| | | | HOUSE BILLS | | |
|---|---|---|---|---|---|
| **Product Line Life/Health/All** | **Bill "Nickname"** | **Bill Number/Link** | **Bill Description/Action** | **ILHIC Position** | **Status** |
| Health | Consumer Health Care Access Liaison | HB 0440 (HFA 0001) Morgan | **Amendment - (RE-REFERRED TO RULES)** *Replaces everything after the enacting clause. Amends the Department of Insurance Law of the Civil Administrative Code of Illinois. Provides that the Governor, with the advice and consent of the Senate, shall appoint a person within the Department of Insurance to serve as the Consumer Health Care Access Liaison for the State of Illinois. Provides that the Consumer Health Care Access Liaison shall receive an annual salary as set by the Governor and beginning July 1, 2023 shall be compensated from appropriations made for this purpose. Provides that the person appointed Consumer Health Care Access Liaison may be an existing employee with other duties. Provides that the Consumer Health Care Access Liaison shall have authority to oversee and direct functions at other State agencies related to network adequacy issues in Illinois, including, but not limited to, the Department of Public Health, the Department of Financial and Professional Regulation, and the Department of Healthcare and Family Services. Makes a conforming change in the Network Adequacy and Transparency Act.* ***Effective immediately.*** | Monitor | HOUSE Re-Referred to Rules |
| Health | Wholesale Acquisition Cost | HB 1034 Flowers | Provides that the amendatory provisions apply to any manufacturer of a prescription drug that is purchased or reimbursed by specified parties. Provides that a manufacturer of a prescription drug with a wholesale acquisition cost of more than $40 for a course of therapy shall notify specified parties if the increase in the wholesale acquisition cost of the prescription drug is more than 10%, including the proposed increase and cumulative increase. Provides that the notice of price increase shall be provided in writing at least 60 days prior to the planned date of the increase. Provides that no later than 30 days after notification of a price increase or new prescription drug the manufacturer shall report specified additional information to specified parties. Provides that a manufacturer of a prescription drug shall provide written notice if the manufacturer is introducing a new | Monitor | HOUSE Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | prescription drug to market at a wholesale acquisition cost that exceeds a specified threshold. Provides that failure to provide notice under the amendatory provisions shall result in a civil penalty of $10,000 per day for every day after the notification period that the manufacturer fails to report the information. Requires the Department of Public Health to conduct an annual public hearing on the aggregate trends in prescription drug pricing. Requires the Department to publish on its website a report detailing findings from the public hearing and a summary of details from reports provided under the amendatory provisions, except for information identified as a trade secret or exempted under the Freedom of Information Act. Provides that the amendatory provisions shall not restrict the legal ability of a pharmaceutical manufacturer to change prices as permitted under federal law. | | |
| Health | Defined Cost Sharing Rx Drugs (Rebates) | HB 1054 Mayfield | Provides that a group or individual policy of accident and health insurance amended, delivered, issued, or renewed on or after January 1, 2024 that provides coverage for prescription drugs shall require that a covered individual's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100% of all rebates received in connection with the dispensation or administration of the prescription drug. Provides that an insurer shall apply any rebate amount in excess of the defined cost sharing amount to the health plan to reduce premiums. Provides that the provisions shall not preclude an insurer from decreasing a covered individual's defined cost sharing by an amount greater than the stated amount at the point of sale. | Oppose | HOUSE Re-Referred to Rules |
| Health | Health Care For All | HB 1094 Flowers | Creates the Health Care for All Illinois Act. Provides that all individuals residing in this State are covered under the Illinois Health Services Program for health insurance. Sets forth requirements and qualifications of participating health care providers. Sets forth the specific standards for provider reimbursement. Provides that it is unlawful for private health insurers to sell health insurance coverage that duplicates the coverage of the program. Requires the State to establish the Illinois Health Services Trust to provide financing for the program. Sets forth the specific requirements for claims billed under the program. Provides that the program shall include funding for long- | Oppose | HOUSE Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | term care services and mental health services. Creates the Pharmaceutical and Durable Medical Goods Committee to negotiate the prices of pharmaceuticals and durable medical goods with suppliers or manufacturers on an open bid competitive basis. Provides that patients in the program shall have the same rights and privacy as they are entitled to under current State and federal law. Provides that the Commissioner, the Chief Medical Officer, the public State board members, and employees of the program shall be compensated in accordance with the current pay scale for State employees and as deemed professionally appropriate by the General Assembly. ***Effective July 1, 2023.*** | | |
| Health | State Based Exchange | HB 1229<br>Jones | Amends the Illinois Health Benefits Exchange Law. Provides that the Department of Insurance has the authority to operate the Illinois Health Benefits Exchange. Provides that the Director of Insurance may require plans in the individual market to be made available for comparison on the exchange, but may not require all plans be purchased exclusively on the exchange. Provides that the Director may require that plans offered on the exchange conform with standardized plan designs. Provides that the Director may apply a monthly assessment to each health benefits plan sold in the Illinois Health Benefits Exchange according to specified rates. Provides that the Director shall establish an advisory committee to provide advice to the Director concerning the operation of the exchange and that the advisory committee shall include specified members. Provides that the Department shall also have the authority to coordinate the operations of the exchange with the operations of the State Medicaid program and the FamilyCare Program to determine eligibility for those programs as soon as practicable. Provides that the Department shall adopt rules. Removes provisions concerning small employer health insurance coverage and markets. Makes other changes. ***Effective January 1, 2024*** | Oppose<br>This is not the Administration's State Based Exchange Bill | HOUSE<br>Re-Referred to Rules |
| Health | Health Plan Benefit Data | HB 1348<br>Collins | Provides that no later than July 1, 2024, each health plan and pharmacy benefit manager operating in this State shall, upon request of a covered individual, his or her health care provider, or an authorized third party on his or her behalf, furnish specified cost, benefit, and coverage data to the covered individual, his or her health | Oppose | HOUSE<br>Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | care provider, or the third party of his or her choosing and shall ensure that the data is: (1) current no later than one business day after any change is made; (2) provided in real time; and (3) in a format that is easily accessible to the covered individual or, in the case of his or her health care provider, through an electronic health records system. | | |
| Health | Family Care Plans For Infants | HB 1468<br>Ford | Requires the Department of Public Health, in consultation with specified agencies and entities, to develop guidelines for hospitals, birthing centers, medical providers, Medicaid managed care organizations, and private insurers on how to conduct a family needs assessment and create a family care plan for an infant who may exhibit clinical signs of withdrawal from a controlled substance or medication. Requires an infant's family care plan to include a family needs assessment performed by a social worker or any other appropriate and trained individual or agency.<br>HB 1468 (HCA 0001) **(REFERRED TO ADOPTION & CHILD WELFARE)**<br>*Replaces everything after the enacting clause. Creates the Family Recovery Plans Implementation Task Force Act. Provides that it is the intent of the General Assembly to require a coordinated, public health, and service-integrated response by various agencies within the State's health and child welfare systems to address the substance use treatment needs of infants born with prenatal substance exposure, as well as the treatment needs of their caregivers and families, by requiring the development, provision, and monitoring of family recovery plans. Creates the Family Recovery Plan Implementation Task Force within the Department of Human Services to review models of family recovery plans that have been implemented in other states; review research regarding implementation of family recovery plans care; and develop recommendations regarding the implementation of a family recovery plan model in Illinois, including developing an implementation plan and identifying any necessary policy, rule, or statutory changes. Contains provisions concerning the composition of the Task Force; meetings; co-chairs; administrative support; and reporting requirements. Provides that the Task Force is dissolved, and the Act is repealed, on January 1, 2027. Amends the Abused and Neglected Child Reporting Act. Requires the Department of Children and Family Services to develop a standardized CAPTA notification form* | Monitor<br><br>Monitor with Amendment #1 | HOUSE Assigned to Family Preservation Subcommittee |

| | | | | | |
|---|---|---|---|---|---|
| | | | *that is separate and distinct from the form for written confirmation reports of child abuse or neglect. Defines "CAPTA notification" to mean notification to the Department of an infant who has been born and identified as affected by prenatal substance exposure or a fetal alcohol spectrum disorder as required under the federal Child Abuse Prevention and Treatment Act. Provides that a CAPTA notification shall not be treated as a report of suspected child abuse or neglect, shall not be recorded in the State Central Registry, and shall not be discoverable or admissible as evidence in any proceeding pursuant to the Juvenile Court Act of 1987 or the Adoption Act unless the named party waives his or her right to confidentiality in writing. Repeals a provision requiring the Department of Children and Family Services to report to the State's Attorney whenever the Department receives a report that a newborn infant's blood contains a controlled substance. Amends the Juvenile Court Act of 1987. Removes newborn infants whose blood, urine, or meconium contains any amount of a controlled substance from the list of children presumed neglected or abused under the Act. In a provision listing the types of evidence that constitutes prima facie evidence of neglect, removes from the list: (i) proof that a minor has a medical diagnosis of fetal alcohol syndrome; (ii) proof that a minor has a medical diagnosis at birth of withdrawal symptoms from narcotics or barbiturates; and (iii) proof that a newborn infant's blood, urine, or meconium contains any amount of a controlled substance. Amends the Adoption Act. In the definition of "unfit parent", removes language providing that there is a rebuttable presumption that a parent who gives birth is unfit if a test result confirms that at birth the child's blood, urine, or meconium contained any amount of a controlled substance. Removes language providing that a parent is unfit if there is a finding that at birth the child's blood, urine, or meconium contained any amount of a controlled substance and that the biological mother of the child is the biological mother of at least one other child who was adjudicated a neglected minor by a court in accordance with the Juvenile Court Act of 1987.* ***Effective immediately.*** | | |
| Health | Provider Non-discrimination | HB 1601 Hoffman | Prohibits issuers from discriminating with respect to participation of a non-participating provider, mandating issuers to reimburse these | Oppose | HOUSE Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | providers acting within the scope of the providers license, regardless if they are in network or not. | | |
| Health | Coverage Mandate low-dose Mammography | HB 2078 Faver Dias | Amends the Accident and Health Article of the Illinois Insurance Code. Provides that coverage for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer shall include a screening MRI or ultrasound (rather than a screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches). | Oppose | HOUSE Re-Referred to Rules |
| Health | Colonoscopy Coverage Mandate | HB 2385 Nichols | Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after January 1, 2024 shall provide coverage for a colonoscopy determined to be medically necessary for persons aged 39 years old to 75 years old.<br>HB 2385 (HFA 0001) **(RE-REFERRED TO RULES)**<br>*Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after January 1, 2024 shall provide coverage for a colonoscopy determined to be medically necessary (rather than determined to be medically necessary for persons aged 39 years old to 75 years old).* | Oppose<br><br>Oppose with Amendment #1<br><br>***Need effective date change*** | HOUSE Re-Referred to Rules |
| Health | Air Ambulance | HB 2391 Scherer | Provides that ground ambulance services are subject to provisions concerning billing for emergency services and nonparticipating providers. Changes the definition of "health care provider" to include ground ambulance services. ***Effective immediately***. | Monitor | HOUSE Referred to Rules |
| Health | Senior Fitness Coverage Mandate | HB 2445 Manley | Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage for basic fitness center membership costs for individuals 65 years of age and older. Makes conforming changes in the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Illinois Public Aid Code. | Oppose | HOUSE Re-Referred to Rules |
| Health | Adverse Determination | HB 2472 Morgan | Department's Adverse Determination bill | Oppose (working with DOI) | HOUSE |

