- **Antitrust Statement**

  a. ILHIC is committed to conducting all our activities in compliance with federal and state antitrust laws. If at any time during the call the discussion should venture into matters that might conflict with antitrust laws, please feel free to speak up and we will stop the discussion and move forward in the agenda.

- **Legislative Overview**

  a. This Friday is the House and Senate Crossover week Deadline. The week started with some much larger (and ongoing) policy discussions regarding rate review, ambulance surprise billing, and the state-based exchange. This week also came with a large fiscal bombshell. HFS underestimated the cost of providing undocumented healthcare. For 2024, health benefits for undocumented individuals are estimated to cost 990 million dollars, which is a 768 million dollar increase from fiscal year 2023. This 990-million-dollar deficit will create a budgetary conundrum, with many Democrats asking for additional funding, and some major policies needing start up funding (SBE).

- **Bills this Week**

April 25th

<u>House Insurance</u>

C-1 Stratton 2:00pm

SB 1282- Liver Disease Testing Mandate- ILHIC has no position.

- Passed out of Committee

SB 1289- Dental Care Reimbursement- ILHIC is Neutral on the underlying bill. **HOWEVER, ILHIC IS OPPOSED to House Amendment 1, which adds Dental Loss Ratio.** Applying MLRs to dental plans would lead to higher premiums, coverage losses, and decreased oral outcomes for families who depend on their dental coverage. Reports for the effectiveness of Dental MLRs in other states have shown that there is not significant data to suggest that Dental MLRs are beneficial for consumers. The Dental Society has had a subject matter on DLR's in the Senate and the DLR language stayed within Insurance Sub-Committee in the House.

- Bill Stayed in Committee. The Dental Society has a lobby day next week and the Chair has agreed to give them another Subject Matter Hearing on the issue.

SB 1527- Compression Sleeves Mandate- ILHIC has no position.

- Passed out of Committee

SB 2195- Prosthetic Device Coverage Mandate- ILHIC has no position.

- Passed out of Committee

SB 1568- Heath Parity Disability Information Collection- ILHIC is Neutral.

- Passed out of Committee

Senate Insurance

400 Capitol 5:30pm

HB 2130- Data Security Law- ILHIC is Neutral.

- Passed out of Committee

HB 3202- Saliva Cancer Screen Mandate- ILHIC has no position.

- Passed out of Committee

HB 3631- PBM Retaliation- ILHIC has no position.

- Passed out of Committee

HB 3639- Epinephrine Coverage Mandate-ILHIC has no position.

- Passed out of Committee

HB 3809- Child Neuromuscular Therapy and Diagnostic Testing Mandate- ILHIC has no position.

- Passed out of Committee

House Prescription Drug Affordability

D-1 Stratton 4:00pm

SB 1344- Coverage for Abortion Care Off Label Abortifacients- ILHIC has no position.

- Passed out of Committee

April 26th

House Healthcare Availability and Access

C-1 Stratton 4:00 PM

SB 1559- Insulin Coverage Mandate- ILHIC has no position.

- Passed out of Committee

Monitor Bills

<u>House Behavioral and Mental Health</u>

400 Capitol 11:00 AM

HB 3230- Behavioral Health Crisis Care (Creates a statewide initiative for Behavioral Crisis Care)

- Passed out of Committee

<u>Senate Executive</u>

212 Capitol 1:30 PM

HB 3129- Equal Pay Act Pay Scale (Mandates the pay scale of a job posting)

- Was not called in Committee

- **Bills Next Week**
    a. **House Insurance 2:00PM May 5, 2023 C-1Stratton**
        i. **HB 2203- Auto Rates (Subject Matter)**
        ii. **SB 1289- Dental DLR (Subject Matter)**
        iii. **HB 1059- Credit Info Underwriting for Auto Insurance (Subject Matter)**
- **State Based Exchange Legislation Update**
    a. The State Based Exchange was rumored to be heard on the floor this week. Surprisingly, we did not hear the State Based Exchange on the House Floor. Both Chambers did very little floor work this week. Most of the work was done in committee. We will likely hear this bill next week on the floor. This policy will be interesting if moved due to the news on the budget bombshell from HFS, an agency working closely with DOI on the implementation of the State Based Exchange.
    b. The Council did have a meeting with Senate Leadership to discuss the political implications of the State Based Exchange and Rate Review. Senate Leadership seemed to play any decisions close to the chest, not giving any indication whether the two pieces of legislation would advance. Regarding Rate Review, the perception of Senate Leadership was that Senator Fine was wearing down other legislators on the policy advancing. Senator Fine has filed some sort of rate review language for at least the past 7 sessions. For both policies, we are working with the Business Communities to assist us in advocating opposition for the overarching policies or Rate Review and State Based Exchange. There is a high likelihood that both Rate Review and the State Based Exchange will advance this Session due to the Senate backstopping other high level priority policies.
- **Rate Review/ Prior Approval Overview**
    a. The Stakeholders, Department, and the Council met twice this week to discuss Rate Review language this week. SB 1912 is shaping up as follows:
        i. **PRIOR APPROVAL/RATE REGULATION – HEALTH INSURANCE RATES (SB 1912)**

ii. As of April 25, the Shriver Center, the Small Business Advocacy Council, and the Department of Insurance (DOI) have proposed language that would give the DOI authority to explicitly approve, disapprove or modify health insurance rates if they are deemed unreasonable or insufficient beginning in 2026 (which aligns with the date set for state transition to the full state-based health insurance exchange provided for in HB 579 (Gabel), as amended by HA #3.)

iii. Summary of changes for Plan Year 2025 (January 1, 2025):

