

1 AN ACT concerning the Comprehensive Health Insurance
2 Plan.

3 Be it enacted by the People of the State of Illinois,
4 represented in the General Assembly:

5 Section 5. The Comprehensive Health Insurance Plan Act
6 is amended by changing Sections 2, 4, 7, and 15 as follows:

7 (215 ILCS 105/2) (from Ch. 73, par. 1302)

8 Sec. 2. Definitions. As used in this Act, unless the
9 context otherwise requires:

10 "Plan administrator" means the insurer or third party
11 administrator designated under Section 5 of this Act.

12 "Benefits plan" means the coverage to be offered by the
13 Plan to eligible persons and federally eligible individuals
14 pursuant to this Act.

15 "Board" means the Illinois Comprehensive Health Insurance
16 Board.

17 "Church plan" has the same meaning given that term in the
18 federal Health Insurance Portability and Accountability Act
19 of 1996.

20 "Continuation coverage" means continuation of coverage
21 under a group health plan or other health insurance coverage
22 for former employees or dependents of former employees that
23 would otherwise have terminated under the terms of that
24 coverage pursuant to any continuation provisions under
25 federal or State law, including the Consolidated Omnibus
26 Budget Reconciliation Act of 1985 (COBRA), as amended,
27 Sections 367.2 and 367e of the Illinois Insurance Code, or
28 any other similar requirement in another State.

29 "Covered person" means a person who is and continues to
30 remain eligible for Plan coverage and is covered under one of
31 the benefit plans offered by the Plan.

1 "Creditable coverage" means, with respect to a federally
2 eligible individual, coverage of the individual under any of
3 the following:

4 (A) A group health plan.

5 (B) Health insurance coverage (including group
6 health insurance coverage).

7 (C) Medicare.

8 (D) Medical assistance.

9 (E) Chapter 55 of title 10, United States Code.

10 (F) A medical care program of the Indian Health
11 Service or of a tribal organization.

12 (G) A state health benefits risk pool.

13 (H) A health plan offered under Chapter 89 of title
14 5, United States Code.

15 (I) A public health plan (as defined in regulations
16 consistent with Section 104 of the Health Care
17 Portability and Accountability Act of 1996 that may be
18 promulgated by the Secretary of the U.S. Department of
19 Health and Human Services).

20 (J) A health benefit plan under Section 5(e) of the
21 Peace Corps Act (22 U.S.C. 2504(e)).

22 (K) Any other qualifying coverage required by the
23 federal Health Insurance Portability and Accountability
24 Act of 1996, as it may be amended, or regulations under
25 that Act.

26 "Creditable coverage" does not include coverage
27 consisting solely of coverage of excepted benefits, as
28 defined in Section 2791(c) of title XXVII of the Public
29 Health Service Act (42 U.S.C. 300 gg-91), nor does it include
30 any period of coverage under any of items (A) through (K)
31 that occurred before a break of more than 90 days or, if the
32 individual has been certified as an eligible person pursuant
33 to the federal Trade Adjustment Act of 2002, a break of more
34 than 63 days during all of which the individual was not

1 covered under any of items (A) through (K) above. Any period
2 that an individual is in a waiting period for any coverage
3 under a group health plan (or for group health insurance
4 coverage) or is in an affiliation period under the terms of
5 health insurance coverage offered by a health maintenance
6 organization shall not be taken into account in determining
7 if there has been a break of more than 90 days in any
8 creditable coverage.

9 "Department" means the Illinois Department of Insurance.

10 "Dependent" means an Illinois resident: who is a spouse;
11 or who is claimed as a dependent by the principal insured for
12 purposes of filing a federal income tax return and resides in
13 the principal insured's household, and is a resident
14 unmarried child under the age of 19 years; or who is an
15 unmarried child who also is a full-time student under the age
16 of 23 years and who is financially dependent upon the
17 principal insured; or who is a child of any age and who is
18 disabled and financially dependent upon the principal
19 insured.

20 "Direct Illinois premiums" means, for Illinois business,
21 an insurer's direct premium income for the kinds of business
22 described in clause (b) of Class 1 or clause (a) of Class 2
23 of Section 4 of the Illinois Insurance Code, and direct
24 premium income of a health maintenance organization or a
25 voluntary health services plan, except it shall not include
26 credit health insurance as defined in Article IX 1/2 of the
27 Illinois Insurance Code.

