ILHIC KEY BILLS – 4-12-2022

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 836 (Evans/ Fine)	Tasks the Department of Insurance to oversee a study to explore rate setting approaches that may yield a misalignment of premiums across different tiers of coverage in Illinois individuals health insurance market. The study shall include a specific analysis on: 1. Number of consumers who are eligible for a premium subsidy under the ACA. 2. If the plan is in a silver level, analysis should include the relation of the premium amount compared to the premium charges for QHPs offering different levels of coverage, 3. Whether the plan issue utilized the induced demand factors developed by CMS for the risk adjustment, 4. Predict cost estimates for Illinois residents addressing metal - level premium misalignment. The report shall be submitted by January 1, 2024.	**NEUTRAL**	**Passed Both Houses**
HB 4271 (Kifowit/Fine)	Mandates coverage for medically necessary breast reduction surgery HA #1 moves the effective date to 1-1-2024	**NEUTRAL With Amendment**	**Passed Both Houses**
HB 4324 (Morgan/Morrison)	In provisions concerning insurance producer licenses, provides that an insurance producer's active participation in a State or national professional insurance association may be approved by the Director of Insurance for up to 4 hours of continuing education credit per biennial reporting period. HA#1 Clarifies that credit shall be certified and provided on an hour per hour basis. These credits will not be used to satisfy ethics education requirements. Defines methods for participation. Effective Upon Becoming Law.	**SUPPORT**	**Passed Both Houses**
HB 4338 (Hernandez/Villanueva)	Mandates coverage for prenatal vitamins. (This medication already required to be covered under the ACA.) HA #1 Moves the effective date to 2024.	**NEUTRAL With Amendment**	**Passed Both Houses**
HB 4349 (Willis/Fine)	Mandates coverage for congenital defects including treatment of cranial facial anomalies that are medically necessary to restore	**NEUTRAL With Amendment**	**Passed Both Houses**

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	normal function or appearance. Cosmetic changes are included in coverage requirement. HA#1 includes Medically necessary provisions. Effective Jan 1, 2024.		
HB 4408 (Conroy/Bush)	Mandates plans that provide coverage for naloxone do so without cost sharing. HA #1 pushed the effective date to 2024 as well as an HAS HDHP carve out.	**NEUTRAL With Amendment**	**Passed Both Houses**
HB 4430 (Cassidy/ Simmons)	Amends the Pharmacy Practice Act. Expands the pharmacist's scope of practice to include the initiation, dispensing, administration of drugs, laboratory testing, assessments, referrals, and consultations for PrEP treatment. Language states that pharmacists shall be covered and reimbursed for these services ordered and administered by a pharmacist at least 85% of the rate that physicians are reimbursed for Medicaid and other payers. HA #1 includes a provision in the Insurance Code that requires insurers to reimburse pharmacists or other health care professionals for dispensing PREP and providing services under the Act. Requires reimbursement for an "adequate consultation" fee or if medical billing is not available, an enhanced dispensing fee that is equivalent to 85% of the fees provided by advanced practice registered nurses or physicians. SA #1 adds PrEP services to the existing "Coverage for Patient Care Services Provided by a Pharmacist" statute presented in 215 ILCS 5/356z.45, which includes that services are covered only if: 1. The pharmacists meet the requirements and scope set forth in Section 43.5 (PrEP); 2. The health plan provides coverage for the same service provided by a licenses physician, advanced practice nurse, or physician assistant; 3. The pharmacist is included in the health benefit plan's network; and 4. The reimbursement has been successfully negotiation in good faith between the pharmacist and the health plan. Effective Jan 1, 2023.	**NEUTRAL With Amendment**	**Passed Both Houses**
HB 4433 (Morgan/Harris)	This language includes model language for Copay Accumulators. This language was agreed to by the Stakeholders, DOI, and ILHIC. Effective Immediately.	**SUPPORT**	**Passed Both Houses**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 4493 (Morgan/Harris)	DOI Initiative Admin Bill. In provisions concerning standard non-forfeiture for individual deferred annuities, changes an interest rate to 0.15% (rather than 1%). Effective Immediately.	**SUPPORT**	**Passed Both Houses**
HB 4595 (Harris/ Hunter)	Prohibits PBMs from various contract language regarding 340b drug pricing entities. Prohibitions include: cannot reimburse at a lower rate than non-340B entities; impose fee, chargeback, or rate adjustments that are not imposed by the pharmacy for non-340B covered entities; the interference of individual choice to receive a prescription drug from a 340B entity; excluding a 340b entity from a pharmacy network; requires a billing modifier to indicate a drug claim is for drugs purchased under 340B drug discount program; prohibits discrimination against 340b covered entities. HA #1 removes prohibition regarding billing modifiers to indicate that a drug claim in purchased for a 340B. Effective July 1, 2022.	**NEUTRAL with amendment**	**Passed Both Houses**
HB 4703 (Morgan/ Gillespie)	Provides that when an insured receives emergency services or covered ancillary services from a nonparticipating provider or a nonparticipating facility, the health insurance issuer shall ensure that cost-sharing requirements are applied as though the services had been received from a participating provider or facility, and that the insured or any group policyholder or plan sponsor shall not be liable to or billed by the health insurance issuer, the nonparticipating provider, or the facility beyond the cost-sharing amount. Contains provisions concerning a notice and consent process for out-of-network coverage; billing for reasonable administrative fees; assignment of benefits to nonparticipating providers; and cost-sharing amounts and deductibles. Amends the Illinois Insurance Code and the Health Maintenance Organization Act to make a change in provisions concerning disclosure of nonparticipating provider benefits. Amends the Network Adequacy and Transparency Act. Provides that a beneficiary who receives care at a participating health care facility shall not be required to search for participating providers under certain circumstances. Amends the Managed Care Reform and Patient	**NEUTRAL with amendment**	**Passed Both Houses**

