HB4475

LRB10336234RPS66329b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB4475

Introduced 1/17/2024, by Rep. Lindsey LaPointe

SYNOPSIS AS INTRODUCED:

5 ILCS 100/5-45.55 new
215 ILCS 5/370c.3 new

Amends the Illinois Insurance Code. Provides that the amendatory Act may be referred to as the Strengthening Mental Health and Substance Use Parity Act. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer, shall cover all out-of-network medically necessary mental health and substance use benefits and services (inpatient and outpatient) as if they were in-network for purposes of cost sharing for the insured. Provides that the insured has the right to select the provider or facility of their choice and the modality, whether the care is provided via in-person visit or telehealth, for medically necessary care. Sets forth minimum reimbursement rates for certain behavioral health benefits. Sets forth provisions concerning responsibility for compliance with parity requirements; coverage and payment for multiple covered mental health and substance use services, mental health or substance use services provided under the supervision of a licensed mental health or substance treatment provider, and 60-minute individual psychotherapy; timely credentialing of mental health and substance use providers; Department of Insurance enforcement and rulemaking; civil penalties; and other matters. Amends the Illinois Administrative Procedure Act to authorize emergency rulemaking. Effective immediately.

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A BILL FOR

AN ACT concerning regulation.

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

Section 1. This Act may be referred to as the Strengthening Mental Health and Substance Use Parity Act.

Section 2. Purpose. The purpose of this Act is to improve mental health and substance use parity, specifically addressing network adequacy and nonquantitative treatment limitations that restrict access to care.

Section 3. Findings. The General Assembly finds that:

(1) A 2021 U.S. Surgeon General Advisory, Protecting Youth Mental Health, reported the COVID-19 pandemic's devastating impact on youth and family mental health:

(A) One in 3 high school students reported persistent feelings of hopelessness and sadness in 2019.

(B) Rates of depression and anxiety for youth doubled during the pandemic.

(C) Black children under 13 are nearly twice as likely to die by suicide than white children.

(2) According to a bipartisan U.S. Senate Finance Committee report on Mental Health Care in the United States, symptoms for depression and anxiety in adults increased nearly

four-fold during the pandemic.

(3) In 2020, 2,944 Illinoisans lost their lives to an opioid overdose according to the Illinois Department of Public Health.

(4) Discriminatory commercial insurance practices that do not live up to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and Illinois' parity laws, specifically regarding insurance network adequacy, severely limit access to care.

(5) Commercial insurance practices disincentivize mental health and substance use treatment providers from participating in insurance networks by erecting significant administrative barriers and by reimbursing providers far below the reimbursement of other health care providers despite a behavioral health workforce crisis.

(A) Such practices lead to restrictive, narrow insurance networks that restrict access care.

(B) 26% of psychiatrists do not participate in insurance networks, according to a report in JAMA Psychiatry.

(C) 21% of psychologists do not participate in insurance networks, according to a 2015 American Psychological Association Survey.

(D) A significant percentage of behavioral health providers do not contract with insurers, leaving patients to see out-of-network providers.

(E) Out-of-network treatment is far more expensive for the patient than in-network care.

(F) Mental health and substance use treatment is inaccessible and unaffordable for millions of Illinoisans for these reasons.

(6) A recent Milliman report analyzing insurance claims for 37,000,000 Americans, including Illinois residents, found major disparities in out-of-network utilization for behavioral health compared to other health care. The report's findings include:

(A) Illinois out-of-network behavioral health utilization was 18.2% for outpatient services in 2017 compared to just 3.9% for medical/surgical services.

(B) Illinois out-of-network behavioral health utilization was 12.1% in 2017 for inpatient care compared to just 2.8% for medical/surgical.

(C) The disparity between out-of-network usage for behavioral health compared to medical/surgical services grew significantly between 2013 and 2017: Out-of-network behavioral health utilization for outpatient visits grew by 44%, while out-of-network utilization for medical/surgical services decreased by 42% over the same period in Illinois.

(D) Nearly 14% of behavioral health office visits for individuals with a preferred provider organization plan were out-of-network in Illinois.

(7) Mental health and substance use care, which represents just 5.2% of all health care spending, does not drive up premiums.

(8) Improved access to behavioral health care is expected to reduce overall health care spending because:

(A) spending on physical health care is 2 to 3 times higher for patients with ongoing mental health and substance use diagnoses, according to a 2018 Milliman research report; and

(B) improved utilization of mental health services has been demonstrated empirically to reduce overall health care spending (Biu, Yoon, & Hines, 2021).

(9) Illinois must strengthen its parity laws to prevent insurance practices that restrict access to mental health and substance use care.

