ILHIC KEY BILLS (By Product Issue) – 4-23-2021

Bill Number	Bill Description/Action	ILHIC Position	Status
GENERAL – ALL PRODUCTS			
HB 241 (Jones)	Allows pre-licensure courses for producers to be completed via webinar (in addition to the classroom setting).	**SUPPORT**	**House Calendar 3rd Reading**
HB 242 (Jones)	Requires the IL Life & Health Insurance Guaranty Association to submit a plan of operation and any amendments thereto to the Director of Insurance within 200 days (instead of 180 days).	**MONITOR**	**House- Rules**
HB 580 (Zalewski)	Ratifies and approves the Nurse Licensure Compact and further provides that the compact shall not interfere with state labor laws. Identical to SB 2068 (Castro) and similar to SB 1807.	**SUPPORT**	**House - Rules**
HB 1955 (Jones)	***DOI Initiative*** adopting Holding Company Act 2014 amendments and providing for additional clean-up provisions to the existing Holding Company Act, effective immediately. Identical to SB 2409 (Harris).	**SUPPORT**	**Senate 1st Reading**
HB 1956 (Jones)	***DOI Initiative*** updating state statute to comply with the Covered Agreement by adopting the Credit for Reinsurance model law, and 2020 Holding Company Act amendments regarding Group Capital Calculation, effective December 31, 2022. Identical to SB 2411 (Harris).	**SUPPORT**	**House Calendar 2nd Reading**
HB 1957 (Jones)	***DOI Initiative*** providing for various Insurance Code clean-up changes, including partial codification of EO 2020-29 to allow for producer prelicensure courses to take place via webinar, effective immediately. Identical to SB 2410 (Harris).	**SUPPORT**	**Senate 1st Reading**
HB 2405 (Hoffman)	Authorizes the Illinois Insurance Guaranty Fund, at the direction of its board of directors and subject to the approval of the Director of Insurance, to form and own a not-for-profit corporation to which the Fund may delegate certain of its powers and duties provided by the Code. Allows the not-for-profit corporation to contract to provide services to the Office of Special Deputy Receiver or any other person or organization authorized by law to carry out the duties of the Director in the capacity of receiver under specified provisions of the Code, the Illinois Life and Health Insurance Guaranty Association, an organizations in another state similar to the Illinois Insurance Guaranty Fund or the Illinois Life and Health Insurance Guaranty Association. Effective immediately. Identical to SB 375 (Harris) and SB 2408 (Harris).	**NO POSITION**	**Senate 1st Reading**
SB 375 (Harris)	Authorizes the Illinois Insurance Guaranty Fund, at the direction of its board of directors and subject to the approval of the Director of Insurance, to form and	**NO POSITION**	**Senate Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	own a not-for-profit corporation to which the Fund may delegate certain of its powers and duties provided by the Code. Allows the not-for-profit corporation to contract to provide services to the Office of Special Deputy Receiver or any other person or organization authorized by law to carry out the duties of the Director in the capacity of receiver under specified provisions of the Code, the Illinois Life and Health Insurance Guaranty Association, an organizations in another state similar to the Illinois Insurance Guaranty Fund or the Illinois Life and Health Insurance Guaranty Association. Effective immediately. Identical to HB 2405 (Hoffman).		
