



Sen. Laura Fine

Filed: 5/14/2021

10200HB2595sam001

LRB102 10633 BMS 26514 a

1 AMENDMENT TO HOUSE BILL 2595

2 AMENDMENT NO. _____. Amend House Bill 2595 by replacing
3 everything after the enacting clause with the following:

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

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

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

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

1 anxiety, and trauma, and rates of substance use and
2 suicidal ideation have increased.

3 (2) Nationally, the suicide rate has increased 35% in
4 the past 20 years. According to the Illinois Department of
5 Public Health, more than 1,000 Illinoisans die by suicide
6 every year, including 1,439 deaths in 2019, and it is the
7 third leading cause of death among young adults aged 15 to
8 34.

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

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

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

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

25 (C) Data from the Illinois Department of Public
26 Health reveals that Black Illinoisans are hospitalized

1 for opioid overdoses at a rate 6 times higher than
2 white Illinoisans.

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

8 (E) According to the Substance Abuse and Mental
9 Health Services Administration, between 2008 and 2018
10 there were significant increases in serious mental
11 illness and suicide ideation in Hispanics aged 18 to
12 25 and there remains a large gap in treatment need
13 among Hispanics.

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

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

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

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

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

17 (1) In March 2019, the United States District Court of
18 the Northern District of California ruled in *Wit v. United*
19 *Behavioral Health*, 2019 WL 1033730 (Wit; N.D.CA Mar. 5,
20 2019), that United Behavioral Health created flawed level
21 of care placement criteria that were inconsistent with
22 generally accepted standards of mental health and
23 substance use disorder care in order to "mitigate" the
24 requirements of the federal Mental Health Parity and
25 Addiction Equity Act of 2008.

26 (2) As described by the federal court in *Wit*, the 8

1 generally accepted standards of mental health and
2 substance use disorder care require all of the following:

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

6 (B) Treatment of co-occurring behavioral health
7 disorders or medical conditions in a coordinated
8 manner.

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

15 (D) Erring on the side of caution, by placing
16 patients in higher levels of care when there is
17 ambiguity as to the appropriate level of care, or when
18 the recommended level of care is not available.

19 (E) Treatment to maintain functioning or prevent
20 deterioration.

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

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

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

4 (3) The court in Wit found that all parties' expert
5 witnesses regarded the American Society of Addiction
6 Medicine (ASAM) criteria for substance use disorders and
7 Level of Care Utilization System (LOCUS), Child and
8 Adolescent Level of Care Utilization System (CALOCUS),
9 Child and Adolescent Service Intensity Instrument (CASII),
10 and Early Childhood Service Intensity Instrument (ECSII)
11 criteria for mental health disorders as prime examples of
12 level of care criteria that are fully consistent with
13 generally accepted standards of mental health and
14 substance use care.

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

22 (5) On November 3, 2020, the court issued a remedies
23 order requiring United Behavioral Health to reprocess
24 67,000 mental health and substance use disorder claims and
25 mandating that, for the next decade, United Behavioral
26 Health must use the relevant nonprofit clinical society

1 guidelines for its medical necessity determinations.

2 (6) The court's findings also demonstrated how United
3 Behavioral Health was in violation of Section 370c of the
4 Illinois Insurance Code for its failure to use the
5 American Society of Addiction Medicine Criteria for
6 substance use disorders. The results of market conduct
7 examinations released by the Illinois Department of
8 Insurance on July 15, 2020 confirmed these findings citing
9 United Healthcare and CIGNA for their failure to use the
10 American Society of Addiction Medicine Criteria when
11 making medical necessity determinations for substance use
12 disorders as required by Illinois law.

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

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

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

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

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

24 (5) In order to realize the promise of mental health
25 and addiction parity and remove barriers to mental health
26 and substance use disorder care for all Illinoisans,

1 insurers must be required to cover medically necessary
2 mental health and substance use disorder care and follow
3 generally accepted standards of mental health and
4 substance use disorder care.

5 Section 5. The Illinois Insurance Code is amended by
6 changing Sections 370c and 370c.1 as follows:

7 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

8 Sec. 370c. Mental and emotional disorders.

9 (a) (1) On and after the effective date of this amendatory
10 Act of the 102nd General Assembly January 1, 2019 ~~(the~~
11 ~~effective date of this amendatory Act of the 101st General~~
12 ~~Assembly Public Act 100-1024)~~, every insurer that amends,
13 delivers, issues, or renews group accident and health policies
14 providing coverage for hospital or medical treatment or
15 services for illness on an expense-incurred basis shall
16 provide coverage for the medically necessary treatment of
17 ~~reasonable and necessary treatment and services for~~ mental,
18 emotional, nervous, or substance use disorders or conditions
19 consistent with the parity requirements of Section 370c.1 of
20 this Code.

21 (2) Each insured that is covered for mental, emotional,
22 nervous, or substance use disorders or conditions shall be
23 free to select the physician licensed to practice medicine in
24 all its branches, licensed clinical psychologist, licensed

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

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

1 professionals at programs licensed pursuant to the Substance
2 Use Disorder Act, those persons who may provide services to
3 individuals shall do so after the licensed clinical social
4 worker, licensed clinical professional counselor, licensed
5 marriage and family therapist, licensed speech-language
6 pathologist, or other licensed or certified professional at a
7 program licensed pursuant to the Substance Use Disorder Act
8 has informed the patient of the desirability of the patient
9 conferring with the patient's primary care physician.

10 (4) "Mental, emotional, nervous, or substance use disorder
11 or condition" means a condition or disorder that involves a
12 mental health condition or substance use disorder that falls
13 under any of the diagnostic categories listed in the mental
14 and behavioral disorders chapter of the current edition of the
15 World Health Organization's International Classification of
16 Disease or that is listed in the most recent version of the
17 American Psychiatric Association's Diagnostic and Statistical
18 Manual of Mental Disorders. "Mental, emotional, nervous, or
19 substance use disorder or condition" includes any mental
20 health condition that occurs during pregnancy or during the
21 postpartum period and includes, but is not limited to,
22 postpartum depression.

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

1 (b) (1) (Blank).

2 (2) (Blank).

3 (2.5) (Blank).

