ILHIC
ILLINOIS LIFE & HEALTH INSURANCE COUNCIL

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Condensed Session Summary

The 2022 Spring Session seemed far from condensed! Due to the primary date being moved, The House and Senate made it a priority to conclude business and adjourn on April 8th, a whopping 6 weeks earlier than usual. It seemed likely that this condensed schedule would mean that there would be a decreased volume of bills. That was not the case. In fact, there were an extremely high volume of bills in addition to flurries of last-minute insurance bills spawned from the need for political talking points as well as media pressures.

The beginning of the legislative session started earlier than usual, with the first day scheduled early in January. Many of the first days were canceled. When both chambers started to return on a regular basis, the House and Senate had to construct and implement rules regarding COVID-19 safety protocols. Unfortunately, the House and Senate had differing rules, which made it difficult to track and manage throughout February. COVID protocol reached a boiling point in late February, when Governor JB Pritzker lifted the state mask mandate, citing dropping cases and hospitalizations. This created a large disruption on the House Floor, which kept their mask requirement well past the date of when the Governor lifted restrictions. This caused concerns for both lobbyists working bills and Representatives because much of the floor actions involved mask theatrics, leaving the much-needed floor work to take a back seat. Finally, in March, the House followed the Senate and the State to lift their mask restrictions. However, this didn't happen without floor drama from both sides of the aisle. Covid protocol was not the only unexpected issue to grace the Statehouse during this Spring session.

In early March, the former speaker of the House of Representatives of 38 years, Michael J. Madigan, was indicted on 22 charges related to racketeering, bribery, and attempted extortion. The indictment accused the former speaker of using his political power of steer business toward his private law firm in addition to obtaining bribes. This led to many of the Representatives removing any support for their former speaker in various news outlets, press releases, and conferences. This event came about in an election year, giving Republicans fuel to tie serving legislators who utilized his staff and fundraising to hold their positions to Madigan. Although this was the first legislative session in the last 38 years that Madigan has not served in the Statehouse, his name still rang out throughout the committee rooms and chambers over the course of the session.

Representative Emanuel Chris Welch ascended to the Speaker position in the beginning of the legislative session, bringing a fresh perspective to procedures and ways the House was to operate. Welch had promised that he would make the legislative process transparent, as well as have an open-door policy. However, with a regime change after a long 38 years, a transfer of power was sure to be messy. For example, for timing purposes, it was a usual process in the second year of a two-year General Assembly cycle that representatives would only be able to run priority bills. This year, Welch did not cap the amount of bills the Democrats could run, which made for an incredibly busy schedule. Additionally, the change in Speaker put more pressure on the House Democrats to "work their bills." Some Representatives had a difficult time adjusting to this change, leaving many bills without sufficient votes to pass when called to the House floor.

In addition to the changes in processes, it seemed like the House and Senate were acting on two completely different timelines. The House acted as if deadlines were not condensed, filing, and sending over many bills to the Senate that essentially became shell bills. The Senate stuck to member's strict priorities. By sending only

priority bills to the House, the House was left with no bills to shell and amend for late-in-session legislation. Instead, the House utilized House bills to move legislation, leaving inadequate time to complete the legislative process before the adjournment date.

Per Illinois tradition, the budget was dropped on the last day of legislative session. The Senate adjourned around 3 AM on April 9 – the day after the scheduled spring session was to adjourn, and the House followed that morning at 6 AM after a 24+ hour trudge to the finish line. The budget was voted on and sent to the Governor's Office on party lines, touting a $46.5 billion dollar spending package, including enhanced funding for public safety and law enforcement (in response to concerns about the rise in crime) and additional funding for many areas of healthcare to help address staffing shortages and access to care, particularly in the areas of behavioral health and underserved communities.

In addition to healthcare, tax relief was another large item in the budget, which called for over $1.8 billion dollars in various tax relief measures, including groceries, gas, and real estate. Fiscal Year 2023 also included a permanent extension in the state's Earned Income Tax Credit for low- to middle-income earners. While there were no tax increases, lawmakers unfortunately failed to fully address the $4.5 billion deficit in the Unemployment Insurance Trust Fund that if the remaining deficit of $1.8 billion is left unaddressed could result in higher unemployment taxes for all employers in the near future. Lawmakers appropriated $2.7 billion in remaining federal ARPA funds towards the deficit, but business groups and labor will continue to negotiate ways in which the remaining deficit can be addressed by way of possibly state borrowing and benefit cuts, in addition to tax increases.

Below are the bills and policy topics that ILHIC tracked and negotiated throughout this Spring.

ILHIC Stats

Total Bills Tracked by ILHIC: **167 Bills**
Bills Successfully Negotiated from Opposition to Neutrality (bills that passed both chambers): **15 Bills**
Bills Unsuccessfully Negotiated (Passed Both Chambers): **0 Bills**

DOI Legislative Agenda

Despite the shorter spring legislative session calendar, DOI unveiled an ambitious legislative agenda with nine proposals covering data privacy, health insurance ID cards, short-term limited duration health plans and excepted benefits, surprise billing, high-deductible health plans (HDHPs), annuity non-forfeiture, new industry fees, insurer diversity reporting, and the repeal of small employer health insurance rating provisions. While the Department included ILHIC-supported language to reduce the annuity non-forfeiture rate from 1% to 0.15% to protect the sale of annuity products in a low-interest rate environment and a bill to preserve HSA-eligible HDHPs as a health insurance option for consumers in 2023 and beyond, the Council spent much of the session negotiating several more problematic proposals including insurance data privacy absent of exclusivity and/or a materiality trigger and the outright prohibition of short-term limited duration plans and restrictions on excepted benefit policies.

Below is a summary of the Department's proposals and their status at the end of the spring session:

DOI Bills Passed

Annuity Non-Forfeiture Rate/Industry Fees – HB 4493 (Morgan/Harris): the bill, as amended, contains a provision strongly supported by the life insurance industry to reduce the annuity nonforfeiture rate from 1% to 0.15% to align with the National Association of Insurance Commissioners (NAIC) model law change. The change is necessary to protect the sale of annuities with guarantees in the current low interest rate environment and any future low interest rate environments.

