SB3678

LRB10120367BMS69913b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB3678

Introduced 2/14/2020, by Sen. Laura Fine

SYNOPSIS AS INTRODUCED:

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

Amends the Illinois Insurance Code. Provides that the Department of Insurance and the Department of Healthcare and Family Services shall each appoint a Mental Health and Substance Use Disorder Parity Compliance Officer to assist with the responsibilities of enforcing the requirements of the Illinois Insurance Code. Provides that group accident and health policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall provide specified coverage for the diagnosis and medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions. Provides criteria and standards for the types of treatment that constitute medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions. Provides that an insurer shall not limit benefits or coverage for chronic or pervasive mental, emotional, nervous, or substance use disorders or conditions to short-term treatment or to alleviating current symptoms. Provides that insurers shall perform specified actions to ensure the proper use of medical necessity criteria. Provides that if medically necessary services for mental, emotional, nervous, or substance use disorders or conditions are not available in-network within the geography and timeliness standards, the insurer must cover out-of-network services. Provides that if the Department of Insurance determines that an insurer has failed to meet the requirements of the amendatory Act, it shall impose a penalty per product line with respect to each beneficiary. Makes other changes.

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FISCAL NOTE ACT MAY APPLY

STATE MANDATES ACT MAY REQUIRE REIMBURSEMENT

A BILL FOR

AN ACT concerning regulation.

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

Section 1. Reference to Act. This Act may be referred to as the Ensuring Coverage of Mental Health and Substance Use Disorder Care Act.

Section 2. Intent; purposes; findings.

(a) The General Assembly intends by this Act to ensure that all health plan medical necessity determinations concerning mental health and substance use disorder services are fully consistent with the generally accepted standards of behavioral healthcare.

(b) The U.S. District Court of the Northern District of California in Wit v. United Behavioral Health, 2019 WL 1033730 (N.D.CA Mar. 5, 2019), a class-action case representing over 50,000 people wrongly and systematically denied coverage of mental health and substance use disorder services they sought, found that generally accepted standards of care require:

(1) effective treatment of underlying conditions, rather than mere amelioration of current symptoms (such as suicidality or psychosis);

(2) treatment of co-occurring behavioral health disorders and medical conditions in a coordinated manner;

(3) treatment of the least intensive and restrictive level of care that is safe and effective; a lower level or less intensive care is appropriate only if it is safe and just as effective as treatment at a higher level of service intensity;

(4) erring on the side of caution by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care or when the recommended level of care is not available;

(5) treatment to maintain functioning or prevent deterioration;

(6) treatment of mental health and substance use disorders for an appropriate duration based on individual patient needs rather than on specific time limits;

(7) accounting for the unique needs of children and adolescents when making level of care decisions; and

(8) applying multidimensional assessments of patient needs when making determinations regarding the appropriate level of care.

(c) In Wit v. United Behavioral Health, the U.S. District Court concluded that all parties' experts agreed that the following standardized assessment tools, used for medical necessity determinations and placement decisions, reflect generally accepted standards of care:

(1) the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM

Criteria) developed by the American Society of Addiction Medicine;

(2) the Level of Care Utilization System (LOCUS) criteria developed by the American Association of Community Psychiatrists;

(3) the Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of Community Psychiatrists;

(4) the Child and Adolescent Services Intensity Instrument (CASII) developed by the American Academy of Child & Adolescent Psychiatry; and

(5) the Early Childhood Service Intensity Instrument (ECSII) developed by the American Academy Child & Adolescent Psychiatry.

(d) Nothing in this Act is intended to be interpreted in such a manner that it undermines patient self determination or in a manner that limits a patient's right to choose his or her preferred course of care or that is inconsistent with the Medical Patient Rights Act.

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

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

Sec. 370c. Mental and emotional disorders.

(a)(1) On and after August 16, 2019 ~~January 1, 2019~~ (the

effective date of Public Act 101-386 ~~this amendatory Act of the 101st General Assembly Public Act 100-1024~~), every insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall, pursuant to subsections (h) through (m), provide coverage for the diagnosis and medically necessary treatment of ~~reasonable and necessary treatment and services for~~ mental, emotional, nervous, or substance use disorders or conditions consistent with the parity requirements of Section 370c.1 of this Code.

(2) Each insured that is covered for mental, emotional, nervous, or substance use disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act up to the limits of

coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, licensed marriage and family therapists, licensed speech-language pathologists, and other licensed or certified professionals at programs licensed pursuant to the Substance Use Disorder Act, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act has informed the patient of the desirability of the patient conferring with the patient's primary care physician.