28 "Director" means the Director of the Illinois Department
29 of Insurance.

30 "Eligible person" means a resident of this State who
31 qualifies for Plan coverage under Section 7 of this Act.

32 "Employee" means a resident of this State who is employed
33 by an employer or has entered into the employment of or works
34 under contract or service of an employer including the

1 officers, managers and employees of subsidiary or affiliated
2 corporations and the individual proprietors, partners and
3 employees of affiliated individuals and firms when the
4 business of the subsidiary or affiliated corporations, firms
5 or individuals is controlled by a common employer through
6 stock ownership, contract, or otherwise.

7 "Employer" means any individual, partnership,
8 association, corporation, business trust, or any person or
9 group of persons acting directly or indirectly in the
10 interest of an employer in relation to an employee, for which
11 one or more persons is gainfully employed.

12 "Family" coverage means the coverage provided by the Plan
13 for the covered person and his or her eligible dependents who
14 also are covered persons.

15 "Federally eligible individual" means an individual
16 resident of this State:

17 (1)(A) for whom, as of the date on which the
18 individual seeks Plan coverage under Section 15 of this
19 Act, the aggregate of the periods of creditable coverage
20 is 18 or more months or, if the individual has been
21 certified as an eligible person pursuant to the federal
22 Trade Adjustment Act of 2002, 3 or more months, and (B)
23 whose most recent prior creditable coverage was under
24 group health insurance coverage offered by a health
25 insurance issuer, a group health plan, a governmental
26 plan, or a church plan (or health insurance coverage
27 offered in connection with any such plans) or any other
28 type of creditable coverage that may be required by the
29 federal Health Insurance Portability and Accountability
30 Act of 1996, as it may be amended, or the regulations
31 under that Act;

32 (2) who is not eligible for coverage under (A) a
33 group health plan, (B) part A or part B of Medicare due
34 to age, or (C) medical assistance, and does not have

1 other health insurance coverage;

2 (3) with respect to whom the most recent coverage
3 within the coverage period described in paragraph (1)(A)
4 of this definition was not terminated based upon a factor
5 relating to nonpayment of premiums or fraud;

6 (4) if the individual, other than an individual who
7 has been certified as an eligible person pursuant to the
8 federal Trade Adjustment Act of 2002, had been offered
9 the option of continuation coverage under a COBRA
10 continuation provision or under a similar State program,
11 who elected such coverage; and

12 (5) who, if the individual elected such
13 continuation coverage, has exhausted such continuation
14 coverage under such provision or program.

15 An individual who has been certified as an eligible
16 person pursuant to the federal Trade Adjustment Act of 2002
17 shall not be required to elect continuation coverage under a
18 COBRA continuation provision or under a similar state
19 program.

20 "Group health insurance coverage" means, in connection
21 with a group health plan, health insurance coverage offered
22 in connection with that plan.

23 "Group health plan" has the same meaning given that term
24 in the federal Health Insurance Portability and
25 Accountability Act of 1996.

26 "Governmental plan" has the same meaning given that term
27 in the federal Health Insurance Portability and
28 Accountability Act of 1996.

29 "Health insurance coverage" means benefits consisting of
30 medical care (provided directly, through insurance or
31 reimbursement, or otherwise and including items and services
32 paid for as medical care) under any hospital and medical
33 expense-incurred policy, certificate, or contract provided by
34 an insurer, non-profit health care service plan contract,

1 health maintenance organization or other subscriber contract,
2 or any other health care plan or arrangement that pays for or
3 furnishes medical or health care services whether by
4 insurance or otherwise. Health insurance coverage shall not
5 include short term, accident only, disability income,
6 hospital confinement or fixed indemnity, dental only, vision
7 only, limited benefit, or credit insurance, coverage issued
8 as a supplement to liability insurance, insurance arising out
9 of a workers' compensation or similar law, automobile
10 medical-payment insurance, or insurance under which benefits
11 are payable with or without regard to fault and which is
12 statutorily required to be contained in any liability
13 insurance policy or equivalent self-insurance.