The legislation also contains DOI proposed clean-up changes to the Insurance Code and was amended in the House to fold in the Department's proposed industry fee increases originally introduced in SB 4048 (Harris). These new fees are summarized below:

- New Certified Reinsurer license fee ($1,000 for initial fee and $400 for renewal).
- Fee for service of process increase from $20 to $40 to offset DOI expenses.
- New Captive Management Company registration fee ($50 initial and $50 for renewal).
- New Informational and Advertising filing fee ($25).
- Annual IL Workers' Compensation Commission Operations Fund Surcharge late payment penalty increase to a flat 10% of the deficiency (on a per month basis).
- New Division Law fee for a domestic stock company seeking to divide into two or more companies to offset DOI expenses for processing and reviewing the plan of division ($10,000).
- Alters $4 fee assessed on auto policies to give insurers the option to pay from their operational budget as opposed to requiring policyholders pay the fee.

ILHIC POSITION: SUPPORT

HSA-Eligible HDHP Copay Accumulator Carve Out – HB 4433 (Morgan/Harris): the bill exempts high-deductible health plans (HDHPs) that are eligible for health savings accounts (HSAs) from the state's copay accumulator law requiring insurers to apply the value of any discount, coupon, or third-party payment for a prescription drug towards the enrollee's deductible or other cost-sharing requirement enacted in 2019 (P.A. 101-0452). The legislation is the result of a lengthy two-year negotiation between the Department, ILHIC, and patient advocates who originally fought the exemption despite confirmation from both the U.S. Department of Treasury (via a memo to the Department) and the U.S. Center for Medicare and Medicaid Services that such a discount or coupon is not considered preventive and may not count towards an enrollee's deductible if the enrollee has an HSA-qualified HDHP.

While ILHIC and the health insurance industry, along with the Department, had advocated for a broader exemption to apply to all current and future first dollar coverage mandates or other coverage requirements that may otherwise skew from federal law regarding eligible contributions to an HSA, advocates pushed for the narrow copay accumulator exemption adopted by the National Conference of Insurance Legislators (NCOIL) that was ultimately included in HB 4433.

The legislative action was also made more urgent by the Department's position set forth in Company Bulletin 2021-13 that absent a legislative fix, they would not approve any HSA-eligible HDHPs for plan year 2023 and beyond due to the misalignment with federal Tax Code provisions.

ILHIC POSITION: SUPPORT

Uniform ID Cards - SB 3910 (Jones/Fine): the bill, as amended, requires health plans to disclose the regulatory entity that holds authority over the plan, customer contact information as well as applicable cost-sharing

requirements and out-of-pocket maximums in alignment with federal No Surprises Act (NSA) changes that took effect January 1st. The Department's rationale for pursuing the changes specifically requiring the disclosure of the regulatory entity that holds authority over the plan is to help consumers more clearly identify whether their plan is regulated by the State of Illinois and therefore held to state-specific coverage mandates and other coverage requirements that would not otherwise apply to ERISA-exempt plans regulated by the US Department of Labor.

ILHIC worked with the Department to exempt dental plans, which were originally included in the legislation, pare down additional card disclosure requirements, and delay the effective date until January 1, 2024 (instead of January 1, 2023) to give insurers additional time to comply. The Department is also expected to issue additional guidance regarding the identification of the regulatory entity after the bill is enacted.

ILHIC POSITION: NEUTRAL as Amended

Surprise Billing – HB 4703 (Morgan/Gillespie): the bill, as amended, attempts to align portions of the Illinois surprise billing statute under Section 356z.3a of the Insurance Code with the federal No Surprises Act that took effect on January 1, 2022. ILHIC worked with the Department to address provisions in the introduced bill that conflicted with the federal No Surprises Act (NSA), specifically provisions related to cost-sharing and out-of-network rates as they relate to billing and arbitration.

Given pending litigation around the federal government's implementation of the NSA Independent Arbitration Resolution (IDR), the Department was unwilling to make additional changes to align Illinois' arbitration process more clearly with the federal IDR but committed to continuing to work with ILHIC on strengthening the state's surprise billing protections to hold providers accountable more forcefully for out-of-networking billing practices.

The legislation takes effect January 1, 2023. In the meantime, the Department released Company Bulletin 2022-03 regarding the initial implementation of the federal NSA and how the state intends to allocate enforcement responsibilities between the Department and the federal Centers for Medicare and Medicaid Services (CMS). Illinois is currently one of one three states that have yet to receive a formal CMS Enforcement Letter detailing these responsibilities further, but the Department anticipates the letter following passage and/or enactment of HB 4703.

ILHIC POSITION: NEUTRAL as Amended

DOI Bills Stalled

Insurance Data Security– HB 4653 (Jones): the bill, as introduced, contains the NAIC Insurance Data Security Law outlining standard consumer data privacy protections for insurers including company written data security program and response, as well as the circumstances in which a company must report a breach or incident to the Department. The Department held several stakeholder negotiations with ILHIC, ACLI and other members of the agent/broker and property & casualty insurance industry to discuss potential changes to address industry concerns, including enforcement exclusivity for the DOI, a materiality trigger for reporting a breach for domestic companies, and clarification of the time frame for compliance when a licensee has an exemption. Despite progress towards addressing many of the industry concerns, the Department remained unwilling to address exclusivity and/or a materiality trigger.

The sponsor chose not to advance the bill this session due to the outstanding opposition. The Department has indicated they intend to revisit this legislation in the fall or more likely the next General Assembly (in 2023).

ILHIC POSITION: OPPOSE

Short-Term Limited Duration Plan Changes – SB 3926 (Fine/Morgan): the bill, as amended, makes changes the state's existing Short-Term Limited Duration Health Insurance (STLDI) Act to impose stronger consumer disclosure and transparency requirements and strengthen the Department's authority to go after misleading or fraudulent marketing of STLDI products. The provisions keep the current less than 181-day, non-renewable restrictions on STDLI intact, but would move the state towards a more restrictive timeline if the federal government changes existing STLDI regulations to pull back on the existing less than 12-month renewable time frames.