SB 1807 (Rose)	Ratifies and approves the Nurse Licensure Interstate Compact. Similar to SB 2068 (Castro) and HB 580 (Zalewski).	**SUPPORT**	**Senate Assignments**
SB 2068 (Castro)	Ratifies and approves the Nurse Licensure Compact and further provides that the compact shall not interfere with state labor laws. Identical to HB 580 (Zalewski) and similar to SB 1807 (Rose)	**SUPPORT**	**Senate Calendar 3rd Reading**
SB 2408 (Harris)	Guaranty Fund – authorization to form and own a not-for-profit corporation to carry out certain delegated duties. Identical to SB 375 (Harris) and HB 2405 (Hoffman).	**NO POSITION**	**Senate Calendar 3rd Reading**
SB 2409 (Harris)	***DOI Initiative*** adopting Holding Company Act 2014 amendments and providing for additional clean-up provisions to the existing Holding Company Act, effective immediately. Identical to HB 1955 (Jones).	**SUPPORT**	**Senate Calendar 3rd Reading**
SB 2410 (Harris)	***DOI Initiative*** providing for various Insurance Code clean-up changes, including partial codification of EO 2020-29 to allow for producer prelicensure courses to take place via webinar, effective immediately. Identical to HB 1957 (Jones).	**SUPPORT**	**Senate Calendar 3rd Reading**
SB 2411 (Harris)	***DOI Initiative*** updating state statute to comply with the Covered Agreement by adopting the Credit for Reinsurance model law, and 2020 Holding Company Act amendments regarding Group Capital Calculation, effective December 31, 2022. Identical to HB 1956 (Jones).	**SUPPORT**	**Senate Calendar 3rd Reading**
Data Privacy & Cybersecurity			
HB 53 (Andrade)	Provides that employers that rely solely upon artificial intelligence to determine whether an applicant will qualify for an in-person interview must gather and report certain demographic information to the Department of Commerce and Economic Opportunity. Requires the Department to analyze the data and report to the Governor and General Assembly whether the data discloses a racial bias in the use of artificial intelligence.	**MONITOR**	**Senate Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
HB 1811 (Andrade)	Amends the Equal Pay Act and the Consumer Fraud and Deceptive Business Practices Act to restrict use of predictive data analytics used to determine a job applicant's credit worthiness or a hiring decision to include information that correlates with the race or zip code of the applicant for credit or employment.	**MONITOR**	**House Calendar 2nd Reading**
HB 2404 (Buckner)	Creates the Right to Know Act to require operators of commercial websites or online services that collect personal information about Illinois customers must, in their terms of service or privacy policy, identify all categories of personal information the operator collects, identify all categories of third party persons or entities with whom the operator may disclose that information, and provide a description of the customer's rights to access their information. Provisions also provide for a private right of action. Provides for blanket exemption for entities subject to GLBA and HIPAA.	**OPPOSE**	**House - Rules**
HB 3030 (Wheeler)	Creates the Cybersecurity Compliance Act to provide for an affirmative defense for every covered entity that creates, maintains, and complies with a written cybersecurity program (as prescribed by the legislation).	**MONITOR**	**House - Rules**
HB 3040 (Wheeler)	Creates the Insurance Data Security Act based on the NAIC Cybersecurity Model Law. The provisions DO NOT contain suggested changes put forward by the joint trades (industry).	**OPPOSE without Joint Trade Suggested Changes**	**House - Rules**
HB 3453 (Williams)	Creates the Geolocation Privacy Protection Act to require a private entity that owns, operates, or controls a location-based application on a user's device from disclosing geolocation information from a location-based application to a third party unless the private entity first receives the user's affirmative express consent after providing a specified notice to the user. The provisions include an exemption for HIPAA and GLBA-regulated entities.	**MONITOR**	**House - Rules**
HB 3910 (Mussman)	Creates the Consumer Privacy Act to set forth numerous data privacy requirements, including a "right to be forgotten" with exceptions. The provisions include exemptions for certain data protected under HIPAA and GLBA.	**MONITOR**	**House - Rules**
SB 731(Cullerton) - SA#3	*As amended in SFA 3 - Creates the Do Not Track Act. Prohibits a party to a user action from tracking another user whenever the party receives a do-not-track signal indicating a user preference not to be tracked, with some exceptions. Provides that data that has been sufficiently de-identified such that it is rendered anonymous data may be processed for any purpose. Provides that a party may disregard a user's do-not-track signal when the user has given express affirmative consent to track. Provides that an organization may process*	**OPPOSE**	**Senate Calendar 3rd Reading Amendment – Judiciary -Privacy**

Bill Number	Bill Description/Action	ILHIC Position	Status
	data for specified uses if the organization: (i) limits the amount of identifiable data collected; (ii) limits the retention of identifiable data to no longer than what is reasonably needed for the permitted uses; (iii) uses anonymous data; (iv) processes the data separately from systems that are used for purposes other than the permitted uses; and (v) does not process the data beyond the permitted uses. Requires an organization that engages in tracking to describe, in understandable language and syntax such that an ordinary user can comprehend, its practices with respect to do-not-track signals in its privacy statement or similar notice, available through a clear and prominent link on the home page of its website. Prohibits a party from blocking a user's do-not-track signal. Provides that the Attorney General shall enforce the Act. Permits a user whose identifiable information has been processed in violation of the Act to bring a civil action in any court of competent jurisdiction. Preempts home rule powers. Effective January 1, 2022.		
