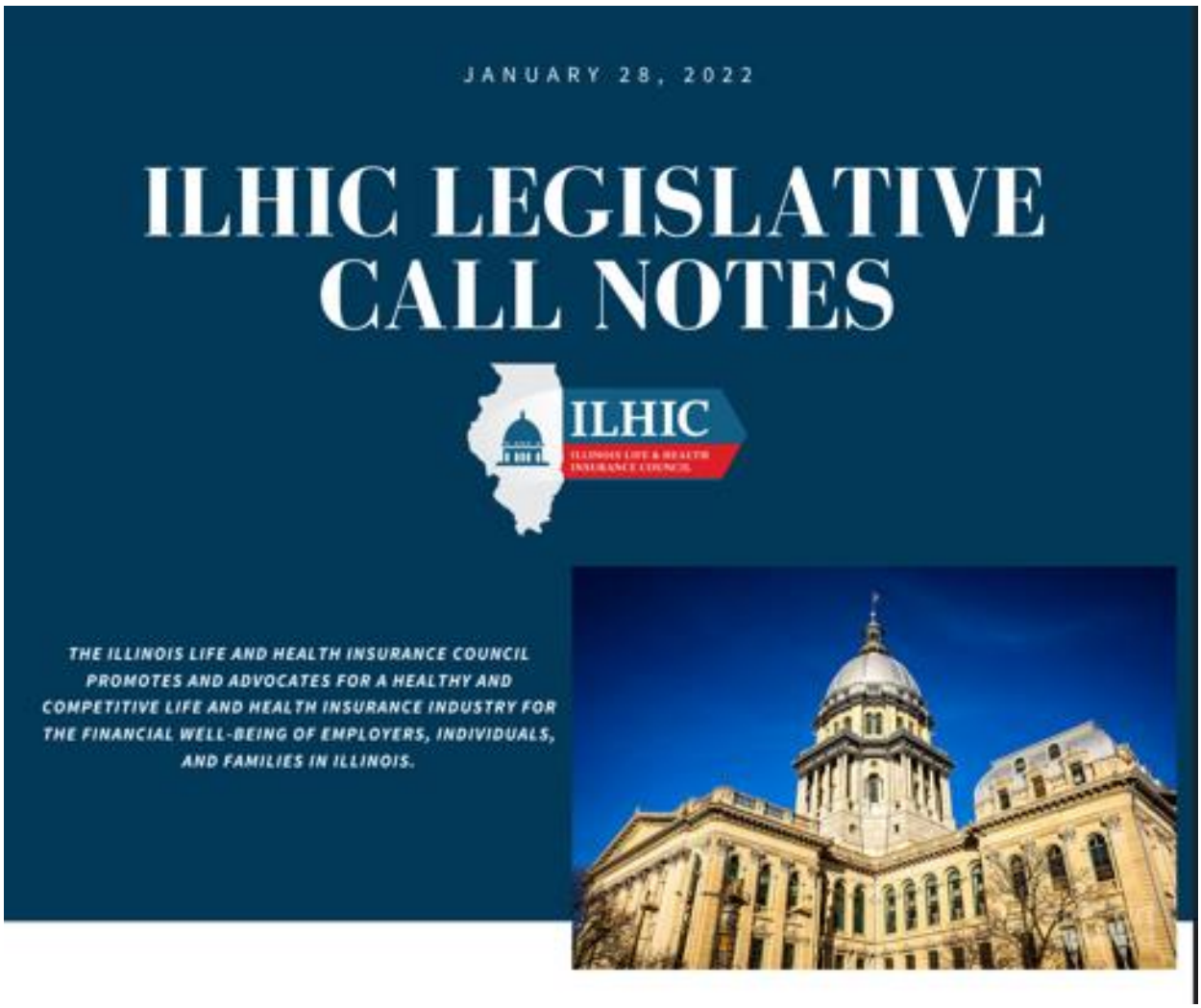

1. **Bills Filed**
    a. **SB 3781 (Munoz)**
        i. Creates the Business Transfer Act. Provides that notwithstanding any other provision of law, a court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this Act. Sets forth provisions concerning notice requirements, application procedure, application to a court for approval of a plan, approval and denial of insurance business transfer plans, and fees and costs. Provides that the Department of Insurance shall adopt rules that are consistent with the provisions and that no insurance business transfer plan shall be approved in the State unless and until such rules are adopted.
        ii. The sponsor has no intention of moving the bill forward. There might be a subject matter hearing in the bill.
    b. **SB 3818 (Fine)**
        i. Includes agreed language (acknowledging current practice) for the irrevocable assignments of benefits to purchase funeral burial services.
    c. **SB 3910 (Fine)**
        i. DOI Initiative. Amends the Uniform Prescription Drug Information Card Act. Mandates that uniform Rx cards issued by health plans shall display on the card the regulatory entity that holds authority over the plan, whether the plan is fully insured or self-insured, the issuer's National Association of Insurance Commissioners company code, any

