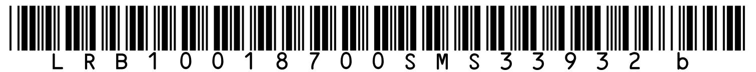
HB5464



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB5464

by Rep. Sara Feigenholtz

SYNOPSIS AS INTRODUCED:

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

Amends the Illinois Insurance Code. Provides that a group health insurance policy, an individual health policy, a group policy of accident and health insurance, group health benefit plan, qualified health plan that is offered through the health insurance marketplace, small employer group health plan, and large employer group health plan that is amended, delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of the amendatory Act, shall provide unlimited benefits for inpatient and outpatient treatment of mental, emotional, nervous, or substance use disorder or conditions at in-network facilities. Provides specified benefits for treatment of mental, emotional, nervous, or substance use disorders or conditions.

LRB100 18700 SMS 33932 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 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 amendatory
9 Act of the 97th General Assembly, every insurer which amends,
10 delivers, issues, or renews group accident and health policies
11 providing coverage for hospital or medical treatment or
12 services for illness on an expense-incurred basis shall offer
13 to the applicant or group policyholder subject to the insurer's
14 standards of insurability, coverage for reasonable and
15 necessary treatment and services for mental, emotional or
16 nervous disorders or conditions, other than serious mental
17 illnesses as defined in item (2) of subsection (b), consistent
18 with the parity requirements of Section 370c.1 of this Code.
19 (2) Each insured that is covered for mental, emotional,
20 nervous, or substance use disorders or conditions shall be free
21 to select the physician licensed to practice medicine in all
22 its branches, licensed clinical psychologist, licensed
23 clinical social worker, licensed clinical professional

1 counselor, licensed marriage and family therapist, licensed
2 speech-language pathologist, or other licensed or certified
3 professional at a program licensed pursuant to the Illinois
4 Alcoholism and Other Drug Abuse and Dependency Act of his
5 choice to treat such disorders, and the insurer shall pay the
6 covered charges of such physician licensed to practice medicine
7 in all its branches, licensed clinical psychologist, licensed
8 clinical social worker, licensed clinical professional
9 counselor, licensed marriage and family therapist, licensed
10 speech-language pathologist, or other licensed or certified
11 professional at a program licensed pursuant to the Illinois
12 Alcoholism and Other Drug Abuse and Dependency Act up to the
13 limits of coverage, provided (i) the disorder or condition
14 treated is covered by the policy, and (ii) the physician,
15 licensed psychologist, licensed clinical social worker,
16 licensed clinical professional counselor, licensed marriage
17 and family therapist, licensed speech-language pathologist, or
18 other licensed or certified professional at a program licensed
19 pursuant to the Illinois Alcoholism and Other Drug Abuse and
20 Dependency Act is authorized to provide said services under the
21 statutes of this State and in accordance with accepted
22 principles of his profession.

23 (3) Insofar as this Section applies solely to licensed
24 clinical social workers, licensed clinical professional
25 counselors, licensed marriage and family therapists, licensed
26 speech-language pathologists, and other licensed or certified

1 professionals at programs licensed pursuant to the Illinois
2 Alcoholism and Other Drug Abuse and Dependency Act, those
3 persons who may provide services to individuals shall do so
4 after the licensed clinical social worker, licensed clinical
5 professional counselor, licensed marriage and family
6 therapist, licensed speech-language pathologist, or other
7 licensed or certified professional at a program licensed
8 pursuant to the Illinois Alcoholism and Other Drug Abuse and
9 Dependency Act has informed the patient of the desirability of
10 the patient conferring with the patient's primary care
11 physician and the licensed clinical social worker, licensed
12 clinical professional counselor, licensed marriage and family
13 therapist, licensed speech-language pathologist, or other
14 licensed or certified professional at a program licensed
15 pursuant to the Illinois Alcoholism and Other Drug Abuse and
16 Dependency Act has provided written notification to the
17 patient's primary care physician, if any, that services are
18 being provided to the patient. That notification may, however,
19 be waived by the patient on a written form. Those forms shall
20 be retained by the licensed clinical social worker, licensed
21 clinical 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 for a period of not less than 5 years.
26 (b)(1) An insurer 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 on or after the effective date of this amendatory Act of the 100th General Assembly shall provide coverage under the policy for treatment of serious mental illness and substance use disorders consistent with the parity requirements of Section 370c.1 of this Code. This subsection does not apply to any group policy of accident and health insurance or health care plan for any plan year of a small employer as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