4 (3) Unless otherwise prohibited by federal law and
5 consistent with the parity requirements of Section 370c.1 of
6 this Code, the reimbursing insurer that amends, delivers,
7 issues, or renews a group or individual policy of accident and
8 health insurance, a qualified health plan offered through the
9 health insurance marketplace, or a provider of treatment of
10 mental, emotional, nervous, or substance use disorders or
11 conditions shall furnish medical records or other necessary
12 data that substantiate that initial or continued treatment is
13 at all times medically necessary. An insurer shall provide a
14 mechanism for the timely review by a provider holding the same
15 license and practicing in the same specialty as the patient's
16 provider, who is unaffiliated with the insurer, jointly
17 selected by the patient (or the patient's next of kin or legal
18 representative if the patient is unable to act for himself or
19 herself), the patient's provider, and the insurer in the event
20 of a dispute between the insurer and patient's provider
21 regarding the medical necessity of a treatment proposed by a
22 patient's provider. If the reviewing provider determines the
23 treatment to be medically necessary, the insurer shall provide
24 reimbursement for the treatment. Future contractual or
25 employment actions by the insurer regarding the patient's
26 provider may not be based on the provider's participation in

1 this procedure. Nothing prevents the insured from agreeing in
2 writing to continue treatment at his or her expense. When
3 making a determination of the medical necessity for a
4 treatment modality for mental, emotional, nervous, or
5 substance use disorders or conditions, an insurer must make
6 the determination in a manner that is consistent with the
7 manner used to make that determination with respect to other
8 diseases or illnesses covered under the policy, including an
9 appeals process. Medical necessity determinations for
10 substance use disorders shall be made in accordance with
11 appropriate patient placement criteria established by the
12 American Society of Addiction Medicine. No additional criteria
13 may be used to make medical necessity determinations for
14 substance use disorders.

15 (4) A group health benefit plan amended, delivered,
16 issued, or renewed on or after January 1, 2019 (the effective
17 date of Public Act 100-1024) or an individual policy of
18 accident and health insurance or a qualified health plan
19 offered through the health insurance marketplace amended,
20 delivered, issued, or renewed on or after January 1, 2019 (the
21 effective date of Public Act 100-1024):

22 (A) shall provide coverage based upon medical
23 necessity for the treatment of a mental, emotional,
24 nervous, or substance use disorder or condition consistent
25 with the parity requirements of Section 370c.1 of this
26 Code; provided, however, that in each calendar year

1 coverage shall not be less than the following:

2 (i) 45 days of inpatient treatment; and

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

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

14 (B) may not include a lifetime limit on the number of
15 days of inpatient treatment or the number of outpatient
16 visits covered under the plan.

17 (C) (Blank).

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

1 (5.5) An individual or group health benefit plan amended,
2 delivered, issued, or renewed on or after September 9, 2015
3 (the effective date of Public Act 99-480) shall offer coverage
4 for medically necessary acute treatment services and medically
5 necessary clinical stabilization services. The treating
6 provider shall base all treatment recommendations and the
7 health benefit plan shall base all medical necessity
8 determinations for substance use disorders in accordance with
9 the most current edition of the Treatment Criteria for
10 Addictive, Substance-Related, and Co-Occurring Conditions
11 established by the American Society of Addiction Medicine. The
12 treating provider shall base all treatment recommendations and
13 the health benefit plan shall base all medical necessity
14 determinations for medication-assisted treatment in accordance
15 with the most current Treatment Criteria for Addictive,
16 Substance-Related, and Co-Occurring Conditions established by
17 the American Society of Addiction Medicine.

18 As used in this subsection:

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

24 "Clinical stabilization services" means 24-hour treatment,
25 usually following acute treatment services for substance
26 abuse, which may include intensive education and counseling

1 regarding the nature of addiction and its consequences,
2 relapse prevention, outreach to families and significant
3 others, and aftercare planning for individuals beginning to
4 engage in recovery from addiction.

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

8 (6.5) An individual or group health benefit plan amended,
9 delivered, issued, or renewed on or after January 1, 2019 (the
10 effective date of Public Act 100-1024):

11 (A) shall not impose prior authorization requirements,
12 other than those established under the Treatment Criteria
13 for Addictive, Substance-Related, and Co-Occurring
14 Conditions established by the American Society of
15 Addiction Medicine, on a prescription medication approved
16 by the United States Food and Drug Administration that is
17 prescribed or administered for the treatment of substance
18 use disorders;

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

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

11 (D) shall not exclude coverage for a prescription
12 medication approved by the United States Food and Drug
13 Administration for the treatment of substance use
14 disorders and any associated counseling or wraparound
15 services on the grounds that such medications and services
16 were court ordered.

17 (7) (Blank).

18 (8) (Blank).

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

25 (c) This Section shall not be interpreted to require
26 coverage for speech therapy or other habilitative services for

1 those individuals covered under Section 356z.15 of this Code.

2 (d) With respect to a group or individual policy of
3 accident and health insurance or a qualified health plan
4 offered through the health insurance marketplace, the
5 Department and, with respect to medical assistance, the
6 Department of Healthcare and Family Services shall each
7 enforce the requirements of this Section and Sections 356z.23
8 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
9 Mental Health Parity and Addiction Equity Act of 2008, 42
10 U.S.C. 18031(j), and any amendments to, and federal guidance
11 or regulations issued under, those Acts, including, but not
12 limited to, final regulations issued under the Paul Wellstone
13 and Pete Domenici Mental Health Parity and Addiction Equity
14 Act of 2008 and final regulations applying the Paul Wellstone
15 and Pete Domenici Mental Health Parity and Addiction Equity
16 Act of 2008 to Medicaid managed care organizations, the
17 Children's Health Insurance Program, and alternative benefit
18 plans. Specifically, the Department and the Department of
19 Healthcare and Family Services shall take action:

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

1 benefits as compared to how they design and apply
2 nonquantitative treatment limitations, as written and in
3 operation, for medical and surgical benefits;

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

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

13 (A) nonquantitative treatment limitations,
14 including, but not limited to, prior authorization
15 requirements, concurrent review, retrospective review,
16 step therapy, network admission standards,
17 reimbursement rates, and geographic restrictions;

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

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

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

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

1 insurance.

2 (e) Availability of plan information.

3 (1) The criteria for medical necessity determinations
4 made under a group health plan, an individual policy of
5 accident and health insurance, or a qualified health plan
6 offered through the health insurance marketplace with
7 respect to mental health or substance use disorder
8 benefits (or health insurance coverage offered in
9 connection with the plan with respect to such benefits)
10 must be made available by the plan administrator (or the
11 health insurance issuer offering such coverage) to any
12 current or potential participant, beneficiary, or
13 contracting provider upon request.

14 (2) The reason for any denial under a group health
15 benefit plan, an individual policy of accident and health
16 insurance, or a qualified health plan offered through the
17 health insurance marketplace (or health insurance coverage
18 offered in connection with such plan or policy) of
19 reimbursement or payment for services with respect to
20 mental, emotional, nervous, or substance use disorders or
21 conditions benefits in the case of any participant or
22 beneficiary must be made available within a reasonable
23 time and in a reasonable manner and in readily
24 understandable language by the plan administrator (or the
25 health insurance issuer offering such coverage) to the
26 participant or beneficiary upon request.

