SB0471

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB0471

Introduced 2/23/2021, by Sen. Laura Fine

SYNOPSIS AS INTRODUCED:

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

Amends the Illinois Insurance Code. Provides that an insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness entered into on or after January 1, 2022 shall ensure that the insured have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions. Provides that network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions must satisfy specified minimum requirements. Provides that if there is no in-network facility or provider available for an insured to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the minimum network adequacy standards, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with those network adequacy standards. Effective immediately.

LRB102 09983 BMS 15301 b

A BILL FOR

1 AN ACT concerning regulation.

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

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

6 (215 ILCS 5/370c) (from Ch. 73, par. 982c)
7 Sec. 370c. Mental and emotional disorders.
8 (a)(1) On and after <u>August 16, 2019</u> ~~January 1, 2019~~ (the
9 effective date of <u>Public Act 101-386</u> ~~this amendatory Act of~~
10 ~~the 101st General Assembly Public Act 100-1024~~), every insurer
11 that amends, delivers, issues, or renews group accident and
12 health policies providing coverage for hospital or medical
13 treatment or services for illness on an expense-incurred basis
14 shall provide coverage for reasonable and necessary treatment
15 and services for mental, emotional, nervous, or substance use
16 disorders or conditions consistent with the parity
17 requirements of Section 370c.1 of this Code.
18 (2) Each insured that is covered for mental, emotional,
19 nervous, or substance use disorders or conditions shall be
20 free to select the physician licensed to practice medicine in
21 all its branches, licensed clinical psychologist, licensed
22 clinical social worker, licensed clinical professional
23 counselor, licensed marriage and family therapist, licensed

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

1 worker, licensed clinical professional counselor, licensed
2 marriage and family therapist, licensed speech-language
3 pathologist, or other licensed or certified professional at a
4 program licensed pursuant to the Substance Use Disorder Act
5 has informed the patient of the desirability of the patient
6 conferring with the patient's primary care physician.

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

19 (b) Notwithstanding the requirements provided in
20 subsection (d) of Section 10 of the Network Adequacy and
21 Transparency Act, every insurer that amends, delivers, issues,
22 or renews group accident and health policies providing
23 coverage for hospital or medical treatment or services for
24 illness entered into on or after January 1, 2022 shall ensure
25 that insureds have timely and proximate access to treatment
26 for mental, emotional, nervous, or substance use disorders or

1 conditions. Insurers shall use a comparable process, strategy,
2 evidentiary standard, and other factors in the development and
3 application of the network adequacy standards for timely and
4 proximate access to treatment for mental, emotional, nervous,
5 or substance use disorders or conditions and those for the
6 access to treatment for medical and surgical conditions. As
7 such, the network adequacy standards for timely and proximate
8 access shall equally be applied to mental health or substance
9 use disorder treatment facilities and providers for mental,
10 emotional, nervous, or substance use disorders or conditions
11 and specialists providing medical or surgical benefits
12 pursuant to the parity requirements of Section 370c.1 of this
13 Code and the federal Paul Wellstone and Pete Domenici Mental
14 Health Parity and Addiction Equity Act of 2008.
15 Notwithstanding the foregoing, the network adequacy standards
16 for timely and proximate access to treatment for mental,
17 emotional, nervous, or substance use disorders or conditions
18 shall, at a minimum, satisfy the following requirements:

19 (1) For insureds residing in Counties of Cook, DuPage,
20 Kane, Lake, McHenry, and Will, network adequacy standards
21 for timely and proximate access to treatment for mental,
22 emotional, nervous, or substance use disorders or
23 conditions means an insured shall not have to travel
24 longer than 30 minutes or 30 miles from the insured's
25 residence to receive outpatient treatment for mental,
26 emotional, nervous, or substance use disorders or

1 conditions from a mental health or substance use disorder
2 provider or treatment facility. Insureds shall not be
3 required to wait longer than 10 business days between
4 requesting an initial or repeat appointment and being seen
5 by the facility or provider of mental, emotional, nervous,
6 or substance use disorders or conditions outpatient
7 treatment.
8 (2) For insureds residing in Illinois counties other
9 than those counties listed in paragraph (1) of this
10 subsection, network adequacy standards for timely and
11 proximate access to treatment for mental, emotional,
12 nervous, or substance use disorders or conditions means an
13 insured shall not have to travel longer than 60 minutes or
14 60 miles from the insured's residence to receive
15 outpatient treatment for mental, emotional, nervous, or
16 substance use disorders or conditions from a mental health
17 or substance use disorder provider or treatment facility.
18 Insureds shall not be required to wait longer than 10
19 business days between requesting an initial or repeat
20 appointment and being seen by the facility or provider of
21 mental, emotional, nervous, or substance use disorders or
22 conditions outpatient treatment.
23 (2.5) For insureds residing in all Illinois counties,
24 network adequacy standards for timely and proximate access
25 to treatment for mental, emotional, nervous, or substance
26 use disorders or conditions means an insured shall not

have to travel longer than 60 minutes or 60 miles from the insured's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions from a mental health or substance use disorder provider or treatment facility.