| | | | | | |
|---|---|---|---|---|---|
| | | | HB 2472 (HCA 0001) **(REFERRED TO RULES)**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Makes changes in provisions concerning uniform medical claim and billing forms. Provides that no law or rule shall be construed to exempt any utilization review program from specified administration and enforcement requirements of the Managed Care Reform and Patient Rights Act with respect to specified forms of insurance. Amends the Dental Service Plan Act, the Health Maintenance Organization Act, the Limited Health Service Organization Act, and the Voluntary Health Services Plans Act. Provides that fraternal benefit societies, dental service plan corporations, health maintenance organizations, limited health service organizations, and health services plan corporations are subject to provisions of the Illinois Insurance Code concerning uniform medical claim and billing forms. Amends the Health Carrier External Review Act. Makes changes in the definitions of "adverse determination" and "final adverse determination". Amends the Managed Care Reform and Patient Rights Act. Provides that even if a health care plan or other utilization review program uses an algorithmic automated process in the course of utilization review, the health care plan or other utilization review program shall ensure that only a clinical peer makes any adverse determination, and that any appeal is processed as required under the provisions, including the restriction that only a clinical peer may review an appeal. Makes other changes concerning utilization review. Provides that utilization review programs that use algorithmic automated processes in the course of utilization review shall use objective, evidence-based criteria compliant with the accreditation requirements of the Health Utilization Management Standards of the Utilization Review Accreditation Commission or the National Committee for Quality Assurance (NCQA) and shall provide proof of such compliance to the Department of Insurance with the required registration. Amends the Prior Authorization Reform Act. Provides that if a health insurance issuer imposes a monetary penalty on the enrollee for the enrollee's, health care professional's, or health care provider's failure to obtain any form of prior authorization for a health care service, the penalty may not exceed the lesser of the actual cost of the health care service* | Neutral with Amendment #1 | Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | *or $1,000 per occurrence in addition to the plan cost-sharing provisions. Provides that a health insurance issuer may not require both the enrollee and the health care professional or health care provider to obtain any form of prior authorization for the same instance of a health care service, nor otherwise require more than one prior authorization for the same instance of a health care service.* ***Effective January 1, 2025.*** | | |
| Health | Eating Disorder Task Force | HB 2498<br>~~Costa~~<br>~~Howard~~<br>Blair Sherlock | Creates the Eating Disorder Treatment Parity Task Force within the Department of Insurance to review reimbursement to eating disorder treatment providers in Illinois as well as out-of-state providers of similar services. Provides for the membership of the Task Force. Provides that the Task Force shall elect a chairperson from its membership and shall have the authority to determine its meeting schedule, hearing schedule, and agendas. Provides that appointments shall be made within 60 days after the effective date of the amendatory Act. Provides that the Task Force shall review insurance plans and rates and provide recommendations for rules, and the findings, recommendations, and other information determined by the Task Force to be relevant shall be made available on the Department's website. Provides that the Task Force shall submit findings and recommendations to the Director of Insurance, the Governor, and the General Assembly by December 31, 2023. Provides for repeal of the provisions on January 1, 2025. | Monitor | HOUSE<br>Re-Referred to Rules |
| Health | Telehealth-Treat – UNI Student | HB2550<br>Rohr<br>Villivalam | Amends the Telehealth Act. Provides that a health care professional may treat a patient located in another state if the patient is a student attending an out-of-state institution of higher education but is otherwise a resident in the State when not attending the institution of higher education.<br>HB2550 HFA001 **(ADOPTED)**<br>*Replaces everything after the enacting clause. Amends the Telehealth Act. Provides that an out-of-state health care professional may treat a patient located in this State through telehealth if the patient is a student attending an institution of higher education in this State, but is otherwise not a resident of the State when not attending the institution of higher education.* | Monitor | SENATE<br>Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| Health | Network Adequacy Specialists | HB 2580 Hauter | Provides that the Department of Insurance shall determine whether the network plan at each in-network hospital and facility has a sufficient number of hospital-based medical specialists to ensure that covered persons have reasonable and timely access to such in-network physicians and the services they direct or supervise. Defines "hospital-based medical specialists". | Monitor | HOUSE Assigned to Insurance |
| Health | Medicare Reimbursement Rate pending resolution | HB 2581 Hauter | Provides that for any bill submitted to arbitration, the health insurance issuer shall pay the provider or facility at least the current Medicare reimbursement rate pending the resolution of the arbitration. | Oppose | HOUSE Assigned to Insurance |
| Health | Repeal Reproductive Health Act | HB 2606 Niemerg | Repeals the Reproductive Health Act | Neutral | HOUSE Referred to Rules |
| Health | Short Term Limited Duration Plans | HB 2613 Davis | Provides that any short-term, limited duration health insurance coverage policy that is delivered or issued for delivery in the State must have an expiration date in the policy that is less than 181 days after the effective date or December 31 of the current year, whichever is later (rather than must have an expiration date in the policy that is less than 181 days after the effective date). | Neutral | HOUSE Assigned to Insurance (Main Subcommittee) |
| Health | Electronic Communication | HB 2779 Rita | Provides that the plan sponsor of a health benefit plan may, on behalf of persons covered by the plan, provide the consent to the mailing of all communications related to the plan by electronic means and to the electronic delivery of any health insurance identification card; that before consenting on behalf of a party, a plan sponsor must confirm that the party routinely uses electronic communications during the normal course of employment; and that before providing communications or delivery by electronic means, the insurer providing the health benefit plan must provide the covered person an opportunity to opt out of communications or delivery by electronic means. | Neutral | HOUSE Referred to Rules |
| Health | White Bagging | HB 2814 Lilly | Provides that a health benefit plan amended, delivered, issued, or renewed on or after January 1, 2023 that provides prescription drug coverage or its contracted pharmacy benefit manager shall not engage in or require an enrollee to engage in specified prohibited acts. Provides that a clinician-administered drug supplied shall meet the | Oppose | HOUSE Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | supply chain security controls and chain of distribution set by the federal Drug Supply Chain Security Act. | | |
| Health | Health Gaps Study | HB 2815 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. Requires the Department to submit a report of its findings and recommendations to the General Assembly 12 months after the effective date of the amendatory Act. Amends the Hospital Licensing Act and the University of Illinois Hospital Act. Provides that hospitals licensed under the Act shall provide health insurance coverage to all of their workforce. | Monitor | HOUSE Re-Referred to Rules |
| Health | Prosthetic Device Mandate | HB 3036 Guzzardi | Provides that with respect to an enrollee at any age, in addition to coverage of a prosthetic or custom orthotic device, benefits shall be provided for a prosthetic or custom orthotic device determined by the enrollee's provider to be the most appropriate model that is medically necessary for the enrollee to perform physical activities, as applicable, such as running, biking, swimming, and lifting weights, and to maximize the enrollee's whole body health and strengthen the lower and upper limb function. Provides that the requirements of the provisions do not constitute an addition to the State's essential health benefits that requires defrayal of costs by the State pursuant to specified federal law. | Oppose | HOUSE Referred to Rules |
| Health | Contraceptive Coverage Mandate | HB 3148 Avelar | Provides that an individual or group policy of accident and health insurance amended, delivered, issued, or renewed in the State after January 1, 2024 shall provide coverage for emergency contraceptives. ***Effective immediately.*** | Oppose | HOUSE Re-Referred to Rules |
| Health | Coronary Calcium Scan | HB 3183 Weber | Provides that an individual or group policy of accident and health insurance that is amended, delivered, issued, or renewed on or after January 1, 2025 shall cover a medically necessary coronary calcium scan and scoring every 24 months for individuals over the age of 40. Defines "coronary calcium scan and scoring". Makes conforming changes in the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health | Neutral | HOUSE Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Medical Assistance Article of the Illinois Public Aid Code. ***Effective January 1, 2024.*** | | |
| Health | Health Care Rare Condition Mandate | HB 3229 LaPointe | Amends the Illinois Insurance Code to require an insurance policy to provide 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 coverage required under the Section. | Oppose | HOUSE Referred to Rules |
| Health | Neonatal Cost Care | HB 3251 Rita | Amends the Accident and Health Article of the Illinois Insurance Code. Provides that no health insurer may charge a patient out-of-network rates for neonatal care at any hospital. | Oppose | HOUSE Re-Referred to Rules |
| Health | Menopause Society Mandate | HB 3347 Costa Howard | Provides that a group or individual policy of accident and health insurance that is amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide, for individuals 40 years of age and older, coverage for an annual menopause health visit with a North American Menopause Society Certified Menopause Practitioner without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement upon the insured. | Oppose | HOUSE Referred to Rules |
| Health | Drugs From Canada | HB 3490 Huynh | Provides that the Department of Public Health shall establish the canadian prescription drug importation program for the importation of safe and effective prescription drugs from Canada which have the highest potential for cost savings to the State. Provides that the | Monitor | HOUSE Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | Department shall contract with a vendor to provide services under the program. Provides that by December 1, 2023, and each year thereafter, the vendor shall develop a wholesale prescription drug importation list identifying the prescription drugs that have the highest potential for cost savings to the State. Provides that the vendor shall identify Canadian suppliers that are in full compliance with the provisions of the Act and contract with the Canadian suppliers to import drugs under the program. Provides for: a bond requirement; requirements for eligible prescription drugs; requirements for eligible Canadian suppliers; requirements for eligible importers; distribution requirements; federal approval; prescription drug supply chain documentation; immediate suspension of specified imported drug; requirements of an annual report; notification of federal approval. | | |
| Health | Medicaid Option | HB 3496 Olickal | Provides that on or after the effective date of the amendatory Act, an insurer shall allow a covered individual to purchase a health plan offered pursuant to the medical assistance program under the Illinois Public Aid Code. | Oppose | HOUSE Assigned to Appropriations – Health & Human Services |
| Health | Long Acting Contra Info Act | HB3585 Weber | Creates the Long-Acting Reversible Contraception Information Act. Provides that the Department of Public Health shall create and allocate funding for an online learning module to promote postpartum and postabortion long-acting reversible contraception insertion. Provides that long-acting reversible contraception services and information may be provided by physicians to any minor over the age of 12 who meets specified qualifications. Provides that the Department shall provide printed materials, guidance, and information on how to obtain low-cost and no-cost contraceptives. Provides that the Department shall develop a long-acting reversible contraception promotion plan intended to reduce cases of neonatal abstinence syndrome and fetal substance exposure. Provides that the Department shall produce an annual report on the program. Provides that the Department shall adopt rules necessary to carry out the Act. Amends the Illinois Insurance Code. Provides that an individual or group policy of accident and health insurance shall also cover long-acting reversible contraception on the day of the abortion as long as the procedure is | Monitor | HOUSE Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | medically feasible. Amends the Pharmacy Practice Act. Provides that a pharmacist licensed under the Act who dispenses self-administered hormonal contraceptives shall provide the patient with information on the effectiveness and availability of intrauterine devices and implants. Amends the Reproductive Health Act. Provides that a health care professional shall provide information about intrauterine devices at the time that a health care professional performs an abortion. | | |
| Health | Protect Health Data Act | HB 3603 Williams | Provides that a regulated entity shall disclose and maintain a health data privacy policy that, in plain language, clearly and conspicuously discloses specified information. Provides that a regulated entity shall prominently publish its health data privacy policy on its website homepage. Provides that a regulated entity shall not collect, share, sell, or store categories of health data not disclosed in the health data privacy policy without first disclosing the categories of health data and obtaining the consumer's consent prior to the collection, sharing, selling, or storing of such data. Prohibits the collection, sharing, selling, or storing of health data. Describes the regulated entity's duty to obtain consent; the consumer's right to withdraw consent; prohibitions on discrimination; prohibitions on geofencing; a private right of action; enforcement by the Attorney General; and conflicts with other laws. | Oppose | HOUSE Re-Referred to Rules |
| Health | PBM Prohibitions | HB 3761 Guzzardi | Provides that a pharmacy benefit manager may not prohibit a pharmacy or pharmacist from selling a more affordable alternative to the covered person if a more affordable alternative is available. Provides that a pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmaceutical product. Provides that a pharmacy benefit manager is prohibited from conducting spread pricing in the State. Sets forth provisions concerning pharmacy network participation, fiduciary responsibility, and pharmacy benefit manager transparency. Provides that a pharmacy benefit manager shall report to the Director on a quarterly basis and that the report is confidential and not subject to disclosure under the Freedom of Information Act. Provides that the provisions apply to contracts entered into or renewed on or after July 1, 2023 (rather than July 1, 2022). Defines terms. Amends the Network Adequacy and | Oppose | HOUSE Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | Transparency Act. Sets forth provisions concerning pharmacy benefit manager network adequacy. Makes other changes. | | |
| Health | PBM Steering Prohibition | HB 3787<br>Lilly | Provides that a pharmacy benefit manager shall not: steer a beneficiary; order a covered individual to fill a prescription or receive pharmacy care services from an affiliated pharmacy; reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the amount that the pharmacy benefit manager reimburses itself or an affiliate for providing the same product or services; offer or implement plan designs that require patients to use an affiliated pharmacy; or advertise, market, or promote a pharmacy by an affiliate to patients or prospective patients | Oppose | HOUSE<br>Re-Referred to Rules |
| Health | First Responder/ Veteran Cost Share | HB 3812<br>Guerrero-Cuellar | Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide any mental health treatment coverage without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement for any police officer, firefighter, emergency medical services personnel, or veteran.<br>HB 3812 (HFA 0001) **(RE-REFERRED TO RULES)**<br>*Removes provisions concerning the Illinois Public Aid Code.*<br>HB 3812 (HFA 0002) **(RE-REFERRED TO RULES)**<br>*Replaces everything after the enacting clause. Amends the Counties Code and the Illinois Municipal Code. Provides that, if a municipality or county, including a home rule municipality or county, is a self-insurer for purposes of providing health insurance coverage for its employees, the insurance coverage shall include mental health counseling for any police officer, firefighter, emergency medical services personnel, or employee who is a veteran without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage to the extent such coverage would disqualify a high-deductible health plan from eligibility from a health savings account pursuant to the Internal Revenue Code. Preempts home rule.* | Oppose<br><br>Oppose with Amendment #1<br><br>Neutral with Amendment #2 | HOUSE<br>Re-Referred to Rules |
| Health | Medicare for All | HB 3855<br>Huynh | Provides that all individuals residing in the State are covered under the Illinois Health Services Program for health insurance. Sets forth the health coverage benefits that participants are entitled to under the Program. Sets forth the qualification requirements for participating | Oppose | HOUSE<br>Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | health providers. Sets forth standards for provider reimbursement. Provides that it is unlawful for private health insurers to sell health insurance coverage that duplicates the coverage of the Program. Provides that investor-ownership of health delivery facilities is unlawful. Provides that the State shall establish the Illinois Health Services Trust to provide financing for the Program. Sets forth the requirements for claims billing under the Program. Provides that the Program shall include funding for long-term care services and mental health services. Provides that the Program shall establish a single prescription drug formulary and list of approved durable medical goods and supplies. Creates the Pharmaceutical and Durable Medical Goods Committee to negotiate the prices of pharmaceuticals and durable medical goods with suppliers or manufacturers on an open bid competitive basis. Sets forth provisions concerning patients' rights. Provides that the employees of the Program shall be compensated in accordance with the current pay scale for State employees and as deemed professionally appropriate by the General Assembly. ***Effective January 1, 2024.*** | | |
| Health | Policy Readability | HB 3861 Benton | Requires insurance policies to be written in language easily readable and understandable by a person of average intelligence and education. Provides the factors the Director of Insurance shall consider in making the determination that the policy is easily readable and understandable by a person of average intelligence and education. | Oppose | HOUSE Re-Referred to Rules |
| Health | Cranial Prostheses Mandate | HB 3920 Meyers-Martin | Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage for cranial prostheses when prescribed as part of a course of rehabilitative treatment by a physician licensed to practice medicine in all of its branches. Makes conforming changes in the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Medical Assistance Article of the Illinois Public Aid Code | Oppose | HOUSE Re-Referred to Rules |
| Health | Congenital Anomaly Mandate | HB 3974 Mason | Provides that an individual or group policy of accident and health insurance amended, delivered, issued, or renewed after the effective date of the amendatory Act shall cover charges incurred and services provided for outpatient and inpatient care in conjunction with services | Oppose | HOUSE Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | that are provided to a covered individual related to the diagnosis and treatment of a congenital anomaly or birth defect. Provides that the required coverage includes any service to functionally improve, repair, or restore any body part involving the cranial facial area that is medically necessary to achieve normal function or appearance. Provides that any coverage provided may be subject to coverage limits, such as pre-authorization or pre-certification, as required by the plan or issuer that are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Provides that the coverage does not apply to a policy that covers only dental care. Defines "treatment". ***Effective January 1, 2024.*** | | |
| Health | Network Adequacy & Transparency Act | HB 4025 Scherer | Amends the Network Adequacy and Transparency Act. Provides that the Department of Insurance shall create a Network Adequacy Unit within the Department for the purpose of investigating insurers for compliance with the Act and enforcing its provisions. Provides that the Director of Insurance may hire and retain insurance analysts, managers, actuaries, and any other staff necessary to operate the Network Adequacy Unit. Provides that the Director may, in the Director's sole discretion, publicly acknowledge the existence of an ongoing network adequacy market conduct examination before filing the examination report. ***Effective July 1, 2023***. | Oppose | HOUSE Referred to Rules |
| Health | Prior Authorization Emergency | HB4055 Hauter | Amends the Prior Authorization Reform Act. Changes the definition of "emergency services" to provide that for the purposes of the provisions, emergency services are not required to be provided in the emergency department of a hospital. Provides that notwithstanding any other provision of law, a health insurance issuer or a contracted utilization review organization may not require prior authorization or approval by the health plan for emergency services. | Oppose | HOUSE Assigned to Insurance |
| Health | INS CD – Infertility Coverage | HB4112 Croke | Amends the Illinois Insurance Code. Provides that no group policy of accident and health insurance providing coverage for more than 25 employees that provides pregnancy related benefits may be issued, amended, delivered, or renewed in this State on or after January 1, 2025 unless the policy contains coverage for the diagnosis and treatment of infertility. Requires such coverage to include procedures necessary to screen or diagnose a fertilized egg before implantation. | Monitor | HOUSE 2nd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | Provides that coverage for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if the procedures: (1) are considered medically appropriate based on clinical guidelines or standards developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the Society for Assisted Reproductive Technology; and (2) are performed at medical facilities or clinics that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization or the American Society for Reproductive Medicine minimum standards for practices offering assisted reproductive technologies. Makes changes in the Counties Code, the Illinois Municipal Code, the School Code, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Illinois Public Aid Code to provide that infertility insurance must be included in health insurance coverage for employees. ***Effective immediately.***<br>HB 4112 (HCA 0001) **(ADOPTED)**<br>*Replaces everything after the enacting clause with the provisions of the introduced bill, and makes the following changes: Amends the State Employees Group Insurance Act of 1971. Provides that the infertility insurance provision added by Public Act 103-8 (effective January 1, 2024) applies only to coverage provided on or after January 1, 2024 and before January 1, 2026. Repeals the provision regarding infertility coverage on January 1, 2026. In a provision regarding infertility coverage in the Illinois Insurance Code, removes language limiting the group policy of accident and health insurance providing pregnancy related benefits to those that provide coverage for more than 25 employees.* ***Effective December 31, 2025.***<br>HB 4112 (HCA 0002) **(TABLED)**<br>*In the State Employees Group Insurance Act of 1971, provides that the infertility insurance provision added by Public Act 103-8 (effective January 1, 2024) applies only to coverage provided on or after January 1, 2024 and before July 1, 2026 (rather than January 1, 2026). Repeals the provision regarding infertility coverage on July 1, 2026 (rather than January 1, 2026). Removes changes to the Illinois Public Aid Code.*<br>HB 4112 (HFA 0003) **(RULES RECOMMENDS ADOPTED )** | Neutral with Amendment #1<br><br>Neutral with Amendment #2 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *In the State Employees Group Insurance Act of 1971, provides that the infertility insurance provision added by Public Act 103-8 (effective January 1, 2024) applies only to coverage provided on or after January 1, 2024 and before July 1, 2026 (rather than January 1, 2026). Repeals the provision regarding infertility coverage on July 1, 2026 (rather than January 1, 2026). Removes changes to the Illinois Public Aid Code.* HB 4112 (HFA 0004) **(REFERRED TO RULES)** *In the State Employees Group Insurance Act of 1971, provides that the infertility insurance provision added by Public Act 103-8 (effective January 1, 2024) applies only to coverage provided on or after January 1, 2024 and before July 1, 2026 (rather than January 1, 2026). Repeals the provision regarding infertility coverage on July 1, 2026 (rather than January 1, 2026). In the Illinois Insurance Code, makes stylistic changes. Removes changes to the Illinois Public Aid Code.* | Neutral with Amendment #3<br><br>Neutral with Amendment #4 | |
| Health | Prohibition Advanced Payment | HB4154 Harper | Amends the Medical Patient Rights Act. Provides that a patient who is covered under a policy of accident and health insurance, dental plan, or vision care plan is entitled to receive medical, dental, or eye care services without being required to pay an amount in excess of the estimated cost share, copayment, or deductible before those services are provided if such services are typically covered under the policy of accident and health insurance, dental plan, or vision care plan. | Monitor | HOUSE Assigned to Insurance (Main Subcommittee) |
| Health | Mammogram Coverage | HB4180 Syed | Amends the Counties Code, the Illinois Municipal Code, the Illinois Insurance Code, the Health Maintenance Organization Act, and the Illinois Public Aid Code. In provisions concerning coverage for mammograms, provides that coverage for certain types of mammography shall be made available to patients of a specified age (rather than only women of a specified age). Makes changes to require coverage for molecular breast imaging and, in those cases where its not already covered, magnetic resonance imaging of breast tissue. Provides that the Department of Healthcare and Family Services shall convene an expert panel, including representatives of hospitals, free-standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including radiologists that are trained in all forms of FDA approved breast imaging technologies, breast surgeons, reconstructive breast, surgeons, oncologists, and primary care | Oppose | HOUSE 2nd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | providers to establish quality standards for breast cancer treatment. Makes technical changes. ***Effective immediately.***<br>HB 4180 (HCA 0001) **(ADOPTED)**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Provides that an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026 shall provide coverage for molecular breast imaging (MBI) of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches. Amends the Health Maintenance Organization Act. Subjects health maintenance organizations to provisions of the Illinois Insurance Code that require coverage for mammograms, mastectomies and certain other breast cancer screenings. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the Department of Healthcare and Family Services shall authorize the provision of and payment for molecular breast imaging (MBI) of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches. **Effective January 1, 2026**.* | Neutral with Amendment #1 | |
| Health | Health Care Funding Act | HB4256<br>Kelly | Creates the Health Care Funding Act. Establishes the Health Care Funding Association for the primary purpose of equitably determining and collecting assessments for the cost of immunizations and health care information lines in the State that are not covered by other federal or State funding. Requires assessed entities, which include, but are not limited to, writers of individual, group, or stop-loss insurance, health maintenance organizations, third-party administrators, fraternal benefit societies, and certain other entities, to pay a specified quarterly assessment to the Association. Sets forth provisions concerning membership of the Association; powers and duties of the Association; methodology for calculating the assessment amount; reports and audits; immunities; tax-exempt status of the Association; an administrative allowance to the Department of Public Health; and other matters. Amends the State Finance Act to make conforming changes. ***Effective immediately.*** | Oppose | HOUSE Assigned to Public Health |

| | | | | | |
|---|---|---|---|---|---|
| Health | Mammogram coverage/ tomosynthesis | HB4421 Yang-Rohr | Amends the Illinois Insurance Code. In a provision concerning coverage for mammograms, provides that if a woman's physician has ordered the patient to receive breast tomosynthesis because it has been determined that high breast density will make low-dose mammography inaccurate or ineffective, the insurer shall not require the physician to order an additional low-dose mammography as a precondition to breast tomosynthesis, nor shall an insurer require the patient to receive a low-dose mammography as a precondition to breast tomosynthesis. Provides that if the results of a woman's first 2-dimensional mammogram screening determine that the patient has high breast density, coverage of breast tomosynthesis shall be provided at no cost to the insured, regardless of whether the breast tomosynthesis and 2-dimensional mammogram occurs within the same calendar year, coverage year, or 365-day period. | Oppose | HOUSE Assigned to Insurance |
| Health | Health Care Availability | HB4472 Syed | Creates the Health Care Availability and Access Board Act. Establishes the Health Care Availability and Access Board to protect State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the State, and other stakeholders within the health care system from the high costs of prescription drug products. Contains provisions concerning Board membership and terms; staff for the Board; Board meetings; circumstances under which Board members must recuse themselves; and other matters. Provides that the Board shall perform the following actions in open session: (i) deliberations on whether to subject a prescription drug product to a cost review; and (ii) any vote on whether to impose an upper payment limit on purchases, payments, and payor reimbursements of prescription drug products in the State. Permits the Board to adopt rules to implement the Act and to enter into a contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the Board. Creates the Health Care Availability and Access Stakeholder Council to provide stakeholder input to assist the Board in making decisions as required by the Act. Contains provisions concerning Council membership, member terms, and other matters. Provides that the Board shall adopt the federal Medicare Maximum Fair Price as the upper payment limit for a prescription drug product intended for use by individuals in the | Neutral | HOUSE Assigned to Health Care Availability & Accessibility |

| | | | | | |
|---|---|---|---|---|---|
| | | | State. Requires the Attorney General to enforce the Act. ***Effective 180 days after becoming law.***<br>**HB 4472 (HCA 0001) (REFERRED TO HEALTH CARE AVAILABILITY & ACCESS)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Provides that, of the 5 members that the Governor shall appoint to the Health Care Availability and Access Stakeholder Council, 2 shall represent health care providers, 2 shall represent patients and health care consumers, and one shall be a patient living with a rare disease or current or former caregiver of a patient living with a rare disease. Provides that the Health Care Availability and Access Board shall consider research and development costs of a manufacturer of a drug and the extent to which the manufacturer has recouped research and development costs when considering whether to conduct a full affordability review of a drug. In language providing that the Board may not use cost-effectiveness analyses that include the cost-per-quality adjusted life year or a similar measure to identify subpopulations for which a treatment would be less cost-effective due to severity of illness, age, or preexisting disability in determining whether a drug creates an affordability challenge or determining an upper payment limit amount, provides that the restrictions apply whether or not the Board directly uses such a cost-effectiveness analysis or indirectly uses the analysis through a contracted entity or other third-party. Provides that the upper payment limit shall not be inclusive of the pharmacy dispensing fee, provider administration fee, or add-on fee for provider-administered drugs (rather than the pharmacy dispensing fee or the provider administration fee). Provides that a health plan that generates savings as a result of an upper payment limit shall pass the savings on to reduce costs to consumers, prioritizing the reduction of out-of-pocket costs for prescription drugs. Provides that each health plan shall submit to the Board an annual report describing the savings achieved as a result of implementing upper payment limits and how the savings were used to reduce costs to consumers. Makes other changes.* ***Effective immediately.*** | Oppose with Amendment #1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | HB 4472 (HCA 0002) **(REFERRED TO HEALTH CARE AVAILABILITY & ACCESS)**<br>*In provisions requiring the Health Care Availability and Access Board to examine how an upper payment limit would affect a covered entity, provides that the upper payment limit shall not be inclusive of the pharmacy dispensing fee, provider administration fee, or any additional payment amount made by a payor to a provider for the drug product related to the provider's procurement, handling, storage, or other activity facilitating administration of the drug product (rather than the upper payment limit shall not be inclusive of the pharmacy dispensing fee, provider administration fee, or add-on fee for provider-administered drugs). Provides that the additional payment amount may be reflected in the payor's fee schedule, provider contract, or any other agreement governing reimbursement of the drug product and associated services.* | Oppose with Amendment #2 | |
| Health | Behavioral Health | HB4475<br>LaPointe | Amends the Illinois Insurance Code. Provides that the amendatory Act may be referred to as the Strengthening Mental Health and Substance Use Parity Act. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer, shall cover all out-of-network medically necessary mental health and substance use benefits and services (inpatient and outpatient) as if they were in-network for purposes of cost sharing for the insured. Provides that the insured has the right to select the provider or facility of their choice and the modality, whether the care is provided via in-person visit or telehealth, for medically necessary care. Sets forth minimum reimbursement rates for certain behavioral health benefits. Sets forth provisions concerning responsibility for compliance with parity requirements; coverage and payment for multiple covered mental health and substance use services, mental health or substance use services provided under the supervision of a licensed mental health or substance treatment provider, and 60-minute individual psychotherapy; timely credentialing of mental health and substance use providers; Department of Insurance enforcement and rulemaking; civil penalties; and other matters. Amends the Illinois | Oppose | HOUSE Assigned to Mental Health Addiction |

