ILHIC KEY BILLS – 2-25-2022

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 61 (Costa Howard)	The provisions require coverage of prescription inhalants and require (instead of make permissive) a health insurer or managed care plan from denying or limiting coverage refills for prescription inhalants to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments if those restrictions are contrary to what has been prescribed and considered medically appropriate.	**MONITOR**	**Re-referred to Rules Committee**
HB 62 (Flowers)	Creates the Health Care For All program establishing single payer health insurance in IL.	**OPPOSE**	**Re-referred to Rules Committee**
HB 74 (Flowers)	Establishes paid family leave requiring employers with 50 or more employees to provide 6 weeks of paid leave.	**MONITOR**	**Re-referred to Rules Committee**
HB 146 (Morgan)	Authorizes the Director of Insurance to actively approve individual and small group ACA health plan rates and may disapprove any rate deemed "unreasonable." The Director must act on the rates within 60 days or else they are deemed approved.	**OPPOSE**	**Re-referred to Rules Committee**
HB 213 (Conroy)	Creates the Eating Disorder Treatment Parity Task Force within the DOI to review reimbursements to eating disorder treatment providers in IL, as well as out-of-state providers of similar services. The Task Force currently does not provide for industry representation, but requires the group to "work cooperatively with the insurance industry. . . to identify the high costs of medical complications, disability, and loss of life associated with eating disorders and to determine whether disparities in insurance reimbursement is limiting access to a full range of evidence-based treatment providers in the State." House Amendment #1 adds 2 members of the insurance industry to the task force.	**NEUTRAL With Amendment**	**Re-referred to Rules Committee**
HB 228 (Mayfield)	Prohibits an insurer or producer from making a distinction or otherwise discriminating between persons, reject an applicant, cancel a policy, or demand or require a higher rate of premium for reasons based SOLELY upon the basis that an applicant or insured has been convicted of a felony. ** An amendment is forthcoming that will address ILHIC's concerns.	**OPPOSE**	**Placed on Calendar for 2nd Reading**
HB 241 (Jones)	Allows pre-licensure courses for producers to be completed via webinar (in addition to the classroom setting).	**SUPPORT**	**Re-referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 242 (Jones)	Requires the IL Life & Health Insurance Guaranty Association to submit a plan of operation and any amendments thereto to the Director of Insurance within 200 days (instead of 180 days).	**MONITOR**	**Re-referred to Rules Committee**
HB 295 (Manley)	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. ILHIC is working with HFS, the IL Funeral Directors Association and the National Academy of Elder Law Attorneys to determine language that appropriately addresses the problem. House Amendment #1 removes the Insurance Code provisions.	**NEUTRAL as amended**	**Re-referred to Assignments**
HB 317 (Jones)	Requires an air ambulance service or other entity that directly or indirectly, whether through an affiliated entity, agreement with a third-party entity, or otherwise, solicits air ambulance membership subscriptions, accepts membership applications, or charges membership fees to be regulated as insurance under the Insurance Code.	**MONITOR**	**Referred to Assignments**
HB 339 (Batinick)	Removes the 181-day, non-renewable limitation on short-term, limited duration health insurance policies.	**SUPPORT**	**Re-referred to Rules Committee**
HB 580 (Zalewski)	Ratifies and approves the Nurse Licensure Compact and further provides that the compact shall not interfere with state labor laws. Identical to SB 2068 (Castro) and similar to SB 1807.	**SUPPORT**	**Re-referred to Rules Committee**
HB 616 (Costa Howard)	Establishes paid family leave requiring employers (regardless of size) to provide 12 weeks of leave and pay the cost of health insurance applicable to the employee during that period.	**MONITOR**	**Re-referred to Rules Committee**
HB 707 (Didech)	Amends the current telehealth coverage provisions, for policies that provide coverage for telehealth services, reimbursement must be made at parity with those same services if they were provided in-person.	**OPPOSE**	**Re-referred to Rules Committee**
HB 1728 (Mazzochi)	Amends the Medical Patient Rights Act to provide, in addition to any other right provided under the Act, certain qualifying patients have the ability to request diagnostic screenings without a physician's order as	**MONITOR**	**Re-referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
	follows: (1) females over the age of 40 have the right to a breast cancer screening mammogram once per year; and all persons have a right to request annual screening under the age of 40 if such person has a family history of breast cancer; or genetic testing has confirmed likelihood that such person has otherwise tested positive for BRCA1 or BRCA2 mutations; (2) males have the right to prostate-specific antigen testing at once per year if specified requirements are met; (3) all persons have the right to colorectal screening under specified conditions; (4) all persons over the age of 18, or under the age of 18 with one parent's consent, have the right to screening for sexually transmitted diseases or infections at least every 6 months, or in the event of unprotected sexual activity; and (5) all persons over the age of 18, or under the age of 18 with a parent's or legal guardian's consent, have the right to screening for COVID-19 infection and testing for COVID-19 antibodies. The provisions of the bill do not require coverage and the patient seeking the diagnostic test without a written order from a physician shall be responsible for paying for the diagnostic test provided that the provider of the diagnostic testing provides the patient in writing the cost of the diagnostic test prior to it being performed and the patient agrees to that cost.		