Paid Family Medical Leave			
HB 74 (Flowers)	Establishes paid family leave requiring employers with 50 or more employees to provide 6 weeks of paid leave.	**MONITOR**	**House - Rules**
HB 616 (Costa Howard)	Establishes paid family leave requiring employers (regardless of size) to provide 12 weeks of leave and pay the cost of health insurance applicable to the employee during that period.	**MONITOR**	**House - Rules**
HB 2625 (Flowers)	Creates the Family Leave Insurance Act. Requires the Department of Employment Security to establish and administer a family leave insurance program. Provides family leave insurance benefits to eligible employees who take unpaid family leave to care for a newborn child, a newly adopted or newly placed foster child, or a family member with a serious health condition. Authorizes family leave of up to 12 weeks during any 24-month period. Authorizes compensation for leave in the amount of 85% of the employee's average weekly wage subject to a maximum of $881 per week. *The state-run leave program does not replace the private market option.*	**MONITOR**	**House - Rules**
HB 3433 (Morgan)	Creates the Paid Family Leave Program directing the IL Department of Employment Security to establish a state-run paid medical leave program for employees. The provisions do not specific duration of leave allowed but does direct the Department to establish a computation of benefit amounts and contributions paid by employees and employers. *The state-run leave program*	**MONITOR**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	does not replace the private market option but does impose contribution requirements on employers with more than 50 employees.		
HB 3898 (Gordon Booth)	Creates the Healthy Workplace Act to require employers to provide a minimum of 40 hours of paid sick leave during a 12-month period for certain purposes. Employees cannot waive their right to paid leave except in cases where the benefits are collectively bargained.	**MONITOR**	**House - Rules**
HB 4053 (Guerrero-Cuellar)	Provides a civil rights violation for an employer to: refuse to allow an employee disabled by pregnancy, childbirth, or related medical condition to take a leave for a reasonable period, not to exceed 4 months, and thereafter return to work; refuse to maintain and pay for coverage for an eligible employee disabled by pregnancy, childbirth, or a related medical conditions who takes leave under a group health plan, for the duration of the leave, not to exceed 4 months over the course of a 12-month period.	**MONITOR**	**House – Rules**
SB 835 – SA#1 Villivalam	SA#1 - Creates the Family and Medical Leave Insurance Program Act. Requires the Department of Labor to establish and administer a Family Leave Insurance Program that provides family leave insurance benefits to eligible employees who take unpaid family leave to care for a newborn child, a newly adopted or newly placed foster child, or a family member with a serious health condition. Sets forth eligibility requirements for benefits under the Act. Defines "employer" to mean an individual or entity that pays wages for work undertaken by an employee. Contains provisions concerning disqualification from benefits; premium payments; the amount and duration of benefits; the recovery of erroneous payments; hearings; defaulted premium payments; elective coverage; employment protection; coordination of family leave; defined terms; and other matters. Amends the State Finance Act. Creates the Family Leave Insurance Account Fund. Provides phase-in periods for collection of moneys and claims for benefits under the Act. Effective January 1, 2022.	**MONITOR**	**Senate Calendar 3rd Reading Amendment – Senate - Labor**
LIFE, DISABILITY, LTCI, & SUPPLEMENTAL			
HB 33 (Mason)	With respect to individuals who are participating in a substance use treatment or recovery support program, the proposed legislation seeks to prohibit life insurers from canceling, terminating, or "refusing to renew" an individual's life insurance policy due to their participation; considering that participation in the underwriting or application process; or denying a claim due to a beneficiary's participation in those programs. The provisions are specific to those individuals in active recovery/treatment programs and do not prohibit these considerations	~~**OPPOSE**~~ **Neutral with HA#1**	**House Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	when applied across broader physical and mental health considerations, or individuals who are not in active recovery/treatment programs.		