ILHIC strongly opposed the bill as it was introduced which called for the outright elimination of these products in the state and further imposed problematic restrictions on excepted benefit products. The Council worked extensively with the Department to negotiate changes that addressed DOI cited issues with the products, including misleading marketing practices that could lead to consumer confusion of less-expensive STLDI products with more comprehensive ACA coverage rather than provisions that imposed restrictions on the availability of STLDI as a viable stop-gap insurance option for those individuals in need of a temporary coverage option.

ILHIC was involved in negotiations on the state's original STLDI law in 2018 when the Council and proponents reached a compromise on the 181-day time limit after the Trump Administration changed the federal regulations to allow for STLDI plans to remain in place for less than 12-months with renewal options. The previous federal regulations provided for a less than 3-month non-renewable time frame. Prior to 2018, Illinois did not have a specific STLDI law and therefore, regulation of the products followed federal rules.

During negotiations, proponents of SB 3926 pushed for reverting to the less than 3-month time frame in state law, as well as a prohibition on the sale of STLDI during open enrollment along with additional coverage requirements that would likely increase the cost of these temporary insurance policies. Those provisions were ultimately left unaddressed due to ILHIC's opposition, citing pending federal action this summer that will likely impose tighter restrictions. The Council also noted that enhanced ACA premium tax credits designed to make comprehensive ACA coverage more affordable for individuals and families who have household incomes 400% or more of federal poverty level are set to expire at the end of this plan year in the absence of Congressional action extending those enhanced tax credits.

The Department cited the widespread availability of the enhanced premium tax credits as another reason STLDI plans needed to be further limited or even eliminated.

SB 3926 advanced to the House in the final week of session, but given procedural requirements to advance a crossover bill, the legislation fell victim to the legislative clock, a busy legislative calendar in the final days/hours of the session, and patient advocates who were not in full support of the compromise language.

ILHIC anticipates the Department pushing to revisit additional restrictions on STLDI later this year or next spring, which was ultimately the Council's initial position that the Department and lawmakers should wait until after pending federal action is taken later this summer and/or fall.

ILHIC POSITION: NEUTRAL as Amended

Insurer Supplier Diversity Reporting – HB 5516 (Jones): the bill, as introduced, requires insurers with assets of at least $50 million to submit an annual report to be posted on their website on their voluntary supplier diversity program or a company procurement program in the absence of a voluntary supplier program. The report must provide for information on the program, as well as voluntary diversity goals. The Department is also required to hold an annual insurance company supplier diversity workshop.

The legislation is similar to HB 3965 (Welch) from the 101st General Assembly. HB 5516 did not advance out of House Rules.

ILHIC POSITION: NEUTRAL

Small Employer Health Insurance Rating Act Repeal – SB 3001 (Gillespie): the bill, as introduced, sought the full repeal of the Small Employer Health Insurance Rating Act, which was intended to eliminate the ability of small employers from renewing "Grandmothered" or transitional health plans that are not fully-ACA compliant. The bill did not advance out of Senate Assignments.

The Department has since recently issued Company Bulletin 2022-05 extending transitional policies for Plan Year 2023 and beyond in line with federal CMS guidance.

ILHIC POSITION: NEUTRAL

Mandates, Mandates, Mandates

Illinois usually sees a high volume of coverage mandate legislation. However, during this election year, there were even more coverage mandates filed. ILHIC's strategy for these mandates were 3-fold. ILHIC worked to: 1. Move the effective date to 2024 to simplify policy filings; 2. Insert medical management "medical necessity" tools into the coverage mandate language; and 2. If the bill included no cost sharing, to include language that exempted high deductible health plans in so far that it did not preclude consumers from utilizing health savings accounts.

The House chamber filed many of the mandates. When the house bills were sent and assigned to the Senate Insurance Committee, Chairman Harris established a "Mandates Subcommittee" and placed many of the house mandates into the subcommittee with the suggestion that they would not move this session. However, at the member's request, some coverage mandates were heard in committee and passed both chambers. The summary of the coverage mandates that passed both chambers are included below.

- Number of Mandates Passing Both Chambers: **9 Bills**
  - **HB 4271** Breast Reduction Coverage Mandate (Effective Jan. 1, 2024)
    - Mandates coverage for medically necessary breast reduction surgery.
    - Neutral
  - **HB 4338** Prenatal Vitamin Coverage Mandate (Effective Jan. 1, 2024)
    - Mandates coverage for prenatal vitamins.
    - Neutral
  - **HB 4349** Congenital Defect Coverage Mandate (Effective Jan. 1, 2024)
    - Mandates coverage for congenital defects including treatment of cranial facial anomalies that are medically necessary to restore normal function or appearance. Cosmetic changes are included in coverage requirement.
    - Neutral

- **HB 4408** Naloxone Coverage Mandate (Effective Jan. 1, 2024)
  - Mandates plans that provide coverage for naloxone do so without cost sharing.
  - Neutral
- **HB 4430** Pharmacy Services for Prep Coverage Mandate (Effective Jan. 1, 2023)
  - 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.
  - Neutral
- **HB 5254** Hormone Therapy Coverage Mandate (Effective Jan. 1, 2023)
  - Provides coverage for hormone therapy treatment to treat menopause that has been induced by a hysterectomy.
  - Neutral
- **HB 5318** Prostate Screening Coverage Mandate (Effective Jan. 1, 2024)
  - 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.
  - Neutral
- **HB 5334** Genetic Testing for Cancer Breast/Ovarian Coverage Mandate (Effective Jan. 1, 2024)
  - 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.
  - Neutral
- **SB 2969** Continuous Glucose Monitors Coverage Mandate (Effective Jan. 1, 2024)
  - Mandates coverage for continuous glucose monitors for individuals diagnosed with type1 or type 2 diabetes and requires insulin for the management of their diabetes.
  - Neutral

Insurance Bills Focusing on Crime

Crime was a high priority during this election year session from both Republicans and Democrats. Democrats recently overhauled the criminal justice system in Illinois with the enactment of the Safety Act at the end of the 101st General Assembly in early 2021. After its enactment, there were concerns regarding the elimination of cash bail and as well as some enforcement changes to police officers. To correct for some concerns, and instead of the Democrats heeding the Republicans' call for full repeal of the previously passed Act, the House and Senate Democratic caucuses filed additional bills with the purpose to make corrections to the previously passed Safety Act. While many of the crime bills did not relate to insurance, ILHIC did track some insurance bills that also dealt with criminal justice.