HB 1811 (Andrade)	Amends the Equal Pay Act and the Consumer Fraud and Deceptive Business Practices Act to restrict use of predictive data analytics used to determine a job applicant's credit worthiness or a hiring decision to include information that correlates with the race or zip code of the applicant for credit or employment.	**MONITOR**	**Placed on the order of 2nd reading House**
HB 1956 (Jones)	***DOI Initiative*** updating state statute to comply with the Covered Agreement by adopting the Credit for Reinsurance model law, and 2020 Holding Company Act amendments regarding Group Capital Calculation, effective December 31, 2022. Identical to SB 2411 (Harris).	**SUPPORT**	**Re-referred to Rules Committee**
HB 1960 (Jones)	Creates the Black Wall Street Program Act. Requires the Department of Commerce and Economic Opportunity to create and administer the Black Wall Street Program to provide loans and financial assistance to designated communities for the creation of Black Wall Street Business Districts.	**MONITOR**	**Re-referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 2370 (Avelar)	"Cap the copay" legislation that restricts an insured's monthly out of pocket cost to $100 per 30-day supply.	**OPPOSE**	**Re-referred to Rules Committee**
HB 2404 (Buckner)	Creates the Right to Know Act to require operators of commercial websites or online services that collect personal information about Illinois customers must, in their terms of service or privacy policy, identify all categories of personal information the operator collects, identify all categories of third party persons or entities with whom the operator may disclose that information, and provide a description of the customer's rights to access their information. Provisions also provide for a private right of action. Provides for blanket exemption for entities subject to GLBA and HIPAA.	**OPPOSE**	**Re-referred to Rules Committee**
HB 2406 (Scherer)	Provides that an individual or group policy of accident and health insurance or managed care plan in effect on and after March 9, 2020 must provide coverage for the cost of administering a COVID-19 vaccination. Language is silent on vaccine as approved by the FDA, which is not addressed in HA #1, which also includes cross-reference to HMOs.	**OPPOSE (*need language to tie vaccine to FDA approval)***	**Re-referred to Assignments**
HB 2472 (Mazzochi)	Requires the Director to solicit information and data from health insurance carriers regarding insurance coverage for pediatric autoimmune neuropsychiatric disorder to report back to the General Assembly by November 15, 2021.	**MONITOR**	**Re-referred to Rules Committee**
HB 2473 (Mazzochi)	In provisions requiring insurance coverage for prostate-specific antigen tests and for colorectal cancer examination and screening, removes provisions requiring the testing be recommended or prescribed by a physician. The provisions also mandate coverage for testing of sexually transmitted diseases or infections.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 2554 (Mah)	For purposes of the Telehealth Act, the provisions add "acupuncturists" to the list of health care professionals; however the bill does not make corresponding changes to the acupuncturists' practice act. The bill also provides IDFPR to adopt rules clarifying applicable services and administration of the Telehealth Act. Identical to SB 1735 (Jones).	**MONITOR**	**Re-referred to Assignments**
HB 2625 (Flowers)	Creates the Family Leave Insurance Act. Requires the Department of Employment Security to establish and administer a family leave insurance program. Provides family leave insurance benefits to eligible	**MONITOR**	**Re-referred to Rules Committee**

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	employees who take unpaid family leave to care for a newborn child, a newly adopted or newly placed foster child, or a family member with a serious health condition. Authorizes family leave of up to 12 weeks during any 24-month period. Authorizes compensation for leave in the amount of 85% of the employee's average weekly wage subject to a maximum of $881 per week. *The state-run leave program does not replace the private market option.*		
HB 2649 (Yednock)	Mandates health insurance plans to provide coverage for (rather than offer optional coverage for an additional premium) for the reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder.	**OPPOSE**	**Re-referred to Assignments**
HB 2896 (Conroy)	Early Intervention omnibus telehealth bill that includes language providing that if a health insurance policy provides coverage for early intervention services, it must also provide coverage for these services delivered via telehealth.	**MONITOR**	**Re-Referred to Rules Committee**
HB 2919 (Mazzochi)	Provides that upon request by a party contracting with a pharmacy benefit manager, the party has an annual right to audit compliance with the terms of the contract by the pharmacy benefit manager, including, but not limited to, full disclosure of any value provided by a pharmaceutical manufacturer to a pharmacy benefit manager or the parent, subsidiary, or affiliate company of a pharmacy benefit manager. Provides for other PBM disclosure requirements.	**MONITOR**	**Re-Referred to Rules Committee**
HB 2930 (Mazzochi)	In provisions concerning health insurance coverage for treatment of pediatric autoimmune neuropsychiatric disorders, provides that on and after the effective date of the amendatory Act, an insured shall have a cause of action for liquidated damages in the amount of $1,000 or actual damages, whichever is greater, against any entity issuing a group or individual policy of accident and health insurance or managed care plan that fails to provide the coverage required for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 2948 (Morgan)	***DOI Initiative*** seeking to address the copay accumulator ban implemented under P.A. 101-0452 as it applies to HSAs paired with a HDHP (to preserve the pre-tax advantages). The language, however,	**OPPOSE**	**Re-Referred to Rules Committee**

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	also requires insurers to identify a non-HSA eligible HDHP and offer a non-HSA eligible product if they do provide an HSA-eligible HDHP.		
HB 2992 (Lilly)	Requires the Department of Insurance to conduct a study to better understand the gaps in health insurance coverage for uninsured residents, including the reasons why individuals are uninsured and whether insured individuals are insured through an employer-sponsored plan or through the Illinois health insurance marketplace. P.A. 101-649 requires the DOI and HFS to conduct a health care affordability feasibility study to address some of the same issues, which is expected to be released by February 28. The bill also requires all hospitals to provide health insurance to their employees.	**MONITOR**	**Placed on Calendar 2nd Reading**
HB 3030 (Wheeler)	Creates the Cybersecurity Compliance Act to provide for an affirmative defense for every covered entity that creates, maintains, and complies with a written cybersecurity program (as prescribed by the legislation).	**MONITOR**	**Re-Referred to Rules Committee**
HB 3040 (Wheeler)	Creates the Insurance Data Security Act based on the NAIC Cybersecurity Model Law. The provisions DO NOT contain suggested changes put forward by the joint trades (industry).	**OPPOSE without Joint Trade Suggested Changes**	**Re-Referred to Rules Committee**
HB 3197 (Conroy)	Creates the Suicide Treatment Improvements Act to require that all at-risk patients be provided with one-on-one suicide prevention counseling by the public or private psychiatric facility at which the at-risk patient is being treated and mandates individual and group health insurance coverage for these services.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 3198 (Conroy)	Creates the Suicide Treatment Improvements Act to require suicide prevention counseling and treatment at facilities and mandates individual and group health insurance coverage for these services (similar to HB 3197); however the provisions of the bill also place certain requirements on IDPH and local public safety officials to identify individuals at risk for suicide.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 3259 (Gong Gershowitz)	Mandates coverage for the diagnosis and medically necessary treatment (instead of reasonable and necessary treatment and services for) mental health and substance use disorders and requires insurers to base medical necessity and utilization review criteria on specific current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care, including exclusively applying the criteria	**OPPOSE**	**Re-Referred to Rules Committee**

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	and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty (similar to HB 2595 (Conroy)). The provisions also prohibit an insurer that authorizes a specific type of treatment by a provider from rescinding or modifying the authorization after that provider renders the health care service. Provides that if services for the medically necessary treatment of a mental health or substance use disorder are not available in-network within the geographic and timely access standards set by law or regulation, the insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services, and the insured shall pay no more in total for benefits rendered than the cost sharing that the insured would pay for the same covered services received from an in-network provider and further require every insurer to sponsor an education program, make the program available to other stakeholders, provide clinical review criteria at no cost to providers and insured patients, conduct interrater reliability testing, and achieve interrate pass rates of at least 90% or comply with specified requirements if the 90% threshold is not met.		
HB 3268 (Flowers)	Amends the Fair Patient Billing Act to prohibit a hospital from aggressively pursue debt collection for non-payment of a hospital bill against a patient with an annual household income of $51,000 or less and further provides that a hospital whenever possible and after reviewing the patient eligibility, shall charge as much as possible of the patient's hospital bill to insurers. ** ONLY EFFECTS THE PUBLIC AID CODE	**MONITOR**	**Re-Referred to Rules Committee**
HB 3312 (Welter)	Requires insurers to cap OOP for a covered prescription inhalant drug to $100 per 30-day supply regardless of the type and amount of the drug needed by the insured. Language aligns with similar OOP limits applied to insulin per P.A. 101-0625. HA #1 makes a technical change to refer to inhalant medications rather than prescription inhalants.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 3327 (Haas)	In provisions concerning timely payment for health care services, provides that failure to make periodic payments within specified time periods shall entitle a health care professional, health care facility,	**MONITOR**	**Re-Referred to Rules Committee**

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	independent practice association, physician-hospital organization, insurer, health maintenance organization, managed care plans health care plan, preferred provider organization, or third party administrator to interest at the rate of 9% semiannually (rather than 9% per year).		
