



Illinois Insurance Facts

Illinois Department of Insurance

Mental Health and Substance Use Disorder Coverage

Revised
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Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

This fact sheet provides information about mental health and substance use disorder (MH/SUD) insurance coverage. This is a very complicated issue, which is impacted by both federal and state laws. Depending on your policy, the requirements vary under the laws. Following is a synopsis of the federal and state laws regarding coverage for MH/SUD, including parity requirements.

The chart attached to this fact sheet explains the mental health coverage that is applicable to different plans, depending on the type of plan involved and the date it was issued. The types of plans are:

Individual Plans:

- Grandfathered individual health plans – Illinois fully insured individual policies issued prior to March 23, 2010. Grandfathered plans are exempt from many changes required under the Affordable Care Act.
- Transitional individual health plans – Illinois fully insured individual policies that were in place beginning after March 10, 2013, and renewed starting January 1, 2014. The transitional period for those plans has been extended for renewals in 2015 and 2016. Transitional plans are exempt from *some* provisions of the Affordable Care Act.
- Marketplace individual plans – Affordable Care Act (ACA) plans sold on and off the Marketplace to Illinois residents beginning on or after January 1, 2014.

Small Employer Group Plans (2-50 employees):

- Grandfathered small group plans – Illinois fully insured small employer groups plans issued prior to March 23, 2010. Grandfathered plans are exempt from many changes required under the Affordable Care Act.
- Transitional small group plans – Illinois fully insured small employer group plans, which were effective after March 23, 2010, and renewed starting January 1, 2014. The transitional period for those plans has been extended for renewals in 2015 and 2016. Transitional plans are exempt from *some* provisions of the Affordable Care Act.
- Marketplace small group plans – ACA plans sold on and off the Marketplace to Illinois small employer groups in Illinois.

Large Employer Group Plans (more than 50 employees):

- Illinois fully insured large employer group plans – pertains to all large employer group plans regardless of issue date;

- Self-insured large employer group plans – pertains to employers who set up plans under the federal Employment Retirement Income Security Act (ERISA) to provide health insurance as a benefit to employees. Under a self-insured plan, the employer is at risk and funds the cost of claims (possibly with reinsurance if claims reach a certain threshold). An insurance company may act as claims administrator and offer its provider networks to the plan. These plans are generally regulated by the United States Department of Labor and are not within the jurisdiction of the State of Illinois Department of Insurance.

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.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (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 mental health or substance use disorder (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.

The MHPAEA of 2008 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.

The federal law may be viewed at: <https://www.cms.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/mhpaea.pdf>.

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.

A fact sheet regarding the interim final regulation may be viewed at:

<http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

The interim regulation is available at: <http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf>.

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 non-quantitative treatment limits (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 may be found at: <http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>.

The final rule confirmed that self-funded, non-federal state and local government plans may continue to opt out of compliance with MHPAEA. A list of those plans is available at:

Section 1563 of The Affordable Care Act (ACA) 2010 extended MHPAEA to the entire individual market, including grandfathered and non-grandfathered plans. The ACA indirectly makes MHPAEA applicable to the small group market due to the fact that it requires coverage of mental health and substance use disorder services as one of the ten Essential Health Benefit (EHB) categories.

Each state was required to select a Benchmark Plan which had to be approved on the federal level. The Benchmark Plan was to be used to develop the template for all plans sold on and off the Marketplace in the individual and small group market that provide essential health benefits. The Benchmark Plan selected for Illinois was the Blue Advantage Entrepreneur Participating Provider Option plan.

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;
- Worker's 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

Benchmark Plan Provisions for MH/SUD

The Benchmark plan contains the following benefits for MH/SUD:

- Inpatient Hospitalization;
- Outpatient Hospital Care including intensive outpatient treatment;
- Partial Hospitalization
- Office Visits

In addition, the Benchmark plan contains the following benefit for SUD only:

- Residential Care in a Substance Abuse Rehabilitation Treatment Facility

The Benchmark plan defines Mental Illness as those illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association:

- i. Schizophrenia;
- ii. Paranoid and other psychotic disorders;
- iii. Bipolar disorders (hypomanic, manic, depressive and mixed);
- iv. Major depressive disorders (single episode or recurrent);

- v. Schizoaffective disorders (bipolar or depressive);
- vi. Pervasive developmental disorders;
- vii. Obsessive-compulsive disorders;
- viii. Depression in childhood and adolescence;
- ix. Panic disorder;
- x. Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- xi. Anorexia nervosa and bulimia nervosa.

The Benchmark plan defines Substance Abuse as the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependent which develops with continued use of such addictive substances requiring medical care as determined by a behavioral health practitioner.

State Law

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 “serious mental illness” and substance use disorders.

The Illinois law does not apply to trusts or insurance policies written outside Illinois. However, for 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. To determine if your HMO is subject to the Serious Mental Illness Law, you should contact the HMO directly or check your certificate of coverage.

What Is Covered?

