Assembly and provide an educational  
18 presentation to the General Assembly. The report and  
19 presentation shall:

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

1 of 2008 and 42 U.S.C. 18031(j).

2 (B) Cover the methodology the Departments use to  
3 check for compliance with this Section and Sections  
4 356z.23 and 370c of this Code.

5 (C) Identify pre-market and post-market conduct  
6 examinations conducted or completed during the  
7 preceding 12-month period regarding compliance with  
8 parity in mental, emotional, nervous, and substance  
9 use disorder or condition benefits under State and  
10 federal laws and summarize the results of such market  
11 conduct examinations. This shall include:

12 (i) the number of market conduct examinations  
13 initiated and completed;

14 (ii) the benefit classifications examined by  
15 each market conduct examination;

16 (iii) the subject matter of each market  
17 conduct examination, including quantitative and  
18 non-quantitative treatment limitations; and

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

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

25 (D) Detail any educational or corrective actions  
26 the Departments have taken to ensure compliance with

1           the federal Paul Wellstone and Pete Domenici Mental  
2           Health Parity and Addiction Equity Act of 2008, 42  
3           U.S.C. 18031(j), this Section, and Sections 356z.23  
4           and 370c of this Code.

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

10          (4) In the event of uncertainty or disagreement with  
11          respect to the application, interpretation,  
12          implementation, or enforcement of the federal Paul  
13          Wellstone and Pete Domenici Mental Health Parity and  
14          Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any  
15          amendments to, and federal guidance or regulations issued  
16          under, those Acts, including, but not limited to, final  
17          regulations issued under the Paul Wellstone and Pete  
18          Domenici Mental Health Parity and Addiction Equity Act of  
19          2008, final regulations applying the Paul Wellstone and  
20          Pete Domenici Mental Health Parity and Addiction Equity Act  
21          of 2008 to Medicaid managed care organizations, the  
22          Children's Health Insurance Program, and alternative  
23          benefit plans, Section 370c of this Code, and this Section,  
24          the Department and the Department of Healthcare and Family  
25          Services may request a formal written opinion from the  
26          Attorney General. The requests and opinions shall be issued

1 in accordance with State law and policies of the Attorney  
2 General. The Departments shall inform the public on their  
3 websites and in writing that any aggrieved beneficiary may  
4 ask the Departments to request a formal written opinion  
5 from the Attorney General.

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

17 (j) An insurer that amends, delivers, issues, or renews a  
18 group or individual policy of accident and health insurance or  
19 a qualified health plan offered through the health insurance  
20 marketplace in this State providing coverage for hospital or  
21 medical treatment and for the treatment of mental, emotional,  
22 nervous, or substance use disorders or conditions shall submit  
23 an annual report to the Department, or with respect to medical  
24 assistance the Department of Healthcare and Family Services, on  
25 or before March 1 that contains the following information  
26 separately for inpatient in-network benefits, inpatient

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

7 (1) The number and percentage of times a benefit limit  
8 is exceeded for a mental, emotional, nervous, or substance  
9 use disorder or condition benefit and the number and  
10 percentage of times a benefit limit is exceeded for other  
11 medical benefits.

12 (2) The number and percentage of times a co-pay or  
13 co-insurance limit for a mental, emotional, nervous, or  
14 substance use disorder or condition benefit is different  
15 from other medical benefits.

16 (3) The number and percentage of claim denials for  
17 mental, emotional, nervous, or substance use disorder or  
18 condition benefits due to benefit limits and the number and  
19 percentage of claim denials for other medical benefits due  
20 to benefit limits.

21 (4) The number and percentage of denials for  
22 experimental benefits or the use of unproven technology for  
23 a mental, emotional, nervous, or substance use disorder or  
24 condition benefit and the number and percentage of denials  
25 for experimental benefits or the use of unproven technology  
26 for other medical benefits.

1           (5) The number and percentage of administrative  
2           denials for no prior authorization for a mental, emotional,  
3           nervous, or substance use disorder or condition benefit and  
4           the number and percentage of administrative denials for no  
5           prior authorization for other medical benefits.

6           (6) The number and percentage of denials due to a  
7           mental, emotional, nervous, or substance use disorder or  
8           condition benefit not being a covered benefit and the  
9           number and percentage of denials for other medical benefits  
10           not being a covered benefit.

11           (7) The number and percentage of denials due to a  
12           mental, emotional, nervous, or substance use disorder or  
13           condition benefit not meeting medical necessity and the  
14           number and percentage of denials for other medical benefits  
15           not meeting medical necessity.

16           (8) The number and percentage of denials upheld on  
17           appeal for a mental, emotional, nervous, or substance use  
18           disorder or condition benefit for not meeting medical  
19           necessity and the number and percentage of those for other  
20           medical benefits.

21           (9) The number and percentage of denials due to a  
22           mental, emotional, nervous, or substance use disorder or  
23           condition benefit being denied administratively or any  
24           reason other than medical necessity.

25           (10) The number and percentage of denials of mental,  
26           emotional, nervous, or substance use disorder or condition



1 benefits that went to the plan's external quality review  
2 organization, or similar reviewing body and were upheld and  
3 those that were overturned for medical necessity.

4 (11) The number and percentage of continued stay review  
5 denials for mental, emotional, nervous, or substance use  
6 disorder or condition benefits.

