ILHIC KEY BILLS – 3-11-2022

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 317 (Jones/Harris)	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 1811 (Andrade/Cunningham)	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**	**Passed the House**
HB 3918 (Stuart/Harmon)	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 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 March 17, 2022 8:00 AM**
HB 4271 (Kifowit/Fine)	Mandates coverage for medically necessary breast reduction surgery HA #1 moves the effective date to 1-1-2024	**NEUTRAL With Amendment**	**Senate Referred to Assignments**
HB 4324 (Morgan/Morrison)	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. HA#1 Clarifies that credit shall be certified and provided on an hour per hour basis. These credits will not be used to satisfy ethics education requirements. Defines methods for participation.	**SUPPORT**	**Senate Referred to Assignments**
HB 4335 (Stuart/Crowe)	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**	**Senate Referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 4338 (Hernandez/Villanueva)	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**	**Senate Assigned to Insurance**
HB 4349 (Willis/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. HA#1 includes Medically necessary provisions.	**NEUTRAL With Amendment**	**Senate Assigned to Insurance**
HB 4408 (Conroy/Bush)	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**	**Senate Referred to Assignments**
HB 4430 (Cassidy/ 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. HA #1 includes a provision in the Insurance Code that requires insurers to reimburse pharmacists or other health care professionals for dispensing PREP and providing services under the Act. Requires reimbursement for an "adequate consultation" fee or if medical billing is not available, an enhanced dispensing fee that is equivalent to 85% of the fees provided by advanced practice registered nurses or physicians.	**OPPOSE (Neutral with forthcoming Amendment in the Senate)**	**Senate Referred to Assignments**
HB 4433 (Morgan/Harris)	This language includes model language for Copay Accumulators. This language was agreed to by the Stakeholders, DOI, and ILHIC.	**SUPPORT**	**Senate Referred to Assignments**
HB 4493 (Morgan/Harris)	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**	**Senate Referred to Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 4595 (Harris/ Hunter)	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. HA #1 removes prohibition regarding billing modifiers to indicate that a drug claim in purchased for a 340B.	**NEUTRAL with amendment**	**Senate Referred to Assignments**
HB 4703 (Morgan/ Gillespie)	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	**NEUTRAL with amendment**	**Senate Referred to Assignments**

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	Insurance Code concerning billing and cost sharing. Makes other changes. Effective July 1, 2022, except that certain changes take effect January 1, 2023. HA #1Clarified ILHIC's concerns,. However, ILHIC intends to keep working with the Department as federal outcomes re: litigation play out.		
HB 4929 (Mah/Murphy)	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**	**Senate Referred to Assignments**
HB 4941 (Mah/Fine)	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. HA# 1 separates fee schedule notifications into two different "buckets," being routine, and non-routine. Non routine changes are changes not required by law, regulation, or regulatory authority. The amendment lowers the notice to provides to 60 days (instead of 90). In addition, the language regarding non routine changes shall be provided via email, or if requested by the provider, mail.	**NEUTRAL with amendment**	**Senate Referred to Assignments**
HB 4979 (Manley/Connor)	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	**NEUTRAL with amendment**	**Senate Referred to Assignments**

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	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 5142 (Harris/ Stadleman)	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. HA #2 is a gut and replace amendment requiring HFS and DOI to submit a form by ?June 1 and November 1 to provide the Department of Revenue describing health insurance enrollment option for taxpayers. The Department of Revue will then send the information to taxpayers who request it. Language includes if a SBE becomes operational, that the Exchange must interface with the Illinois tax system.	**SUPPORT**	**Senate Referred to Assignments**
HB 5254 (Wheeler/Holmes)	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**	**Senate Assigned to Insurance**
HB 5318 (Ford/Jones III)	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	**NEUTRAL with Amendment**	**Senate Referred to Assignments**

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	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.		
HB 5334 (Stuart/Crowe)	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**	**Senate Assigned to Insurance**
HB 5534 (Jones/ Cunningham)	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. HA #1 adds reinsurers to the language.	**OPPOSE**	**Senate Referred to Assignments**
HB 5585 (Lilly/Harris)	Home Health Services Mandate Mandates coverage for access to home health services for the duration of medically necessary care.	**NEUTRAL**	**Senate Referred to Assignments**
SB 1099 (Collins/Tarver)	Creates the Consumer Legal Funding Act. Sets forth provisions concerning consumer legal funding contract requirements and right of rescission. Sets forth consumer legal funding company prohibitions. Sets forth the fees that may be charged by a consumer legal funding company and provides that a consumer legal funding company shall not collect any additional fees besides those specified in the Act. Provides that all consumer legal funding contracts shall contain specified disclosures. Provides that the contingent right to receive an amount of the potential proceeds of a legal claim is assignable by a consumer. Provides that an attorney or law firm retained by the consumer in	**MONITOR**	**Assigned to Judiciary- Civil Committee March 16, 2022 9:00 AM**

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	the legal claim shall not have a financial interest in the consumer legal funding company offering consumer legal funding to that consumer. Sets forth provisions concerning application and fees for a consumer legal funding license.		
SB 2963 (Syverson/Keicher)	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**	**Assigned to Insurance Committee March 15, 2022 3:00PM**
SB 2969 (Morrison/Mah)	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 with amendment**	**Assigned to Insurance Committee March 15, 2022 3:00PM**
SB 3819 (Fine/Gabel)	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 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.	**NEUTRAL with amendment**	**Assigned to Insurance Committee March 15, 2022 3:00PM**
SB 3910 (Fine/Jones)	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	**NEUTRAL with amendment**	**Assigned to Insurance Committee March 15, 2022 3:00PM**

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	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).		
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**