

All Lines - HOUSE BILLS					
Product Line Life/Health/All	Bill “Nickname”	Bill Number/Link	Bill Description/Action	ILHIC Position	Status
All	Cyber Security Insurance	HB47 Hoffman (Harris, N.)	Provides that if the entry of an Order of Liquidation occurs on or after January 1, 2023, then the obligations shall not exceed \$500,000 or exceed without any deduction \$50,000 for any unearned premium claim or refund under any one policy. Provides that in no event shall the Fund be obligated to pay an amount in excess of \$500,000 in the aggregate for all first-party and third-party claims under a policy or endorsement providing cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or number of claimants. Provides that the Illinois Insurance Guaranty Fund shall have the right to appoint or approve and to direct legal counsel and other service providers under any other insurance policies subject to the provisions, regardless of any limitations in the policy. Provides that the Fund may employ or retain such persons as are necessary to provide policy benefits and services. Provides that the Fund may, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy of an insolvent company on behalf of a high net worth insured.	Monitor	HOUSE Passed Both Houses
All	Dental Network Plan Change	HB 2072 Gong- Gershowitz (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	HOUSES Passed Both Houses

		<p>shall provide notice of that assignment or lease within 30 days after the assignment or lease to the contracting dentist). Provides that an 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 that leases or assigns its network shall not cancel a network participating dentist's contractual relationship or otherwise penalize a network participating dentist in any way based on whether or not the dentist accepts the terms of the assignment or lease.</p> <p>HB 2072 (HCA 0001) (PASSED) (TABLED) <i>Further amends the Illinois Insurance Code. Provides that no insurer, dental service plan corporation, professional service corporation, insurance network leasing company, or any company that amends, delivers, issues, or renews an individual or group policy of accident and health insurance on or after the effective date of the amendatory Act shall require a dental care provider to incur a fee to access and obtain payment or reimbursement for services provided. Provides that a dental plan carrier shall provide a dental care provider with 100% of the contracted amount of the payment or reimbursement.</i></p> <p>HB 2072 (HFA 0002) (TABLED) <i>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</i></p>	<p>No position change/Oppose</p> <p>No position change/Oppose</p>	
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All	Insurance Data Security Law	<p>HB 2130 Morgan (Harris, N)</p>	<p>Sets forth provisions concerning an information security program, investigations of cybersecurity events, and notifications of cybersecurity events. Provides that the Director of Insurance shall have power to examine and investigate into the affairs of any licensee to determine whether the licensee has been or is engaged in any conduct in violation of the Act. Provides that whenever the Director has reason to believe that a licensee has been or is engaged in conduct in the State which violates the Act, the Director may take action that is necessary or appropriate to enforce the provisions of the Act. Provides that any documents, materials, or other information in the control or possession of the Department of Insurance that are furnished by a licensee or an employee or agent acting on behalf of a licensee or that are obtained by the Director in an investigation or examination shall be confidential by law and privileged, shall not be subject to the Freedom of Information Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.</p> <p>HB 2130 (HFA 0001) (ADOPTED) <i>Makes a change in provisions concerning notification of a cybersecurity event. Sets forth provisions concerning an exemption from specified provisions.</i></p>	<p>Oppose</p> <p>No position change/Oppose</p>	<p>HOUSE Passed Both Houses</p>

ALL LINES - SENATE BILLS					
All	Cybersecurity	SB 89 Harris (Hoffman)	Provides that if the entry of an Order of Liquidation occurs on or after January 1, 2023, then the obligations shall not exceed \$500,000 or exceed without any deduction \$50,000 for any unearned premium claim or refund under any one policy. Provides that in no event shall the Fund be obligated to pay an amount in excess of \$500,000 in the aggregate for all first-party and third-party claims under a policy or endorsement providing cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or number of claimants. Provides that the Illinois Insurance Guaranty Fund shall have the right to appoint or approve and to direct legal counsel and other service providers under any other insurance policies subject to the provisions, regardless of any limitations in the policy. Provides that the Fund may employ or retain such persons as are necessary to provide policy benefits and services. Provides that the Fund may, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy of an insolvent company on behalf of a high net worth insured.	Monitor	HOUSE Rules
All	Illinois Work Without Fear Act	SB 0504 (SFA 0001) Aquino	<i>Replaces everything after the enacting clause. Creates the Illinois Work Without Fear Act. Provides that it is unlawful for any person to engage in, or to direct another person to engage in, retaliation against any person or their family member or household member for the purpose of, or with the intent of, retaliating against any person for exercising any right protected under State employment laws or by any local employment ordinance. Sets forth the duties and powers of the Department of Labor under the Act. Allows the Attorney General to initiate or intervene in a civil action to obtain appropriate relief if the Attorney General has reasonable cause to believe that any person has violated the Act and deems it necessary to protect the rights and interests of Illinois workers. Provides that nothing in the Act shall be construed to prevent any person from making complaint or prosecuting his or her own claim for damages caused by retaliation. Allows a person who is the subject of retaliation prohibited by the Act to bring a</i>	Monitor	SENATE Re-Referred to Assignments

