SB2943

LRB093 15990 SAS 41614 b

93RD GENERAL ASSEMBLY

State of Illinois

2003 and 2004

Introduced 2/6/2004, by Mattie Hunter

SYNOPSIS AS INTRODUCED:

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

Amends the Illinois Insurance Code. Changes the Section heading. In provisions requiring insurers providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis, adds coverage for the treatment of substance abuse as defined in this Section. Deletes language that does not require a group health benefit plan to provide coverage for treatment of an addiction to a controlled substance or cannabis that is used in violation of law or mental illness resulting from the use of a controlled substance or cannabis in violation of law. Requires insurers that provide coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan to cover the treatment of substance abuse under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases.

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A BILL FOR

AN ACT concerning insurance coverage.

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

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

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

Sec. 370c. Mental health and substance abuse. ~~Mental and emotional disorders.~~

(a) (1) On and after the effective date of this Section, every insurer which delivers, issues for delivery or renews or modifies group A&H policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b), and the treatment of substance abuse as defined in item (2) of subsection (c), up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed

clinical social worker, or licensed clinical professional counselor up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, or licensed clinical professional counselor is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers and licensed clinical professional counselors, those persons who may provide services to individuals shall do so after the licensed clinical social worker or licensed clinical professional counselor has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker or licensed clinical professional counselor has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker or licensed clinical professional counselor for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence; and

(I) panic disorder.

(3) Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness,

an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year;

(i) 45 days of inpatient treatment; and

(ii) 35 visits for outpatient treatment including group and individual outpatient treatment;

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

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

(7) Blank. ~~This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:~~

~~(A) an addiction to a controlled substance or cannabis that is used in violation of law; or~~

~~(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.~~

(8) This subsection (b) is inoperative after December 31, 2005.

(c)(1) An insurer that provides coverage for hospital or

medical expenses under a group policy of accident and health insurance or health care plan, amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 93rd General Assembly shall provide coverage under the policy for the treatment of substance abuse under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 2 or fewer employees.

(2) "Substance abuse" means any condition or disorder that involves the abuse or addiction to alcohol and/or drugs as defined in the International Classification of Diseases (ICD-9-CM).

(3) A group health benefit plan:

(A) shall provide the same coverage for the diagnosis, detoxification and treatment of substance abuse on an inpatient, outpatient, or residential treatment basis as for physical illnesses;

(B) shall provide coverage for the same durational limits, amount limits, annual limits, lifetime limits, deductibles, copayments and co-insurance requirements for the treatment of substance use as are provided for other illnesses and diseases; and

(C) shall not establish any rate, term or condition that places a greater financial burden on an insured for access to the treatment of substance abuse than for access to any other illness or disease.

(Source: P.A. 92-182, eff. 7-27-01; 92-185, eff. 1-1-02; 92-651, eff. 7-11-02.)