(4) "Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and

behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. "Mental, emotional, nervous, or substance use disorder or condition" includes any mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(b)(1) (Blank).

(2) (Blank).

(2.5) (Blank).

(3) Unless otherwise prohibited by federal law and consistent with the parity requirements of Section 370c.1 of this Code, the reimbursing insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance, a qualified health plan offered through the health insurance marketplace, or a provider of treatment of mental, emotional, nervous, or substance use disorders or conditions shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or

herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity, made pursuant to subsections (h) through (m), of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity pursuant to subsections (h) through (m) for a treatment modality for mental, emotional, nervous, or substance use disorders or conditions, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. Medical necessity determinations made pursuant to subsections (h) through (m) for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations, pursuant to subsections (h) through (m), for substance use disorders.

(4) A group health benefit plan amended, delivered, issued,

or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024) or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall provide coverage based upon medical necessity, pursuant to subsections (h) through (m), for the treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the parity requirements of Section 370c.1 of this Code; provided, however, that in each calendar year coverage shall not be less than the following:

(i) 45 days of inpatient treatment; and

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

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

(B) may not include a lifetime limit on the number of

days of inpatient treatment or the number of outpatient visits covered under the plan.

(C) (Blank).

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

(5.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after September 9, 2015 (the effective date of Public Act 99-480) shall offer coverage for medically necessary acute treatment services and medically necessary clinical stabilization services. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations, pursuant to subsections (h) through (m), for substance use disorders in accordance with the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations, pursuant to subsections (h) through (m), for

medication-assisted treatment in accordance with the most current Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

As used in this subsection:

"Acute treatment services" means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

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

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

(6.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall not impose prior authorization requirements, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring

Conditions established by the American Society of Addiction Medicine, on a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(B) shall not impose any step therapy requirements, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine, before authorizing coverage for a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(C) shall place all prescription medications approved by the United States Food and Drug Administration prescribed or administered for the treatment of substance use disorders on, for brand medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers brand medications and, for generic medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers generic medications; and

(D) shall not exclude coverage for a prescription medication approved by the United States Food and Drug Administration for the treatment of substance use

disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

(7) (Blank).

(8) (Blank).

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

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

(d) With respect to a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace, the Department and, with respect to medical assistance, the Department of Healthcare and Family Services shall each enforce the requirements of this Section and Sections 356z.23 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under, those Acts, including, but not limited to, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and final regulations applying the Paul Wellstone and

Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans. Specifically, the Department and the Department of Healthcare and Family Services shall take action:

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers submit comparative analyses, as set forth in paragraph (6) of subsection (k) of Section 370c.1, demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits;

(2) evaluating all consumer or provider complaints regarding mental, emotional, nervous, or substance use disorder or condition coverage for possible parity violations;

(3) performing parity compliance market conduct examinations or, in the case of the Department of Healthcare and Family Services, parity compliance audits of individual and group plans and policies, including, but not limited to, reviews of:

(A) nonquantitative treatment limitations, including, but not limited to, prior authorization

requirements, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates, and geographic restrictions;

(B) denials of authorization, payment, and coverage; and

(C) other specific criteria as may be determined by the Department.

The findings and the conclusions of the parity compliance market conduct examinations and audits shall be made public.

The Director may adopt rules to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

(d-1) The Department of Insurance and the Department of Healthcare and Family Services shall each appoint a Mental Health and Substance Use Disorder Parity Compliance Officer to assist the departments with the responsibilities of enforcing the requirements of this Section and Section 370c.1.

(e) Availability of plan information.

(1) The criteria for medical necessity determinations, pursuant to subsections (h) through (m), made under a group health plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect

to such benefits) must be made available by the plan administrator (or the health insurance issuer 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 benefit plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace (or health insurance coverage offered in connection with such plan or policy) of reimbursement or payment for services with respect to mental, emotional, nervous, or substance use disorders or conditions benefits in the case of any participant or beneficiary must be made available within a reasonable time and in a reasonable manner and in readily understandable language 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 or which purport to provide coverage for a resident of this State; and (2) State employee health plans.