1. Requires DOI posting of all insurers' rate filings and summaries on the website within 5 business days after the rate filings are submitted to the Department (per a date set in the annual guidance). The information excludes proprietary or trade secret information.
2. Requires the summaries to include a brief justification of any rate increase or decrease requested, including the number of individual members, the medical loss ratio, medical trends, administrative costs, and other information required by rule.
3. Requires the DOI to open a 30-day public comment period on the filings upon posting. The comments shall be posted to the website within 5 business days after the close of the comment period.

iv. Summary of changes for Plan Year 2026 (January 1, 2026):

1. Provides that for any plan year during with the state operates a full state-based exchange, the Department shall provide insurers at least 30 days' notice of the deadline for submission of the rate filings. ***(ILHIC requested time frame)***
2. Requires the Department to hold a public hearing within 10 days after the public comments are posted to the website.
3. Requires an insurer whose proposed rate increase is greater than the statewide average rate increase for the individual and/or small group market to attend the public hearing and provide further explanation and justification of their proposed rate increase.
4. Requires the Department to consider the actuarial justifications, public comments, and information presented in the public hearing and issue a decision to approve, disapprove, or modify a rate filing with <u>60 days</u> after the close of the public comment period and notify the insurer of the rationale for any decision.
5. Provides companies the ability to appeal the decision if the rate has been modified or disapproved within 10 days of the action taken subject to judicial review under the Administrative Review Law. ***(ILHIC requested appeal rights for insurers)***
6. Beginning May 1, 2026 and each May thereafter, the DOI must report to the Governor and the General Assembly on health insurance coverage, affordability and cost trends including information related to: 1) medical cost trends related to utilization and prescription drug costs; 2) benefit changes, including benefits in excess of the essential health benefits (new state coverage mandates); 3) enrollment trends; 4) demographic shifts; 5) changes in provider availability; 6) health care quality improvement initiatives; 7) medical inflation and economic factors; 8) availability of financial assistance and trends in out-of-pocket costs.

(ILHIC requested annual reporting of factors contributing to the cost of health insurance)

b. Outstanding Issues as of April 26, 2023:

i. DOI has agreed to a 60-day time limit (versus a 90-day) for a decision on the rate filing from the close of the comment period, but the language is absent "automatic deemer" language if no action is taken as is done in other prior approval states.

ii. While the language currently only addresses prior approval for individual and small group health insurance plans, ILHIC is advocating for further clarification in Section 143 and Section 355 that any classification of risks and premium rates filed relative to a policy of accident and health insurance (i.e. large group), shall be held to a 90-day time limit for action or else the policy and the rates filed thereto are automatically deemed approved.

- **Ambulance Legislation**

a. The Council participated in a stakeholder meeting to discuss possible legislation on surprise billing with ambulances. Ground ambulances were excluded from the Federal No Surprises Act. However, within the Federal Act, there was a task force created to look at options for the States to pursue regarding ground Ambulances and surprise billing issues. The ambulances and fire chiefs in Illinois did not want to wait on the Federal Government to see what those recommendations will be. They put forth language requiring insurers to pay 100% of their cost, and industry recently countered with language suggesting that insurers should pay whatever is less: 1. The negotiated rate between the provider and health insurance issuer, or 200% of the Medicare fee schedule amount. The ambulance pushed back on the 200% figure, stating that they would not be able to function. They also pushed back on any discussion around inserting arbitration, stating that they are so small that they would be unable to arbitrate any claims. The service providers are taking the language back to draft a counter proposal.

- **Mental Health Legislation Update**

a. Good news, the Sponsor and Thresholds (advocacy group) has agreed to drop the portion of their original filed bill that mandates insurers to pay providers out-of-network coverage for mental health services. They might want to relook at this policy over the summer. However, for now, they are leaving this policy option alone. Moving forward, they are still interested in looking at the language requiring 2 mental health checkups to be covered as preventative services. The Council did request 1 visit, which would be similar to physical coverage. The Sponsor indicated that she really would like 2 visits. The Council will keep members updated on how this legislation plans to proceed. We do know the Sponsor would like to move this bill this session.

b. HB 2847 House Amendment #2 was filed on Thursday of this week, which includes the changes that the Council suggested. The bill creates a educational program on mental health wellness (this portion does not touch insurance plans). The bill provides coverage for 2 mental health prevention visits without cost sharing. The language does exempt HDHP's with HSAs for tax purposes. The language also includes coding, which I know the Department will take issue with. We shall see if that language comes out with the addition of the Department's pressure.

- **Mental Health Working Group Sunset**

a. The Mental Health Working Group has agreed to sunset the Working Group and give the authority back to the Department regarding the development of NQTL instructions. The bill sunsetting the Working Group will be HB 1364.

- **Proposed Rules**

a. The Department of Insurance provided notice of a proposed rule that:1. Ensures that individuals who qualify for Medicare after the end of COVID-19 Public Health Emergency receive no less than 63 days after the loss of Medicaid coverage or notice of their termination, whichever is later in which they will be guaranteed issue of a Medicare Supplement Policy; and 2. Ensure that the existing text in 50 Ill. Adm. Code 2008.74(a) is not misconstrued to exclude individuals who apply for Medicare supplement policies while under a Medicare penalty, as the existing rule text is straightforwardly based on when the applicant actually enrolls in Medicare Part B coverage rather than when they first become eligible for Medicare Part B.

b. The rule making is the ensure that, no matter when individuals disenroll from Medicaid, they will have at least 63 days, and possibly the full Medicare supplement open enrollment period, to enroll in any Medicare Supplement Policy.

- **Important Dates**

a. April 28, 2023 (Senate and House Crossover Deadline)
b. May 11, 2023 (Senate 3rd Reading Deadline (House Bills))
c. May 12, 2023 (House 3rd Reading Deadline (Senate Bills))
d. May 19, 2023 House and Senate Adjournment