ILHIC HEALTH INSURANCE KEY BILLS (By ISSUE) – 4-16-2021

Bill Number	Bill Description/Action	ILHIC Position	Status
Health Coverage Reform			
HB 62 (Flowers)	Creates the Health Care For All program establishing single payer health insurance in IL.	**OPPOSE**	**House Calendar 2nd Reading**
HB 2992 (Lilly)	Requires the Department of Insurance to conduct a study to better understand the gaps in health insurance coverage for uninsured residents, including the reasons why individuals are uninsured and whether insured individuals are insured through an employer-sponsored plan or through the Illinois health insurance marketplace. P.A. 101-649 requires the DOI and HFS to conduct a health care affordability feasibility study to address some of the same issues, which is expected to be released by February 28. The bill also requires all hospitals to provide health insurance to their employees.	**MONITOR**	**House Calendar 2nd Reading**
Telehealth			
HB 707 (Didech)	Amends the current telehealth coverage provisions, for policies that provide coverage for telehealth services, reimbursement must be made at parity with those same services if they were provided in-person.	**OPPOSE**	**House - Rules**
HB 1976 (Moeller)	Allows optometrists to provide services via telehealth. Identical to SB 567 (Villivalam).	**MONITOR**	**House Calendar 3rd Reading**
HB 2554 (Mah)	For purposes of the Telehealth Act, the provisions add "acupuncturists" to the list of health care professionals; however the bill does not make corresponding changes to the acupuncturists' practice act. The bill also provides IDFPR to adopt rules clarifying applicable services and administration of the Telehealth Act. Identical to SB 1735 (Jones).	**MONITOR**	**House Calendar 2nd Reading**
HB 2896 (Conroy)	Early Intervention omnibus telehealth bill that includes language providing that if a health insurance policy provides coverage for early intervention services, it must also provide coverage for these services delivered via telehealth.	**MONITOR**	**House - Rules**
HB 3308 (Jones)	As introduced, updates telehealth insurance coverage requirements to include "telephone usage" in the definition of "telehealth services" and provides that insurers must cover telehealth services "when clinically appropriate." Reinforces existing provisions that patient cost-sharing cannot be more than if the health care service were delivered in-person. Provides that no excepted benefit policy may deny or reduce any benefit to a patient based on the use of clinically appropriate telehealth services in the course of satisfying the	**SUPPORT as introduced OPPOSE with HA #1**	**House Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	policy's benefit criteria. HA #1 contains similar coverage and reimbursement requirements as contained in HB 3498, but limits the reimbursement requirements to behavioral health services.		
HB 3498 (Conroy)	Codifies some provisions of the telehealth coverage requirements set forth in Executive Order 2020-09., including payment parity. The provisions do not remove cost-sharing for telehealth.	**OPPOSE**	**House Calendar 3rd Reading**
HB 3758 (Spain)	Provides that if an insurer covers telehealth services, then coverage must also include telehealth services used to treat behavioral health conditions.	**NO POSITION**	**House - Rules**
HB 3759 (Spain)	Creates the Telehealth Parity Act to require health insurers, including excepted benefit plans that provided limited scope dental benefits, limited scope vision benefits, LTC benefits, accident-only, and specified disease or illness coverage, to cover the costs of all medically necessary telehealth services rendered by in-network providers. The provisions allow insurers to apply coverage criteria, but that criteria must be in compliance with provisions set forth in Executive Order 2020-09 . Prohibits insurers from applying prior authorization for any COVID-19 related telehealth services and further provides that coverage for in-network telehealth services shall be provided without cost-share (exemption applicability to HSAs). HA #1 creates the Telehealth Parity Act with respect to parity in the benefits and NOT with respect to reimbursement requirements.	**OPPOSE as introduced SUPPORT(?) with HA #1**	**House - Rules**
SB 332 (Collins)	Amends the Network Adequacy and Transparency Act to require a network plan to include in their provider directory, information about whether the provider offers the use of telehealth or telemedicine to deliver services, what modalities are used and what services via telehealth or telemedicine are provided, and whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient so wishes and provides his or her consent. *Initiative of AARP.* As amended by SB 332 SA #1 . *in provisions concerning information that a network plan shall make available through an electronic provider directory or in print, provides that information concerning use of telehealth or telemedicine includes, but is not limited to, whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate (rather than whether the provider offers the use of telehealth or telemedicine to deliver services) and what modalities are used and what types of services may be provided via telehealth or telemedicine (rather than what modalities are used and what services via telehealth or telemedicine are*	**OPPOSE NEUTRAL with amendment**	**Senate Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	provided). In provisions requiring providers to notify the network plan of changes to their information listed in the provider directory, includes the information concerning use of telehealth or telemedicine. Effective immediately.		