HB 62 (Flowers)	Creates the Health Care For All program establishing single payer health insurance in IL.	**OPPOSE**	**House Calendar 2nd Reading**
HB 228 (Mayfield)	Prohibits an insurer or producer from making a distinction or otherwise discriminating between persons, reject an applicant, cancel a policy, or demand or require a higher rate of premium for reasons based SOLELY upon the basis that an applicant or insured has been convicted of a felony. **As amended by** HA#1 *In provisions concerning prohibited discrimination for life insurance, provides that no life company authorized to issue life insurance final expense policies in the State shall refuse to insure, refuse to continue to insure, limit the amount, extent, or kind of coverage available to, or charge an individual a different rate for the same coverage solely on the basis that an insured or applicant has been convicted of a felony. Provides that nothing in the provisions shall be construed to require a life company to issue or otherwise provide coverage for a life insurance policy to a person who is actively incarcerated pursuant to a felony conviction. Defines "final expense policy".*	**OPPOSE**	**House Calendar 2nd Reading Amendment - Rules**
HB 295 (Manley)	As introduced, the provisions currently require insurers to issue an irrevocable assignment of benefits to a funeral home in an amount not to exceed the purchase price of a funeral or burial expense policy. The language is intended to address a current issue with Medicaid beneficiaries seeking eligibility and avoidance of current asset limitations. Current law allows exemptions in assets up to a certain dollar amount in addition to exemptions for final expense policies that must be irrevocably assigned. ILHIC is working with HFS, the IL Funeral Directors Association and the National Academy of Elder Law Attorneys to determine language that appropriately addresses the problem. HA#1 removes the Insurance Code provisions. **As amended by** HA#2 *Provides that an insured or any other person who may be the owner of rights under a policy of life insurance may make an irrevocable assignment of all or a part of his or her rights under the policy to a funeral home in accordance with a specified provision of the Illinois Funeral or Burial Funds Act. Provides that a policy owner who executes a designation beneficiary form irrevocably waives and cannot exercise certain rights, including the right to collect from the insurance company the net proceeds of the policy when it becomes a claim by death and the right to collect or receive income,*	**NEUTRAL as amended NEUTRAL on HA#2**	**House PASSED**

Bill Number	Bill Description/Action	ILHIC Position	Status
	distributions, or shares of surplus, dividend deposits, refunds of premium, or additions to the policy. Amends the Illinois Funeral or Burial Funds Act. In a provision concerning pre-need contracts funded through the purchase of a life insurance policy or tax-deferred annuity contract, provides that nothing shall prohibit the purchaser from irrevocably assigning ownership of the policy or annuity to a person or trust or from irrevocably assigning the benefits of the policy or annuity to a funeral home for the purpose of obtaining favorable consideration for Medicaid, Supplemental Security Income, or another public assistance program. Provides that the form prepared by the Department of Healthcare and Family Services or by the insurance company shall provide for an irrevocable designation of beneficiary of one or more life insurance policies. Requires the insured or any other person who may be the owner of rights under the policy of whole life insurance to sign a guaranteed pre-need contract with the provider that describes the cost of the funeral goods and services to be provided upon the person's death, up to $6,774, in addition to the purchase of burial spaces as defined under the Act. Requires the licensee to annually report certain information to the Comptroller. Requires the proceeds of the life insurance policy to be paid to the provider and disbursed in a certain order upon the death of the insured. Amends the Medical Assistance Article of the Illinois Public Aid Code. In a provision requiring the Department of Healthcare and Family Services to exempt certain prepaid funeral or burial contracts from consideration when making an eligibility determination for medical assistance, provides that at any time after submitting an application for medical assistance and before the Department makes a final determination of eligibility, an applicant may use available resources to purchase one of the exempted prepaid funeral or burial contracts. Exempts up to $6,774 (rather than $5,874) in funds under an irrevocable prepaid funeral or burial contract when determining an individual's resources and eligibility for medical assistance. Provides that existing life insurance policies are exempt if there has been an irrevocable declaration of proceeds at the death of the insured. Requires the insured person to sign an irrevocable designation of beneficiary form declaring that any amounts payable from the policies not used for funeral goods and services shall be received by the State up to an amount equal to the total medical assistance paid on behalf of the person with any remaining funds paid to a secondary beneficiary (if any) listed on the policy.		