| | | | | | |
|---|---|---|---|---|---|
| | | | Administrative Procedure Act to authorize emergency rulemaking. ***Effective immediately*** | | |
| Health | Provider Non-Discrimination | HB4477 Schmidt | Amends the Illinois Insurance Code. Provides that a group health plan or an accident and health insurer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. Provides that nothing in the provisions shall be construed as preventing a group health plan, an accident and health insurer, or the Director of Insurance from establishing varying reimbursement rates based on quality or performance measures | Oppose | HOUSE Assigned to Insurance (Main Subcommittee) |
| Health | Inhaler Coverage | HB4504 Dias | Amends the Illinois Insurance Code. Provides that a health plan shall limit the total amount that a covered person is required to pay for a covered prescription inhaler at an amount not to exceed $25 per 30-day supply and shall limit the total amount that a covered person is required to pay for all covered prescription inhalers at an amount not to exceed $50 in total per 30 days. Provides that coverage for prescription inhalers shall not be subject to any deductible. Provides that nothing in the provisions prevents a health plan from reducing a covered person's cost sharing to an amount less than the cap. Authorizes rulemaking and enforcement by the Department of Insurance. ***Effective January 1, 2025.***<br>HB 4504 (HCA 0001) **(ADOPTED)**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or before December 31, 2025 that provides coverage for prescription drugs may not deny or limit coverage for prescription inhalers (instead of prescription inhalants) based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to those restrictions, the inhalants have been ordered or prescribed by the treating physician and are medically appropriate. Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after January 1, 2026 that provides coverage for prescription drugs shall limit the total amount that a covered person is* | Oppose<br><br>Neutral with Amendment #1 | HOUSE 2nd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | *required to pay for a covered prescription inhaler to an amount not to exceed $25 dollars per 30-day supply, and provides that nothing in the provisions prevents a group or individual policy of accident and health insurance or managed care plan from reducing a covered person's cost sharing to an amount less than the cap. Makes a conforming change. Provides that coverage for prescription inhalers shall not be subject to any deductible, except to the extent that the coverage would disqualify a high-deductible health plan from eligibility for a health savings account. Authorizes rulemaking and enforcement by the Department of Insurance. Amends the State Employees Group Insurance Act of 1971. Provides that the program of health benefits shall provide coverage for prescription inhalers under the Illinois Insurance Code.* | | |
| Health | Pharmacy Benefits Manager | HB4548 Jones | Amends the Illinois Insurance Code. Defines "health benefit plan" and other terms. Provides that a pharmacy benefit manager or an affiliate acting on the pharmacy benefit manager's behalf is prohibited from conducting spread pricing, from steering a covered individual, and from limiting a covered individual's access to prescription drugs from a pharmacy or pharmacist enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area by unreasonably designating the covered prescription drugs as a specialty drug. Provides that a pharmacy benefit manager or an affiliate acting on the pharmacy benefit manager's behalf must remit 100% of rebates and fees to the health benefit plan sponsor, consumer, or employer. Provides that a pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee. Provides that a contract between a pharmacy benefit manager and an insurer or health benefit plan sponsor must allow and provide for the pharmacy benefit manager's compliance with an audit at least once per calendar year of the rebate and fee records remitted from a pharmacy benefit manager or its contracted party to a health benefit plan. Provides that provisions concerning pharmacy benefit manager contracts apply to any health benefit plan (instead of any group or individual policy of accident and health insurance or managed care plan) that provides | Oppose | HOUSE Assigned to Health Care Availability & Accessibility |

| | | | | | |
|---|---|---|---|---|---|
| | | | coverage for prescription drugs and that is amended, delivered, issued, or renewed on or after July 1, 2020. Requires a pharmacy benefit manager to submit an annual report that includes specified information concerning prescription drugs. Makes other changes. Amends the Freedom of Information Act to make a conforming change***. Effective July 1, 2024.*** | | |
| Health | Cancer Genetic Testing | HB4562<br>Lilly | Amends the Illinois Insurance Code. Defines terms. Provides that a group policy of accident and health insurance that provides coverage for hospital or medical treatment or services for illness on an expense-incurred basis and that is amended, delivered, issued, or renewed after January 1, 2025 shall provide coverage, without imposing any cost-sharing requirement, for clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer that is recommended by a health care professional; and evidence-based cancer imaging for individuals with an increased risk of cancer as recommended by National Comprehensive Cancer Network clinical practice guidelines. Provides that the requirements do not apply to coverage of genetic testing or evidence-based cancer imaging to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to the Internal Revenue Code.<br>HB 4562 (HCA 0001) **(REFERRED TO INSURANCE)**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Provides that a group policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed after January 1, 2026 shall provide coverage, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement, for clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer as recommended by a health care professional in accordance with current evidence-based clinical practice guidelines. Provides that for individuals with a genetic test that is positive for an inherited mutation associated with an increased risk of cancer, coverage shall include any cancer risk management strategy as recommended by a health care professional in accordance with current evidence-based clinical practice guidelines to the extent that the management recommendation is not already* | Oppose<br><br>Oppose with Amendment #1 | HOUSE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | *covered by the policy. Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, and the Voluntary Health Services Plans Act to make a conforming change.* | | |
| Health | School- Based Health Center | HB 4633 Avelar | Amends the Illinois Insurance Code. Provides that an individual or group policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed in this State on or after the effective date of the amendatory Act shall provide coverage for health care services provided at a school-based health center at the same rate that would apply if those health care services were provided in a different health care setting. | Oppose | HOUSE Assigned to Insurance |
| Health | Dental Loss Ratio | HB 4780 Gershowitz | Creates the Dental Loss Ratio Act. Sets forth provisions concerning dental loss ratio reporting. Provides that a health insurer or dental plan carrier that issues, sells, renews, or offers a specialized health insurance policy covering dental services shall, beginning January 1, 2025, annually submit to the Department of Insurance a dental loss ratio filing. Provides a formula for calculating minimum dental loss ratios. Sets forth provisions concerning minimum dental loss ratio requirements. Provides that the Department may adopt rules to implement the Act. Provides that the Act does not apply to an insurance policy issued, sold, renewed, or offered for health care services or coverage provided as a function of the State of Illinois Medicaid coverage for children or adults or disability insurance for covered benefits in the single specialized area of dental-only health care that pays benefits on a fixed benefit, cash payment-only basis. Defines terms. ***Effective January 1, 2025.*** | Oppose | HOUSE Assigned to Insurance (Main Subcommittee) |
| Health | Dental Pre Authorization | HB 4789 Morgan | Amends the Illinois Insurance Code. Provides that no insurer, dental service plan corporation, insurance network leasing company, or any company that amends, delivers, issues, or renews an individual or group policy of accident and health insurance that provides dental insurance on or after the effective date of the amendatory Act shall deny any claim subsequently submitted for procedures specifically included in a prior authorization unless certain circumstances apply. Provides that a dental service contractor shall not recoup a claim solely due to a loss of coverage for a patient or ineligibility if, at the time of treatment, the dental service contractor erroneously confirmed | TBD | HOUSE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | coverage and eligibility, but had sufficient information available to the dental service contractor indicating that the patient was no longer covered or was ineligible for coverage. Prohibits waiver of the provisions by contract. | | |
| Health | Practice of Pharmacy-Influenza | HB 4822 Manley | Amends the Pharmacy Practice Act and the Illinois Insurance Code. In the definition of "practice of pharmacy", includes the ordering of testing, screening, and treatment (rather than the ordering and administration of tests and screenings) for influenza. Makes conforming changes. ***Effective January 1, 2025.*** | Oppose | HOUSE Assigned to Health Availability & Access |
| Health | Medicaid-Birth Center Rates | HB 4824 Olickal | Amends the Birth Center Licensing Act. Provides that all reimbursement rates set by the Department of Healthcare and Family Services for services provided at a birth center shall be equal to the reimbursement rates set by the Department for the same services provided at a hospital. Amends the Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for all services provided at a licensed birth center by a certified nurse midwife or a licensed certified professional midwife, including, but not limited to, prenatal care, labor and delivery care, care after birth, gynecological exams, and newborn care. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that notwithstanding any other provision of the Code, all services provided at a birth center by a certified nurse midwife or a licensed certified professional midwife, including, but not limited to, prenatal care, labor and delivery care, care after birth, gynecological exams, and newborn care shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance. Provides that all reimbursement rates set by the Department for services provided at a birth center shall be equal to the reimbursement rates set by the Department for the same services provided at a hospital. Requires the Department to seek a State Plan amendment or any federal waivers or approvals necessary to implement the provisions of the amendatory Act. Removes a provision providing that licensed certified professional midwife services shall be covered under the medical assistance program, subject to | Oppose | HOUSE Assigned to Appropriations – Health & Human Services |

| | | | | | |
|---|---|---|---|---|---|
| | | | appropriation, and that the Department shall consult with midwives on reimbursement rates for midwifery services. ***Effective January 1, 2025.*** | | |
| Health | Replace Missing Teeth | HB 4830 Olickal | Amends the Illinois Insurance Code, the Dental Care Patient Protection Act, and the Dental Service Plan Act. Provides that no insurer, dental service plan corporation, professional service corporation, insurance network leasing company, company offering a managed care dental plan, company offering a point-of-service plan, or any company that amends, delivers, issues, or renews an individual or group policy of accident and health insurance that provides dental insurance in this State may deny coverage for replacement of teeth to any insured on the basis of those teeth having been extracted or otherwise lost prior to the person becoming covered under the plan. | Oppose | HOUSE Assigned to Insurance |
| Health | Prescription Drug Info. | HB 4862 Smith | Amends the Illinois Insurance Code. Provides that a pharmacy benefit manager or health benefit plan issuer that covers prescription drugs shall provide certain information, including the issuer's patient-specific prescription benefit information, the enrollee's specific eligibility, and cost-sharing information, regarding a covered prescription drug to an enrollee or the enrollee's prescribing provider on request. Sets forth requirements for providing that information. Provides that a pharmacy benefit manager or health benefit plan issuer may not deny or delay a response to a request for that information for the purpose of blocking the release of the information; restrict a prescribing provider from communicating certain information to the enrollee; interfere with, prevent, or materially discourage access to or the exchange or use of the information; or penalize a prescribing provider for disclosing the information or prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug. Amends the State Employees Group Insurance Act of 1971, the School Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, and the Voluntary Health Services Plans Act to require plans issued under those Acts to comply with the requirements. ***Effective January 1, 2025.*** | Oppose | HOUSE Referred to Rules |
| Health | Human Rights/Health Discrimination | HB 4867 Moeller | Amends the Illinois Human Rights Act. Adds to the definition of unlawful discrimination to include discrimination of reproductive health decisions. Reproductive health decisions mean any decision by a person affecting the use or intended use of health care, goods, or | Oppose | HOUSE Assigned to Human Services |

| | | | | | |
|---|---|---|---|---|---|
| | | | services related to reproductive processes, functions, and systems, including, but not limited to, family planning, pregnancy testing, and contraception; fertility or sterilization care; miscarriage; continuation or termination of pregnancy; prenatal, intranatal, and postnatal care. Provides that discrimination based on reproductive health decisions includes unlawful discrimination against a person because of the person's association with another person's reproductive health decisions.<br>HB 4867 (HCA 0001) **(REFERRED TO HUMAN SERVICES)**<br>*Replaces everything after the enacting clause. Amends the Employment Article of the Illinois Human Rights Act. Includes, in the definition of "harassment", unwelcome conduct on the basis of an individual's reproductive health decisions. Defines "reproductive health decisions" as a person's decision regarding use of contraception; fertility or sterilization care; miscarriage management care; health care related to the continuation or termination of pregnancy; or prenatal, intranatal, or postnatal care. Makes it a civil rights violation for an employer, employment agency, and labor organization to engage in harassment or certain other conduct on the basis of reproductive health care decisions.* | Monitor with Amendment #1 | |
| Health | Dental Third Party Financing | HB 4891<br>Croke | Amends the Illinois Dental Practice Act. Provides that a dentist, employee of a dentist, or agent of a dentist shall provide the patient with a written treatment plan that includes a description of each anticipated service to be provided and a good faith estimate of expected charges before arranging for, offering, brokering, or establishing open-end credit, a line of credit, or a loan extended by a third party. Provides a form that a dentist, employee of a dentist, or agent of a dentist must provide before arranging for, offering, brokering, or establishing open-end credit, a line of credit, or a loan extended by a third party. Provides that a dentist, employee of a dentist, or agent of a dentist may not complete any portion of an application for open-end credit, a line of credit, or a loan extended by a third party. Provides that a dentist, employee of a dentist, or agent of a dentist may not arrange for, offer, broker, or establish open-end credit, a line of credit, or a loan extended by a third party that contains a deferred interest provision. Provides that a dentist, employee of a | Monitor | HOUSE Assigned to Financial Institutions & Licensing |

| | | | | | |
|---|---|---|---|---|---|
| | | | dentist, or agent of a dentist may not arrange for, offer, broker, or establish open-end credit, a line of credit, or a loan extended by a third party if (i) the treatment has yet to be rendered or costs associated with the treatment have yet to be incurred; (ii) the dentist, employee of a dentist, or agent of a dentist has not provided the patient with a treatment plan, and informed the patient in writing about which costs associated with the treatment are being charged in advance; and (iii) that dentist's office arranged for, offered, brokered, or established the open-end credit, line of credit, or loan extended by a third party. Provides that a dentist, employee of a dentist, or agent of a dentist shall, within 15 days business days of a patient's request or within 15 business days of the dentist, employee of a dentist, or agent of a dentist becoming aware of treatment that has not been rendered or costs that have not been incurred, whichever occurs first, refund to the lender any payment received through open-end credit, a line of credit, or a loan extended by a third party that is arranged for, offered, brokered, or established in that dentist's office. Provides that the Department of Financial and Professional Regulation may adopt rules to implement these provisions. ***Effective January 1, 2025***. | | |
| Health | Gym Membership | HB 4929 Williams | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage or reimbursement for gym memberships. Provides that the coverage or reimbursement required under the provisions is limited to $50 per month. Defines "gym membership". ***Effective January 1, 2025.*** | Oppose | HOUSE Assigned to Insurance (Main Subcommittee) |
| Health | Non-Participating Providers | HB 4931 Croke | Amends the Illinois Insurance Code. In a provision concerning billing for services provided by nonparticipating providers or facilities, provides that when calculating an enrollee's contribution to the annual limitation on cost sharing set forth under specified federal law, a health insurance issuer or its subcontractors shall include expenditures for any item or health care service covered under the policy issued to the enrollee by the health insurance issuer or its subcontractors if that item or health care service is included within a category of essential health benefits and regardless of whether the health insurance issuer | Oppose | HOUSE Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | or its subcontractors classify that item or service as an essential health benefit. ***Effective immediately.*** | | |
| Health | Prior Authorization Prescription | HB 5051 Douglass | Amends the Prior Authorization Reform Act. Provides that a health insurance issuer may not require prior authorization for a prescription drug prescribed to a patient by a health care professional for 6 or more consecutive months, regardless of whether the prescription drug is a non-preferred medication pursuant to the patient's health insurance coverage; or for specified prescription drugs, including insulin, human immunodeficiency virus prevention medication; human immunodeficiency virus treatment medication; viral hepatitis medication; estrogen; and progesterone. | Oppose | HOUSE Assigned to Health Care Availability & Access |
| Health | Medical Records Copy Expenses | HB 5074 Chung | Amends the Code of Civil Procedure. Prohibits a health care provider from charging a handling fee for providing medical records to a patient or patient's representative if they are electronic records retrieved from a scanning, digital imaging, electronic information, or other digital format in an electronic document. Repeals the annual adjustment for the handling fee for inflation. | Monitor | HOUSE Referred to Rules |
| Health | Physical Therapy/ Telehealth | HB 5087 Walsh | Amends the Illinois Physical Therapy Act. Provides that physical therapy through telehealth services may be used to address access issues to care, enhance care delivery, or increase the physical therapist's ability to assess and direct the patient's performance in the patient's own environment. Provides that a physical therapist or a physical therapist assistant working under the general supervision of a physical therapist may provide physical therapy through telehealth services pursuant to the terms and use defined in the Telehealth Act and the Illinois Insurance Code under specified conditions. | Monitor | HOUSE 2nd Reading |
| Health | Cancer Screenings | HB 5103 Davis | Amends the Illinois Insurance Code. In a provision concerning coverage of certain cancer screenings, adds having a high level of CA-125, as indicated by a blood test screening, to the definition of "at risk for ovarian cancer". Provides that "surveillance tests for ovarian cancer" means all medically viable methods for the detection and diagnosis of ovarian cancer, including, but not limited to, ultrasounds, magnetic resonance imagings (MRIs), x-rays, computed tomography (CT) scans, and CA-125 blood test screenings (instead of an annual screening using | Oppose | HOUSE Assigned to Insurance (Main Subcommittee) |