(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;

1 (J) post-traumatic stress disorders (acute, chronic,
2 or with delayed onset); and
3 (K) eating disorders, including, but not limited to,
4 anorexia nervosa, bulimia nervosa, pica, rumination
5 disorder, avoidant/restrictive food intake disorder, other
6 specified feeding or eating disorder (OSFED), and any other
7 eating disorder contained in the most recent version of the
8 Diagnostic and Statistical Manual of Mental Disorders
9 published by the American Psychiatric Association.
10 (2.5) "Substance use disorder" means the following mental
11 disorders as defined in the most current edition of the
12 Diagnostic and Statistical Manual (DSM) published by the
13 American Psychiatric Association:
14 (A) substance abuse disorders;
15 (B) substance dependence disorders; and
16 (C) substance induced disorders.
17 (3) Unless otherwise prohibited by federal law and
18 consistent with the parity requirements of Section 370c.1 of
19 this Code, the reimbursing insurer, a provider of treatment of
20 serious mental illness or substance use disorder shall furnish
21 medical records or other necessary data that substantiate that
22 initial or continued treatment is at all times medically
23 necessary. An insurer shall provide a mechanism for the timely
24 review by a provider holding the same license and practicing in
25 the same specialty as the patient's provider, who is
26 unaffiliated with the insurer, jointly selected by the patient

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

24 (4) A group health benefit plan amended, delivered, issued,
25 or renewed on or after the effective date of this amendatory
26 Act of the 97th General Assembly:

1 (A) shall provide coverage based upon medical
2 necessity for the treatment of mental illness and substance
3 use disorders consistent with the parity requirements of
4 Section 370c.1 of this Code; provided, however, that in
5 each calendar year coverage shall not be less than the
6 following:
7 (i) 45 days of inpatient treatment; and
8 (ii) beginning on June 26, 2006 (the effective date
9 of Public Act 94-921), 60 visits for outpatient
10 treatment including group and individual outpatient
11 treatment; and
12 (iii) for plans or policies delivered, issued for
13 delivery, renewed, or modified after January 1, 2007
14 (the effective date of Public Act 94-906), 20
15 additional outpatient visits for speech therapy for
16 treatment of pervasive developmental disorders that
17 will be in addition to speech therapy provided pursuant
18 to item (ii) of this subparagraph (A); and
19 (B) may not include a lifetime limit on the number of
20 days of inpatient treatment or the number of outpatient
21 visits covered under the plan.
22 (C) (Blank).
23 (5) An issuer of a group health benefit plan may not count
24 toward the number of outpatient visits required to be covered
25 under this Section an outpatient visit for the purpose of
26 medication management and shall cover the outpatient visits

1 under the same terms and conditions as it covers outpatient
2 visits for the treatment of physical illness.
3 (5.5) An individual or group health benefit plan amended,
4 delivered, issued, or renewed on or after the effective date of
5 this amendatory Act of the 99th General Assembly shall offer
6 coverage for medically necessary acute treatment services and
7 medically necessary clinical stabilization services. The
8 treating provider shall base all treatment recommendations and
9 the health benefit plan shall base all medical necessity
10 determinations for substance use disorders in accordance with
11 the most current edition of the American Society of Addiction
12 Medicine Patient Placement Criteria.
13 As used in this subsection:
14 "Acute treatment services" means 24-hour medically
15 supervised addiction treatment that provides evaluation and
16 withdrawal management and may include biopsychosocial
17 assessment, individual and group counseling, psychoeducational
18 groups, and discharge planning.
19 "Clinical stabilization services" means 24-hour treatment,
20 usually following acute treatment services for substance
21 abuse, which may include intensive education and counseling
22 regarding the nature of addiction and its consequences, relapse
23 prevention, outreach to families and significant others, and
24 aftercare planning for individuals beginning to engage in
25 recovery from addiction.
26 (6) An issuer of a group health benefit plan may provide or

