Regular Session 2021- End of Session Report

June 2, 2021

Illinois legislators worked until the early hours of June 1 attempting to bring the spring legislative session to close. Although lawmakers managed to tackle numerous big policy issues in the waning hours before their scheduled adjournment date of May 31– including passage of telehealth coverage reforms, new legislative maps, election and ethics reforms and a $42 billion state spending plan – more work lies ahead before legislators can formally close the books on the spring session. The House and Senate are expected to return next week to address a few outstanding items, namely an omnibus clean energy bill.

To say that it was an active first session of the 102nd General Assembly may be a bit of an understatement. At this point in time, the House and Senate will send or have sent more than 660 bills to the Governor, including bills he previously enacted (such as pre-judgment interest) and bills expected to pass once lawmakers formally wrap their session.

This legislative session was not only defined by the vast number of complex policy issues that came before lawmakers during the past 5 months, but also by new leadership, new faces, and an ongoing pandemic that was still prevalent in the sessions proceedings.

This session marked the first time that all members of the House of Representatives and the Senate had been back under the Capitol dome since early March of 2020 when the public health emergency abruptly cut the regular session short. It also marked the first time a new Speaker presided over the House of Representatives in 37 years (not counting the two-year turnover to Republicans in 1995-1996) and the first time Illinois saw a Black Speaker of the House after Democrat Representative Emanuel "Chris" Welch was selected to take over for long-time House Speaker Michael Madigan.

In fact, three of the four legislative leaders had less than 2 years of leadership experience with Democrat Senate President Don Harmon taking the helm in January 2020 and Republican Senate Minority Leader Dan McConchie taking over shortly after the 2020 General Election. House Republican Minority Leader Jim Durkin has served in that role since 2013.

Democrats also maintained their healthy supermajority in the 102nd General Assembly, only losing one Democrat House seat to give them a 73-45 seat advantage over their Republican counterparts while Senate Democrats picked up an additional seat to increase their advantage over Republicans in that chamber by a margin of 41-18. Nearly a quarter of those lawmakers, however, had never experienced a full legislative session.

The fallout from COVID, including re-exposure of racial and economic divides, along with a growing list of policy issues that were left unaddressed in the previous year gave rise to a very heavy legislative

agenda. In the meantime, interest groups, including ILHIC, and lawmakers alike were still navigating the realities of tackling that agenda in a largely virtual environment.

Below is a summary of major issues facing ILHIC and its members this legislative session that ranged from restrictions on life insurance underwriting practices, disability income coverage of mental health to reforms on prior authorization and medical necessity criteria, pharmacy benefit managers, and telehealth. The summary also includes a recap of key business issues that will address how companies report equal pay, negotiate non-competes, and a state budget that has some direct impacts on the industry and its stakeholders.

Life Insurance: Risk Classification, Exemption of Assets, and Secondary Notification

Risk Classification

Lawmakers revisited two proposals first introduced in the last General Assembly that would have significantly altered the way in which life insurers classify risk as it relates to individuals in substance use recovery and treatment programs, as well as individuals who have a felony conviction.

HB 33 (Mason/Johnson), as introduced, sought to prohibit life insurers from underwriting on the basis of an individual's current and active participation in a substance use recovery or treatment program. ILHIC was successful in working with the sponsor to amend the language to prohibit discrimination solely "*and without sound actuarial principles or reasonable anticipated experience"* in addition to limiting the provisions to those individuals who have been out of a treatment or recovery support program for at least 5 years. The bill passed both houses on May 29 and now goes to the Governor.

HB 228 (Mayfield) was also a re-introduction of legislation introduced in 2019 that sought to prohibit discrimination in underwriting ***solely*** on the basis of a felony conviction. ILHIC attempted to work with the sponsor to narrow the scope of the language to only impact those life insurance policies marketed and sold as final expense policies to cover expenses related to funeral and burial costs to align with the sponsor's stated intent. The sponsor later proposed an amendment to address this intent, however, the language still tied the prohibition back to the life insurance company and not the policy itself. Ultimately, the legislation did not advance beyond the House Insurance Committee and the bill remains in the House, but the Council anticipates this issue could re-emerge in the fall or spring 2022 legislative session.