14 "Health insurance issuer" means an insurance company,
15 insurance service, or insurance organization (including a
16 health maintenance organization and a voluntary health
17 services plan) that is authorized to transact health
18 insurance business in this State. Such term does not include
19 a group health plan.

20 "Health Maintenance Organization" means an organization
21 as defined in the Health Maintenance Organization Act.

22 "Hospice" means a program as defined in and licensed
23 under the Hospice Program Licensing Act.

24 "Hospital" means a duly licensed institution as defined
25 in the Hospital Licensing Act, an institution that meets all
26 comparable conditions and requirements in effect in the state
27 in which it is located, or the University of Illinois
28 Hospital as defined in the University of Illinois Hospital
29 Act.

30 "Individual health insurance coverage" means health
31 insurance coverage offered to individuals in the individual
32 market, but does not include short-term, limited-duration
33 insurance.

34 "Insured" means any individual resident of this State who

1 is eligible to receive benefits from any insurer (including
2 health insurance coverage offered in connection with a group
3 health plan) or health insurance issuer as defined in this
4 Section.

5 "Insurer" means any insurance company authorized to
6 transact health insurance business in this State and any
7 corporation that provides medical services and is organized
8 under the Voluntary Health Services Plans Act or the Health
9 Maintenance Organization Act.

10 "Medical assistance" means the State medical assistance
11 or medical assistance no grant (MANG) programs provided under
12 Title XIX of the Social Security Act and Articles V (Medical
13 Assistance) and VI (General Assistance) of the Illinois
14 Public Aid Code (or any successor program) or under any
15 similar program of health care benefits in a state other than
16 Illinois.

17 "Medically necessary" means that a service, drug, or
18 supply is necessary and appropriate for the diagnosis or
19 treatment of an illness or injury in accord with generally
20 accepted standards of medical practice at the time the
21 service, drug, or supply is provided. When specifically
22 applied to a confinement it further means that the diagnosis
23 or treatment of the covered person's medical symptoms or
24 condition cannot be safely provided to that person as an
25 outpatient. A service, drug, or supply shall not be medically
26 necessary if it: (i) is investigational, experimental, or for
27 research purposes; or (ii) is provided solely for the
28 convenience of the patient, the patient's family, physician,
29 hospital, or any other provider; or (iii) exceeds in scope,
30 duration, or intensity that level of care that is needed to
31 provide safe, adequate, and appropriate diagnosis or
32 treatment; or (iv) could have been omitted without adversely
33 affecting the covered person's condition or the quality of
34 medical care; or (v) involves the use of a medical device,

1 drug, or substance not formally approved by the United States
2 Food and Drug Administration.

3 "Medical care" means the ordinary and usual professional
4 services rendered by a physician or other specified provider
5 during a professional visit for treatment of an illness or
6 injury.

7 "Medicare" means coverage under both Part A and Part B of
8 Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395,
9 et seq.

10 "Minimum premium plan" means an arrangement whereby a
11 specified amount of health care claims is self-funded, but
12 the insurance company assumes the risk that claims will
13 exceed that amount.

14 "Participating transplant center" means a hospital
15 designated by the Board as a preferred or exclusive provider
16 of services for one or more specified human organ or tissue
17 transplants for which the hospital has signed an agreement
18 with the Board to accept a transplant payment allowance for
19 all expenses related to the transplant during a transplant
20 benefit period.

21 "Physician" means a person licensed to practice medicine
22 pursuant to the Medical Practice Act of 1987.

23 "Plan" means the Comprehensive Health Insurance Plan
24 established by this Act.

25 "Plan of operation" means the plan of operation of the
26 Plan, including articles, bylaws and operating rules, adopted
27 by the board pursuant to this Act.

28 "Provider" means any hospital, skilled nursing facility,
29 hospice, home health agency, physician, registered pharmacist
30 acting within the scope of that registration, or any other
31 person or entity licensed in Illinois to furnish medical
32 care.

33 "Qualified high risk pool" has the same meaning given
34 that term in the federal Health Insurance Portability and

1 Accountability Act of 1996.

2 "Resident" means a person who is and continues to be
3 legally domiciled and physically residing on a permanent and
4 full-time basis in a place of permanent habitation in this
5 State that remains that person's principal residence and from
6 which that person is absent only for temporary or transitory
7 purpose.

