HB1372

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97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB1372

Introduced 2/9/2011, by Rep. Lou Lang

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.14	
215 ILCS 5/370c	from Ch. 73, par. 982c
215 ILCS 5/370c.1 new	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2

Amends the Illinois Insurance Code and the Health Maintenance Organization Act. Provides that coverage for autism spectrum disorders shall be subject to the parity requirements of the provision concerning mental health parity. Provides that an accident and health policy or managed care plan must provide a minimum (instead of a maximum) benefit of $36,000 per year. Deletes language concerning copayments, deductibles, and limits. Provides that every insurer that issues an accident and health policy that provides coverage for hospital or medical treatment, and for the treatment of mental, emotional, nervous, or substance use disorders shall ensure that the financial requirements and treatment limitations for such coverage are no more restrictive than the requirements and limitations applied to substantially all hospital and medical benefits covered by the policy. Sets forth provisions concerning aggregate lifetime limits on benefits, annual limits on benefits, and a single deductible applicable for both physical and mental health conditions. Makes other changes. Effective immediately.

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A BILL FOR

AN ACT concerning insurance.

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

Section 5. The Illinois Insurance Code is amended by changing Sections 356z.14 and 370c and by adding Sections 370c.1 and 370c as follows:

(215 ILCS 5/356z.14)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section <u>through a group or individual policy of accident and health insurance or managed care plan</u> shall be subject to <u>the parity requirements of Section 370c.1 of this Code. A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after the effective date of</u>

this amendatory Act of the 97th General Assembly must provide a minimum ~~maximum~~ benefit of $36,000 per year, but shall not be subject to any limits on the number of visits to a service provider. After December 30, 2009, the Director of ~~the Division of~~ Insurance shall, on an annual basis, adjust the minimum ~~maximum~~ benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any minimum ~~maximum~~ benefit established under this subsection.

(c) (Blank). ~~Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.~~

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan ~~and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that~~

1 ~~apply to physical illness generally~~.

2 (e) An insurer may not deny or refuse to provide otherwise
3 covered services, or refuse to renew, refuse to reissue, or
4 otherwise terminate or restrict coverage under an individual
5 contract to provide services to an individual because the
6 individual or their dependent is diagnosed with an autism
7 spectrum disorder or due to the individual utilizing benefits
8 in this Section.

9 (f) Upon request of the reimbursing insurer, a provider of
10 treatment for autism spectrum disorders shall furnish medical
11 records, clinical notes, or other necessary data that
12 substantiate that initial or continued medical treatment is
13 medically necessary and is resulting in improved clinical
14 status. When treatment is anticipated to require continued
15 services to achieve demonstrable progress, the insurer may
16 request a treatment plan consisting of diagnosis, proposed
17 treatment by type, frequency, anticipated duration of
18 treatment, the anticipated outcomes stated as goals, and the
19 frequency by which the treatment plan will be updated.

20 (g) When making a determination of medical necessity for a
21 treatment modality for autism spectrum disorders, an insurer
22 must make the determination in a manner that is consistent with
23 the manner used to make that determination with respect to
24 other diseases or illnesses covered under the policy, including
25 an appeals process. During the appeals process, any challenge
26 to medical necessity must be viewed as reasonable only if the

1 review includes a physician with expertise in the most current
2 and effective treatment modalities for autism spectrum
3 disorders.

4 (h) Coverage for medically necessary early intervention
5 services must be delivered by certified early intervention
6 specialists, as defined in 89 Ill. Admin. Code 500 and any
7 subsequent amendments thereto.

8 (i) As used in this Section:

9 "Autism spectrum disorders" means pervasive developmental
10 disorders as defined in the most recent edition of the
11 Diagnostic and Statistical Manual of Mental Disorders,
12 including autism, Asperger's disorder, and pervasive
13 developmental disorder not otherwise specified.

14 "Diagnosis of autism spectrum disorders" means one or more
15 tests, evaluations, or assessments to diagnose whether an
16 individual has autism spectrum disorder that is prescribed,
17 performed, or ordered by (A) a physician licensed to practice
18 medicine in all its branches or (B) a licensed clinical
19 psychologist with expertise in diagnosing autism spectrum
20 disorders.

21 "Medically necessary" means any care, treatment,
22 intervention, service or item which will or is reasonably
23 expected to do any of the following: (i) prevent the onset of
24 an illness, condition, injury, disease or disability; (ii)
25 reduce or ameliorate the physical, mental or developmental
26 effects of an illness, condition, injury, disease or

1 disability; or (iii) assist to achieve or maintain maximum
2 functional activity in performing daily activities.

