ILHIC HEALTH INSURANCE KEY BILLS (By ISSUE) – 5-28-2021

Bill Number	Bill Description/Action	ILHIC Position	Status
Health Coverage Reform			
Telehealth			
HB 1976 (Moeller) (Villivalam)	Allows optometrists to provide services via telehealth. Identical to SB 567 (Villivalam).	**MONITOR**	**Senate Calendar 3rd Reading**
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 Insurance**
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. ***HB 3308 SA #1 includes:*** 1. ***Permanent payment parity for behavioral health.*** 2. ***Physical health parity with a 5-year sunset.*** 3. ***Payment parity provisions are explicit that if a service cannot be billed as an in-person service, then it is not subject to parity. Provisions also allow for negotiation of alternative reimbursement rates.*** 4. ***Originating site reimbursement is permissive and may be considered if the site is a facility.*** 5. ***IDPH and DOI will commission a study for telehealth utilization, impact on access, outcomes, and health equity, as well as cost to be reported out in 2026.*** 6. ***Medicaid is not included in the language.***	~~**SUPPORT as introduced**~~ ~~**OPPOSE with HA#1**~~ ~~HB 3308 HA#1~~ **SUPPORT with SA #1** HB 3308 SA#1	**Senate Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
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. **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. 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".*	**OPPOSE**	**Senate Insurance**
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.* **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*	~~**OPPOSE**~~ **NEUTRAL with SA#1** SB 332 SA#1	**PASSED BOTH HOUSES**

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	changes to their information listed in the provider directory, includes the information concerning use of telehealth or telemedicine. Effective immediately.		
SB 567 (Villivalam) (Moeller)	Allows optometrists to provide services via telehealth. Identical to HB 1976 (Moeller).	**MONITOR**	**PASSED BOTH HOUSES**
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" campaign in support of prior authorization reform. Identical to SB 177 (Holmes). **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.*	~~**OPPOSE**~~ **NEUTRAL with HA #2** HB 711 HA#2	**PASSED BOTH HOUSES**
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. **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*	**NEUTRAL with SA#2** SB 1592 SA#1	**PASSED BOTH HOUSES**

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	clinically appropriate services are provided by a health care professional with appropriate certification." **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."*		
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 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). ***As amended SA #1*** *Mandates coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions on or after January 1, 2023 (rather than January 1, 2022). Provides that an insurer or Medicaid managed care organization shall not be required to pay for services if the individual was not the insurer's enrollee or eligible for Medicaid at the time the service was rendered. Provides that an insurer shall not be required to cover benefits that have been authorized and provided for a covered person by a public entitlement program. Provides that for medical necessity determinations (rather than in conducting utilization review of covered health care services and benefits) relating to level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental, emotional, and nervous disorders or conditions, insurers and Medicaid managed care organizations shall apply specified patient placement criteria. Makes various changes to provisions concerning requirements for insurers regarding education of the insurer's staff and other stakeholders, publishing of utilization review criteria, and documentation of interrater reliability testing and remediation actions. Further amends the Illinois Insurance Code. In provisions concerning mental, emotional,*	~~**OPPOSE**~~ **NEUTRAL with SA#1** HB 2595 SA#1	**Senate Calendar 3rd Reading**

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	nervous, or substance use disorder or condition parity, provides that not later than January 1 (rather than August 1) of each year, the Department of Insurance shall issue a joint report to the General Assembly and provide an educational presentation to the General Assembly. Removes language that provides that insurers shall base the duration of treatment on the insured's individual needs; that an insurer shall only engage applicable qualified providers in the treatment of mental, emotional, nervous, or substance use disorders or conditions or the appropriate subspecialty and who possess an active professional license or certificate to review, approve, or deny services; and that every insurer shall sponsor a formal education program by nonprofit clinical specialty associations. Makes other changes. Effective January 1, 2022, except that specified provisions take effect immediately. ***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 Re-Referred to Assignments**
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.*** **As amended by** SA#1*sets forth provisions concerning timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders*	~~**OPPOSE**~~ **NEUTRAL with SA#1** SB 471 SA#1	**PASSED BOTH HOUSES**

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	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 930 - SA#1 (Morrison)	**Amends by** providing that the task force on disability income insurance and parity for behavioral health conditions shall submit findings and recommendations to the Governor and the General Assembly by December 31, 2022 (rather than December 31, 2020). Provides that the task force is dissolved and the provision is repealed on January 1, 2023 (rather than December 31, 2021).	**NEUTRAL**	**PASSED BOTH HOUSES**
SB 967 (Castro) SA#1 SB 967 - SA#2 (Greenwood)	*SFA #2-1. The language streamlines the mandate language by a simple subsection reorganization. 2. Includes mandate language that refers to the essential health benefits for pregnancy, maternity, and newborn care. ACA plans are mandated to provide coverage for the above services under 42.U.S.C. 18022(b).* *3. Includes language requiring insurers to provide "high-risk" consumers access to clinically appropriate case management programs consistent with the Medical Patient Rights Act.* *4. Includes hypertension, diabetes, and hemorrhage as "high-risk" within the mandate.* *The amendment adds a definition to "case management" in the Insurance Code.*	~~**OPPOSE**~~ **NEUTRAL with SA#2** SB 967 SA#2	**PASSED BOTH HOUSES**

