Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness

Annual Report

Produced by:
State of Illinois
Department of Insurance

January 2017

Illinois Department of Insurance

BRUCE RAUNER
Governor

ANNE MELISSA DOWLING
Acting Director

To: Members of the General Assembly
Governor Bruce Rauner

From: Anne Melissa Dowling, Acting Director of the Department of Insurance

Re: Annual Report of the Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness

The Department of Insurance (DOI) is pleased to submit its Annual Report of the Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness as required by The Heroin Crisis Act (Public Act 99-0480) and specifically pursuant to 215 ILCS 5/370c.1(h)(2).

215 ILCS 5/370c.1(h)(2) requires the DOI, in coordination with the Department of Human Services and the Department of Healthcare and Family Services, to convene a working group of health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups for the purpose of discussing issues related to the treatment and coverage of substance abuse disorders and mental illness. 215 ILCS 5/370c.1(h)(2) required the Working Group to meet once before January 1, 2016, and semiannually thereafter.

The attached Annual Report to the General Assembly includes a list of the health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups that participated in the Working Group meetings, details on the issues and topics covered, and legislative recommendations as required by statute.

Throughout 2016, the DOI engaged with prominent organizations in debating and defining some of the most pressing issues surrounding the treatment and coverage of behavioral health and substance use disorders while establishing an open and transparent regulatory environment. We have included a summary of DOI's deep involvement and accomplishments in the behavioral health area including: publishing a Consumer Toolkit, FAQs and Fact Sheets; providing statewide, in-person parity training; launching a parity hotline, and bolstering these impactful efforts with $1.3 million in federal grant funds for enforcement and consumer protections.

DOI is proud of its work in this area, anticipates continued success in the upcoming years and values any comments or suggestions you may have.

Respectfully submitted,

Anne Melissa Dowling

122 South Michigan 19th Floor
Chicago, Illinois 60603
(312) 814-2420
http://insurance.illinois.gov

Table of Contents

Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness
Annual Report

In 2015, Public Act 99-0480 (The Heroin Crisis Act) created a Working Group with the stated purpose of discussing issues related to the treatment and coverage of substance abuse disorders and mental illness. The specific statutory language that established the Working Group can be found in Appendix A.

The Illinois Department of Insurance (DOI) manages the oversight of and provides staff support for the Working Group in coordination with the Department of Human Services (DHS), the Department of Healthcare and Family Services (HFS) and the Department of Public Health (DPH). The Working Group meets in accordance with the Illinois Open Meetings Act. Meeting Agendas and Approved Minutes are available on the DOI website.

DOI's ultimate goal for the Working Group is to learn what type of education is still needed and accurately determine where to devote resources. Working Group meeting participants are encouraged to use the DOI for assistance, to convene meetings and have conversations.

Working Group Participants

- Health care insurance carriers
- Mental health advocacy groups
- Substance abuse patient advocacy groups
- Mental health and substance use disorder treatment providers
- Representatives from relevant state regulatory and human service agencies

The list of Working Group members can be found in Appendix B and attendees of each meeting can be found in Appendix C.

Working Group meetings covered in this first Annual Report

- December 16, 2015 from 3:30 p.m. to 5:00 p.m. CT (Initial Meeting)
- July 28, 2016 from 3:30 p.m. to 5:00 p.m. CT (First Semiannual Meeting)
- November 30, 2016 from 3:30 p.m. to 5:00 p.m. CT (Second Semiannual Meeting)

Meeting Location

All Working Group meetings are held in the Illinois Department of Public Health Conference Room at 69 W. Washington St., 35th Floor, Chicago, Illinois 60601 with a second video conference location at the Illinois Department of Public Health Conference Room at 535 W. Jefferson St., Springfield, Illinois 62767. In order to maintain full and accurate attendance records as required by the statute, no-telephone dial in is permitted.

Initial Meeting – December 2015

The initial meeting focused on commercial health insurance and several carriers sent their senior behavioral health experts to participate in the discussion. The following issues and topics were covered:

Clarification regarding the prohibition of "fail first" as a path to obtain care. "Fail first" may have different meanings to different people, but generally it means that someone has to fail a lower level treatment before obtaining another, higher level of treatment.

Usage of the American Society of Addiction Medicine (ASAM) criteria. Sometimes providers use ASAM guidelines while payers use other guidelines. The combination of systems and approaches to obtain information regarding medical necessity leads to confusion. Increased transparency may help decrease misunderstanding. It will be beneficial to continue to work to find a consistent set of criteria so needed services can be provided.

Discussion of the July 2014 clarification of non-quantitative standards in the Mental Health Parity Act. There does seem to be a greater amount of clarity with more conversations taking place and great strides toward greater transparency. However, even with the improvements, in some areas, confusion still exists. There is more progress to be made in this area. It is important to distinguish between provider network confusion and parity confusion.

Standardized credentialing, network adequacy and telemedicine as an appropriate option for some diagnoses. The group discussed how deep into the service providers will carriers permit mental health treatment. There were many different viewpoints expressed in this area which led to a discussion about network adequacy, the potential to develop a standardized credentialing process for carriers and telemedicine as an appropriate option for some diagnoses, but not for others.

Process for Authorization of Residential Treatment, particularly for adolescents. Discussion of what is the best path for families to pursue in order to obtain commercial insurance coverage for loved ones. The discussion emphasized the fact that this is a very complex issue, to which an entire meeting could be devoted. Part of the confusion is due to the fact that the term "residential care" can refer to both residential addiction therapy services as well as behavioral therapy services. This reinforces the need to have consistent ASAM criteria applied by statute.

First Semiannual Meeting – July 2016

The first semiannual meeting focused on the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (DASA) requirements in PA 99-0480. The following issues and topics were covered.

State Fiscal Year 2015 Admissions to DHS/DASA funded treatment services. DASA observed a decrease in DASA-funded treatment from FY 2014 to FY 2015 noting that the decrease may be due partially to people shifting to Medicaid coverage from DASA-funded treatment. DASA's focus is on outpatient methadone treatment and medication-assisted treatment (MAT) for opioid dependence.

DASA HFS Partnership. DASA has been working alongside HFS to help provide Medicaid coverage of methadone by January 1, 2017. They are also currently working together to "clean up" the billing process for Medicaid Managed Care Organizations (MCOs) and fee-for-service sites and services. This is an important partnership as Medicaid helps increase access to care for those in need of opioid addiction treatment and services. There was discussion surrounding billing discrepancies and difficulties because MCOs each have their own billing guidelines. Smaller social service agencies and providers do not have experience completing the complex forms required for reimbursement. DHS has worked to help make billing more consistent and streamline the process for providers. DASA has found working alongside and in communication with HFS to be helpful. DASA providers have been asked to send any questions or issues they have related to MCOs directly to DASA's Medicaid Liaison.

