



Illinois Insurance Facts

Illinois Department of Insurance

Mental Health and Substance Use Disorder Coverage

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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 regarding mental health and substance use disorder coverage required by State and federal law.

Serious Mental Illness

Who Must Provide the Coverage?

Illinois law 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 illnesses” and substance use disorders. (215 ILCS 5/370c(b)).

The Illinois law does not apply to self-insured employers* or 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.

*Self insured employers are impacted by the federal law. See information below regarding the federal law.

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 for residential treatment facilities, and ensure that medical necessity determinations are made in accordance with appropriate clinical standards.

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. If your insurance company or HMO denies a claim or pre-certification request on the grounds that a particular treatment is not medically necessary, 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 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 amended law requires "parity," or equivalence, between coverage for mental health or substance use disorder benefits and coverage for medical or surgical benefits. The new Illinois parity requirements, effective August 18, 2011, include:

- 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 does not include, or 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 does include an aggregate lifetime limit or annual limit on 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 group 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: The above requirements for mental health coverage have been in place under federal law since October 3, 2009. The Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008 (MHPAEA), which applies to group health insurance policies and HMO plans covering 51 or more employees, became effective on **October 3, 2009**. Policies issued, delivered, amended or renewed after that date were required to abide by the parity requirements established by the MHPAEA.

Do I Have to Receive Treatment from a Certain Provider?

You may receive treatment for mental illnesses of 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 Law Apply to Small Group and Individual Policies?

Illinois law [215 ILCS 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 provide benefits required above.

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

- Ten 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.
- Twenty 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.

Who Is Covered by the Federal Law?

The MHPAEA, which applies to group health plans offering medical/surgical and mental health or substance use disorder benefits and health insurance issuers offering coverage for mental health or substance use disorder benefits in connection with a group health plan. MHPAEA does apply to self-insured employer plans, in addition to fully insured plans..

Exempt entities include small employers, (2-50 employees or 100 or fewer employees for non-Federal governmental plans). There is an op-out for self-funded non-Federal governmental plans and there is an increased cost exemption. See

http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs5.html for more information.

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 benefits for employer groups of 51 or more employees.

For more information on federal mental health parity laws, please see this http://cciio.cms.gov/programs/protections/mhpaea/mhpaea_factsheet.html prepared by the U.S. Centers for Medicare and Medicaid Services. and <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html> prepared by the United States Department of Labor.

Who Enforces the Laws?

Fully Insured Illinois insurance policies and HMO plans (state law) – Illinois Department of Insurance
Self-funded non-Federal governmental plans – U.S. Centers for Medicare and Medicaid Services
Self insured employer and health and welfare plans – United States Department of Labor
Employers and church plans – Internal Revenue Service

For More Information

Call our Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at <http://www.insurance.illinois.gov/>