Felony Conviction: HB 228, as filed by Representative Mayfield, prohibited an insurer or producer from making a distinction or otherwise discriminating between persons, reject an applicant, cancel a policy, or demand or require a higher rate of premium for reasons based solely upon the basis that an applicant or insured has been convicted of a felony. However, ILHIC was able to negotiate this bill to neutrality by adding language that narrowed the language to specifically apply the prohibition on discrimination on the basis of a felony to final expense policies marketed and sold for the purposes of covering funeral and burial expenses. The amendment did include language that insurers are not required to provide coverage to a person *actively incarcerated pursuant to a* felony conviction. Although this bill was set to move this session, the sponsor had last minute concerns regarding ILHIC's suggested language, specifically with the exclusion of those actively incarcerated if relatives of an incarcerated individual sought coverage of the individual while they were in prison given elevated risks of violence. There is more work on this issue and the Sponsor would like to revisit this issue in the future. Due to her concerns, she did not move the bill through the legislative process.

ILHIC Position: Neutral with Amendment

Mental Healthcare Coverage for Police: HB 4480, mandated coverage with no cost sharing for mental health wellness checks for probationary and permanent police officers. This bill was filed by Representative Conroy, who is extremely passionate about mental health and access to mental health services. ILHIC, as well as Democratic staff did discuss with Conroy that while we understood that her bill is well intentioned, it will not have the affect desired, because most police officers have coverage through their employing county, and the language only referred to individual and group ACA coverage. In addition, if the bill did advance, there would need to be language exempting high deductible health plans. The bill did not advance farther in the legislative process. Instead, the House Democrats suggested a fund to assist police officers (not including insurance) in a different legislative package.

ILHIC Position: Oppose

Filing, Fees, and Process Bills

Beyond the many mandate bills, there were also bills filed that alter requirements regarding fee change notices, and an opportunity for the State to promote ACA coverage.

Fee Schedule Changes: HB 4941, filed by Representative Mah, mandated 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. Representative Mah filed the bill on behalf of a provider in her district that wanted more notice regarding fee changes. ILHIC worked with the sponsor as well as stakeholders to offer language that moved the Council to neutral. The first amendment filed separated 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.

ILHIC Position: Neutral

Easy Enrollment: HB 5142, filed by Leader Harris, created an agency process in which HFS and DOI to provide the Department of Revenue a form describing health insurance enrollment option for taxpayers. The Department of Revenue will then send the information regarding ACA coverage to taxpayers who request it. An amendment was filed that stated that if a state-based health insurance exchange (SBE) becomes operational, that the Exchange must interface with the Illinois tax system. The legislation was filed in response to a concern that the Department of Revenue did not want to hold this responsibility if there was an expanded state platform that is better suited to implement this process.

ILHIC Position: Support

Group Life Continuation: A success for ILHIC- **SB 2963**, filed by Senator Severson, passed both chambers and is heading to the Governor's Office for signature. HB 2963 fixes a concern that the new group life continuation of coverage provisions enacted last year 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. This bill is effective immediately.

ILHIC Position: Support

PBMs and Pharmacy Bills

It would not be an Illinois legislative session without legislation further regulating PBMs and pharmacy service expansions. Some bills were revived from the previous years and other large policies were introduced just this year.

Omnibus PBM Bills: PBM bills recognized from the previous year included **SB 2008**, filed by Senator Koehler, and **HB 3630**, filed by Leader Harris. These identical bills were often referenced on ILHIC legislative calls as "The PBM Christmas Tree" bills, largely in part because many portions of the bill were negotiated out in good faith through HB 465, now Public Act 101-0452, that went into effect on January 1, 2020. ILHIC argued that much of the Public Act 101- 0452, hasn't been fully implemented by the Department. However, that didn't stop the Independent Pharmacists at making the attempt to jam something through. Both bills did not make it far in the legislative process. Rather, PBM processes such as white bagging and 340B took center stage as the PBM policy bills this legislative session.

ILIHC Position: Oppose

White Bagging: Illinois joined a growing number of states that have seen provider-backed legislation designed to prohibit the practice of "white bagging." With the growth of specialty medications, health plans and PBMs have deployed the use of "white bagging" to safely ship physician-administered drugs directly to the patient's health care provider for patient administration. The practice is designed to reduce the cost of the drug by avoiding the provider's "buy and bill" method that can increase the cost of the prescription drug by as much as 400%.

Physician and hospital groups advocated for SB 3924 (Castro)/ HB 4774 (Lilly) to protect those "buy and bill" practices by: 1) prohibiting health plans and PBMs from requiring the use of their specialty pharmacies for obtaining clinician-administered drugs; 2) prohibiting health plans and PBMs from differentiating their reimbursements to provider-operated specialty pharmacies or applying different cost-sharing for provider-operated specialty pharmacies; 3) prohibiting prior approval for site of services for clinician-administered

drugs; and 4) prohibiting health plans and PBMs from requiring the insured to use a home infusion pharmacy or a site of service directed by the plan or PBM.

A cost analysis of the proposal performed by PCMA showed that the cost of the proposal to the fully-insured group and ACA marketplace in Illinois is approximately $136 million in the first year alone.

ILHIC met with the sponsor and proponents of the legislation to discuss the impact of the proposal as introduced and discuss concerns the proponents raised regarding the use of health plan and PBM-directed specialty pharmacies. In response to those concerns, ILHIC offered alternative language to address patient safety; tracking delays; inability to make changes prior to administration to avoid disruption of care; and prior approval of site of service requirements.