1 offer coverage required under this Section through a managed
2 care plan.
3 (7) (Blank).
4 (8) (Blank).
5 (9) With respect to substance use disorders, coverage for
6 inpatient treatment shall include coverage for treatment in a
7 residential treatment center licensed by the Department of
8 Public Health or the Department of Human Services.
9 (c) This Section shall not be interpreted to require
10 coverage for speech therapy or other habilitative services for
11 those individuals covered under Section 356z.15 of this Code.
12 (d) The Department shall enforce the requirements of State
13 and federal parity law, which includes ensuring compliance by
14 individual and group policies; detecting violations of the law
15 by individual and group policies proactively monitoring
16 discriminatory practices; accepting, evaluating, and
17 responding to complaints regarding such violations; and
18 ensuring violations are appropriately remedied and deterred.
19 (e) Availability of plan information.
20 (1) The criteria for medical necessity determinations
21 made under a group health plan with respect to mental
22 health or substance use disorder benefits (or health
23 insurance coverage offered in connection with the plan with
24 respect to such benefits) must be made available by the
25 plan administrator (or the health insurance issuer
26 offering such coverage) to any current or potential

participant, beneficiary, or contracting provider upon request.

(2) The reason for any denial under a group health plan (or health insurance coverage offered in connection with such plan) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available within a reasonable time and in a reasonable manner by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary upon request.

(f) As used in this Section, "group policy of accident and health insurance" and "group health benefit plan" includes (1) State-regulated employer-sponsored group health insurance plans written in Illinois and (2) State employee health plans.

(g) A group health insurance policy, an individual health policy, a group policy of accident and health insurance, group health benefit plan, qualified health plan that is offered through the health insurance marketplace, small employer group health plan, and large employer group health plan that is amended, delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this amendatory Act of the 100th General Assembly, shall provide unlimited benefits for inpatient and outpatient treatment of mental, emotional, nervous, or substance use disorder or conditions at in-network facilities.

1 The services for the treatment of mental, emotional, nervous,
2 or substance use disorder or condition shall be prescribed by a
3 licensed physician, licensed psychologist, licensed
4 psychiatrist, or licensed advanced practice registered nurse
5 and provided by licensed health care professionals or licensed
6 or certified mental, emotional, nervous, or substance use
7 disorder or conditions providers in licensed, certified, or
8 otherwise State-approved facilities.
9 Benefits under this subsection shall be as follows:
10 (1) The benefits provided for treatment services for
11 the first 180 days per plan year of inpatient and
12 outpatient treatment of mental, emotional, nervous, or
13 substance use disorder or conditions shall be provided when
14 determined medically necessary by the covered person's
15 licensed physician, licensed psychologist, licensed
16 psychiatrist, licensed advanced practice registered nurse,
17 or licensed or certified mental, emotional, nervous, or
18 substance use disorder or conditions provider without the
19 imposition of any prior authorization or other prospective
20 utilization review requirements. The facility or provider
21 shall notify the insurer of both the admission and the
22 initial treatment plan within 48 hours after admission or
23 initiation of treatment. If there is no in-network facility
24 immediately available for a covered person, the insurer
25 shall provide necessary exceptions to its network to ensure
26 admission and treatment with a provider or at a treatment

1 facility within 24 hours.
2 (2) The benefits for the first 28 days of an inpatient
3 stay, detoxification/withdrawal management, partial
4 hospitalization, intensive outpatient treatment, and
5 outpatient treatment during each plan year shall be
6 provided without any retrospective review or concurrent
7 review of medical necessity and medical necessity shall be
8 as determined solely by the covered person's physician,
9 licensed psychologist, licensed psychiatrist, licensed
10 advanced practice registered nurse, or licensed or
11 certified mental, emotional, nervous, or substance use
12 disorder or conditions provider.
13 (3) The benefits for days 29 and thereafter of
14 inpatient care, detoxification/withdrawal management,
15 partial hospitalization, intensive outpatient treatment,
16 and outpatient treatment shall be subject to concurrent
17 review as defined in the Health Carrier External Review
18 Act. A request for approval of inpatient care,
19 detoxification/withdrawal management, partial
20 hospitalization, intensive outpatient treatment, and
21 outpatient treatment beyond the first 28 days shall be
22 submitted for concurrent review before the expiration of
23 the initial 28-day period. A request for approval of
24 inpatient care, detoxification/withdrawal management,
25 partial hospitalization, intensive outpatient treatment,
26 and outpatient treatment beyond any period that is approved