Bill Number	Bill Description/Action	ILHIC Position	Status
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 339 (Batinick)	Removes the 181-day, non-renewable limitation on short-term, limited duration health insurance policies.	**SUPPORT**	**House – Rules**
HB 2649 (Yednock)	Mandates health insurance plans to provide coverage for (rather than offer optional coverage for an additional premium) for the reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder.	**OPPOSE**	**Senate Assignments**
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 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**	**House PASSED**
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).	**OPPOSE**	**House – Rules**
SB 147 (Murphy)	Establishes a "birthday rule" for Medigap policies to provide that an existing Medicare supplement policyholder would be entitled to an annual open enrollment period of 60 days or more commencing on their birthday with guaranteed issuance of a replacement policy that offers benefits equal or less than those provided by the previous coverage.	**OPPOSE Neutral with forthcoming amendment**	**Senate Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	An amendment is forthcoming and will include: 1. Providing for an annual open enrollment of 45 days for those individuals aged 65 and older, but no more than 75 years of age who currently have a Medicare supplement policy; 2. Allow eligible applicants to enroll in a plan of equal or less benefits with the same issuer without medical underwriting; and 3. Require issuers to incorporate the annual enrollment open enrollment provisions for eligible Medicare Supplement policyholders into the buyer's guide (which is subject to the Director's Approval.)		
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. **As amended by** 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 493 (Syverson)	Creates the Uniform Electronic Transactions in Dental Care Billing Act. Requires all dental plan carriers and dental care providers to exchange claims and eligibility information electronically using the standard electronic data interchange transactions for claims submissions, payments, and verification of benefits required under the Health Insurance Portability and Accountability Act in order to be compensable by the dental plan carrier.	**MONITOR**	**Senate Calendar 3rd Reading**
SB 1588 (Fine)	Sets forth requirements for travel insurance per the NAIC Travel Insurance Model Act, including requiring policies that contain preexisting condition exclusions to disclose to the consumer information regarding the exclusions prior to purchase, immediately following, but no later than 5 business days following policy purchase. SB 2111 (Fine) sets forth licensing and registration requirements for travel insurance. **As amended** SA#1 *Provides that the Director of Insurance may issue producer licenses and limited lines producer licenses. Provides that each travel insurance business entity shall pay the Department of Insurance a fee of $500 for its initial license and $500 for each renewal license, payable on May 31 annually.*	**MONITOR**	**Senate Calendar 3rd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
SB 1876 (Syverson)	Requires policies of group life insurance to contain, if replacing another policy of group life insurance in force, a provision preventing loss of coverage, subject to premium payments, for those active employees who are not actively at work on the effective date of the new policy as long as certain conditions are met.	**TBD**	**House**
SB 2086 (Castro)	Creates the Vision Care Plan Regulation Act to set forth certain contractual requirements with eye care providers and disclosures and coverage requirements for enrollees.	**OPPOSE**	**Senate Assignments**
SB 2111 (Fine)	Creates the Travel Insurance Act and sets forth provisions concerning the licensing and registration of travel insurance business entities. SB 1588 (Fine) sets forth the marketing requirements for travel insurance.	**MONITOR**	**Senate Assignments**
SB 2112 (Harris)	Requires secondary notice for lapse of life insurance. Provides that a contract for life insurance covering an individual 64 years of age or older that has been in force for at least one year may not be lapsed for nonpayment of premium unless the insurer has mailed a notification of the impending lapse in coverage to the policyowner and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyowner at least 21 days before the expiration of the grace period. The bill also requires an agent of record to be notified of the impending lapse. Life insurance contracts under which premiums are paid monthly or more frequently and are regularly collected by a licensed agent or are paid by credit card or any preauthorized check processing or automatic debit service of a financial institution are exempt. *Initiative of NAIFA-IL.