Substance Abuse Prevention and Treatment (SAPT) Block Grant. Opportunities for Innovation in Recovery Support. This is an annual grant that DHS/DASA obtains to help fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time. It specifically funds priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery services that are not covered by Medicaid, Medicare or private insurance.

Medicaid Institutions for Mental Diseases (IMD) exclusion and access to care. Illinois looking at issues related to access to time-limited residential care that currently restricts Medicaid reimbursement for programs with 16 or more beds. Illinois has 24 IMDs in the state that currently provide mental health or substance use disorder (MH/SUD) crisis stabilization and detoxification services, but the IMD exclusion serves as a barrier to allow these programs to provide the full continuum of care.

DHS Heroin and Drug Overdose Prevention Program (DOPP). PA 99-0480 helped facilitate coordination between multiple state agencies to increase drug abuse prevention and manage fatal opioid overdoses. DHS/DASA has been responsible for tracking the administration of Naloxone (medication used to treat a narcotic overdose in an emergency situation). They have created two databases to accurately monitor the program and have focused future efforts on increasing visibility of the Naloxone program.

Second Semiannual Meeting – November 2016

The second semiannual meeting focused on the treatment and coverage of MH/SUD for Medicaid enrollees. The following issues and topics were covered.

States must ensure that their Medicaid benefit packages comply with Mental Health Parity and Addiction Equity Act (MHPAEA) final rule requirements by October 1, 2017. Unlike other states that carve out behavioral health, Illinois Medicaid managed care plans require the inclusion of behavioral health coverage. HFS plans to strategically evaluate the delivery, quality and availability of behavioral health services to its Medicaid population, using the MHPAEA framework to further physical and behavioral health integration.

Medication assisted treatment (MAT). As a result of Public Act 99-0480, HFS is required to provide coverage for all U S Food and Drug Administration (FDA)-approved forms of MAT prescribed for alcohol

or opioid dependence to Medicaid eligible participants. This requirement applies to both fee-for-service and MCO participants. HFS removed all utilization controls, prior authorization requirements and lifetime restriction limits and instructed MCOs to do the same. There was continued concern regarding the availability and implementation of the required pharmacist training to dispense as well as no prior authorization requirement leading to diversion. A discussion around support for clinical counseling along with MAT highlighted the need for the providers to engage regularly with patients when providing the services for improved outcomes. Note effective January 1, 2017, Medicaid will cover Methadone.

ASAM Criteria as Guidance. Each MCO has different criteria, and ASAM Criteria could provide assistance for patient placement. The State would be able to provide some additional guidance. ASAM may have restrictions on the use of telehealth for behavioral health. Because some third-party vendors manage behavioral health, they may be located out of state, not have access to all information, and use different coding for procedures and care. HFS should consider reviewing ASAM criteria, request data from other states, and solicit comments at its Medicaid Advisory Committee (MAC).

MCO Oversight. A concern of the Working Group was that the law is a circular loop and that consumers could be shifted around. Does HFS regulate MCOs in connection with parity compliance, no prior authorizations and use ASAM criteria? MCO plan members have grievance and appeal rights within each plan and these are well-documented in the MCO handbooks and on their websites. HFS has tracked these grievances and will implement a new MCO online dashboard. This dashboard will collect and maintain data on grievances or appeals and any overturned decisions. This will allow HFS to identify consumers and provide additional education. MCO data received by the HFS dashboard will be vital for reviewing imposed mandates and reaffirm the no limits on fee-for-service enrollees.

Consumer Assistance and Education. Health literacy is a problem overall and education is important. A guide on navigating treatment, educational videos and a chart outlining MATs for providers would be helpful as well as a DASA training program so providers can better assist consumers. The Working Group asked whether there was a way for forms and appeals to be consistent across Medicaid and commercial insurance. An option would be to create a “one stop shop” outside of the state agencies involved. For example, in California HealthNet has plans in the commercial market and Medicaid and uses one portal for all plans.

2017 Working Group Meetings

The Working Group requested a longer meeting of two hours and start time of 3:00 p.m. CT for the 2017 semiannual meetings.

The week of July 24, 2017, and the week of November 27, 2017, were decided upon as dates for the 2017 semiannual meetings. The official Meeting Notice will be posted on the DOI website in Q1 of 2017.

Potential Topics for 2017 Working Group Meetings

Discuss compliance with parity obligations under state and federal law.

How to get beyond anecdotes and discuss how to collect, measure, track and share parity compliance data and determine where should that responsibility (gathering, scrubbing, analyzing) be housed.

How to ensure the data sets are representative: i.e. include input beyond DOI- and HFS-regulated entities and include ERISA plans, Union plans and state, county and municipal employees in order to give a more fulsome picture of the Illinois market.

Legislative Recommendations and Considerations

- There continues to be some uncertainty surrounding the design and administration of non-quantitative treatment limitations (NQTLs). NQTLs are processes and standards that cannot be quantified, but are part of the management and decision-making apparatus for administering benefits. Examples would include: the need for pre-authorization before covering a benefit, the frequency of reviews, the requirement that a patient "fail first" at a lower level of care before authorizing a higher level of care, or the application of medical necessity criteria.

- Consider adding the definition of NQTL based upon MHPAEA as discussed in the technical amendment to PA 99-480 below.

- Consider adding penalties for use of "fail first" rationales for denying coverage and additional clarity in connection with residential treatment for SUD.

- Oversight and enforcement of parity implementation for Medicaid MCOs and fee-for-service plans is not clearly set forth in existing law. A technical amendment to PA 99-480 is discussed below.

- Consider whether DOI is the appropriate state agency to coordinate a Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness. DOI does not opine on, advise on, or administer behavioral health services. Approximately 21 percent of Illinois residents have health insurance plans regulated by the DOI. DOI does not have regulatory jurisdiction over the 25 percent of Illinois residents who are Medicaid enrollees and does not regulate self-insured health plans which cover nearly 40 percent of Illinois residents through their employer or union.

- Consider whether DOI is the appropriate state agency to manage a hotline to assist *all* consumers in navigating the parity process. More than 1/3 of the calls coming into OCHI overall (not only MH/SUD parity) do not fall under the regulatory jurisdiction of DOI and are referred to the appropriate place for assistance. For example, in 2015, OCHI referred 622 callers to the U.S. Department of Labor, 696 callers to HFS and more than 900 calls related to Medicare and were referred to the Federal Centers for Medicare & Medicaid Services (CMS) or to the Senior Health Insurance Program (SHIP) at the Illinois Department on Aging.

- Does Illinois law need to adjust its lexicon surrounding diseases of the brain? Where it appears in Illinois statutes and rules, "substance abuse" or "substance abuse disorders" should be

changed to “substance use disorders.” Where it appears in Illinois statutes and rules, “mental illness” and “mental health” should be changed to “behavioral health” or even better “brain health”– the brain is an organ like the liver or kidneys therefore this is a term frequently used by providers which makes patients feel more normalized than the terms behavioral or mental.