Section 5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.55 as follows:

(5 ILCS 100/5-45.55 new)

Sec. 5-45.55. Emergency rulemaking; this amendatory Act of the 103rd General Assembly. To provide for the expeditious and timely implementation of this amendatory Act of the 103rd General Assembly, emergency rules implementing Section 370c.3 of the Illinois Insurance Code may be adopted in accordance with Section 5-45 by the Department of Insurance. The adoption

of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed one year after the effective date of this amendatory Act of the 103rd General Assembly.

Section 10. The Illinois Insurance Code is amended by adding Section 370c.3 as follows:

(215 ILCS 5/370c.3 new)

Sec. 370c.3. Mental health and substance use parity.

(a) Definitions. In this Section:

"Applicant" means a psychiatrist licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act who is engaged in treating mental, emotional, nervous, or substance use disorders or conditions and who submits an application to become a participating provider in the insurer's network. "Applicant" includes a person who is provisionally licensed.

"Application" means an applicant's application to become credentialed by an insurer as a participating provider in at least one of the insurer's provider networks.

"Credentialing" or "credential" means the process by which an insurer, a third-party administrator administering the behavioral health benefits for the insurer, or a designee collects information concerning an applicant; assesses whether the applicant satisfies the relevant licensing, education, and training requirements to become a participating provider; verifies the assessment; approves or disapproves the applicant's application; and, for purposes of a group practice, rosters providers.

"Designee" means a third party to which an insurer, or a third-party administrator administering the behavioral health benefits for the insurer, delegates or contracts for activities for responsibilities pertaining to credentialing.

"Participating provider" means a psychiatrist licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act engaged in treating mental, emotional, nervous, or substance use disorders or conditions, or is provisionally licensed as such, and who is credentialed by an insurer, or any third-party administrator administering the behavioral health benefits for the insurer or a designee to provide health care services to covered persons in at least one of the insurer's provider networks.

"Provisionally licensed" means a person seeking to be a psychiatrist licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act engaged in treating mental, emotional, nervous, or substance use disorders or conditions, who has a license to practice under the supervision of a licensed mental health or substance use provider and is in the process of meeting additional licensure requirements.

"Recredentialing" or "recredential" means the process by which an insurer or its designee confirms that a participating provider is in good standing and continues to satisfy the insurer's requirements for participating providers.

"Supervisee" means an individual who is:

(1) a master's or doctoral level degree-seeking student in an accredited medical, clinical mental health, substance use, or counseling program working toward graduation, or has completed a masters or doctoral degree from such a program, and is seeking full licensure as a psychiatrist licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist,

licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act engaged in treating mental, emotional, nervous, or substance use disorders or conditions; or

(2) provisionally licensed as a psychiatrist licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act engaged in treating mental, emotional, nervous, or substance use disorders or conditions, and such individual is under the supervision of a psychiatrist licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act engaged in treating mental, emotional, nervous, or substance use disorders.

"Supervisory billing" means the process of billing for medically necessary mental health or substance use services provided by a mental health or substance use provider that is a

supervisee under the supervision of a licensed behavioral health (mental health or substance use) provider, including a psychiatrist licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act.

"Third-party administrator" means an administrator, as defined in subsection (a) of Section 511.101, that administers any behavioral health (mental health or substance use) benefits on behalf of a plan sponsor or insurer. "Third-party administrator" includes any entity, subcontractor, or person who performs administrative or operational functions related to the insured's behavioral health benefits.

(b) Expanding mental health and substance use network participation to improve access to care; third-party administrators administering behavioral health benefits subject to parity. Notwithstanding the provisions of the Network Adequacy and Transparency Act, a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer, shall cover all out-of-network medically necessary mental

health and substance use benefits and services (inpatient and outpatient) as if they were in-network for purposes of cost sharing for the insured. The insured has the right to select the provider or facility of the insured's choice and the modality, including whether the care is provided via an in-person visit or telehealth, for medically necessary care. No action shall be required by the insured to treat an out-of-network mental health or substance use service as an in-network service pursuant to this Section.

(1) The insurer, or any third-party administrator administering the behavioral health benefits for the insurer, shall reimburse Illinois-based mental health or substance use treatment providers and facilities for out-of-network medically necessary services provided at a reimbursement rate for such services at least equal to 116% of the most recently published Medicare Fee Schedule published by the Centers for Medicare and Medicaid Services for the specific service delivered, or at an agreed upon rate that is no lower. For any mental health or substance use service that is not covered by Medicare, the reimbursement rate for such service shall be at least equal to 119% of the standard in-network reimbursement rate for such service, or at an agreed upon rate that is no lower. This paragraph applies to all medically necessary outpatient and inpatient mental health and substance use services and includes all mental health and substance use

CPT Codes, add-ons, and modifiers.