			<p><i>civil action for: (1) back pay, with interest, and front pay, or, in lieu of actual damages, liquidated damages of \$30,000; (2) a civil penalty in an amount of \$10,000; (3) reasonable attorney's fees and court costs; and (4) equitable relief as the court may deem appropriate and just. Provides that a person that violates any provision of the Act shall be subject to an additional civil penalty in an amount of \$25,000 for each violation, or \$50,000 for each repeat violation within a 5-year period. Sets forth license suspension penalties for violations of the Act. Amends the Whistleblower Act. Changes the definitions of "employer" and "employee". Defines "public body", "retaliatory action", and "supervisor". Provides that an employer may not take retaliatory action against an employee who discloses or threatens to disclose information about an activity, policy, or practice of the employer that the employee has reasonable cause to believe violates a State or federal law, rule, or regulation or poses a substantial and specific danger to public health or safety. Includes additional relief, damages, and penalties for violation of the Act. Allows the Attorney General to initiate or intervene in a civil action to obtain appropriate relief if the Attorney General has reasonable cause to believe that any person or entity is engaged in a practice prohibited by the Act and deems it necessary to protect the rights and interests of Illinois workers.</i></p>		
All	Insurance Business Transfer Act	<p>SB 0762 (SFA 0001) Cunningham (Jones)</p> <p>Swapped for SB 1961</p>	<p><i>Replaces everything after the enacting clause. Amends the Illinois Insurance Code. Changes the definition of "insolvent company" to include any company which has assumed or has been allocated a policy obligation through an approved insurance business transfer plan. Provides that the fee for filing an insurance business transfer plan is \$25,000. Creates the Insurance Business Transfers Article of the Illinois Insurance Code and provides that the Article may be cited as the Insurance Business Transfers Law. Sets forth provisions concerning notice requirements, application procedure, application to a court for approval of a plan, approval and denial of insurance business transfer plans, and fees and costs. Provides that the Department of Insurance may adopt rules that are consistent with the provisions. Provides that the portion of the application for an insurance business transfer that would otherwise be confidential, including any documents, materials,</i></p>	Monitor	SENATE Passed Both Houses

			<p>communications, or other information submitted to the Director of Insurance in contemplation of an application, shall not lose such confidentiality. Provides that insurers consent to the jurisdiction of the Director with regard to ongoing oversight of operations, management, and solvency relating to the transferred business. Provides that the Director may direct the applicant to retain parties to assist Department personnel. Defines terms. Effective immediately, except specified provisions take effect January 1, 2025.</p>		
All	Vision Care Plan Regulation Act	<p>SB 0764 (SFA 0001) Castro</p>	<p>SB 0764 (SFA 0001) (ADOPTED) Replaces everything after the enacting clause. Creates the Vision Care Plan Regulation Act. Provides that no vision care organization may issue a contract that requires an eye care provider, as a condition of participation in the vision care plan, to provide services or materials to an enrollee at a fee set by the vision care plan unless the services or materials are covered under the vision care plan. Provides that an eye care provider who chooses not to accept amounts set by a vision care plan for noncovered services or noncovered materials shall post a specified notice. Requires fees for covered services and materials to be reasonable and clearly listed on a fee schedule provided to the eye care provider. Prohibits a vision care organization from misrepresenting the benefits of a vision care plan as a means of selling coverage or communicating the benefit coverage to enrollees. Provides that the Act applies to any subcontractors used by a vision care organization to supply materials or services to an eye care provider or an enrollee under a vision care plan. Prohibits a vision care organization from restricting an eye care provider's freedom to choose suppliers, materials, or labs or from requiring an eye care provider to purchase materials from a source owned by the entity that issued the vision care plan. Provides that fees paid for materials supplied by a non-network lab are not required to be identical to fees paid for materials ordered through a network lab, but non-network lab fees shall be reasonable. Provides that a vision care organization and its officers, directors, agents, and employees are subject to specified laws. Provides that at the request of an enrollee, an eye care provider recommending an out-of-network source or supplier of vision care materials to an enrollee</p>	Neutral	<p>HOUSE Insurance Committee</p> <p>SFA #1 ADOPTED</p> <p>COMMITTEE/ FINAL ACTION DEADLINE EXTENDED 5/19/23)</p>