(g) (1) As used in this subsection:

"Benefits", with respect to insurers, means the benefits provided for treatment services for inpatient and outpatient

treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1 (Clinically Managed Low-Intensity Residential), 3.3 (Clinically Managed Population-Specific High-Intensity Residential), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

"Benefits", with respect to managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

"Substance use disorder treatment provider or facility" means a licensed physician, licensed psychologist, licensed psychiatrist, licensed advanced practice registered nurse, or licensed, certified, or otherwise State-approved facility or provider of substance use disorder treatment.

(2) A group health insurance policy, an individual health benefit plan, or 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 January 1, 2019 (the effective date of Public Act 100-1023) shall comply with the requirements of this Section and Section 370c.1. The services for the treatment and the ongoing assessment of the patient's progress in treatment shall follow the requirements of 77 Ill. Adm. Code 2060.

(3) Prior authorization shall not be utilized for the benefits under this subsection. The substance use disorder treatment provider or facility shall notify the insurer of the initiation of treatment. For an insurer that is not a managed care organization, the substance use disorder treatment provider or facility notification shall occur for the initiation of treatment of the covered person within 2 business days. For managed care organizations, the substance use disorder treatment provider or facility notification shall occur in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization. Treatment plans shall be developed in accordance with the requirements and timeframes established in 77 Ill. Adm. Code 2060. If the substance use disorder treatment provider or facility fails to notify the

insurer of the initiation of treatment in accordance with these provisions, the insurer may follow its normal prior authorization processes.

(4) For an insurer that is not a managed care organization, if an insurer determines that benefits are no longer medically necessary, the insurer shall notify the covered person, the covered person's authorized representative, if any, and the covered person's health care provider in writing of the covered person's right to request an external review pursuant to the Health Carrier External Review Act. The notification shall occur within 24 hours following the adverse determination.

Pursuant to the requirements of the Health Carrier External Review Act, the covered person or the covered person's authorized representative may request an expedited external review. An expedited external review may not occur if the substance use disorder treatment provider or facility determines that continued treatment is no longer medically necessary. Under this subsection, a request for expedited external review must be initiated within 24 hours following the adverse determination notification by the insurer. Failure to request an expedited external review within 24 hours shall preclude a covered person or a covered person's authorized representative from requesting an expedited external review.

If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization shall make a final determination of medical

necessity, pursuant to subsections (h) through (m), within 72 hours. If an independent review organization upholds an adverse determination, an insurer shall remain responsible to provide coverage of benefits through the day following the determination of the independent review organization. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(5) The substance use disorder treatment provider or facility shall provide the insurer with 7 business days' advance notice of the planned discharge of the patient from the substance use disorder treatment provider or facility and notice on the day that the patient is discharged from the substance use disorder treatment provider or facility.

(6) The benefits required by this subsection shall be provided to all covered persons with a diagnosis of substance use disorder or conditions. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection.

(7) Nothing in this subsection shall be construed to require an insurer to provide coverage for any of the benefits in this subsection.

(h)(1) Every insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis on or after July 1, 2020 shall, pursuant to this Section, provide coverage for the diagnosis and

medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions.

(2) Medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions shall be an item or service that is:

(A) recommended by the patient's treatment provider;

(B) furnished in the manner and setting that can most effectively and comprehensively address patients' conditions, including, but not limited to, functional impairments, lack of coping skills, symptoms, and the underlying bio-psycho-social determinants of mental health, substance use, medical disorders, and any combination thereof;

(C) provided in sufficient amount, duration, and scope to:

(i) prevent, diagnose, or treat a disorder;

(ii) achieve age-appropriate growth and development;

(iii) manage the progression of disability; or

(iv) attain, maintain, or regain full functional capacity.

(D) consistent with generally accepted standards of practice, which shall be based on:

(i) scientific evidence published in peer-reviewed medical or scientific literature generally recognized by the relevant clinical community; or

(ii) clinical specialty society recommendations, professional standards, or consensus statements.

(3) An insurer shall not limit benefits or coverage for chronic or pervasive mental, emotional, nervous, or substance use disorders or conditions to short-term treatment or to alleviating current symptoms.

