# ILHIC HEALTH INSURANCE KEY BILLS (By ISSUE) – 4-30-2021

| Bill Number | Bill Description/Action | ILHIC Position | Status |
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| **Health Coverage Reform** | | | |
| **Telehealth** | | | |
| HB 1976 (Moeller) (Villivalam) | Allows optometrists to provide services via telehealth. Identical to SB 567 (Villivalam). | **MONITOR** | **Senate Assignments** |
| HB 2554 (Mah) (E. 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 SB 1735 (Jones). | **MONITOR** | **Senate Assignments** |
| HB 3308 (Jones) (N. Harris) | 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 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. | **SUPPORT as introduced OPPOSE with HA #1** | **Senate Assignments** |
| HB 3498 (Conroy) (Hunter) | 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. HA #1 contains similar coverage and reimbursement requirements as contained in HB 3498, but limits the reimbursement requirements to behavioral health services.<br>**As amended by** HA#1 *Provides coverage for all telehealth services rendered by a health care professional to deliver any clinically appropriate, medically necessary covered services, and shall not engage in specified activities. Provides that any policy, contract, or certificate of health insurance coverage that does not distinguish between in-network and out-of-network providers shall be subject to the Act as though all providers were in-network. Provides that health care professionals and facilities shall determine the appropriateness of specific sites, technology platforms, and technology vendors for a telehealth service, as long as delivered services adhere to privacy laws.* | **OPPOSE** | **Senate Assignments** |

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| | *Provides that there shall be no restrictions on originating site requirements for telehealth coverage or reimbursement to the distant site. Changes the term "telehealth" to "telehealth services".* | | |
| SB 332 (Collins) (Avelar) | 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.*<br>**As amended by** 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 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.* | **OPPOSE**<br><br>**NEUTRAL with SA#1** | **House Rules** |
| SB 567 (Villivalam) (Moeller) | Allows optometrists to provide services via telehealth. Identical to HB 1976 (Moeller). | **MONITOR** | **House Rules** |
| **Utilization Management** | | | |
| HB 711 (G. Harris) (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. 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” | **OPPOSE**<br><br>**NEUTRAL with HA #2** | **Senate Insurance** |

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| | campaign in support of prior authorization reform. Identical to SB 177 (Holmes).<br>**As amended by** HA#2) *In the Prior Authorization Reform Act, deletes a Section concerning obligations with respect to prior authorization concerning emergency health care services, and makes changes in provisions governing applicability; definitions; disclosure and review of prior authorization requirements; obligations with respect to prior authorizations; personnel qualified to make adverse determinations of a prior authorization request; adverse determinations; review of appeals; denials; length of prior authorization approval; continuity of care; effect of failure to comply with the Act; and administration and enforcement. Makes further changes in the Illinois Insurance Code in a Section concerning obligations under the Managed Care Reform and Patient Rights Act. Deletes changes made to the Managed Care Reform and Patient Rights Act in a Section concerning emergency services prior to stabilization.* | | |
| SB 1592 (Fine) (Welter) | 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.<br>**As amended by** 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."*<br>**As amended by** SA#2 *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."* | **NEUTRAL with SA#2** | **House Rules** |
| **Behavioral Health** | | | |
| HB 2595 (Conroy (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 | **OPPOSE** | **Senate Assignments** |

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| | 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 SB 697 (Fine). ***KFI initiative & priority for 2021.*** | | |
| 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) (LaPointe) | 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 was never completely finalized before COVID interrupted the legislative session.***<br>**As amended by** 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* | **OPPOSE NEUTRAL with SA#1** | **House Rules** |

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| | *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.* | | |
| **Prescription Drugs/PBMs** | | | |
| HB 1745 (G. Harris) (N. 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** | **Senate Assignments** |
| 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** |
| **Surprise Billing** | | | |
| HB 317 (Jones) (N. Harris) | Requires an air ambulance service or other entity that directly or indirectly, whether through an affiliated entity, agreement with a third-party entity, or | **MONITOR** | **Senate Assignments** |

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| | otherwise, solicits air ambulance membership subscriptions, accepts membership applications, or charges membership fees to be regulated as insurance under the Insurance Code. | | |
| | **Coverage Mandates** | | |
| HB 135 (Mussman) (Bush) | 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** | **Senate Assignments** |
| HB 1779 (Flowers) (Munoz) | 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) (Glowiak-Hilton) | 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 vaccine as approved by the FDA, which is not addressed in HA #1, which also includes cross-reference to HMOs. | **OPPOSE (*need language to tie vaccine to FDA approval*)** | **Senate Assignments** |
| HB 2589 (Conroy) (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 SB 679 (Fine). | **OPPOSE** | **Senate Assignments** |
| HB 2653 (Mason) (Johnson) | Mandates first dollar coverage for a diagnostic colonoscopy. The provisions include HSA tax preservation language. | **OPPOSE** | **Senate Assignments** |
| HB 3709 (Croke) (Fine) | 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** |
| SB 968 - SA #1 - Johnson (Welch) | 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.<br>**As amended** SA#2 *Provides that a group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or* | **OPPOSE**<br><br>**NEUTRAL with SA #2** | **House Rules** |

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| | *renewed on or after January 1, 2022 shall provide coverage for medically necessary pancreatic cancer screening.* | | |
| SB 1854 (Ellman) (Rohr) | Mandates coverage for A1C testing recommended by a health care provider for prediabetes, type 1 diabetes, and type 2 diabetes in accordance with 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. | **OPPOSE** | **House Rules** |
| SB 1917 (Morrison) (Carroll) | Removes the age limit (18) in mandated coverage provisions for medically necessary epinephrine injectors. | **NEUTRAL** | **House Insurance** |
| 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** |
| **Miscellaneous/Other** | | | |
| HB 3175 (Jones) (Gillespie) | ***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** | **Senate Assignments** |
| HB 3598 (Avelar) (Castro) | Requires companies that issue group policies of accident and health insurance to offer such policies to local chambers of commerce. | **NEUTRAL** | **Senate Assignments** |
| 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 1682 (Bennett) (Avelar) | Pharmacy retail price disclosure – identical to SB 1625 (Turner). | **MONITOR** | **House Health Care License** |
| SB 1905 (Morrison) (Croke) | 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 State and disclose the coverages that are not included in the coverage provided to the employees. | **MONITOR** | **House Rules** |

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| SB 1974 (Fine) (Morgan) | 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).<br>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**<br><br>**NEUTRAL with SA#1** | **House Rules** |
| SB 2294 (Gillespie) (G. Harris) | ***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** | **House Rules** |