HB 3397 (Mazzochi)	Requires first dollar coverage on diagnostic testing for a pediatric autoimmune neuropsychiatric disorder if such diagnostic testing is ordered by a physician (coverage is not required if the physician indicates that the diagnostic testing is requested by a guardian or parent). *Provisions do not include exemptions for HSAs.*	**OPPOSE**	**Re-Referred to Rules Committee**
HB 3403 (Ness)	Reduces OOP limit on insulin drugs from $100 (originally set under P.A. 101-0625 to $30.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 3421 (Dina Delgado)	Provides that if a patient unknowingly and through no fault of his or her own receives care from a health care professional or health care provider who is not among the network of health care providers for the patient's health care plan, the health care professional or health care provider may not charge or bill that patient for that care.	**MONITOR**	**Re-Referred to Rules Committee**
HB 3433 (Morgan)	Creates the Paid Family Leave Program directing the IL Department of Employment Security to establish a state-run paid medical leave program for employees. The provisions do not specific duration of leave allowed but does direct the Department to establish a computation of benefit amounts and contributions paid by employees and employers. *The state-run leave program does not replace the private market option but does impose contribution requirements on employers with more than 50 employees.*	**MONITOR**	**Re-Referred to Rules Committee**
HB 3453 (Williams)	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.	**MONITOR**	**Assigned to Cybersecurity, Data Analytics, and IT Committee**
HB 3498 (Conroy)	Codifies some provisions of the telehealth coverage requirements set forth in Executive Order 2020-09., including payment parity. The provisions do not remove cost-sharing for telehealth.	**OPPOSE**	**Re-referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 3517 (Wheeler)	In provisions concerning development of medical necessity criteria for the coverage of CSC/ACT treatment models for early treatment of serious mental illness, provides that the rules adopted by the DOI defining medical necessity shall be updated during calendar year 2021 to include nationally recognized, generally acceptable clinical criteria sourced to evidence-based medicine and to avoid unnecessary anti-competitive impacts. Identical to SB 2381 (Fine).	**MONITOR**	**Re-Referred to Rules Committee**
HB 3583 (Avelar)	Creates the Affordable Drug Manufacturing Act requiring IDPH to enter into partnerships to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs. Requires the partnerships to result in the production or distribution of generic prescription drugs with the intent that these drugs be made widely available to public and private purchasers, providers and suppliers, and pharmacies. IDPH is directed to consult with entities, including health insurers, regarding the establishment of a fair price for the prescription drugs.	**MONITOR**	**Re-Referred to Rules Committee**
HB 3609 (Flowers)	Requires prescription drug manufacturers to provide advance notice of a price increase of a prescription drug with a wholesale acquisition cost of more than $40 if the increase is more than 10% and to disclose information regarding factors associated with the price increase. Requires the Department of Public Health to conduct an annual public hearing on the aggregate trends in prescription drug pricing.	**MONITOR**	**Re-Referred to Rules Committee**
HB 3630 (Harris)	Requires insurers to replace a brand name drug with a new generic equivalent on the formulary once it becomes available in the market or move the brand name drug to the lowest cost tier. In provisions concerning a contract between a health insurer and a pharmacy benefit manager, provides that a pharmacy benefit manager must update and publish maximum allowable cost pricing information according to specified requirements, must provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs, and must comply with specified requirements if an appeal is denied.	**OPPOSE**	**Assigned to Prescription Drug Affordability & Accessibility Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
	The legislation also sets forth contracting requirements for PBMs, including fiduciary responsibilities. Identical to SB 2008 (Koehler).		
HB 3707 (Yingling)	For purposes of group health insurance coverage, revises the definition of "small employer" to mean an employer who employs an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year (rather than an employer who employs an average of at least 2 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year).	**MONITOR**	**Re-Referred to Rules Committee**
HB 3758 (Spain)	Provides that if an insurer covers telehealth services, then coverage must also include telehealth services used to treat behavioral health conditions.	**NO POSITION**	**Re-Referred to Rules Committee**
HB 3759 (Spain)	Creates the Telehealth Parity Act to require health insurers, including excepted benefit plans that provided limited scope dental benefits, limited scope vision benefits, LTC benefits, accident-only, and specified disease or illness coverage, to cover the costs of all medically necessary telehealth services rendered by in-network providers. The provisions allow insurers to apply coverage criteria, but that criteria must be in compliance with provisions set forth in Executive Order 2020-09 . Prohibits insurers from applying prior authorization for any COVID-19 related telehealth services and further provides that coverage for in-network telehealth services shall be provided without cost-share (exemption applicability to HSAs). HA #1 creates the Telehealth Parity Act with respect to parity in the benefits and NOT with respect to reimbursement requirements.	**SUPPORT with HA #1**	**Re-Referred to Rules Committee**
HB 3777 (Ortiz)	Prohibits prior authorization for prescription drugs used in the treatment of COVID-19 that have received emergency authorization from the FDA.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 3794 (Stephens)	Requires insurers to cap OOP for a diabetic self-management supplies (not including insulin) to $100 per 30-day supply regardless of the type and amount of the supply needed by the insured. Language aligns with similar OOP limits applied to insulin per P.A. 101-0625.	**OPPOSE**	**Re-Referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 3845 (LaPointe)	Mandates coverage for medically necessary treatments for genetic, rare, unknown or unnamed, and unique conditions, including Ehlers-Danlos syndrome and altered drug metabolism. Provides that an insurance policy that provides coverage for prescription drugs shall include coverage for opioid alternatives, coverage for medicines included in the Model List of Essential Medicines published by the World Health Organization, and coverage for custom-made medications and medical food. Provides that an insurance policy that limits the quantity of a medication in accordance with applicable State and federal law shall not require pre-approval for the treatment of patients with rare metabolism conditions that may need a higher dose of medication than what is otherwise allowed within a time frame or prescription schedule. Provides that the burden of proving that treatment is medically necessary shall not lie with the insured in cases of rejections for filing claims, preauthorization requests, and appeals related to the coverage.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 3867 (Moeller)	Requires IDPH to design a prescription drug importation program where the State serves as the licensed wholesaler of imported drugs from Canada. The provisions set forth auditing and AG enforcement criteria, including ensuring that any participating health plan formularies, cost-sharing, and reimbursement criteria is based on the actual acquisition cost of the imported drug.	**NO POSITION**	**Re-Referred to Rules Committee**
HB 3874 (Yang Rohr)	In provisions concerning infertility coverage and coverage for epinephrine injectors, provides that specified coverage shall be applicable to policies of insurance written in other states that insure an Illinois resident.	**MONITOR**	**Re-Referred to Rules Committee**
HB 3898 (Gordon Booth)	Creates the Healthy Workplace Act to require employers to provide a minimum of 40 hours of paid sick leave during a 12-month period for certain purposes. Employees cannot waive their right to paid leave except in cases where the benefits are collectively bargained.	**MONITOR**	**Placed on the Order of 2nd Reading House**
HB 3910 (Mussman)	Creates the Consumer Privacy Act to set forth numerous data privacy requirements, including a "right to be forgotten" with exceptions. The provisions include exemptions for certain data protected under HIPAA and GLBA.	**MONITOR**	**Re-Referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 3918 (Stuart)	Adds investment advisors and insurance adjusters as mandated reporters. Existing law extends criminal and civil liability to mandated reporters.	**MONITOR**	**Senate placed on the order of 3rd reading**