(2) The insurer, or any third-party administrator administering the behavioral health benefits for the insurer, shall reimburse Illinois-based mental health or substance use treatment providers and facilities for in-network medically necessary services provided at a reimbursement rate for such services at least equal to 141% of the most recently published Medicare Fee Schedule published by the Centers for Medicare and Medicaid Services for the specific service delivered, or at an agreed upon rate that is no lower. For any mental health or substance use service that is not covered by Medicare, the reimbursement rate for such service shall be at least equal to 144% of the standard in-network reimbursement rate for such service, or at an agreed upon rate that is no lower. This paragraph applies to medically necessary outpatient and inpatient mental health and substance use services and shall include all mental health and substance use CPT Codes, add-ons, and modifiers.

(3) A health care plan that is created and operated under the Health Maintenance Organization Act and is administered by the health maintenance organization, as defined in the Section 1-2 of the Health Maintenance Organization Act, or any third-party administrator administering the behavioral health benefits for the health maintenance organization, shall reimburse

Illinois-based mental health or substance use treatment providers and facilities that are contracted with the health maintenance organization for medically necessary services provided at a reimbursement rate for such services at least equal to 141% of the most recently published Medicare Fee Schedule published by the Centers for Medicare and Medicaid Services for the specific service delivered, or at an agreed upon rate that is no lower. For any mental health or substance use service that is not covered by Medicare, the reimbursement rate for such service shall be at least equal to 144% of the standard contracted reimbursement rate for such service, or at an agreed upon rate that is no lower. This paragraph applies to all medically necessary outpatient and inpatient mental health and substance use services and includes all mental health and substance use CPT Codes, add-ons, and modifiers.

(4) A health care plan that is created and operated under the Health Maintenance Organization Act and is administered by the health maintenance organization, as defined in Section 1-2 of the Health Maintenance Organization Act, or any third-party administrator administering the behavioral health benefits for the health maintenance organization, shall reimburse Illinois-based mental health or substance use treatment providers and facilities that are not contracted with the

health maintenance organization, for medically necessary services provided to the insured at a reimbursement rate for such services at least equal to 116% of the most recently published Medicare Fee Schedule published by the Centers for Medicare and Medicaid Services for the specific service delivered, or at an agreed upon rate that is no lower. For any mental health or substance use service that is not covered by Medicare, the reimbursement rate for such service shall be at least equal to 119% of the standard contracted reimbursement rate for such service, or at an agreed upon rate that is no lower. This paragraph applies to all medically necessary outpatient and inpatient mental health and substance use services and includes all mental health and substance use CPT Codes, add-ons, and modifiers.

(c) Third-party administrators of behavioral health benefits are responsible for mental health and substance use services parity compliance. A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health (mental health or substance use) benefits for the insurer shall be subject to Section 370c and the parity requirements of Section 370c.1. The Department has the same authority to enforce this Section as it has to enforce compliance with Sections 370c and 370c.1.

(1) If an insured receives a medically necessary mental health or substance use service from a mental health or substance use treatment provider or facility that is in-network with their insurer, or for purposes of a health maintenance organization, from a contracted mental health or substance use provider or facility, the service shall be treated as an in-network, or as a service with a contracted provider or facility with a health maintenance organization, with any third-party administrator for the insurer for purposes of cost sharing. The mental health or substance use provider or facility that renders such service that is treated as in-network or as a contracted provider or facility under this Section, shall be reimbursed by the third-party administrator at the reimbursement rate that is no less than the in-network or contracted rate for such service in accordance with this Section.

(2) Insurers shall require contractual language with any third-party administrator or entity administering the behavioral health benefits for the insurer that expressly obligates any third-party administrator that administers such benefits to comply with this Section, Section 370c, and the parity requirements of Section 370c.1 and shall be required to assist the insurer with compliance with those provisions.

(d) Coverage and payment for multiple covered mental

health and substance use services on the same day. Mental health and substance use services received by an insured on the same day shall be fully covered and fully reimbursed. A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer, shall cover all medically necessary mental health or substance use services received by the same insured on the same day from the same or different mental health or substance use provider or facility for both outpatient and inpatient care. The insurer, or any third-party administrator administering the behavioral health benefits for the insurer, shall fully reimburse a mental health or substance use provider or facility for each medically necessary service, whether inpatient or outpatient, delivered to the same insured on the same day by the same or different provider or facility.