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	Rights Act. Provides that prior authorization or approval by the plan shall not be required for post-stabilization services that constitute emergency services. Amends the Health Maintenance Organization Act and the Voluntary Health Services Plans Act to provide that health maintenance organizations and voluntary health services plans are subject to provisions of the Illinois Insurance Code concerning billing and cost sharing. Makes other changes. Effective July 1, 2022, except that certain changes take effect January 1, 2023. HA #1Clarified ILHIC's concerns,. However, ILHIC intends to keep working with the Department as federal outcomes re: litigation play out.		
HB 4929 (Mah/Murphy)	Provides that a licensed optometrist may independently administer the influenza vaccine, the COVID-19 vaccine, or the shingles vaccine upon completion of the required training. Provides that vaccinations for influenza and COVID-19 shall be limited to patients 5 years of age and older. Provides that vaccines ordered and administered in accordance with the amendatory Act shall be covered and reimbursed at no less than the rate the vaccine is reimbursed when ordered and administered by a physician. Effective Upon Becoming Law.	**MONITOR**	**Passed Both Houses**
HB 4941 (Mah/Fine)	Mandates insurers, independent practice associations, physician hospital organizations to provide contracted health care professionals or providers with notice of fee changes at least 90 days before the fee change. Changes to fees cannot be made retroactively and providers cannot waive advance notice of fee changes. If there is a fee change that is totals more than a 3% reduction of the Medicare rate for a stated year, the provider can propose alternative fee schedules. Any fee changes must be final at least 30 days before the effective date of the change. HA# 1 separates fee schedule notifications into two different "buckets," being routine, and non-routine. Non routine changes are changes not required by law, regulation, or regulatory authority. The amendment lowers the notice to provides to 60 days (instead of 90). In addition, the language regarding non routine changes shall be provided via email, or if requested by the provider, mail. SA #1 makes a change excluding HMOs that provide care or	**NEUTRAL with amendment**	**Passed Both Houses**