- DOI has identified a gap in protection for insureds in the individual market upon a carrier’s uniform discontinuance of coverage. Current DOI Rules require an extension of benefits in the group markets (HMO and indemnity plans). However, the individual market does not require a reasonable extension of benefits. Should the extension of benefits also apply to insureds in the individual market that are mid-treatment of a condition, disease or injury, who are in postoperative treatment for a condition, disease or injury, who are receiving inpatient treatment for a condition, disease or injury, or who have a total disability upon uniform discontinuance of coverage? The group indemnity or HMO group carrier is also required to cover liabilities established on the date an injury is sustained or an illness commences prior to discontinuance. Continuation of care for individual indemnity plans would require an amendment to Section 20 of the Illinois Health Insurance Portability and Accountability and Suitability Act. 215 ILCS 97/1 et seq. Indemnity rights to subrogation and reimbursement would require amendment to the Health Care Reimbursement Act in Article XX ½. 215 ILCS 5/370f et seq.

Suggested Technical Drafting Edits to Public Act 99-480
215 ICLS 5/370c

- In Sec. 370c(a)(1), clarify that the section is applicable to individual as well as group accident health policies. (Individual policies are already subject to the provisions of the Act – in 370c.1. This makes the provisions consistent.)

- In Sec. 370c(a)(3), remove all text after: “primary care physician.” This seems to be an outdated reference.

- In Sec. 370c(a) Consider adding a definition for “mental, emotional, nervous, or substance use disorders or conditions” a term that is used in other parts of Public Act 99-480, but which was not fully defined. “(4) Mental, emotional, nervous, or substance use disorders or conditions” mean any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.” Amend Sections 370c(b)(1); 370c(b)(3); 370c(b)(9) and 370c.1(g) to be consistent.

- In Sec. 370c(b)(2.5), Remove definition of “substance use disorder” as included in broader definition as set forth in 370c(a)(4) suggested above.

- More definition and clarification surrounding medical necessity for MH/SUD may be needed. Sec. 370c(b)(3) requires that medical necessity determinations for substance use disorders shall

be made in accordance with appropriate patient placement criteria established by ASAM and no additional criteria may be used to make medical necessity determinations for substance use disorders. ASAM does not have criteria for pharmaceuticals, so what medical necessity criteria should be applied for medication-assisted treatment? "Medically necessary" is defined overall in 215 ILCS 105/2.

- In Sec. 370c(b)(3), (4) and (5); 370c(d) and 370c(e)(1) and (2), clarify the scope of coverage to expressly include all insurers amending, delivering, issuing or renewing a group or individual policy, or a qualified health plan offered through the Health Insurance Marketplace.

- Clarify Sec. 370c(b)(5.5) so that all medication assisted treatment (MAT) determinations must comply with ASAM criteria.

- In 370c(d), a semi-colon is missing between "group policies" and "proactively monitoring" in the list of activities to be performed by the DOI to enforce compliance of State and federal parity laws. The missing semicolon renders some of the activities listed nonsensical. At a minimum this should be corrected. However, additional revisions would make the law more clear. Specifically, identify the authority and jurisdiction of various state agencies by stating that for a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace, the Department of Insurance shall have jurisdiction and that for public assistance under Medicaid managed care, the Department of Healthcare and Family Services, shall have jurisdiction. Spell out the requirements set forth under MHPAEA and what compliance obligations each state agency has with respect to MHPAEA.

215 ICLS 5/370c1

- In Sec. 370c.1(d), add mental health to conditions for which an insurer must use policies and procedures for drugs on their formulary that are no less favorable than those for other drugs and add a reference to comparison to drugs for medical/surgical conditions.

- In 370c.1(g), add the definition for "mental, emotional, nervous, or substance use disorders or conditions" discussed above and add the definition of NQTL based upon MHPAEA and include a reference to state and federal network adequacy criteria.

- 370c.1(h)(1) refers to "trainings." The word training is a gerund. Gerunds have no plural, therefore "trainings" is not a technically a word. The correct term is either "training" or "training session". Also, the parity training regions are defined two different ways within the same paragraph. The regions described overlap, so why define it two different ways? This should be clarified.

- In Sec. 370c.1(h)(2) The list of working group participants mandated by the statute includes "health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups." The term "mental health physician groups" excludes psychologists who are not physicians. A more accurate term for this set of participants would be "mental health and substance use disorder treatment providers."

Additionally, “representatives from relevant state regulatory and human service agencies” should be added. Moreover, if it is the legislature’s intent that the Treatment and Coverage of Substance Abuse Disorders and Mental Illness Working Group should be a Parity Working Group, then the language regarding the working group’s obligations should be amended to include parity-related discussion and tasks.

- The Parity Education Fund referenced in 370c.1(i) was never appropriated by the General Assembly. This provision should be removed from statute altogether if no intent to ever fund it exists. DOI was able to minimally meet most of the parity education-related mandates in PA 99-480 using existing staff and resources.

2016 Behavioral Health Accomplishments

Throughout 2016, DOI maintained a steadfast commitment to an open and transparent regulatory environment. DOI routinely met with the various stakeholders involved in the coverage of and treatment of the behavioral health needs of Illinois residents. A list is available on page 12. Illinois is a leader in the fair, sophisticated and transparent regulation of insurance, generating an environment that protects consumer rights in all aspects of their behavioral health insurance needs.

Below are selected 2016 accomplishments in connection with behavioral health at DOI.

1. Hotline

Effective March 1, 2016, DOI directed resources within its Office of Consumer Health Insurance (OCHI) in response to families looking for assistance in navigating access to mental health and substance use disorder needs within their health insurance plans. Illinois residents can call OCHI toll-free at 1-877-527-9431, Monday through Friday 8:00 a.m. to 5:00 p.m. OCHI hotline analysts explain health insurance coverage for MH/SUD, help navigate the mental health parity process and assist with appeals and complaints. DOI updated its internal phone inquiry and response tracking system (PIRT) to include specific data tracking categories for MH/SUD and for Parity Concern. Analysts are trained to tag every call related to MH/SUD and select Parity Concern when a caller has concerns, questions or complaints regarding MH/SUD benefits being more restrictive than medical/surgical benefits. DOI also updated its on-line agency resources (OAR) to include MH/SUD resources. OCHI analysts use OAR while they are on a call and the information can be sent to the consumer via email, fax or U.S. mail. Calls to the DOI hotline regarding plans that are not regulated by DOI are referred to the appropriate agency. i.e. HFS for Medicaid enrollees and U.S. Department of Labor for self-funded plans.