* Similar to SB 2407 (Harris), but applies the notification requirement to covered individuals aged 64 and older. **As amended by** SA#1 *Provides that a life company issuing an individual life insurance contract on or after January 1, 2022 shall notify an applicant, in writing on a form prescribed by the company at the time of application for the policy, of the applicant's right to designate a secondary addressee to receive notice of cancellation of the policy based on nonpayment of premium. Provides that the applicant may make the secondary addressee designation at the time of application for such policy or at any time such policy is in force by submitting a written notice to the insurer containing the name and address of the secondary addressee. Provides that an insurer's transmission to a secondary addressee of a copy of a notice of cancellation based on nonpayment of premium shall be in addition to the transmission of the original document to the policyholder, and that the copy of the notice of cancellation transmitted to the*	**OPPOSE** **NEUTRAL with SA#1**	**Senate Calendar 3rd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	secondary addressee shall be made in the same manner and form required for the transmission of the notice to the policyholder. Provides that the designation of a secondary addressee shall not constitute acceptance of any liability on the part of the secondary addressee or insurer for services provided to the policyholder. Provides that the secondary notice requirement does not apply to any individual life insurance contract under which premiums are payable monthly or more frequently and are regularly collected by a licensed agent or are paid by credit card or any preauthorized check processing or automatic debit service of a financial institution. Provides that nothing in the language shall prohibit an applicant or policyholder from designating a life insurance agent of record as his or her secondary addressee.		
SB 2407 (Harris)	Requires secondary notification for life insurance lapse. Similar to SB 2112 (Harris), but removes the reference to individuals aged 64 and older. *Initiative of NAIFA-IL.*	**OPPOSE**	**Senate Assignments**
RETIREMENT/ANNUITIES			
HB 117 (Guzzardi) (Martwick)	**As amended by HA #1**, expands the Secure Choice Savings Program to apply to **employers with a minimum of 5 employees** ~~sole proprietors and employers~~ (rather than employers with fewer than 25 employees) and allows for (rather than employers with fewer than 25 employees) and allows for automatic increases in contributions. The provisions also expand the penalties levied on employers for failure to comply with the requirements of the Act. Identical to SB 208 (Martwick) **as amended by SA#1**.	**NEUTRAL with HA#1**	**Senate Assignments**
HB 3918 (Stuart)	Adds investment advisors and insurance adjusters as mandated reporters. Existing law extends criminal and civil liability to mandated reporters.	**MONITOR**	**House Calendar 2nd Reading**
SB 208 (Martwick)	Expands the Secure Choice Savings Program to apply to ~~sole proprietors and employers~~ **employers with at least 5 employees** (rather than employers with fewer than 25 employees) and allows for automatic increases in contributions. The provisions also expand the penalties levied on employers for failure to comply with the requirements of the Act. Identical to HB 117 (Guzzardi) **as amended by HA#1.**	**NEUTRAL as amended**	**Senate Calendar 3rd Reading**
HEALTH INSURANCE			
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	**MONITOR**	**House – Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	those restrictions are contrary to what has been prescribed and considered medically appropriate.		
HB 62 (Flowers)	Creates the Health Care For All program establishing single payer health insurance in IL.	**OPPOSE**	**House Calendar 2nd Reading**
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 PASSED**
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 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 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 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). **As amended by** HA#2) *In the Prior Authorization Reform Act, deletes a Section concerning obligations with respect to prior authorization concerning*	~~**OPPOSE**~~ **NEUTRAL with HA#2**	**Senate Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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.		
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, 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.	**MONITOR**	**House - Rules**
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	**NEUTRAL with HA #1**	**Senate Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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).		