3 "Treatment for autism spectrum disorders" shall include
4 the following care prescribed, provided, or ordered for an
5 individual diagnosed with an autism spectrum disorder by (A) a
6 physician licensed to practice medicine in all its branches or
7 (B) a certified, registered, or licensed health care
8 professional with expertise in treating effects of autism
9 spectrum disorders when the care is determined to be medically
10 necessary and ordered by a physician licensed to practice
11 medicine in all its branches:

12 (1) Psychiatric care, meaning direct, consultative, or
13 diagnostic services provided by a licensed psychiatrist.

14 (2) Psychological care, meaning direct or consultative
15 services provided by a licensed psychologist.

16 (3) Habilitative or rehabilitative care, meaning
17 professional, counseling, and guidance services and
18 treatment programs, including applied behavior analysis,
19 that are intended to develop, maintain, and restore the
20 functioning of an individual. As used in this subsection
21 (i), "applied behavior analysis" means the design,
22 implementation, and evaluation of environmental
23 modifications using behavioral stimuli and consequences to
24 produce socially significant improvement in human
25 behavior, including the use of direct observation,
26 measurement, and functional analysis of the relations

between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-1005, eff. 12-12-08; 96-1000, eff. 7-2-10.)

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

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this amendatory Act of the 97th General Assembly ~~Section~~, every insurer which amends, delivers, issues, or renews ~~delivers, issues for delivery or renews or modifies~~ group accident and health ~~A&H~~ policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the

insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b) consistent with the parity requirements of section 370c.1~~, up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit~~.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, ~~or~~ licensed marriage and family therapist, or licensed speech therapist 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, or licensed marriage and family therapist 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, or licensed marriage and family therapist 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, and licensed marriage and family therapists, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group 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 97th ~~92nd~~ General Assembly shall provide coverage under the policy for treatment of serious mental illness consistent with the parity requirements of Section 370c.1 of this Code

~~under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases~~. This subsection does not apply to 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 ~~coverage provided to employees by employers who have 50 or fewer employees~~.

(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) anorexia nervosa and bulimia nervosa; and~~.~~
4 (L) substance use disorders.
5 (3) Unless otherwise prohibited by federal law, upon ~~Upon~~
6 request of the reimbursing insurer, a provider of treatment of
7 serious mental illness shall furnish medical records or other
8 necessary data that substantiate that initial or continued
9 treatment is at all times medically necessary. An insurer shall
10 provide a mechanism for the timely review by a provider holding
11 the same license and practicing in the same specialty as the
12 patient's provider, who is unaffiliated with the insurer,
13 jointly selected by the patient (or the patient's next of kin
14 or legal representative if the patient is unable to act for
15 himself or herself), the patient's provider, and the insurer in
16 the event of a dispute between the insurer and patient's
17 provider regarding the medical necessity of a treatment
18 proposed by a patient's provider. If the reviewing provider
19 determines the treatment to be medically necessary, the insurer
20 shall provide reimbursement for the treatment. Future
21 contractual or employment actions by the insurer regarding the
22 patient's provider may not be based on the provider's
23 participation in this procedure. Nothing prevents the insured
24 from agreeing in writing to continue treatment at his or her
25 expense. When making a determination of the medical necessity
26 for a treatment modality for serous mental illness, an insurer

must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.

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

(A) shall provide coverage based upon medical necessity for the ~~following~~ treatment of mental illness consistent with the parity requirements of Section 370c.1 of this Code. In ~~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.~~; and~~

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

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

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

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

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

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

(8) (Blank).

(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.

(Source: P.A. 95-331, eff. 8-21-07; 95-972, eff. 9-22-08; 95-973, eff. 1-1-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; 96-1000, eff. 7-2-10.)

1 (215 ILCS 5/370c.1 new)
2 Sec. 370c.1. Mental health parity.
3 (a) As used in this Section:
4 "Financial requirement" means deductibles, copayments,
5 coinsurance, and out-of-pocket expenses, but excludes an
6 aggregate lifetime limit and an annual limit subject to
7 subsections (c), (d), and (e) of this Section.
8 "Treatment limitation" means limits on the frequency of
9 treatment, number of visits, days of coverage, or other similar
10 limits on the scope or duration of treatment.
11 (b) Beginning on the effective date of this amendatory Act
12 of the 97th General Assembly, every insurer that amends,
13 delivers, issues, or renews a group policy of accident and
14 health insurance in this State providing coverage for hospital
15 or medical treatment and for the treatment of mental,
16 emotional, nervous, or substance use disorders or conditions
17 shall ensure that:
18 (1) the financial requirements applicable to such
19 mental, emotional, nervous, or substance use disorder or
20 condition benefits are no more restrictive than the
21 predominant financial requirements applied to
22 substantially all hospital and medical benefits covered by
23 the policy and that there are no separate cost-sharing
24 requirements that are applicable only with respect to
25 mental, emotional, nervous, or substance use disorder or

condition benefits; and

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

(c) In the case of a group policy of accident and health insurance amended, delivered, issued, or renewed in this State on and after the effective date of this amendatory Act of the 97th General Assembly that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions, the policy shall not include an aggregate lifetime limit on benefits provided under the policy.