1 (f) As used in this Section, "group policy of accident and
2 health insurance" and "group health benefit plan" includes (1)
3 State-regulated employer-sponsored group health insurance
4 plans written in Illinois or which purport to provide coverage
5 for a resident of this State; and (2) State employee health
6 plans.

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

8 "Benefits", with respect to insurers, means the benefits
9 provided for treatment services for inpatient and outpatient
10 treatment of substance use disorders or conditions at American
11 Society of Addiction Medicine levels of treatment 2.1
12 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1
13 (Clinically Managed Low-Intensity Residential), 3.3
14 (Clinically Managed Population-Specific High-Intensity
15 Residential), 3.5 (Clinically Managed High-Intensity
16 Residential), and 3.7 (Medically Monitored Intensive
17 Inpatient) and OMT (Opioid Maintenance Therapy) services.

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

26 "Substance use disorder treatment provider or facility"

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

5 (2) A group health insurance policy, an individual health
6 benefit plan, or qualified health plan that is offered through
7 the health insurance marketplace, small employer group health
8 plan, and large employer group health plan that is amended,
9 delivered, issued, executed, or renewed in this State, or
10 approved for issuance or renewal in this State, on or after
11 January 1, 2019 (the effective date of Public Act 100-1023)
12 shall comply with the requirements of this Section and Section
13 370c.1. The services for the treatment and the ongoing
14 assessment of the patient's progress in treatment shall follow
15 the requirements of 77 Ill. Adm. Code 2060.

16 (3) Prior authorization shall not be utilized for the
17 benefits under this subsection. The substance use disorder
18 treatment provider or facility shall notify the insurer of the
19 initiation of treatment. For an insurer that is not a managed
20 care organization, the substance use disorder treatment
21 provider or facility notification shall occur for the
22 initiation of treatment of the covered person within 2
23 business days. For managed care organizations, the substance
24 use disorder treatment provider or facility notification shall
25 occur in accordance with the protocol set forth in the
26 provider agreement for initiation of treatment within 24

1 hours. If the managed care organization is not capable of
2 accepting the notification in accordance with the contractual
3 protocol during the 24-hour period following admission, the
4 substance use disorder treatment provider or facility shall
5 have one additional business day to provide the notification
6 to the appropriate managed care organization. Treatment plans
7 shall be developed in accordance with the requirements and
8 timeframes established in 77 Ill. Adm. Code 2060. If the
9 substance use disorder treatment provider or facility fails to
10 notify the insurer of the initiation of treatment in
11 accordance with these provisions, the insurer may follow its
12 normal prior authorization processes.

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

22 Pursuant to the requirements of the Health Carrier
23 External Review Act, the covered person or the covered
24 person's authorized representative may request an expedited
25 external review. An expedited external review may not occur if
26 the substance use disorder treatment provider or facility

1 determines that continued treatment is no longer medically
2 necessary. Under this subsection, a request for expedited
3 external review must be initiated within 24 hours following
4 the adverse determination notification by the insurer. Failure
5 to request an expedited external review within 24 hours shall
6 preclude a covered person or a covered person's authorized
7 representative from requesting an expedited external review.

8 If an expedited external review request meets the criteria
9 of the Health Carrier External Review Act, an independent
10 review organization shall make a final determination of
11 medical necessity within 72 hours. If an independent review
12 organization upholds an adverse determination, an insurer
13 shall remain responsible to provide coverage of benefits
14 through the day following the determination of the independent
15 review organization. A decision to reverse an adverse
16 determination shall comply with the Health Carrier External
17 Review Act.

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

24 (6) The benefits required by this subsection shall be
25 provided to all covered persons with a diagnosis of substance
26 use disorder or conditions. The presence of additional related

1 or unrelated diagnoses shall not be a basis to reduce or deny
2 the benefits required by this subsection.

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

6 (h) As used in this Section:

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

23 "Medically necessary treatment of mental, emotional,
24 nervous, or substance use disorders or conditions" means a
25 service or product addressing the specific needs of that
26 patient, for the purpose of screening, preventing, diagnosing,

1 managing, or treating an illness, injury, or condition or its
2 symptoms and comorbidities, including minimizing the
3 progression of an illness, injury, or condition or its
4 symptoms and comorbidities in a manner that is all of the
5 following:

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

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

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

14 "Utilization review" means either of the following:

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

22 (2) evaluating the medical necessity, appropriateness,
23 level of care, service intensity, efficacy, or efficiency
24 of health care services, benefits, procedures, or
25 settings, under any circumstances, to determine whether a
26 health care service or benefit subject to a medical

1 necessity coverage requirement in an insurance policy is
2 covered as medically necessary for an insured.

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

6 (i)(1) Every insurer that amends, delivers, issues, or
7 renews a group or individual policy of accident and health
8 insurance or a qualified health plan offered through the
9 health insurance marketplace in this State and Medicaid
10 managed care organizations providing coverage for hospital or
11 medical treatment on or after January 1, 2023 shall, pursuant
12 to subsections (h) through (s), provide coverage for medically
13 necessary treatment of mental, emotional, nervous, or
14 substance use disorders or conditions.

15 (2) An insurer shall not set a specific limit on the
16 duration of benefits or coverage of medically necessary
17 treatment of mental, emotional, nervous, or substance use
18 disorders or conditions or limit coverage only to alleviation
19 of the insured's current symptoms.

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

26 (4) An insurer that authorizes a specific type of

1 treatment by a provider pursuant to this Section shall not
2 rescind or modify the authorization after that provider
3 renders the health care service in good faith and pursuant to
4 this authorization for any reason, including, but not limited
5 to, the insurer's subsequent cancellation or modification of
6 the insured's or policyholder's contract, or the insured's or
7 policyholder's eligibility. Nothing in this Section shall
8 require the insurer to cover a treatment when the
9 authorization was granted based on a material
10 misrepresentation by the insured, the policyholder, or the
11 provider. Nothing in this Section shall require Medicaid
12 managed care organizations to pay for services if the
13 individual was not eligible for Medicaid at the time the
14 service was rendered. Nothing in this Section shall require an
15 insurer to pay for services if the individual was not the
16 insurer's enrollee at the time services were rendered. As used
17 in this paragraph, "material" means a fact or situation that
18 is not merely technical in nature and results in or could
19 result in a substantial change in the situation.

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

1 that excludes otherwise covered benefits on the basis that
2 those services should be or could be covered by a public
3 entitlement program. Nothing in this subsection shall be
4 construed to require an insurer to cover benefits that have
5 been authorized and provided for a covered person by a public
6 entitlement program. Medicaid managed care organizations are
7 not subject to this subsection.