7 (12) The number and percentage of out-of-network  
8 claims for mental, emotional, nervous, or substance use  
9 disorder or condition benefits in each classification of  
10 benefits and the number and percentage of out-of-network  
11 claims for other medical benefits in each classification of  
12 benefits.

13 (13) The number and percentage of emergency care claims  
14 for mental, emotional, nervous, or substance use disorder  
15 or condition benefits in each classification of benefits  
16 and the number and percentage of emergency care claims for  
17 other medical benefits in each classification of benefits.

18 (14) The number and percentage of network directory  
19 providers in the outpatient benefits classification who  
20 filed no claims in the last 6 months of the plan's claims  
21 reporting period and all pertinent summary information and  
22 results respecting the tests and metrics the insurer used  
23 to assess the availability of each of the following types  
24 of mental, emotional, nervous, or substance use disorder or  
25 condition providers: MD/DO; doctoral level non-MD/DO and  
26 non-doctoral level non-MD/DO practitioners; and inpatient,

1       residential, and ambulatory provider organizations.

2           (15) A summary of the plan's pharmacy management  
3 processes for mental, emotional, nervous, or substance use  
4 disorder or condition benefits compared to those for other  
5 medical benefits.

6           (16) A summary of the internal processes of review for  
7 experimental benefits and unproven technology for mental,  
8 emotional, nervous, or substance use disorder or condition  
9 benefits and those for other medical benefits.

10          (17) A summary of how the plan's policies and  
11 procedures for utilization management for mental,  
12 emotional, nervous, or substance use disorder or condition  
13 benefits compare to those for other medical benefits.

14          (18) The results of an analysis that demonstrates that  
15 for each nonquantitative treatment limitation, as written  
16 and in operation, the processes, strategies, evidentiary  
17 standards, or other factors used to apply each  
18 nonquantitative treatment limitation to mental, emotional,  
19 nervous, or substance use disorder or condition benefits  
20 are comparable to, and are applied no more stringently than  
21 the processes, strategies, evidentiary standards, or other  
22 factors used to apply each nonquantitative treatment  
23 limitation, as written and in operation, to medical and  
24 surgical benefits; at a minimum, the results of the  
25 analysis shall:

26           (A) identify the factors used to determine that a

1       nonquantitative treatment limitation will apply to a  
2       benefit, including factors that were considered but  
3       rejected;

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

8           (C) identify and describe the methods and analyses  
9       used, including the results of the analyses, to  
10       determine that the processes and strategies used to  
11       design each nonquantitative treatment limitation as  
12       written for mental, emotional, nervous, or substance  
13       use disorders or conditions benefits are comparable to  
14       and no more stringent than the processes and strategies  
15       used to design each nonquantitative treatment  
16       limitation as written for medical and surgical  
17       benefits;

18           (D) identify and describe the methods and analyses  
19       used, including the results of the analyses, to  
20       determine that the processes and strategies used to  
21       apply each nonquantitative treatment limitation in  
22       operation for mental, emotional, nervous, or substance  
23       use disorders or conditions benefits are comparable to  
24       and no more stringent than the processes or strategies  
25       used to apply each nonquantitative treatment  
26       limitation in operation for medical and surgical

1           benefits; and

2                   (E) disclose the specific findings and conclusions  
3                   reached by the insurer that the results of the analyses  
4                   above indicate that the insurer is in compliance with  
5                   this Section and the Mental Health Parity and Addiction  
6                   Equity Act of 2008 and its implementing regulations,  
7                   which includes 45 CFR 146.136 and any other relevant  
8                   current or future regulations.

9           (19) A certification signed by the insurer's chief  
10           executive officer and chief medical officer that states  
11           that the insurer has completed a comprehensive review of  
12           the administrative practices of the insurer for the prior  
13           calendar year for compliance with the necessary provisions  
14           of this Section and Sections 356z.23 and 370c of this Code,  
15           the federal Paul Wellstone and Pete Domenici Mental Health  
16           Parity and Addiction Equity Act of 2008, 42 U.S.C.  
17           18031(j), and any amendments to, and federal guidance or  
18           regulations issued under, those Acts, including, but not  
19           limited to, final regulations issued under the Paul  
20           Wellstone and Pete Domenici Mental Health Parity and  
21           Addiction Equity Act of 2008 and final regulations applying  
22           the Paul Wellstone and Pete Domenici Mental Health Parity  
23           and Addiction Equity Act of 2008 to Medicaid managed care  
24           organizations, the Children's Health Insurance Program,  
25           and alternative benefit plans.

26           (20) Any other information necessary to clarify data

1 provided in accordance with this Section requested by the  
2 Director, including information that may be proprietary or  
3 have commercial value.

4 The Director shall not certify any policy of an insurer  
5 that fails to submit all data as required by this Section.

6 (k) There is created within the Office of the Attorney  
7 General an Office of Consumer Advocate, which shall assist  
8 consumers, insureds, health care providers, and recipients in:

9 (1) ensuring compliance with the requirements of this  
10 Section;

11 (2) addressing issues related to insurance  
12 availability;

13 (3) identifying and rectifying claims processing  
14 issues;

15 (4) clarifying and resolving coverage questions; and

16 (5) addressing other matters related to insurance  
17 consumer education and assistance.

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