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	arrange for an pay or reimburse for the cost of any healthcare services for persons enrolled in the medical assistance programs under the Illinois Public Aid Code to comply with provider notification requirements established by the Department of Healthcare and Family Services. Effective Upon Becoming Law.		
HB 4979 (Manley/ Connor)	SA #1 becomes the bill. Allows any owner of rights under a life insurance policy to make an irrevocable assignment to a funeral home. The insurance company shall notify the funeral home and owner of the policy of its receipt of the form. Once the owner irrevocably assigns right to the funeral home, the owner cannot 1. Collect from the insurance company when it becomes a claim upon death, 2. Surrender the policy for cash value, 3. The right to obtain a policy loan. 4. The right to designate as primary beneficiary of the policy other than provided in that Act. 5. The right to collect or receive income, shares or surplus, dividend deposits, refunds of premium, or additions to the policy. An insured may make an irrevocable assignment or all or part of his her rights for the purpose of obtaining favorable consideration for Medicaid, Supplemental Security Income, or another public assistance program. The form to do this will be provided by HFS of a form prepared by the insurance company that has been approved by HFS. The insured shall sign a guaranteed pre-need contract with the provider that describes the cost for funeral goods and services to be provided upon the person's death, up to $7,248. This amount can be adjusted annually by HFS. For guaranteed preneed contracts with cash advances, the contract shall include a disclosure that states (in 12 pt. font) that cash allowances are merely an allowance toward the then-current costs for the involved for the involved items to be purchased after death. Burial spaces allowances may only be excluded from resources under Medicaid if a separate contract is executed for such burial space with a cemetery. Upon the death of the insured, the proceeds shall be paid as follows 1. The provider, 2. The State of Illinois, 3. Payment of proceeds to a secondary beneficiary (if any) Effective Jan 1, 2023.	**NEUTRAL (Working with HFS on Issues)**	**Passed Both Houses**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 5142 (Harris/ Stadleman)	Provides that the Department shall provide the Department of Healthcare and Family Services and the Department of Insurance with the individual income tax information collected as soon as practicable. Amends the Illinois Insurance Code. Provides that the Department of Insurance shall use taxpayer income information provided by the Department of Revenue to determine if an individual is eligible for a premium tax credit under the Patient Protection and Affordable Care Act. Provides that if the individual is determined to be eligible for a premium tax credit, the Department shall notify the individual of his or her eligibility as soon as practicable. Provides that the Department shall inform the individual of the next open enrollment period in the federal health insurance marketplace, and shall inform the individual of the special enrollment period triggered by a qualifying life event. HA #1 changes some implementation provisions for the Department of Revenue only. HA #2 is a gut and replace amendment requiring HFS and DOI to submit a form by ?June 1 and November 1 to provide the Department of Revenue describing health insurance enrollment option for taxpayers. The Department of Revue will then send the information to taxpayers who request it. Language includes if a SBE becomes operational, that the Exchange must interface with the Illinois tax system. Effective Immediately.	**SUPPORT**	**Passed Both Houses**
HB 5254 (Wheeler/Holmes)	Provides coverage for hormone therapy treatment to treat menopause that has been induced by a hysterectomy. HA#1 adds medical necessity to the language as well as moves the effective date to 1-1-24.	**NEUTRAL with Amendment**	**Passed Both Houses**
HB 5318 (Ford/Jones III)	Mandate Expansion for Prostate Screenings No Cost Share Mandates prostate cancer screenings without cost sharing, broadening cancer screening testing beyond prostate specific antigen tests and digital rectal exams. The mandate coverage includes follow up testing including 1. Urinary analysis, serum biomarkers, and medical imaging, including, but not limited to magnetic resonance imaging. HA#1 adds a carve out for HDHPs,	**NEUTRAL with Amendment**	**Passed Both Houses**