(d) In the case of a group policy of accident and health insurance amended, delivered, issued, or renewed in this State on or after the effective date of this amendatory Act of the 97th General Assembly that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions, the policy shall not include an annual limit on benefits provided under the policy.

(e) In the case of a group policy of accident and health

insurance amended, delivered, issued, or renewed in this State on or after the effective date of this amendatory Act of the 97th General Assembly that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions, such plans shall include a single deductible applicable for both physical and mental health conditions.

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

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health

1 Maintenance Organizations in the following categories are
2 deemed to be "domestic companies":
3 (1) a corporation authorized under the Dental Service
4 Plan Act or the Voluntary Health Services Plans Act;
5 (2) a corporation organized under the laws of this
6 State; or
7 (3) a corporation organized under the laws of another
8 state, 30% or more of the enrollees of which are residents
9 of this State, except a corporation subject to
10 substantially the same requirements in its state of
11 organization as is a "domestic company" under Article VIII
12 1/2 of the Illinois Insurance Code.
13 (c) In considering the merger, consolidation, or other
14 acquisition of control of a Health Maintenance Organization
15 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
16 (1) the Director shall give primary consideration to
17 the continuation of benefits to enrollees and the financial
18 conditions of the acquired Health Maintenance Organization
19 after the merger, consolidation, or other acquisition of
20 control takes effect;
21 (2)(i) the criteria specified in subsection (1)(b) of
22 Section 131.8 of the Illinois Insurance Code shall not
23 apply and (ii) the Director, in making his determination
24 with respect to the merger, consolidation, or other
25 acquisition of control, need not take into account the
26 effect on competition of the merger, consolidation, or

1 other acquisition of control;
2 (3) the Director shall have the power to require the
3 following information:
4 (A) certification by an independent actuary of the
5 adequacy of the reserves of the Health Maintenance
6 Organization sought to be acquired;
7 (B) pro forma financial statements reflecting the
8 combined balance sheets of the acquiring company and
9 the Health Maintenance Organization sought to be
10 acquired as of the end of the preceding year and as of
11 a date 90 days prior to the acquisition, as well as pro
12 forma financial statements reflecting projected
13 combined operation for a period of 2 years;
14 (C) a pro forma business plan detailing an
15 acquiring party's plans with respect to the operation
16 of the Health Maintenance Organization sought to be
17 acquired for a period of not less than 3 years; and
18 (D) such other information as the Director shall
19 require.
20 (d) The provisions of Article VIII 1/2 of the Illinois
21 Insurance Code and this Section 5-3 shall apply to the sale by
22 any health maintenance organization of greater than 10% of its
23 enrollee population (including without limitation the health
24 maintenance organization's right, title, and interest in and to
25 its health care certificates).
26 (e) In considering any management contract or service

agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

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

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

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the

1 period (and, for purposes of a refund or additional
2 premium, the profitable or unprofitable experience shall
3 be calculated taking into account a pro rata share of the
4 Health Maintenance Organization's administrative and
5 marketing expenses, but shall not include any refund to be
6 made or additional premium to be paid pursuant to this
7 subsection (f)). The Health Maintenance Organization and
8 the group or enrollment unit may agree that the profitable
9 or unprofitable experience may be calculated taking into
10 account the refund period and the immediately preceding 2
11 plan years.

12 The Health Maintenance Organization shall include a
13 statement in the evidence of coverage issued to each enrollee
14 describing the possibility of a refund or additional premium,
15 and upon request of any group or enrollment unit, provide to
16 the group or enrollment unit a description of the method used
17 to calculate (1) the Health Maintenance Organization's
18 profitable experience with respect to the group or enrollment
19 unit and the resulting refund to the group or enrollment unit
20 or (2) the Health Maintenance Organization's unprofitable
21 experience with respect to the group or enrollment unit and the
22 resulting additional premium to be paid by the group or
23 enrollment unit.

24 In no event shall the Illinois Health Maintenance
25 Organization Guaranty Association be liable to pay any
26 contractual obligation of an insolvent organization to pay any

1 refund authorized under this Section.
2 (g) Rulemaking authority to implement Public Act 95-1045,
3 if any, is conditioned on the rules being adopted in accordance
4 with all provisions of the Illinois Administrative Procedure
5 Act and all rules and procedures of the Joint Committee on
6 Administrative Rules; any purported rule not so adopted, for
7 whatever reason, is unauthorized.
8 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
9 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
10 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
11 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff.
12 6-1-10; 96-1000, eff. 7-2-10.)

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