8 (k) An insurer shall base any medical necessity
9 determination or the utilization review criteria that the
10 insurer, and any entity acting on the insurer's behalf,
11 applies to determine the medical necessity of health care
12 services and benefits for the diagnosis, prevention, and
13 treatment of mental, emotional, nervous, or substance use
14 disorders or conditions on current generally accepted
15 standards of mental, emotional, nervous, or substance use
16 disorder or condition care. All denials and appeals shall be
17 reviewed by a professional with experience or expertise
18 comparable to the provider requesting the authorization.

19 (l) For medical necessity determinations relating to level
20 of care placement, continued stay, and transfer or discharge
21 of insureds diagnosed with mental, emotional, and nervous
22 disorders or conditions, an insurer shall apply the patient
23 placement criteria set forth in the most recent version of the
24 treatment criteria developed by an unaffiliated nonprofit
25 professional association for the relevant clinical specialty
26 or, for Medicaid managed care organizations, patient placement

1 criteria determined by the Department of Healthcare and Family
2 Services that are consistent with generally accepted standards
3 of mental, emotional, nervous or substance use disorder or
4 condition care. Pursuant to subsection (b), in conducting
5 utilization review of all covered services and benefits for
6 the diagnosis, prevention, and treatment of substance use
7 disorders an insurer shall use the most recent edition of the
8 patient placement criteria established by the American Society
9 of Addiction Medicine.

10 (m) For medical necessity determinations relating to level
11 of care placement, continued stay, and transfer or discharge
12 that are within the scope of the sources specified in
13 subsection (l), an insurer shall not apply different,
14 additional, conflicting, or more restrictive utilization
15 review criteria than the criteria set forth in those sources.
16 For all level of care placement decisions, the insurer shall
17 authorize placement at the level of care consistent with the
18 assessment of the insured using the relevant patient placement
19 criteria as specified in subsection (l). If that level of
20 placement is not available, the insurer shall authorize the
21 next higher level of care. In the event of disagreement, the
22 insurer shall provide full detail of its assessment using the
23 relevant criteria as specified in subsection (l) to the
24 provider of the service and the patient.

25 Nothing in this subsection or subsection (l) prohibits an
26 insurer from applying utilization review criteria that were

1 developed in accordance with subsection (k) to health care
2 services and benefits for mental, emotional, and nervous
3 disorders or conditions that are not related to medical
4 necessity determinations for level of care placement,
5 continued stay, and transfer or discharge. If an insurer
6 purchases or licenses utilization review criteria pursuant to
7 this subsection, the insurer shall verify and document before
8 use that the criteria were developed in accordance with
9 subsection (k).

10 (n) In conducting utilization review that is outside the
11 scope of the criteria as specified in subsection (l) or
12 relates to the advancements in technology or in the types or
13 levels of care that are not addressed in the most recent
14 versions of the sources specified in subsection (l), an
15 insurer shall conduct utilization review in accordance with
16 subsection (k).

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

19 (p) This Section does not in any way limit early and
20 periodic screening, diagnostic, and treatment benefits as
21 defined under 42 U.S.C. 1396d(r).

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

24 (1) Educate the insurer's staff, including any third
25 parties contracted with the insurer to review claims,
26 conduct utilization reviews, or make medical necessity

1 determinations about the utilization review criteria.

2 (2) Make the educational program available to other
3 stakeholders, including the insurer's participating or
4 contracted providers and potential participants,
5 beneficiaries, or covered lives. The education program
6 must be provided at least once a year, in-person or
7 digitally, or recordings of the education program must be
8 made available to the aforementioned stakeholders.

9 (3) Provide, at no cost, the utilization review
10 criteria and any training material or resources to
11 providers and insured patients upon request. For
12 utilization review criteria not concerning level of care
13 placement, continued stay, and transfer or discharge used
14 by the insurer pursuant to subsection (m), the insurer may
15 place the criteria on a secure, password-protected website
16 so long as the access requirements of the website do not
17 unreasonably restrict access to insureds or their
18 providers. No restrictions shall be placed upon the
19 insured's or treating provider's access right to
20 utilization review criteria obtained under this paragraph
21 at any point in time, including before an initial request
22 for authorization.

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

26 (5) Conduct interrater reliability testing to ensure

1 consistency in utilization review decision making that
2 covers how medical necessity decisions are made; this
3 assessment shall cover all aspects of utilization review
4 as defined in subsection (h).

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

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

15 (8) Maintain documentation of interrater reliability
16 testing and the remediation actions taken for those with
17 pass rates lower than 90% and submit to the Department of
18 Insurance or, in the case of Medicaid managed care
19 organizations, the Department of Healthcare and Family
20 Services the testing results and a summary of remedial
21 actions as part of parity compliance reporting set forth
22 in subsection (k) of Section 370c.1.

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

1 prescription drugs.

2 (s) This Section applies to an insurer that amends,
3 delivers, issues, or renews a group or individual policy of
4 accident and health insurance or a qualified health plan
5 offered through the health insurance marketplace in this State
6 providing coverage for hospital or medical treatment and
7 conducts utilization review as defined in this Section,
8 including Medicaid managed care organizations, and any entity
9 or contracting provider that performs utilization review or
10 utilization management functions on an insurer's behalf.

11 (t) If the Director determines that an insurer has
12 violated this Section, the Director may, after appropriate
13 notice and opportunity for hearing, by order, assess a civil
14 penalty between \$1,000 and \$5,000 for each violation. Moneys
15 collected from penalties shall be deposited into the Parity
16 Advancement Fund established in subsection (i) of Section
17 370c.1.

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

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

1 (Source: P.A. 100-305, eff. 8-24-17; 100-1023, eff. 1-1-19;
2 100-1024, eff. 1-1-19; 101-81, eff. 7-12-19; 101-386, eff.
3 8-16-19; revised 9-20-19.)