Exemption of Assets

The Illinois Funeral Directors Association and the National Association of Elder Law Attorneys sought legislation this year to provide for an irrevocable assignment of life insurance policies for final expense purposes to avoid asset limitations on individuals applying for Medicaid benefits. HB 295 (Manley/ Feigenholtz) attempted to tackle a complicated policy issue that at its core would have allowed individuals to exempt assets associated with a whole life policy to qualify for Medicaid by irrevocably assigning those assets over to a funeral home to cover funeral and burial expenses for that beneficiary. Medicaid eligibility currently sets a $2,000 asset limitation, but life insurance policies used to fund a funeral and burial contract are exempt from these asset limitations.

ILHIC was one of a number of stakeholders, including several state agencies – the Departments of Insurance, Human Services, Healthcare and Family Services, and the Comptroller's Office governing the

regulation of insurance, Medicaid and funeral home services – attempting to provide a path for individuals to use cash or assets associated with a life insurance policy not explicitly used to fund a funeral and burial contract in order to qualify for Medicaid while still guaranteeing those assets will be used to cover expenses related to that individual's funeral and burial arraignments with any excess going to the state to cover expenses related to their care while on the Medicaid program in order to comply with the spend down requirements set forth in the Public Aid Code.

Discussions stalled when the bill moved to the Senate after the Department of Healthcare and Family Services asked for additional time to determine whether a state plan amendment would be needed to allow this exemption in the first place. There were also ongoing concerns about irrevocably assigning these benefits over to a funeral home to distribute rather than a trust. The bill remains in the Senate and further negotiations with stakeholders and the impacted agencies is expected this summer.

Secondary Notification

NAIFA-IL and the Independent Insurance Agents of IL reintroduced provisions from 2020 that sought secondary notification for impending lapse of a life insurance policy under SB 2112 (Harris/Gabel), which, as introduced, would have applied these provisions to individuals aged 64 or older. The provisions also would have required mandatory notification to an agent of record.

ACLI and ILHIC were successful in working with NAIFA-IL and IIA of IL to negotiate compromise language based on Connecticut's law that requires life insurance companies, at time of application, of an applicant's right (regardless of their age) to designate a secondary addressee for notification of lapse purposes. The applicant may designate a licensed life insurance agent as their secondary addressee. The provisions do not apply to policies in which the premium is collected monthly or more frequently and regularly collected by a licensed agent or paid by a credit card or automatic debit or pre-authorized check processing services.

SB 2112, as amended, passed both houses unanimously and will move to the Governor's desk.

Health Insurance: Telehealth, Medical Management Standards, PBMs, Coverage Mandates, Rate Review, and Healthcare Reforms

Telehealth Coverage

As session days dwindled, there were two primary bills HB 3308 (Jones/Harris) and HB 3498 (Conroy/Hunter) that focused on establishing telehealth as a permanent healthcare delivery service. Although the bills both mandated telehealth coverage, they proposed different approaches to the way telehealth would be implemented and reimbursed.

HB 3498 mandated provider payment parity for all services provided by telehealth. In addition to payment parity, insurers were mandated to reimburse facilities that were originating sites for services. As it passed the House, HB 3498 extended guaranteed reimbursement to hospitals and all providers, including additional facility fees that threatened to make telehealth services more expensive than in-person services.

HB 3308 took a more moderate approach to telehealth coverage expansion. As amended in the House, HB 3308 mandated coverage of telehealth as well as provider payment parity for behavioral health services only, while establishing a task force to study payment parity.

Given the different paths of the two bills in the House with HB 3498 moving through the House Health Care Availability and Access Committee and HB 3308 moving through the Insurance Committee, negotiations on telehealth provisions were difficult to navigate.

Despite several attempts by ILHIC to offer compromise language, the hospitals and their coalition pressed ahead with passage of HB 3498 out of the House a day after HB 3308 passed on April 22. Once the bills arrived in the Senate where they were both assigned to Senate Insurance Committee, Chairman Harris was able to play an integral role in directing all of the stakeholders to seek a compromise that assured consumers would continue to have coverage for and access to clinically appropriate telehealth services while also preserving affordability of this coverage.

After intense negotiation, the IL Health and Hospital Association and their provider coalition, ILHIC and America's Health Insurance Plans (AHIP) came to an agreement the weekend before the last week of session that was later amended onto HB 3308. The agreement included:

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.