SB 567 (Villivalam)	Allows optometrists to provide services via telehealth. Identical to HB 1976 (Moeller).	**MONITOR**	**Senate Calendar 3rd Reading**
SB 1735 (Jones)	For purposes of the Telehealth Act, the provisions add "acupuncturists" to the list of health care professionals; however the bill does not make corresponding changes to the acupuncturists' practice act. The bill also provides IDFPR to adopt rules clarifying applicable services and administration of the Telehealth Act. Identical to HB 2554 (Mah).	**MONITOR**	**Senate Assignments**
SB 2518 (Rose)	Amends the Telehealth Act to add "athletic trainers" to the definition of "health care professionals" (with no additional changes made to a scope of practice act).	**MONITOR**	**Senate Assignments**
Utilization Management			
HB 711 (Harris)	Creates the Prior Authorization Reform Act to establish new requirements regarding disclosure and review of PA requirements, denial of claims or coverage by a utilization review organization for various levels of service, including nonurgent and urgent care effective January 1, 2022. The provisions of the bill incorporate some feedback provided by ILHIC to HB 5510 (Harris) of the 101st General Assembly. Proponents of the bill, including ISMS and other provider and patient advocacy groups, have formed a "Your Care Can't Wait" campaign in support of prior authorization reform. Identical to SB 177 (Holmes).	**OPPOSE**	**House Calendar 2nd Reading**
HB 3777 (Ortiz)	Prohibits prior authorization for prescription drugs used in the treatment of COVID-19 that have received emergency authorization from the FDA.	**OPPOSE**	**House- Rules**
SB 158 (Holmes)	Creates the Prior Authorization Reform Act to establish new requirements regarding disclosure and review of PA requirements, denial of claims or coverage by a utilization review organization for various levels of service, including nonurgent and urgent care effective January 1, 2022. ***This bill will be tabled in favor of SB 177 (Holmes).***	**OPPOSE**	**Senate Assignments**
SB 177 (Holmes)	Creates the Prior Authorization Reform Act to establish new requirements regarding disclosure and review of PA requirements, denial of claims or coverage by a utilization review organization for various levels of service,	**OPPOSE**	**Senate Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	including nonurgent and urgent care effective January 1, 2022. The provisions of the bill incorporate some feedback provided by ILHIC to HB 5510 (Harris) of the 101st General Assembly. Proponents of the bill, including ISMS and other provider and patient advocacy groups, have formed a "Your Care Can't Wait" campaign in support of prior authorization reform. Identical to HB 711 (Harris).		
SB 1592 (Fine)	In provisions regarding coverage for individuals under the of 21 with a diagnosis of autism spectrum disorders, prohibits a health insurance carrier from denying or refusing to provide otherwise covered services solely because of the location where services are provided. As amended by SB 1592 - SA #1 *" an insurer may not deny or refuse to provide otherwise covered services under a group or individual policy of accident and health insurance or a managed care plan solely because of the location wherein the clinically appropriate services are provided by a health care professional with appropriate certification."*	**NEUTRAL with amendment**	**Senate Calendar 2nd Reading**
Behavioral Health			
HB 213 (Conroy)	Creates the Eating Disorder Treatment Parity Task Force within the DOI to review reimbursements to eating disorder treatment providers in IL, as well as out-of-state providers of similar services. The Task Force currently does not provide for industry representation, but requires the group to "work cooperatively with the insurance industry. . . to identify the high costs of medical complications, disability, and loss of life associated with eating disorders and to determine whether disparities in insurance reimbursement is limiting access to a full range of evidence-based treatment providers in the State." House Amendment #1 adds 2 members of the insurance industry to the task force.	**NEUTRAL with HA #1**	**House - Rules**
HB 2595 (Conroy)	Mandates coverage for medically necessary treatment for mental health and substance use conditions. Requires insurers to base medical necessity and utilization review criteria on specific current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care, including exclusively applying the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Provides that an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in the treatment criteria. Provides that the Director may, after	**OPPOSE**	**House Calendar 3rd Reading**

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	appropriate notice and opportunity for hearing, assess a civil penalty between $5,000 and $20,000 for each violation. Identical to SB 697 (Fine). ***KFI initiative & priority for 2021.***		
HB 3197 (Conroy)	Creates the Suicide Treatment Improvements Act to require that all at-risk patients be provided with one-on-one suicide prevention counseling by the public or private psychiatric facility at which the at-risk patient is being treated and mandates individual and group health insurance coverage for these services.	**OPPOSE**	**House- Rules**
HB 3198 (Conroy)	Creates the Suicide Treatment Improvements Act to require suicide prevention counseling and treatment at facilities and mandates individual and group health insurance coverage for these services (similar to HB 3197); however the provisions of the bill also place certain requirements on IDPH and local public safety officials to identify individuals at risk for suicide.	**OPPOSE**	**House Calendar 2nd Reading**