4 (215 ILCS 5/370c.1)

5 Sec. 370c.1. Mental, emotional, nervous, or substance use
6 disorder or condition parity.

7 (a) On and after the effective date of this amendatory Act
8 of the 99th General Assembly, every insurer that amends,
9 delivers, issues, or renews a group or individual policy of
10 accident and health insurance or a qualified health plan
11 offered through the Health Insurance Marketplace in this State
12 providing coverage for hospital or medical treatment and for
13 the treatment of mental, emotional, nervous, or substance use
14 disorders or conditions shall ensure that:

15 (1) the financial requirements applicable to such
16 mental, emotional, nervous, or substance use disorder or
17 condition benefits are no more restrictive than the
18 predominant financial requirements applied to
19 substantially all hospital and medical benefits covered by
20 the policy and that there are no separate cost-sharing
21 requirements that are applicable only with respect to
22 mental, emotional, nervous, or substance use disorder or
23 condition benefits; and

24 (2) the treatment limitations applicable to such
25 mental, emotional, nervous, or substance use disorder or

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

7 (b) The following provisions shall apply concerning
8 aggregate lifetime limits:

9 (1) In the case of a group or individual policy of
10 accident and health insurance or a qualified health plan
11 offered through the Health Insurance Marketplace amended,
12 delivered, issued, or renewed in this State on or after
13 the effective date of this amendatory Act of the 99th
14 General Assembly that provides coverage for hospital or
15 medical treatment and for the treatment of mental,
16 emotional, nervous, or substance use disorders or
17 conditions the following provisions shall apply:

18 (A) if the policy does not include an aggregate
19 lifetime limit on substantially all hospital and
20 medical benefits, then the policy may not impose any
21 aggregate lifetime limit on mental, emotional,
22 nervous, or substance use disorder or condition
23 benefits; or

24 (B) if the policy includes an aggregate lifetime
25 limit on substantially all hospital and medical
26 benefits (in this subsection referred to as the

1 "applicable lifetime limit"), then the policy shall
2 either:

3 (i) apply the applicable lifetime limit both
4 to the hospital and medical benefits to which it
5 otherwise would apply and to mental, emotional,
6 nervous, or substance use disorder or condition
7 benefits and not distinguish in the application of
8 the limit between the hospital and medical
9 benefits and mental, emotional, nervous, or
10 substance use disorder or condition benefits; or

11 (ii) not include any aggregate lifetime limit
12 on mental, emotional, nervous, or substance use
13 disorder or condition benefits that is less than
14 the applicable lifetime limit.

15 (2) In the case of a policy that is not described in
16 paragraph (1) of subsection (b) of this Section and that
17 includes no or different aggregate lifetime limits on
18 different categories of hospital and medical benefits, the
19 Director shall establish rules under which subparagraph
20 (B) of paragraph (1) of subsection (b) of this Section is
21 applied to such policy with respect to mental, emotional,
22 nervous, or substance use disorder or condition benefits
23 by substituting for the applicable lifetime limit an
24 average aggregate lifetime limit that is computed taking
25 into account the weighted average of the aggregate
26 lifetime limits applicable to such categories.

1 (c) The following provisions shall apply concerning annual
2 limits:

3 (1) In the case of a group or individual policy of
4 accident and health insurance or a qualified health plan
5 offered through the Health Insurance Marketplace amended,
6 delivered, issued, or renewed in this State on or after
7 the effective date of this amendatory Act of the 99th
8 General Assembly that provides coverage for hospital or
9 medical treatment and for the treatment of mental,
10 emotional, nervous, or substance use disorders or
11 conditions the following provisions shall apply:

12 (A) if the policy does not include an annual limit
13 on substantially all hospital and medical benefits,
14 then the policy may not impose any annual limits on
15 mental, emotional, nervous, or substance use disorder
16 or condition benefits; or

17 (B) if the policy includes an annual limit on
18 substantially all hospital and medical benefits (in
19 this subsection referred to as the "applicable annual
20 limit"), then the policy shall either:

21 (i) apply the applicable annual limit both to
22 the hospital and medical benefits to which it
23 otherwise would apply and to mental, emotional,
24 nervous, or substance use disorder or condition
25 benefits and not distinguish in the application of
26 the limit between the hospital and medical

1 benefits and mental, emotional, nervous, or
2 substance use disorder or condition benefits; or

3 (ii) not include any annual limit on mental,
4 emotional, nervous, or substance use disorder or
5 condition benefits that is less than the
6 applicable annual limit.

7 (2) In the case of a policy that is not described in
8 paragraph (1) of subsection (c) of this Section and that
9 includes no or different annual limits on different
10 categories of hospital and medical benefits, the Director
11 shall establish rules under which subparagraph (B) of
12 paragraph (1) of subsection (c) of this Section is applied
13 to such policy with respect to mental, emotional, nervous,
14 or substance use disorder or condition benefits by
15 substituting for the applicable annual limit an average
16 annual limit that is computed taking into account the
17 weighted average of the annual limits applicable to such
18 categories.

19 (d) With respect to mental, emotional, nervous, or
20 substance use disorders or conditions, an insurer shall use
21 policies and procedures for the election and placement of
22 mental, emotional, nervous, or substance use disorder or
23 condition treatment drugs on their formulary that are no less
24 favorable to the insured as those policies and procedures the
25 insurer uses for the selection and placement of drugs for
26 medical or surgical conditions and shall follow the expedited

1 coverage determination requirements for substance abuse
2 treatment drugs set forth in Section 45.2 of the Managed Care
3 Reform and Patient Rights Act.

4 (e) This Section shall be interpreted in a manner
5 consistent with all applicable federal parity regulations
6 including, but not limited to, the Paul Wellstone and Pete
7 Domenici Mental Health Parity and Addiction Equity Act of
8 2008, final regulations issued under the Paul Wellstone and
9 Pete Domenici Mental Health Parity and Addiction Equity Act of
10 2008 and final regulations applying the Paul Wellstone and
11 Pete Domenici Mental Health Parity and Addiction Equity Act of
12 2008 to Medicaid managed care organizations, the Children's
13 Health Insurance Program, and alternative benefit plans.

14 (f) The provisions of subsections (b) and (c) of this
15 Section shall not be interpreted to allow the use of lifetime
16 or annual limits otherwise prohibited by State or federal law.

17 (g) As used in this Section:

18 "Financial requirement" includes deductibles, copayments,
19 coinsurance, and out-of-pocket maximums, but does not include
20 an aggregate lifetime limit or an annual limit subject to
21 subsections (b) and (c).

22 "Mental, emotional, nervous, or substance use disorder or
23 condition" means a condition or disorder that involves a
24 mental health condition or substance use disorder that falls
25 under any of the diagnostic categories listed in the mental
26 and behavioral disorders chapter of the current edition of the

1 International Classification of Disease or that is listed in
2 the most recent version of the Diagnostic and Statistical
3 Manual of Mental Disorders.

4 "Treatment limitation" includes limits on benefits based
5 on the frequency of treatment, number of visits, days of
6 coverage, days in a waiting period, or other similar limits on
7 the scope or duration of treatment. "Treatment limitation"
8 includes both quantitative treatment limitations, which are
9 expressed numerically (such as 50 outpatient visits per year),
10 and nonquantitative treatment limitations, which otherwise
11 limit the scope or duration of treatment. A permanent
12 exclusion of all benefits for a particular condition or
13 disorder shall not be considered a treatment limitation.