Medical Management Standards

Prior Authorization

Prior Authorization reform - HB 711 (Harris) -was an initiative of the Illinois State Medical Society (ISMS) that like other issues was sidelined when the legislative session was cut short last year. As introduced, the proposed legislation significantly restricted insurers' ability to effectively apply a medical management program to ensure that patients receive safe and appropriate medications, treatments, and procedures. ILHIC joined with the IL Association of Medicaid Health Plans (IAMHP), AHIP, and the Pharmaceutical Care Management Association (PCMA) to provide extensive comments and suggested revisions that addressed some of the most significant concerns with the bill as introduced, including: 1) applying turn-around-times for non-urgent and urgent health care services and treatments that are much more aggressive than current national accreditation standards; 2) applying stringent and untenable requirements on utilization review organizations (UROs) with respect to conducting reviews of requests for prior authorization and appeals; 3) codifying approval requirements that put patient safety at risk; and 4) requiring disclosure of detailed statistics regarding the approval or denial or prior authorizations that fail to accurately capture the complete process.

As with telehealth, negotiations on prior authorization were slow to get underway and several attempts by ILHIC and industry partners to offer compromise language were rejected by ISMS and the coalition. However, through the efforts of our members and those of our industry partners, as well as the expertise of their clinicians, ILHIC and the health insurance industry was successful in negotiating an agreement that was reflected in House Amendment #2, before the bill was sent to the Senate. The provisions of this agreement include:

1. Updates to requirements for clinical review criteria to be used for prior authorization purposes to include that it must be evidence-based and updated annually.
2. Elimination of provisions that would have prohibited application of prior authorization solely on the basis of lack of independently developed, evidence-based standards, the standards conflict, standards from an expert consensus panel do not exist; or if a product or treatment has been recommended by a treating provider for "off label use."
3. Non-urgent and urgent turn-around-times (TATs) are 5 days and 48 hours, respectively, notwithstanding any other provision of law (acknowledging for other areas of statute that apply different TATs).
4. Establish the personnel requirements for those qualified to make an adverse determination and those who can review appeals to align with existing standards (eliminating previous requirements that the initial determination be made by a physician in active practice and those handling appeals must also be in active practice and not employed by the URO).
5. Eliminate requirements that an insurer and a utilization review organization provide a peer-to-peer prior to denial of a request, as well as eliminate a requirement that the insurer/URO maintain a 24/7 hotline to manage urgent requests.
6. Require prior authorization approvals to remain valid for 6 months (instead of 12) or the length of the treatment as determined by the treating provider (or the renewal of the plan), inclusive of dosage changes; however, dosage increases must be subject to evidentiary standards and insurers are permitted to apply safety edits.
7. Require prior authorization approvals for chronic or long-term conditions to remain valid for the lesser of 12 months or the length of treatment as determined by the treating provider (with policy exclusions accounted for).
8. Reduce the statistical information insurers and UROs are required to publish on prior authorization to include the number of requests received (instead of approved) and denied in the previous plan year; top 5 reasons for denial; the number of requests appealed and the number of appeal requests that were upheld or overturned; and average time between submission and action taken.

Medical Necessity

The Kennedy Forum's 2021 priority for the regular session was HB 2595, which establishes that nonprofit criteria to determine medical necessity for patient placement for individuals in need of mental health services. For non-placement purposes, other criteria may be utilized.

As introduced, HB 2595 was extremely broad and mandated that issuers use nonprofit criteria exclusively for all services. ILHIC expressed concerns that the language did not leave enough space for insurers to navigate services outside of the narrow scope of nonprofit criteria.

The language, which was modeled after a CA law enacted just this year, would have also required insurers and Medicaid managed care plans to sponsor nonprofits in providing educational programs to staff and stakeholders regarding the criteria, which ILHIC opposed due to the precedent it set in statute mandating a profit stream to certain entities. ILHIC also pushed back on the effective date of the changes after insurers and Medicaid managed care plans noted the challenges of implementing the CA law that took effect on January 1 within months of passage. Additionally, ILHIC and IAMHP sought changes to provisions that would have conflicted with reporting requirements agreed to by KFI through the mental health parity working group that has been charged with developed NQTL reporting compliance templates for insurers to begin submitting on July 1.

The negotiated agreement, which was included in Senate Amendment #1, provided for: 1) the changes outlined above narrowing of the application of the non-profit professional association criteria to only include patient placement for mental health with some flexibility provided to apply additional criteria if the level of care is not accounted for in the non-profit criteria; 2) requirements that insurers train their staff and stakeholders on the criteria at least annually (instead of use the non-profit training on a quarterly basis); 3) apply the requirements to plans issued or renewed on January 1, 2023; and 4) align inter-rater reliability reporting requirements with those requirements already set forth and accounted for in the mental health parity NQTL reporting templates.