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	~~*SFA #1 - Provides that the amendatory Act may be referred to as the Improving Health Care for Pregnant and Postpartum Individuals Act. Amends the Illinois Insurance Code. Provides that insurers shall allow hospitals separate reimbursement for a long-acting reversible contraceptive device provided immediately postpartum in the inpatient hospital setting before hospital discharge. Requires certain group health insurance policies and other specified policies to provide coverage for: (1) medically necessary treatment for postpartum complications; (2) medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions at in-network facilities for a pregnant or postpartum individual up to one year after giving birth to a child; and (3) case management and outreach for a postpartum individual that had a high-risk pregnancy.*~~		
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** HB 1745 HA#1	**PASSED BOTH HOUSES**
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 Re-Referred to Assignments**
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 otherwise, solicits air ambulance membership subscriptions, accepts	**MONITOR**	**Senate Assignments**

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	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 *if certain requirements are met.*	~~**OPPOSE**~~ **NEUTRAL with SA#1** HB 135 SA#1	**Senate Calendar 3rd Reading**
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** HB 1779 HA#1	**PASSED BOTH HOUSES**
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 Re-Referred to Assignments**
HB 2109 - HA#1 – (Lewis) (Lightford)	**As amended** *Provides that an individual or group policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage for medically necessary comprehensive cancer testing and testing of blood or constitutional tissue for cancer predisposition testing as determined by a physician licensed to practice medicine in all of its branches. Provides that the coverage shall be provided without any prior authorization requirements.* ~~Rep. Lewis has agreed to remove prohibited prior authorization language in a forthcoming amendment~~**.** ***SA#1 removes language prohibiting prior authorization.***	~~**OPPOSE**~~ **NEUTRAL with SA#1** HB 2109 SA#1	**Senate Calendar 3rd Reading**
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**~~ **NEUTRAL with SA #1**	**Senate Calendar 3rd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	SA#1 Removes the mandated coverage language from the Insurance Code.	HB 2589 SA#1	
HB 2653 (Mason) (Johnson)	Mandates first dollar coverage for a diagnostic colonoscopy. The provisions include HSA tax preservation language.	**NEUTRAL**	**PASSED BOTH HOUSES**
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** HB 3709 HA#1	**PASSED BOTH HOUSES**
SB 968 - SA #1 - Johnson (Ammons)	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. **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 renewed on or after January 1, 2022 shall provide coverage for medically necessary pancreatic cancer screening.*	~~**OPPOSE**~~ **NEUTRAL with SA #2** SB 968 SA#2	**PASSED BOTH HOUSES**
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.	**NEUTRAL**	**PASSED BOTH HOUSES**
SB 1917 (Morrison) (Carroll)	Removes the age limit (18) in mandated coverage provisions for medically necessary epinephrine injectors.	**NEUTRAL**	**House Re-Referred to Rules**
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. ***SA #2 tightens the mandate by listing out early intervention treatments as well as providing an age limit of 18. The condition is treated with the intention to prevent functional impairment. Cosmetic coverage is not included.***	~~**OPPOSE**~~ **NEUTRAL with SA #2** SB 2158 SA #2	**House Calendar 3rd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
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**	**PASSED BOTH HOUSES**
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 Calendar 3rd Reading**
SB 1096 - SA#1 (Gilespie) (G. Harris)	**As amended** *Provides that a health plan amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage of diagnostic testing for enrollees that is performed by a testing provider in accordance with specified federal and State COVID-19 testing requirements, and that diagnostic testing for enrollees shall be considered medically necessary. Provides that a health plan may inquire as to whether an enrollee is an employee of the long-term care facility but shall not require further evidence or verification of the enrollee's employment status. Provides that the coverage requirements set forth in the provisions shall only apply when specified federal and State testing requirements are in effect. Provides that any failure to provide coverage of diagnostic testing pursuant to the provisions shall be deemed a failure to substantially comply with this Code. Provides that the provisions are repealed on January 1, 2022. Defines terms. Makes corresponding changes in the Health Maintenance Organization Act. Repeals the COVID-19 Medically Necessary Diagnostic Testing Act.*	**NEUTRAL with SA#1** SB 1096 HA#1	**Senate Calendar Order of Concurrence HA#1**
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 Re-Referred to Assignments**
SB 1682 (Bennett) (Avelar)	Pharmacy retail price disclosure – identical to SB 1625 (Turner).	**MONITOR**	**PASSED BOTH HOUSES**
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** SB 1905 HA#1	**Senate Calendar Order of Concurrence – HA#1**
SB 1974 (Fine) (Morgan)	Provides that an insurer, health maintenance organization, independent practice association, or physician hospital organization may not attempt a	~~**OPPOSE**~~	**Senate**

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	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".*	**NEUTRAL with SA#1** SB 1974 SA#1 SB 1974 HA#1	**Calendar Order of Concurrence – HA#1**
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 Calendar 2nd Reading**