2. Internal Training

In conjunction with its focus on behavioral health coverage, DOI provided specialized training for OCHI analysts on Illinois and Federal parity laws as well as the new health insurance-related mandates in Public Act 99-0480. Further, DOI's Health Products Division hosted a speaker from the Depression and Bipolar Support Alliance (DBSA) who provided additional education for the hotline and consumer complaints team, including a robust discussion surrounding hypothetical examples that involved potential parity violations.

3. Consumer Toolkit

DOI developed a *Consumer Toolkit for Navigating Behavioral Health and Substance Use Disorder Care Through Your Health Insurance Plan*. The Toolkit is a free, step-by-step, plain-language template that families and providers can use to submit requests for pre-authorization of medically necessary behavioral health services to insurance companies. The Toolkit includes easy-to-follow instructions, a glossary of terms and a checklist for organizing information. It is available in hard copy and on the DOI website at http://insurance.illinois.gov/HealthInsurance/ILToolKitMentalHealth.pdf. DOI has distributed more than 250 hard copies and received a very positive response.

4. Consumer Education Campaign on Parity for Behavioral Health Services

DOI launched a consumer education campaign in partnership with other state agencies and healthcare organizations across the state to help Illinois families navigate health insurance coverage for MH/SUD. DOI conducted public educational seminars throughout the state including sessions in the northern, southern, and central regions and covering each of the five DHS managed care regions. A presenter from DOI headlined each program which also featured a speaker from one of the following state agencies involved with behavioral health coverage and treatment: Department of Human Services, Department of Healthcare and Family Services and Department of Public Health. Professionals from the DOI's Health Products Division were on hand at each of the sessions to answer specific questions from attendees. DOI relied on its close relationship with community-based service organizations and healthcare organizations across the state to host and promote the events to consumers, providers and advocates throughout each region.

DOI's consumer education training took place at the following locations and times.

Date & Time	Location
Tuesday April 26, 2016 6:00 p.m. to 8:00 p.m.	The Project of the Quad Cities 1202 4th Avenue, Moline
Thursday May 19, 2016 6:00 p.m. to 8:00 p.m.	Crusader Community Health 1200 West State Street, Rockford
Thursday, May 26, 2016 6:00 p.m. to 8:00 p.m.	Normal Public Library 206 W. College Ave., Normal
Tuesday May 31, 2016 6:00 p.m. to 8:00 p.m.	Collinsville Memorial Library 408 West Main Street, Collinsville
Wednesday, June 1, 2016 6:00 p.m. to 8:00 p.m.	Near North Komed-Holman Health Center 4259 S. Berkeley Avenue, Chicago

In addition to the parity training programs listed above, DOI presented at The 2016 HERO-HELPS-Southwest Coalition Community Summit on April 29, 2016, at Edward Hospital Athletic and Events Center in Romeoville. Heroin Epidemic Relief Organization (HERO), Will County Heroine Education Leads to Prevention Solutions (HELPS) in conjunction with the Southwest Coalition for Substance Abuse Issues organized the annual event. The 2016 Summit agenda focused on implementation of the Heroin Crisis Act (Public Act 99-0480). DOI presented on its role in implementation of the Act and health insurance coverage parity as it relates to MH/SUD.

5. Health Insurance Enforcement and Consumer Protections Grant

DOI applied for and received a $1.3 million Health Insurance Enforcement and Consumer Protections Grant from the U.S. Department of Health & Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO). DOI will use the grant funds to enhance consumer and healthcare provider outreach with a particular focus on parity in MH/SUD benefits. Through this grant, DOI will work with health plans, consumers, providers and

advocates to ensure that MH/SUD parity compliance is understood and achieved. The grant will allow DOI to develop community-focused health insurance consumer education for Illinois residents in connection with behavioral health coverage and preventative health coverage. It will also help DOI improve awareness of the internal and external appeals processes for health insurance consumers.

The Health Insurance Enforcement and Consumer Protections Grant will also provide additional resources for DOI health plan oversight and data analysis. A portion of the grant will go to strengthening the Office of Consumer Health Insurance (OCHI) and improving data tracking and consumer complaint analysis.

6. External Reviews

The Health Carrier External Review Act (215 ILCS 180) gives health insurance consumers the right under specific circumstances to apply for an External Review for the denial, reduction, termination or failure to make payment, in whole or in part, under the health carrier's health benefit plan. DOI coordinates the External Review process on behalf of consumers. OCHI saw a 2.3 percent increase in completed External Reviews related to MH/SUD from 2015 to 2016. Below is a table with details.

	2016	**2015**
Mental Health	71	43
Substance Abuse	32	20
All Reviews Submitted	2,706	1,888
All Completed Reviews	829	622

Medicaid Waiver to Improve Delivery of Behavioral Healthcare

In October 2016, Illinois officially submitted its 1115 Medicaid waiver proposal to the federal government. The waiver will allow Illinois to address MH/SUD treatment for some of our most vulnerable residents by helping the whole person through integrated and comprehensive care. It allows Illinois to take a holistic look at the individual, better coordinate care across all state agencies, intervene earlier and increase access to services, all leading to more stability and a more productive life.

Through this waiver, Illinois requests to use $2.7 billion in federal Medicaid funds that would not otherwise be offered. This money will be invested in early interventions and infrastructure over the next five years to improve the quality of care delivered while avoiding more costly admissions and treatment.

The waiver was developed from the collaboration between 12 state agencies and the Governor's Office, as well as community partners and stakeholders. The state sought input from more than 2,000 stakeholders and incorporated feedback from roughly 200 written responses. The State also held public hearings to gather further input from stakeholders.

DOI Outreach to Illinois Mental Health and Substance Use Disorder Providers and Advocates

Since July 2015, Director Dowling and DOI staff personally met (invited in to the DOI office or gone to visit), and/or corresponded (often multiple times) with the following organizations to gather input and suggestions in connection with access to commercial insurance coverage of MH/SUD.

The Abbey Addiction Treatment Center

Access To Care

ACLU of Illinois

Aetna/Coventry Health Care

AIDS Foundation of Chicago

AMITA Health Systems

Anthem Inc.

Blue Cross and Blue Shield of Illinois

Chicago Pacific Founders (CPF)

Cigna Corporation

Depression and Bipolar Support Alliance

Easter Seals DuPage & Fox Valley

EverThrive Illinois

Fight the Stigma, Break Silence, Raise Awareness Roundtable

Gateway Foundation Alcohol & Drug Treatment Centers

Haymarket Center

Health & Disability Advocates

The Health Care Council of Chicago (HC3)

Health and Medicine Policy Group

Humana

Illinois Association for Behavioral Health (formerly IADDA)

Illinois Consortium on Drug Policy at Roosevelt University

Illinois Health and Hospital Association

Illinois Life Insurance Council

Illinois PANDAS/PANS Advisory Council

Illinois Psychiatric Society

Illinois State Medical Society

Independent Insurance Agents of Illinois

The Kennedy Forum

The Kennedy Forum Illinois

MADO Healthcare Centers

MATTER

Mental Health America of Illinois

Mercy Home for Boys & Girls

National Alliance on Mental Illness (NAMI) Chicago

No Shame On U

Planned Parenthood

Popovits Law Group, P.C.