ILHIC would note that while the provisions represented a compromise, the litigation that KFI used to suggest these changes were necessary is still ongoing and we are likely to pursue further revisions in the 2022 legislative session. Additionally, ILHIC also suggested that effectively addressing barriers to mental health treatment, providers and facilities that will handle placement of patients with mental health and substance use disorder needs should be subject to similar education and training requirements.

Senator Feigenholtz, the Vice President on the Kennedy Forum's Board, suggested that there be a trailer bill in the future that mandates this training for other entities/providers in the same way as insurers.

PBM Reforms

SB 2008 was introduced this year by Senator Koehler on behalf of the Independent Pharmacists. Much of what was proposed was duplicative of existing law (Public Act 101-0452). Recently negotiated Public Act 101-0452 included definitions, appeals processes, and pharmacy network participation that SB 2008 sought to alter or include. ILHIC did note that there needs to be time to allow the Department of Insurance to implement Public Act 101-0452, which mandated the Department to register PBMs conducting business in Illinois by July 1, 2020. ILHIC attended two subject matter hearings as well as multiple stakeholder meetings to express concerns regarding drafted language. Specifically, ILHIC concerns were: 1) formulary placement requirements; 2) provisions related to consumer access to appropriate medication; and 3) the network adequacy provisions. Legislators were quick to understand that SB 2008 included massive implementation changes/ requirements that would need additional discussion over the summer months. The Independent Pharmacists will likely request additional conversations after session this summer.

Mandated Coverage

Reproductive Health Mandates

This session brought many specific healthcare coverage mandates. ILHIC tracked and negotiated more than 13 mandate bills through the General Assembly.

The pandemic highlighted pregnancy and postpartum as a silent crisis in the United States. Legislators used this momentum to push legislation expanding coverage and altering health management tools for pregnant and postpartum women.

Senator Castro utilized momentum of providing postpartum coverage in the Medicaid space by introducing SB 967. After being negotiated to remove duplicative language, the bill mandates access to case management programs and MH/SUD services for high-risk pregnancies. It also mandates that the provider is the sole individual that may determine medical necessity within the first 48 hours after initiation of partial hospitalization admission, inpatient admission, detoxification, or withdrawal management program.

Another coverage mandate regarding reproductions was HB 135 (Bush/ Mussman), which mandated patient care service coverage when pharmacists prescribe and dispense hormonal birth control. During negotiation, the Independent Pharmacists made a strong push to mandate blanket patient services coverage for any expansion of scope within the Pharmacy Practice Act. Their argument centered around vaccine dispensing and the push to provide more patient services at pharmacies. While ILHIC did understand that healthcare might be placing more patient services under Pharmacists, ILHIC stated that a blanket mandate for services would need a larger discussion with multiple stakeholder input. There might be interest from the Independent Pharmacists to pick up this discussion in the summer months.

As a further point of note, SB 2017, as amended, contained the FY 2022 Budget Implementation language, inclusive of a provision that expands the pharmacists' scope of practice to allow them to administer COVID vaccines (and other federally recommended vaccines) to individuals aged 7 (instead of 14) and older. Notably, the provisions also include reference to Medicaid and private payer coverage and reimbursement of these services; however, the provisions only amend the Pharmacy Practice Act and not the Public Aid Code or the Insurance Code. HB 135, as amended, limited the coverage and reimbursement only to those services set forth in the Pharmacy Practice Act that applied to contraceptive coverage.

Other Coverage Mandates

There were several coverage mandates passed this session, even though State may be required to defray the costs of any coverage mandate outside of an essential health benefit. The Department must submit a list of coverage mandates beyond essential health benefits this summer to Federal CMS. Currently, without the legislative mandate bills passed this session, Illinois has more than 20 additional coverage mandates that the State will be required to defray if the federal government requires enforcement of the law 45 CFR §155.170. The following coverage mandates passed this session are:

- COVID Testing Trailer Bill (SB 1096)(Harris/Gillespie)
    - Sunsets a mandate passed in the Lame Duck session in January that provides insurance coverage for diagnostic COVID testing to all nursing home employees. The sunset is set for January 1, 2022.
- Prescription Drugs (HB 1745)(G. Harris/N. Harris)

