House Insurance (Cancelled)
February 20, 2024
2:00PM
Room C-1 Stratton

HB 4112- Infertility Coverage- ILHIC has no position on this bill.

HB 4180- Diagnostic Mammogram Coverage- In its current form, ILHIC is opposed. However, we submitted a request with the following changes. Language changes to HB 4180. These language changes include cross references to the Insurance Code Mandate. Each code has a section listing out mandates to follow in the Insurance Code. The Counties Code and Municipal Code both had this mandate already cross referenced in their codes. However, the HMO act did not cross reference so I made that change to align with the intent. We also condensed the language within the mandate while keeping the intent of the bill to apply coverage to MBI. Finally, we requested the effective date of 1-1-26 for a more seamless QHP policy filing timeline. (The Department was making this request as well). **The Sponsor has agreed to these changes and plans on filing an amendment. Once the amendment is filed, ILHIC will be Neutral on the bill.**

HB 4367- Insurance Guaranty Fund- ILHIC has no position on this bill.

HB 4421- Breast Tomosynthesis- ILHIC is opposed to this bill. ILHIC requested an effective date change to 2026 to align with DOI policy filing timelines. ILHIC has concerns regarding the increase of no-cost sharing mandates and the corresponding increase in premium costs to 30% of the insurance market regulated by state law. The Council has reached out to the Sponsor to discuss the bill.

HB 4477- Provider Nondiscrimination- ILHIC is opposed to this bill. Provider networks are a critical tool to an insurer to ensure that patients receive care that 1) achieves the quality standards of the health plans; and 2) contracts with the health plan on reimbursements. This bill completely dismantles insurance networks, which will create substantial costs to consumers.

HB 4562- Cancer Genetic Testing- ILHIC is opposed to this bill. Technical changes must include 2026 effective date. In addition, ILHIC still has concerns on intent. ILHIC has expressed to the stakeholders that this testing is included. The Council is waiting to hear back on what is considered “evidenced-based cancer imaging” within the guidelines in statute. The Council has requested these guidelines. We have not received them to date.

HB 4767- Auto Rate Review- ILHIC is opposed to this bill. We stand in solidarity with the larger insurance industry in opposition against bills that undermine critical rate setting processes.

HB 4780- Dental Loss Ratio- ILHIC is opposed to this bill. Dental benefits, which are sold by many of our health and life insurers, are typically a small but vitally important part of the portfolio of products available to IL employers and

individuals and families designed to provide financial protection while also focusing on preventive aspects of health care. Three-quarters of those with dental benefits regularly see a dentist versus less than 50% of those who don't, so the value of dental insurance clearly demonstrates that those who have it are much more likely to obtain routine cleanings and preventive exams, which ultimately translates into better overall health outcomes. HB 4780 imposing a dental loss ratio would essentially threaten those outcomes. It does not equate to more dental care and will decrease the availability of affordable dental coverage. It is important to draw a distinction between the MLR that is applied to health insurance and why a similar measurement applied to dental insurance would not yield the same outcomes. The MLR for health plans (imposed by the ACA) requires health plans to spend 80 cents out of every premium dollar collected on clinical services and quality improvement while the remaining 20 cents must cover administrative costs and profit, including claims administration, enrollments systems, salaries, overhead, and marketing. Health insurers that fail to meet the MLR standard each year must pay a rebates to their consumers. For several reasons, MLR requirements were not applied to dental plans. Dental plan premiums on average are 1/20th of the health insurance premiums (in part because health insurance is technically a mandated product while dental is voluntary). Dental plans therefore have far fewer premium dollars to support the same basic administrative functions as that of the health insurers. It is therefore reasonable to expect that dental insurers would have lower minimum loss ratios than that of the health insurers. In fact, the NAIC also recognized the impact of these fixed costs and suggested that lower loss ratios could be appropriate for limited benefit plans or lower premium products like dental plans. For example, Dental is on average $25 per member per month versus $600 per member per month for comprehensive health insurance. With the 80% MLR, Dental only has $5 PMPM for admin purposes vs. $120 PMPM for Medical. This is why no other state imposes a DLR, with the exception of MA, which did so by ballot initiative. CA for example has had an annual MLR reporting law since 2014 that authorizes the Dept of Managed Healthcare to recommend a DLR, but chose not to do so. Unlike health and dental claims that tend to be paid closer to the issue date of the policy, life insurance claims are usually larger but also paid many years after the policy is issued. Because of this, life insurers report their financial solvency using a formula and form that are different from health or dental insurance. There are also huge variations in the costs of administration between large group, small group, and individual plans. It is far more difficult to administer a loss ratio the smaller a group gets, as there are fewer economies of scale. MLR on the health side accounts for this (80% in small/individual vs. 85% in large group). MA did not recognize for these differences and therefore, it has had a compounding and chilling effect on the dental insurance market. Life insurers are not only disadvantaged, but at least one health insurance carrier has already stopped marketing their product in MA as a result, which speaks to the overarching concern that this type of proposal would have the exact opposite effect of what the dentists are suggesting in that the dental insurance market will contract.

HB 4789- Dental Preauthorization- ILHIC is opposed. There are various deviations from the language presented in HB 4789 and the agreed NCOIL model. The Council is working through the language with other stakeholders to come to a consensus on the language presented.

Senate Insurance
February 20, 2024
4:30 PM
400 Capitol

SB 2641- ILHIC is monitoring this bill and currently has no position.

SB 2735- Electronic Payment Fees- As written, ILHIC is opposed. The Council believes there is an opportunity for neutrality with further negotiations. We are currently working with our members to provide alternative language to the Sponsor.

SB 3896- Behavioral Health- ILHIC is opposed to this bill. We are currently working with the Sponsor and stakeholders on language. As written, placing reimbursement rates in statute might have the unintended consequence of lowering a

provider reimbursement that was getting reimbursed higher than what is in statute. In addition, requiring plans to reimburse providers at in-network rates, regardless of any contacting obligation, will disincentivize providers to join insurance networks, deepening the issue of access to mental health care providers in this State.

SB 3130 SBM Omnibus bill- ILHIC is currently opposed. The Council has submitted comments to the Department of Insurance and is currently working through remaining issues.

SB 3203- Inhaler Coverage- ILHIC is currently opposed to this bill. ILHIC reached out to the Sponsor to provide the following changes: 1. Deleted the health plan definition and placed standard benefit mandate language within the language of the mandate. This language is consistent with other benefit mandate bills. 2. Deleted the "" around the 2nd and 3rd prescription drug term in the definition. Now each sentence is encompassed in one definition. I didn't want readers to think there were three different definitions for prescription inhaler. 3. Changed the filing timeline to January 1, 2026. This aligned with the Department of Insurance's policy filing timelines. The Department also usually requests this change. 4. Deleted the $50 dollar coverage piece. The Council has concerns regarding rising costs of premiums to consumers through no-cost sharing mandates. Although this mandate will remain no cost sharing (by not applying to the deductible), ILHIC will be able to remove opposition by removing the $50 requirement. 5. HDHP Exemption. The Department and the Council both request standard language exemption for HDHP plans if the mandate would disqualify the consumer from participating in their health savings account. This is so any mandate does not run afoul with federal tax law. **If these changes are accepted, ILHIC will remove its opposition.**