8 "Skilled nursing facility" means a facility or that
9 portion of a facility that is licensed by the Illinois
10 Department of Public Health under the Nursing Home Care Act
11 or a comparable licensing authority in another state to
12 provide skilled nursing care.

13 "Stop-loss coverage" means an arrangement whereby an
14 insurer insures against the risk that any one claim will
15 exceed a specific dollar amount or that the entire loss of a
16 self-insurance plan will exceed a specific amount.

17 "Third party administrator" means an administrator as
18 defined in Section 511.101 of the Illinois Insurance Code who
19 is licensed under Article XXXI 1/4 of that Code.

20 (Source: P.A. 91-357, eff. 7-29-99; 91-735, eff. 6-2-00;
21 92-153, eff. 7-25-01.)

22 (215 ILCS 105/4) (from Ch. 73, par. 1304)

23 Sec. 4. Powers and authority of the board. The board
24 shall have the general powers and authority granted under the
25 laws of this State to insurance companies licensed to
26 transact health and accident insurance and in addition
27 thereto, the specific authority to:

- 28 a. Enter into contracts as are necessary or proper to
- 29 carry out the provisions and purposes of this Act, including
- 30 the authority, with the approval of the Director, to enter
- 31 into contracts with similar plans of other states for the
- 32 joint performance of common administrative functions, or with
- 33 persons or other organizations for the performance of

1 administrative functions including, without limitation,
2 utilization review and quality assurance programs, or with
3 health maintenance organizations or preferred provider
4 organizations for the provision of health care services.

5 b. Sue or be sued, including taking any legal actions
6 necessary or proper.

7 c. Take such legal action as necessary to:

8 (1) avoid the payment of improper claims against
9 the plan or the coverage provided by or through the plan;

10 (2) to recover any amounts erroneously or
11 improperly paid by the plan;

12 (3) to recover any amounts paid by the plan as a
13 result of a mistake of fact or law; or

14 (4) to recover or collect any other amounts,
15 including assessments, that are due or owed the Plan or
16 have been billed on its or the Plan's behalf.

17 d. Establish appropriate rates, rate schedules, rate
18 adjustments, expense allowances, agents' referral fees, claim
19 reserves, and formulas and any other actuarial function
20 appropriate to the operation of the plan. Rates and rate
21 schedules may be adjusted for appropriate risk factors such
22 as age and area variation in claim costs and shall take into
23 consideration appropriate risk factors in accordance with
24 established actuarial and underwriting practices.

25 e. Issue policies of insurance in accordance with the
26 requirements of this Act.

27 f. Appoint appropriate legal, actuarial and other
28 committees as necessary to provide technical assistance in
29 the operation of the plan, policy and other contract design,
30 and any other function within the authority of the plan.

31 g. Borrow money to effect the purposes of the Illinois
32 Comprehensive Health Insurance Plan. Any notes or other
33 evidence of indebtedness of the plan not in default shall be
34 legal investments for insurers and may be carried as admitted

1 assets.

2 h. Establish rules, conditions and procedures for
3 reinsuring risks under this Act.

4 i. Employ and fix the compensation of employees. Such
5 employees may be paid on a warrant issued by the State
6 Treasurer pursuant to a payroll voucher certified by the
7 Board and drawn by the Comptroller against appropriations or
8 trust funds held by the State Treasurer.

9 j. Enter into intergovernmental cooperation agreements
10 with other agencies or entities of State government for the
11 purpose of sharing the cost of providing health care services
12 that are otherwise authorized by this Act for children who
13 are both plan participants and eligible for financial
14 assistance from the Division of Specialized Care for Children
15 of the University of Illinois.

16 k. Establish conditions and procedures under which the
17 plan may, if funds permit, discount or subsidize premium
18 rates that are paid directly by senior citizens, as defined
19 by the Board, and other plan participants, who are retired or
20 unemployed and meet other qualifications.