(2.7) If there is no in-network facility or provider available for an insured to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

~~(b)(1) (Blank).~~

~~(2) (Blank).~~

~~(2.5) (Blank).~~

(3) Unless otherwise prohibited by federal law and consistent with the parity requirements of Section 370c.1 of this Code, the reimbursing insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance, a qualified health plan offered through the health insurance marketplace, or a provider of treatment of mental, emotional, nervous, or substance use disorders or conditions shall furnish medical records or other necessary data that substantiate

1 that initial or continued treatment is at all times
2 medically necessary. An insurer shall provide a mechanism
3 for the timely review by a provider holding the same
4 license and practicing in the same specialty as the
5 patient's provider, who is unaffiliated with the insurer,
6 jointly selected by the patient (or the patient's next of
7 kin or legal representative if the patient is unable to
8 act for himself or herself), the patient's provider, and
9 the insurer in the event of a dispute between the insurer
10 and patient's provider regarding the medical necessity of
11 a treatment proposed by a patient's provider. If the
12 reviewing provider determines the treatment to be
13 medically necessary, the insurer shall provide
14 reimbursement for the treatment. Future contractual or
15 employment actions by the insurer regarding the patient's
16 provider may not be based on the provider's participation
17 in this procedure. Nothing prevents the insured from
18 agreeing in writing to continue treatment at his or her
19 expense. When making a determination of the medical
20 necessity for a treatment modality for mental, emotional,
21 nervous, or substance use disorders or conditions, an
22 insurer must make the determination in a manner that is
23 consistent with the manner used to make that determination
24 with respect to other diseases or illnesses covered under
25 the policy, including an appeals process. Medical
26 necessity determinations for substance use disorders shall

1 be made in accordance with appropriate patient placement
2 criteria established by the American Society of Addiction
3 Medicine. No additional criteria may be used to make
4 medical necessity determinations for substance use
5 disorders.

6 (4) A group health benefit plan amended, delivered,
7 issued, or renewed on or after January 1, 2019 (the
8 effective date of Public Act 100-1024) or an individual
9 policy of accident and health insurance or a qualified
10 health plan offered through the health insurance
11 marketplace amended, delivered, issued, or renewed on or
12 after January 1, 2019 (the effective date of Public Act
13 100-1024):

14 (A) shall provide coverage based upon medical
15 necessity for the treatment of a mental, emotional,
16 nervous, or substance use disorder or condition
17 consistent with the parity requirements of Section
18 370c.1 of this Code; provided, however, that in each
19 calendar year coverage shall not be less than the
20 following:

21 (i) 45 days of inpatient treatment; and

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

26 (iii) for plans or policies delivered, issued

1 for delivery, renewed, or modified after January
2 1, 2007 (the effective date of Public Act 94-906),
3 20 additional outpatient visits for speech therapy
4 for treatment of pervasive developmental disorders
5 that will be in addition to speech therapy
6 provided pursuant to item (ii) of this
7 subparagraph (A); and
8 (B) may not include a lifetime limit on the number
9 of days of inpatient treatment or the number of
10 outpatient visits covered under the plan.
11 (C) (Blank).
12 (5) An issuer of a group health benefit plan or an
13 individual policy of accident and health insurance or a
14 qualified health plan offered through the health insurance
15 marketplace may not count toward the number of outpatient
16 visits required to be covered under this Section an
17 outpatient visit for the purpose of medication management
18 and shall cover the outpatient visits under the same terms
19 and conditions as it covers outpatient visits for the
20 treatment of physical illness.
21 (5.5) An individual or group health benefit plan
22 amended, delivered, issued, or renewed on or after
23 September 9, 2015 (the effective date of Public Act
24 99-480) shall offer coverage for medically necessary acute
25 treatment services and medically necessary clinical
26 stabilization services. The treating provider shall base

1 all treatment recommendations and the health benefit plan
2 shall base all medical necessity determinations for
3 substance use disorders in accordance with the most
4 current edition of the Treatment Criteria for Addictive,
5 Substance-Related, and Co-Occurring Conditions
6 established by the American Society of Addiction Medicine.
7 The treating provider shall base all treatment
8 recommendations and the health benefit plan shall base all
9 medical necessity determinations for medication-assisted
10 treatment in accordance with the most current Treatment
11 Criteria for Addictive, Substance-Related, and
12 Co-Occurring Conditions established by the American
13 Society of Addiction Medicine.
14 As used in this subsection:
15 "Acute treatment services" means 24-hour medically
16 supervised addiction treatment that provides evaluation
17 and withdrawal management and may include biopsychosocial
18 assessment, individual and group counseling,
19 psychoeducational groups, and discharge planning.
20 "Clinical stabilization services" means 24-hour
21 treatment, usually following acute treatment services for
22 substance abuse, which may include intensive education and
23 counseling regarding the nature of addiction and its
24 consequences, relapse prevention, outreach to families and
25 significant others, and aftercare planning for individuals
26 beginning to engage in recovery from addiction.