deductible applicable to the plan, any out-of-pocket maximum limitation applicable to the plan, and a toll-free telephone number and Internet website address through which the cardholder may seek consumer assistance information. Provides that a discounted health care services plan administrator shall issue to its beneficiaries a card that contains information about the regulatory entity that holds authority over the plan and whether the plan is fully insured or self-insured. Provides that a health care benefit information card or other technology containing uniform health care benefit information issued by a health benefit plan or a dental plan shall specifically identify and display on the card the regulatory entity that holds authority over the plan, whether the plan is fully insured or self-insured, the issuer's National Association of Insurance Commissioners company code, any deductible applicable to the plan, any out-of-pocket maximum limitation applicable to the plan, and a toll-free telephone number and Internet website address through which the cardholder may seek consumer assistance information. Makes other changes. Effective January 1, 2023.

ii. This does apply to dental plan.

d. SB 3819 (Fine)

i. Mandates coverage for community-based pediatric palliative or hospice care. Provides that the care shall be delivered to any qualifying child by a trained interdisciplinary team in accordance with all the terms of the Pediatric Palliative Care Act, which allows a child to receive community-based pediatric palliative and hospice care while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness.

ii. ILHIC met with Senator Fine on the bill and she is willing to change the effective date and tie back to medical necessity as well as some clean up language for Medicaid.

e. SB 3924 (Castro) and HB 4774 (Lilly)

i. Includes various prohibitions on "White Bagging"; which includes that PBMS may not 1. Require an enrollee to obtain a drug from a specified pharmacy; 2. Steer or offer incentives to the enrollee in order to incentivize them to choose the pharmacy identified by a PBM or health plan; 3. Limit or restrict benefits and coverage to an enrollee for medically necessary drugs obtained by a provider and not administered from a pharmacy that is selected by the health plan/PBM; 4. Condition deny restrict or limit reimbursement to a provider for drugs administered that do not come from a specialized pharmacy; 5. Assess higher deductibles, copayments, coinsurance on clinician administered drugs that is not from a selected pharmacy; 6. Prohibition again the requirement for the enrollee to use a home infusion pharmacy to receive clinician administered drugs in their home or use a site of service selected by the PBM/ Health Plan.

f. SB 3926 (Fine)

i. DOI Initiative – Prohibits the sale of STLDs in Illinois. Effective January 1, 2023. This language also gives the Department rule making authority to prescribe specific standards for or restrictions on policy provisions, benefit design, disclosures, and sales and marketing practices for excepted benefits.

g. SB 3729 (Hunter and Feigenholtz)

i. 340B Drug Pricing Program Restrictions. Includes prohibitions on contracts between PBMS and 340B covered entities, including 1. Reimbursement at a lower cost than that of a 340B covered entity; imposing fees, chargeback, or rate adjustments that is not imposed on a pharmacy that is not a 340B program; impose a fee, chargeback, or rate adjustment that exceeds what is imposed on a non 340B covered entity; prevents or interferes with an individual's choice to receive a prescription drug from a 340B entity; exclude any 340 covered entity from a pharmacy network, requires a 340 entity to use a

billing modifier to indicate that the drug was purchased under the program; and any other violation that discriminates against a 340B entity.

h. SB 4037 (Simmons)

i. Mandates coverage for preventative screenings for individuals 18 years of age or older and under the age of 65 at high risk for liver disease every 6 months without cost sharing

i. SB 4041 (Simmons)

i. Mandates coverage for annual examinations for the prescription and fitting of hearing aids and for medically necessary hearing instruments and related services for all individuals under the age of 65 when a hearing care professional prescribes a hearing instrument to augment communication. Coverage is to be provided at no cost share.