| | | | | | |
|---|---|---|---|---|---|
| | | | (i) CA-125 serum tumor marker testing, (ii) transvaginal ultrasound, (iii) pelvic examination).<br>HB 5103 (HCA 0001) **(REFERRED TO INSURANCE)**<br>***Adds a January 1, 2026 effective date.*** | Neutral | |
| Health | Pregnancy/ Postpartum Care | HB 5142<br>Gabel | Amends the Illinois Insurance Code. Provides that insurers shall cover all services for pregnancy, postpartum, and newborn care that are rendered by perinatal doulas or licensed certified professional midwives, including home births, home visits, and support during labor, abortion, or miscarriage. Provides that the required coverage includes the necessary equipment and medical supplies for a home birth. Provides that coverage for pregnancy, postpartum, and newborn care shall include home visits by lactation consultants and the purchase of breast pumps and breast pump supplies, including such breast pumps, breast pump supplies, breastfeeding supplies, and feeding aides as recommended by the lactation consultant. Provides that coverage for postpartum services shall apply for at least one year after birth. Provides that certain pregnancy and postpartum coverage shall be provided without cost-sharing requirements. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that post-parturition care benefits shall not be subject to any cost-sharing requirement. Provides that the medical assistance program shall cover home visits for lactation counseling and support services. Provides that the medical assistance program shall cover counselor-recommended or provider-recommended breast pumps as well as breast pump supplies, breastfeeding supplies, and feeding aides. Provides that nothing in the provisions shall limit the number of lactation encounters, visits, or services; breast pumps; breast pump supplies; breastfeeding supplies; or feeding aides a beneficiary is entitled to receive under the program. Makes other changes. ***Effective January 1, 2026.***<br>**HB 5142 (HCA 0001) (ADOPTED)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Removes language providing that post-parturition care benefits shall not be subject to any cost-sharing requirement. Provides that coverage for postpartum services shall apply for at least one year after the end of the pregnancy* | Oppose<br><br>Oppose with Amendment #1 | HOUSE<br>2nd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | *(rather than one year after birth). Provides that beginning January 1, 2025, certified professional midwife services (instead of licensed certified professional midwife services) shall be covered under the medical assistance program. Removes language providing that midwifery services covered under the provisions shall include home births and home prenatal, labor and delivery, and postnatal care. Removes changes to a provision of the Illinois Public Aid Code concerning reimbursement for postpartum visits.* ***Effective January 1, 2026, except that certain changes to the Illinois Public Aid Code are effective January 1, 2025.***<br>HB 5142 (HCA 0002) **(ADOPTED)**<br>*Provides that all outpatient coverage required under a provision concerning coverage for pregnancy, postpartum, and newborn care must be provided without cost sharing, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account and except that, for treatment of substance use disorders, the prohibition on cost-sharing applies to the levels of treatment below and not including 3.1 (Clinically Managed Low-Intensity Residential) established by the American Society of Addiction Medicine. Makes a conforming change. Further amends the Illinois Insurance Code. Provides that coverage for abortion care may not impose any deductible, coinsurance, waiting period, or other cost-sharing (instead of other cost-sharing limitation that is greater than that required for other pregnancy-related benefits covered by the policy). Provides that the provision does not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account.* | Oppose with Amendment #2 | |
| Health | Dependent Parent Coverage | HB 5258<br>Huynh | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance issued, amended, delivered, or renewed after January 1, 2026 that provides dependent coverage shall make that dependent coverage available to the parent or stepparent of the insured if the parent or stepparent meets the definition of a qualifying relative under specified federal law and lives or resides within the accident and health insurance policy's service area. Exempts specialized health care service plans, Medicare supplement insurance, | Oppose | HOUSE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | hospital-only policies, accident-only policies, or specified disease insurance policies from the provisions. Defines "dependent". | | |
| Health | Miscarriages/ Stillbirth | HB 5282 Stava-Murray | Amends the Illinois Insurance Code. Requires coverage of medically necessary treatment of a mental, emotional, nervous, or substance use disorder or condition for all individuals who have experienced a miscarriage or stillbirth to the same extent and cost-sharing as for any other medical condition covered under the policy. ***Effective January 1, 2025.*** | Oppose | HOUSE 2nd Reading |
| Health | Hormone Therapy | HB 5295 Dias | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed in this State shall provide coverage for medically necessary hormone therapy treatment to treat menopause (instead of to treat menopause that has been induced by a hysterectomy). ***Effective January 1, 2026.***<br>HB 5295 (HCA 0001) **(REFERRED TO RULES)**<br>*Replaces everything after the enacting clause. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026 shall provide coverage for medically necessary hormonal and non-hormonal therapy to treat menopausal symptoms if the therapy is recommended by a qualified health care provider who is licensed, accredited, or certified under Illinois law and the therapy has been proven safe and effective in peer-reviewed scientific studies. Provides that coverage for therapy to treat menopausal symptoms shall include all federal Food and Drug Administration-approved modalities of hormonal and non-hormonal administration, including, but not limited to, oral, transdermal, topical, and vaginal rings. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the medical assistance program shall provide coverage for medically necessary hormone therapy treatment to treat menopause that has been induced by a hysterectomy. Makes a conforming change.* ***Effective January 1, 2026.*** | Neutral<br><br>Neutral with Amendment #1 | HOUSE Assigned to Insurance |
| Health | Network Adequacy Directory | HB 5313 Croke | Amends the Network Adequacy and Transparency Act. Provides that a network plan shall, at least annually, audit (instead of audit periodically) at least 25% of its provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. | Oppose | HOUSE 2nd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | Provides that the network plan shall submit the audit to the Department of Insurance (instead of to the Director of Insurance upon request). Provides that the Department shall make the audit publicly available. Provides that a network plan shall include in the print format provider directory (i) a detailed description of the process to dispute charges for out-of-network providers or facilities that were incorrectly listed as in-network prior to the provision of care and (ii) a telephone number and email address to dispute those charges. Makes changes to the information that must be provided in a network plan's electronic and print directory. Requires the Director to conduct random audits of the accuracy of provider directories for at least 10% of plans each year. Provides that a consumer who incurs a cost for inappropriate out-of-network charges for a provider, facility, or hospital that was listed as in-network prior to the provision of services may file a verified complaint with the Department, and the Department shall conduct an investigation of the verified complaint and determine whether the complaint is sufficient. Provides that, upon a finding of sufficiency, the Director shall have the authority to levy a fine for not less than the cost incurred by the consumer for inappropriate out-of-network charges for a provider, facility, or hospital that was listed in-network. Provides that the fines collected by the Director shall be remitted to the consumer.<br>HB 5313 (HCA 0001) **(TABLED)**<br>*Provides that the network plan shall, at least every 90 days (rather than at least annually), audit its provider directories for accuracy (rather than audit periodically at least 25% of its provider directories for accuracy), make any corrections necessary, and retain documentation of the audit. In provisions about complaints of incorrect charges, allows a beneficiary (rather than a consumer) who incurs a cost for inappropriate out-of-network charges for a provider, facility, or hospital that was listed as in-network prior to the provision of services may file a complaint (rather than a verified complaint) with the Department of Insurance. Provides that the network plan shall reimburse the beneficiary the amount necessary to ensure the beneficiary is held harmless for all amounts exceeding the amount of the beneficiary would have paid had the services been provided in-network (rather than the Director of Insurance shall have the authority* | Oppose with Amendment #1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *to levy a fine for not less than the cost incurred by the consumer for inappropriate out-of-network charges for a provider, facility, or hospital that was listed as in-network). Requires all out-of-pocket costs incurred by the beneficiary to apply toward the in-network deductible and out-of-pocket maximum (rather than requiring the fines collected by the Director to be remitted to the consumer).* | | |
| Health | Dental Care Electronic Billing | HB 5317<br>Rita | Amends the Uniform Electronic Transactions in Dental Care Billing Act. Provides that beginning January 1, 2027 (instead of 2025), no dental plan carrier is required to accept from a dental care provider eligibility for a dental plan transaction or dental care claims or equivalent encounter information transaction. Sets forth exemptions from the requirements of the Act, and requires a dental care provider who is exempt from the requirements of the Act to file a form with the Department of Insurance indicating the applicable exemption. Requires each dental plan carrier to establish a portal that provides certain benefit and billing information. Requires a dental plan carrier to establish an electronic portal that allows dental care providers to submit claims electronically and directly to the dental care provider; accept attachments in an electronic format with the initial electronic claim's submission; and provide remittance advice with the corresponding payment. Provides that nothing in the Act requires a dental care provider to only accept electronic payment from a dental plan carrier. Provides that dental plan carriers shall allow alternative forms of payment, without additional fees or charges, to a dental care provider, if requested. ***Effective immediately.*** | Oppose | HOUSE Assigned to Insurance |
| Health | Nonopioid Alternative Act | HB 5355<br>~~LaPointe~~<br>Yang Rohr | Creates the Nonopioid Alternatives for Pain Act. Requires the Department of Public Health to develop and publish an educational pamphlet regarding the use of nonopioid alternatives for pain treatment. Provides that a health care practitioner shall exercise professional judgment in selecting appropriate treatment modalities for pain in accordance with specified Centers for Disease Control and Prevention guidelines, including the use of nonopioid alternatives whenever nonopioid alternatives exist. Requires a health care practitioner who prescribes an opioid drug to provide certain information to the patient, discuss certain topics, and document the reasons for the prescription. Requires the Department to develop a | Oppose | HOUSE Assigned to Health Care Availability & Access |

| | | | | | |
|---|---|---|---|---|---|
| | | | nonopioid directive form for patients. Sets forth provisions concerning exceptions, execution of a nonopioid directive, opioid administration to a patient with a nonopioid directive, and limitations of liability. Amends the Illinois Insurance Code. Provides that when a licensed health care practitioner prescribes a nonopioid medication for the treatment of acute pain, it shall be unlawful for a health insurance issuer to deny coverage of the nonopioid prescription drug in favor of an opioid prescription drug or to require the patient to try an opioid prescription drug before providing coverage. Provides that in establishing and maintaining its drug formulary, a health insurance issuer shall ensure that no nonopioid drug approved by the Food and Drug Administration for the treatment or management of pain shall be disadvantaged or discouraged, with respect to coverage or cost sharing, relative to any opioid or narcotic drug for the treatment or management of pain. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that whenever a licensed health care practitioner prescribes a nonopioid medication for the treatment of acute pain, neither the Department of Healthcare and Family Services nor a managed care organization shall deny coverage of the nonopioid prescription drug in favor of an opioid prescription drug or require a patient to try an opioid prescription drug prior to providing coverage of the nonopioid prescription drug. Makes other changes. | | |
| Health | Continuous Glucose Monitor | HB 5382 Ladisch Douglass | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for continuous glucose monitors, related supplies, and training in the use of continuous glucose monitors for any individual who is diagnosed with diabetes mellitus and meets other requirements, including that the prescriber had an in-person or covered telehealth visit with the individual to evaluate the individual's diabetes control and has determined that the eligibility criteria is met. Provides that to qualify for a continuous glucose monitor, a patient is not required to have a diagnosis of uncontrolled diabetes; have a history of emergency room visits or hospitalizations; or show improved glycemic control. Provides that an individual who is diagnosed with diabetes mellitus and meets the requirements shall not be required to | Oppose | HOUSE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | obtain prior authorization for coverage for a continuous glucose monitor, and coverage shall be continuous once the continuous glucose monitor is prescribed. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the Department of Healthcare and Family Services shall adopt rules to implement the changes made by the amendatory Act. Specifies that the rules shall, at a minimum contain certain provisions concerning the ordering provider, continuous glucose monitors not being required to have certain functionalities, eligibility requirements for a beneficiary, and not requiring prior authorization. ***Effective July 1, 2024.*** | | |
| Health | Alzheimer Treatment | HB 5383<br>Gill | Amends the State Employees Group Insurance Act. Requires the State Employees Group Insurance Program to provide coverage for all FDA-approved treatments or medications prescribed to slow the progression of Alzheimer's Disease or another related dementia, as determined by a physician licensed to practice medicine in all its branches. Provides that diagnostic testing necessary for a physician to determine the appropriate use of treatments or medications shall be covered by the State Employees Group Insurance Program.<br>HB 5383 (HCA 0001) **(REFERRED TO INSURANCE)**<br>*Replaces everything after the enacting clause with the provisions of the introduced bill with the following changes. In a provision regarding coverage for Alzheimer's Disease or other related dementia, limits the provision to beginning on July 1, 2025 (rather than January 1, 2025). Requires FDA-approved treatments or medications prescribed to slow the progression of Alzheimer's Disease or another related dementia to be medically necessary in order to qualify for coverage under the State Employees Group Insurance Program. Adds a specific prohibition on step therapy for treatment of Alzheimer's Disease or another related dementia.*<br>HB 5383 (HCA 0002) **(REFERRED TO INSURANCE*)***<br>*Replaces everything after the enacting clause with the provisions of House Amendment No. 1 with the following changes. Provides that treatment for Alzheimer's Disease under the State Employees Group Insurance Program shall be covered if determined to be medically necessary by a physician licensed to practice medicine under the Illinois* | Monitor<br><br>Neutral with Amendment #1<br><br>Neutral with Amendment #2 | HOUSE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | *Medical Practice Act of 1987 (rather than by a physician licensed to practice medicine in all its branches).* | | |
| Health | Network Adequacy Standards | HB 5395<br>Moeller | Amends the Network Adequacy and Transparency Act. Adds definitions. Provides that the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services. Provides that the maximum travel time and distance standards and appointment wait time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services. Makes changes to provisions concerning network adequacy, notice of nonrenewal or termination, transition of services, network transparency, administration and enforcement, provider requirements, and provider directory information. Amends the Managed Care Reform and Patient Rights Act. Makes changes to provisions concerning notice of nonrenewal or termination and transition of services. Amends the Illinois Administrative Procedure Act to authorize the Department of Insurance to adopt emergency rules implementing federal standards for provider ratios, time and distance, or appointment wait times when such standards apply to health insurance coverage regulated by the Department of Insurance and are more stringent than the State standards extant at the time the final federal standards are published. Amends the Illinois Administrative Procedure Act to make a conforming change. ***Effective immediately.***<br>HB 5395 (HCA 0001) **(REFERRED TO HUMAN SERVICES)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Provides that the amendatory Act may be referred to as the Health Care Consumer Access and Protection Act. Amends the Illinois Insurance Code. Provides that, unless prohibited under federal law, for plan year 2026 and thereafter, for each insurer proposing to offer a qualified health plan issued in the individual market through the Illinois Health Benefits Exchange, the insurer's rate filing must apply a cost-sharing reduction defunding adjustment factor within a range that is uniform across all insurers; is consistent with the total adjustment expected to be needed* | Oppose<br><br>Oppose with Amendment #1 | HOUSE Assigned to Human Services |

| | | | | | |
|---|---|---|---|---|---|
| | | | *to cover actual cost-sharing reduction costs across all silver plans on the Illinois Health Benefits Exchange statewide; and makes certain assumptions. Provides that the rate filing must apply an induced demand factor based on a specified formula. Provides that certain provisions concerning filing of premium rates for group accident and health insurance for approval by the Department of Insurance do not apply to group policies issued to large employers. Removes language providing that certain provisions do not apply to the large group market. Provides that for large employer group policies issued, delivered, amended, or renewed on or after January 1, 2026, the premium rates and risk classifications must be filed with the Department annually for approval. Amends the Limited Health Service Organization Act to provide that pharmaceutical policies are subject to the provisions of the amendatory Act. Sets forth provisions concerning short-term, limited-duration insurance. Provides that no company shall issue, deliver, amend, or renew short-term, limited-duration insurance. Provides that the Department may adopt rules as deemed necessary that prescribe specific standards for or restrictions on policy provisions, benefit design, disclosures, and sales and marketing practices for excepted benefits. Provides that the Director of Insurance's authority under specified provisions is extended to group and blanket excepted benefits. Makes conforming changes in the Health Maintenance Organization Act. Repeals the Short-Term, Limited-Duration Health Insurance Coverage Act. Provides that no later than July 1, 2025, insurance companies that use a drug formulary shall post the formulary on their websites. Makes changes concerning utilization reviews and step therapy requirements. Provides that beginning January 1, 2026, coverage for inpatient mental health treatment at participating hospitals or other licensed facilities shall comply with specified requirements concerning prior authorization, coverage, and concurrent review. Makes other changes. Further amends the Managed Care Reform and Patient Rights Act. Removes provisions concerning step therapy. Provides that only a clinical peer may make an adverse determination. Sets forth certain requirements for utilization review programs. Provides that no utilization review program or any policy, contract, certificate, evidence of coverage, or formulary shall impose* | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *step therapy requirements for any health care service, including prescription drugs. Amends the Health Carrier External Review Act. Requires a health insurance issuer to publish on its public website a list of services for which prior authorization is required.* ***Effective January 1, 2025.*** | | |
| Health | HIV TLC Act | HB 5417<br>Cassidy | Amends the Department of Public Health Act. Establishes the role of HIV Treatment Innovation Coordinator to be housed within the Department. Provides that the Department shall create and fill the Coordinator role within 6 months after the effective date of the amendatory Act. Requires the Coordinator to develop and execute a comprehensive strategy to adopt a Rapid Start model for HIV treatment as the standard of care. Requires compensation and benefits for the Coordinator be at the Program Director level. Describes the specific job responsibilities of the Coordinator. Amends the Illinois Insurance Code. Provides that an individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State on or after January 1, 2025 shall provide coverage for home test kits for sexually transmitted infections, including any laboratory costs of processing the home test kit, that are deemed medically necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. Makes a conforming change to the Illinois Public Aid Code regarding coverage for home test kits for sexually transmitted infections. Amends the AIDS Confidentiality Act. Creates the Illinois AIDS Drug Assistance Program. Provides that Illinois AIDS Drug Assistance Program applications shall be processed within 72 hours after the time of submission. Provides for conditional approval of Illinois AIDS Drug Assistance Program applications within 24 hours after time of submission. Requires Illinois AIDS Drug Assistance Program applicants to document residency within the State of Illinois. Provides for 8 Rapid Start for HIV Treatment pilot sites established by the Department of Public Health. Provides that the Department shall publish a report on the operation of the pilot program 15 months after the pilot sites have launched. Establishes requirements for the report, requires that the report be shared with the General Assembly, the Governor's Office, and requires | Oppose | HOUSE<br>Assigned to<br>Human<br>Services |

