AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Sections 356z.14 and 356z.15 as follows:

(215 ILCS 5/356z.14)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section shall be subject to a maximum benefit of $36,000 per year, but shall not be subject to any limits on the number of visits to a service provider. After December 30, 2009, the Director of the Division of Insurance shall, on an annual basis, adjust the maximum benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index

for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or their dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits

in this Section.

(e-5) An insurer may not deny or refuse to provide otherwise covered services under a group or individual policy of accident and health insurance or a managed care plan solely because of the location wherein the clinically appropriate services are provided.

(f) Upon request of the reimbursing insurer, a provider of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism

spectrum disorders.

(h) Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill. Admin. Code 500 and any subsequent amendments thereto.

(h-5) If an individual has been diagnosed as having an autism spectrum disorder, meeting the diagnostic criteria in place at the time of diagnosis, and treatment is determined medically necessary, then that individual shall remain eligible for coverage under this Section even if subsequent changes to the diagnostic criteria are adopted by the American Psychiatric Association. If no changes to the diagnostic criteria are adopted after April 1, 2012, and before December 31, 2014, then this subsection (h-5) shall be of no further force and effect.

(h-10) An insurer may not deny or refuse to provide covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract, for a person diagnosed with an autism spectrum disorder on the basis that the individual declined an alternative medication or covered service when the individual's health care provider has determined that such medication or covered service may exacerbate clinical symptomatology and is medically contraindicated for the individual and the individual has requested and received a medical exception as provided for under Section 45.1 of the

Managed Care Reform and Patient Rights Act. For the purposes of this subsection (h-10), "clinical symptomatology" means any indication of disorder or disease when experienced by an individual as a change from normal function, sensation, or appearance.

(h-15) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage outlined in subsection (h-10), then subsection (h-10) is inoperative with respect to all coverage outlined in subsection (h-10) other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage set forth in subsection (h-10).

(i) As used in this Section:

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

"Medically necessary" means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease or disability; (ii) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or (iii) assist to achieve or maintain maximum functional activity in performing daily activities.

"Treatment for autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

(1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.

(2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

(3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any

purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-788, eff. 8-12-16.)

(215 ILCS 5/356z.15)

Sec. 356z.15. Habilitative services for children.

(a) As used in this Section, "habilitative services" means occupational therapy, physical therapy, speech therapy, and other services prescribed by the insured's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

(b) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide coverage for habilitative services for children under 19 years of age with a congenital,

genetic, or early acquired disorder so long as all of the following conditions are met:

(1) A physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder.

(2) The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a physician licensed to practice medicine in all its branches.

(3) The initial or continued treatment must be medically necessary and therapeutic and not experimental or investigational.

(c) The coverage required by this Section shall be subject to other general exclusions and limitations of the policy, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services, including review of medical necessity, case management, experimental, and investigational treatments, and other managed care provisions.

(d) Coverage under this Section does not apply to those services that are solely educational in nature or otherwise

paid under State or federal law for purely educational services. Nothing in this subsection (d) relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a child with a disability.

(e) Coverage under this Section for children under age 19 shall not apply to treatment of mental or emotional disorders or illnesses as covered under Section 370 of this Code as well as any other benefit based upon a specific diagnosis that may be otherwise required by law.

(f) The provisions of this Section do not apply to short-term travel, accident-only, limited, or specific disease policies.

(g) Any denial of care for habilitative services shall be subject to appeal and external independent review procedures as provided by Section 45 of the Managed Care Reform and Patient Rights Act.

(h) Upon request of the reimbursing insurer, the provider under whose supervision the habilitative services are being provided shall furnish medical records, clinical notes, or other necessary data to allow the insurer to substantiate that initial or continued medical treatment is medically necessary and that the patient's condition is clinically improving. When the treating provider anticipates that continued treatment is or will be required to permit the patient to achieve demonstrable progress, the insurer may request that the

provider furnish a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

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

(j) An insurer may not deny or refuse to provide otherwise covered services under a group or individual policy of accident and health insurance or a managed care plan solely because of the location wherein the clinically appropriate services are provided.

(Source: P.A. 95-1049, eff. 1-1-10; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10.)