HB 3259 (Gong Gershowitz)	Mandates coverage for the diagnosis and medically necessary treatment (instead of reasonable and necessary treatment and services for) mental health and substance use disorders and requires insurers to base medical necessity and utilization review criteria on specific current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care, including exclusively applying the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty (similar to HB 2595 (Conroy)). The provisions also prohibit an insurer that authorizes a specific type of treatment by a provider from rescinding or modifying the authorization after that provider renders the health care service. Provides that if services for the medically necessary treatment of a mental health or substance use disorder are not available in-network within the geographic and timely access standards set by law or regulation, the insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services, and the insured shall pay no more in total for benefits rendered than the cost sharing that the insured would pay for the same covered services received from an in-network provider and further require every insurer to sponsor an education program, make the program available to other stakeholders, provide clinical review criteria at no cost to providers and insured patients, conduct interrater reliability testing, and achieve interrate pass rates of at least 90% or comply with specified requirements if the 90% threshold is not met.	**OPPOSE**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 3517 (Wheeler)	In provisions concerning development of medical necessity criteria for the coverage of CSC/ACT treatment models for early treatment of serious mental illness, provides that the rules adopted by the DOI defining medical necessity shall be updated during calendar year 2021 to include nationally recognized, generally acceptable clinical criteria sourced to evidence-based medicine and to avoid unnecessary anti-competitive impacts. Identical to SB 2381 (Fine).	**MONITOR**	**House - Rules**
HB 3583 (Avelar)	Creates the Affordable Drug Manufacturing Act requiring IDPH to enter into partnerships to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs. Requires the partnerships to result in the production or distribution of generic prescription drugs with the intent that these drugs be made widely available to public and private purchasers, providers and suppliers, and pharmacies. IDPH is directed to consult with entities, including health insurers, regarding the establishment of a fair price for the prescription drugs.	**MONITOR**	**House - Rules**
SB 202 (Morrison)	Provides that it is a civil rights violation to offer a group or individual policy of accident and health insurance, including coverage against disablement or death, that does not include equal terms and conditions of coverage for the treatment of a mental, emotional, nervous, or substance use disorder or condition or a history thereof. Senator Morrison sponsored P.A. 101-0332 establishing a task force to study disability income insurance and parity for behavioral health conditions, but the Governor has not yet made appointments to the task force and the group has not yet met or begun that work. **SA#1 requires equal coverage for all protected characteristics under the IL Human Rights Act, which would restrict underwriting practices for health, supplemental and DI products.**	**OPPOSE**	**Senate Calendar 2nd Reading**
SB 471 (Fine)	Sets forth time and distance standards for mental health providers. The proposed changes do not amend the existing network adequacy law (P.A. 100-502) and instead set these specific standards forth in Section 370c of the Insurance Code addressing mental health parity coverage. P.A. 100- 502, which was negotiated by the industry, gave the Department authority to determine network standards for different providers annually and while mental health and substance abuse providers were not explicitly included in the list of specialists, the law allows the Department to consider other specialties. ***ILHIC worked with the sponsor in 2020 to address some of these concerns; however, the language***	**OPPOSE NEUTRAL with amendment**	**Senate Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	was never completely finalized before COVID interrupted the legislative session. As amended by SB 471 - SA #1 *sets forth provisions concerning timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions. Provides that network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions must satisfy specified minimum requirements. Provides that if there is no in-network facility or provider available for an insured to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the minimum network adequacy standards, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with those network adequacy standards. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the medical assistance program shall be subject to provisions of the Network Adequacy and Transparency Act concerning timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions. In provisions concerning network adequacy and transparency, provides that the Department of Healthcare and Family Services shall require managed care organizations to comply with provisions of the Network Adequacy and Transparency Act concerning timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions. Effective immediately*.		
