House Insurance
March 5, 2024
2:00 PM

HB 2613 Short Term Expiration-ILHIC has no position on the bill.

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

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

HB 4421 Breast Tomosynthesis- ILHIC is opposed to the bill. The Illinois General Assembly enacted PA 101-580, SB 162. This language mandated coverage for "second look" mammograms. Specifically, the statute already covered a diagnostic mammogram, and this legislation expanded to second look mammograms. We are waiting for some information from the Sponsor to determine whether this is an issue that is seen in self-insured individuals. Meaning, these individuals are regulated under the federal government and do not have access to this state coverage mandate.

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

HB 4504 Inhaler Coverage- ILHIC is currently opposed to the bill. However, we have worked with the stakeholders and will remove our opposition with a forthcoming amendment. Specifically, the amendment 1. Places the new mandate language within the existing inhaler mandate statute. This will alleviate interpretation concerns of two existing and conflicting statutes. 2. Maintains the prescription inhaler definition and adds the originating mandate language to include "asthma" and other life-threatening bronchial ailments. 3. Phases out the existing coverage mandate on December 31, 2025.4. Incorporates the new mandate language to go into effect on January 1, 2026, to align with DOI's policy filing guidelines. 5. Removes the $50 cap

but maintains the $25 cap per thirty days. 6. Cross references the mandate within the State Employee Group Insurance Act (to apply to State Employees as well).

HB 4562 Cancer Genetic Testing- ILHIC is opposed to the bill. We are still working with stakeholders and the Senate sponsor on language.

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

HB 4789 Dental Preauthorization- ILHIC is opposed. There are various deviations from the language presented in HB 4789 and the agreed NCOIL model. The Council is currently working on a compromise with the dental groups.

HB 5103 Cancer Screening- ILHIC has no position.

HB 5295 Hormone Therapy Menopause- ILHIC has no position.

HB 5493 Insurance Various (DOI ADMIN BILL) ILHIC is currently opposed. However, we are working with the Department and have provided feedback. They have indicated that an amendment is forthcoming. **With the agreed amendment, the Council will remove opposition.**

HB 5643 Pregnancy Tests- ILHIC is currently opposed. However, the Council had discussions with the stakeholder and provided suggested language aimed at the Sponsor's intent. Specifically, 1. Moves the effective date to 2026 to align with the Department of Insurance's policy filing timelines. 2. Provides coverage for up to two at home pregnancy tests every thirty days. This was taken from some of the conversation surrounding testing appropriately. (This avoids the over testing problem provided by fertility physicians.)

Senate Judiciary Committee
March 5, 2024
3:00PM

SB 3331Consumer Fraud Mandatory Fees- ILHIC is opposed. As broadly drafted, this language would include the insurance industry.

House Health Care Availability and Accessibility
March 5, 2024
4:00 PM

HB 4548 Pharmacy Benefit Managers- ILHIC is opposed to the bill. The Council has concerns regarding restricting processes that provide drug cost savings to consumers as well as mandatory payments to pharmacies, which increases costs to consumers.

HB 5142 Pregnancy Postpartum Care- ILHIC is opposed to the bill. There are concerning fiscal implications of covering all services for pregnancy at no cost share. We are meeting with the Sponsor and the Governor's Office to discuss.

House Human Services Committee
March 6, 2024
8:30 AM

HB 5417 HIV TLC Act- ILHIC is currently opposed to this bill. However, the Council has worked with stakeholders to change the effective date. With an amendment, we will remove our opposition.

Senate Insurance
March 6, 2024
9:00 AM

SB 56 Medicare Enrollment Period- ILHIC has no position on this bill.

SB 2442 Fair Patient Billing – ILHIC has no position on this bill.

SB 2573 Cancer Coverage Wigs- ILHIC is Neutral with Senate Amendment 1.

SB 2672- Generic Drugs- ILHIC is Neutral with Senate Amendment 1.

SB 2735 Electronic Fees- ILHIC is currently opposed. ILHIC provided alternative language to the Sponsor and stakeholders. The Council is meeting with the Sponsor on Tuesday, March 5.