(4) Consistent with paragraph (2), for all medical necessity determinations concerning level of care placement, continued stay, and transfer and discharge, to the extent applicable services are described therein, an insurer must exclusively rely on the most recent editions of:

(A) the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM Criteria) developed by the American Society of Addiction Medicine for substance use disorders for patients of any age;

(B) the Level of Care Utilization System (LOCUS) criteria developed by the American Association of Community Psychiatrists for mental health disorders for patients ages 18 years and over;

(C) the Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of Community Psychiatrists or the Child and Adolescent Services Intensity Instrument (CASII) developed by the American Academy of Child & Adolescent Psychiatry for mental health disorders for patients ages 6 to 17;

(D) the Early Childhood Service Intensity Instrument (ECSII) developed by the American Academy Child & Adolescent Psychiatry for mental health disorders for patients ages 0 to 5 years; or

(E) the American Psychiatric Association criteria for eating disorders for a primary diagnosis of an eating disorder for patients of any age.

(5) To ensure the proper use of criteria described in paragraph (4), insurers shall:

(A) track, identify, and analyze how the clinical guidelines are used to certify care, deny care, and support the appeals process and submit the results of this analysis to the Department or, in the case of Medicaid managed care organizations, to the Department of Healthcare and Family Services on July 1 of every year. The Departments are to submit a joint report summarizing the submitted analyses to the General Assembly by January 1 of every year;

(B) apply the criteria to the level of treatment proposed by the insured patient's treatment provider and not impose criteria for a different or higher level of treatment;

(C) run inter-rater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities;

(D) achieve inter-rater reliability pass rates of at

least 90% and, whenever this threshold is not met, immediately provide for the remediation of poor inter-rater reliability and inter-reliability testing for all new staff before they can conduct utilization review without supervision; and

(E) report the activities in this subsection to the plan's quality assurance committee.

(i) Every insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall, at minimum, include the following services as covered benefits for mental, emotional, nervous, or substance use disorders or conditions:

(1) outpatient services;

(2) inpatient services;

(3) intermediate services, including the full range of levels of care in the most recent edition of the ASAM criteria, LOCUS, CALOCUS, ECSII, and CASII (including, but not limited to, partial hospitalization, intensive outpatient, psycho-social treatment models, and coordinated specialty care);

(4) emergency and urgent care services, both inpatient and outpatient;

(5) all medications approved by the United States Food and Drug Administration for the treatment of substance use disorders; and

(6) emergency medication without prior authorization.

(j) If any medically necessary services for mental, emotional, nervous, or substance use disorders or conditions are not available in-network within the geography and timeliness standards set by law or regulation, the insurer must immediately cover out-of-network services, whether secured by the patient or insurer, at an in-network benefit level and reimburse out-of-network providers for such services at full billed charges. An insurer may not interrupt a course of treatment initiated out-of-network due to inadequacy if in-network services subsequently become available.

(k) An insurer shall not limit the benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(l) An insurer shall only engage applicable qualified physicians who specialize in the treatment of mental, emotional, nervous, or substance use disorders or conditions or the appropriate subspecialty therein and who possess an active professional license or certificate, to review, approve, or

deny services.

(m) An insurer shall not adopt, impose, or enforce any terms in its policies or provider agreements, in writing or in operation, that undermine or alter the requirements in this Section.

(n) If the Department determines that an insurer has failed to meet any requirement of this Section or Section 370c.1, the Department shall impose a penalty per product line with respect to each participant or beneficiary to whom such failure relates.

(1) The amount of the penalty imposed shall be as follows:

(A) for violations in which it is established that the insurer did not know and, by exercising reasonable diligence, would not have known that the insurer violated a provision, an amount not less than $100 or more than $50,000 for each violation;

(B) for a violation in which it is established that the violation was due to reasonable cause and not to willful neglect, an amount not less than $1,000 or more than $50,000 for each violation;

(C) for a violation in which it is established that the violation was due to willful neglect and was timely corrected, an amount not less than $10,000 or more than $50,000 for each violation; and

(D) for a violation in which it is established that

the violation was due to willful neglect and was not timely corrected, an amount not less than $50,000 for each violation.

(2) Except that a penalty for violations of the same requirement or prohibition under any of these categories may not exceed $3,000,000 in a calendar year.

(3) With respect to parity, violations of different State or federal requirements or prohibitions shall be considered a unique violation for the purposes of paragraph (2).

(4) The amounts in this subsection shall be annually adjusted for inflation in accordance with 26 U.S.C. 1(f)(3).

(5) Notwithstanding paragraph (3) of Section 403A, penalties under this Section and Section 370c.1 shall not be subject to time limits.

(Source: P.A. 100-305, eff. 8-24-17; 100-1023, eff. 1-1-19; 100-1024, eff. 1-1-19; 101-81, eff. 7-12-19; 101-386, eff. 8-16-19; revised 9-20-19.)