Rosecrance Health Network

Sargent Shriver National Center on Poverty Law

Scattergood Foundation

The Sonia Shankman Orthogenic School at The University of Chicago

Thresholds

Trustmark Insurance Company

United Power for Action and Justice

UnitedHealthcare/Harken Health

215 ILCS 5/370c.1(h)(2)

The Department, in coordination with the Department of Human Services and the Department of Healthcare and Family Services, shall convene a working group of health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups for the purpose of discussing issues related to the treatment and coverage of substance abuse disorders and mental illness. The working group shall meet once before January 1, 2016 and shall meet semiannually thereafter. The Department shall issue an annual report to the General Assembly that includes a list of the health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups that participated in the working group meetings, details on the issues and topics covered, and any legislative recommendations.

2015 – 2016 Working Group Members	
Acting Director Anne Melissa Dowling	Illinois Department of Insurance
Secretary James Dimas	Illinois Department of Human Services
Director Felicia Norwood	Illinois Department of Healthcare and Family Services
Director Nirav Shah	Illinois Department of Public Health
Vern Rowen	Aetna
Jill Wolowitz	Blue Cross and Blue Shield of Illinois
Laura Minzer	Blue Cross and Blue Shield of Illinois
(Vacant)	Cigna
Marvin Lindsey	Community Behavioral Healthcare Association of Illinois
Mark Loafman	Cook County Health and Hospitals System
Stephanie Place	Erie Foster Avenue Health Center
Dr. Thomas Britton	Gateway Foundation
Harmony Harrington	Humana
Vincent Keenan	Illinois Academy of Family Physicians
Sara Howe	Illinois Alcoholism and Drug Dependence Association
Sam Gillespie	Illinois Department of Children and Family Services
Susan Fonfa	Illinois Department of Healthcare and Family Services
Dan Wasmer	Illinois Department of Human Services
Maria Bruni	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Anne Marie Skallerup	Illinois Department of Insurance
Paulette Dove	Illinois Department of Insurance
Representative Lou Lang	Illinois General Assembly
Rajesh Parikh	Illinois Primary Health Care Association
Meryl Sosa	Illinois Psychiatric Society
Dr. Fahmy Abdel	Illinois Society of Addiction Medicine
Scott Reimers	Illinois State Medical Society
Kelly O'Brien	The Kennedy Forum
Renée Popovits	Popovits Law Group, P.C.
Heather O'Donnell	Thresholds
Catherine Bresler	Trustmark
Brendan Hostetler	United HealthCare

Working Group Meeting Participants December 2015	
Acting Director Anne Melissa Dowling	Illinois Department of Insurance
Director Nirav Shah	Illinois Department of Public Health
Vernon Rowen	Aetna
Jill Wolowitz	Blue Cross and Blue Shield of Illinois
Mike Brady	Blue Cross and Blue Shield of Illinois
Joe Sternberg	Blue Cross and Blue Shield of Illinois
Judy King	Chicago Health Project
Michael Murphy	Cigna
Laura Minzer	Cigna
Doug Nemecek	Cigna
Marvin Lindsey	Community Behavioral Healthcare Association of Illinois
Mark Loafman	Cook County Health & Hospitals System
Frank Webster	HCSC (Blue Cross and Blue Shield)
David Szostak	HCSC (Blue Cross and Blue Shield)
Allison Huckstep	Humana
Jay Shattuck	Humana
Taylor Shattuck	Humana
Larry Weinstein	Humana
Harmony Harrington	Humana
Ron Vlasaty	Illinois Advisory Council on Alcoholism & Other Drug Dependency
Eric Foster	Illinois Association for Behavioral Health
Sam Gillespie	Illinois Department of Children and Family Services
Susan Fonfa	Illinois Department of Healthcare and Family Services
Patty Steward	Illinois Department of Healthcare and Family Services
Mark Huston	Illinois Department of Healthcare and Family Services/Division of Medical Programs Bureau of Pharmacy Services
Maria Bruni	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Randy Malan	Illinois Department of Human Services/Prescription Monitoring Program
Alissandra Calderon	Illinois Department of Insurance
Carla Ripley	Illinois Department of Insurance
Amy Pinkerman Condo	Illinois Department of Insurance
Michael Rohan	Illinois Department of Insurance
Paulette Dove	Illinois Department of Insurance
Mary Petersen	Illinois Department of Insurance
Jeff Scott	Illinois Department of Insurance
Sabrina Auer	Illinois Department of Public Health
Larry Barry	Illinois Life Insurance Council

Working Group Meeting Participants December 2015	
Tanya Triche	Illinois Retail Merchants Association (IRMA)
Kate Wagner	The Kennedy Forum
Kelly O'Brien	The Kennedy Forum
Chelsea Laliberte	Live4Lali
Charlie Weikel	Office of the Governor
Amanda Brooks	PCC Community Wellness/ Illinois Primary Health Care Association (IPHCA)
Brianna Lantz	Pharmaceutical Care Management Association
Tom Taylor	PHRMA
Renée Popovits	Popovits Law Group, P.C.
Kathie Kane-Willis	Roosevelt University
Heather O'Donnell	Thresholds
Pam Rodriguez	Treatment Alternatives for Safe Communities, Inc. (TASC)
David Hill	UnitedHealthcare

Working Group Meeting Participants July 2016	
Acting Director Anne Melissa Dowling	Illinois Department of Insurance
Secretary James Dimas	Illinois Department of Human Services
Director Nirav Shah	Illinois Department of Public Health
Lynn Williams	Beacon Health Options
Denise Meginniss	Beacon Health Options
Laura Minzer	Blue Cross and Blue Shield of Illinois
Jud LeLoss	Clark Hill (The Kennedy Forum)
Marvin Lindsey	Community Behavioral Healthcare Association of Illinois
Renée Ennis McGee	Gateway Foundation
Dan Rabbit	Heartland Alliance
Harmony Harrington	Humana
Ron Vlasaty	Illinois Advisory Council on Alcoholism & Other Drug Dependency
Sara Howe	Illinois Alcoholism and Drug Dependence Association
Scott Metzger	Illinois Consortium on Drug Policy
Sam Gillespie	Illinois Department of Children and Family Services
Rosie Gianforte	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Danielle Kirby	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse

Working Group Meeting Participants July 2016	
Maria Bruni	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Jayne Antonacci	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Norma Seibert	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Rick Nance	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Michael Batkins	Illinois Department of Insurance
Carla Ripley	Illinois Department of Insurance
Laura Kotelman	Illinois Department of Insurance
Michael Rohan	Illinois Department of Insurance
Paulette Dove	Illinois Department of Insurance
Mai Pho	Illinois Department of Public Health
Amanda Kim	Illinois Department of Public Health
Don Kauerauf	Illinois Department of Public Health
Sara Gubala	Illinois Pharmacists Association
Sarah Wagner	Illinois Pharmacists Association
Michael Patton	Illinois Pharmacists Association
Meryl Sosa	Illinois Psychiatric Society
David Porter	Illinois State Medical Society
Kelly O'Brien	The Kennedy Forum
Jen Layden	Loyola University
Renée Popovits	Popovits Law Group, P.C.
Heather O'Donnell	Thresholds
Sherie Arriazola	Treatment Alternatives for Safe Communities, Inc. (TASC)

Working Group Meeting Participants November 2016	
Acting Director Anne Melissa Dowling	Illinois Department of Insurance
Director Nirav Shah	Illinois Department of Public Health
Karen White	Aetna
Bruce Himelstein	Aetna Better Health
Laura Minzer	Blue Cross and Blue Shield of Illinois
Kathie Kane-Willis	Chicago Urban League/Illinois Consortium on Drug Policy
Erica Kaitz	Cigna-HealthSpring
Joel Hahn	Cigna-HealthSpring
Dr. Melanie Hunter	Cigna-HealthSpring
Marvin Lindsey	Community Behavioral Healthcare Association of Illinois

Working Group Meeting Participants November 2016	
Felix Hernandez	CountyCare Health Plan
Jud LeLoss	Greensfelder, Hemker & Gale, P.C. (The Kennedy Forum)
Eric Foster	Illinois Association for Behavioral Health
Samantha Olds Frey	Illinois Association of Medicaid Health Plans
Sam Gillespie	Illinois Department of Children and Family Services
Kim McCullough	Illinois Department of Healthcare and Family Services
Robert Mendonsa	Illinois Department of Healthcare and Family Services
Maria Bruni	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse
Amy Condo	Illinois Department of Insurance
Andrew Wille	Illinois Department of Insurance
Karen Woods	Illinois Department of Insurance
Laura Kotelman	Illinois Department of Insurance
Michael Batkins	Illinois Department of Insurance
Paulette Dove	Illinois Department of Insurance
Donald Kauerauf	Illinois Department of Public Health
Lia Daniels	Illinois Health and Hospital Association
Meryl Sosa	Illinois Psychiatric Society
Kimberly Janas	Illinois State Medical Society
Scott Reimers	Illinois State Medical Society
Kelly O'Brien	The Kennedy Forum
Laura Fry	Live 4 Lali
David Vinkler	Molina Healthcare
Renée Popovits	Popovits Law Group, P.C.
Sherrie Arriazola	Treatment Alternatives for Safe Communities, Inc. (TASC)

Summary of Selected Relevant Illinois and Federal Laws Regarding Treatment and Coverage of MH/SUD

Mental health and substance use disorder insurance coverage is complex and impacted by both federal and state laws. Depending on the underlying policy, the requirements vary under the laws. The following is a synopsis of the state and federal laws regarding coverage for MH/SUD, including parity requirements.

A chart on page 24 explains the MH/SUD coverage for various scenarios under federal and Illinois laws.

Illinois Law

Illinois provides some protections that the federal laws do not provide, namely that fully insured large employers (51+ employees) must provide coverage for MH/SUD. However, individual insurance policies are not required by state law to provide coverage for the treatment of mental illnesses.

Illinois law does not apply to trusts or insurance policies written outside Illinois. However, for Health Maintenance Organizations (HMOs), the Law does apply in certain situations to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois.

What Is Covered?

Like coverage for other conditions, coverage for the treatment of serious MH/SUD may be subject to insurance company determinations of medical necessity.

Group insurance and HMO plans subject to Illinois law must provide coverage for the treatment of MH/SUD under the same terms and conditions as coverage for other illnesses or diseases.

Subject to medical necessity determination, in each calendar year, coverage for these benefits under group plans cannot be less than:

- 45 days of inpatient treatment,
- 60 visits for outpatient treatment, and
- 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders.

Individual HMO policies are required to provide 45 days inpatient mental health care per year and 60 individual outpatient mental health care visits per enrollee per year in accordance with Title 50, Section 5421.130(h) of the Illinois Administrative Code.

Under Public Act 99-0480, Illinois law also mandated coverage for medically necessary acute treatment services and medically necessary clinical stabilization services.

215 ILCS 5/356z.14 requires insurance coverage for autism.

Parity

In the Illinois Insurance Code, 215 ILCS 5/370c (Mental and Emotional Disorders) and 215 ILCS 5/370c.1 (Mental Health and Addiction Parity) deal with parity. Public Act 99-480 applied the mandates of Sections 370c and 370c.1 of the Insurance Code to the State Employees Group Insurance Act and to Medicaid and Children's Health Insurance Program (CHIP) recipients. Public Act 99-480 also applied the mandate of Section 370c to the Counties Code and the Municipal Code.

Insurance or HMO coverage for serious mental illness in Illinois requires parity with respect to financial requirements such as dollar limits, deductibles, and coinsurance requirements.

Small Group. 215 ILCS 5/370c(a) requires insurance companies and HMOs that provide group coverage for hospital or medical benefits to offer coverage for the treatment of mental illnesses, other than serious mental illnesses, to the group policyholder, regardless of the group size. The group policyholder (i.e., the employer) may accept or decline the offer. Once accepted, the policy must adhere to the parity laws.

Large Group. 215 ILCS 5/370c(b) requires insurance companies and HMOs that provide coverage for hospital or medical benefits to employer groups of 51 or more employees must also provide coverage for MH/SUD.

Individuals. For individual HMO policies and for any individual insurance policies that do provide coverage for the treatment of mental illnesses or substance use disorders, 215 ILCS 5/370c.1 requires that the financial requirements and treatment limitations applicable to such benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to other hospital and medical benefits.

Illinois law incorporated the MHPAEA requirements in 2011. Illinois statutes were amended effective September 9, 2015, such that the following requirements apply to **both individual and group** plans:

- Prohibits imposition of aggregate lifetime limits (refers to the dollar limitation on the total amount that will be paid as benefits under the plan on a lifetime basis) or annual limits on mental, emotional, nervous, or substance use disorders if there is no aggregate lifetime limit or annual limit on benefits for other hospital and medical benefits.
    - If the policy includes different aggregate lifetime limits or annual limits on different categories of hospital and medical benefits, the Director of Insurance shall establish rules with respect to mental, emotional, nervous, or substance use disorders by substituting for the applicable lifetime limit or annual limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.
    - If the policy includes an aggregate lifetime limit or annual limit on substantially all hospital and medical benefits, then it must either (1) apply the aggregate lifetime limit or annual limit to mental, emotional, nervous, or substance use disorders

without distinguishing between any benefits; or (2) not include any aggregate lifetime limits or annual limits on mental, emotional, nervous, or substance use disorders that is less than the aggregate lifetime limit on hospital and medical benefits.