HB 4053 (Guerrero-Cuellar)	Provides a civil rights violation for an employer to: refuse to allow an employee disabled by pregnancy, childbirth, or related medical condition to take a leave for a reasonable period, not to exceed 4 months, and thereafter return to work; refuse to maintain and pay for coverage for an eligible employee disabled by pregnancy, childbirth, or a related medical conditions who takes leave under a group health plan, for the duration of the leave, not to exceed 4 months over the course of a 12-month period.	**MONITOR**	**House – Rules Committee**
HB 4140 (Ford)	Mandates a healthcare plan to provide medical facts regarding COVID-19 to all patients under the hospital's care. There are some vague implementation considerations within this language.	**MONITOR**	**Referred to Rules Committee**
HB 4162 (Carroll)	Amends the Insurance Code and adds regulations regarding marketing and operations of healthcare sharing ministries	**MONITOR**	**Referred to Rules Committee**
HB 4175 (Jones)	Creates the authority for the State to pursue a platform transition to SBE-FP or a full SBE. ILHIC has implementation concerns within the language.	**MONITOR**	**Assigned to Appropriations-Human Services Committee**
HB 4214 (Vella)	Amends the Illinois Income Tax Act. Creates an income tax credit for hospitality employers, for taxable years that begin on or after January 1, 2022 and begin prior to January 1, 2023, in an amount equal to 100% of the amount paid by the taxpayer to provide vision and dental benefits, life insurance, and short term disability coverage for its employees during the taxable year. Effective immediately.	**MONITOR**	**Re-Referred to Rules Committee**
HB 4259 (Carroll)	Any insured who is hospitalized due to COVID-19 and is unvaccinated will be responsible for all costs incurred for care related to COVID-19. The language is unconstitutional.	**OPPOSE**	**Referred to Rules Committee**
HB 4263 (Grant)	Provides that no company, in any policy of accident or health insurance issued in the State, shall make or permit any distinction or discrimination against an individual solely because of the individual's vaccination status in the amount of payment of premiums or rates charged for policies of insurance, in the amount of any dividends or other benefits payable thereon, or in any other terms and conditions of the contract it makes.	**OPPOSE**	**Re-Referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
	For the same reasons as HB 4259, the language presented is unconstitutional.		
HB 4271 (Kifowit)	Mandates coverage for medically necessary breast reduction surgery HA #1 moves the effective date to 1-1-2024	**NEUTRAL With Amendment**	**Held on the order of 2nd Reading Consent Calendar**
HB 4324 (Morgan)	In provisions concerning insurance producer licenses, provides that an insurance producer's active participation in a State or national professional insurance association may be approved by the Director of Insurance for up to 4 hours of continuing education credit per biennial reporting period.	**SUPPORT**	**Placed on the Order of 2nd Reading House**
HB 4335 (Stuart)	Mandates coverage for vaginal estrogen without cost sharing. HA #1 removes ILHIC opposition by only requiring 1 therapeutic equivalent as well as push the timeline to 1-1-2024.	**NEUTRAL**	**Held on the order of 2nd Reading Consent Calendar**
HB 4337 (Cassidy)	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.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 4338 (Hernandez)	Mandates coverage for prenatal vitamins. (This medication already required to be covered under the ACA.) HA #1 Moves the effective date to 2024.	**NEUTRAL With Amendment**	**Held on the Order of 2nd Reading Consent Calendar**
HB 4349 (Willis)	Mandates coverage for congenital defects including treatment of cranial facial anomalies that are medically necessary to restore normal function or appearance. Cosmetic changes are included in coverage requirement. HA#1 includes Medically necessary provisions.	**NEUTRAL With Amendment**	**Held on the Order of 2nd Reading Consent Calendar**
HB 4413 (Hernandez)	Provides that a group or individual policy that provides dependent coverage shall make dependent coverage available to an insured's parent or stepparent who meets the qualifying relative definition and resides within the insurance policy's service area.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 4408 (Conroy)	Mandates plans that provide coverage for naloxone do so without cost sharing. HA #1 pushed the effective date to 2024 as well as an HAS HDHP carve out.	**NEUTRAL With Amendment**	**Held on the Order of 2nd Reading Consent Calendar**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 4430 (Cassidy)	Amends the Pharmacy Practice Act. Expands the pharmacist's scope of practice to include the initiation, dispensing, administration of drugs, laboratory testing, assessments, referrals, and consultations for PrEP treatment. Language states that pharmacists shall be covered and reimbursed for these services ordered and administered by a pharmacist at least 85% of the rate that physicians are reimbursed for Medicaid and other payers.	**MONITOR**	**Placed on the Order of 2nd Reading House**
HB 4433 (Morgan)	This language includes model language for Copay Accumulators. This language was agreed to by the Stakeholders, DOI, and ILHIC.	**SUPPORT**	**Held on the Order of 2nd Reading Consent Calendar**
HB 4480 (Conroy)	Mandates coverage with no cost sharing for mental health wellness checks for probationary and permanent police officers.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 4483 (Kifowit)	Mandates coverage with no cost sharing for 3 primary care visits and 3 behavioral health visits. Treatment limitations for each of the 6 covered visits cannot be more restrictive than the treatment limitations applied to other primary care visits or behavioral health visits covered by the plan. Separate treatment limitations are prohibited.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 4493 (Morgan)	DOI Initiative Admin Bill. In provisions concerning standard non-forfeiture for individual deferred annuities, changes an interest rate to 0.15% (rather than 1%).	**SUPPORT**	**Held on the Order of 2nd Reading Consent Calendar**
HB 4595 (Harris)	Prohibits PBMs from various contract language regarding 340b drug pricing entities. Prohibitions include: cannot reimburse at a lower rate than non-340B entities; impose fee, chargeback, or rate adjustments that are not imposed by the pharmacy for non-340B covered entities; the interference of individual choice to receive a prescription drug from a 340B entity; excluding a 340b entity from a pharmacy network; requires a billing modifier to indicate a drug claim is for drugs purchased under 340B drug discount program; prohibits discrimination against 340b covered entities.	**OPPOSE**	**Placed on the Order of 2nd Reading**
HB4603 (Crespo)	Provides that the Department shall develop a comprehensive licensing and registration process for sites that test for COVID-19.	**MONITOR**	**Placed on the Order of 2nd Reading House**
HB 4653 (Jones)	DOI Initiative- Data security law that tracks with the Model NAIC data security law.	**OPPOSE**	**Referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 4703 (Morgan)	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.	**NEUTRAL**	**Placed on the Order of 2nd Reading**
HB 4774 (Lilly)	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 of 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	**OPPOSE**	**Referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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. Similar to SB 3924 (Castro)		
HB 4844 (Moeller)	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)	**OPPOSE**	**Re-Referred to Rules Committee**
HB 4929 (Mah)	Provides that a licensed optometrist may independently administer the influenza vaccine, the COVID-19 vaccine, or the shingles vaccine upon completion of the required training. Provides that vaccinations for influenza and COVID-19 shall be limited to patients 5 years of age and older. Provides that vaccines ordered and administered in accordance with the amendatory Act shall be covered and reimbursed at no less than the rate the vaccine is reimbursed when ordered and administered by a physician.	**MONITOR**	**Placed on the Order of 3nd Reading House**
HB 4941 (Mah)	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.	**OPPOSE (NEUTRAL if ILHIC Alternative Language is Accepted)**	**Placed on the Order of 2nd Reading House**
HB 4943 (Mazzochi)	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.	**OPPOSE**	**Referred to Rules Committee**
HB 4946 (Hirschauer)	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.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 4979 (Manley)	As introduced, the provisions currently require insurers to issue an irrevocable assignment of benefits to a funeral home in an amount not to	**NEUTRAL with amendment**	**Placed on the Order of 3nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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. HA #1 Mirrors industry current practice, removing ILHIC opposition.		