SB 697 (Fine)	Mandates coverage for medically necessary treatment for mental health and substance use conditions. Requires insurers to base medical necessity and utilization review criteria on specific current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care, including exclusively applying the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Provides that an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in the treatment criteria. Provides that the Director may, after appropriate notice and opportunity for hearing, assess a civil penalty between $5,000 and $20,000 for each violation. Identical to HB 2595 (Conroy). ***KFI initiative & priority for 2021.***	**OPPOSE**	**Senate Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
SB 2381 (Fine)	In provisions concerning the development of medical necessity criteria for the coverage of CSC/ACT treatment models for early treatment of serious mental illness, provides that the rules adopted by the DOI defining medical necessity shall be updated during calendar year 2021 to include nationally recognized, generally acceptable clinical criteria sourced to evidence-based medicine and to avoid unnecessary anti-competitive impacts. Identical to HB 3517 (Wheeler).	**NO POSITION**	**Senate Insurance**
Prescription Drugs/PBMs			
HB 1745 (Harris)	As amended by HA #1, beginning 1/1/23, requires health insurance carriers that provide coverage for prescription drugs to ensure that, within service areas and levels of coverage specified by federal law, at least 10% of individual health plans (and at least 1 group plan) apply a pre-deductible flat-dollar copayment structure to the entire drug benefit and beginning 1/1/24, at least 25% of individual health plans (and at least 2 group plans) apply a pre-deductible flat-dollar copayment structure to the entire drug benefit. The bill, as introduced, is identical to SB 275 (Bennett).	**NEUTRAL with HA #1**	**House Calendar 3rd Reading**
HB 2370 (Avelar)	"Cap the copay" legislation that restricts an insured's monthly out of pocket cost to $100 per 30-day supply.	**OPPOSE**	**House - Rules**
HB 2919 (Mazzochi)	Provides that upon request by a party contracting with a pharmacy benefit manager, the party has an annual right to audit compliance with the terms of the contract by the pharmacy benefit manager, including, but not limited to, full disclosure of any value provided by a pharmaceutical manufacturer to a pharmacy benefit manager or the parent, subsidiary, or affiliate company of a pharmacy benefit manager. Provides for other PBM disclosure requirements.	**MONITOR**	**House - Rules**
HB 3312 (Welter)	Requires insurers to cap OOP for a covered prescription inhalant drug to $100 per 30-day supply regardless of the type and amount of the drug needed by the insured. Language aligns with similar OOP limits applied to insulin per P.A. 101-0625. HA #1 makes a technical change to refer to inhalant medications rather than prescription inhalants.	**OPPOSE**	**House - Rules**
HB 3403 (Ness)	Reduces OOP limit on insulin drugs from $100 (originally set under P.A. 101-0625 to $30.	**OPPOSE**	**House - Rules**
HB 3609 (Flowers)	Requires prescription drug manufacturers to provide advance notice of a price increase of a prescription drug with a wholesale acquisition cost of more than $40 if the increase is more than 10% and to disclose information regarding factors associated with the price increase. Requires the Department of Public	**MONITOR**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	Health to conduct an annual public hearing on the aggregate trends in prescription drug pricing.		
