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 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) In this Section:

"Application" means a person's or facility's application to become a participating provider with an insurer in at least one of the insurer's provider networks.

"Applying provider" means a provider or facility that has

submitted a completed application to become a participating provider or facility with an insurer.

"Behavioral health trainee" means any person: (1) engaged in the provision of mental health or substance use disorder clinical services as part of that person's supervised course of study while enrolled in a master's or doctoral psychology, social work, counseling, or marriage or family therapy program or as a postdoctoral graduate working toward licensure; and (2) who is working toward clinical State licensure under the clinical supervision of a fully licensed mental health or substance use disorder treatment provider.

"Completed application" means a person's or facility's application to become a participating provider that has been submitted to the insurer and includes all the required information for the application to be considered by the insurer according to the insurer's policies and procedures for verifying a provider's or facility's credentials.

"Contracting process" means the process by which a mental health or substance use disorder treatment provider or facility makes a completed application with an insurer to become a participating provider with the insurer until the effective date of a final contract between the provider or facility and the insurer. "Contracting process" includes the process of verifying a provider's credentials.

"Participating provider" means any mental health or substance use disorder treatment provider that has a contract

to provide mental health or substance use disorder services with an insurer.

(b) For all group or individual policies of accident and health insurance or managed care plans that are amended, delivered, issued, or renewed on or after January 1, 2026, or any contracted third party administering the behavioral health benefits for the insurer, reimbursement for in-network mental health and substance use disorder treatment services delivered by Illinois providers and facilities must be equal to or greater than 141% of the Medicare rate for the mental health or substance use disorder service delivered. For services not covered by Medicare, the reimbursement rates must be, on average, equal to or greater than 144% of the insurer's in-network reimbursement rate for such service on the effective date of this amendatory Act of the 103rd General Assembly. This Section applies to all covered office, outpatient, inpatient, and residential mental health and substance use disorder services.

(c) 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 contracted third party administering the behavioral health benefits for the insurer, shall cover all medically necessary mental health or substance use disorder 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.

(d) 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 contracted third party administering the behavioral health benefits for the insurer, shall cover any medically necessary mental health or substance use disorder service provided by a behavioral health trainee when the trainee is working toward clinical State licensure and is under the supervision of a fully licensed mental health or substance use disorder treatment provider, which is a physician 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. Services provided by the trainee must be billed under the supervising clinician's rendering National Provider Identifier.

(e) 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 contracted third party administering the behavioral health benefits for the insurer, shall:

(1) cover medically necessary 60-minute psychotherapy billed using the CPT Code 90837 for Individual Therapy;

(2) not impose more onerous documentation requirements on the provider 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.

(f)(1) Any 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, 2026, or any contracted third party administering the behavioral health benefits for the insurer, shall complete the contracting process with a mental health or substance use disorder treatment provider or facility for becoming a participating provider in the insurer's network, including the verification of the provider's credentials, within 60 days from the date of a completed application to the insurer to become a participating provider. Nothing in this paragraph (1), however, presumes or establishes a contract between an insurer and a provider.

(2) Any 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 contracted third party administering the behavioral health benefits for the insurer, shall reimburse a participating

mental health or substance use disorder treatment provider or facility at the contracted reimbursement rate for any medically necessary services provided to an insured from the date of submission of the provider's or facility's completed application to become a participating provider with the insurer up to the effective date of the provider's contract. The provider's claims for such services shall be reimbursed only when submitted after the effective date of the provider's contract with the insurer. This paragraph (2) does not apply to a provider that does not have a completed contract with an insurer. If a provider opts to submit claims for medically necessary mental health or substance use disorder services pursuant to this paragraph (2), the provider must notify the insured following submission of the claims to the insurer that the services provided to the insured may be treated as in-network services.

(3) Any 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 contracted third party administering the behavioral health benefits for the insurer, shall cover any medically necessary mental health or substance use disorder service provided by a fully licensed mental health or substance use disorder treatment provider affiliated with a mental health or substance use disorder treatment group practice who has submitted a completed application to become a participating

provider with an insurer who is delivering services under the supervision of another fully licensed participating mental health or substance use disorder treatment provider within the same group practice up to the effective date of the applying provider's contract with the insurer as a participating provider. Services provided by the applying provider must be billed under the supervising licensed provider's rendering National Provider Identifier.

(4) Upon request, an insurer, or any contracted third party administering the behavioral health benefits for the insurer, shall provide an applying provider with the insurer's credentialing policies and procedures. An insurer, or any contracted third party administering the behavioral health benefits for the insurer, shall post the following nonproprietary information on its website and make that information available to all applicants:

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

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

(C) designated contact information of a network representative, including a designated point of contact, an email address, and a telephone number, to which an applicant may address any credentialing inquiries.

(g) 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 a contracted third party administering the behavioral health benefits for the insurer has violated this Section, the Department shall, after appropriate notice and opportunity for hearing in accordance with Section 402, by order assess a civil penalty of $1,000 for each violation. The Department shall establish any processes or procedures necessary to monitor compliance with this Section.

(h) The Department shall adopt any rules necessary to implement this Section by no later than May 1, 2025.

(i) This Section does not apply to a health care plan serving Medicaid populations that provides, arranges for, pays for, or reimburses the cost of any health care service for persons who are enrolled under the Illinois Public Aid Code or under the Children's Health Insurance Program Act.

Section 15. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356v,

356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67, 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.3, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to

substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be

acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into

account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.

1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

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