(e) Coverage of mental health or substance use services provided under the supervision of a licensed mental health or substance use treatment provider shall be covered and reimbursed. A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer, shall accept and reimburse for supervisory billing for any medically necessary mental

health or substance use service delivered. An insurer or third-party administrator administering the behavioral health benefits for an insurer shall accept and reimburse claims submitted for supervisory billing for medically necessary mental health or substance use services when such claims are submitted by the supervising licensed mental health or substance use provider, as the rendering provider, using such provider's National Provider Identifier. A modifier shall be used to specify the supervisee's degree level.

(f) Coverage of and payment for 60-minute individual psychotherapy. A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer shall:

(1) accept and reimburse for a medically necessary 60-minute psychotherapy visit billed using the CPT Code 90837 for Individual Therapy;

(2) not impose more onerous documentation requirements than is required for other psychotherapy CPT Codes; and

(3) not audit the use of CPT Code 90837 any more frequently than audits for the use of other psychotherapy CPT Codes.

(g) Timely credentialing of mental health and substance use providers. A group or individual policy of accident and health insurance or managed care plan that is amended,

delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer, shall comply with this subsection to ensure timely credentialing with the insurer or third-party administrator. All notices required by this subsection shall come directly from the insurer.

(1) An insurer shall provide the applicant a written or electronic receipt within 5 calendar days after the insurer receives the applicant's credentialing application.

(2) If an insurer determines an application is incomplete, the insurer shall notify the applicant in writing or electronically that the application is incomplete within 10 calendar days from the date the insurer received the application. The notice shall specify what specific information is required to complete the application.

(3) An insurer shall conclude the process of credentialing an applicant within 30 calendar days following receipt of an applicant's completed application and shall provide each applicant written or electronic notice of the outcome of the applicant's credentialing application within such 30-day timeframe.

(4) If an insurer fails to provide the applicant notice of a completed application or the outcome of the applicant's completed application as required under this

Section, the insurer shall consider the applicant a participating provider effective no later than 30 days following the insurer's receipt of the applicant's completed application. The applicant shall be reimbursed for all medically necessary mental health or substance use services delivered at the standard in-network rate for services provided in compliance with this Section.

(5) An insurer, or the third-party administrator administering the behavioral health benefits for the insurer, shall post the following nonproprietary information on its website and make it available to all applicants:

(A) the insurer's and any third-party administrator's credentialing policies and procedures, consistent with this Section;

(B) a list of the information required to be included in an application;

(C) a checklist of the materials that must be submitted in the credentialing process;

(D) designated contact information, including a designated point of contact, an email address, and a telephone number, to which an applicant may address any credentialing inquiries; and

(6) An insurer, third-party administrator, or a designee may recredential a participating provider if the recredentialing is required by federal or State law or by

the insurer's accreditation standards or is permitted by the insurer's or third-party administrator's contract with the participating provider. An insurer or third-party administrator shall not require a participating provider to submit an application or participate in a contracting process in order to be recredentialed.

(7) Except as provided in paragraph (6) of subsection (g), an insurer, or third-party administrator, shall allow a participating provider to remain credentialed and include the participating provider in the insurer's or third-party administrator's provider network unless the insurer or third-party administrator discovers information indicating that the provider no longer satisfies the insurer's guidelines for participation, in which case the insurer, or the third-party administrator, shall notify the participating provider in writing or electronically at least 60 days before the termination of the participating provider from the insurer's, or third-party administrator's, network. The insurer, or third-party administrator, shall provide written notice to all covered persons seen by that provider within 15 business days after issuance of a notice of termination to that provider that such provider will no longer be a participating provider in the insurer's, or third-party administrator's, plan network by a certain specified date.

(8) Nothing in this Section affects the contract

termination rights of an insurer or a participating provider.

(h) Enforcement. The Department has the same authority to enforce this Section as it has to enforce compliance with Sections 370c and 370c.1. Additionally, if the Department determines that an insurer or any third-party administrator administering the behavioral health benefits for the insurer has violated this Section, including denying medically necessary services, failing to reimburse in accordance with this Section, failing to meet the specified timelines and notice requirements, treating in-network or contracted services as out-of-network or noncontracted services, or failing to meet any other requirement pursuant to this Section, the Department shall, after appropriate notice and opportunity for hearing in accordance with Section 1016, by order assess a civil penalty of $20,000 for each violation. The Department shall establish any processes or procedures necessary to monitor compliance with this Section, including the ability to receive complaints from mental health and substance use providers impacted by an insurer's or third-party administrator's failure to comply, while ensuring adherence to all federal and State privacy and confidentiality laws.

(i) Rulemaking. The Department shall adopt any rules, including emergency rules, necessary to implement this Section by no later than November 1, 2024.

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