HB 3630 (Harris)	Requires insurers to replace a brand name drug with a new generic equivalent on the formulary once it becomes available in the market or move the brand name drug to the lowest cost tier. In provisions concerning a contract between a health insurer and a pharmacy benefit manager, provides that a pharmacy benefit manager must update and publish maximum allowable cost pricing information according to specified requirements, must provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs, and must comply with specified requirements if an appeal is denied. The legislation also sets forth contracting requirements for PBMs, including fiduciary responsibilities. Identical to SB 2008 (Koehler).	**OPPOSE**	**House - Rules**
HB 3867 (Moeller)	Requires IDPH to design a prescription drug importation program where the State serves as the licensed wholesaler of imported drugs from Canada. The provisions set forth auditing and AG enforcement criteria, including ensuring that any participating health plan formularies, cost-sharing, and reimbursement criteria is based on the actual acquisition cost of the imported drug.	**NO POSITION**	**House - Rules**
SB 275 (Bennett)	Requires health insurance carriers that provide coverage for prescription drugs to ensure that, within service areas and levels of coverage specified by federal law, at least half of individual and group plans meet one or more of the following criteria: 1) apply a pre-deductible and flat-dollar copayment structure to the entire drug benefit; 2) limit a beneficiary's monthly out-of-pocket financial responsibility for prescription drugs to a specified amount; or 3) limit a beneficiary's annual out-of-pocket financial responsibility for prescription drugs to a specified amount. Effective January 1, 2022. Identical to HB 1745 (Harris).	**OPPOSE**	**Senate Insurance**
SB 2008 (Koehler)	Requires insurers to replace a brand name drug with a new generic equivalent on the formulary once it becomes available in the market or move the brand name drug to the lowest cost tier. In provisions concerning a contract between a health insurer and a pharmacy benefit manager, provides that a pharmacy benefit manager must update and publish maximum allowable cost pricing information according to specified requirements, must provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs, and must comply with specified requirements if an appeal is denied. The legislation also sets forth contracting requirements for PBMs, including fiduciary responsibilities. Similar to HB 3630 (Harris).	**OPPOSE**	**Senate Insurance**

Bill Number	Bill Description/Action	ILHIC Position	Status
Surprise Billing			
HB 317 (Jones)	Requires an air ambulance service or other entity that directly or indirectly, whether through an affiliated entity, agreement with a third-party entity, or otherwise, solicits air ambulance membership subscriptions, accepts membership applications, or charges membership fees to be regulated as insurance under the Insurance Code.	**MONITOR**	**House Calendar 2nd Reading**
HB 3268 (Flowers)	Amends the Fair Patient Billing Act to prohibit a hospital from aggressively pursue debt collection for non-payment of a hospital bill against a patient with an annual household income of $51,000 or less and further provides that a hospital whenever possible and after reviewing the patient eligibility, shall charge as much as possible of the patient's hospital bill to insurers.	**OPPOSE**	**House - Rules**
HB 3421 (Dina Delgado)	Provides that if a patient unknowingly and through no fault of his or her own receives care from a health care professional or health care provider who is not among the network of health care providers for the patient's health care plan, the health care professional or health care provider may not charge or bill that patient for that care.	**MONITOR**	**House - Rules**
Coverage Mandates			
HB 61 (Costa Howard)	The provisions require coverage of prescription inhalants and require (instead of make permissive) a health insurer or managed care plan from denying or limiting coverage refills for prescription inhalants to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments if those restrictions are contrary to what has been prescribed and considered medically appropriate.	**MONITOR**	**House - Rules**
HB 135 (Mussman)	Authorizes the IL Department of Public Health to issue a standing order for contraceptives and authorizes a pharmacist to dispense hormonal contraceptives. The legislation requires health insurers to cover patient care services related to the dispensing of hormonal contraceptives for pharmacists.	**OPPOSE**	**House Calendar 2nd Reading**
HB 1779 (Flowers)	As introduced, prohibits health insurers from requiring prior authorization for biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer or biomarker testing of cancer progression or recurrence in the insured with advanced or metastatic stage 3 or 4 cancer. HA #1 mandates coverage for biomarker testing for treatment and disease management purposes.	**OPPOSE as introduced and with HA #1**	**Senate Assignments**
HB 2406 (Scherer)	Provides that an individual or group policy of accident and health insurance or managed care plan in effect on and after March 9, 2020 must provide coverage for the cost of administering a COVID-19 vaccination. Language is silent on	**OPPOSE**	**House Calendar 3rd Reading**

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	vaccine as approved by the FDA, which is not addressed in HA #1, which also includes cross-reference to HMOs.	***(need language to tie vaccine to FDA approval)***	
