AN ACT concerning regulation.

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

Section 1. This Act may be referred to as the Generally Accepted Standards of Behavioral Health Care Act of 2021.

Section 2. The General Assembly finds and declares the following:

(a) The State of Illinois and the entire country faces a mental health and addiction crisis.

(1) One in 5 adults experience a mental health disorder, and data from 2017 shows that one in 12 had a substance use disorder. The COVID-19 pandemic has exacerbated the nation's mental health and addiction crisis. According the U.S. Center for Disease Control and Prevention, since the start of the COVID-19 pandemic, Americans have experienced higher rates of depression, anxiety, and trauma, and rates of substance use and suicidal ideation have increased.

(2) Nationally, the suicide rate has increased 35% in the past 20 years. According to the Illinois Department of Public Health, more than 1,000 Illinoisans die by suicide every year, including 1,439 deaths in 2019, and it is the third leading cause of death among young adults aged 15 to

34.

(3) Between 2013 and 2019, Illinois saw a 1,861% increase in synthetic opioid overdose deaths and a 68% increase in heroin overdose deaths. In 2019 alone, there were 2.3 and 2 times as many opioid deaths as homicides and car crash deaths, respectively.

(4) Communities of color are disproportionately impacted by lack of access to and inequities in mental health and substance use disorder care.

(A) According to the Substance Abuse and Mental Health Services Administration, two-thirds of Black and Hispanic Americans with a mental illness and nearly 90% with a substance use disorder do not receive medically necessary treatment.

(B) Data from the U.S. Census Bureau demonstrates that Black Americans saw the highest increases in rates of anxiety and depression in 2020.

(C) Data from the Illinois Department of Public Health reveals that Black Illinoisans are hospitalized for opioid overdoses at a rate 6 times higher than white Illinoisans.

(D) In the first half of 2020, the number of suicides among Black Chicagoans had increased 106% from the previous year. Nationally, from 2001 to 2017, suicide rates doubled among Black girls aged 13 to 19 and increased 60% for Black boys of the same age.

(E) According to the Substance Abuse and Mental Health Services Administration, between 2008 and 2018 there were significant increases in serious mental illness and suicide ideation in Hispanics aged 18 to 25 and there remains a large gap in treatment need among Hispanics.

(5) According to the U.S. Center for Disease Control and Prevention, children with adverse childhood experiences are more likely to experience negative outcomes like post-traumatic stress disorder, increased anxiety and depression, suicide, and substance use. A 2020 report from Mental Health America shows that 62.1% of Illinois youth with severe depression do not receive any mental health treatment. Survey results found that 80% of college students report that COVID-19 has negatively impacted their mental health.

(6) In rural communities, between 2001 and 2015, the suicide rate increased by 27%, and between 1999 and 2015 the overdose rate increased 325%.

(7) According to the U.S. Department of Veterans Affairs, 154 veterans died by suicide in 2018, which accounts for more than 10% of all suicide deaths reported by the Illinois Department of Public Health in the same year, despite only accounting for approximately 5.7% of the State's total population. Nationally, between 2008 and 2017, more than 6,000 veterans died by suicide each year.

(8) According to the National Alliance on Mental Illness, 2,000,000 people with mental illness are incarcerated every year, where they do not receive the treatment they need.

(b) A recent landmark federal court ruling offers a concrete demonstration of how the mental health and addiction crisis described in subsection (a) is worsened through the denial of medically necessary mental health and substance use disorder treatment.

(1) In March 2019, the United States District Court of the Northern District of California ruled in Wit v. United Behavioral Health, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019), that United Behavioral Health created flawed level of care placement criteria that were inconsistent with generally accepted standards of mental health and substance use disorder care in order to "mitigate" the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.

(2) As described by the federal court in Wit, the 8 generally accepted standards of mental health and substance use disorder care require all of the following:

(A) Effective treatment of underlying conditions, rather than mere amelioration of current symptoms, such as suicidality or psychosis.

(B) Treatment of co-occurring behavioral health disorders or medical conditions in a coordinated

manner.

(C) Treatment at the least intensive and restrictive level of care that is safe and effective and meets the needs of the patient's condition; a lower level or less intensive care is appropriate only if it is safe and just as effective as treatment at a higher level or service intensity.

(D) 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.

(E) Treatment to maintain functioning or prevent deterioration.

(F) Treatment of mental health and substance use disorders for an appropriate duration based on individual patient needs rather than on specific time limits.

(G) Accounting for the unique needs of children and adolescents when making level of care decisions.

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

(3) The court in Wit found that all parties' expert witnesses regarded the American Society of Addiction Medicine (ASAM) criteria for substance use disorders and Level of Care Utilization System (LOCUS), Child and

Adolescent Level of Care Utilization System (CALOCUS), Child and Adolescent Service Intensity Instrument (CASII), and Early Childhood Service Intensity Instrument (ECSII) criteria for mental health disorders as prime examples of level of care criteria that are fully consistent with generally accepted standards of mental health and substance use care.