    - This bill mandates issuers to ensure that at least 10% of health plans offered provide a flat-dollar copayment structure to the entire drug benefit.
- Biomarker Testing (HB 1779)(Flowers/Munoz)
    - Mandates coverage for biomarker testing for treatment and disease management purposes.
- Comprehensive Cancer Testing (HB 2109)(Lewis/Lightford)
    - Mandate to provide coverage for comprehensive cancer testing.
- TMJ Coverage (SB 499)(Barickman)
    - This bill adds existing optional coverage requirements for reasonable and necessary treatment of TMJ disorder.
- Diagnostic Colonoscopy (HB 2653)(Mason/Johnson)
    - HB 2653 mandated first dollar coverage for a diagnostic colonoscopy. The provisions include HSA preservation language.
- Waiting Period Infertility (HB 3709)(Croke/Fine)
    - Removes one year requirement of unsuccessful pregnancy before coverage begins. For women ages 35 or older who are unable to conceive, the waiting period is 6 months instead of 1 year.
- Pancreatic Cancer Screening (SB 968)(Johnson/Ammons)
    - Mandates coverage for medically necessary pancreatic cancer screening.
- A1C Testing (SB 1854)(Ellman/Yang 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.
- Port Wine Stains (SB 2158)(Tracy/Buckner)
    - Mandates coverage for maximum feasible treatment for nevus flammeus. Prohibits coverage for cosmetic purposes as well as tightens up the mandate by listing situations creating functional impairment, which would trigger the coverage.

Coverage Mandate – Applicability to HSA-eligible HDHPs

HB 2948, which was an initiative of the Department of Insurance, sought to address protections for HSAs with respect to state mandates, including the copay accumulator ban. The provisions of the bill also required insurers to identify a non-HSA eligible HDHP and offer a non-HSA eligible product if they do provide an HSA-eligible HDHP.

Due to advocate opposition to the exemption language, the sponsor held the bill on House Second Reading to allow the Department to obtain an IRS ruling that will indicate the copay accumulator ban violates federal tax rules as it applies to HSAs. The IRS took the position that prescription copay coupons may be used to discount out of pocket costs, but the amount the consumer pays based on that discount must still apply to the deductible. Additionally, state mandates that require first dollar coverage for services that are not considered preventive under federal tax code would disqualify an HDHP from being an HDHP, and therefore, the plan would not be eligible for an HSA.

This position supported ILHIC's interpretation that in specific cases, explicit exemption language for these plans is necessary to preserve those options. Given the IRS' position, it is clear that changes in the statute will be needed in order to preserve these product offerings and the Department is likely to revisit this in the fall veto or spring 2022 session.

The Department also committed to continue discussions about the other provisions of the bill that require certain HDHP offerings and labeling of products. ILHIC opposed the provisions related to the marketing requirements for HSA and non-HSA eligible HDHPs, but supported the exclusions for HSAs from the copay accumulator in order to preserve the tax advantages of these products.

Rate Review

Advocates and Senator Fine tried once again to push rate review (SB 1590), which would grant Illinois the ability to disapprove rates if the rate is unreasonable or insufficient. However, this year there was an addition to their policy initiative that included a public comment period for all rates submitted based on Oregon law. ILHIC explained in a stakeholder call with Senator Fine and advocates that currently, in Illinois, if an insurer submits a rate increase of 10%, the Illinois Department of Insurance conducts an in-depth review and determines if the rate is reasonable. Insurers must submit a rate justification for any increase of 10% or more, and rate justifications must be posted publicly.

Illinois is considered an effective rate review state and rate review regulations work in conjunction with the Affordable Care Act. Public transparency is already a requirement of an effective rate review state; the analysis is already happening, and an avenue for public comment is required.

Giving the State the authority to reject rates will not accomplish transparency. It will only place responsibility of insurance increase (even in actuarily justified) into the hands of policymakers. Chairman Harris held Senator Fine's rate review bill in committee and the language was not revived elsewhere. However, this is an extremely important priority of Senator Fine and the issue will likely be raised in Veto or 2022 Regular Session.

