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 Sections 356z.14 and 356z.15 as follows:

6 (215 ILCS 5/356z.14)
7 Sec. 356z.14. Autism spectrum disorders.
8 (a) A group or individual policy of accident and health
9 insurance or managed care plan amended, delivered, issued, or
10 renewed after the effective date of this amendatory Act of the
11 95th General Assembly must provide individuals under 21 years
12 of age coverage for the diagnosis of autism spectrum disorders
13 and for the treatment of autism spectrum disorders to the
14 extent that the diagnosis and treatment of autism spectrum
15 disorders are not already covered by the policy of accident
16 and health insurance or managed care plan.
17 (b) Coverage provided under this Section shall be subject
18 to a maximum benefit of $36,000 per year, but shall not be
19 subject to any limits on the number of visits to a service
20 provider. After December 30, 2009, the Director of the
21 Division of Insurance shall, on an annual basis, adjust the
22 maximum benefit for inflation using the Medical Care Component
23 of the United States Department of Labor Consumer Price Index

1 for All Urban Consumers. Payments made by an insurer on behalf
2 of a covered individual for any care, treatment, intervention,
3 service, or item, the provision of which was for the treatment
4 of a health condition not diagnosed as an autism spectrum
5 disorder, shall not be applied toward any maximum benefit
6 established under this subsection.

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

13 (d) This Section shall not be construed as limiting
14 benefits that are otherwise available to an individual under a
15 policy of accident and health insurance or managed care plan
16 and benefits provided under this Section may not be subject to
17 dollar limits, deductibles, copayments, or coinsurance
18 provisions that are less favorable to the insured than the
19 dollar limits, deductibles, or coinsurance provisions that
20 apply to physical illness generally.

21 (e) An insurer may not deny or refuse to provide otherwise
22 covered services, or refuse to renew, refuse to reissue, or
23 otherwise terminate or restrict coverage under an individual
24 contract to provide services to an individual because the
25 individual or their dependent is diagnosed with an autism
26 spectrum disorder or due to the individual utilizing benefits

1 in this Section.
2 (e-5) An insurer may not deny or refuse to provide
3 otherwise covered services under a group or individual policy
4 of accident and health insurance or a managed care plan solely
5 because of the location wherein the clinically appropriate
6 services are provided.
7 (f) Upon request of the reimbursing insurer, a provider of
8 treatment for autism spectrum disorders shall furnish medical
9 records, clinical notes, or other necessary data that
10 substantiate that initial or continued medical treatment is
11 medically necessary and is resulting in improved clinical
12 status. When treatment is anticipated to require continued
13 services to achieve demonstrable progress, the insurer may
14 request a treatment plan consisting of diagnosis, proposed
15 treatment by type, frequency, anticipated duration of
16 treatment, the anticipated outcomes stated as goals, and the
17 frequency by which the treatment plan will be updated.
18 (g) When making a determination of medical necessity for a
19 treatment modality for autism spectrum disorders, an insurer
20 must make the determination in a manner that is consistent
21 with the manner used to make that determination with respect
22 to other diseases or illnesses covered under the policy,
23 including an appeals process. During the appeals process, any
24 challenge to medical necessity must be viewed as reasonable
25 only if the review includes a physician with expertise in the
26 most current and effective treatment modalities for autism

1 spectrum disorders.
2 (h) Coverage for medically necessary early intervention
3 services must be delivered by certified early intervention
4 specialists, as defined in 89 Ill. Admin. Code 500 and any
5 subsequent amendments thereto.
6 (h-5) If an individual has been diagnosed as having an
7 autism spectrum disorder, meeting the diagnostic criteria in
8 place at the time of diagnosis, and treatment is determined
9 medically necessary, then that individual shall remain
10 eligible for coverage under this Section even if subsequent
11 changes to the diagnostic criteria are adopted by the American
12 Psychiatric Association. If no changes to the diagnostic
13 criteria are adopted after April 1, 2012, and before December
14 31, 2014, then this subsection (h-5) shall be of no further
15 force and effect.
16 (h-10) An insurer may not deny or refuse to provide
17 covered services, or refuse to renew, refuse to reissue, or
18 otherwise terminate or restrict coverage under an individual
19 contract, for a person diagnosed with an autism spectrum
20 disorder on the basis that the individual declined an
21 alternative medication or covered service when the
22 individual's health care provider has determined that such
23 medication or covered service may exacerbate clinical
24 symptomatology and is medically contraindicated for the
25 individual and the individual has requested and received a
26 medical exception as provided for under Section 45.1 of the

Managed Care Reform and Patient Rights Act. For the purposes of this subsection (h-10), "clinical symptomatology" means any indication of disorder or disease when experienced by an individual as a change from normal function, sensation, or appearance.

(h-15) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage outlined in subsection (h-10), then subsection (h-10) is inoperative with respect to all coverage outlined in subsection (h-10) other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage set forth in subsection (h-10).

(i) As used in this Section:

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

1 "Diagnosis of autism spectrum disorders" means one or more
2 tests, evaluations, or assessments to diagnose whether an
3 individual has autism spectrum disorder that is prescribed,
4 performed, or ordered by (A) a physician licensed to practice
5 medicine in all its branches or (B) a licensed clinical
6 psychologist with expertise in diagnosing autism spectrum
7 disorders.