(4) In particular, the coverage of intermediate levels of care, such as residential treatment, which are essential components of the level of care continuum called for by nonprofit, and clinical specialty associations such as the American Society of Addiction Medicine, are often denied through overly restrictive medical necessity determinations.

(5) On November 3, 2020, the court issued a remedies order requiring United Behavioral Health to reprocess 67,000 mental health and substance use disorder claims and mandating that, for the next decade, United Behavioral Health must use the relevant nonprofit clinical society guidelines for its medical necessity determinations.

(6) The court's findings also demonstrated how United Behavioral Health was in violation of Section 370c of the Illinois Insurance Code for its failure to use the American Society of Addiction Medicine Criteria for substance use disorders. The results of market conduct examinations released by the Illinois Department of

Insurance on July 15, 2020 confirmed these findings citing United Healthcare and CIGNA for their failure to use the American Society of Addiction Medicine Criteria when making medical necessity determinations for substance use disorders as required by Illinois law.

(c) Insurers should not be permitted to deny medically necessary mental health and substance use disorder care through the use of utilization review practices and criteria that are inconsistent with generally accepted standards of mental health and substance use disorder care.

(1) Illinois parity law (Sections 370c and 370c.1 of the Illinois Insurance Code) requires that health plans treat illnesses of the brain, such as addiction and depression, the same way they treat illness of other parts of the body, such as cancer and diabetes. The Illinois General Assembly significantly strengthened Illinois' parity law, which incorporates provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, in both 2015 and 2018.

(2) While the federal Patient Protection and Affordable Care Act includes mental health and addiction coverage as one of the 10 essential health benefits, it does not contain a definition for medical necessity, and despite the Patient Protection and Affordable Care Act, needed mental health and addiction coverage can be denied through overly restrictive medical necessity

determinations.

(3) Despite the strong actions taken by the Illinois General Assembly, the court in Wit v. United Behavioral Health demonstrated how insurers can mitigate compliance with parity laws due by denying medically necessary mental health and treatment by using flawed medical necessity criteria.

(4) When medically necessary mental health and substance use disorder care is denied, the manifestations of the mental health and addiction crisis described in subsection (a) are severely exacerbated. Individuals with mental health and substance use disorders often have their conditions worsen, sometimes ending up in the criminal justice system or on the streets, resulting in increased emergency hospitalizations, harm to individuals and communities, and higher costs to taxpayers.

(5) In order to realize the promise of mental health and addiction parity and remove barriers to mental health and substance use disorder care for all Illinoisans, insurers must be required to cover medically necessary mental health and substance use disorder care and follow generally accepted standards of mental health and substance use disorder care.

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 the effective date of this amendatory Act of the 102nd General Assembly ~~January 1, 2019 (the effective date of 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 provide coverage for the 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 or her 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 or her 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 World Health Organization's International Classification of Disease or that is listed in the most recent version of the American Psychiatric Association's 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.

(5) Medically necessary treatment and medical necessity determinations shall be interpreted and made in a manner that is consistent with and pursuant to subsections (h) through (t).

(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 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 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 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 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 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 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 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.

(e) Availability of plan information.

(1) The criteria for medical necessity determinations 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 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) As used in this Section:

"Generally accepted standards of mental, emotional,

nervous, or substance use disorder or condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms in a manner that is all of the following:

(1) in accordance with the generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

"Utilization review" means either of the following:

(1) prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to insureds.

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

"Utilization review criteria" means patient placement criteria or any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

(i)(1) Every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the

health insurance marketplace in this State and Medicaid managed care organizations providing coverage for hospital or medical treatment on or after January 1, 2022 shall, pursuant to subsections (h) through (s), provide coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions.

(2) An insurer shall not set a specific limit on the duration of benefits or coverage of medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions or limit coverage only to alleviation of the insured's current symptoms; insurers shall base the duration of treatment on the insured's individual needs, including treating the insured's underlying mental, emotional, nervous, or substance use disorders or conditions and comorbidities.

(3) All medical necessity determinations made by the insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental, emotional, nervous, or substance use disorders or conditions shall be conducted in accordance with the requirements of subsections (k) through (u).

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this Section shall not rescind or modify the authorization after that provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited

to, the insurer's subsequent cancellation or modification of the insured's or policyholder's contract, or the insured's or policyholder's eligibility. Nothing in this Section shall require the insurer to cover a treatment when the authorization was granted based on a material misrepresentation by the insured, the policyholder, or the provider. As used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results in or could result in a substantial change in the situation.

(j) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public 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 program.

(k) An insurer shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions on current generally accepted

standards of mental, emotional, nervous, or substance use disorder or condition care. All denials and appeals shall be reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.