j. HB 4703 (Morgan)

i. DOI Initiative (Surprise Billing)-Provides that when an insured receives emergency services or covered ancillary services from a nonparticipating provider or a nonparticipating facility, the health insurance issuer shall ensure that cost-sharing requirements are applied as though the services had been received from a participating provider or facility, and that the insured or any group policyholder or plan sponsor shall not be liable to or billed by the health insurance issuer, the nonparticipating provider, or the facility beyond the cost-sharing amount. Contains provisions concerning a notice and consent process for out-of-network coverage; billing for reasonable administrative fees; assignment of benefits to nonparticipating providers; and cost-sharing amounts and deductibles. Amends the Illinois Insurance Code and the Health Maintenance Organization Act to make a change in provisions concerning disclosure of nonparticipating provider benefits. Amends the Network Adequacy and Transparency Act. Provides that a beneficiary who receives care at a participating health care facility shall not be required to search for participating providers under certain circumstances. Amends the Managed Care Reform and Patient Rights Act. Provides that prior authorization or approval by the plan shall not be required for post-stabilization services that constitute emergency services. Amends the Health Maintenance Organization Act and the Voluntary Health Services Plans Act to provide that health maintenance organizations and voluntary health services plans are subject to provisions of the Illinois Insurance Code concerning billing and cost sharing. Makes other changes. Effective July 1, 2022, except that certain changes take effect January 1, 2023.

k. HB 4844 (Moeller)

i. Creates the Vision Care Plan Regulation Act to set forth certain contractual requirements with eye care providers and disclosures and coverage requirements for enrollees. Similar to SB 2086 (Castro)

l. HB 4941 (Mah)

i. Mandates insurers, independent practice associations, physician hospital organizations to provide contracted health care professionals or providers with notice of fee changes at least 90 days before the fee change. Changes to fees cannot be made retroactively and providers cannot waive advance notice of fee changes. If there is a fee change that is totals more than a 3% reduction of the Medicare rate for a stated year, the provider can propose alternative fee schedules. Any fee changes must be final at least 30 days before the effective date of the change.

m. HB 4943 (Mazzochi)

i. Redefines retail price to not include the pharmacist's dispensing fee. States that if a retail price is used the pharmacy must: report the retail price and any programs available to retail pharmacies that could reduce the price of the drug, or reduce the retail price

reported to account for price reductions that would be available to the individual without prescription drug coverage.

n. HB 4946 (Hirschauer)

i. Prohibits any provision denying benefits for treatment of an injury sustained as a result of domestic violence. Prohibits denying expenses incurred in a provision of mental health treatment or therapy to an insured who is a victim of domestic violence. Mental health services and health benefits shall be provided to the same extent as other coverage in a policy.

o. HB 4979 (Manley)

i. As introduced, the provisions currently require insurers to issue an irrevocable assignment of benefits to a funeral home in an amount not to exceed the purchase price of a funeral or burial expense policy. The language is intended to address a current issue with Medicaid beneficiaries seeking eligibility and avoidance of current asset limitations. Current law allows exemptions in assets up to a certain dollar amount in addition to exemptions for final expense policies that must be irrevocably assigned. Similar to HB 295 as introduced

2. Bills in Committee this Week

a. House Cybersecurity Data Analytics, and IT

i. HB 3453 (Williams) Monitor

1. Creates the Geolocation Privacy Protection Act to require a private entity that owns, operates, or controls a location-based application on a user's device from disclosing geolocation information from a location-based application to a third party unless the private entity first receives the user's affirmative express consent after providing a specified notice to the user. The provisions include an exemption for HIPAA and GLBA-regulated entities.

ii. Committee was Cancelled. Bill was not called.

b. House Insurance

i. HB 4271 (Kifowit) Oppose (Neutral with forthcoming Amendment)

1. Mandates coverage for medically necessary breast reduction surgery

ii. HB 4337 (Cassidy) Oppose

1. Mandates coverage for aesthetic services and restorative care provided for the treatment of physical injuries to victims of domestic violence when medically necessary. No language is present regarding how that is determined by a physician.
2. We are still waiting on feedback from advocates authoring this bill.

iii. Bills were not called in House Insurance this week.

3. Remaining Issues

a. Data Security Law Meeting with DOI

i. ILHIC did submit comments on the bill. DOI had several questions on our comments.

b. DOI Bulletin

i. Re: At Home Testing Coverage, Colorectal Cancer Screening, and Coverage of FDA Approved Contraception

c. Reminder: January 31 Deadline to comment on Infertility Coverage Proposed Rule

4. Upcoming Deadlines

a. 1-28-22 Deadline to File House Bills
b. 2-2-22 Governor's Budget Address
c. 2-10-22 Committee Bill Deadline Senate
d. 2-18-22 Committee Bill Deadline House