SB 3130 Insurance Various- ILHIC is currently opposed to this bill. However, there is a draft forthcoming from the Department that will remove our opposition.

SB 3203 Inhaler Coverage- ILHIC is currently opposed to the bill. However, we have worked with the stakeholders and will remove our opposition with a forthcoming amendment.

SB 3305 Dental Loss Ratio- ILHIC is opposed to this bill. The Council participated in subject matter hearing last year on this issue topic. Dental benefits, which are sold by many of our health and life insurers, are typically a small but vitally important part of the portfolio of products available to IL employers and individuals and families designed to provide financial protection while also focusing on preventive aspects of health care. Three-quarters of those with dental benefits regularly see a dentist versus less than 50% of those who don't, so the value of dental insurance clearly demonstrates that those who have it are much more likely to obtain routine cleanings and preventive exams, which ultimately translates into better overall health outcomes. HB 4780 imposing a dental loss ratio would essentially threaten those outcomes. It does not equate to more dental care and will decrease the availability of affordable dental coverage. It is important to draw a distinction between the MLR that is applied to health insurance and why a similar measurement applied to dental insurance would not yield the same outcomes. The MLR for health plans (imposed by the ACA) requires health plans to spend 80 cents out of every premium dollar collected on clinical services and quality improvement while the remaining 20 cents must cover administrative costs and profit, including claims administration, enrollments systems, salaries, overhead, and marketing. Health insurers that fail to meet the MLR standard each year must pay rebates to their consumers. For several reasons, MLR requirements were not applied to dental plans. Dental plan premiums on average are 1/20th of the health insurance premiums (in part because health insurance is technically a mandated product while dental is voluntary). Dental plans therefore have far fewer premium dollars to support the same basic administrative functions as that of the health insurers. It is therefore reasonable to expect that dental insurers would have lower minimum loss ratios than that of the health insurers. In fact, the NAIC also recognized the impact of these fixed costs and suggested that lower loss ratios could be appropriate for limited benefit plans or lower premium products like dental plans. For example, Dental is on average $25 per member per month versus $600 per member per month for comprehensive health insurance. With the 80% MLR, Dental only has $5 PMPM for admin purposes vs. $120 PMPM for Medical. This is why no other state imposes a DLR, with the exception of MA, which did so by ballot initiative. CA for example has had an annual MLR reporting law since 2014 that authorizes the Dept of Managed Healthcare to recommend a DLR, but chose not to do so. Unlike health and dental claims that tend to be paid closer to the issue date of the policy, life insurance claims are usually larger but also paid many years after the policy is issued. Because of this, life insurers report their financial solvency using a formula and form that are different from health or dental insurance. There are also huge variations in the costs of administration between large group, small group, and individual plans. It is far more difficult to administer a loss ratio the smaller a group gets, as there are fewer economies of scale. MLR on the health side accounts for this (80% in small/individual vs. 85% in large group). MA did not recognize these differences and therefore, it has had a compounding and chilling effect on the dental insurance market. Life insurers are not only disadvantaged, but at least one health insurance carrier has already stopped marketing their product in MA as a result, which speaks to the overarching concern that this type of proposal would have the exact opposite effect of what the dentists are suggesting in that the dental insurance market will contract.

SB 3318 Alzheimer Treatment- ILHIC has no position on this bill.

SB 3414 Continuous Glucose Monitor- ILHIC is currently opposed to this bill. The Council is concerned that the increase of no cost sharing mandates and the fiscal impact to consumers premiums.

SB 3599 Mobile Integrated Health- ILHIC is currently opposed to this bill. The Council would need an effective date change as well as ensuring that these services are in-network. Additionally, we are requesting discussions with the Sponsor re: Medicaid issues.

House Mental Health and Addiction Committee
March 7, 2024
10:00AM

Subject Matter: Prior Authorizations

HB 4475- Behavioral Health- ILHIC is currently opposed. We are working with the Sponsor and stakeholders on the possibility of alternative language.

HB 5313 Network Adequacy Directory- ILHIC is currently opposed. We are currently working with our members on alternative language.