



Illinois Department of Insurance

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TO: All Health Insurance Issuers Writing Accident and Health Insurance, Health Maintenance Organization Health Care Plans, Limited Health Care Plans, and Voluntary Health Services Plans

FROM: Ann Gillespie, Director *ARG*

DATE: April 3, 2026

RE: Company Bulletin 2026-05 Biomarker Testing Coverage Requirements

The purpose of this bulletin is to inform, clarify, and promote uniformity in the application of the biomarker testing coverage as required by 215 ILCS 5/356z.46.

Background:

The Department has received inquiries and complaints indicating that some issuers may not be providing coverage for biomarker testing to the extent required by Public Act 102-0203,¹ which is codified as 215 ILCS 5/356z.46. P.A. 102-0203 requires all group and individual accident and health insurance policies, HMO health care plans, and limited health care plans or voluntary health services plans that cover laboratory services, which are amended, delivered, issued, or renewed on or after January 1, 2022, to provide coverage for biomarker testing pursuant to criteria established under Section 356z.46(d). This bulletin serves as a reminder of issuers' obligations under this statute.

Scope of Biomarker Testing Coverage:

The statute relies on the following definitions:

“Biomarker” means “a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention” and includes, but is not limited to, gene mutations or protein expression.

“Biomarker testing” means the analysis of a patient’s tissue, blood, or fluid biospecimen for the presence of a biomarker. “Biomarker testing” includes, but is not limited to, single-analyte tests, multiplex panels, and partial or whole genome sequencing. 215 ILCS 5/356z.46(a).

Under Section 356z.46(c), biomarker testing, including, but not limited to, single-analyte tests, multiplex panels, and partial or whole genome sequencing tests, “must be covered and conducted in an efficient

¹ [Illinois General Assembly - Public Act 102-0203](#)

manner to provide the most complete range of results to the patient’s health care provider without requiring multiple biopsies, biospecimen samples, or other delays or disruptions in patient care.”

The law requires coverage for biomarker testing “for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee’s disease or condition when the test is supported by medical and scientific evidence” as further described in Section 356z.46(d).

In the event coverage is restricted, Section 356z.46(e) requires issuers to maintain a clear, readily accessible, and convenient process for patients and prescribing practitioners to request an exception, which must be available on the issuer’s website.

Issuers should review and update medical policies and billing practices as appropriate to ensure coverage aligns with current evidence-based recommendations in the statutorily listed sources for biomarker testing.

Issuers retain the right to determine and deny claims for biomarker testing based on medical necessity only if compliant with Section 356z.46 of the Illinois Insurance Code.

Issuers are required to use only current definitions and coverage requirements.

Issuers are required to render a biomarker coverage decision in a timely manner under existing laws. *E.g.*, 215 ILCS 5/154.6(c), (i), (m), (o); 215 ILCS 5/368a(c); 215 ILCS 200/25 and 200/30; and 50 Ill. Adm. Code 919.50(a).

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