14 "Nonquantitative treatment" means those limitations as
15 described under federal regulations (26 CFR 54.9812-1).

16 "Nonquantitative treatment limitations" include, but are not
17 limited to, those limitations described under federal
18 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
19 146.136.

20 (h) The Department of Insurance shall implement the
21 following education initiatives:

22 (1) By January 1, 2016, the Department shall develop a
23 plan for a Consumer Education Campaign on parity. The
24 Consumer Education Campaign shall focus its efforts
25 throughout the State and include trainings in the
26 northern, southern, and central regions of the State, as

1 defined by the Department, as well as each of the 5 managed
2 care regions of the State as identified by the Department
3 of Healthcare and Family Services. Under this Consumer
4 Education Campaign, the Department shall: (1) by January
5 1, 2017, provide at least one live training in each region
6 on parity for consumers and providers and one webinar
7 training to be posted on the Department website and (2)
8 establish a consumer hotline to assist consumers in
9 navigating the parity process by March 1, 2017. By January
10 1, 2018 the Department shall issue a report to the General
11 Assembly on the success of the Consumer Education
12 Campaign, which shall indicate whether additional training
13 is necessary or would be recommended.

14 (2) The Department, in coordination with the
15 Department of Human Services and the Department of
16 Healthcare and Family Services, shall convene a working
17 group of health care insurance carriers, mental health
18 advocacy groups, substance abuse patient advocacy groups,
19 and mental health physician groups for the purpose of
20 discussing issues related to the treatment and coverage of
21 mental, emotional, nervous, or substance use disorders or
22 conditions and compliance with parity obligations under
23 State and federal law. Compliance shall be measured,
24 tracked, and shared during the meetings of the working
25 group. The working group shall meet once before January 1,
26 2016 and shall meet semiannually thereafter. The

1 Department shall issue an annual report to the General
2 Assembly that includes a list of the health care insurance
3 carriers, mental health advocacy groups, substance abuse
4 patient advocacy groups, and mental health physician
5 groups that participated in the working group meetings,
6 details on the issues and topics covered, and any
7 legislative recommendations developed by the working
8 group.

9 (3) Not later than January ~~August~~ 1 of each year, the
10 Department, in conjunction with the Department of
11 Healthcare and Family Services, shall issue a joint report
12 to the General Assembly and provide an educational
13 presentation to the General Assembly. The report and
14 presentation shall:

15 (A) Cover the methodology the Departments use to
16 check for compliance with the federal Paul Wellstone
17 and Pete Domenici Mental Health Parity and Addiction
18 Equity Act of 2008, 42 U.S.C. 18031(j), and any
19 federal regulations or guidance relating to the
20 compliance and oversight of the federal Paul Wellstone
21 and Pete Domenici Mental Health Parity and Addiction
22 Equity Act of 2008 and 42 U.S.C. 18031(j).

23 (B) Cover the methodology the Departments use to
24 check for compliance with this Section and Sections
25 356z.23 and 370c of this Code.

26 (C) Identify market conduct examinations or, in

1 the case of the Department of Healthcare and Family
2 Services, audits conducted or completed during the
3 preceding 12-month period regarding compliance with
4 parity in mental, emotional, nervous, and substance
5 use disorder or condition benefits under State and
6 federal laws and summarize the results of such market
7 conduct examinations and audits. This shall include:

8 (i) the number of market conduct examinations
9 and audits initiated and completed;

10 (ii) the benefit classifications examined by
11 each market conduct examination and audit;

12 (iii) the subject matter of each market
13 conduct examination and audit, including
14 quantitative and nonquantitative treatment
15 limitations; and

16 (iv) a summary of the basis for the final
17 decision rendered in each market conduct
18 examination and audit.

19 Individually identifiable information shall be
20 excluded from the reports consistent with federal
21 privacy protections.

22 (D) Detail any educational or corrective actions
23 the Departments have taken to ensure compliance with
24 the federal Paul Wellstone and Pete Domenici Mental
25 Health Parity and Addiction Equity Act of 2008, 42
26 U.S.C. 18031(j), this Section, and Sections 356z.23

1 and 370c of this Code.

2 (E) The report must be written in non-technical,
3 readily understandable language and shall be made
4 available to the public by, among such other means as
5 the Departments find appropriate, posting the report
6 on the Departments' websites.

7 (i) The Parity Advancement Fund is created as a special
8 fund in the State treasury. Moneys from fines and penalties
9 collected from insurers for violations of this Section shall
10 be deposited into the Fund. Moneys deposited into the Fund for
11 appropriation by the General Assembly to the Department shall
12 be used for the purpose of providing financial support of the
13 Consumer Education Campaign, parity compliance advocacy, and
14 other initiatives that support parity implementation and
15 enforcement on behalf of consumers.

16 (j) The Department of Insurance and the Department of
17 Healthcare and Family Services shall convene and provide
18 technical support to a workgroup of 11 members that shall be
19 comprised of 3 mental health parity experts recommended by an
20 organization advocating on behalf of mental health parity
21 appointed by the President of the Senate; 3 behavioral health
22 providers recommended by an organization that represents
23 behavioral health providers appointed by the Speaker of the
24 House of Representatives; 2 representing Medicaid managed care
25 organizations recommended by an organization that represents
26 Medicaid managed care plans appointed by the Minority Leader

1 of the House of Representatives; 2 representing commercial
2 insurers recommended by an organization that represents
3 insurers appointed by the Minority Leader of the Senate; and a
4 representative of an organization that represents Medicaid
5 managed care plans appointed by the Governor.

6 The workgroup shall provide recommendations to the General
7 Assembly on health plan data reporting requirements that
8 separately break out data on mental, emotional, nervous, or
9 substance use disorder or condition benefits and data on other
10 medical benefits, including physical health and related health
11 services no later than December 31, 2019. The recommendations
12 to the General Assembly shall be filed with the Clerk of the
13 House of Representatives and the Secretary of the Senate in
14 electronic form only, in the manner that the Clerk and the
15 Secretary shall direct. This workgroup shall take into account
16 federal requirements and recommendations on mental health
17 parity reporting for the Medicaid program. This workgroup
18 shall also develop the format and provide any needed
19 definitions for reporting requirements in subsection (k). The
20 research and evaluation of the working group shall include,
21 but not be limited to:

22 (1) claims denials due to benefit limits, if
23 applicable;

24 (2) administrative denials for no prior authorization;

25 (3) denials due to not meeting medical necessity;

26 (4) denials that went to external review and whether

1 they were upheld or overturned for medical necessity;

2 (5) out-of-network claims;

3 (6) emergency care claims;

4 (7) network directory providers in the outpatient
5 benefits classification who filed no claims in the last 6
6 months, if applicable;

7 (8) the impact of existing and pertinent limitations
8 and restrictions related to approved services, licensed
9 providers, reimbursement levels, and reimbursement
10 methodologies within the Division of Mental Health, the
11 Division of Substance Use Prevention and Recovery
12 programs, the Department of Healthcare and Family
13 Services, and, to the extent possible, federal regulations
14 and law; and

15 (9) when reporting and publishing should begin.