HB 2473 (Mazzochi)	In provisions requiring insurance coverage for prostate-specific antigen tests and for colorectal cancer examination and screening, removes provisions requiring the testing be recommended or prescribed by a physician. The provisions also mandate coverage for testing of sexually transmitted diseases or infections.	**OPPOSE**	**House- Rules**
HB 2589 (Conroy)	The bill includes provisions mandating coverage for ALL opioid antagonists approved by the FDA in addition to reimbursing a hospital for the hospital's cost of any FDA approved opioid antagonist. Identical to SB 679 (Fine).	**OPPOSE**	**House Calendar 2nd Reading**
HB 2653 (Mason)	Mandates first dollar coverage for a diagnostic colonoscopy. The provisions include HSA tax preservation language.	**OPPOSE**	**House Calendar 2nd Reading**
HB 2930 (Mazzochi)	In provisions concerning health insurance coverage for treatment of pediatric autoimmune neuropsychiatric disorders, provides that on and after the effective date of the amendatory Act, an insured shall have a cause of action for liquidated damages in the amount of $1,000 or actual damages, whichever is greater, against any entity issuing a group or individual policy of accident and health insurance or managed care plan that fails to provide the coverage required for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome.	**OPPOSE**	**House - Rules**
HB 3397 (Mazzochi)	Requires first dollar coverage on diagnostic testing for a pediatric autoimmune neuropsychiatric disorder if such diagnostic testing is ordered by a physician (coverage is not required if the physician indicates that the diagnostic testing is requested by a guardian or parent). *Provisions do not include exemptions for HSAs.*	**OPPOSE**	**House- Rules**
HB 3709 (Croke)	As amended by HA #1, amends the current health insurance mandate for infertility treatment to allows those who cannot conceive a child naturally or due to a medical condition documented by a medical professional shall not be held to the one-year requirement of unsuccessful pregnancy before coverage begins. For those women aged 35 or older who are otherwise able to conceive shall only be required to a 6-month waiting period for coverage.	**NEUTRAL with HA #1**	**Senate Assignments**
HB 3794 (Stephens)	Requires insurers to cap OOP for a diabetic self-management supplies (not including insulin) to $100 per 30-day supply regardless of the type and amount	**OPPOSE**	**House**

Bill Number	Bill Description/Action	ILHIC Position	Status
	of the supply needed by the insured. Language aligns with similar OOP limits applied to insulin per P.A. 101-0625.		**Calendar 3rd Reading**
HB 3845 (LaPointe)	Mandates coverage for medically necessary treatments for genetic, rare, unknown or unnamed, and unique conditions, including Ehlers-Danlos syndrome and altered drug metabolism. Provides that an insurance policy that provides coverage for prescription drugs shall include coverage for opioid alternatives, coverage for medicines included in the Model List of Essential Medicines published by the World Health Organization, and coverage for custom-made medications and medical food. Provides that an insurance policy that limits the quantity of a medication in accordance with applicable State and federal law shall not require pre-approval for the treatment of patients with rare metabolism conditions that may need a higher dose of medication than what is otherwise allowed within a time frame or prescription schedule. Provides that the burden of proving that treatment is medically necessary shall not lie with the insured in cases of rejections for filing claims, preauthorization requests, and appeals related to the coverage.	**OPPOSE**	**House - Rules**
SB 679 (Fine)	The bill includes provisions mandating coverage for ALL opioid antagonists approved by the FDA in addition to reimbursing a hospital for the hospital's cost of any FDA approved opioid antagonist. Identical to HB 2589 (Conroy).	**OPPOSE**	**Senate Insurance**
SB 968 - SA #1 - Johnson	Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage for pancreatic cancer screening.	**OPPOSE**	**Senate Calendar 3rd Reading Amendment - Assignments**
SB 1587 (Fine)	Mandates coverage for cleft palate corrective surgery, including necessary dental procedures related to the cleft palate for the duration the correction is required until age 26. The provisions do not apply to standalone dental plans.	**OPPOSE**	**Senate Insurance**
SB 1589 (Fine)	Mandates coverage for anti-epileptic drugs and may not impose a waiting period or any deductible, coinsurance, copayment, or other cost-sharing limitation greater than other coverage provided. Further provides that anti-seizure prescription drugs may not be substituted with a generic drug under provisions of the Pharmacy Practice Act under which a pharmacist may substitute a therapeutically equivalent generic drug for a prescription drug or interchange an anti-epileptic drug or formulation of an antiepileptic drug for the treatment of epilepsy.	**OPPOSE**	**Senate Insurance**
SB 1854 (Ellman)	Mandates coverage for A1C testing recommended by a health care provider for prediabetes, type 1 diabetes, and type 2 diabetes in accordance with	**OPPOSE**	**Senate Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	prediabetes and diabetes risk factors identified by the CDC and coverage for vitamin D testing recommended by a health care provider in accordance with vitamin D deficiency risk factors identified by the CDC.		