(l) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, and nervous disorders or conditions in children, adolescents, and adults, an insurer shall exclusively apply without modification the criteria and guidelines set forth in the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty. Pursuant to subsection (b), in conducting utilization review of all covered services and benefits for the diagnosis, prevention, and treatment of substance use disorders an insurer shall use the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine.

(m) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subsection (l), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care

consistent with the assessment of the insured using the relevant criteria and guidelines as specified in subsection (l). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its assessment using the relevant criteria and guidelines as specified in subsection (l) to the provider of the service.

This subsection does not prohibit an insurer from applying utilization review criteria that were developed in accordance with subsection (k) to health care services and benefits for mental, emotional, and nervous disorders or conditions that:

(1) are outside the scope of the criteria and guidelines set forth in the sources specified in subsection (l); or

(2) relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subsection (l).

(n) An insurer shall only engage applicable qualified providers 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.

(o) This Section does not in any way limit the rights of a patient under the Medical Patient Rights Act.

(p) This Section does not in any way limit early and periodic screening, diagnostic, and treatment benefits as

defined under 42 U.S.C. 1396d(r).

(q) To ensure the proper use of the criteria described in subsection (l), every insurer shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the insurer's participating or contracted providers and potential participants, beneficiaries, or covered lives. The education program must be provided, at minimum, on a quarterly basis, in-person or digitally, or recordings of the education program must be made available to the aforementioned stakeholders.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decision making that covers how medical necessity decisions are made; this

assessment shall cover all aspects of utilization review as defined in subsection (h).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization review process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(8) Submit to the Department of Insurance or, in the case of Medicaid managed care organizations, the Department of Healthcare and Family Services every year on or before July 1 results of interrater reliability reports and a summary of the remediation actions taken for those with pass rates lower than 90%.

(r) This Section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions covered by an insurance policy, including prescription drugs.

(s) This Section applies to an insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan

offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and conducts utilization review as defined in this Section, including Medicaid managed care organizations, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(t) If the Director determines that an insurer has violated this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty between $1,000 and $5,000 for each violation. Moneys collected from penalties shall be deposited into the Parity Advancement Fund established in subsection (i) of Section 370c.1.

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

(v) The provisions of this Section are severable. If any provision of this Section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(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.)

Section 10. The Health Carrier External Review Act is amended by changing Sections 35 and 40 as follows:

(215 ILCS 180/35)

Sec. 35. Standard external review.

(a) Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination, a covered person or the covered person's authorized representative may file a request for an external review with the Director. Within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to the health carrier.

(b) Within 5 business days following the date of receipt of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) the individual is or was a covered person in the health benefit plan at the time the health care service was requested or at the time the health care service was provided;

(2) the health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but the health carrier has determined that the health care service is not covered;

(3) the covered person has exhausted the health

carrier's internal appeal process unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to this Act;

(4) (blank); and

(5) the covered person has provided all the information and forms required to process an external review, as specified in this Act.

(c) Within one business day after completion of the preliminary review, the health carrier shall notify the Director and covered person and, if applicable, the covered person's authorized representative in writing whether the request is complete and eligible for external review. If the request:

(1) is not complete, the health carrier shall inform the Director and covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are required by this Act to make the request complete; or

(2) is not eligible for external review, the health carrier shall inform the Director and covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

The Department may specify the form for the health carrier's notice of initial determination under this subsection (c) and any supporting information to be included

in the notice.

The notice of initial determination of ineligibility shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director.

Notwithstanding a health carrier's initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(d) Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted pursuant to this Section, within one business day after the date of receipt of the notice, the Director shall:

(1) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director pursuant to this Act and notify the health carrier of the name of the assigned

independent review organization; and

(2) notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (2) of this subsection (d), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

(e) The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act.

(f) Within 5 business days after the date of receipt of the notice provided pursuant to item (1) of subsection (d) of this Section, the health carrier or its designee utilization review

organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

(1) Except as provided in item (2) of this subsection (f), failure by the health carrier or its utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

(2) If the health carrier or its utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(3) Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (2) of this subsection (f), the independent review organization shall notify the Director, the health carrier, the covered person and, if applicable, the covered person's authorized representative, of its decision to reverse the adverse determination.

(g) Upon receipt of the information from the health carrier or its utilization review organization, the assigned

independent review organization shall review all of the information and documents and any other information submitted in writing to the independent review organization by the covered person and the covered person's authorized representative.

(h) Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall forward the information to the health carrier within 1 business day.

(1) Upon receipt of the information, if any, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:

(A) Within one business day after making the decision to reverse its adverse determination or final

adverse determination, the health carrier shall notify the Director, the covered person and, if applicable, the covered person's authorized representative, and the assigned independent review organization in writing of its decision.