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	moves effective date back to 1-1-2024, and adds medical necessity to follow up testing.		
HB 5334 (Stuart/Crowe)	Mandate Coverage for Genetic Testing Breast/ Ovarian Cancer Mandates coverage for genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and ovarian cancer if recommended by a health care provider in accordance with the United States Preventive Service Task Force's recommendations for testing. Effective Jan 1, 2024.	**NEUTRAL**	**Passed Both Houses**
HB 5585 (Lilly/Harris)	Home Health Services Mandate Mandates coverage for access to home health services for the duration of medically necessary care. Effective Jan 1, 2024.	**NEUTRAL**	**Passed Both Houses**
SB 1099 (Collins/Tarver)	Creates the Consumer Legal Funding Act. Sets forth provisions concerning consumer legal funding contract requirements and right of rescission. Sets forth consumer legal funding company prohibitions. Sets forth the fees that may be charged by a consumer legal funding company and provides that a consumer legal funding company shall not collect any additional fees besides those specified in the Act. Provides that all consumer legal funding contracts shall contain specified disclosures. Provides that the contingent right to receive an amount of the potential proceeds of a legal claim is assignable by a consumer. Provides that an attorney or law firm retained by the consumer in the legal claim shall not have a financial interest in the consumer legal funding company offering consumer legal funding to that consumer. Sets forth provisions concerning application and fees for a consumer legal funding license. Effective Immediately.	**MONITOR**	**Passed both Houses**
SB 2963 (Syverson/Keicher)	Fixes Department concern that the new group life continuation of coverage provisions could potentially create an unintended gap in continuation of coverage for those active employees who may be receiving or eligible to receive benefits under the prior carrier's group life policy. Effective Immediately.	**SUPPORT**	**Passed Both Houses**

Bill Number	Bill Description/Action	ILHIC Position	Status
SB 2969 (Morrison/Mah)	Mandates coverage of continuous glucose monitors. SA#1 Moves the effective date to 1-1-2024, add medical necessity to glucose monitors for individuals diagnosed with type1 or type 2 diabetes and requires insulin for the management of their diabetes	**NEUTRAL with amendment**	**Passed Both Houses**
SB 3819 (Fine/Gabel)	Provides that a group or individual policy of accident and health insurance or a managed care plan amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage for community-based pediatric palliative or hospice care. Provides that the care shall be delivered to any qualifying child by a trained interdisciplinary team in accordance with all the terms of the Pediatric Palliative Care Act, which allows a child to receive community-based pediatric palliative and hospice care while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness. SA #1 moves the effective date to 1-1-24 as well as linked palliative care and serious illness to the Pediatric Palliative Care Act.	**NEUTRAL with Amendment**	**Passed Both Houses**
SB 3910 (Fine/Jones)	DOI INITIATIVE. Amends the Uniform Prescription Drug Information Card Act. Mandates that uniform Rx cards issued by health plans shall display on the card the regulatory entity that holds authority over the plan, whether the plan is fully insured or self-insured, the issuer's National Association of Insurance Commissioners company code, any deductible applicable to the plan, any out-of-pocket maximum limitation applicable to the plan, and a toll-free telephone number and Internet website address through which the cardholder may seek consumer assistance information. Provides that a discounted health care services plan administrator shall issue to its beneficiaries a card that contains information about the regulatory entity that holds authority over the plan and whether the plan is fully insured or self-insured. Provides that a health care benefit information card or other technology containing uniform health care benefit information issued by a health benefit plan or a dental plan shall specifically identify and display on the card the regulatory entity that holds authority over the plan, whether the plan is fully insured or self-insured, the issuer's National Association of Insurance Commissioners company code, any deductible	**NEUTRAL with amendment**	**Passed Both Houses**

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	applicable to the plan, any out-of-pocket maximum limitation applicable to the plan, and a toll-free telephone number and Internet website address through which the cardholder may seek consumer assistance information. Makes other changes. Effective January 1, 2023. HA # 1 Amendment includes removing the NAIC number and the fully insured/self insured portion for space as well as removing the dental card requirement on the No Surprises language (as well as a 1-1-24 effective Date).		