Group insurance and HMO plans subject to the Illinois law must provide coverage for the treatment of “serious mental illnesses” and “substance use disorders” under the same terms and conditions as coverage for other illnesses or diseases. As defined by the law, serious mental illnesses include:

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Major depressive disorders (single episode or recurrent)
- Schizoaffective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders
- Depression in childhood and adolescence;
- Panic disorder;
- Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- Anorexia nervosa and bulimia nervosa.

The Illinois law was amended by Public Act 97-0437 to add substance use disorders. Substance use disorder means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- Substance abuse disorders;
- Substance dependence disorders; and
- Substance induced disorders.

Benefits for substance use disorders include coverage at residential treatment centers licensed by the Illinois Department of Public Health or Illinois Department of Human Services. Under Public Act 99-0480, Illinois law also mandates coverage for medically necessary acute treatment services and medically necessary clinical stabilization services:

- “Acute treatment services” means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.
- “Clinical stabilization services” means 24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

Like coverage for other conditions, coverage for the treatment of serious mental illnesses and substance use disorders may be subject to insurance company determinations of medical necessity. Medical necessity determinations for substance use disorders must be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. Your plan administrator or health insurance issuer is required to make available its criteria for medical necessity determinations with respect to mental health or substance use disorder benefits.

If your insurance company or HMO denies a claim or pre-certification request on the grounds that a particular treatment is not medically necessary, the plan administrator or health insurance issuer must make available to you the reason for the denial within a reasonable time and in a reasonable manner. Illinois law provides you the right to an independent review of the company’s determination. For more information see <http://insurance.illinois.gov/ExternalReview/default.asp>.

Can an Insurer or HMO Impose Limits on Mental Health Coverage?

Coverage for serious mental illness in Illinois requires parity with respect to financial requirements such as dollar limits, deductibles, and coinsurance requirements. However, 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.

The Illinois law was amended effective August 18, 2011, to incorporate the federal MHPAEA requirements which were in place at the time. It was amended again 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.

NOTE: As noted above, these requirements for mental health coverage were in place under the federal MHPAEA since October 3, 2009. The MHPAEA applies to group health insurance policies and HMO plans covering 51 or more employees for policies issued, delivered, amended or renewed on or after **October 3, 2009**.

NOTE: The MHPAEA Final Regulations effective January 13, 2014, for plan years issued, delivered, amended, or renewed on or after July 1, 2014, are not reflected in the Illinois law but they DO apply.

Do I Have to Receive Treatment from a Certain Provider?

You may receive treatment for mental illnesses or substance use disorder from a provider of your choice as listed below:

- licensed physician;
- licensed clinical psychologist;
- licensed clinical social worker;
- licensed clinical professional counselor;
- licensed marriage and family therapist;
- licensed speech-language pathologist
- other licensed or certified professional at a program licensed pursuant to the Illinois Alcoholism and Other Drug Abuse and Dependency Act.

However, you must follow the requirements of the plan in order to receive optimum benefits. For example, you must use a preferred provider under a PPO plan in order to receive the preferred benefit level. In the HMO setting, if you do not follow plan requirements regarding referrals from your primary care physician, your benefit may be reduced.

Does the Illinois Law Apply to Small Group and Individual Policies?

Illinois law (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 the “serious mental illnesses” described above, 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.

Individual *insurance* policies are not required by state law to provide coverage for the treatment of mental illnesses; however, *HMO* individual policies are required to provide the following benefits in accordance with Title 50, Section 5421.130(h) of the Illinois Administrative Code:

- 45 days inpatient mental health care per year. Care in a day hospital, residential non-hospital or intensive outpatient mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by the primary care physician.
- 60 individual outpatient mental health care visits per enrollee per year, as appropriate for evaluation, short-term treatment and crisis intervention services. Group outpatient mental health care visits may be substituted on a two-to-one basis for individual mental health care visits as deemed appropriate by the primary care physician.

Furthermore, for HMO individual policies and for any individual insurance policies that *do* provide coverage for the treatment of mental illnesses or substance use disorders, Illinois law (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 provides some protections that the federal laws do not provide, namely that fully insured large employers (51+ employees) *must* provide coverage for MH/SUD. The federal laws extend MH/SUD coverage to all individual plans and indirectly to some small employer plans. Attached is a spreadsheet which explains the MH/SUD coverage for various scenarios under the federal and Illinois laws.

For More Information

Call our Office of Consumer Health Insurance at (877) 527-9431
or visit us on our website at <http://insurance.illinois.gov>

Mental Health and Substance Use Disorders Applicability to Coverage

| Plan Type | MH/SUD required by federal Law? | 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 policies; 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 policies; 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 and insurance plans. | 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. |

Mental Health and Substance Use Disorders Applicability to Coverage

| Plan Type | MH/SUD required by federal Law? | MH/SUD required by state law? | Federal Parity MHPAEA | Illinois Parity | Result |
|---|---------------------------------|--|-----------------------|-----------------------------|--|
| 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;
- Worker’s 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