16 Representatives from the Department of Healthcare and
17 Family Services, representatives from the Division of Mental
18 Health, and representatives from the Division of Substance Use
19 Prevention and Recovery shall provide technical advice to the
20 workgroup.

21 (k) An insurer that amends, delivers, issues, or renews a
22 group or individual policy of accident and health insurance or
23 a qualified health plan offered through the health insurance
24 marketplace in this State providing coverage for hospital or
25 medical treatment and for the treatment of mental, emotional,
26 nervous, or substance use disorders or conditions shall submit

1 an annual report, the format and definitions for which will be
2 developed by the workgroup in subsection (j), to the
3 Department, or, with respect to medical assistance, the
4 Department of Healthcare and Family Services starting on or
5 before July 1, 2020 that contains the following information
6 separately for inpatient in-network benefits, inpatient
7 out-of-network benefits, outpatient in-network benefits,
8 outpatient out-of-network benefits, emergency care benefits,
9 and prescription drug benefits in the case of accident and
10 health insurance or qualified health plans, or inpatient,
11 outpatient, emergency care, and prescription drug benefits in
12 the case of medical assistance:

13 (1) A summary of the plan's pharmacy management
14 processes for mental, emotional, nervous, or substance use
15 disorder or condition benefits compared to those for other
16 medical benefits.

17 (2) A summary of the internal processes of review for
18 experimental benefits and unproven technology for mental,
19 emotional, nervous, or substance use disorder or condition
20 benefits and those for other medical benefits.

21 (3) A summary of how the plan's policies and
22 procedures for utilization management for mental,
23 emotional, nervous, or substance use disorder or condition
24 benefits compare to those for other medical benefits.

25 (4) A description of the process used to develop or
26 select the medical necessity criteria for mental,

1 emotional, nervous, or substance use disorder or condition
2 benefits and the process used to develop or select the
3 medical necessity criteria for medical and surgical
4 benefits.

5 (5) Identification of all nonquantitative treatment
6 limitations that are applied to both mental, emotional,
7 nervous, or substance use disorder or condition benefits
8 and medical and surgical benefits within each
9 classification of benefits.

10 (6) The results of an analysis that demonstrates that
11 for the medical necessity criteria described in
12 subparagraph (A) and for each nonquantitative treatment
13 limitation identified in subparagraph (B), as written and
14 in operation, the processes, strategies, evidentiary
15 standards, or other factors used in applying the medical
16 necessity criteria and each nonquantitative treatment
17 limitation to mental, emotional, nervous, or substance use
18 disorder or condition benefits within each classification
19 of benefits are comparable to, and are applied no more
20 stringently than, the processes, strategies, evidentiary
21 standards, or other factors used in applying the medical
22 necessity criteria and each nonquantitative treatment
23 limitation to medical and surgical benefits within the
24 corresponding classification of benefits; at a minimum,
25 the results of the analysis shall:

26 (A) identify the factors used to determine that a

1 nonquantitative treatment limitation applies to a
2 benefit, including factors that were considered but
3 rejected;

4 (B) identify and define the specific evidentiary
5 standards used to define the factors and any other
6 evidence relied upon in designing each nonquantitative
7 treatment limitation;

8 (C) provide the comparative analyses, including
9 the results of the analyses, performed to determine
10 that the processes and strategies used to design each
11 nonquantitative treatment limitation, as written, for
12 mental, emotional, nervous, or substance use disorder
13 or condition benefits are comparable to, and are
14 applied no more stringently than, the processes and
15 strategies used to design each nonquantitative
16 treatment limitation, as written, for medical and
17 surgical benefits;

18 (D) provide the comparative analyses, including
19 the results of the analyses, performed to determine
20 that the processes and strategies used to apply each
21 nonquantitative treatment limitation, in operation,
22 for mental, emotional, nervous, or substance use
23 disorder or condition benefits are comparable to, and
24 applied no more stringently than, the processes or
25 strategies used to apply each nonquantitative
26 treatment limitation, in operation, for medical and

1 surgical benefits; and

2 (E) disclose the specific findings and conclusions
3 reached by the insurer that the results of the
4 analyses described in subparagraphs (C) and (D)
5 indicate that the insurer is in compliance with this
6 Section and the Mental Health Parity and Addiction
7 Equity Act of 2008 and its implementing regulations,
8 which includes 42 CFR Parts 438, 440, and 457 and 45
9 CFR 146.136 and any other related federal regulations
10 found in the Code of Federal Regulations.

11 (7) Any other information necessary to clarify data
12 provided in accordance with this Section requested by the
13 Director, including information that may be proprietary or
14 have commercial value, under the requirements of Section
15 30 of the Viatical Settlements Act of 2009.

16 (1) An insurer that amends, delivers, issues, or renews a
17 group or individual policy of accident and health insurance or
18 a qualified health plan offered through the health insurance
19 marketplace in this State providing coverage for hospital or
20 medical treatment and for the treatment of mental, emotional,
21 nervous, or substance use disorders or conditions on or after
22 the effective date of this amendatory Act of the 100th General
23 Assembly shall, in advance of the plan year, make available to
24 the Department or, with respect to medical assistance, the
25 Department of Healthcare and Family Services and to all plan
26 participants and beneficiaries the information required in

1 subparagraphs (C) through (E) of paragraph (6) of subsection
2 (k). For plan participants and medical assistance
3 beneficiaries, the information required in subparagraphs (C)
4 through (E) of paragraph (6) of subsection (k) shall be made
5 available on a publicly-available website whose web address is
6 prominently displayed in plan and managed care organization
7 informational and marketing materials.

8 (m) In conjunction with its compliance examination program
9 conducted in accordance with the Illinois State Auditing Act,
10 the Auditor General shall undertake a review of compliance by
11 the Department and the Department of Healthcare and Family
12 Services with Section 370c and this Section. Any findings
13 resulting from the review conducted under this Section shall
14 be included in the applicable State agency's compliance
15 examination report. Each compliance examination report shall
16 be issued in accordance with Section 3-14 of the Illinois
17 State Auditing Act. A copy of each report shall also be
18 delivered to the head of the applicable State agency and
19 posted on the Auditor General's website.

