Mental Health and Substance Use Disorder Coverage FAQ

Illinois Department of Insurance

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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.

Frequently Asked Questions on Mental Health Parity Rights under your Health Insurance Plan

The Illinois Insurance Department wants to provide consumers with information about Illinois' insurance laws on mental health parity as well as the applicable federal laws including the Affordable Care Act (ACA) federal health care reform legislation and the Paul Wellstone Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Illinois has had mental health parity insurance laws in effect for specified group health insurance policies HMO plans since 2011. Further, effective in 2014 the ACA has required, with limited exceptions, that individual and small employer health insurance plans include ten Essential Health Benefits including mental health and substance use disorder services. Beginning January 1, 2015, Illinois law requires mental health parity for group and individual health and HMO plans, including qualified health plans.
Below are questions and answers that the Department hopes will help consumers to better understand their rights to mental health benefits under health plans.

1) **What types of health insurance policies and plans are required to provide mental health benefits under Illinois' insurance laws and the ACA?**

   Illinois' mental health laws extend protections to large employer fully insured Illinois group health insurance policies (over 50 employees) and all HMO plans. Fully-insured large group policies providing coverage for hospital or medical expense, as well as all HMO plans, that are issued in Illinois, must include these important safeguards. Further, effective in 2014 the ACA requires, with limited exceptions, that individual and small employer health insurance plans must include ten Essential Health Benefits including mental health and substance use disorder services. (See Answer 6 for more information).

2) **What benefits and protections must be provided in policies under Illinois insurance laws and the ACA?**

   Plans subject to Illinois laws and the ACA must contain two primary requirements:
   a) The policy must cover mental health benefits and substance use disorder benefits;
   b) The policy cannot establish any terms, conditions or benefits that place a greater financial burden on an individual to obtain mental health benefits than for diagnosis and treatment of medical benefits.

3) **How are the terms "serious mental illness and "substance use disorder" defined under Illinois insurance laws?**

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

a) Schizophrenia;
b) paranoid and other psychotic disorders;
c) bipolar disorders (hypomanic, manic, depressive, and missed);
d) major depresseive disorders (single episode or recurrent);
e) schizoaffective disorders (bipolar or depressive);
f) pervasive developmental disorders;
g) obsessive-compulsive disorders;
h) depression in childhood and adolescence;
i) panic disorder;
j) post-traumatic stress disorders (acute, chronic, or with delayed onset); and
k) anorexia nervosa and bulimia nervosa.

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:

a) substance abuse disorders;
b) substance dependence disorders; and
c) substance induced disorders.

4) **Are there additional protections under Illinois law?**

Yes. Individual or group policies of accident and health insurance, amended, delivered, issued or renewed on or after January 1, 2015 that provide coverage for prescription drugs must provide coverage for at least one opioid antagonist, including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the opioid antagonist. This coverage must include refills for expired utilized opioid antagonists.

5) **What laws apply to self-insured plans?**

State insurance laws only apply to insured plans; they do not apply to self-insured employer or union plans. However, self-insured plans are subject to the federal requirements. The federal Paul Wellstone and Pete Domenici Mental Health and Addiction Parity and Addiction Equity Act of 2008 (MHPAEA) applies to employers of 51 or more employees. This law does not require an employer to provide mental health benefits, but generally provides that if an employer chooses to provide mental health benefits (and most do), it must do so on a parity basis with medical benefits. The U.S Department of Labor has jurisdiction over private sector self-insured plans, and the Center for Medicare and Medicaid Services has jurisdiction over self-insured government (state and municipal) plans.

6) **What other federal laws provide protection for mental health benefits?**

In addition to MHPAEA referenced in 5 above, which applies to employers with 51 or

more employees, the federal Affordable Care Act (ACA) now contains requirements which apply to individual and small group plans. Under the ACA new individual and small group plans issued on and after January 1, 2014 must include "Essential Health Benefits" as required by the ACA. "Essential Health Benefits" includes mental health benefits which must be provided on a parity basis. The effect of this ACA change is that the federal mental health parity rules now apply to individual plans and virtually all employer plans (small and large group). There are narrow exceptions to the federal rules, including for grandfathered individual, grandfathered small group plans, transition individual plans and transition small group plans. Grandfathered plans are those in existence when the ACA passed on March 23, 2010 and which have not been substantially amended since then. Transition plans are those in existence beginning on March 23, 2013 and renewed in 2014, 2015 and will renew in 2016.

7) **What are some of the features of the federal mental health parity law (MHPAEA)?**

MHPAEA requires that insurers meet mental health parity standards in two areas, quantitative limits and non- quantitative limits as they relate to benefit design and treatment limitations.

8) **What are Quantitative Treatment Limitations?**

Health insurers generally cannot impose a financial requirement (such as a copayment or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or the number of impatient days covered) on mental health or substance abuse disorder benefits that is more restrictive than the financial requirement or quantitative treatment limitations that apply to at least 2/3 of medical/surgical benefits in the same classification. MHPAEA requires that mental health parity analysis must be done by classification type. These classifications are defined as: (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.

9) **What are Non-Quantitative Treatment Limitations (NQTLs)?**

Under MHPAEA, certain utilization review, prior authorization and plan provisions may only be applied to mental health or substance abuse benefits if they meet the standards for the "comparable to and applied no more stringently than the limitations applied to medical/surgical benefits" rule.

Policy provisions that are subject to these standards include:

a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative;
b) Formulary design for prescriptions drugs;
c) Standards for provider admission to participate in network, including reimbursement rates for contracted providers;
d) Plan methods used to determine usual, customary, and reasonable fee charges (for out-of-network benefits);
e) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
f) Exclusions based on failure to complete a course of treatment;
g) Network tier design;

h) Restrictions based on geographic location, facility type, provider specialty; and
i) Other criteria that limit the scope or duration of benefits for services provided under the plan.

Important Note: The NQTL provisions referred to above are not prohibited outright, but are prohibited if they are applied more stringently to mental health benefits than to medical/ surgical benefits.

10) **What can I do if I have further questions about mental health parity or the mental health benefits under my health insurance policy or HMO coverage?**

Consumers interested in having the Illinois Department of Insurance review an insurance complaint or consumers who have questions about their individual insurance situation, may contact us for assistance:

Illinois Department of Insurance
Office of Consumer Health Insurance
(877) 527-9431

https://mc.insurance.illinois.gov/messagecenter.nsf
Department website: http://insurance2.illinois.gov/