Healthcare Feasibility Study

On July 7, 2020, the Governor signed SB 1864, which instructed the Department of Healthcare and Family Services (HFS), in consultation with the Department of Insurance (DOI), to oversee a feasibility study that explores healthcare policy options for the state of Illinois. The policies selected for the study were: 1. Basic Health Plan; 2. State Premium and Cost Sharing Subsidies; 3. Public Option; 4. Medicaid Buy-In; 5. Moving to a State Based Marketplace; and 6. State-Supported Marketing and Outreach. Each policy was analyzed by looking at other states in addition to Illinois' healthcare landscape. Most policy analysis resulted in potential cost shifts for the consumer as well as large administrative costs. Due to the large cost considerations, the State does not plan to push any policy in the immediate future. However, there will likely be renewed interest in these policies throughout the summer and next year.

Supplemental Products: Disability Income, Medicare Supplement, and Paid Leave

Disability Income – Mental Health Parity

The sponsor of legislation in 2019 that sought to apply mental health coverage parity requirements to disability income policies returned this year with a proposal that would have required disability income

policies (including health and accident policies) to apply equal terms of coverage to protected classes under the Illinois Human Rights Act. The new proposal set forth in Senate Amendment #1 to SB 202 (Morrison) was pushed by the same advocacy groups, including Kennedy Forum of IL, that sought similar changes in 2019.

ILHIC was successful in 2019 to secure a compromise (P.A. 101-0332) with the sponsor that established a task force to study disability income policies available in the market, as well as ways in which to increase uptake. Proponents of SB 202 and the original 2019 legislation argued that requiring equal terms of coverage for all behavioral health conditions in a disability income policy would not result in a substantial price increase and despite the low uptake in the products – particularly in the individual market – the consumer would purchase policies that provided for equal coverage, even if that coverage was more expensive.

The task force was established to look at the data and the market impact, but due to the public health emergency last year, gubernatorial appointments to that task force stalled.

The Senate Insurance Committee did approve SB 202, as amended, but only with the understanding that the Senate sponsor would continue to work with ILHIC on our concerns. In the meantime, ILHIC was successful in redirecting the sponsor to push for legislation authorizing the extension of the December 31, 2021 sunset on the task force before it was up and running.

SB 930 (Morrison/Morgan) contains the sunset extension until January 1, 2023 and further establishes the final report out deadline of December 31, 2022. The bill now goes to the Governor to extend the task force.

In the meantime, the Governor's Office has moved forward on appointments, with ILHIC recently appointed to represent the insurance industry. The task force is expected to get underway this summer.

Medicare Supplement – Birthday Rule

Senator Murphy reintroduced legislation first proposed in 2020 that sought an annual open enrollment for all individuals eligible for a Medicare supplement product within 60 days of their birthday. The "birthday rule" proposal, which was reintroduced under SB 147 (Murphy/Harper), was modeled after California law.

ILHIC worked with the sponsor to address concerns that the legislation could prove disruptive to an otherwise healthy Medicare supplement market. Under the original proposal, individuals, including those eligible for Medicare prior to the age of 65, could change to a plan providing equal or lesser coverage every year with no medical underwriting.

The Council was able to secure changes to the bill prior to passage out of the Senate that provided for; 1) an annual open enrollment of 45 days for those individuals age 65 and older, but no more than 75 years of age who currently have a Medicare supplement policy; 2) allows eligible applicants to enroll in a plan of equal or less benefits with the same issuer without medical underwriting; and 3) requires issuers to inform individuals of the open enrollment option at the time of initial application on a form prescribed by the Department.

The measure now goes to the Governor for signature.

Paid Family & Medical Leave

While there were several paid leave proposals introduced in the House and Senate this year, few advanced beyond committee and much less their originating chamber. There was a late push in the legislation session to revive provisions that were similar to those that advanced in 2020 that required employers to provide 7 days of paid leave to employees. House Amendment #1 (Booth) to SB 208 introduced in the last week of the scheduled session was supported by business groups but opposed by labor and ultimately did not advance.

One paid leave bill that did pass both houses, however, is a bill that provides 30 days of paid sick leave to teachers and other school workers (outside the Chicago Public School District) after childbirth, fostering, or adoption. HB 816 (Mussman/Feigenholtz) also removed an existing requirement that the paid sick leave days have to be taken consecutively, a nod to a recent IL Supreme Court case addressing non-consecutive paid leave for teachers. ILHIC did not weigh in on the proposal, which still faced opposition from school groups.