20 (Source: P.A. 99-480, eff. 9-9-15; 100-1024, eff. 1-1-19.)

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

23 (215 ILCS 180/35)

24 Sec. 35. Standard external review.

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

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

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

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

21 (3) the covered person has exhausted the health
22 carrier's internal appeal process unless the covered
23 person is not required to exhaust the health carrier's
24 internal appeal process pursuant to this Act;

25 (4) (blank); and

26 (5) the covered person has provided all the

1 information and forms required to process an external
2 review, as specified in this Act.

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

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

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

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

23 The notice of initial determination of ineligibility shall
24 include a statement informing the covered person and, if
25 applicable, the covered person's authorized representative
26 that a health carrier's initial determination that the

1 external review request is ineligible for review may be
2 appealed to the Director by filing a complaint with the
3 Director.

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

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

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

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

1 organization.

2 The Director shall include in the notice provided to the
3 covered person and, if applicable, the covered person's
4 authorized representative a statement that the covered person
5 or the covered person's authorized representative may, within
6 5 business days following the date of receipt of the notice
7 provided pursuant to item (2) of this subsection (d), submit
8 in writing to the assigned independent review organization
9 additional information that the independent review
10 organization shall consider when conducting the external
11 review. The independent review organization is not required
12 to, but may, accept and consider additional information
13 submitted after 5 business days.

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

19 (f) Within 5 business days after the date of receipt of the
20 notice provided pursuant to item (1) of subsection (d) of this
21 Section, the health carrier or its designee utilization review
22 organization shall provide to the assigned independent review
23 organization the documents and any information considered in
24 making the adverse determination or final adverse
25 determination; in such cases, the following provisions shall
26 apply:

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

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

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

20 (g) Upon receipt of the information from the health
21 carrier or its utilization review organization, the assigned
22 independent review organization shall review all of the
23 information and documents and any other information submitted
24 in writing to the independent review organization by the
25 covered person and the covered person's authorized
26 representative.

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

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

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

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

20 (A) Within one business day after making the
21 decision to reverse its adverse determination or final
22 adverse determination, the health carrier shall notify
23 the Director, the covered person and, if applicable,
24 the covered person's authorized representative, and
25 the assigned independent review organization in
26 writing of its decision.

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

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

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

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

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

22 (4) the terms of coverage under the covered person's
23 health benefit plan with the health carrier to ensure that
24 the independent review organization's decision is not
25 contrary to the terms of coverage under the covered
26 person's health benefit plan with the health carrier,

1 unless the terms are inconsistent with applicable law;

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

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

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

16 (8) (blank); and

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

21 (i-5) For an adverse determination or final adverse
22 determination involving mental, emotional, nervous, or
23 substance use disorders or conditions, the independent review
24 organization shall:

25 (1) consider the documents and information as set
26 forth in subsection (i), except that all practice

1 guidelines and clinical review criteria must be consistent
2 with the requirements set forth in Section 370c of the
3 Illinois Insurance Code; and

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

11 (j) Within 5 days after the date of receipt of all
12 necessary information, but in no event more than 45 days after
13 the date of receipt of the request for an external review, the
14 assigned independent review organization shall provide written
15 notice of its decision to uphold or reverse the adverse
16 determination or the final adverse determination to the
17 Director, the health carrier, the covered person, and, if
18 applicable, the covered person's authorized representative. In
19 reaching a decision, the assigned independent review
20 organization is not bound by any claim determinations reached
21 prior to the submission of information to the independent
22 review organization. In such cases, the following provisions
23 shall apply:

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

26 (A) a general description of the reason for the

1 request for external review;

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

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

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

10 (E) the date of its decision;

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

15 (G) the rationale for its decision.

16 (2) (Blank).

17 (3) (Blank).

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

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

24 (215 ILCS 180/40)

25 Sec. 40. Expedited external review.

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

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

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

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

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

20 (1) The health carrier shall immediately notify the
21 Director, the covered person, and, if applicable, the
22 covered person's authorized representative of its
23 eligibility determination.

24 (2) The notice of initial determination shall include
25 a statement informing the covered person and, if
26 applicable, the covered person's authorized representative

1 that a health carrier's initial determination that an
2 external review request is ineligible for review may be
3 appealed to the Director.

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

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

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

19 (c) Upon receipt of the notice that the request meets the
20 reviewability requirements, the Director shall immediately
21 assign an independent review organization from the list of
22 approved independent review organizations compiled and
23 maintained by the Director to conduct the expedited review. In
24 such cases, the following provisions shall apply:

25 (1) The assignment of an approved independent review
26 organization to conduct an external review in accordance

1 with this Section shall be made from those approved
2 independent review organizations qualified to conduct
3 external review as required by Sections 50 and 55 of this
4 Act.

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

17 (3) If the health carrier or its utilization review
18 organization fails to provide the documents and
19 information within the specified timeframe, the assigned
20 independent review organization may terminate the external
21 review and make a decision to reverse the adverse
22 determination or final adverse determination.

23 (4) Within one business day after making the decision
24 to terminate the external review and make a decision to
25 reverse the adverse determination or final adverse
26 determination under item (3) of this subsection (c), the

1 independent review organization shall notify the Director,
2 the health carrier, the covered person, and, if
3 applicable, the covered person's authorized representative
4 of its decision to reverse the adverse determination or
5 final adverse determination.

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

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

21 (e) As expeditiously as the covered person's medical
22 condition or circumstances requires, but in no event more than
23 72 hours after the date of receipt of the request for an
24 expedited external review, the assigned independent review
25 organization shall:

26 (1) make a decision to uphold or reverse the final

1 adverse determination; and

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

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

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

16 (h) If the notice provided pursuant to subsection (e) of
17 this Section was not in writing, then within 48 hours after the
18 date of providing that notice, the assigned independent review
19 organization shall provide written confirmation of the
20 decision to the Director, the health carrier, the covered
21 person, and, if applicable, the covered person's authorized
22 representative including the information set forth in
23 subsection (j) of Section 35 of this Act as applicable.

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

26 (j) The assignment by the Director of an approved

1 independent review organization to conduct an external review
2 in accordance with this Section shall be done on a random basis
3 among those independent review organizations approved by the
4 Director pursuant to this Act.

5 (Source: P.A. 96-857, eff. 7-1-10; 97-333, eff. 8-12-11;
6 97-574, eff. 8-26-11.)

7 Section 99. Effective date. This Act takes effect January
8 1, 2022, except that this Section and the changes to Section
9 370c.1 of the Illinois Insurance Code take effect upon
10 becoming law."