SB 1875 (Syverson)	Requires that any new coverage mandate, beginning 1/1/22, shall apply only to the state employee group health insurance benefit plan. The provisions of the bill require that before the mandate is expanded to apply to private individual and group insurance plans, CMS must conduct a cost-benefit analysis and the DOI Director shall not enforce compliance with the mandate until the analysis is performed.	**SUPPORT**	**Senate Assignments**
SB 1917 (Morrison)	Removes the age limit (18) in mandated coverage provisions for medically necessary epinephrine injectors.	**NO POSITION**	**Senate Calendar 3rd Reading**
SB 2158 (Tracy)	Mandates coverage for the treatment, removal, elimination, or maximum feasible treatment of nevus flammeus (port-wine stains), including, but not limited to, port-wine stains caused by Sturge-Weber syndrome. Prohibits insurers, including HMOs, from reducing or eliminating coverage due to coverage of port-wine stain treatment OR increasing rates due to the coverage requirement.	**OPPOSE**	**Senate Insurance**
SB 2241 (Murphy)	Mandates coverage for hippotherapy and other forms of therapeutic riding.	**OPPOSE**	**Senate Insurance**
Miscellaneous/Other			
HB 146 (Morgan)	Authorizes the Director of Insurance to actively approve individual and small group ACA health plan rates and may disapprove any rate deemed "unreasonable." The Director must act on the rates within 60 days or else they are deemed approved.	**OPPOSE**	**House - Rules**
HB 1728 (Mazzochi)	Amends the Medical Patient Rights Act to provide, in addition to any other right provided under the Act, certain qualifying patients have the ability to request diagnostic screenings without a physician's order as follows: (1) females over the age of 40 have the right to a breast cancer screening mammogram once per year; and all persons have a right to request annual screening under the age of 40 if such person has a family history of breast cancer; or genetic testing has confirmed likelihood that such person has otherwise tested positive for BRCA1 or BRCA2 mutations; (2) males have the right to prostate-specific antigen testing at once per year if specified requirements are met; (3) all persons have the right to colorectal screening under specified conditions; (4) all persons over the age of 18, or under the age of 18 with one parent's consent,	**MONITOR**	**House - Rules**

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	have the right to screening for sexually transmitted diseases or infections at least every 6 months, or in the event of unprotected sexual activity; and (5) all persons over the age of 18, or under the age of 18 with a parent's or legal guardian's consent, have the right to screening for COVID-19 infection and testing for COVID-19 antibodies. The provisions of the bill do not require coverage and the patient seeking the diagnostic test without a written order from a physician shall be responsible for paying for the diagnostic test provided that the provider of the diagnostic testing provides the patient in writing the cost of the diagnostic test prior to it being performed and the patient agrees to that cost.		
HB 2472 (Mazzochi)	Requires the Director to solicit information and data from health insurance carriers regarding insurance coverage for pediatric autoimmune neuropsychiatric disorder to report back to the General Assembly by November 15, 2021.	**MONITOR**	**House Rules**
HB 2948 (Morgan)	***DOI Initiative*** seeking to address the copay accumulator ban implemented under P.A. 101-0452 as it applies to HSAs paired with a HDHP (to preserve the pre-tax advantages). The language, however, also requires insurers to identify a non-HSA eligible HDHP and offer a non-HSA eligible product if they do provide an HSA-eligible HDHP.	**OPPOSE**	**House Calendar 2nd Reading**
HB 3175 (Jones)	***DOI Initiative*** increasing the wellness coverage cap from 20% to 30% per federal rules and further provides for clean-up of the Navigator Certification Act. Identical to SB 2294 (Gillespie).	**NO POSITION**	**House Calendar 2nd Reading**
HB 3327 (Haas)	In provisions concerning timely payment for health care services, provides that failure to make periodic payments within specified time periods shall entitle a health care professional, health care facility, independent practice association, physician-hospital organization, insurer, health maintenance organization, managed care plans health care plan, preferred provider organization, or third party administrator to interest at the rate of 9% semiannually (rather than 9% per year).	**MONITOR**	**House - Rules**
HB 3598 (Avelar)	Requires companies that issue group policies of accident and health insurance to offer such policies to local chambers of commerce.	**NEUTRAL**	**House Calendar 2nd Reading**
HB 3707 (Yingling)	For purposes of group health insurance coverage, revises the definition of "small employer" to mean an employer who employs an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the	**MONITOR**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	plan year (rather than an employer who employs an average of at least 2 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year).		