21 l. Establish and maintain the Plan Fund authorized in
22 Section 3 of this Act, which shall be divided into separate
23 accounts, as follows:

24 (1) accounts to fund the administrative, claim, and
25 other expenses of the Plan associated with eligible
26 persons who qualify for Plan coverage under Section 7 of
27 this Act, which shall consist of:

28 (A) premiums paid on behalf of covered
29 persons;

30 (B) appropriated funds and other revenues
31 collected or received by the Board;

32 (C) reserves for future losses maintained by
33 the Board; and

34 (D) interest earnings from investment of the

1 funds in the Plan Fund or any of its accounts other
2 than the funds in the account established under item
3 2 of this subsection;

4 (2) an account, to be denominated the federally
5 eligible individuals account, to fund the administrative,
6 claim, and other expenses of the Plan associated with
7 federally eligible individuals who qualify for Plan
8 coverage under Section 15 of this Act, which shall
9 consist of:

10 (A) premiums paid on behalf of covered
11 persons;

12 (B) assessments and other revenues collected
13 or received by the Board;

14 (C) reserves for future losses maintained by
15 the Board; and

16 (D) interest earnings from investment of the
17 federally eligible individuals account funds; and

18 (E) grants provided pursuant to the federal
19 Trade Adjustment Act of 2002; and

20 (3) such other accounts as may be appropriate.

21 m. Charge and collect assessments paid by insurers
22 pursuant to Section 12 of this Act and recover any
23 assessments for, on behalf of, or against those insurers.

24 (Source: P.A. 90-30, eff. 7-1-97; 91-357, eff. 7-29-99.)

25 (215 ILCS 105/7) (from Ch. 73, par. 1307)

26 Sec. 7. Eligibility.

27 a. Except as provided in subsection (e) of this Section
28 or in Section 15 of this Act, any person who is either a
29 citizen of the United States or an alien lawfully admitted
30 for permanent residence and who has been for a period of at
31 least 180 days and continues to be a resident of this State
32 shall be eligible for Plan coverage under this Section if
33 evidence is provided of:

1 (1) A notice of rejection or refusal to issue
2 substantially similar individual health insurance
3 coverage for health reasons by a health insurance issuer;
4 or

5 (2) A refusal by a health insurance issuer to issue
6 individual health insurance coverage except at a rate
7 exceeding the applicable Plan rate for which the person
8 is responsible.

9 A rejection or refusal by a group health plan or health
10 insurance issuer offering only stop-loss or excess of loss
11 insurance or contracts, agreements, or other arrangements for
12 reinsurance coverage with respect to the applicant shall not
13 be sufficient evidence under this subsection.

14 b. The board shall promulgate a list of medical or
15 health conditions for which a person who is either a citizen
16 of the United States or an alien lawfully admitted for
17 permanent residence and a resident of this State would be
18 eligible for Plan coverage without applying for health
19 insurance coverage pursuant to subsection a. of this Section.
20 Persons who can demonstrate the existence or history of any
21 medical or health conditions on the list promulgated by the
22 board shall not be required to provide the evidence specified
23 in subsection a. of this Section. The list shall be
24 effective on the first day of the operation of the Plan and
25 may be amended from time to time as appropriate.

26 c. Family members of the same household who each are
27 covered persons are eligible for optional family coverage
28 under the Plan.

29 d. For persons qualifying for coverage in accordance
30 with Section 7 of this Act, the board shall, if it determines
31 that such appropriations as are made pursuant to Section 12
32 of this Act are insufficient to allow the board to accept all
33 of the eligible persons which it projects will apply for
34 enrollment under the Plan, limit or close enrollment to

1 ensure that the Plan is not over-subscribed and that it has
2 sufficient resources to meet its obligations to existing
3 enrollees. The board shall not limit or close enrollment for
4 federally eligible individuals.

5 e. A person shall not be eligible for coverage under the
6 Plan if:

7 (1) He or she has or obtains other coverage under a
8 group health plan or health insurance coverage
9 substantially similar to or better than a Plan policy as
10 an insured or covered dependent or would be eligible to
11 have that coverage if he or she elected to obtain it.
12 Persons otherwise eligible for Plan coverage may,
13 however, solely for the purpose of having coverage for a
14 pre-existing condition, maintain other coverage only
15 while satisfying any pre-existing condition waiting
16 period under a Plan policy or a subsequent replacement
17 policy of a Plan policy.

18 (1.1) His or her prior coverage under a group
19 health plan or health insurance coverage, provided or
20 arranged by an employer of more than 10 employees was
21 discontinued for any reason without the entire group or
22 plan being discontinued and not replaced, provided he or
23 she remains an employee, or dependent thereof, of the
24 same employer.