| | | | | | |
|---|---|---|---|---|---|
| | | | that the report be made available on the Department's Internet website. Amends the County Jail Act. Creates new annual adult correctional facility public inspection report requirements on the topics of HIV and AIDS. | | |
| Health | Regulation Network Adequacy | HB 5419 Moeller | Amends the Network Adequacy and Transparency Act. Makes a technical change in a Section concerning the Act's short title. | Monitor | HOUSE Referred to Rules |
| Health | Pharmacists-Vaccines & Dosage | HB 5462 Moeller | Amends the Pharmacy Practice Act. Provides that it is the practice of pharmacy to order and administer vaccines to patients 7 years of age and older for COVID-19 or influenza subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the United States Food and Drug Administration or in accordance with the United States Centers for Disease Control and Prevention's Recommended Immunization Schedule or the United States Centers for Disease Control and Prevention's Health Information for International Travel (rather than as authorized, approved, or licensed by the United States Food and Drug Administration). Provides that a pharmacist who is exercising his or her professional judgment may change the quantity of medication prescribed if specified conditions are satisfied. Provides that a pharmacist may change the dosage form of a prescription if it is in the best interest of patient care, so long as the prescriber's directions are also modified to equate to an equivalent amount of drug dispensed as prescribed. Provides that a pharmacist may complete missing information on a prescription if there is evidence to support the change. Repeals provisions concerning the administration of vaccines, tests, and therapeutics by registered pharmacy technicians and student pharmacists. Makes other changes. Amends the Illinois Insurance Code and the Medical Assistance Article of the Illinois Public Aid Code. Provides that the ordering and administration of vaccines by a pharmacist as part of the practice of pharmacy shall be covered and reimbursed under the medical assistance program and by other insurers at no less than the rate that the vaccine is reimbursed at when ordered and administered by a licensed physician. | Oppose | HOUSE Referred to Rules |
| Health | Insurance Various | HB 5493 Jones | Amends the Illinois Insurance Code. Provides that certain coverage requirements apply to an individual policy of accident and health insurance (currently, a policy of accident and health insurance). | Oppose | HOUSE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | Provides that an individual or group policy of accident and health insurance or a managed care plan must not require authorization or referral by the plan, issuer, or any person, including a primary care provider, for any covered individual who seeks coverage for certain obstetrical or gynecological care. Provides that if a policy, contract, or certificate requires or allows a covered individual to designate a primary care provider and provides coverage for any obstetrical or gynecological care, the insurer shall provide the notice required under specified federal regulations in all circumstances required under those regulations. Makes changes in provisions concerning post-parturition care. Changes the language required in the disclosure of a limited benefit. Increases the fee for filing a plan of division of a domestic stock company and for filing an insurance business transfer plan. Makes changes in provisions concerning fraud reporting; coverage for epinephrine injectors; blanket accident and health insurance; authorization of policies, agreements, or arrangements with incentives or limits on reimbursement; and refunds and penalties. Repeals a provision concerning the application of certain provisions. Amends the Network Adequacy and Transparency Act. Changes references from "woman's principal health care provider" to "obstetrical and gynecological health care professional". Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Limited Health Service Organization Act, and the Illinois Public Aid Code to make conforming changes. Amends the Health Maintenance Organization Act. Makes changes to the required disclosures. Provides that health maintenance organizations are subject to certain coverage requirements for pharmacy testing, screening, vaccinations, and treatment; for proton beam therapy; for children with neuromuscular, neurological, or cognitive impairment; and for no-cost mental health prevention and wellness visits. ***Effective immediately, except that certain provisions are effective January 1, 2025.***<br>HB 5493 (HCA 0001) **(REFERRED TO INSURANCE)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Further amends the Illinois Insurance Code. Repeals a provision requiring certain policies to* | Neutral with Amendment #1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *offer, for an additional premium and subject to the insurer's standard of insurability, optional coverage or optional reimbursement for hearing instruments and related services for all individuals when a hearing care professional prescribes a hearing instrument to augment communication. Makes conforming changes. In a provision concerning the scope of the Casualty Insurance, Fidelity Bonds and Surety Contracts Article, includes certain policies that are not otherwise excluded under the Unauthorized Companies Article. Removes changes to a provision concerning fraud reporting. Further amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, and the School Code. Requires coverage or reimbursement for hearing instrument and related services. Provides that coverage may be offered on an optional basis for an additional premium or contribution. Preempts home rule powers. Makes other changes.* ***Effective immediately, except that certain provisions are effective January 1, 2025.*** | | |
| Health | Health Care Costs | HB 5517<br>Ladisch<br>Douglass | Creates the Protection Against Unnecessary Health Care Costs Act. Requires the State Comptroller to establish the Drug Discount Card Program to be made available for all residents of this State. Requires the Department of Insurance to report to the General Assembly and to the Governor recommendations for establishing an outreach and education program to inform licensed physicians on when a drug patent will expire and become available in generic form, and when generic alternatives exist for drugs whose patent recently expired. Provides that on and after October 1, 2025, a pharmaceutical manufacturer that employs an individual to perform the duties of a pharmaceutical sales representative shall register annually with the Department of Financial and Professional Regulation as a pharmaceutical marketing firm. Provides that each pharmaceutical marketing firm shall provide to the Department a list of all individuals employed by the pharmaceutical marketing firm as a pharmaceutical sales representative. Sets forth provisions concerning registration; registration fees; discipline of pharmaceutical marketing firms; the Department posting a list of all individuals employed by the pharmaceutical marketing firm as a pharmaceutical sales representative; and reports by pharmaceutical marketing firms to the | Monitor | HOUSE<br>Assigned to Health Care Availability & Access |

| | | | | | |
|---|---|---|---|---|---|
| | | | Department. Requires the Department of Public Health to report to the General Assembly and the Governor, an analysis of pharmacy benefit managers' practices of prescription drug distribution. Requires the Department of Public Health to prepare a list of not more than 10 outpatient prescription drugs that the Director of Public Health, in the Director's discretion, determines are provided at substantial cost to the State or critical to public health. Requires the pharmaceutical manufacturer of an outpatient prescription drug included on that list to provide specified information to the Department of Public Health. Sets forth provisions concerning hearings; violations of the Act by health care facilities; civil penalties; and a report of the utilization management and provider payment practices of Medicare Advantage plans. Makes other changes. Amends the Illinois Health Facilities Planning Act. Requires a health care facility to post notice of its intent to file an application for a certificate of need. ***Effective immediately***. | | |
| Health | Drug Formulary Posting | HB 5518<br>Ladisch<br>Douglass | Amends the Illinois Insurance Code. Provides that "State-regulated health plan" means any health insurance plan issued by an insurer regulated by the State or health insurance plan operated and administered by the State, including, but not limited to, the medical assistance program under the Medical Assistance Article of the Illinois Public Aid Code, fee-for-service plans, and managed care organizations. Provides that for every State-regulated health plan, an information packet on all insurance products offered to enrollees must be made available to the public, which must be viewable before choosing a health plan, that includes specified information concerning the plan's drug formulary and the costs for drugs. Provides that the information packet must be made available both online in any patient portal and in a printed format. Provides that the information packet must be updated within 7 days after any change to the drug formulary, and notice of the change to the drug formulary and change to drug costs must be sent to beneficiaries by mail or electronically. | Oppose | HOUSE<br>Assigned to Insurance |
| Health | Provider Panels | HB 5580<br>Huynh | Amends the Managed Care Reform and Patient Rights Act. Sets forth requirements for carriers that offer a provider panel. Requires notice of the development of a provider panel to be filed with Department of Public Health prior to establishment. Provides that a carrier that uses a provider panel shall establish procedure for notifying an enrollee of the | Oppose | HOUSE<br>Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | termination of a health care provider. Sets forth provisions permitting, under certain circumstances, a health care provider to continue to render health care services following termination from the carrier's provider panel. Requires a carrier to provide a list of members in the carrier's provider panel. Establishes notice requirements for benefit reductions and termination of health care providers from the carrier's provider panel. Requires any carrier requiring preauthorization for medical treatment to have personnel available to provide preauthorization at all times when the preauthorization is required. Provides that no contract between a health care provider and a carrier shall include provisions that require a health care provider to deny covered services that the provider knows to be medically necessary and appropriate that are provided with respect to a specific enrollee or group of enrollees with similar medical conditions. Sets forth prohibited provisions in a contract between a carrier and a health care provider. Defines terms. Makes other and conforming changes. | | |
| Health | Pregnancy Tests | HB 5643<br>Katz Muhl | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage for at-home, urine-based pregnancy tests that are prescribed to the covered person, regardless of whether the tests are otherwise available over-the-counter. | Oppose | HOUSE<br>Assigned to Insurance |

| | | | SENATE BILLS | | |
|---|---|---|---|---|---|
| Health | Insulin Pump coverage Mandate | SB 54<br>Fine | Amends the Illinois Insurance Code. Provides that coverage for self-management training and education, equipment, and supplies for diabetes treatment shall include insulin pumps and medical supplies required for the use of an insulin pump when medically necessary and prescribed by a physician licensed to practice medicine in all of its branches. | Oppose (amendment with effective date change forthcoming) | SENATE<br>Re-Referred to Assignments |
| Health | Medicare Enrollment Period | SB 56<br>Fine | Amends the Illinois Insurance Code. In provisions concerning Medicare supplement policy minimum standards, provides that if an individual is at least 65 years of age but no more than 75 years of age and has an existing Medicare supplement policy, then the individual is entitled to an annual open enrollment period lasting 45 days, commencing with the individual's birthday, and the individual may purchase any Medicare supplement policy with the same issuer or any affiliate authorized to transact business in the State (instead of only the same issuer) that offers benefits equal to or lesser than those provided by the previous coverage.<br>SB 0056 (SCA 0001) **(ADOPTED)**<br>***Adds a January 1, 2026 effective date.*** | Oppose<br><br>Neutral with Amendment #1 | SENATE<br>2nd Reading |
| Health | Coverage and Deductible Year Alignment | SB 92<br>Fine | Provides that the Director of Insurance shall issue rules to establish specific standards which may cover, but shall not be limited to, alignment of an accident and health insurance policy's coverage year and deductible year for the purpose of determining patient out-of-pocket cost-sharing limits. Defines "coverage year" and "deductible year". | Oppose | SENATE<br>Referred to Assignments |
| Health | HMO In-Network Referral | SB 130<br>Fine | Provides that the powers of a health maintenance organization include the voluntary use of a referral system for enrollees to access providers under contract with or employed by the health maintenance organization. Provides that the provisions shall not be construed as requiring the use of a referral system to obtain a certificate of authority. | Support | SENATE<br>Re-Referred to Assignments |
| Health | Reproductive Healthcare | SB 241<br>Ellman | Provides that an insurer providing a network plan shall file a description with the Director of Insurance of written policies and procedures on how the network plan will provide 24-hour, 7-day per | Oppose | SENATE<br>Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | Network Adequacy | | week access to reproductive health care. Provides that the Department of Insurance shall consider establishing ratios for reproductive health care physicians or other providers. ***Effective July 1, 2024, except that certain changes take effect January 1, 2025***. | | |
| Health | Insurance Waiver ACA | SB 288 Rezin | Prohibits the State from applying for any federal waiver that would reduce or eliminate any protection or coverage required under the Patient Protection and Affordable Care Act (Affordable Care Act) that was in effect on January 1, 2017, including, but not limited to, any protection for persons with preexisting conditions and coverage for services identified as essential health benefits under the Affordable Care Act. Provides that the State or an agency of the executive branch may apply for such a waiver only if granted authorization by the General Assembly through joint resolution. Amends the Illinois Insurance Code. Prohibits the State from applying for any federal waiver that would permit an individual or group health insurance plan to reduce or eliminate any protection or coverage required under the Affordable Care Act that was in effect on January 1, 2017, including, but not limited to, any protection for persons with preexisting conditions and coverage for services identified as essential health benefits under the Affordable Care Act. Provides that the State or an agency of the executive branch may apply for such a waiver only if granted authorization by the General Assembly through joint resolution. Amends the Illinois Public Aid Code. Prohibits the State or an agency of the executive branch from applying for any federal Medicaid waiver that would result in more restrictive standards, methodologies, procedures, or other requirements than those that were in effect in Illinois as of January 1, 2017 for the Medical Assistance Program, the Children's Health Insurance Program, or any other medical assistance program in Illinois operating under any existing federal waiver authorized by specified provisions of the Social Security Act. Provides that the State or an agency of the executive branch may apply for such a waiver only if granted authorization by the General Assembly through joint resolution. ***Effective immediately***. | Monitor | SENATE Referred to Assignments |
| Health | Riding Therapy | SB 311 Murphy | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed after the effective date of the | Oppose | SENATE Re-Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | Coverage Mandate | | amendatory Act shall provide coverage for hippotherapy and other forms of therapeutic riding. | | |
| Health | Rate Review | SB 324<br>Fine | Provides that all individual and small group accident and health policies written subject to certain federal standards must file rates with the Department of Insurance for approval. Provides that unreasonable rate increases or inadequate rates shall be disapproved. Provides that when an insurer files a schedule or table of premium rates for individual or small employer health benefit plans, the Department of Insurance shall post notice of the premium rate filings, rate filing summaries, and other information about the rate increase or decrease online on the Department's website. Provides that the Department shall open a 30-day public comment period on the date that a rate filing is posted on the website. Provides that after the close of the public comment period, the Department shall issue a decision to approve, disapprove, or modify a rate filing, and post the decision on the Department's website. Provides that the Department shall adopt rules implementing specified procedures. Defines "inadequate rate" and "unreasonable rate increase". | Oppose | SENATE<br>Referred to Assignments |
| Health | PBM | SB 0757<br>(SFA 0001)<br>Koehler<br>(Welch) | **Amendment – (WITHDRAWN)**<br>*Replaces everything after the enacting clause. Amends the Pharmacy Benefit Managers Article of the Illinois Insurance Code. Provides that when conducting a pharmacy audit, an auditing entity shall comply with specified requirements. Provides that an auditing entity conducting a pharmacy audit may have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity. Provides that information collected during a pharmacy audit shall be confidential by law, except that the auditing entity conducting the pharmacy audit may share the information with the health benefit plan for which a pharmacy audit is being conducted and with any regulatory agencies and law enforcement agencies as required by law. Provides that a violation of the provisions shall be an unfair and deceptive act or practice. Provides that a pharmacy may not be subject to a chargeback or recoupment for a clerical or recordkeeping error in a required document or record unless the pharmacy benefit manager can provide proof of intent to commit fraud or such error results in actual financial harm to the pharmacy benefit manager, a health plan* | Oppose | HOUSE<br>Re-Referred to Rules |

| | | | | | |
|---|---|---|---|---|---|
| | | | *managed by the pharmacy benefit manager, or a consumer. Provides that a pharmacy shall have the right to file a written appeal of a preliminary and final pharmacy audit report in accordance with the procedures established by the entity conducting the pharmacy audit. Provides that no interest shall accrue for any party during the audit period. Provides that a contract between a pharmacy or pharmacist and a pharmacy benefit manager must contain specified provisions. Defines terms.*<br>SB 0757 (SFA 0002) **(ADOPTED)**<br>*Replaces everything after the enacting clause. Amends the Pharmacy Benefit Managers Article of the Illinois Insurance Code. Provides that when conducting a pharmacy audit, an auditing entity shall comply with specified requirements. Provides that an auditing entity conducting a pharmacy audit may have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity. Provides that information collected during a pharmacy audit shall be confidential by law, except that the auditing entity conducting the pharmacy audit may share the information with the health benefit plan for which a pharmacy audit is being conducted and with any regulatory agencies and law enforcement agencies as required by law. Provides that a pharmacy may not be subject to a chargeback or recoupment for a clerical or recordkeeping error in a required document or record unless the pharmacy benefit manager can provide proof of intent to commit fraud or such error results in actual financial harm to the pharmacy benefit manager, a health plan managed by the pharmacy benefit manager, or a consumer. Provides that a pharmacy shall have the right to file a written appeal of a preliminary and final pharmacy audit report in accordance with the procedures established by the entity conducting the pharmacy audit. Provides that no interest shall accrue for any party during the audit period. Provides that an auditing entity must provide a copy to the plan sponsor of its claims that were included in the audit, and any recouped money shall be returned to the plan sponsor, unless otherwise contractually agreed upon by the plan sponsor and the pharmacy benefit manager. Defines terms.* | Neutral with Amendment #2 | |