ILHIC's alternative language attempted to reinforce that the health plan and PBM must meet the supply chain security controls as set forth in the federal Drug Supply Chain Security Act (DSCSA); confirm delivery date and location and provide tracking details; provide for an exception process by which the prescribing provider may request changes, including dosage changes prior to administration; and clearly disclose any prior approval requirements for site of service in accordance with the state's Prior Authorization Reform Act that took effect January 1.

Provider groups ultimately balked at the alternative approach and the sponsor stated that she would hold the bill this session to continue discussions with the stakeholders but noted that she intended to move the legislation in the fall veto session even if the discussions yielded an impasse and the language failed to address ILHIC and the industry's concerns.

ILHIC POSITION: OPPOSE

340B Nondiscrimination: The federal 340B program took center stage early in the spring session when provider groups, spearheaded by the Illinois Primary Health Care Association (IPHCA), introduced legislation targeting health plan and PBM discrimination of 340B entities and their contract pharmacies.

HB 4595 (Harris/Hunter)/ SB 3729 (Hunter), as introduced, applied nondiscrimination provisions prohibiting differentiation in reimbursement, contracting, and patient access based on whether the pharmacy is a 340B contract pharmacy in both the commercial and Medicaid markets. The language also included a much more problematic prohibition against health plans and PBMs requiring the use of a billing modifier to indicate whether the drug was a 340B drug.

The 340B program was first established in the early 1990s to leverage additional federal resources to serve vulnerable and at-risk populations. Under the 340B program, drug manufacturers – as a condition of participation in Medicaid – must agree to provide steeply discounted prices on covered outpatient drugs to eligible hospitals, FQHCs and other provider grantees known as covered entities.

The program has run into several challenges over the years, including limitations on the federal Department of Health and Human Services' Health Resources and Services Administration's (HRSA) regulatory authority over 340B contract pharmacies, which have exploded in recent years due to HRSA-initiated action in 2010 authorizing covered entities to contract with multiple contract pharmacies to address patient access issues.

The growth in contract pharmacies along with other issues has raised compliance concerns with the program and prompted a complex series of actions taken at the federal level and in the courts to clarify regulatory

authority and return the program to its intended goal of serving vulnerable patient populations. Illinois' Medicaid agency – the Illinois Department of Healthcare and Family Services (HFS) – also took steps last year to remind 340B covered entities of their responsibility under the federal program to carefully track the dispensing of 340B drugs at their contract pharmacies to avoid running afoul of the program's Medicaid prohibition on duplicate discounts that disallows a drug manufacturer's 340B discount and their rebate to HFS on the same covered outpatient drug.

Although there is no duplicate discount prohibition on the private commercial market, health plans and their PBMs track 340B discounts for accounting purposes and in accordance with their own contractual arrangements with the drug manufacturers.

IPHCA raised concerns that PBM requirements of a modifier and the HFS memo regarding programmatic integrity and compliance would threaten the availability of contract pharmacies and ultimately their ability to adequately serve their patient populations. The IPHCA's legislative solution, however, was met with broad opposition from PBMs, Medicaid and commercial health plans, ILHIC, PhRMA and HFS.

House Democrat Majority Leader Greg Harris, who sponsored HB 4595, convened a series of stakeholder negotiations, including ILHIC, to address the opposition's concern – namely regarding the prohibition of the use of the modifier. After a lengthy series of negotiations and a narrow avoidance of an impasse, the stakeholders reached a compromise on language that focused on the nondiscrimination of 340B entities and their contract pharmacies and removed the ban on the modifier.

HB 4595, as amended, passed both houses unanimously and will go to the Governor who is expected to sign it.

ILHIC POSITION: NEUTRAL as Amended

Pharmacy Scope of Practice: Increasing pharmacy services and scope of practice is not a novel idea in the Illinois legislature. It is no surprise that the Independent Pharmacists have been pushing to expand their scope of practice along with seeking reimbursement at the same level as medical professionals that usually provide such services. **HB 4430,** filed by Representative Cassidy, expanded a pharmacist's scope of practice to include the initiation, dispensing, administration of drugs, laboratory testing, assessments, referrals, and consultations for PrEP treatment. The bill also included a provision in the Insurance Code that required insurers to reimburse pharmacists or other health care professionals for dispensing PREP and providing services under the Act. The bill required 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. This language was far from the agreement ILHIC and the independent pharmacists negotiated last year in a new law regarding hormonal contraceptives. ILHIC and the industry were able to negotiate with the stakeholders to file an amendment which added PrEP services to the existing "Coverage for Patient Care Services Provided by a Pharmacist" statute presented in 215 ILCS 5/356z.45.

ILHIC Position: Neutral as Amended

Prepaid Funeral and Burial – Medicaid Eligibility

The Illinois Funeral Directors Association and the National Association of Elder Law Attorneys once again sought to revisit legislation to provide for an irrevocable assignment of life insurance policies for final expense purposes to avoid asset limitations on individuals applying for Medicaid benefits. HB 295 (Manley/ Feigenholtz) passed the House in the spring 2021 session, but ongoing discussions forced the legislation to

stall in the Senate after the Department of Healthcare and Family Services (HFS) asked for additional time to determine whether a state plan amendment would be needed to allow this exemption. There were also ongoing concerns about irrevocably assigning these benefits over to a funeral home to distribute rather than a trust.

The proponents of the bill reintroduced HB 295 provisions into HB 4979 (Manley/Connor), but the bill was later amended in the House to only clarify that a Medicaid applicant can exempt certain prepaid funeral or burial contracts from eligibility consideration and use available resources, such as life insurance policy, to purchase on of the exempted prepaid funeral or burial contracts through an irrevocable assignment at any time between time of application and determination of eligibility.

Stakeholders, including ILHIC, and several state agencies – DOI, HFS, the IL Comptroller's office, and the Illinois Department of Financial and Professional Regulation (IDFPR) – met several times to try and address the proponents ongoing concern that some life insurance policies would not provide for an irrevocable assignment to cover funeral and burial expenses (only a revocable assignment that did not meet the HFS threshold for exemption of assets for Medicaid eligibility purposes).