HB 5029 (Harper)	Creates the Family and Medical Leave Insurance Program Act. Requires the Department of Employment Security to establish and administer a Family Leave Insurance Program that provides family leave insurance benefits to eligible employees. Sets forth eligibility requirements for benefits under the Act. Contains provisions concerning disqualification from benefits; premium payments; the amount and duration of benefits; the recovery of erroneous payments; hearings; defaulted premium payments; elective coverage; employment protection; coordination of family leave; defined terms; and other matters. Amends the State Finance Act. Creates the Family Leave Insurance Account Fund. Provides phase-in periods for the collection of money and making of claims for benefits under the Act. Effective January 1, 2023.	**MONITOR**	**Re-Referred to Rules Committee**
HB 5142 (Harris)	Provides that the Department shall provide the Department of Healthcare and Family Services and the Department of Insurance with the individual income tax information collected as soon as practicable. Amends the Illinois Insurance Code. Provides that the Department of Insurance shall use taxpayer income information provided by the Department of Revenue to determine if an individual is eligible for a premium tax credit under the Patient Protection and Affordable Care Act. Provides that if the individual is determined to be eligible for a premium tax credit, the Department shall notify the individual of his or her eligibility as soon as practicable. Provides that the Department shall inform the individual of the next open enrollment period in the federal health insurance marketplace, and shall inform the individual of the special enrollment period triggered by a qualifying life event. HA #1 changes some implementation provisions for the Department of Revenue only.	**SUPPORT**	**Placed on the Order of 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 5172 (Grant)	Hormonal Contraceptives Mandate Removal Removes the assessment and consultation of patients and dispensing of hormonal contraceptives from the "practice of pharmacy." Removes the mandate covering hormonal birth control 356z.43	**Neutral**	**Re-Referred to Rules Committee**
HB 5243 (Wheeler)	Cybersecurity Compliance Act Creates an affirmative defense for every covered entity that creates, maintains, and complies with a written cyber security program that contains administrative technical and physical safeguards for the protection of information conforming to an industry-recognized cybersecurity framework.	**Neutral**	**Re-Referred to Rules Committee**
HB 5253 (Wheeler)	Criminal Testing Insurance Mandate Reimbursement Removal Removes mandate for insurers to release information to the Department of Public Health regarding information testing of a victim. Removes the ability for the Department of Public Health to receive reimbursement when paying all or part of hospital or medical expenses from insurance companies.	**No Position**	**Re-Referred to Rules Committee**
HB 5254 (Wheeler)	Provides coverage for hormone therapy treatment to treat menopause that has been induced by a hysterectomy. HA#1 adds medical necessity to the language as well as moves the effective date to 1-1-24.	**NEUTRAL with Amendment**	**Placed on the Order of 3rd Reading**
HB 5300 (Guzzardi)	Insulin Drug Discount Programs Allows pharmacists to dispense insulin if a patient can attest that they are in dire need of the drug. After dispensing the drug, the pharmacist notifies the provider. Mandates that drug distributors can reimburse pharmacies with refills of insulin or the amount that covers the pharmacies acquisition cost. Allows a drug manufacturer to send insulin directly to the patient. Mandates 30-day coverage of insulin not to exceed 35 dollars (changed from 100 dollars).	**OPPOSE**	**Re-Referred to Rules Committee**
HB 5305 (Nichols)	Coverage Mandate for colonoscopy 39-75 years	**OPPOSE**	**Placed on the Order of 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	Mandates coverage for Medically necessary colonoscopies for persons ages 39-75 years old.		