| | | | | | |
|---|---|---|---|---|---|
| Health | Mandate for Insulin Injectables for Weight loss (STATE EMPLOYEES ONLY) | SB 0853 (SFA 0003) Joyce | *Amends the State Employees Group Insurance Act of 1971. Provides that, beginning on July 1, 2024 (rather than January 1, 2024), the program of health benefits covered under the Act (rather than the State Employees Group Insurance Program) shall provide coverage for all types of medically necessary injectable medicines (rather than injectable medicines) prescribed on-label or off-label to improve glucose or weight loss for use by adults diagnosed or previously diagnosed with prediabetes, gestational diabetes, or obesity. Provides that, to continue to qualify for coverage under the provisions, the continued treatment must be medically necessary, and covered members must, if given advance, written notice, participate in a lifestyle management plan administered by their health plan. Amends the Emergency Telephone System Act. Provides that the Governor's appointments to the Statewide 9-1-1 Advisory Board shall have a term of 3 years and until their respective successors are appointed (rather than a term of 3 years).* | Monitor | SENATE Referred to Assignments |
| Health | White Bagging | SB 1255 Castro | Provides that a health benefit plan amended, delivered, issued, or renewed on or after January 1, 2024 that provides prescription drug coverage or its contracted pharmacy benefit manager shall not engage in or require an enrollee to engage in specified prohibited acts. Provides that a clinician-administered drug supplied shall meet the supply chain security controls and chain of distribution set by the federal Drug Supply Chain Security Act. | Oppose | SENATE Re-Assigned to Insurance |
| Health | Dental Network Plan Change | SB 1288 Fine | In provisions concerning provider notification of dental plan changes, provides that no insurer, service corporation, dental service plan corporation, insurance network leasing company, or any company that issues, delivers, amends, or renews an individual or group policy of accident and health insurance on or after the effective date of the amendatory Act that provides dental insurance may automatically enroll a provider in a leased network without the provider's written consent. Provides that any contract entered into or renewed on or after the effective date of the amendatory Act that allows the rights and obligations of the contract to be assigned or leased to another insurer shall provide for notice that informs each provider in writing via certified mail 90 days before any scheduled assignment or lease of the network to which the provider is a contracted provider (rather than | Oppose | SENATE Re-Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | | | shall provide notice of that assignment or lease within 30 days after the assignment or lease to the contracting dentist).<br>SB 1288 (SFA 0001) **(ADOPTED)**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Provides that no dental carrier may automatically enroll a provider in a leased network without allowing any provider that is part of the dental carrier's provider network to choose to not participate by opting out. Provides that the provisions do not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to a provider network contract for dental services provided to beneficiaries of specified health plans. Provides that any contract entered into or renewed on or after the effective date of the amendatory Act that allows the rights and obligations of the contract to be assigned or leased to another insurer shall provide for notice that informs each provider in writing via certified mail 60 days before any scheduled assignment or lease of the network to which the provider is a contracted provider (rather than shall provide notice of that assignment or lease within 30 days after the assignment or lease to the contracting dentist). Makes other changes.* | Neutral with Amendment #1 | |
| Health | Medical Patient Rights | SB 1300<br>Joyce | Establishes the right of each patient to receive from his or her health care provider an estimated cost of nonemergency medical treatment prior to undergoing the nonemergency medical treatment. | Monitor | SENATE Referred to Assignments |
| Health | Home Equipment Reimbursement | SB 1422<br>Joyce | Provides that if the policies, agreements, or arrangements of an insurer operate unreasonably in restricting an insured individual's ability to obtain home medical equipment, then an insurer is required to reasonably reimburse its insured for expenses incurred due to the unreasonable restriction. Defines "arrangement". | Oppose | SENATE Referred to Assignments |
| Health | Mental Health First Responders | SB 1512<br>Hastings | Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide any mental health treatment coverage without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement for any police officer, firefighter, emergency medical services personnel, or veteran. | Oppose | SENATE Re-Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| Health | Insurance Coverage Changes | SB 1557 Murphy | Provides that no individual or group policy of accident and health insurance or managed care organization shall change an insured's eligibility or coverage during a contract period. Provides that during a contract period, insureds shall have the protection and continuity of their providers, medication, covered benefits, and formulary during the contract period. Amends the Illinois Public Aid Code making conforming changes.<br>SB1557 (SCA1) (**RE-REFERRED TO ASSIGNMENTS)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. In provisions concerning insurance contract terms, removes a managed care organization from policies subject to specified requirements. Removes provisions concerning the Illinois Public Aid Code.* | Oppose<br><br>Neutral with Amendment #1 | SENATE Re-Referred to Assignments |
| Health | Athletic Trainers | SB 1585 Cunningham | Provides that the definition of "health care professional" includes athletic trainers. | Monitor | SENATE Re-Referred to Assignments |
| Health | Health Plan Benefit Data | SB 1618 Morrison | Provides that no later than July 1, 2024, each health plan and pharmacy benefit manager operating in this State shall, upon request of a covered individual, his or her health care provider, or an authorized third party on his or her behalf, furnish specified cost, benefit, and coverage data to the covered individual, his or her health care provider, or the third party of his or her choosing and shall ensure that the data is: (1) current no later than one business day after any change is made; (2) provided in real time; and (3) in a format that is easily accessible to the covered individual or, in the case of his or her health care provider, through an electronic health records system. Provides that the format of the request shall use specified industry content and transport standards. | Oppose | SENATE Re-Referred to Assignments |
| Health | Health Insurance Employment | SB 1708 Simmons | Provides that a group 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 that an employer makes available to any employee shall also be made available to all individuals employed by the employer, regardless of the amount of hours per week an employee works. | Oppose | SENATE Re-Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| Health | $35 Insulin Co Pay | SB 1756 Turner | Provides that an insurer that provides coverage for prescription insulin drugs pursuant to the terms of a health coverage plan the insurer offers shall limit the total amount that an insured is required to pay for a 30-day supply of covered prescription insulin drugs at an amount not to exceed $35 (rather than $100). | Oppose | SENATE Referred to Assignments |
| Health | Insurance billing | SB 1762 Gillespie | In provisions concerning required disclosures on contracts and evidence of coverage of accident and health insurance, provides that insurers must notify beneficiaries that nonparticipating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except for specified services, including items or services provided to a Medicare beneficiary, insured, or enrollee. | Oppose | SENATE Re-Assigned to Insurance |
| Health | Glucose Monitor Mandate | SB 1773 Morrison | Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2024 shall provide coverage for medically necessary continuous glucose monitors for individuals who are diagnosed with type 1 or type 2 diabetes, gestational diabetes, maturity-onset diabetes of the young, neonatal diabetes, diabetes caused by Wolfram syndrome, diabetes caused by Alstrom syndrome, latent autoimmune diabetes in adults, steroid-induced diabetes, or cystic fibrosis diabetes (rather than only type 1 or type 2 diabetes) and require insulin for the management of their diabetes. | Oppose | SENATE Re-Referred to Assignments |
| Health | Patient Billing Collection | SB 1802 Murphy | Provides that before pursuing a collection action against an insured patient for the unpaid amount of services rendered, a health care provider must review a patient's file to ensure that the patient does not have a Medicare supplement policy or any other secondary payer health insurance plan. Provides that if, after reviewing a patient's file, the health care provider finds no supplemental policy in the patient's record, the provider must then provide notice to the patient and give that patient an opportunity to address the issue. | Monitor | SENATE Re-Referred to Assignments |
| Health | Rate Review | SB 1912 Fine | Provides that the Department of Insurance shall establish the Office of the Healthcare Advocate. Provides that the Office shall be administered by the Chief Health Care Advocate, who shall report to the Director of Insurance. Amends the Illinois Insurance Code and the Health Maintenance Organization Act. Provides that all individual and small group accident and health policies written subject to certain | Oppose | SENATE Re-Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | | | federal standards must file rates with the Department for approval. Provides that unreasonable rate increases or inadequate rates shall be modified or disapproved. Provides that when an insurer files a schedule or table of premium rates for individual or small group health benefit plans, the insurer shall post notice of the premium rate filings and a filing summary in plain language on the insurer's website. Provides that the Department shall post all insurers' rate filings and summaries on the Department's website. Provides that the Department shall open a 30-day public comment period on the date that a rate filing is posted on the website. Provides that the Department shall hold a public hearing during the 30-day comment period. Provides that the Director shall adopt affordability standards that must be considered in any decision to approve, disapprove, or modify rate filings. Provides that after the close of the public comment period, the Department shall issue a decision to approve, disapprove, or modify a rate filing, and post the decision on the Department's website.<br>SB 1912 (SCA 0001) **(RE-REFERRED TO ASSIGNMENTS**)<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill. Provides that the Department of Insurance shall establish the Office of the Healthcare Advocate within the State health benefits exchange (rather than only the Department shall establish the Office of Healthcare Advocate). Provides that the Healthcare Advocate (rather than the Director of Insurance) shall develop and recommend affordability standards that must be considered by the Director in any decision to approve, disapprove, or modify rates. Provides that beginning plan year 2026 (rather than without a specified application date), rate increases for all individual and small group accident and health insurance policies subject to specified provisions must be filed with the Department for approval. Provides that beginning plan year 2025 (rather than without a specified application date), when an insurer or a health maintenance organization files a schedule or table of premium rates for individual or small group health benefit plans, the insurer or health maintenance organization shall post notice of the rate filing and a filing summary in plain language on the insurer's or organization's website. Provides that the Department shall hold a* | Oppose with Amendment 1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *public hearing within 10 days after public comments are posted on the Department's website (rather than the Department shall hold a public hearing during a 30-day comment period). Provides that all insurers and health maintenance organizations selling plans in the individual and small group markets shall appear at the public hearing to explain their rate filings and justifications. Makes other changes.* | | |
| Health | Ambulance | SB 1925<br>Holmes | Provides that nothing in the provisions shall require an ambulance provider to bill a beneficiary, insured, enrollee, or health insurance issuer when prohibited by any other law, rule, ordinance, contract, or agreement. Limits home rule powers. Changes the definition of "emergency services" and "health care provider". Amends the Health Maintenance Organization Act. Removes language providing that upon reasonable demand by a provider of emergency transportation by ambulance, a health maintenance organization shall promptly pay to the provider, subject to coverage limitations stated in the contract or evidence of coverage, the charges for emergency transportation by ambulance provided to an enrollee in a health care plan arranged for by the health maintenance organization.<br>SB 1925 (SCA 0001) **(RE-ASSIGNED TO INSURANCE)**<br>*Includes a provider of ground ambulance services in the definition of "health care provider".* | Monitor<br><br>Monitor with Amendment #1 | SENATE<br>Re-Assigned to Insurance |
| Health | Patient Billing | SB 2080<br>Peters | Requires hospitals to screen patients for health insurance and financial assistance. Prohibits the sale of a patient's medical debt by a hospital. Prohibits hospitals from offering a payment plan to an uninsured patient without first exhausting any discount available to the uninsured patient under the Hospital Uninsured Patient Discount Act and from entering into a payment plan for a bill that is eligible to be discounted by 100% under the Hospital Uninsured Patient Discount Act. Makes other changes. Amends the Hospital Uninsured Patient Discount Act. Provides that hospital may not make the availability of a discount and maximum collectible amount contingent upon an uninsured patient's eligibility for specified programs if the patient declines to apply for a public health insurance program on the basis of concern for immigration-related consequences to the patient, which shall not be grounds for the hospital to deny financial assistance under the hospital's financial assistance policy. | Monitor | SENATE<br>Re-Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| Health | Benefit Screenings | SB 2176 Simmons | Provides that notwithstanding any provision to the contrary, an individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State on or after the effective date of the amendatory Act shall provide coverage of specified health benefits for individuals at least 55 years of age but no more than 65 years of age. | Oppose | SENATE Re-Referred to Assignments |
| Health | Family Benefit Screenings | SB 2191 Villivalam | Provides that every policy issued, amended, delivered, or renewed in this State on or after January 1, 2025 shall provide coverage for the domestic partner, child of the domestic partner, sibling, parent, or live-in family member of an insured or policyholder that is equal to and subject to the same terms and conditions as the coverage provided to a spouse or an insured policyholder. | Oppose | SENATE Referred to Assignments |
| Health | ISMS Batch Bill | SB 2295 Morrison | In provisions concerning billing for services provided by nonparticipating providers or facilities, provides that if attempts to negotiate reimbursement for services provided by a nonparticipating provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the health insurance issuer, then the health insurance issuer, nonparticipating provider, or the facility may initiate binding arbitration to determine payment for services provided on a per-bill or a batched-bill basis (instead of only a per-bill basis) in accordance with specified law. | Neutral | SENATE Re-Referred to Assignments |
| Health | Easy Enrollment | SB 2312 Villanueva | Provides that the Department of Insurance shall establish an easy enrollment program that shall establish a State–based reporting system to provide information about the health insurance status of State residents obtained through State income tax returns to identify uninsured individuals and determine whether an uninsured individual is interested in obtaining minimum essential coverage through the program of medical assistance under the Illinois Public Aid Code or another State health plan, determine whether an uninsured individual who is interested in obtaining minimum essential coverage qualifies for an insurance affordability program, proactively contact an uninsured individual who is interested in obtaining minimum essential coverage to assist in enrolling the uninsured individual in an insurance affordability program and minimum essential coverage, and maximize enrollment of eligible uninsured individuals in insurance affordability | Monitor | SENATE Re-Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | | | programs and minimum essential coverage to improve access to care and reduce insurance costs for all residents of the State. | | |
| Health | Vison Hearing Dental | SB 2362 Ventura | Provides that every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in the State and Medicaid managed care organizations providing coverage for hospital or medical treatment on or after January 1, 2024 shall provide coverage for medically necessary treatment of vision, hearing, and dental disorders or conditions. Sets forth provisions concerning availability of plan information, notification, external review, limitations on benefits for medically necessary services, and medical necessity determinations. Provides that if the Director of Insurance determines that an insurer has violated the provisions, the Director may assess a civil penalty between $1,000 and $5,000 for each violation. Sets forth provisions concerning vision, hearing, and dental disorder or condition parity. | Oppose | SENATE Re-Referred to Assignments |
| Health | Benefit Mandate non-insulin injectables | SB2572 Castro | Amends the Illinois Insurance Code. In provisions concerning infertility coverage, provides that no group policy of accident and health insurance providing coverage for more than 25 employees that provides pregnancy related benefits may be issued, amended, delivered, or renewed in the State on or after January 1, 2024 unless the policy contains coverage for the diagnosis and treatment of infertility, including procedures necessary to screen or diagnose a fertilized egg before implantation. Provides that coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if the procedures comply with specified requirements. Provides that a group or individual policy of accident and health insurance providing coverage for more than 25 employees that is amended, delivered, issued, or renewed on or after January 1, 2024 shall provide, for individuals 45 years of age and older, coverage for an annual menopause health visit. Provides that a group or individual policy of accident and health insurance providing coverage for more than 25 employees that is amended, delivered, issued, or renewed on or after January 1, 2024 shall provide coverage for all types of injectable medicines prescribed on-label or off-label to improve glucose or | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | weight loss for use by adults diagnosed or previously diagnosed with prediabetes, gestational diabetes, or obesity. Makes other changes. Makes conforming changes in the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Medical Assistance Article of the Illinois Public Aid Code. ***Effective immediately.*** | | |
| Health | Benefit Mandate/ Wigs | SB2573 Harris, III | Amends the Accident and Health Article of the Illinois Insurance Code. Provides that a group or individual plan of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of the amendatory Act must provide coverage for wigs or other scalp prostheses worn for hair loss caused by alopecia, chemotherapy, or radiation treatment for cancer or other conditions. Makes a conforming change in the Health Maintenance Organization Act and the Voluntary Health Services Plans Act. ***Effective immediately.***<br>SB 2573 (SCA 0001) **(ADOPTED)**<br>*Provides that a group or individual plan of accident and health insurance or managed care plan amended, delivered, issued, or renewed after January 1, 2026 (instead of the effective date of the amendatory Act) must provide coverage for, no less than once every 12 months, one wig or other scalp prosthesis (instead of coverage for wigs or other scalp prostheses) worn for hair loss caused by alopecia, chemotherapy, or radiation treatment for cancer or other conditions.* | Oppose<br><br>Neutral with Amendment #1 | SENATE 2nd Reading |
| Health | Fertility Preservation | SB2623 Toro | Amends the Illinois Insurance Code. Requires an individual or group policy of accident and health insurance amended, delivered, issued, or renewed in the State after June 1, 2024 to provide coverage for expenses for standard fertility preservation services and follow-up services related to that coverage. Defines "standard fertility preservation services" as procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care. Makes conforming changes in the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | Code, the School Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Illinois Public Aid Code. ***Effective immediately.*** | | |
| Health | Provide pregnancy related benefits | SB2639 Hastings | Amends the Illinois Insurance Code. Provides that, for a group policy of accident and health insurance providing coverage for more than 25 employees that provides pregnancy related benefits that is issued, amended, delivered, or renewed in this State after the effective date of the amendatory Act, if a covered individual obtains, from a physician licensed to practice medicine in all its branches, a recommendation approving the covered individual to seek in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer based on any of the following: the covered individual's medical, sexual, and reproductive history; the covered individual's age; physical findings; or diagnostic testing, then the procedure shall be covered without any other restrictions or requirements. | Oppose | SENATE 2nd Reading |
| Health | Network Adequacy | SB2641 Holmes | Amends the Network Adequacy and Transparency Act. Provides that the Department of Insurance shall determine whether the network plan at each in-network hospital and facility has a sufficient number of hospital-based medical specialists to ensure that covered persons have reasonable and timely access to such in-network physicians and the services they direct or supervise. Defines "hospital-based medical specialists". | Monitor | SENATE 2nd Reading |
| Health | Colonoscopy Coverage | SB2659 Preston | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for a colonoscopy determined to be medically necessary for persons aged 39 years old to 75 years old. | Oppose | SENATE Referred to Assignments |
| Health | Riding Therapy | SB2671 Murphy | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed after the effective date of the amendatory Act shall provide coverage for hippotherapy and other forms of therapeutic riding. Makes conforming changes in the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | Municipal Code, the School Code, and the Health Maintenance Organization Act.<br>SB 2671 (SCA 0001) **(ASSIGNED TO INSURANCE)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed after the effective date of the amendatory Act shall provide coverage for equine therapy. Defines "equine therapy"*<br>SB 2671 (SCA 0002) **(ASSIGNED TO INSURANCE)**<br>*Replaces everything after the enacting clause. Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following change. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026 (instead of the effective date of the amendatory Act) shall provide medically necessary coverage (instead of coverage) for hippotherapy and other forms of therapeutic riding.* | Oppose with Amendment #1<br><br>Neutral with Amendment #2 | |
| Health | Generic Drug Shortage | SB2672<br>Murphy | Amends the Accident and Health Article of the Illinois Insurance Code. Provides that if a generic drug is unavailable due to a supply issue and dosage cannot be adjusted, a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed after January 1, 2025 shall provide coverage for a brand name eligible prescription drug until supply of the generic drug is available. Defines "eligible prescription drug" and "generic drug". Makes conforming changes in the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Medical Assistance Article of the Illinois Public Aid Code.<br>SB 2672 (SCA 0001)**(ADOPTED)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Adds a definition of "unavailable". Provides that if a generic drug or a therapeutic equivalent is unavailable (rather than if a generic drug is unavailable) due to a supply issue and dosage cannot be adjusted, a group or individual policy of accident and health insurance or a managed care* | Oppose<br><br>Neutral with Amendment #1 | SENATE<br>2nd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | *plan that is amended, delivered, issued, or renewed after January 1, 2026 (instead of January 1, 2025) shall provide coverage for a brand name eligible prescription drug until supply of the generic drug or a therapeutic equivalent is available.* | | |
| Health | Cancer – Genetic Testing | SB2697<br>Morrison | Amends the Illinois Insurance Code. Defines terms. Provides that a group policy of accident and health insurance that provides coverage for hospital or medical treatment or services for illness on an expense-incurred basis and that is amended, delivered, issued, or renewed after January 1, 2025 shall provide coverage, without imposing any cost-sharing requirement, for clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer that is recommended by a health care professional; and evidence-based cancer imaging for individuals with an increased risk of cancer as recommended by National Comprehensive Cancer Network clinical practice guidelines. Provides that the requirements do not apply to coverage of genetic testing or evidence-based cancer imaging to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to the Internal Revenue Code.<br>SB 2697 (SCA 0001) **(ADOPTED )**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Provides that a group policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed after January 1, 2026 shall provide coverage for clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer as recommended by a health care professional in accordance with current evidence-based clinical practice guidelines. Provides that the coverage shall limit the total amount that a covered person is required to pay for a clinical genetic test under this subsection to an amount not to exceed $50. Provides that for individuals with a genetic test that is positive for an inherited mutation associated with an increased risk of cancer, coverage shall include any cancer risk management strategy as recommended by a health care professional in accordance with current evidence-based clinical practice guidelines to the extent that the management recommendation is not already covered by the policy. Amends the State Employees Group* | Oppose<br><br>Neutral with Amendment #1 | SENATE<br>3RD Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | *Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, and the Voluntary Health Services Plans Act to make a conforming change.* | | |
| Health | Electronic Payment Fees | SB2735<br>Fine | Amends the Illinois Insurance Code. Provides that no insurer, health maintenance organization, managed care plan, health care plan, preferred provider organization, or third-party administrator, or bank or payment processing company under contract with one of those entities, shall charge a provider a fee, fine, or cost for using an electronic funds transfer process, including, but not limited to, direct deposit, virtual or digital checks, or virtual credit cards, to receive payment for health care services provided to an insured. Amends the Health Maintenance Organization Act to make a conforming change. ***Effective immediately.***<br>SB 2735 (SCA 0001) **(ADOPTED)**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Provides that any group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after January 1, 2026 shall offer all reasonably available methods of payment from the insurer or managed care plan, or its contracted vendor, to the contracted health care provider. Provides that an insurer or managed care plan shall not mandate payment by credit card. Provides that if one of the available payment methods has a fee associated with it, the insurer or managed care plan, or its contracted vendor, shall notify the health care provider of certain information and provide the health care provider with instructions on how to select each method. Provides that if a health care provider requests a change in the available payment method, the insurer or managed care plan, or its contracted vendor, shall implement the change to the payment method selected by the health care provider within 30 business days, subject to federal and State verification measures to prevent fraud and abuse. Provides that an insurer or managed care plan shall not use a health care provider's preferred method of payment as a factor when deciding whether to provide credentials to a health care provider. Defines terms. Amends the Health Maintenance Organization Act to make a conforming change.* | Oppose<br><br>Neutral with Amendment #1 | SENATE<br>3rd Reading |

| | | | | | |
|---|---|---|---|---|---|
| Health | Vaccine Admin. Fee | SB2744 Fine | Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the Health Maintenance Organization Act, and the Voluntary Health Services Plans Act to provide that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for vaccine administration fees, regardless of the type of provider that administers the vaccine, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement. Provides that the coverage does not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account under the Internal Revenue Code of 1986. | Oppose | SENATE Assigned to Insurance |
| Health | Adoptee Medical Testing | SB2759 Hunter | Creates the Adoptee Baseline Medical Testing Act. Requires medical intake forms for services provided by health care providers to include questions concerning the patient's adoption status and, if adopted, whether the patient has access to the patient's biological medical history. Provides that, if a patient has indicated on the medical intake form that the patient is adopted and does not have access to the patient's biological medical history, then, upon request by the patient or patient's parent or guardian, the health care provider shall provide no-cost, baseline testing with minimized time-bound restrictions for genetically predisposed conditions or diseases. Provides that if the patient or patient's parent or guardian requests such testing and the health care provider does not have personnel qualified to perform the testing, the health care provider must make a referral to another health care provider that is qualified to perform the testing and that will accept the referral. Subject to appropriation, requires the Department of Public Health, by rule, to create a State-funded system to pay for the baseline testing to the extent that another source does not cover the cost of the testing. Requires the Department of Public Health to develop educational materials and presentations for distribution to health care providers that provide information on the need for access to biological medical history and the detriments of lack of access to biological medical history for adoptees. Provides that the Department of Public Health shall administer and enforce the Act. | Oppose | SENATE Assigned to Appropriations |