Through what can only be described as a confusing array of legislative language proposals attempting to address the problem over the course of the session, as well as industry and agency concerns around the directing of these resources towards the funeral home and not a trust, the Senate sponsor introduced an amendment in the final days of session designed to address the irrevocable assignment, funeral home accounting of the proceeds, and Medicaid eligibility determination based on the exemption of these resources.

State agency opposition, including that of HFS, DOI, and IDFPR, pulled back with the amendment's inclusion of language making the irrevocable assignment mechanism and the bill's changes entirely dependent on HFS receiving federal approval by way of a state Medicaid plan amendment or waiver.

HB 4979, as amended, passed both houses in the final days of session. ILHIC will continue working with members and the agencies on potential clean-up language to be offered in the fall veto session.

ILHIC POSITION: NEUTRAL as Amended

Health Benefit Exchange

The State Based Exchange is a policy that Illinois subject matter experts have been toiling with since Governor JB Pritzker came into office. In 2020, the Department issued a declaration that Illinois intended to move platforms. However, this move did not come into fruition due to unknown and underprepared budgetary considerations. The State Based Exchange was not included in the Department's Feasibility Study, required by Public Act 101-0649, other than to explain that some policies that the State analyzed would be easier to implement with more autonomy that comes with moving to a different platform.

ILHIC was surprised to see the introduction of **HB 4175**, filed by Representative Jones, which established that the State would move to a full State Based Exchange in addition to providing assessments for insurance companies to pick up the cost to run the new platform. The legislation, which was actively being pushed behind the scenes by a company that operates these platforms in other states, threatened to upend previous discussions with the Department and lawmakers on delaying consideration of a major policy undertaking in year that would not have afforded much time to hold stakeholder discussions. ILHIC worked to meet with

House Leadership on both sides of the aisle and budget staff to provide education on the policy, explain that the bill did have large up-front costs, and discuss the lack of stakeholder engagement on the subject. ILHIC was not opposed to the underlying policy. Rather, ILHIC was concerned with the process and lack of stakeholder input. All parties did agree that the State moving to this platform has budget implementation considerations and this sweeping policy should not be driven by an entity with a financial interest. The bill was posted multiple times to House State Appropriations Committee, but never received a hearing. While this bill was not called this session, this might signal some renewed interest in moving platforms in the future.

Upcoming Summer Issues

With condensed session, many bills were unable to be successfully negotiated within the deadline timeframe. Below are some bills that sponsors requested to work with ILHIC and other stakeholders over the summer to receive clarification or the opportunity to negotiate to neutrality.

Domestic Violence: **HB 4946**, filed by Representative Hirschauer, and **HB 4337**, filed by Representative Cassidy, both attempted to amend the insurance code by prohibiting lack of coverage if an injury was sustained by an act of domestic violence. Specifically, HB 4946 prohibited any provision denying benefits for treatment of an injury sustained as a result of domestic violence. HB 4946 also prohibited denying expenses incurred in a provision of mental health treatment or therapy to an insured who is a victim of domestic violence. HB 4337 mandates coverage for aesthetic services and restorative care provided for the treatment of physical injuries to victims of domestic violence when medically necessary. There was no language present regarding how those injuries would be determined by a physician. ILHIC met with both sponsors and explained that insurance companies do not delineate coverage decisions based on the source of the injury. Representative Cassidy requested all stakeholders in addition to both sponsors meet over the summer to discuss this legislation and any opportunities to advance their cause. ILHIC committed to work with them on this legislation.

ILHIC Positions (Both Bills): Oppose

Immigrant Access to Healthcare: ILHIC also committed to discuss legislation with Representative Hernandez, regarding **HB 4413**. As introduced, HB 4413 provided that a group or individual policy that provides dependent coverage shall make dependent coverage available to an insured's parent or stepparent who meets the qualifying relative definition and resides within the insurance policy's service area. ILHIC met with the sponsor to explain that the plans listed in the bill are Marketplace plans. Dependent coverage for Marketplace plans is defined in Federal law. To require a state expansion of that federal definition might conflict with said federal law. Dependents are used in Marketplace tax credit calculation, and dependent parents may be included only if they are their tax dependents. Representative Hernandez understood the explanation and suggested a post session meeting to explain the federal requirements in more depth. ILHIC has agreed to hold this meeting at her convenience.

ILHIC Position: Oppose

COVID-19 Testing: Another piece of legislation which required a substantial amount of education was **HB 5454**, filed by Representative Crespo. HB 5454 mandated coverage for COVID-19 Diagnostic Testing without cost sharing if the purpose of the testing is for the individualized diagnosis or treatment of COVID-19, in accordance with the Federal Cares Act. HB 5454 also mandated all testing sites to collect insurance information from patients. ILHIC have several meetings with the Sponsor to discuss the negative impacts to

consumers if they are tested for workplaces at free sites with respect to surveillance testing. Specifically, ILHIC explained that federal law already requires plans to cover the cost of a COVID-19 test for diagnostic purposes. ILHIC was hesitant to codify an already existing process due to the fact that science of COVID-19 is changing rapidly and the State should not get into a situation where federal guidance changes and state law and federal law would conflict. Additionally, mandating testing sites to collect insurance from individuals might lead to an unintended consequence regarding surveillance/workplace testing. COVID-19 testing under a requirement of the workplace is categorized in a familiar fashion as drug testing, in which the employer is required to cover the test. However, some employees might utilize free testing sites. If HB 5454 passed and sites are required to collect insurance information, this might hurt said employees that utilize the free testing sites. Representative Crespo did suggest that he might be interested to pick up further conversation in the summer. However, ILHIC worked to shore up opposition with the Chamber and NFIB, which provided significant pushback on this legislation. The sponsor ultimately sidelined the issue, but, ILHIC stands ready to discuss further if the sponsor is interested.

ILHIC Position: Oppose

Insurance Business Transfer: A new voluntary restructuring mechanism for insurance companies was proposed in a pair of bills introduced this session – HB 5534 (Jones/Cunningham)/ SB 3781 (Munoz) – designed to initiate a broader stakeholder discussion about the merits of allowing an Insurance Business Transfer (IBT) in Illinois. Restructuring mechanisms like IBT and corporate divisions, which Illinois enacted in 2018 (and took effect on January 1, 2019), have been a topic of regulatory and policy discussions at both the NAIC and the NCOIL level.