HB 5318 (Ford)	Mandate Expansion for Prostate Screenings No Cost Share Mandates prostate cancer screenings without cost sharing, broadening cancer screening testing beyond prostate specific antigen tests and digital rectal exams. The mandate coverage includes follow up testing including 1. Urinary analysis, serum biomarkers, and medical imaging, including, but not limited to magnetic resonance imaging. HA#1 adds a carve out for HDHPs, moves effective date back to 1-1-2024, and adds medical necessity to follow up testing.	**NEUTRAL with Amendment**	**Placed on the Order of 2nd Reading**
HB 5327 (Stoneback)	All Payer Claims Database Act Provides that the Department of Insurance shall establish an All-Payer Claims database for sharing limited use health care data. DOI shall determine criteria for plans to submit. The database will serve as a resource for insurers, providers, consumers, and state agencies to continuously review utilization, expenditures, and performance. DOI shall make information regarding healthcare costs public on its Website. Requires plans to submit health insurance price information annually.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 5332 (Ness)	Mandate for Glucose Monitors Mandates Coverage for continuous glucose monitors.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 5334 (Stuart)	Mandate Coverage for Genetic Testing Breast/ Ovarian Cancer Mandates coverage for genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and ovarian cancer if recommended by a health care provider in accordance with the United States Preventive Service Task Force's recommendations for testing.	**Neutral**	**Held on the Order of Second Reading- Consent Calendar**
HB 5383 (Mason)	Coverage Mandate for Hippotherapy/Therapeutic Riding Mandates Coverage for hippotherapy and other forms of therapeutic riding.	**OPPOSE**	**Re-Referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 5399 (Hammond)	Coverage Mandate for Proton Therapy Requires coverage (in 2024) for medically necessary hypofractionated proton therapy protocols the same payment level as that of the same biological dose with standard radiation protocol delivered if certain conditions are satisfied. Cost sharing cannot have a limitation that is greater than what is required for radiation therapy and other similar benefits.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 5426 (Mazzochi)	COVID-19 Safe Treatments for Early Response Mandates that physicians may dispense drugs used to treat COVID-19 if certain conditions are met. Allows a pharmacist to consult a patient after a self-assessment on COVID-19 treatments. Allows a pharmacist to refer patients to providers for the treatment of COVID-19.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 5454 (Crespo)	COVID-19 Testing Coverage Mandates Coverage for COVID-19 Diagnostic Testing without cost sharing if the purpose of the testing is for the individualized diagnosis or treatment of COVID-19, in accordance with the Federal Cares Act. Mandates all testing sites to collect insurance information from patients.	**OPPOSE**	**Placed on the Order of 2nd Reading House**
HB 5514 (Manley)	Hearing Instrument Mandate Mandate of Coverage for Medically Necessary coverage of hearing instruments for all individuals (Removal of under 18 language).	**Neutral**	**Re-Referred to Rules Committee**
HB 5516 (Jones)	Supplier Diversity Report Requires every company with at least 50 million in assets to submit a 2-page report on its voluntary supplier diversity program to the Department. The Report shall include Contact information; local and state certifications for minority-owned, women-owned, LGBT -owned and Veteran Owned business Status; narrative explaining diversity goals and program; voluntary goals for the calendar year. The Department is tasked with holding an annual insurance company supplier diversity workshop in 2023 to discuss reports with companies and vendors. The department shall also provide the template.	**Neutral**	**Referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 5534 (Jones)	Insurance Business Transfer Act Creates the Insurance Business Transfer Act. Create 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.	**OPPOSE**	**Placed on the Order of 2nd Reading House**
HB 5539 (Kelly)	Healthcare Cost Info Provides that each insurer shall make available on its publicly accessible website or through a toll-free telephone number an interactive mechanism where any member of the public may access specified health care cost information. Provides that an insurer shall provide notification on its website that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforeseen costs that arise during the provision of the service. Provides that each estimate of out-of-pocket costs provided shall provide the out-of-pocket costs a covered person may owe if he or she has exceeded his or her deductible and the out-of-pocket costs a covered person may owe if he or she has not exceeded his or her deductible. Provides that an insurer may contract with a third party to satisfy part or all of the requirements. Provides that nothing in the provisions shall prohibit an insurer from charging a covered person cost sharing beyond that included in the estimate provided if the additional cost sharing resulted from unforeseen provisions of additional health care services and the cost-sharing requirements of the unforeseen health care services were disclosed in the covered person's policy or certificate of insurance. Provides that some of the provisions do not apply to a health maintenance organization.	**OPPOSE**	**Re-Referred to Rules Committee**
HB 5579 (Durkin)	Healthcare Providers ID Act Requires healthcare providers to care ID on them when treating patients.	**Monitor**	**Re-Referred to Rules Committee**
HB 5585 (Lilly)	Home Health Services Mandate	**Neutral**	**Held on the Order of 2nd Reading Consent Calendar**

Bill Number	Bill Description/Action	ILHIC Position	Status
	Mandates coverage for access to home health services for the duration of medically necessary care.		
SB 158 (Holmes)	Creates the Prior Authorization Reform Act to establish new requirements regarding disclosure and review of PA requirements, denial of claims or coverage by a utilization review organization for various levels of service, including nonurgent and urgent care effective January 1, 2022. ***This bill will be tabled in favor of SB 177 (Holmes).***	**OPPOSE**	**Referred to Assignments**
SB 177 (Holmes)	Creates the Prior Authorization Reform Act to establish new requirements regarding disclosure and review of PA requirements, denial of claims or coverage by a utilization review organization for various levels of service, including nonurgent and urgent care effective January 1, 2022. The provisions of the bill incorporate some feedback provided by ILHIC to HB 5510 (Harris) of the 101st General Assembly. Proponents of the bill, including ISMS and other provider and patient advocacy groups, have formed a "Your Care Can't Wait" campaign in support of prior authorization reform. Identical to HB 711 (Harris).	**OPPOSE**	**Referred to Assignments**
SB 202 (Morrison)	Provides that it is a civil rights violation to offer a group or individual policy of accident and health insurance, including coverage against disablement or death, that does not include equal terms and conditions of coverage for the treatment of a mental, emotional, nervous, or substance use disorder or condition or a history thereof. Senator Morrison sponsored P.A. 101-0332 establishing a task force to study disability income insurance and parity for behavioral health conditions, but the Governor has not yet made appointments to the task force and the group has not yet met or begun that work. **SA#1 requires equal coverage for all protected characteristics under the IL Human Rights Act, which would restrict underwriting practices for health, supplemental and DI products.**	**OPPOSE**	**Re-referred to Assignments**
SB 208 (Martwick)	Expands the Secure Choice Savings Program to apply to ~~sole proprietors and employers~~ **with at least 5 employees** (rather than employers with fewer than 25 employees) and allows for automatic increases in contributions. The provisions also expand the penalties levied on	**NEUTRAL as amended**	**Re-referred to Rules Committee**

Bill Number	Bill Description/Action	ILHIC Position	Status
	employers for failure to comply with the requirements of the Act. Identical to HB 117 (Guzzardi) **as amended by HA#1**.		