- The financial requirements (e.g. deductibles, co-pays and co-insurance) and treatment limitations (e.g. number of visits or days of coverage) that apply to mental health/substance abuse disorder benefits must be no more restrictive than the financial requirements or treatment limitations that apply to other hospital or medical benefits. For example, a policy that does not contain a limit on the number of outpatient visits for hospital and medical benefits cannot limit the number of outpatient visits for mental health or substance use disorder benefits.

- A plan may not impose non-quantitative treatment limitations for mental health/substance abuse disorders that are more stringent than those applied to medical/surgical benefits except to the extent that recognized clinically appropriate standards of care may permit a difference.

- Examples of non-quantitative treatment limitations include medical management standards such as pre-authorization and utilization review, prescription drug formulary design, standards for a provider to participate in network, usual and customary fees, and step therapy (using less costly therapies first) and conditioning benefits on completion of treatment.

- Mental health/substance abuse disorder benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits. For example, there cannot be a separate deductible for mental health/substance abuse disorder benefits in addition to a deductible for all other hospital and medical benefits covered under a policy.

Federal Law

The Mental Health Parity Act 1996 (MHP) prohibited the imposition of annual or lifetime dollar limits on mental health benefits that were less favorable than any such limits imposed on medical/surgical benefits. This law applied only to large group health plans and was applicable only if mental health benefits were offered within the plan.

MHPAEA extended the parity provisions of the MHP by adding substance use disorders and by prohibiting group health plans and health insurance issuers that provided MH/SUD benefits from imposing less favorable benefit limitations than on medical/surgical benefits, such as financial requirements, treatment limitations, separate cost sharing or treatment limitations, out-of-network benefits, and medically necessary determinations. The law generally applied for plan years beginning after October 3, 2009.

MHPAEA applied to group health plans offering medical/surgical and MH/SUD benefits and to health insurance issuers offering coverage for MH/SUD benefits in connection with a group health plan. MHPAEA also applied to self-insured employer plans, in addition to fully insured plans.

Exempt entities included small employers (i.e., 2–50 employees or 100 or fewer employees for non-Federal governmental plans). There was an opt-out for large self-funded non-Federal governmental plans and there was an increased cost exemption.

NOTE: MHPAEA does not mandate that a group health plan provide mental health or substance use benefits, unlike the Illinois law, which does require provision of benefit for fully insured employer groups of 51 or more employees.

The MHPAEA Interim Final Regulation, effective April 5, 2010, and applicable to plan years beginning on or after July 1, 2010, addressed pressing issues to allow compliance in the near term. The interim rules specified six classifications of benefits as follows:

1. Inpatient, in-network;
2. Inpatient, out-of-network;
3. Outpatient, in-network;
4. Outpatient, out-of-network;
5. Emergency care; and
6. Prescription drugs.

The interim rules provided that the parity requirement for financial requirements and treatment limitations were to be generally applied on a classification-by-classification basis.

The MHPAEA Final Regulation effective January 13, 2014, and applicable to plan years or policy years beginning on or after July 1, 2014, provided clarification of the parity requirements including prohibiting plans and issuers from imposing a financial requirement or quantitative treatment limitation on MH/SUD benefits that is more restrictive than the “predominant” financial requirement or quantitative treatment limit that applies to “substantially all” medical/surgical benefits in the same classification. “Substantially all” is defined as meaning two-thirds and “predominant” is defined as meaning more than one-half of medical/surgical benefits in the same classification.

The final rule stated that the six classifications of benefits contained in the interim rule were never intended to exclude intermediate levels of care, such as partial hospitalization, residential care, and intensive outpatient care. Plans must assign intermediate services in the behavioral health area to the same classification they assign intermediate levels of service for medical/surgical conditions.

The rules provided further clarification regarding cumulative financial requirements and cumulative quantitative treatment limits for MH/SUD. Financial requirements such as deductibles and out-of-pocket maximums and treatment limits, such as number of visits allowed per year or lifetime, for MH/SUD may not accumulate separately from those financial and quantitative limits for medical/surgical in the same classification.

The requirements for NQTLs are different than those for financial and quantitative limits. Plans and issuers may not apply NQTLs on MH/SUD benefits more stringently than on medical/surgical benefits. NQTLs are defined as limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization, network adequacy, facility-type limits, provider reimbursement rates, tiered networks and scope or duration of benefits for services). For example, a plan or issuer may not require pre-authorization for mental health outpatient services if it does not require a pre-authorization for outpatient medical/surgical services.

The final rule confirmed that self-funded, non-federal state and local government plans may continue to opt out of compliance with MHPAEA.

Mental Health and Substance Use Disorders Applicability to Coverage

The chart below explains the MH/SUD coverage that is applicable to different plans, depending on the type of plan involved and the date it was issued.

Plan Type	MH/SUD required by federal Lav	MH/SUD required by state law?	Federal Parity MHPAEA	Illinois Parity	Result
Grandfathered individual plans (in place prior to March 10, 2010)	No	No for insurance polices; yes for HMO plans 50 Ill Adm Code 5421.130(h)	Yes - Section 1563 of the ACA amended the MHPAEA to require parity to the extent MH/SUD benefits are in the policy	No but federal law pre-empts	To the extent the plan offers MH/SUD benefits, MHPAEA applies
Transitional individual plans (Beginning after March 2010 and renewed in 2014, 2015 and 2016)	No	No for insurance polices; yes for HMO plans 50 Ill Adm Code 5421.130(h)	Yes - Section 1563 of the ACA amended the MHPAEA to require parity to the extent MH/SUD benefits are in the policy	No but federal law pre-empts	To the extent the plan offers MH/SUD benefits, MHPAEA applies
Non-grandfathered individual plans offering essential health benefits* beginning on or after January 1 2014	Yes - The ACA requires MH/SUD coverage as an essential health benefit in the individual market and must be covered as provided in the Benchmark plan.	Yes for HMO 50 Ill Adm Code 5421.130(h); No for insurance - however, the federal law pre-empts the state law. Therefore, the Benchmark MH/SUD requirements must be provided for individual HMO	Yes - Section 1563 of the ACA made MHPAEA applicable to the individual market	No but federal law pre-empts	MH/SUD provisions from the Benchmark plan must be included and MHPAEA applies.
Grandfathered small group plans (in place prior to March 10, 2010)	No	Illinois requires a "shall offer" to small groups for coverage other than serious MH/SUD as defined by the law.	No	To the extent the plan offers MH/SUD benefits, Illinois parity applies	To the extent a fully insured small group covers MH/SUD, it must abide by Illinois parity law.
Transitional small group plans (Beginning after March 2010 and renewed in 2014, 2015 and 2016)	No	Illinois requires a "shall offer" to small groups for coverage other than serious MH/SUD as defined by the law.	No	To the extent the plan offers MH/SUD benefits, Illinois parity applies	To the extent a fully insured small group covers MH/SUD, it must abide by Illinois parity law.
Non-grandfathered small group plans beginning on or after Jan 1 2014	Yes - The ACA requires MH/SUD coverage as an essential health benefit in the small group market and must be covered as provided in the Benchmark plan.	Illinois requires a "shall offer" to small groups; however, the federal law pre-empts the state law. Therefore, the Benchmark plan's MH/SUD requirements must be provided for HMOs and insurance plans.	Yes - the ACA indirectly makes MHPAEA applicable to small group market due to EHB requirement.	Yes	MH/SUD provisions from the Benchmark plan must be included and MHPAEA applies.
Fully insured Illinois large group plans Grandfathered, non-grandfathered, transitional	No	Yes - Illinois Law requires coverage of MH/SUD 215 ILCS 5/370	Yes	Yes	MH/SUD as defined by Illinois law must be covered and must abide by MHPAEA
Self- insured large group plans Grandfathered, non-grandfathered, transitional	No	State law does not apply	Yes	State law does not apply	If a self-insured large group provides benefits for MH/SUD, it must comply with MHPAEA