Group Capital, Credit for Reinsurance and Producer Pre-Licensure

The Department of Insurance pursued several initiatives this legislative session, including legislation (HB 1955) supported by ILHIC that addresses several NAIC accreditation issues, including:

- Updates to the 2014 Holding Company Act;
- Implementation of the Covered Agreements between the US and the EU and the US and the UK to authorize credit for insurance; and
- Implementation of the 2020 Holding Company Act amendments as it applies to Group Capital Calculation.

The Department also introduced omnibus Insurance Code clean-up provisions under HB 1957, which includes partial codification of EO 2020-29 to allow for producer prelicensure courses to take place via webinar. ILHIC also supported the measure.

Both bills now go to the Governor's desk for approval.

Business Issues: Equal Pay, Non-Competes, and FY 2022 Budget and Revenues

Equal Pay Certificate Requirements

Business groups, led by the IL Chamber of Commerce, negotiated clean-up provisions to requirements enacted as part of the Legislative Black Caucus' economic equity pillar earlier this year -P.A. 101-0656- that require employers with more than 100 employees to obtain an equal pay registration certificate from the Department of Labor within 3 years of the effective date of the Act (and every 2 years thereafter).

The clean-up provisions, which were passed under SB 1847 (Hunter/Harper), delayed the implementation of the provisions to allow impacted employers time to comply with the law. Covered businesses as of March 23, 2021 will be required to obtain an equal pay certificate between March 24, 2022 and March 23, 2024 and must recertify every 2 years thereafter. For those covered businesses

after March 23, 2021, an equal pay certificate must be completed within 3 years of business operation but no later than January 1, 2024.

The provisions also clarify information required to be included in the equal pay compliance statement, as well as provide employers an opportunity to cure any deficiencies in the statement. Additionally, data submitted to the Department protects individually identifiable information.

Finally, penalties associated with non-compliance set forth in the original law allowed the Department of Labor to impose a penalty of up to 1% of "gross profits." Those penalties have since been aligned with existing civil penalties within the Department's existing authority, as well as revocation or suspension of the certificate.

The legislation passed both houses and will now go the Governor.

Non-Competes

Business groups also secured updates to the Illinois Freedom to Work Act under SB 672 (Hunter/Burke) that apply reasonable limitations on covenants to compete and covenants not to solicit, aligning the provisions with judicial standards set forth under case law. The provisions also nullify covenants not to compete for employees terminated, furloughed, or laid off because of the COVID 19 pandemic.

SB 672 applies covenants not to compete to those employees with an actual or expected annualized rate of earnings in excess of $75,000 and covenants not to solicit those employees with an actual or expected annualized rate of earnings in excess of $45,000. Both of those salary thresholds increase under a schedule set forth under the bill, and further applies the provisions to only those non-competes entered into after the January 1, 2022 effective date.

The bill now goes to the Governor for action.

FY 2022 Spending Plan – New Revenues

The General Assembly approved a new FY 2022 budget, inclusive of approximately $655 in new revenues generated by several Governor-supported changes to business tax incentives. The new $42. 3 billion spending plan also allocates a portion of the $8 billion in federal American Rescue Plan Act (ARPA) that Illinois received, distributing approximately $1.5 billion of those dollars towards economic recovery, public health, and affordable housing initiatives with another $1 billion directed towards capital projects.

The tax code changes included in the budget implementation plan (SB 2017) include:

- Capping the corporate Net Operating Loss Deduction at $100,000 for the next three years, beginning with tax years starting on or after December 31, 2021 and prior to December 31, 2024;
- Align the tax treatment of dividends from foreign sources and global intangible low-taxed income (GILTI) to the treatment of domestic dividends, meaning companies, beginning in tax years ending on or after June 30, 2021, will have to add back these foreign source/GILTI dividends allowed under the 2017 federal Tax Cuts and Jobs Act back into their Illinois base income; and
- Decouple from the 100% accelerated depreciation rule added under the 2017 federal Tax Cuts and Jobs Act, beginning for tax years on or after December 31, 2021.

The budget implementation bill also included a fee increase on licensed producers as follows: 1) a 20% increase for in-state producers from $180 to $215, and 2) 52% increase for out-of-state producers from $250 to $380, effective July 1, 2021. The fee increase will generate approximately $26 million to be directed towards state police and law enforcement training purposes and will not otherwise be used for purposes related to the regulation of insurance.

Authority to impose an additional fee was also included on auto insurance policies only in an amount not to exceed $4 to help fund the same law enforcement training budget items.

The new budget will take effect on July 1, 2021.