SB 275 (Bennett)	Requires health insurance carriers that provide coverage for prescription drugs to ensure that, within service areas and levels of coverage specified by federal law, at least half of individual and group plans meet one or more of the following criteria: 1) apply a pre-deductible and flat-dollar copayment structure to the entire drug benefit; 2) limit a beneficiary's monthly out-of-pocket financial responsibility for prescription drugs to a specified amount; or 3) limit a beneficiary's annual out-of-pocket financial responsibility for prescription drugs to a specified amount. Effective January 1, 2022. Identical to HB 1745 (Harris).	**OPPOSE**	**Re-referred to Assignments**
SB 375 (Harris)	Authorizes the Illinois Insurance Guaranty Fund, at the direction of its board of directors and subject to the approval of the Director of Insurance, to form and own a not-for-profit corporation to which the Fund may delegate certain of its powers and duties provided by the Code. Allows the not-for-profit corporation to contract to provide services to the Office of Special Deputy Receiver or any other person or organization authorized by law to carry out the duties of the Director in the capacity of receiver under specified provisions of the Code, the Illinois Life and Health Insurance Guaranty Association, an organizations in another state similar to the Illinois Insurance Guaranty Fund or the Illinois Life and Health Insurance Guaranty Association. Effective immediately. Identical to HB 2405 (Hoffman).	**NO POSITION**	**Re-referred to Assignments**
SB 679 (Fine)	The bill includes provisions mandating coverage for ALL opioid antagonists approved by the FDA in addition to reimbursing a hospital for the hospital's cost of any FDA approved opioid antagonist. Identical to HB 2589 (Conroy).	**OPPOSE**	**Re-referred to Assignments**
SB 697 (Fine)	Mandates coverage for medically necessary treatment for mental health and substance use conditions. Requires insurers to base medical necessity and utilization review criteria on specific current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care, including exclusively applying the criteria and guidelines set forth in the most recent versions of the treatment	**OPPOSE**	**Referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	criteria developed by the nonprofit professional association for the relevant clinical specialty. Provides that an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in the treatment criteria. Provides that the Director may, after appropriate notice and opportunity for hearing, assess a civil penalty between $5,000 and $20,000 for each violation. Identical to HB 2595 (Conroy). ***KFI initiative & priority for 2021.***		
SB 700 (Crowe)	Amends the Adult Protective Services Act. In a provision listing mandated reporters, excludes the State Long Term Care Ombudsman and all representatives of the State Long Term Care Ombudsman Program. Expands the definition of "mandated reporter" to include investment advisors and insurance adjusters. Defines "insurance adjuster" and "investment adviser". HB #1 defines insurance adjuster and investment advisor.	**MONITOR**	**Referred to Assignments**
SB 731 (Cullerton)	Creates the Do Not Track Act. Establishes the Data Transparency and Privacy Act	**MONITOR**	**Re-referred to Assignments**
SB 835 (Villivalam)	Creates the Family and Medical Leave Insurance Program Act. SA #1 Shells the bill.	**MONITOR**	**Re-referred to Assignments**
SB 1587 (Fine)	Mandates coverage for cleft palate corrective surgery, including necessary dental procedures related to the cleft palate for the duration the correction is required until age 26. The provisions do not apply to standalone dental plans.	**OPPOSE**	**Re-referred to Assignments**
SB 1589 (Fine)	Mandates coverage for anti-epileptic drugs and may not impose a waiting period or any deductible, coinsurance, copayment, or other cost-sharing limitation greater than other coverage provided. Further provides that anti-seizure prescription drugs may not be substituted with a generic drug under provisions of the Pharmacy Practice Act under which a pharmacist may substitute a therapeutically equivalent generic drug for a prescription drug or interchange an anti-epileptic drug or formulation of an antiepileptic drug for the treatment of epilepsy.	**OPPOSE**	**Re-referred to Assignments**
SB 1590 (Fine)	Provides the Department of Insurance with the authority to disapprove “unreasonable” or “inadequate” rates for individual and small group ACA compliant health insurance plans. The provisions require the	**OPPOSE**	**Re-referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	Department to review the rates within 45 days with the option of a 30-day extension.		
SB 1625 (Turner)	Requires pharmacies to post a notice informing customers that they may request, in person or by telephone, the current usual and customary retail price of any brand or generic prescription drug or medical device that the pharmacy offers for sale to the public. Provides that a pharmacist or his or her authorized employee must disclose to the consumer at the point of sale the current pharmacy retail price for each prescription medication the consumer intends to purchase and if the consumer's cost-sharing amount for a prescription exceeds the current pharmacy retail price, the pharmacist or his or her authorized employee must disclose to the consumer that the pharmacy retail price is less than the patient's cost-sharing amount. Identical to SB 1682 (Bennett).	**MONITOR**	**Re-referred to Assignments**
SB 1735 (Jones)	For purposes of the Telehealth Act, the provisions add "acupuncturists" to the list of health care professionals; however the bill does not make corresponding changes to the acupuncturists' practice act. The bill also provides IDFPR to adopt rules clarifying applicable services and administration of the Telehealth Act. Identical to HB 2554 (Mah).	**MONITOR**	**Referred to Assignments**
SB 1788 (Murphy)	Prohibits any mid-year change in health insurance coverage, including changes to the formulary or provider network. The insurance industry and PBMs negotiated compromise language to provide consumers with an avenue to remain on their prescription drugs in situations where a midyear change to the formulary may have adversely impacted their coverage: P.A. 100-1052. Similarly, network adequacy requirements implemented in 2019 provide for continuity of care for certain individuals in the middle of treatment if there is a change in the provider network: P.A. 100-0502. SA #1 removes managed care from the requirements.	**OPPOSE**	**Postponed Senate Insurance**
SB 1807 (Rose)	Ratifies and approves the Nurse Licensure Interstate Compact. Similar to SB 2068 (Castro) and HB 580 (Zalewski).	**SUPPORT**	**Re-referred to Assignments**
SB 1875 (Syverson)	Requires that any new coverage mandate, beginning 1/1/22, shall apply only to the state employee group health insurance benefit plan. The provisions of the bill require that before the mandate is expanded to	**SUPPORT**	**Referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	apply to private individual and group insurance plans, CMS must conduct a cost-benefit analysis and the DOI Director shall not enforce compliance with the mandate until the analysis is performed.		