25 (2) He or she is a recipient of or is approved to
26 receive medical assistance, except that a person may
27 continue to receive medical assistance through the
28 medical assistance no grant program, but only while
29 satisfying the requirements for a preexisting condition
30 under Section 8, subsection f. of this Act. Payment of
31 premiums pursuant to this Act shall be allocable to the
32 person's spenddown for purposes of the medical assistance
33 no grant program, but that person shall not be eligible
34 for any Plan benefits while that person remains eligible

1 for medical assistance. If the person continues to
2 receive or be approved to receive medical assistance
3 through the medical assistance no grant program at or
4 after the time that requirements for a preexisting
5 condition are satisfied, the person shall not be eligible
6 for coverage under the Plan. In that circumstance,
7 coverage under the plan shall terminate as of the
8 expiration of the preexisting condition limitation
9 period. Under all other circumstances, coverage under
10 the Plan shall automatically terminate as of the
11 effective date of any medical assistance.

12 (3) Except as provided in Section 15, the person
13 has previously participated in the Plan and voluntarily
14 terminated Plan coverage, unless 12 months have elapsed
15 since the person's latest voluntary termination of
16 coverage.

17 (4) The person fails to pay the required premium
18 under the covered person's terms of enrollment and
19 participation, in which event the liability of the Plan
20 shall be limited to benefits incurred under the Plan for
21 the time period for which premiums had been paid and the
22 covered person remained eligible for Plan coverage.

23 (5) The Plan has paid a total of \$1,000,000 in
24 benefits on behalf of the covered person.

25 (6) The person is a resident of a public
26 institution.

27 (7) The person's premium is paid for or reimbursed
28 under any government sponsored program or by any
29 government agency or health care provider, except as an
30 otherwise qualifying full-time employee, or dependent of
31 such employee, of a government agency or health care
32 provider or, except when a person's premium is paid by
33 the U.S. Treasury Department pursuant to the federal
34 Trade Adjustment Act of 2002.

1 (8) The person has or later receives other benefits
2 or funds from any settlement, judgement, or award
3 resulting from any accident or injury, regardless of the
4 date of the accident or injury, or any other
5 circumstances creating a legal liability for damages due
6 that person by a third party, whether the settlement,
7 judgment, or award is in the form of a contract,
8 agreement, or trust on behalf of a minor or otherwise and
9 whether the settlement, judgment, or award is payable to
10 the person, his or her dependent, estate, personal
11 representative, or guardian in a lump sum or over time,
12 so long as there continues to be benefits or assets
13 remaining from those sources in an amount in excess of
14 \$100,000.

15 (9) Within the 5 years prior to the date a person's
16 Plan application is received by the Board, the person's
17 coverage under any health care benefit program as defined
18 in 18 U.S.C. 24, including any public or private plan or
19 contract under which any medical benefit, item, or
20 service is provided, was terminated as a result of any
21 act or practice that constitutes fraud under State or
22 federal law or as a result of an intentional
23 misrepresentation of material fact; or if that person
24 knowingly and willfully obtained or attempted to obtain,
25 or fraudulently aided or attempted to aid any other
26 person in obtaining, any coverage or benefits under the
27 Plan to which that person was not entitled.

28 f. The board or the administrator shall require
29 verification of residency and may require any additional
30 information or documentation, or statements under oath, when
31 necessary to determine residency upon initial application and
32 for the entire term of the policy.

33 g. Coverage shall cease (i) on the date a person is no
34 longer a resident of Illinois, (ii) on the date a person

1 requests coverage to end, (iii) upon the death of the covered
 2 person, (iv) on the date State law requires cancellation of
 3 the policy, or (v) at the Plan's option, 30 days after the
 4 Plan makes any inquiry concerning a person's eligibility or
 5 place of residence to which the person does not reply.

6 h. Except under the conditions set forth in subsection g
 7 of this Section, the coverage of any person who ceases to
 8 meet the eligibility requirements of this Section shall be
 9 terminated at the end of the current policy period for which
 10 the necessary premiums have been paid.