8 "Medically necessary" means any care, treatment,
9 intervention, service or item which will or is reasonably
10 expected to do any of the following: (i) prevent the onset of
11 an illness, condition, injury, disease or disability; (ii)
12 reduce or ameliorate the physical, mental or developmental
13 effects of an illness, condition, injury, disease or
14 disability; or (iii) assist to achieve or maintain maximum
15 functional activity in performing daily activities.

16 "Treatment for autism spectrum disorders" shall include
17 the following care prescribed, provided, or ordered for an
18 individual diagnosed with an autism spectrum disorder by (A) a
19 physician licensed to practice medicine in all its branches or
20 (B) a certified, registered, or licensed health care
21 professional with expertise in treating effects of autism
22 spectrum disorders when the care is determined to be medically
23 necessary and ordered by a physician licensed to practice
24 medicine in all its branches:

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

1 (2) Psychological care, meaning direct or consultative
2 services provided by a licensed psychologist.
3 (3) Habilitative or rehabilitative care, meaning
4 professional, counseling, and guidance services and
5 treatment programs, including applied behavior analysis,
6 that are intended to develop, maintain, and restore the
7 functioning of an individual. As used in this subsection
8 (i), "applied behavior analysis" means the design,
9 implementation, and evaluation of environmental
10 modifications using behavioral stimuli and consequences to
11 produce socially significant improvement in human
12 behavior, including the use of direct observation,
13 measurement, and functional analysis of the relations
14 between environment and behavior.
15 (4) Therapeutic care, including behavioral, speech,
16 occupational, and physical therapies that provide
17 treatment in the following areas: (i) self care and
18 feeding, (ii) pragmatic, receptive, and expressive
19 language, (iii) cognitive functioning, (iv) applied
20 behavior analysis, intervention, and modification, (v)
21 motor planning, and (vi) sensory processing.
22 (j) Rulemaking authority to implement this amendatory Act
23 of the 95th General Assembly, if any, is conditioned on the
24 rules being adopted in accordance with all provisions of the
25 Illinois Administrative Procedure Act and all rules and
26 procedures of the Joint Committee on Administrative Rules; any

purported rule not so adopted, for whatever reason, is unauthorized.
(Source: P.A. 99-788, eff. 8-12-16.)

(215 ILCS 5/356z.15)
Sec. 356z.15. Habilitative services for children.
(a) As used in this Section, "habilitative services" means occupational therapy, physical therapy, speech therapy, and other services prescribed by the insured's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.
(b) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide coverage for habilitative services for children under 19 years of age with a congenital,

1 genetic, or early acquired disorder so long as all of the
2 following conditions are met:
3 (1) A physician licensed to practice medicine in all
4 its branches has diagnosed the child's congenital,
5 genetic, or early acquired disorder.
6 (2) The treatment is administered by a licensed
7 speech-language pathologist, licensed audiologist,
8 licensed occupational therapist, licensed physical
9 therapist, licensed physician, licensed nurse, licensed
10 optometrist, licensed nutritionist, licensed social
11 worker, or licensed psychologist upon the referral of a
12 physician licensed to practice medicine in all its
13 branches.
14 (3) The initial or continued treatment must be
15 medically necessary and therapeutic and not experimental
16 or investigational.
17 (c) The coverage required by this Section shall be subject
18 to other general exclusions and limitations of the policy,
19 including coordination of benefits, participating provider
20 requirements, restrictions on services provided by family or
21 household members, utilization review of health care services,
22 including review of medical necessity, case management,
23 experimental, and investigational treatments, and other
24 managed care provisions.
25 (d) Coverage under this Section does not apply to those
26 services that are solely educational in nature or otherwise

1 paid under State or federal law for purely educational
2 services. Nothing in this subsection (d) relieves an insurer
3 or similar third party from an otherwise valid obligation to
4 provide or to pay for services provided to a child with a
5 disability.

6 (e) Coverage under this Section for children under age 19
7 shall not apply to treatment of mental or emotional disorders
8 or illnesses as covered under Section 370 of this Code as well
9 as any other benefit based upon a specific diagnosis that may
10 be otherwise required by law.

11 (f) The provisions of this Section do not apply to
12 short-term travel, accident-only, limited, or specific disease
13 policies.

14 (g) Any denial of care for habilitative services shall be
15 subject to appeal and external independent review procedures
16 as provided by Section 45 of the Managed Care Reform and
17 Patient Rights Act.

18 (h) Upon request of the reimbursing insurer, the provider
19 under whose supervision the habilitative services are being
20 provided shall furnish medical records, clinical notes, or
21 other necessary data to allow the insurer to substantiate that
22 initial or continued medical treatment is medically necessary
23 and that the patient's condition is clinically improving. When
24 the treating provider anticipates that continued treatment is
25 or will be required to permit the patient to achieve
26 demonstrable progress, the insurer may request that the

1 provider furnish a treatment plan consisting of diagnosis,
2 proposed treatment by type, frequency, anticipated duration of
3 treatment, the anticipated goals of treatment, and how
4 frequently the treatment plan will be updated.

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

12 (j) An insurer may not deny or refuse to provide otherwise
13 covered services under a group or individual policy of
14 accident and health insurance or a managed care plan solely
15 because of the location wherein the clinically appropriate
16 services are provided.

17 (Source: P.A. 95-1049, eff. 1-1-10; 96-833, eff. 6-1-10;
18 96-1000, eff. 7-2-10.)