

1 AN ACT concerning insurance.

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

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

6 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

7 Sec. 370c. Mental and emotional disorders.

8 (a) (1) On and after the effective date of this Section,
9 every insurer which delivers, issues for delivery or renews
10 or modifies group A&H policies providing coverage for
11 hospital or medical treatment or services for illness on an
12 expense-incurred basis or through a health maintenance
13 organization, as defined in Section 1-2 of the Health
14 Maintenance Organization Act shall offer to the applicant or
15 group policyholder subject to the insurers standards of
16 insurability, coverage for reasonable and necessary treatment
17 and services for mental, emotional or nervous disorders or
18 conditions, other than serious mental illnesses as defined in
19 item (2) of subsection (b), up to the limits provided in the
20 policy for other disorders or conditions, except (i) the
21 insured may be required to pay up to 50% of expenses incurred
22 as a result of the treatment or services, and (ii) the annual
23 benefit limit may be limited to the lesser of \$10,000 or 25%
24 of the lifetime policy limit.

25 (2) Each insured that is covered for mental, emotional
26 or nervous disorders or conditions shall be free to select
27 the physician licensed to practice medicine in all its
28 branches, licensed clinical psychologist, licensed clinical
29 social worker, or licensed clinical professional counselor of
30 his or her choice to treat such disorders, and the insurer
31 shall pay the covered charges of such physician licensed to

1 practice medicine in all its branches, licensed clinical
2 psychologist, licensed clinical social worker, or licensed
3 clinical professional counselor up to the limits of coverage,
4 provided (i) the disorder or condition treated is covered by
5 the policy, and (ii) the physician, licensed psychologist,
6 licensed clinical social worker, or licensed clinical
7 professional counselor is authorized to provide said services
8 under the statutes of this State and in accordance with
9 accepted principles of his or her profession.

10 (3) Insofar as this Section applies solely to licensed
11 clinical social workers and licensed clinical professional
12 counselors, those persons who may provide services to
13 individuals shall do so after the licensed clinical social
14 worker or licensed clinical professional counselor has
15 informed the patient of the desirability of the patient
16 conferring with the patient's primary care physician and the
17 licensed clinical social worker or licensed clinical
18 professional counselor has provided written notification to
19 the patient's primary care physician, if any, that services
20 are being provided to the patient. That notification may,
21 however, be waived by the patient on a written form. Those
22 forms shall be retained by the licensed clinical social
23 worker or licensed clinical professional counselor for a
24 period of not less than 5 years.

25 (b) (1) An insurer that provides coverage for hospital
26 or medical expenses under a group policy of accident and
27 health insurance, through a health maintenance organization,
28 as defined in Section 1-2 of the Health Maintenance
29 Organization Act, or health care plan amended, delivered,
30 issued, or renewed after the effective date of this
31 amendatory Act of the 93rd 92nd General Assembly shall
32 provide coverage under the policy for treatment of serious
33 mental illness under the same terms and conditions as
34 coverage for hospital or medical expenses related to other

1 illnesses and diseases. The coverage required under this
2 Section must provide for same durational limits, amount
3 limits, deductibles, and co-insurance requirements for
4 serious mental illness as are provided for other illnesses
5 and diseases. This subsection does not apply to coverage
6 provided to employees by employers who have 50 or fewer
7 employees.

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

12 (A) schizophrenia;

13 (B) paranoid and other psychotic disorders;

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

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

18 (E) schizoaffective disorders (bipolar or
19 depressive);

20 (F) pervasive developmental disorders;

21 (G) obsessive-compulsive disorders;

22 (H) depression in childhood and adolescence; and

23 (I) panic disorder;

24 (J) anorexia nervosa (restricting or binge-eating
25 and purging); and

26 (K) bulimia nervosa (purging or nonpurging).

27 (3) Upon request of the reimbursing insurer, a provider
28 of treatment of serious mental illness shall furnish medical
29 records or other necessary data that substantiate that
30 initial or continued treatment is at all times medically
31 necessary. An insurer shall provide a mechanism for the
32 timely review by a provider holding the same license and
33 practicing in the same specialty as the patient's provider,
34 who is unaffiliated with the insurer, jointly selected by the

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

19 (4) A group health benefit plan:

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

23 (i) 45 days of inpatient treatment; and

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

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

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

32 (5) An issuer of a group health benefit plan may not
33 count toward the number of outpatient visits required to be
34 covered under this Section an outpatient visit for the

1 purpose of medication management and shall cover the
2 outpatient visits under the same terms and conditions as it
3 covers outpatient visits for the treatment of physical
4 illness.

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

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

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

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

15 (8) This subsection (b) is inoperative after December
16 31, 2005.

17 (Source: P.A. 92-182, eff. 7-27-01; 92-185, eff. 1-1-02;
18 92-651, eff. 7-11-02.)

19 Section 10. The Health Maintenance Organization Act is
20 amended by changing Section 5-3 as follows:

21 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

22 Sec. 5-3. Insurance Code provisions.

23 (a) Health Maintenance Organizations shall be subject to
24 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
25 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
26 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x,
27 356y, 356z.2, 367i, 368a, 370c, 401, 401.1, 402, 403, 403A,
28 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
29 subsection (2) of Section 367, and Articles IIA, VIII 1/2,
30 XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois
31 Insurance Code.

32 (b) For purposes of the Illinois Insurance Code, except

1 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
2 Health Maintenance Organizations in the following categories
3 are deemed to be "domestic companies":

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

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

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

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

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

23 (2)(i) the criteria specified in subsection (1)(b)
24 of Section 131.8 of the Illinois Insurance Code shall not
25 apply and (ii) the Director, in making his determination
26 with respect to the merger, consolidation, or other
27 acquisition of control, need not take into account the
28 effect on competition of the merger, consolidation, or
29 other acquisition of control;

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

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

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

9 (C) a pro forma business plan detailing an
10 acquiring party's plans with respect to the
11 operation of the Health Maintenance Organization
12 sought to be acquired for a period of not less than
13 3 years; and

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

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

22 (e) In considering any management contract or service
23 agreement subject to Section 141.1 of the Illinois Insurance
24 Code, the Director (i) shall, in addition to the criteria
25 specified in Section 141.2 of the Illinois Insurance Code,
26 take into account the effect of the management contract or
27 service agreement on the continuation of benefits to
28 enrollees and the financial condition of the health
29 maintenance organization to be managed or serviced, and (ii)
30 need not take into account the effect of the management
31 contract or service agreement on competition.

32 (f) Except for small employer groups as defined in the
33 Small Employer Rating, Renewability and Portability Health
34 Insurance Act and except for medicare supplement policies as

1 defined in Section 363 of the Illinois Insurance Code, a
2 Health Maintenance Organization may by contract agree with a
3 group or other enrollment unit to effect refunds or charge
4 additional premiums under the following terms and conditions:

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

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

26 The Health Maintenance Organization shall include a
27 statement in the evidence of coverage issued to each enrollee
28 describing the possibility of a refund or additional premium,
29 and upon request of any group or enrollment unit, provide to
30 the group or enrollment unit a description of the method used
31 to calculate (1) the Health Maintenance Organization's
32 profitable experience with respect to the group or enrollment
33 unit and the resulting refund to the group or enrollment unit
34 or (2) the Health Maintenance Organization's unprofitable

1 experience with respect to the group or enrollment unit and
2 the resulting additional premium to be paid by the group or
3 enrollment unit.

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

8 (Source: P.A. 91-357, eff. 7-29-99; 91-406, eff. 1-1-00;
9 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff.
10 6-9-00; 92-764, eff. 1-1-03.)

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