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 1976 (Moeller)	Allows optometrists to provide services via telehealth. Identical to SB 567 (Villivalam)	**MONITOR**	**Senate Assignments**
HB 2109 - HA#1 - LEWIS	**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	**OPPOSE Neutral with a forthcoming amendment**	**House Calendar 2nd Reading Amendment - Insurance**
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 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 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 1st Reading**
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 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**

Bill Number	Bill Description/Action	ILHIC Position	Status
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 PASSED**
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 PASSED**
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 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.***	**OPPOSE**	**House PASSED**
HB 2653 (Mason)	Mandates first dollar coverage for a diagnostic colonoscopy. The provisions include HSA tax preservation language.	**OPPOSE**	**House PASSED**
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 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 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	**OPPOSE**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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.		
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 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**
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 PASSED**
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,	**OPPOSE**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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.		
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 3308 (Jones)	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.	**SUPPORT as introduced OPPOSE with HA #1**	**House PASSED**
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**

Bill Number	Bill Description/Action	ILHIC Position	Status
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 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 3403 (Ness)	Reduces OOP limit on insulin drugs from $100 (originally set under P.A. 101-0625 to $30.	**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**
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. **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**	**House Calendar 3rd Reading**
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	**MONITOR**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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).		
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**
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 3RD Reading**
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 Health to conduct an annual public hearing on the aggregate trends in prescription drug pricing.	**MONITOR**	**House - Rules**
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. Similar ~~Identical~~ to SB 2008 (Koehler).	**OPPOSE**	**House - Rules**
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	**MONITOR**	**House - Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	calendar year and who employs at least one employee on the first day of the 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 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 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**
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**
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 of the supply needed by the insured. Language aligns with similar OOP limits applied to insulin per P.A. 101-0625.	**OPPOSE**	**House 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,	**OPPOSE**	**House – Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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.		
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**
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 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, 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).	**OPPOSE**	**Senate Assignments**
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	**OPPOSE**	**Senate Calendar 2nd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	to the task force and the group has not yet met or begun that work. **As amended by** 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*.		
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 Assignments**
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 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** **NEUTRAL** **with amendment**	**Senate Calendar 3rd 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	**OPPOSE** **NEUTRAL** **with amendment**	**Senate Calendar 3rd Reading**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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 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 499 (Barickman) (Yednock	Adds existing optional coverage requirements regarding coverage for reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder, for an additional premium and subject to the insurer's standard of insurability, to the State Employees Group Insurance; County, Municipality, and School Insurance requirements, and HMOs (as well as LHSOs, Voluntary Health Services, and Medicaid).	**NO POSITION**	**House Rules**
SB 567 (Villivalam) (Moeller)	Allows optometrists to provide services via telehealth. Identical to HB 1976 (Moeller).	**MONITOR**	**House Rules**

Bill Number	Bill Description/Action	ILHIC Position	Status
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 Assignments**
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**
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. **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**	**Senate Calendar 3rd Reading Amendment Insurance**
SB 1096 - SA#1	**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*	**NEUTRAL With SA#1**	**Senate Calendar 3rd Reading Amendment - Assignments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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.		
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 Assignment**
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 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 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."* **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 amendment**	**Senate Calendar 3rd Reading**
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	**MONITOR**	**Senate Assisgnments**

Bill Number	Bill Description/Action	ILHIC Position	Status
	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).		
SB 1682 (Bennett)	Pharmacy retail price disclosure – identical to SB 1625 (Turner).	**MONITOR**	**House**
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 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 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 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**	**Senate PASSED**
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 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 Calendar 3rd Reading**

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 1917 (Morrison) (Carroll)	Removes the age limit (18) in mandated coverage provisions for medically necessary epinephrine injectors.	**NEUTRAL**	**House Rules**
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 3rd Reading**
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**
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	**OPPOSE**	**Senate Insurance**

Bill Number	Bill Description/Action	ILHIC Position	Status
	coverage of port-wine stain treatment OR increasing rates due to the coverage requirement.		
SB 2241 (Murphy)	Mandates coverage for hippotherapy and other forms of therapeutic riding.	**OPPOSE**	**Senate Assignments**
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 3rd Reading**
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).	**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**