HB 3874 (Yang Rohr)	In provisions concerning infertility coverage and coverage for epinephrine injectors, provides that specified coverage shall be applicable to policies of insurance written in other states that insure an Illinois resident.	**MONITOR**	**House - Rules**
SB 1590 (Fine)	Provides the Department of Insurance with the authority to disapprove "unreasonable" or "inadequate" rates for individual and small group ACA compliant health insurance plans. The provisions require the Department to review the rates within 45 days with the option of a 30-day extension.	**OPPOSE**	**Senate Insurance**
SB 1625 (Turner)	Requires pharmacies to post a notice informing customers that they may request, in person or by telephone, the current usual and customary retail price of any brand or generic prescription drug or medical device that the pharmacy offers for sale to the public. Provides that a pharmacist or his or her authorized employee must disclose to the consumer at the point of sale the current pharmacy retail price for each prescription medication the consumer intends to purchase and if the consumer's cost-sharing amount for a prescription exceeds the current pharmacy retail price, the pharmacist or his or her authorized employee must disclose to the consumer that the pharmacy retail price is less than the patient's cost-sharing amount. Identical to SB 1682 (Bennett).	**MONITOR**	**Senate Licensed Activities**
SB 1682 (Bennett)	Pharmacy retail price disclosure – identical to SB 1625 (Turner).	**MONITOR**	**Senate Calendar 3rd Reading**
SB 1788 (Murphy)	Prohibits any mid-year change in health insurance coverage, including changes to the formulary or provider network. The insurance industry and PBMs negotiated compromise language to provide consumers with an avenue to remain on their prescription drugs in situations where a midyear change to the formulary may have adversely impacted their coverage: P.A. 100-1052. Similarly, network adequacy requirements implemented in 2019 provide for continuity of care for certain individuals in the middle of treatment if there is a change in the provider network: P.A. 100-0502.	**OPPOSE**	**Senate Insurance**
SB 1905 (Morrison)	Creates the Family and Fertility Disclosure in Health Insurance Act to require employers that provide health insurance coverage to employees through policies written outside of this State to disclose to employees specified coverages required under the Illinois Insurance Code for policies written is this	**MONITOR**	**Senate Reassign - Labor**

Bill Number	Bill Description/Action	ILHIC Position	Status
	State and disclose the coverages that are not included in the coverage provided to the employees.		
SB 1971 (Fine)	Authorizes the Director of Insurance to actively disapprove "unreasonable" or "inadequate" rate increases. The provisions further require the DOI to post notice of the individual and small group premium rate filings, rate filing summaries, and other information about a rate increase or decrease online and provide for a 30-day public comment period prior to approve or disapproving the rates.	**OPPOSE**	**Senate Assignments**
SB 1974 (Fine)	Provides that an insurer, health maintenance organization, independent practice association, or physician hospital organization may not attempt a recoupment or offset until all appeal rights of a health care professional or health care provider are exhausted and no recoupment or offset may be requested or withheld from future payments 6 months or more after the original payment is made (rather than 18 months or more after the original payment is made). As amended by SB 1974 - SA #1 *deletes "An insurer, health maintenance organization, independent practice association, or physician hospital organization may not attempt a recoupment or offset until all appeal rights are exhausted."; and on page 2, line 17, by replacing "6" with "12".*	**OPPOSE** **NEUTRAL** **with amendment**	**Senate Calendar 2nd Reading**
SB 2294 (Gillespie)	***DOI Initiative*** increasing the wellness coverage cap from 20% to 30% per federal rules and further provides clean-up of the Navigator Certification Act. Identical to HB 3175 (Jones).	**NO POSITION**	**Senate Calendar 2nd Reading**