11 (Source: P.A. 90-30, eff. 7-1-97; 91-639, eff. 8-20-99;
 12 91-735, eff. 6-2-00.)

13 (215 ILCS 105/15)

14 Sec. 15. Alternative portable coverage for federally
 15 eligible individuals.

16 (a) Notwithstanding the requirements of subsection a. of
 17 Section 7 and except as otherwise provided in this Section,
 18 any federally eligible individual for whom a Plan
 19 application, and such enclosures and supporting documentation
 20 as the Board may require, is received by the Board within 90
 21 days after the termination of prior creditable coverage shall
 22 qualify to enroll in the Plan under the portability
 23 provisions of this Section. A federally eligible person who
 24 has been certified as an eligible person pursuant to the
 25 federal Trade Adjustment Act of 2002 and whose Plan
 26 application and enclosures and supporting documentation as
 27 the Board may require is received by the Board within 63 days
 28 after the termination of previous creditable coverage shall
 29 qualify to enroll in the Plan under the portability
 30 provisions of this Section.

31 (b) Any federally eligible individual seeking Plan
 32 coverage under this Section must submit with his or her
 33 application evidence, including acceptable written

1 certification of previous creditable coverage, that will
2 establish to the Board's satisfaction, that he or she meets
3 all of the requirements to be a federally eligible individual
4 and is currently and permanently residing in this State (as
5 of the date his or her application was received by the
6 Board).

7 (c) Except as otherwise provided in this Section, a
8 period of creditable coverage shall not be counted, with
9 respect to qualifying an applicant for Plan coverage as a
10 federally eligible individual under this Section, if after
11 such period and before the application for Plan coverage was
12 received by the Board, there was at least a 90 day period
13 during all of which the individual was not covered under any
14 creditable coverage. For a federally eligible person who has
15 been certified as an eligible person pursuant to the federal
16 Trade Adjustment Act of 2002, a period of creditable coverage
17 shall not be counted, with respect to qualifying an applicant
18 for Plan coverage as a federally eligible individual under
19 this Section, if after such period and before the application
20 for Plan coverage was received by the Board, there was at
21 least a 63 day period during all of which the individual was
22 not covered under any creditable coverage.

23 (d) Any federally eligible individual who the Board
24 determines qualifies for Plan coverage under this Section
25 shall be offered his or her choice of enrolling in one of
26 alternative portability health benefit plans which the Board
27 is authorized under this Section to establish for these
28 federally eligible individuals and their dependents.

29 (e) The Board shall offer a choice of health care
30 coverages consistent with major medical coverage under the
31 alternative health benefit plans authorized by this Section
32 to every federally eligible individual. The coverages to be
33 offered under the plans, the schedule of benefits,
34 deductibles, co-payments, exclusions, and other limitations

1 shall be approved by the Board. One optional form of
2 coverage shall be comparable to comprehensive health
3 insurance coverage offered in the individual market in this
4 State or a standard option of coverage available under the
5 group or individual health insurance laws of the State. The
6 standard benefit plan that is authorized by Section 8 of this
7 Act may be used for this purpose. The Board may also offer a
8 preferred provider option and such other options as the Board
9 determines may be appropriate for these federally eligible
10 individuals who qualify for Plan coverage pursuant to this
11 Section.

12 (f) Notwithstanding the requirements of subsection f. of
13 Section 8, any plan coverage that is issued to federally
14 eligible individuals who qualify for the Plan pursuant to the
15 portability provisions of this Section shall not be subject
16 to any preexisting conditions exclusion, waiting period, or
17 other similar limitation on coverage.

18 (g) Federally eligible individuals who qualify and
19 enroll in the Plan pursuant to this Section shall be required
20 to pay such premium rates as the Board shall establish and
21 approve in accordance with the requirements of Section 7.1 of
22 this Act.

23 (h) A federally eligible individual who qualifies and
24 enrolls in the Plan pursuant to this Section must satisfy on
25 an ongoing basis all of the other eligibility requirements of
26 this Act to the extent not inconsistent with the federal
27 Health Insurance Portability and Accountability Act of 1996
28 in order to maintain continued eligibility for coverage under
29 the Plan.

30 (Source: P.A. 92-153, eff. 7-25-01.)

31 Section 99. Effective date. This Act takes effect upon
32 becoming law.