HB 5534 and SB 3781 contained the NCOIL IBT Model adopted in March 2020 based on a law enacted in Oklahoma in 2018 that was in turn based off the United Kingdom's Part VII of the *Financial Services and Markets Act of 2000*.

The Senate sponsor indicated he had no intention of moving SB 3781 in the shortened session but left open the possibility of requesting a subject matter hearing on the legislation before the Senate Insurance Committee. While the House sponsor indicated a similar desire, HB 5534 ultimately advanced out of the House with no stakeholder discussions and over ILHIC and ACLI's opposition.

ILHIC met with the new Senate sponsor of HB 5534, Senate Assistant Majority Leader and President Pro Tempore Senator Cunningham, shortly after the legislation arrived in the Senate to discuss outstanding concerns, including the legislation's deficiency in adequately addressing the possibility of orphan policies should an assuming insurer become insolvent as a result of the transferred block of business.

ILHIC believes that any IBT should adhere to principles that policyholders and other impacted stakeholders have access to the process; be subject to a robust regulatory review that utilizes independent experts; be subject to a court's approval process; and provide adequate protections to policyholders and our state guaranty associations.

While HB 5534 (Jones/Cunningham) currently encompasses many of these principles, it does not currently provide for adequate protections to policyholders and our state guaranty association – specifically the Illinois Life & Health Insurance Guaranty Association. The legislation currently requires notice to be provided to the National Organization of Life & Health Guaranty Insurance Associations (NOLGHA) and other guaranty associations as well as a description of guaranty association coverage in the IBT plan. However, it stops short

of requiring guaranty association coverage to be maintained by way of requiring licensure of the assuming insurer and ILHIC believes it is critical that the assuming insurer be licensed in every jurisdiction in which the original or transferring insurer is licensed and impacted policyholders reside thereby extending guaranty association protections in those respective states.

Additionally, while the DOI did not have an opportunity to weigh in on the legislation in the House, they too met with Leader Cunningham to express implementation and compliance concerns, including the current lack of solvency protections for life and heath insurance policyholders. Due to the outstanding opposition by both the Department and ILHIC, Leader Cunningham stated he would hold the bill in exchange for future stakeholder discussions to address the outstanding concerns.

Pending outcome of those forthcoming discussions and further revisions to the legislation, HB 5534 could potentially advance in the fall veto session.

ILHIC POSITION: OPPOSE

Vision Care Regulation: The Illinois Optometrists' Association (IOA) reintroduced legislation this session that would prohibit vision care plans from setting discounts and fees on noncovered materials and further prohibits the plans from restricting the provider's choice of suppliers, materials or labs. HB 4484 (Moeller), as introduced, would drive up consumer costs on eyewear and possibly force consumers who need contacts or glasses to obtain these supplies from other providers that are outside of their optometrist, especially as lower cost options like Warby Parker and Zenni have entered the market.

ILHIC met with representatives from the association last fall after the IOA chose not to advance SB 2086 (Castro) in the 2021 session due to ILHIC and other vision care plan opposition. The Council pointed to other states that have worked out compromise language between the plans and the eye care providers and offered up alternative language to prohibit vision care plans from setting prices on noncovered services and materials as a condition of joining the network without giving the optometrist the ability to voluntarily choose to participate in the plan's discount program. The suggested language would also guarantee the optometrist the freedom to describe all options to the patient and protect the patient's ability to be informed when pricing can differ.

Despite the offer of a compromise, the IOA introduced the 2021 legislation as HB 4844, but indicated they did not intend to move forward in the spring session in the hopes of continuing to discuss alternative language. ILHIC anticipates revisiting these discussions this summer.

Insulin has been a topic on many legislator's minds. Specifically, Representative Guzzardi has taken insulin costs as a high priority issue during this spring's session. Representative Guzzardi filed **HB 5300**, allows pharmacists to dispense insulin if a patient can attest that they are in dire need of the drug. After dispensing the drug, the pharmacist notifies the provider. The bill also mandated that drug distributors can reimburse pharmacies with refills of insulin or the amount that covers the pharmacies acquisition cost. Allows a drug manufacturer to send insulin directly to the patient. The bill requires 30-day coverage of insulin not to exceed 35 dollars (changed from 100 dollars). This specific bill did not move this session. However, a different iteration of the language was refiled as a part of the Democratic Healthcare Package late in session. A part of that healthcare package, HB 1466, lowered the insulin cap from $100 to $35 dollars. ILHIC were opposed to both bills, stating that 35 dollars is artificial price control, and it only has a minimal impact on the insured market. Both bills were unable to advance in the legislative process. However, there have been pressure by

consumer advocates to address further regulations around the cost of insulin. ILHIC expects conversations to resurface this summer regarding the cost of insulin and drug prices.

ILHIC Position: Oppose

Democratic Healthcare Package: The House Democrats dropped a grouping of healthcare bills aimed at providing affordability and access to consumers with health insurance in Illinois during the last scheduled week of session. The package included **HB 1462**, sponsored by Yang- Rohr, which created the Prescription Drug Affordability Board. HB 1462 establishes the Prescription Drug Affordability Board to protect against high prescription drug costs and **HB 1465,** sponsored by Representative Morgan, which established Illinois as a rate review state. An alternative bill was filed (**HB 836**), which included a portion of previously filed bill. However, HB 836 only included language mandating the Department of Insurance to conduct a premium misalignment study in Illinois, which includes 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 last bill filed as part of the package was **HB 1466**, which moves the insulin cap from $100 to $35 dollars and is effective immediately. The only bill that advanced through both chambers is HB 836, which requires the Department to conduct the premium misalignment study. The rest of the bills are ripe for negotiations and conversations over the summer.