1 (6) An issuer of a group health benefit plan may
2 provide or offer coverage required under this Section
3 through a managed care plan.
4 (6.5) An individual or group health benefit plan
5 amended, delivered, issued, or renewed on or after January
6 1, 2019 (the effective date of Public Act 100-1024):
7 (A) shall not impose prior authorization
8 requirements, other than those established under the
9 Treatment Criteria for Addictive, Substance-Related,
10 and Co-Occurring Conditions established by the
11 American Society of Addiction Medicine, on a
12 prescription medication approved by the United States
13 Food and Drug Administration that is prescribed or
14 administered for the treatment of substance use
15 disorders;
16 (B) shall not impose any step therapy
17 requirements, other than those established under the
18 Treatment Criteria for Addictive, Substance-Related,
19 and Co-Occurring Conditions established by the
20 American Society of Addiction Medicine, before
21 authorizing coverage for a prescription medication
22 approved by the United States Food and Drug
23 Administration that is prescribed or administered for
24 the treatment of substance use disorders;
25 (C) shall place all prescription medications
26 approved by the United States Food and Drug

1 Administration prescribed or administered for the
2 treatment of substance use disorders on, for brand
3 medications, the lowest tier of the drug formulary
4 developed and maintained by the individual or group
5 health benefit plan that covers brand medications and,
6 for generic medications, the lowest tier of the drug
7 formulary developed and maintained by the individual
8 or group health benefit plan that covers generic
9 medications; and
10 (D) shall not exclude coverage for a prescription
11 medication approved by the United States Food and Drug
12 Administration for the treatment of substance use
13 disorders and any associated counseling or wraparound
14 services on the grounds that such medications and
15 services were court ordered.
16 (7) (Blank).
17 (8) (Blank).
18 (9) With respect to all mental, emotional, nervous, or
19 substance use disorders or conditions, coverage for
20 inpatient treatment shall include coverage for treatment
21 in a residential treatment center certified or licensed by
22 the Department of Public Health or the Department of Human
23 Services.
24 (c) This Section shall not be interpreted to require
25 coverage for speech therapy or other habilitative services for
26 those individuals covered under Section 356z.15 of this Code.

1 (d) With respect to a group or individual policy of
2 accident and health insurance or a qualified health plan
3 offered through the health insurance marketplace, the
4 Department and, with respect to medical assistance, the
5 Department of Healthcare and Family Services shall each
6 enforce the requirements of this Section and Sections 356z.23
7 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
8 Mental Health Parity and Addiction Equity Act of 2008, 42
9 U.S.C. 18031(j), and any amendments to, and federal guidance
10 or regulations issued under, those Acts, including, but not
11 limited to, final regulations issued under the Paul Wellstone
12 and Pete Domenici Mental Health Parity and Addiction Equity
13 Act of 2008 and final regulations applying the Paul Wellstone
14 and Pete Domenici Mental Health Parity and Addiction Equity
15 Act of 2008 to Medicaid managed care organizations, the
16 Children's Health Insurance Program, and alternative benefit
17 plans. Specifically, the Department and the Department of
18 Healthcare and Family Services shall take action:
19 (1) proactively ensuring compliance by individual and
20 group policies, including by requiring that insurers
21 submit comparative analyses, as set forth in paragraph (6)
22 of subsection (k) of Section 370c.1, demonstrating how
23 they design and apply nonquantitative treatment
24 limitations, both as written and in operation, for mental,
25 emotional, nervous, or substance use disorder or condition
26 benefits as compared to how they design and apply

1 nonquantitative treatment limitations, as written and in
2 operation, for medical and surgical benefits;
3 (2) evaluating all consumer or provider complaints
4 regarding mental, emotional, nervous, or substance use
5 disorder or condition coverage for possible parity
6 violations;
7 (3) performing parity compliance market conduct
8 examinations or, in the case of the Department of
9 Healthcare and Family Services, parity compliance audits
10 of individual and group plans and policies, including, but
11 not limited to, reviews of:
12 (A) nonquantitative treatment limitations,
13 including, but not limited to, prior authorization
14 requirements, concurrent review, retrospective review,
15 step therapy, network admission standards,
16 reimbursement rates, and geographic restrictions;
17 (B) denials of authorization, payment, and
18 coverage; and
19 (C) other specific criteria as may be determined
20 by the Department.
21 The findings and the conclusions of the parity compliance
22 market conduct examinations and audits shall be made public.
23 The Director may adopt rules to effectuate any provisions
24 of the Paul Wellstone and Pete Domenici Mental Health Parity
25 and Addiction Equity Act of 2008 that relate to the business of
26 insurance.