| | | | | | |
|---|---|---|---|---|---|
| | | | Amends the Illinois Insurance Code to require coverage for baseline testing for genetically predisposed conditions or diseases if a patient has indicated on a medical intake form that the patient is adopted and does not have access to the patient's biological medical history. Provides that such a policy shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided. Makes conforming changes in the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Medical Assistance Article of the Illinois Public Aid Code. | | |
| Health | Coverage Changes | SB2789 Murphy | Amends the Illinois Insurance Code. Provides that no individual or group policy of accident and health insurance shall amend, deliver, issue, or renew a policy in a way that changes an insured's eligibility or coverage during a contract period. During a contract period, an insured shall have the protection and continuity of his or her providers, his or her medication, his or her covered benefits, and the formulary during the contract period. | Oppose | SENATE Assigned to Insurance |
| Health | Short term Limited Duration Insurance | SB2836 Fine | Amends the Illinois Insurance Code. Sets forth provisions concerning short-term, limited-duration insurance. Provides that on and after January 1, 2025, no company shall issue, deliver, amend, or renew short-term, limited-duration insurance to any natural or legal person that is a resident or domiciled in the State. Provides that the Department of Insurance may adopt rules as deemed necessary that prescribe specific standards for or restrictions on policy provisions, benefit design, disclosures, and sales and marketing practices for excepted benefits. Provides that the Director of Insurance's authority under specified provisions is extended to group and blanket excepted benefits. Provides that the language does not apply to limited-scope dental, limited-scope vision, long-term care, Medicare supplement, credit life, credit health, or any excepted benefits that are filed under specified provisions. Provides that nothing in the language shall be construed to limit the Director's authority under other statutes. Makes conforming changes in the Health Maintenance Organization Act and the Limited Health Service Organization Act. Repeals the Short-Term, | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | Limited-Duration Health Insurance Coverage Act. ***Effective January 1, 2025.*** | | |
| Health | IL Health Benefits Exchange Law | SB2858 Harris | Amends the Illinois Health Benefits Exchange Law. Provides that the Department of Insurance and the Department of Healthcare and Family Services have the authority to require, when the Department of Insurance operates the Illinois Health Benefits Exchange as a State-based exchange, the Illinois Health Benefits Exchange to offer enhanced direct enrollment technology that allows approved enhanced direct enrollment entities to maintain enrollment services as offered through the Federally Facilitated Marketplace's enhanced direct enrollment implementation; to require enhanced direct enrollment to be available for the first open enrollment period for the State-based exchange; to require that the State-based exchange adopt the application programming interface for the Federally Facilitated Marketplace's enhanced direct enrollment or adopt an application programming interface that is substantially similar; and to require enhanced direct enrollment entities to be approved to operate in the Federally Facilitated Marketplace and maintain compliance with all Centers for Medicare and Medicaid Services' privacy, security, and business requirements. Defines terms. | Monitor *(Presently working on language)* | SENATE Assigned to Insurance |
| Health | Behavioral Health | SB2896 Villa | Amends the Illinois Insurance Code. Provides that the amendatory Act may be referred to as the Strengthening Mental Health and Substance Use Parity Act. Provides that a group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025, or any third-party administrator administering the behavioral health benefits for the insurer, shall cover all out-of-network medically necessary mental health and substance use benefits and services (inpatient and outpatient) as if they were in-network for purposes of cost sharing for the insured. Provides that the insured has the right to select the provider or facility of their choice and the modality, whether the care is provided via in-person visit or telehealth, for medically necessary care. Sets forth minimum reimbursement rates for certain behavioral health benefits. Sets forth provisions concerning responsibility for compliance with parity requirements; coverage and payment for multiple covered mental health and substance use services, mental | Monitor | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | health or substance use services provided under the supervision of a licensed mental health or substance treatment provider, and 60-minute individual psychotherapy; timely credentialing of mental health and substance use providers; Department of Insurance enforcement and rulemaking; civil penalties; and other matters. Amends the Illinois Administrative Procedure Act to authorize emergency rulemaking. ***Effective immediately.*** | | |
| Health | Medicare Enrollment Period | SB 2910 Fine | Amends the Illinois Insurance Code. In provisions concerning Medicare supplement policy minimum standards, provides that if an individual is at least 65 years of age but no more than 75 years of age and has an existing Medicare supplement policy, then the individual is entitled to an annual open enrollment period lasting 45 days, commencing with the individual's birthday, and the individual may purchase any Medicare supplement policy with the same issuer or any affiliate authorized to transact business in the State (instead of only the same issuer) that offers benefits equal to or lesser than those provided by the previous coverage. | Monitor | SENATE Assigned to Insurance |
| Health | Medicaid Waiver - ACA | SB 2985 Rezin | Amends the State Employees Group Insurance Act of 1971. Prohibits the State from applying for any federal waiver that would reduce or eliminate any protection or coverage required under the Patient Protection and Affordable Care Act (Affordable Care Act) that was in effect on January 1, 2017, including, but not limited to, any protection for persons with preexisting conditions and coverage for services identified as essential health benefits under the Affordable Care Act. Provides that the State or an agency of the executive branch may apply for such a waiver only if granted authorization by the General Assembly through joint resolution. Amends the Illinois Insurance Code. Prohibits the State from applying for any federal waiver that would permit an individual or group health insurance plan to reduce or eliminate any protection or coverage required under the Affordable Care Act that was in effect on January 1, 2017, including, but not limited to, any protection for persons with preexisting conditions and coverage for services identified as essential health benefits under the Affordable Care Act. Provides that the State or an agency of the executive branch may apply for such a waiver only if granted authorization by the General Assembly through joint resolution. | Support | SENATE Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | | | Amends the Illinois Public Aid Code. Prohibits the State or an agency of the executive branch from applying for any federal Medicaid waiver that would result in more restrictive standards, methodologies, procedures, or other requirements than those that were in effect in Illinois as of January 1, 2017 for the Medical Assistance Program, the Children's Health Insurance Program, or any other medical assistance program in Illinois operating under any existing federal waiver authorized by specified provisions of the Social Security Act. Provides that the State or an agency of the executive branch may apply for such a waiver only if granted authorization by the General Assembly through joint resolution. ***Effective immediately.*** | | |
| Health | Health Data Privacy Act | SB 3080 Villanueva | Creates the Protect Health Data Privacy Act. Provides that a regulated entity shall disclose and maintain a health data privacy policy that clearly and conspicuously discloses specified information. Sets forth provisions concerning health data privacy policies. Provides that a regulated entity shall not collect, share, or store health data, except in specified circumstances. Provides that it is unlawful for any person to sell or offer to sell health data concerning a consumer without first obtaining valid authorization from the consumer. Provides that a valid authorization to sell consumer health data must contain specified information; a copy of the signed valid authorization must be provided to the consumer; and the seller and purchaser of health data must retain a copy of all valid authorizations for sale of health data for 6 years after the date of its signature or the date when it was last in effect, whichever is later. Sets forth provisions concerning the consent required for collection, sharing, and storage of health data. Provides that a consumer has the right to withdraw consent from the collection, sharing, sale, or storage of the consumer's health data. Provides that it is unlawful for a regulated entity to engage in discriminatory practices against consumers solely because they have not provided consent to the collection, sharing, sale, or storage of their health data or have exercised any other rights provided by the provisions or guaranteed by law. Sets forth provisions concerning a consumer's right to confirm whether a regulated entity is collecting, selling, sharing, or storing any of the consumer's health data; a consumer's right to have the consumer's health data that is collected by a regulated entity deleted; | Oppose | SENATE Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | | | prohibitions regarding geofencing; and consumer health data security. Provides that any person aggrieved by a violation of the provisions shall have a right of action in a State circuit court or as a supplemental claim in federal district court against an offending party. Provides that the Attorney General may enforce a violation of the provisions as an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act. Defines terms. Makes a conforming change in the Consumer Fraud and Deceptive Business Practices Act. | | |
| Health | Health Care Availability | SB 3108 Koehler | Creates the Health Care Availability and Access Board Act. Establishes the Health Care Availability and Access Board to protect State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the State, and other stakeholders within the health care system from the high costs of prescription drug products. Contains provisions concerning Board membership and terms; staff for the Board; Board meetings; circumstances under which Board members must recuse themselves; and other matters. Provides that the Board shall perform the following actions in open session: (i) deliberations on whether to subject a prescription drug product to a cost review; and (ii) any vote on whether to impose an upper payment limit on purchases, payments, and payor reimbursements of prescription drug products in the State. Permits the Board to adopt rules to implement the Act and to enter into a contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the Board. Creates the Health Care Availability and Access Stakeholder Council to provide stakeholder input to assist the Board in making decisions as required by the Act. Contains provisions concerning Council membership, member terms, and other matters. Provides that the Board shall adopt the federal Medicare Maximum Fair Price as the upper payment limit for a prescription drug product intended for use by individuals in the State. Requires the Attorney General to enforce the Act. ***Effective 180 days after becoming law.*** | TBD | SENATE Referred to Assignments |
| Health | State Based Exchange | SB 3130 Gillespie | Amends the Illinois Insurance Code. Provides that beginning with the operation of a State-based exchange in plan year 2026, a pregnant individual has the right to enroll in a qualified health plan through a special enrollment period at any time after a qualified health care | TBD (working with DOI) | SENATE 2nd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | professional certifies that the individual is pregnant. Amends the Illinois Health Insurance Portability and Accountability Act. Provides that notice of a health insurance issuer's election to uniformly modify coverage, uniformly terminate coverage, or discontinue coverage in a marketplace shall be sent by certified mail to the Department of Insurance 45 days (instead of 90 days) in advance of any notification of the company's actions sent to plan sponsors, participants, beneficiaries, and covered individuals. Makes conforming changes. Amends the Managed Care Reform and Patient Rights Act. Makes changes in provisions concerning flat-dollar copayment structures for prescription drug benefits. Amends the Network Adequacy and Transparency Act. Provides that the Act does not apply to an individual or group policy for excepted benefits or short-term, limited-duration health insurance coverage (instead of an individual or group policy for dental or vision insurance or a limited health service organization) with a network plan, except to the extent that federal law establishes network adequacy and transparency standards for stand-alone dental plans, which the Department shall enforce. Provides that if the Centers for Medicare and Medicaid Services establishes minimum provider ratios for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year. Requires the Department of Insurance to enforce certain appointment wait-time standards, time and distance standards, and other standards if the Centers for Medicare and Medicaid Services establishes those standards for plans in the type of exchange in use in this State. Makes other changes.<br>SB 3130 (SCA 0001) **(REFERRED TO ASSIGNMENTS – TO STAY IN ASSIGNMENTS)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Amends the Department of Insurance Law of the Civil Administrative Code of Illinois. Provides that the Marketplace Director of the Illinois Health Benefits Exchange shall serve for a term of 2 years, and until a successor is appointed and qualified; except that the term of the first Marketplace Director appointed shall expire on the third Monday in January 2027.* | Neutral with Amendment #1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *Provides that the Marketplace Director may serve for more than one term. Removes language providing that the Marketplace Director may be an existing employee with other duties. Provides that the Marketplace Director shall (instead of shall not) be subject to the Personnel Code. In the Illinois Insurance Code, provides that a pregnant individual has the right to enroll in a qualified health plan through a special enrollment period within 60 days (instead of at any time) after any qualified health care professional certifies that the individual is pregnant. In the Managed Care Reform and Patient Rights Act, provides that each level of coverage that a health insurance carrier offers of a standardized option in each applicable service area shall be deemed to satisfy (instead of shall satisfy) the requirements for a flat-dollar copay structure. Amends the Health Maintenance Organization Act. Provides that health maintenance organizations shall comply with the Illinois Insurance Code's requirements concerning pregnancy as a qualifying life event.* ***Effective immediately, except that the changes to the Network Adequacy and Transparency Act take effect January 1, 2025.***<br>SB 3130 (SFA 0002) **(REFERRED TO ASSIGNMENTS)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Amends the Department of Insurance Law of the Civil Administrative Code of Illinois. Provides that the Marketplace Director of the Illinois Health Benefits Exchange shall serve for a term of 2 years, and until a successor is appointed and qualified; except that the term of the first Marketplace Director appointed shall expire on the third Monday in January 2027. Provides that the Marketplace Director may serve for more than one term. Removes language providing that the Marketplace Director may be an existing employee with other duties. Provides that the Marketplace Director shall (instead of shall not) be subject to the Personnel Code. In the Illinois Insurance Code, provides that a pregnant individual has the right to enroll in a qualified health plan through a special enrollment period within 60 days (instead of at any time) after any qualified health care professional certifies that the individual is pregnant. In the Managed Care Reform and Patient Rights Act, provides that each level of coverage that a health insurance carrier* | Neutral with Amendment 2 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *offers of a standardized option in each applicable service area shall be deemed to satisfy (instead of shall satisfy) the requirements for a flat-dollar copay structure. Amends the Health Maintenance Organization Act. Provides that health maintenance organizations shall comply with the Illinois Insurance Code's requirements concerning pregnancy as a qualifying life event.* ***Effective immediately, except that the changes to the Network Adequacy and Transparency Act take effect January 1, 2025.*** | | |
| Health | Pharma Benefit Manager | SB 3179<br>Harris | Amends the Illinois Insurance Code. Provides that all compensation remitted by or on behalf of a pharmaceutical manufacturer, pharmaceutical developer, or pharmaceutical labeler, directly or indirectly, to a health insurer or to a pharmacy benefit manager under contract with a health insurer that is related to the health insurer's prescription drug benefits must be either remitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular prescription drug or remitted to and retained by the health insurer. Requires a health insurer to file with the Department of Insurance a report demonstrating the health insurer's compliance with the provisions. | Oppose | SENATE<br>Referred to Assignments |
| Health | Inhaler Coverage | SB 3203<br>Hunter | Amends the Illinois Insurance Code. Provides that a health plan shall limit the total amount that a covered person is required to pay for a covered prescription inhaler at an amount not to exceed $25 per 30-day supply and shall limit the total amount that a covered person is required to pay for all covered prescription inhalers at an amount not to exceed $50 in total per 30 days. Provides that coverage for prescription inhalers shall not be subject to any deductible. Provides that nothing in the provisions prevents a health plan from reducing a covered person's cost sharing to an amount less than the cap. Authorizes rulemaking and enforcement by the Department of Insurance. ***Effective January 1, 2025.***<br>SB 3203 (SCA 0001) **(ADOPTED)**<br>*Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or before December 31, 2025 that provides coverage for prescription drugs may not deny or limit coverage for* | Oppose<br><br>Neutral with Amendment #1 | SENATE<br>3rd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | *prescription inhalers (instead of prescription inhalants) based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to those restrictions, the inhalants have been ordered or prescribed by the treating physician and are medically appropriate. Provides that a group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after January 1, 2026 that provides coverage for prescription drugs shall limit the total amount that a covered person is required to pay for a covered prescription inhaler to an amount not to exceed $25 dollars per 30-day supply, and provides that nothing in the provisions prevents a group or individual policy of accident and health insurance or managed care plan from reducing a covered person's cost sharing to an amount less than the cap. Makes a conforming change. Provides that coverage for prescription inhalers shall not be subject to any deductible, except to the extent that the coverage would disqualify a high-deductible health plan from eligibility for a health savings account. Authorizes rulemaking and enforcement by the Department of Insurance. Amends the State Employees Group Insurance Act of 1971. Provides that the program of health benefits shall provide coverage for prescription inhalers under the Illinois Insurance Code.* | | |
| Health | Clinician Administer Drug | SB 3225 Castro | Amends the Illinois Insurance Code. Provides that a health benefit plan amended, delivered, issued, or renewed on or after January 1, 2025 that provides prescription drug coverage through a medical or pharmacy health benefit or its contracted pharmacy benefit manager shall not engage in or require an enrollee to engage in specified prohibited acts. Provides that a clinician-administered drug shall meet the supply chain security controls and chain of distribution set by the federal Drug Supply Chain Security Act. Provides that the Department of Insurance may adopt rules as necessary to implement the provisions. Defines terms. Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, and the Voluntary Health Services Plans Act to require policies under those Acts to comply with the provisions. | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| Health | Dental Preauthorization | SB 3278 Syverson | Amends the Illinois Insurance Code. Provides that no insurer, dental service plan corporation, insurance network leasing company, or any company that amends, delivers, issues, or renews an individual or group policy of accident and health insurance that provides dental insurance on or after the effective date of the amendatory Act shall deny any claim subsequently submitted for procedures specifically included in a prior authorization unless certain circumstances apply. Provides that a dental service contractor shall not recoup a claim solely due to a loss of coverage for a patient or ineligibility if, at the time of treatment, the dental service contractor erroneously confirmed coverage and eligibility, but had sufficient information available to the dental service contractor indicating that the patient was no longer covered or was ineligible for coverage. Prohibits waiver of the provisions by contract. | Oppose | SENATE Assigned to Insurance |
| Health | Dental Loss Ratio | SB 3305 | Creates the Dental Loss Ratio Act. Sets forth provisions concerning dental loss ratio reporting. Provides that a health insurer or dental plan carrier that issues, sells, renews, or offers a specialized health insurance policy covering dental services shall, beginning January 1, 2025, annually submit to the Department of Insurance a dental loss ratio filing. Provides a formula for calculating minimum dental loss ratios. Sets forth provisions concerning minimum dental loss ratio requirements. Provides that the Department may adopt rules to implement the Act. Provides that the Act does not apply to an insurance policy issued, sold, renewed, or offered for health care services or coverage provided as a function of the State of Illinois Medicaid coverage for children or adults or disability insurance for covered benefits in the single specialized area of dental-only health care that pays benefits on a fixed benefit, cash payment-only basis. Defines terms. ***Effective January 1, 2025.*** | Oppose | SENATE Assigned to Insurance |
| Health | Non-Participating Providers | SB 3307 Holmes | Amends the Illinois Insurance Code. In a provision concerning billing for services provided by nonparticipating providers or facilities, provides that when calculating an enrollee's contribution to the annual limitation on cost sharing set forth under specified federal law, a health insurance issuer or its subcontractors shall include expenditures for any item or health care service covered under the policy issued to the enrollee by the health insurance issuer or its subcontractors if that | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | item or health care service is included within a category of essential health benefits and regardless of whether the health insurance issuer or its subcontractors classify that item or service as an essential health benefit. ***Effective immediately***. | | |
| Health | Practice of Pharmacy Influenza | SB 3336 Morrison | Amends the Pharmacy Practice Act and the Illinois Insurance Code. In the definition of "practice of pharmacy", includes the ordering of testing, screening, and treatment (rather than the ordering and administration of tests and screenings) for influenza. Makes conforming changes. ***Effective January 1, 2025.*** | Oppose | SENATE Referred to Assignments |
| Health | Continuous Glucose Monitor | SB 3414 Morrison | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed before January 1, 2025 shall provide coverage for medically necessary continuous glucose monitors for individuals who are diagnosed with any form of diabetes mellitus (instead of type 1 or type 2 diabetes) and require insulin for the management of their diabetes. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for continuous glucose monitors, related supplies, and training in the use of continuous glucose monitors for any individual who is diagnosed with diabetes, who requires at least one daily injection or infusion of insulin, and who has been prescribed a continuous glucose monitor by a physician, a certified nurse practitioner, or a physician assistant. Provides that an individual who is diagnosed with diabetes and meets the specified requirements shall not be required to obtain prior authorization for coverage for a continuous glucose monitor, and coverage shall be continuous once the continuous glucose monitor is prescribed. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage required under the provisions. ***Effective July 1, 2024.***<br>SB 3414 (SCA 0001) **(REFERRED TO ASSIGNMENTS – TO STAY IN ASSIGNMENTS)** | Oppose<br><br>Oppose with Amendment #1 | SENATE 3rd Reading |