*Essential Health Benefits are **not** required for excepted benefit plans, including but not limited to:

- Short-term limited duration insurance;
- Accident or disability income insurance;
- Liability insurance, including general liability and auto liability and auto medical payment;
- Workers' compensation or similar insurance;
- Credit only insurance;
- Coverage for on-site medical clinics;
- Long-term care, nursing home care, home health care and community based care;
- Medicare supplements;
- Specified disease or illness;
- Limited dental and vision;
- Hospital indemnity or other fixed indemnity insurance

Mental Health Parity and Medicaid

Federal

The Balanced Budget Act of 1997 extended certain aspects of MHPA to Medicaid MCOs and CHIP.

In 2009, legislative amendments to Children's Health Insurance Program Reauthorization Act (CHIPRA) provided that the MH/SUD parity requirements apply to state-only CHIP plans.

In 2010, provisions of the Patient Protection and Affordable Care Act (ACA) also extended certain provisions of MHPAEA to Medicaid managed care plans, Medicaid alternative benefit plans (ABPs) and CHIP.

CMS issued final rules on March 29, 2016, implementing major portions of MHPAEA. The proposed regulation is similar to one released in November 2013 for private insurers. These rules:

- Prohibit the application of any "quantitative treatment limitation" or "financial requirement" to MH/SUD benefits that is more restrictive than the corresponding predominant financial requirement or treatment limitation.
- Apply to Medicaid managed care plans, alternative benefit plans and CHIP plans covering millions of Medicaid recipients. The rule does not apply to recipients receiving their services through fee-for-service.

States must ensure that their Medicaid benefit packages comply with MHPAEA final rule requirements by October 1, 2017. Illinois Medicaid managed care plans already require the inclusion of behavioral health coverage.

State

As a result of Public Act 99-0480, HFS is required to provide coverage for all FDA-approved forms of medication-assisted treatment prescribed for alcohol or opioid dependence to Medicaid-eligible participants. This requirement applies to both fee-for-service and managed care participants.

Public Act 99-0480 also made the parity requirements of Sections 215 ILCS 5/370c and 215 ILCS 5/370c.1 of the Insurance Code applicable to Medicaid.

MH/SUD Benefits and the Affordable Care Act (ACA)

Given the uncertainty surrounding the future of the federal Patient Protection and Affordable Care Act of 2010 (ACA), below is a summary of selected provisions in that law affecting coverage and treatment of MH/SUD.

Preexisting Conditions

Section 2705 of the ACA prevents insurance companies from denying coverage to consumers on the basis of health status. Therefore pre-existing conditions such as schizophrenia, depression, bipolar disorder or drug or alcohol dependence cannot be used for underwriting purposes.

MH/SUD Coverage

The ACA created a coverage mandate for MH/SUD services broadly for Qualified Health Plans (QHPs) offered both on and off the Exchange and Medicaid non-managed care benchmark and benchmark-equivalent plans.

It also extended this coverage mandate to plans offered in the small group and individual market (but not self-insured plans). It does this by defining Essential Health Benefits (EHB), which it requires the various plans to offer. EHB includes 10 categories of benefits as defined under the ACA. Two of those categories are MH/SUD services and rehabilitative and habilitative services.

Parity

The ACA expanded the reach of MHPAEA to three main types of plans: QHPs, as established by the ACA; plans offered through the individual market, including grandfathered and non-grandfathered plans; and Medicaid non-managed care benchmark and benchmark-equivalent plans.

The ACA indirectly makes MHPAEA applicable to the small group market because it requires coverage of MH/SUD services as one of the 10 Essential Health Benefit (EHB) categories.

***

As of 2014, most individual and small group health insurance plans and Medicaid ABPs are required to cover MH/SUD services and comply with federal MH/SUD parity requirements. The chart below sets forth the plans impacted by ACA expansion of federal mental health parity requirements and MH/SUD coverage mandates.

Plan Type	Expansion of Parity Requirements	Coverage Mandate
Individual Plans*	ACA Sec. 1563(c)(4)	ACA Sec. 1201 PHSA Sec. 2707(a)
Qualified Health Plans	ACA Sec. 1311(j)	ACA Sec. 1301(a)(1)(B)

Plan Type	Expansion of Parity Requirements	Coverage Mandate
Small Group**	ACA Sec. 1563(c)(4)	ACA Sec. 1201 PHSA Sec. 2707(a)
Medicaid Non-Managed Care Benchmark and Benchmark Equivalent Plans	ACA Sec. 2001(c)	ACA Sec. 2001(c)

Source: Congressional Research Service analysis (December 28, 2011).

*Grandfathered individual health insurance coverage is not subject to the EHB requirements however coverage must comply with the Federal parity requirements.

**Grandfathered small group coverage is not required to comply with either the EHB provisions or MHPAEA.

In general, grandfathered coverage is coverage in which an individual was enrolled on March 23, 2010, and that has not made certain changes in coverage since that date.

Illinois Department of Insurance

http://insurance.illinois.gov/

866-445-5364 Toll Free Consumer Line
866-323-5321 TDD

Springfield Office
320 W. Washington
Springfield, IL 62767
217-782-4515 Phone
217-782-5020 Fax

Chicago Office
122 S. Michigan Ave., 19th Floor
Chicago, IL 60603
312-814-2420 Phone
312-814-5416 Fax