1 (e) Availability of plan information.
2 (1) The criteria for medical necessity determinations
3 made under a group health plan, an individual policy of
4 accident and health insurance, or a qualified health plan
5 offered through the health insurance marketplace with
6 respect to mental health or substance use disorder
7 benefits (or health insurance coverage offered in
8 connection with the plan with respect to such benefits)
9 must be made available by the plan administrator (or the
10 health insurance issuer offering such coverage) to any
11 current or potential participant, beneficiary, or
12 contracting provider upon request.
13 (2) The reason for any denial under a group health
14 benefit plan, an individual policy of accident and health
15 insurance, or a qualified health plan offered through the
16 health insurance marketplace (or health insurance coverage
17 offered in connection with such plan or policy) of
18 reimbursement or payment for services with respect to
19 mental, emotional, nervous, or substance use disorders or
20 conditions benefits in the case of any participant or
21 beneficiary must be made available within a reasonable
22 time and in a reasonable manner and in readily
23 understandable language by the plan administrator (or the
24 health insurance issuer offering such coverage) to the
25 participant or beneficiary upon request.
26 (f) As used in this Section, "group policy of accident and

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

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

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

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

25 "Substance use disorder treatment provider or facility"
26 means a licensed physician, licensed psychologist, licensed

1 psychiatrist, licensed advanced practice registered nurse, or
2 licensed, certified, or otherwise State-approved facility or
3 provider of substance use disorder treatment.
4 (2) A group health insurance policy, an individual health
5 benefit plan, or qualified health plan that is offered through
6 the health insurance marketplace, small employer group health
7 plan, and large employer group health plan that is amended,
8 delivered, issued, executed, or renewed in this State, or
9 approved for issuance or renewal in this State, on or after
10 January 1, 2019 (the effective date of Public Act 100-1023)
11 shall comply with the requirements of this Section and Section
12 370c.1. The services for the treatment and the ongoing
13 assessment of the patient's progress in treatment shall follow
14 the requirements of 77 Ill. Adm. Code 2060.
15 (3) Prior authorization shall not be utilized for the
16 benefits under this subsection. The substance use disorder
17 treatment provider or facility shall notify the insurer of the
18 initiation of treatment. For an insurer that is not a managed
19 care organization, the substance use disorder treatment
20 provider or facility notification shall occur for the
21 initiation of treatment of the covered person within 2
22 business days. For managed care organizations, the substance
23 use disorder treatment provider or facility notification shall
24 occur in accordance with the protocol set forth in the
25 provider agreement for initiation of treatment within 24
26 hours. If the managed care organization is not capable of

1 accepting the notification in accordance with the contractual
2 protocol during the 24-hour period following admission, the
3 substance use disorder treatment provider or facility shall
4 have one additional business day to provide the notification
5 to the appropriate managed care organization. Treatment plans
6 shall be developed in accordance with the requirements and
7 timeframes established in 77 Ill. Adm. Code 2060. If the
8 substance use disorder treatment provider or facility fails to
9 notify the insurer of the initiation of treatment in
10 accordance with these provisions, the insurer may follow its
11 normal prior authorization processes.

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

21 Pursuant to the requirements of the Health Carrier
22 External Review Act, the covered person or the covered
23 person's authorized representative may request an expedited
24 external review. An expedited external review may not occur if
25 the substance use disorder treatment provider or facility
26 determines that continued treatment is no longer medically

1 necessary. Under this subsection, a request for expedited
2 external review must be initiated within 24 hours following
3 the adverse determination notification by the insurer. Failure
4 to request an expedited external review within 24 hours shall
5 preclude a covered person or a covered person's authorized
6 representative from requesting an expedited external review.

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

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

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

1 the benefits required by this subsection.

2 (7) Nothing in this subsection shall be construed to
3 require an insurer to provide coverage for any of the benefits
4 in this subsection.
5 (Source: P.A. 100-305, eff. 8-24-17; 100-1023, eff. 1-1-19;
6 100-1024, eff. 1-1-19; 101-81, eff. 7-12-19; 101-386, eff.
7 8-16-19; revised 9-20-19.)

8 Section 99. Effective date. This Act takes effect upon
9 becoming law.