| | | | | | |
|---|---|---|---|---|---|
| | | | *Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed before January 1, 2026 (rather than January 1, 2025) shall provide coverage for medically necessary continuous glucose monitors for individuals who are diagnosed with any form of diabetes mellitus and require insulin for the management of their diabetes. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026 shall provide coverage for continuous glucose monitors, related supplies, and training in the use of continuous glucose monitors for any individual if specified requirements are met and the policy is in full alignment with Medicare. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the Department of Healthcare and Family Services shall adopt rules to implement the changes made by the amendatory Act. Specifies that the rules shall, at a minimum contain certain provisions concerning the ordering provider, continuous glucose monitors not being required to have certain functionalities, eligibility requirements for a beneficiary, and not requiring prior authorization.*<br>SB 3414 (SCA 0002) **(ADOPTED)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with changes that include the following. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed before January 1, 2026 (rather than January 1, 2025) shall provide coverage for medically necessary continuous glucose monitors for individuals who are diagnosed with any form of diabetes mellitus and require insulin for the management of their diabetes. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026 shall provide coverage for continuous glucose monitors, related supplies, and training in the use of continuous glucose monitors for any individual if specified requirements are met and the policy is in full alignment with Medicare. Sets forth eligibility requirements and requirements for covered glucose monitors. Provides that the coverage of one glucose monitor shall be provided with a* | Neutral with Amendment #2 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *deductible, coinsurance, copayment, or any other cost-sharing requirement. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the Department of Healthcare and Family Services shall adopt rules to implement the changes made by the amendatory Act. Specifies that the rules shall, at a minimum contain certain provisions concerning the ordering provider, continuous glucose monitors not being required to have certain functionalities, eligibility requirements for a beneficiary, and not requiring prior authorization.* ***Effective July 1, 2024.*** | | |
| Health | Human Rights/Health Disclosure | SB 3492 Gillespie | Amends the Illinois Human Rights Act. Adds to the definition of unlawful discrimination to include discrimination of reproductive health decisions. Reproductive health decisions mean any decision by a person affecting the use or intended use of health care, goods, or services related to reproductive processes, functions, and systems, including, but not limited to, family planning, pregnancy testing, and contraception; fertility or sterilization care; miscarriage; continuation or termination of pregnancy; prenatal, intranatal, and postnatal care. Provides that discrimination based on reproductive health decisions includes unlawful discrimination against a person because of the person's association with another person's reproductive health decisions. | Oppose | SENATE Referred to Assignments |
| Health | Mobile Integrated Health | SB 3599 Edly-Allen | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for medically necessary services provided by emergency medical services providers operating under a mobile integrated health care model. Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Voluntary Health Services Plans Act, and the Illinois Public Aid Code to require coverage under those provisions. | Oppose | SENATE 2nd Reading |
| Health | Pregnancy/ Postpartum Care | SB 3665 Collins | Amends the Illinois Insurance Code. Provides that insurers shall cover all services for pregnancy, postpartum, and newborn care that are rendered by perinatal doulas or licensed certified professional midwives, including home births, home visits, and support during | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | labor, abortion, or miscarriage. Provides that the required coverage includes the necessary equipment and medical supplies for a home birth. Provides that coverage for pregnancy, postpartum, and newborn care shall include home visits by lactation consultants and the purchase of breast pumps and breast pump supplies, including such breast pumps, breast pump supplies, breastfeeding supplies, and feeding aides as recommended by the lactation consultant. Provides that coverage for postpartum services shall apply for at least one year after birth. Provides that certain pregnancy and postpartum coverage shall be provided without cost-sharing requirements. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that post-parturition care benefits shall not be subject to any cost-sharing requirement. Provides that the medical assistance program shall cover home visits for lactation counseling and support services. Provides that the medical assistance program shall cover counselor-recommended or provider-recommended breast pumps as well as breast pump supplies, breastfeeding supplies, and feeding aides. Provides that nothing in the provisions shall limit the number of lactation encounters, visits, or services; breast pumps; breast pump supplies; breastfeeding supplies; or feeding aides a beneficiary is entitled to receive under the program. Makes other changes. ***Effective January 1, 2026.***<br>SB 3665 (SCA 0001) **(ASSIGNED TO INSURANCE)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Removes language providing that post-parturition care benefits shall not be subject to any cost-sharing requirement. Provides that coverage for postpartum services shall apply for at least one year after the end of the pregnancy (rather than one year after birth). Provides that beginning January 1, 2025, certified professional midwife services (instead of licensed certified professional midwife services) shall be covered under the medical assistance program. Removes language providing that midwifery services covered under the provisions shall include home births and home prenatal, labor and delivery, and postnatal care. Removes changes to a provision of the Illinois Public Aid Code concerning reimbursement for postpartum visits.* ***Effective January 1,*** | Oppose with Amendment #1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | ***2026, except that certain changes to the Illinois Public Aid Code are effective January 1, 2025.***<br>SB 3665 (SCA 0002) **(ASSIGNED TO INSURANCE)**<br>*Provides that all outpatient coverage required under a provision concerning coverage for pregnancy, postpartum, and newborn care must be provided without cost sharing, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account and except that, for treatment of substance use disorders, the prohibition on cost-sharing applies to the levels of treatment below and not including 3.1 (Clinically Managed Low-Intensity Residential) established by the American Society of Addiction Medicine. Makes a conforming change. Further amends the Illinois Insurance Code. Provides that coverage for abortion care may not impose any deductible, coinsurance, waiting period, or other cost-sharing (instead of other cost-sharing limitation that is greater than that required for other pregnancy-related benefits covered by the policy). Provides that the provision does not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account.*<br>SB 3665 (SCA 0003) **(ASSIGNED TO INSURANCE)**<br>*Provides that all outpatient coverage required under a provision concerning coverage for pregnancy, postpartum, and newborn care must be provided without cost sharing, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account and except that, for treatment of substance use disorders, the prohibition on cost-sharing applies to the levels of treatment below and not including 3.1 (Clinically Managed Low-Intensity Residential) established by the American Society of Addiction Medicine. Makes a conforming change. Further amends the Illinois Insurance Code. Provides that coverage for abortion care may not impose any deductible, coinsurance, waiting period, or other cost-sharing (instead of other cost-sharing limitation that is greater than that required for other pregnancy-related benefits covered by the policy). Provides that the provision does not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account.* | Oppose with Amendment #2<br><br>Oppose with Amendment #3 | |

| | | | | | |
|---|---|---|---|---|---|
| Health | Short Term Health Insurance | SB 3675 Harris | Amends the Illinois Insurance Code. Provides that any failure to make a disclosure or obtain a signed confirmation required under specified provisions of the Short-Term, Limited-Duration Health Insurance Coverage Act is an unfair method of competition and an unfair and deceptive act or practice in the business of insurance. Provides that the Director of Insurance shall have the power to examine and investigate into the affairs of every person subject to specified provisions of the Short-Term, Limited-Duration Health Insurance Coverage Act. Provides that the Director may place on probation, suspend, revoke, or refuse to issue or renew an insurance producer's license or may levy a civil penalty or take any combination of actions for any failure to make a disclosure or obtain a signed confirmation required or any unlawful practice described under specified provisions of the Short-Term, Limited-Duration Health Insurance Coverage Act. Amends the Short-Term, Limited-Duration Health Insurance Coverage Act. Sets forth provisions concerning the purpose and scope of the Act. Provides that the Act applies to health insurance issuers that offer short-term, limited-duration health insurance coverage to groups and individuals (rather than only individuals) in the State. Sets forth provisions concerning duration of coverage; cancellation; and disclosure, filing, and coverage requirements of short term, limited-duration health insurance coverage. Sets forth provisions concerning unfair or deceptive practices relating to the sale of supplemental or short-term, limited-duration health insurance coverage. Defines terms. Makes other changes. ***Effective January 1, 2026.*** | Support | SENATE Referred to Assignments |
| Health | HIV TLC Act | SB 3711 Collins | Amends the Department of Public Health Act. Establishes the role of HIV Treatment Innovation Coordinator to be housed within the Department. Provides that the Department shall create and fill the Coordinator role within 6 months after the effective date of the amendatory Act. Requires the Coordinator to develop and execute a comprehensive strategy to adopt a Rapid Start model for HIV treatment as the standard of care. Requires compensation and benefits for the Coordinator be at the Program Director level. Describes the specific job responsibilities of the Coordinator. Amends the Illinois Insurance Code. Provides that an individual or group policy of accident and health insurance amended, delivered, issued, or | Oppose | SENATE Assigned to Appropriations – Health & Human Services |

| | | | | | |
|---|---|---|---|---|---|
| | | | renewed in this State on or after January 1, 2025 shall provide coverage for home test kits for sexually transmitted infections, including any laboratory costs of processing the home test kit, that are deemed medically necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. Makes a conforming change to the Illinois Public Aid Code regarding coverage for home test kits for sexually transmitted infections. Amends the AIDS Confidentiality Act. Creates the Illinois AIDS Drug Assistance Program. Provides that Illinois AIDS Drug Assistance Program applications shall be processed within 72 hours after the time of submission. Provides for conditional approval of Illinois AIDS Drug Assistance Program applications within 24 hours after time of submission. Requires Illinois AIDS Drug Assistance Program applicants to document residency within the State of Illinois. Provides for 8 Rapid Start for HIV Treatment pilot sites established by the Department of Public Health. Provides that the Department shall publish a report on the operation of the pilot program 15 months after the pilot sites have launched. Establishes requirements for the report, requires that the report be shared with the General Assembly, the Governor's Office, and requires that the report be made available on the Department's Internet website. Amends the County Jail Act. Creates new annual adult correctional facility public inspection report requirements on the topics of HIV and AIDS. | | |
| Health | Pet Scan Coverage | SB 3719 Johnson | Amends the Illinois Insurance Code. Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after July 1, 2024 shall provide coverage for the full cost of an annual PET scan for insureds age 35 or older who elect to get a PET scan, regardless of whether the PET scan was ordered by a physician licensed to practice medicine in all its branches and regardless of whether the insured displays symptoms. Sets forth findings and definitions. ***Effective immediately*** | Oppose | SENATE Referred to Assignments |
| Health | Dental Care/ Electronic Billing | SB 3721 Syverson | Amends the Uniform Electronic Transactions in Dental Care Billing Act. Provides that beginning January 1, 2027 (instead of 2025), no dental plan carrier is required to accept from a dental care provider eligibility for a dental plan transaction or dental care claims or equivalent | Oppose | SENATE Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | | | encounter information transaction. Sets forth exemptions from the requirements of the Act, and requires a dental care provider who is exempt from the requirements of the Act to file a form with the Department of Insurance indicating the applicable exemption. Requires each dental plan carrier to establish a portal that provides certain benefit and billing information. Requires a dental plan carrier to establish an electronic portal that allows dental care providers to submit claims electronically and directly to the dental care provider; accept attachments in an electronic format with the initial electronic claim's submission; and provide remittance advice with the corresponding payment. Provides that nothing in the Act requires a dental care provider to only accept electronic payment from a dental plan carrier. Provides that dental plan carriers shall allow alternative forms of payment, without additional fees or charges, to a dental care provider, if requested. ***Effective immediately.*** | | |
| Health | Patient Access 340B Pharmacy | SB 3727 Gillespie | Creates the Patient Access to Pharmacy Protection Act. Defines terms. Provides that no person, including a pharmaceutical manufacturer, may deny, restrict, prohibit, condition, or otherwise interfere with, either directly or indirectly, the acquisition of a 340B drug by, or delivery of a 340B drug to, a 340B covered entity or a 340B contract pharmacy authorized to receive 340B drugs on behalf of the 340B covered entity unless such receipt is prohibited by federal law. Provides that no person, including a pharmaceutical manufacturer, may impose any restriction on the ability of a 340B covered entity to contract with or designate a 340B contract pharmacy including restrictions relating to the number, location, ownership, or type of 340B contract pharmacy. Provides that no person, including a pharmaceutical manufacturer, may require or compel a 340B covered entity or 340B contract pharmacy to submit or otherwise provide ingredient cost or pricing data pertinent to 340B drugs; institute requirements in any way relating to how a 340B covered entity manages its inventory of 340B drugs that are not required by a State or federal agency, including requirements relating to the frequency or scope of audits of inventory management systems of a 340B covered entity or a 340B contract pharmacy; or require a 340B covered entity or its 340B contract pharmacy to submit or otherwise provide data or | Oppose | SENATE Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| | | | information that is not required by State or federal law. Sets forth provisions concerning enforcement of this Act; preemption of this Act; and severability of this Act. ***Effective immediately.*** | | |
| Health | Prior Auth Chronic Health | SB 3732 Castro | Amends the Prior Authorization Reform Act. Provides that the Act applies to the program of group health benefits under the State Employees Group Insurance Act of 1971. Provides that a health insurance issuer shall not require prior authorization: where a medication is prescribed for a chronic condition, long-term condition, or mental health condition, has been prescribed for 6 months or more, or is a treatment for the clinical indication as supported by peer-reviewed medical publications; or for patients currently managed with an established treatment regimen. Removes language requiring a health insurance issuer to periodically review its prior authorization requirements and consider removal of prior authorization requirements under certain circumstances. Makes a conforming change. ***Effective July 1, 2024***.<br>SB 3732 (SCA 0001)(**ADOPTED)**<br>***Changes the effective date from July 1, 2024 to July 1, 2026***. | Oppose<br><br>Neutral with Amendment #1 | SENATE 2ND Reading |
| Health | Network Adequacy Standards | SB 3739 Peters | Amends the Network Adequacy and Transparency Act. Adds definitions. Provides that the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services. Provides that the maximum travel time and distance standards and appointment wait time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services. Makes changes to provisions concerning network adequacy, notice of nonrenewal or termination, transition of services, network transparency, administration and enforcement, provider requirements, and provider directory information. Amends the Managed Care Reform and Patient Rights Act. Makes changes to provisions concerning notice of nonrenewal or termination and transition of services. Amends the Illinois Administrative Procedure Act to authorize the Department of Insurance to adopt emergency rules implementing federal standards for provider ratios, time and distance, or appointment wait times when | Oppose | SENATE Assigned to Insurance |

| | | | | | |
|---|---|---|---|---|---|
| | | | such standards apply to health insurance coverage regulated by the Department of Insurance and are more stringent than the State standards extant at the time the final federal standards are published. Amends the Illinois Administrative Procedure Act to make a conforming change. ***Effective immediately.***<br>SB 3739 (SCA 0001) **((REFERRED TO ASSIGNMENTS – TO STAY IN ASSIGNMENTS)**<br>*Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Provides that the amendatory Act may be referred to as the Health Care Consumer Access and Protection Act. Amends the Illinois Insurance Code. Provides that, unless prohibited under federal law, for plan year 2026 and thereafter, for each insurer proposing to offer a qualified health plan issued in the individual market through the Illinois Health Benefits Exchange, the insurer's rate filing must apply a cost-sharing reduction defunding adjustment factor within a range that is uniform across all insurers; is consistent with the total adjustment expected to be needed to cover actual cost-sharing reduction costs across all silver plans on the Illinois Health Benefits Exchange statewide; and makes certain assumptions. Provides that the rate filing must apply an induced demand factor based on a specified formula. Provides that certain provisions concerning filing of premium rates for group accident and health insurance for approval by the Department of Insurance do not apply to group policies issued to large employers. Removes language providing that certain provisions do not apply to the large group market. Provides that for large employer group policies issued, delivered, amended, or renewed on or after January 1, 2026, the premium rates and risk classifications must be filed with the Department annually for approval. Amends the Limited Health Service Organization Act to provide that pharmaceutical policies are subject to the provisions of the amendatory Act. Sets forth provisions concerning short-term, limited-duration insurance. Provides that no company shall issue, deliver, amend, or renew short-term, limited-duration insurance. Provides that the Department may adopt rules as deemed necessary that prescribe specific standards for or restrictions on policy provisions, benefit design, disclosures, and sales and marketing practices for | Oppose with Amendment #1 | |

| | | | | | |
|---|---|---|---|---|---|
| | | | *excepted benefits. Provides that the Director of Insurance's authority under specified provisions is extended to group and blanket excepted benefits. Makes conforming changes in the Health Maintenance Organization Act. Repeals the Short-Term, Limited-Duration Health Insurance Coverage Act. Provides that no later than July 1, 2025, insurance companies that use a drug formulary shall post the formulary on their websites. Makes changes concerning utilization reviews and step therapy requirements. Provides that beginning January 1, 2026, coverage for inpatient mental health treatment at participating hospitals or other licensed facilities shall comply with specified requirements concerning prior authorization, coverage, and concurrent review. Makes other changes. Further amends the Managed Care Reform and Patient Rights Act. Removes provisions concerning step therapy. Provides that only a clinical peer may make an adverse determination. Sets forth certain requirements for utilization review programs. Provides that no utilization review program or any policy, contract, certificate, evidence of coverage, or formulary shall impose step therapy requirements for any health care service, including prescription drugs. Amends the Health Carrier External Review Act. Requires a health insurance issuer to publish on its public website a list of services for which prior authorization is required.* ***Effective January 1, 2025.*** | | |
| Health | Prior Auth Substance Use | SB 3741 Morrison | Amends the Illinois Insurance Code. In provisions prohibiting certain individual or group health benefit plans from imposing prior authorization requirements on medications prescribed or administered for the treatment of substance use disorder, provides that the prohibition includes limitations on dosage. Makes similar changes in the Medical Assistance Article of the Illinois Public Aid Code. ***Effective immediately.*** | Oppose | SENATE 3rd Reading |
| Health | Non Participating Providers | SB 3778 Collins | Amends the Illinois Insurance Code. In a provision concerning services provided by nonparticipating providers, provides that "health care facility" in the context of non-emergency services, includes a facility or office in which a patient receives reproductive health care, as defined in the Reproductive Health Act. | Monitor | SENATE Referred to Assignments |

| | | | | | |
|---|---|---|---|---|---|
| Health | Nonopioid Alternatives Act | SB 3781 Villa | Creates the Nonopioid Alternatives for Pain Act. Requires the Department of Public Health to develop and publish an educational pamphlet regarding the use of nonopioid alternatives for pain treatment. Provides that a health care practitioner shall exercise professional judgment in selecting appropriate treatment modalities for pain in accordance with specified Centers for Disease Control and Prevention guidelines, including the use of nonopioid alternatives whenever nonopioid alternatives exist. Requires a health care practitioner who prescribes an opioid drug to provide certain information to the patient, discuss certain topics, and document the reasons for the prescription. Requires the Department to develop a nonopioid directive form for patients. Sets forth provisions concerning exceptions, execution of a nonopioid directive, opioid administration to a patient with a nonopioid directive, and limitations of liability. Amends the Illinois Insurance Code. Provides that when a licensed health care practitioner prescribes a nonopioid medication for the treatment of acute pain, it shall be unlawful for a health insurance issuer to deny coverage of the nonopioid prescription drug in favor of an opioid prescription drug or to require the patient to try an opioid prescription drug before providing coverage. Provides that in establishing and maintaining its drug formulary, a health insurance issuer shall ensure that no nonopioid drug approved by the Food and Drug Administration for the treatment or management of pain shall be disadvantaged or discouraged, with respect to coverage or cost sharing, relative to any opioid or narcotic drug for the treatment or management of pain. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that whenever a licensed health care practitioner prescribes a nonopioid medication for the treatment of acute pain, neither the Department of Healthcare and Family Services nor a managed care organization shall deny coverage of the nonopioid prescription drug in favor of an opioid prescription drug or require a patient to try an opioid prescription drug prior to providing coverage of the nonopioid prescription drug. Makes other changes. | Oppose | SENATE Referred to Assignments |
| Health | DHFS Managed Care Assessment | SB 3783 Gillespie | Amends the Managed Care Organization Provider Assessment Article of the Illinois Public Aid Code. Changes the Tier 1 assessment amount for managed care organizations to $78.90 per member month (rather | Monitor | SENATE Assigned to Appropriations |

| | | | | | |
|---|---|---|---|---|---|
| | | | than $60.20 per member month). Changes the Tier 2 assessment amount for managed care organizations to $1.40 per member month (rather than $1.20 per member month). Provides that for State fiscal year 2020, and for each State fiscal year thereafter (rather than for State fiscal year 2020 through State fiscal year 2025), the Department of Healthcare and Family Services may adjust rates or tier parameters or both. Makes changes to the definition of "base year". ***Effective January 1, 2025.*** | | – Health & Human Services |