SB 1917 (Morrison)	Removes the age limit (18) in mandated coverage provisions for medically necessary epinephrine injectors.	**NEUTRAL**	**Re-referred to Rules Committee**
SB 1971 (Fine)	Authorizes the Director of Insurance to actively disapprove "unreasonable" or "inadequate" rate increases. The provisions further require the DOI to post notice of the individual and small group premium rate filings, rate filing summaries, and other information about a rate increase or decrease online and provide for a 30-day public comment period prior to approve or disapproving the rates.	**OPPOSE**	**Referred to Assignments**
SB 1974 (Fine)	Provides that an insurer, health maintenance organization, independent practice association, or physician hospital organization may not attempt a recoupment or offset until all appeal rights of a health care professional or health care provider are exhausted and no recoupment or offset may be requested or withheld from future payments 6 months or more after the original payment is made (rather than 18 months or more after the original payment is made).	**OPPOSE**	**Re-referred to Assignments**
SB 2008 (Koehler)	Requires insurers to replace a brand name drug with a new generic equivalent on the formulary once it becomes available in the market or move the brand name drug to the lowest cost tier. In provisions concerning a contract between a health insurer and a pharmacy benefit manager, provides that a pharmacy benefit manager must update and publish maximum allowable cost pricing information according to specified requirements, must provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs, and must comply with specified requirements if an appeal is denied. The legislation also sets forth contracting requirements for PBMs, including fiduciary responsibilities. Similar to HB 3630 (Harris). AMENDMENT 3 removes all references to Medicaid yet keeps the underlying provisions.	**OPPOSE**	**Re-referred to Assignments**
SB 2068 (Castro)	Ratifies and approves the Nurse Licensure Compact and further provides that the compact shall not interfere with state labor laws. Identical to HB 580 (Zalewski) and similar to SB 1807 (Rose).	**SUPPORT**	**Re-referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
SB 2086 (Castro)	Creates the Vision Care Plan Regulation Act to set forth certain contractual requirements with eye care providers and disclosures and coverage requirements for enrollees.	**OPPOSE**	**Re-referred to Assignments**
SB 2111 (Fine)	Creates the Travel Insurance Act and sets forth provisions concerning the licensing and registration of travel insurance business entities. SB 1588 (Fine) sets forth the marketing requirements for travel insurance.	**MONITOR**	**Re-referred to Assignments**
SB 2241 (Murphy)	Mandates coverage for hippotherapy and other forms of therapeutic riding.	**OPPOSE**	**Re-referred to Assignments**
SB 2381 (Fine)	In provisions concerning the development of medical necessity criteria for the coverage of CSC/ACT treatment models for early treatment of serious mental illness, provides that the rules adopted by the DOI defining medical necessity shall be updated during calendar year 2021 to include nationally recognized, generally acceptable clinical criteria sourced to evidence-based medicine and to avoid unnecessary anti-competitive impacts. Identical to HB 3517 (Wheeler).	**MONITOR**	**Rr-referred to Assignments**
SB 2407 (Harris)	Requires secondary notification for life insurance lapse. Similar to SB 2112 (Harris), but removes the reference to individuals aged 64 and older. *Initiative of NAIFA-IL.*	**OPPOSE**	**Referred to Assignments**
SB 2409 (Harris)	***DOI Initiative*** adopting Holding Company Act 2014 amendments and providing for additional clean-up provisions to the existing Holding Company Act, effective immediately. Identical to HB 1955 (Jones).	**SUPPORT**	**Re-referred to Assignments**
SB 2410 (Harris)	***DOI Initiative*** providing for various Insurance Code clean-up changes, including partial codification of EO 2020-29 to allow for producer prelicensure courses to take place via webinar, effective immediately. Identical to HB 1957 (Jones).	**SUPPORT**	**Re-referred to Assignments**
SB 2518 (Rose)	Amends the Telehealth Act to add "athletic trainers" to the definition of "health care professionals" (with no additional changes made to a scope of practice act).	**MONITOR**	**Referred to Assignments**
SB 2963 (Syverson)	Fixes Department concern that the new group life continuation of coverage provisions could potentially create an unintended gap in continuation of coverage for those active employees who may be receiving or eligible to receive benefits under the prior carrier's group life policy.	**SUPPORT**	**Arrived in House**

Bill Number	Bill Description/Action	ILHIC Position	Status
SB 2969 (Morrison)	Mandates coverage of continuous glucose monitors. SA#1 Moves the effective date to 1-1-2024, add medical necessity to glucose monitors for individuals diagnosed with type1 or type 2 diabetes and requires insulin for the management of their diabetes	**NEUTRAL**	**Senate Placed on the Calendar for 3rd Reading**
SB 3001 (Gillespie)	DOI Initiative Repeal of the Small Employer Health Insurance Rating Act that will eliminate grandfathered/transitional plans (ILHIC has already raised concerns with the inclusion of this repeal and would anticipate agent and business group pushback as well).	**OPPOSE**	**Referred to Assignments**
SB 3054 (Ellman)	Mandates coverage for compression sleeves. SA #1 moves the effective date to 1-1-24 as well as add medical necessity.	**NEUTRAL With Amendment**	**Re-referred to Assignments**
SB 3067 (Fine)	Mandates coverage for congenital defects including treatment of cranial facial anomalies that are medically necessary to restore normal function or appearance. Cosmetic changes are included in coverage requirement. (Similar to HB 4349 Willis)	**NEUTRAL**	**Re-Referred to Assignments**
SB 3068 (Bush)	Creates the Immunization Data Registry Act. Provides that health care providers, physician's designees, or pharmacist's designees shall (rather than may) provide immunization data to be entered into the immunization data registry.	**MONITOR**	**Referred to Assignments**
SB 3110 (Hastings)	Creates the Access to Specialty Care Act. Currently, this is a shell bill.	**MONITOR**	**Referred to Assignments**
SB 3209 (Simmons)	Amends the Pharmacy Practice Act. Expands the pharmacist's scope of practice to include the initiation, dispensing, administration of drugs, laboratory testing, assessments, referrals, and consultations for PrEP treatment. Language states that pharmacists shall be covered and reimbursed for these services ordered and administered by a pharmacist at least 85% of the rate that physicians are reimbursed for Medicaid and other payers. Identical to HB 4430 (Cassidy)	**MONITOR**	**Re-Referred to Assignments**
SB 3466 (Munoz)	In provisions concerning prohibited payment or acceptance of rebates, provides that nothing in the language shall prohibit an insurer, by or	**NEUTRAL**	**Re-Referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	through its employees, affiliates, insurance producers, or third-party representatives, or an insurance producer acting on its own behalf, from offering or providing products or services that are at least tangentially related to an insurance contract or the administration of an insurance contract for free or for less than fair market value as long as the receipt of the products or services is not contingent upon the purchase of insurance and the products or services are offered on the same terms to all potential insurance customers based on documented objective criteria and in a manner that is not unfairly discriminatory.		
SB 3781 (Munoz)	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. Provides that the portion of the application for an insurance business transfer that would otherwise be confidential, including any documents, materials, communications, or other information submitted to the Director of Insurance in contemplation of an application, shall not lose such confidentiality. Provides that insurers consent to the jurisdiction of the Director with regard to ongoing oversight of operations, management, and solvency relating to the transferred business. Defines terms.	**OPPOSE**	**Senate Referred to Assignments**
SB 3818 (Fine)	Includes agreed language for the irrevocable assignments of benefits to purchase funeral burial services	**NEUTRAL**	**Re-Referred to Assignments**
SB 3819 (Fine)	Provides that a group or individual policy of accident and health insurance or a managed care plan amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide 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	**NEUTRAL**	**Passed 3rd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	community-based pediatric palliative and hospice care while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness. SA #1 moves the effective date to 1-1-24 as well as linked palliative care and serious illness to the Pediatric Palliative Care Act.		
SB 3910 (Fine)	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. HA # 1 Amendment includes removing the NAIC number and the fully insured/self insured portion for space as well as removing the dental card requirement on the No Surprises language (as well as a 1-1-24 effective Date).	**NEUTRAL**	**Passed Third Reading**
SB 3924 (Castro)	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 of 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	**OPPOSE**	**Re-Referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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. Similar to HB 4774 (Lilly)		
SB 3926 (Fine)	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.	**OPPOSE**	**Assigned to Senate Insurance Committee**
SB 3729 (Hunter and Feigenholtz)	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.	**OPPOSE**	**Re-Referred to Assignments**
SB 4037 (Simmons)	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	**OPPOSE**	**Re-Referred to Assignments**
SB 4041 (Simmons)	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.	**OPPOSE**	**Re-Referred to Assignments**

Bill Number	**Bill Description/Action**	**ILHIC Position**	**Status**