ILHIC Positions: Oppose (Neutral on HB 836, which passed both chambers)

Market Conduct Examinations and Network Adequacy & Transparency: The insurance industry was thrown a late session curve ball after lawmakers engaged on what was otherwise a private contract dispute between a large physician and specialty group in the Springfield and surrounding areas and Blue Cross Blue Shield of Illinois (BCBSIL). Although the provider and the insurer terminated their contractual relationship in the fall of 2021, the combined pressure of a local legislator and aggressive media coverage of the falling out prompted lawmakers to hold a subject matter hearing on the contract dispute itself.

At the same time, Governor Pritzker and the Department of Insurance under political pressure to respond to certain concerns the dispute yielded, including whether or not the insurer had complied with a network adequacy material change notification set forth in the state's Network Adequacy and Transparency Act enacted in 2017, imposed sanctions on BCBSIL and backed sweeping new legislation designed to expand Network Adequacy and Transparency Act as well as perplexing changes to the Department's market conduct examination authority. HB 5729 (Scherer) was introduced on March 23 – a day after the House Insurance Committee was to hold the subject matter hearing – but in a bizarre twist of events, the committee was canceled at the last minute and later moved to another House committee – the House State Government Administration committee- on March 30.

During the subject matter hearing on the contract dispute, the Director of Insurance acknowledged that the Department had not yet issued implementing rules for the original Network Adequacy and Transparency Act but expected to file those rules on March 31 (the proposed rules are not expected to be formally published until April 15). The Director also noted challenges with promulgating rules as the current state rulemaking timelines do not coincide with any updates that would be needed to time and distance standards established

by the federal government for network adequacy purposes for the upcoming plan year, and cited their support for emergency rulemaking authority granted to the Department under HB 5729. The Department also noted that they lacked the authority to publicly acknowledge when they have initiated a market conduct examination on a company, which could have potentially avoided some of the perceived lack of engagement on the part of the regulator.

On the same day as the rescheduled subject matter hearing, Representative Scherer introduced House Floor Amendment #1 to HB 1463 (Scherer) containing most of the provisions originally introduced in HB 5729 and stated before the close of the hearing that she intended to bring the amendment before the same committee the following week.

Although legislation that typically has as widespread of an impact on the insurance industry as the proposed amendment to HB 1463 does would normally go before the House Insurance Committee, it was referred instead to the House State Government Administration Committee where it faced heavy opposition from the industry, including ILHIC, the Illinois Insurance Association (IIA), the Independent Insurance Agents of Illinois (IIA of IL) and business groups like the Illinois Chamber of Commerce, the Illinois Manufacturers' Association (IMA), and the National Federation of Independent Business (NFIB). ILHIC and America's Health Insurance Plans (AHIP) testified in opposition to the amendment to HB 1463, noting the scope of the proposal which, in provisions regarding market conduct examinations, had widespread impact on the entire insurance industry. Several of the proposed changes set forth in the Network Adequacy and Transparency Act reintroduced changes that had also been heavily negotiated with the provider groups in 2017. Additionally, several of the changes sought were clarifications that were now included in the Department's long-awaited proposed rules implementing the original Act.

The Department testified in support of the amendment, stating that many of the proposed changes to the market conduct examination provisions were in line with the NAIC market conduct examination model law and provisions simply codifying current Department practice. Furthermore, with respect to the Network Adequacy provisions, the Department testified that the proposed changes were necessary to address perceived gaps in the law that were identified under the BCBSIL and Springfield Clinic contract dispute.

ILHIC pushed back on the notion that the market conduct examination provisions were simply a codification of NAIC model law and Department practice, noting omission of provisions that ensure any fines are consistent, reasonable and justified, pointing out that the amendment cites specific fine amounts that would be substantial for findings that may be less egregious than other more problematic violations. Additionally, the time frames for company response with market conduct findings are also misaligned with model act provisions and would be difficult for companies to meet as proposed.

With respect to the Network Adequacy and Transparency changes, ILHIC stated that the Department had already sanctioned BCBSIL indicating they already had the authority to oversee perceived compliance gaps in the Act and had further only issued rules for a law that was already five years old. The proposed changes also reintroduced tight turn around timeframes for network audit and filing requirements that the industry had previously pushed back on in 2017 as untenable and negotiated in good faith when the law was first enacted. Furthermore, the proposed changes impose new provider directory updates that would rely on the provider supplying the information (for example, whether the provider is at the location for at least 3 days a week) with penalties falling on the insurers for a provider failing to make those updates. There is currently no real authority on the part of the DOI or IDFPR to go after providers who fail to meet their obligations under the

proposed changes to furnish these updates to the insurer. The provisions also expand the scope of the Network Adequacy and Transparency Act to apply to dental and third-party administrators, which again, had been addressed during the negotiations in 2017 on the original law.

Finally, ILHIC noted that they had spent the entire legislative session working collaboratively with the Department on their legislative agenda consisting of nine different legislative proposals and the DOI had never once raised issues or proposed changes to the market conduct examination provisions. As an entire package, the amendment to HB 1463 would have raised more compliance questions and concerns than it would have solved and would have no bearing on the private contract dispute between BCBSIL and Springfield Clinic. While the sponsor acknowledged the concerns of ILHIC and the opponents, she insisted the legislation as introduced was necessary, but not related to the contract dispute itself.

The House State Government Administration Committee approved HA #1 to HB 1463 along partisan lines on April 4 with only four days left in the scheduled legislative session calendar. ILHIC met with the Department, the bill sponsor, and the Chair of the State Government Administration Committee later that day to discuss the points of concern in more detail. However, the meeting yielded little result with the House sponsor indicating she intended to move forward with the legislation on the House floor.

In the end, the sponsor's unwillingness to compromise, the procedural maneuvering to circumvent the House Insurance Committee, and the heavy push back from ILHIC and the industry resulted in the legislation's failure on the House floor on April 6 by a vote of 40-27-7 with another 60 legislators not even voting on the measure.

ILHIC anticipates the Department will push for revisiting the market conduct examination provisions in a separate measure in the fall or spring 2023 session. In the meantime, ILHIC is reviewing the DOI's proposed rule implementing the 2017 Network Adequacy and Transparency Act.

ILHIC Position: OPPOSE