1 under concurrent review shall be submitted within the
2 period that was previously approved. No insurer shall
3 initiate concurrent review more frequently than at
4 two-week intervals. If an insurer determines that
5 continued inpatient care, detoxification/withdrawal
6 management, partial hospitalization, intensive outpatient
7 treatment, or outpatient treatment in a facility is no
8 longer medically necessary, the insurer shall, within 24
9 hours, provide written notice to the covered person and the
10 covered person's physician, licensed psychologist,
11 licensed psychiatrist, licensed advanced practice
12 registered nurse, or licensed or certified mental,
13 emotional, nervous, or substance use disorder or
14 conditions provider of its decision and the right to file
15 an expedited internal appeal of the determination. The
16 insurer shall review and make a determination with respect
17 to the internal appeal within 24 hours and communicate such
18 determination to the covered person and the covered
19 person's physician, licensed psychologist, licensed
20 psychiatrist, licensed advanced practice registered nurse,
21 or licensed or certified mental, emotional, nervous, or
22 substance use disorder or conditions provider. If the
23 determination is to uphold the denial, the covered person
24 and the covered person's physician, licensed psychologist,
25 licensed psychiatrist, licensed advanced practice
26 registered nurse, or licensed or certified mental,

1 emotional, nervous, or substance use disorder or
2 conditions provider have the right to file an expedited
3 external appeal. An independent utilization review
4 organization shall make a determination within 24 hours. If
5 the insurer's determination is upheld and it is determined
6 continued inpatient care, detoxification/withdrawal
7 management, partial hospitalization, intensive outpatient
8 treatment, or outpatient treatment is not medically
9 necessary, the insurer shall remain responsible to provide
10 benefits for the inpatient care, detoxification/withdrawal
11 management, partial hospitalization, intensive outpatient
12 treatment, or outpatient treatment through the day
13 following the date the determination is made and the
14 covered person shall only be responsible for any applicable
15 co-payment, deductible, and co-insurance for the stay
16 through that date as applicable under the policy. The
17 covered person shall not be discharged or released from the
18 inpatient facility, detoxification/withdrawal management,
19 partial hospitalization, intensive outpatient treatment,
20 or outpatient treatment until all internal appeals and
21 independent utilization review organization appeals are
22 exhausted.
23 (4) The benefits for outpatient prescription drugs to
24 treat mental, emotional, nervous, or substance use
25 disorder or conditions shall be provided when determined
26 medically necessary by the covered person's physician,

1 licensed psychologist, licensed psychiatrist, licensed
2 advanced practice registered nurse, or licensed or
3 certified mental, emotional, nervous, or substance use
4 disorder or conditions provider with prescriptive
5 authority, without the imposition of any prior
6 authorization or other prospective utilization management
7 requirements.
8 (5) The first 180 days per plan year of benefits shall
9 be computed based on inpatient days. One or more unused
10 inpatient days may be exchanged for 2 outpatient visits.
11 All extended outpatient services, such as partial
12 hospitalization and intensive outpatient, shall be deemed
13 inpatient days for the purpose of the visit to day exchange
14 provided in this subsection.
15 (6) Except as otherwise stated in this subsection, the
16 benefits and cost-sharing shall be provided to the same
17 extent as for any other medical condition covered under the
18 policy.
19 (7) The benefits required by this subsection are to be
20 provided to all covered persons with a diagnosis of mental,
21 emotional, nervous, or substance use disorder or
22 conditions. The presence of additional related or
23 unrelated diagnoses shall not be a basis to reduce or deny
24 the benefits required by this subsection.
25 (Source: P.A. 99-480, eff. 9-9-15; 100-305, eff. 8-24-17.)