(B) Upon notice from the health carrier that the health carrier has made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

(i) In addition to the documents and information provided by the health carrier or its utilization review organization and the covered person and the covered person's authorized representative, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the covered person's health care provider's recommendation;

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier or its designee utilization review organization, the covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) the terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier, unless the terms are inconsistent with applicable law;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(6) any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization;

(7) the opinion of the independent review organization's clinical reviewer or reviewers after considering items (1) through (6) of this subsection (i) to the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents appropriate;

(8) (blank); and

(9) in the case of medically necessary determinations for substance use disorders, the patient placement criteria established by the American Society of Addiction Medicine.

(i-5) For an adverse determination or final adverse

determination involving mental, emotional, nervous, or substance use disorders or conditions, the independent review organization shall:

(1) consider the documents and information as set forth in subsection (i), except that all practice guidelines and clinical review criteria must be consistent with the requirements set forth in Section 370c of the Illinois Insurance Code; and

(2) make its decision, pursuant to subsection (j), whether to uphold or reverse the adverse determination or final adverse determination based on whether the service constitutes medically necessary treatment of a mental, emotional, nervous, or substance use disorders or condition as defined in Section 370c of the Illinois Insurance Code.

(j) Within 5 days after the date of receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information to the independent

review organization. In such cases, the following provisions shall apply:

(1) The independent review organization shall include in the notice:

(A) a general description of the reason for the request for external review;

(B) the date the independent review organization received the assignment from the Director to conduct the external review;

(C) the time period during which the external review was conducted;

(D) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;

(E) the date of its decision;

(F) the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and

(G) the rationale for its decision.

(2) (Blank).

(3) (Blank).

(4) Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final

adverse determination.

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

(215 ILCS 180/40)

Sec. 40. Expedited external review.

(a) A covered person or a covered person's authorized representative may file a request for an expedited external review with the Director either orally or in writing:

(1) immediately after the date of receipt of a notice prior to a final adverse determination as provided by subsection (b) of Section 20 of this Act;

(2) immediately after the date of receipt of a notice upon final adverse determination as provided by subsection (c) of Section 20 of this Act; or

(3) if a health carrier fails to provide a decision on request for an expedited internal appeal within 48 hours as provided by item (2) of Section 30 of this Act.

(b) Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to the health carrier. Immediately upon receipt of the request for an expedited external review, the health carrier shall determine whether the request meets the reviewability requirements set forth in subsection (b) of Section 35. In such cases, the following provisions shall apply:

(1) The health carrier shall immediately notify the Director, the covered person, and, if applicable, the

covered person's authorized representative of its eligibility determination.

(2) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the Director.

(3) The Director may determine that a request is eligible for expedited external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(4) In making a determination under item (3) of this subsection (b), the Director's decision shall be made in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(5) The Director may specify the form for the health carrier's notice of initial determination under this subsection (b) and any supporting information to be included in the notice.

(c) Upon receipt of the notice that the request meets the reviewability requirements, the Director shall immediately assign an independent review organization from the list of

approved independent review organizations compiled and maintained by the Director to conduct the expedited review. In such cases, the following provisions shall apply:

(1) The assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of this Act.

(2) The Director shall immediately notify the health carrier of the name of the assigned independent review organization. Immediately upon receipt from the Director of the name of the independent review organization assigned to conduct the external review, but in no case more than 24 hours after receiving such notice, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(3) If the health carrier or its utilization review organization fails to provide the documents and information within the specified timeframe, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse

determination or final adverse determination.

(4) Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (3) of this subsection (c), the independent review organization shall notify the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative of its decision to reverse the adverse determination or final adverse determination.

(d) In addition to the documents and information provided by the health carrier or its utilization review organization and any documents and information provided by the covered person and the covered person's authorized representative, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider information as required by subsection (i) of Section 35 of this Act in reaching a decision.

(d-5) For expedited external reviews involving mental, emotional, nervous, or substance use disorders or conditions, the independent review organization shall consider documents and information and shall make a decision to uphold or reverse the adverse determination or final adverse determination pursuant to subsection (i-5) of Section 35.

(e) As expeditiously as the covered person's medical

condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review, the assigned independent review organization shall:

(1) make a decision to uphold or reverse the final adverse determination; and

(2) notify the Director, the health carrier, the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative, of the decision.

(f) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal appeal process.

(g) Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(h) If the notice provided pursuant to subsection (e) of this Section was not in writing, then within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized

representative including the information set forth in subsection (j) of Section 35 of this Act as applicable.

(i) An expedited external review may not be provided for retrospective adverse or final adverse determinations.

(j) The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act.

(Source: P.A. 96-857, eff. 7-1-10; 97-333, eff. 8-12-11; 97-574, eff. 8-26-11.)

Section 99. Effective date. This Act takes effect January 1, 2022.