			<p><i>shall provide written notice to the enrollee stating that the source or supplier is an out-of-network laboratory or supplier of vision care materials, and any business interest the eye care provider has in the out-of-network source or supplier recommended to the enrollee. Provides that an eye care provider is required to offer an enrollee in-network sources or suppliers of vision care materials at the enrollee's request. Provides that the terms, fees, discounts, or reimbursement rates in a vision care plan may not be changed during the term of the contract unless mutually agreed to in writing by the eye care provider and the vision care organization. Provides that a change proposed to a vision care plan by the vision care organization shall become effective if the eye care provider fails to respond to the vision care organization within 60 days after receipt of notice of the proposed changes. Provides that the terms of a vision care plan contract that is amended, delivered, issued, or renewed after the effective date of the Act shall comply with the provisions. Provides that a vision care plan may enter into an agreement with a health care plan to deliver routine vision care services that are covered under the enrollee's plan. Provides that a vision care plan may act as a network regarding routine vision care services offered by a health care plan. Makes other changes. Amends the Consumer Fraud and Deceptive Business Practices Act to provide that any person who violates the Vision Care Plan Regulation Act commits an unlawful practice. Effective immediately.</i></p>		
All	Dental Reimbursement	<p>SB 1289 Fine (Gong-Gershowitz)</p>	<p>Provides that no insurer, dental service plan corporation, professional service corporation, insurance network leasing company, or any company that amends, delivers, issues, or renews an individual or group policy of accident and health insurance on or after the effective date of the amendatory Act shall require a dental care provider to incur a fee to access and obtain payment or reimbursement for services provided. Provides that a dental plan carrier shall provide a dental care provider with 100% of the contracted amount of the payment or reimbursement. Effective immediately. SB 1289 (SFA 0001) (ADOPTED) <i>Provides that fees incurred directly by a dental care provider from third parties related to transmitting an automated clearing house network</i></p>	<p>Oppose</p> <p>Neutral with Amendment #1</p>	<p>HOUSE Re-Referred to Rules Committee</p>

			<p><i>claim, transaction management, data management, or portal services and other fees charged by third parties that are not in the control of the dental plan carrier shall not be prohibited by the provisions.</i></p> <p><u>SB 1289 (HCA 0001)</u> (RE-REFERRED TO RULES)</p> <p><i>Replaces everything after the enacting clause. Reinserts the provisions of the engrossed bill with the following changes. 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, 2024, 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. Amends the Dental Service Plan Act. Provides that dental service plan corporations and all persons interested therein or dealing therewith shall be subject to the Insurance Holding Company Systems Article of the Illinois Insurance Code. Provides that a dental service plan corporation shall not disburse during any one year (rather than shall not disburse during any one year, except upon the approval of the Director of Insurance) a sum greater than 20% of payments received from subscribers during that year as administrative expenses. Effective January 1, 2024.</i></p>	Oppose	
All	Stock Division	<u>SB 1494</u> Harris (Jones,T)	In provisions concerning plan of division approval, provides that any decision by the Director of Insurance on whether or not to hold a public hearing on either a plan of division or an amended plan of division may be made independently by the Director. Provides that if a dividing company amends its plan of division at any time before the plan of division becomes effective, then the dividing company shall file the amended plan of division for approval by the Director. Provides	Monitor	SENATE Passed Both Houses

			<p>that if a hearing is conducted on the amended plan of division after the Director has approved a previous plan of division, then the hearing shall not be considered a rehearing. Provides that the fee assessed for filing a plan of division shall not apply to the filing of an amended plan of division. In provisions concerning certificates of division, provides that if the dividing company files an amended plan of division with the Director after a certificate of division has been filed for a previous plan, then the dividing company shall file a certificate of stay with the recorder. Provides that the certificate of stay shall identify the certificate of division being stayed and the date on which the amended plan of division was filed with the Director. Makes other changes. <i>Effective immediately.</i></p>		
ALL	Vision Care	<p>SB 1540 (SCA 0001) Castro</p>	<p><i>Replaces everything after the enacting clause. Reinserts the provisions of the introduced bill with the following changes. Provides that no vision care organization may issue a contract that requires an eye care provider, as a condition of participation in the vision care plan (rather than only requires an eye care provider), to provide services or materials to an enrollee at a fee set by the vision care plan unless the services or materials are covered under the vision care plan. Provides that fees paid for materials supplied by a non-network lab are not required to be identical to fees paid for materials ordered through a network lab, but non-network lab fees shall be reasonable. Provides that a vision care organization and its officers, directors, agents, and employees are subject to specified laws. Provides that at the request of an enrollee, an eye care provider recommending an out-of-network source or supplier of vision care materials to an enrollee shall provide written notice to the enrollee stating that the source or supplier is an out-of-network laboratory or supplier of vision care materials, and any business interest the eye care provider has in the out-of-network source or supplier recommended to the enrollee (rather than shall provide written notice thereof). Provides that an eye care provider is required to offer an enrollee in-network sources or suppliers of vision care materials at the enrollee's request. Provides that the terms, fees, discounts, or reimbursement rates in a vision care plan may not be changed during the term of the contract (rather than only may not be</i></p>	Neutral	SENATE Re-Referred to Assignments

		<p><i>changed) unless mutually agreed to in writing by the eye care provider and the vision care organization. Provides that a change proposed to a vision care plan by the vision care organization shall become effective if the eye care provider fails to respond to the vision care organization within 60 days after receipt of notice of the proposed changes. Provides that the terms of a vision care plan contract that is amended, delivered, issued, or renewed after the effective date of the Act shall comply with the provisions. Provides that a vision care plan may enter into an agreement with a health care plan to deliver routine vision care services that are covered under the enrollee's plan. Provides that a vision care plan may act as a network regarding routine vision care services offered by a health care plan. Removes provisions concerning misrepresentation and provisions concerning injunctive relief. Makes other changes. Adds an immediate effective date</i></p>		
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