AMENDMENT TO SENATE BILL 783

AMENDMENT NO. _____. Amend Senate Bill 783 by replacing everything after the enacting clause with the following:

"Section 5. The Comprehensive Health Insurance Plan Act is amended by changing Sections 2, 3, and 15 as follows:

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

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

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

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

"Board" means the Illinois Comprehensive Health Insurance Board.

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

"Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that

coverage pursuant to any continuation provisions under federal or State law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2, 367e, and 367e.1 of the Illinois Insurance Code, or any other similar requirement in another State.

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

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

(A) A group health plan.

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

(C) Medicare.

(D) Medical assistance.

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

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

(G) A state health benefits risk pool.

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

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

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

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

"Creditable coverage" does not include coverage

consisting solely of coverage of excepted benefits, as defined in Section 2791(c) of title XXVII of the Public Health Service Act (42 U.S.C. 300 gg-91), nor does it include any period of coverage under any of items (A) through (K) that occurred before a break of more than 90 days or, if ~~after-September-30,-2003,~~ the individual has ~~either~~ been certified as eligible pursuant to the federal Trade Act of 2002 ~~or-initially-been-paid-a-benefit-by-the-Pension--Benefit Guaranty-Corporation~~, a break of more than 63 days during all of which the individual was not covered under any of items (A) through (K) above.

~~For-an--individual--who--between--December--1,--2002--and September--30,-2003-has-either-(1)-been-certified-as-eligible pursuant-to-the-federal-Trade-Act-of-2002,-(2)-initially-been paid-a-benefit-by-the-Pension-Benefit--Guaranty--Corporation, or--(3)--as-of-December-1,-2002,-been-receiving-benefits-from the--Pension--Benefit--Guaranty--Corporation--and---who---has qualified--health--insurance,-as-defined-by-the-federal-Trade Act-of-2002,-"creditable-coverage"--includes--any--period--of coverage--aggregating-3-or-more-months-under-any-of-items-(A) through-(K),-irrespective-of-the-length-of-a-break-during-all of-which-the-individual-was-not-covered-under--any--of--items (A)-through-(K).~~

Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than 90 days in any creditable coverage.

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is claimed as a dependent by the principal insured for purposes of filing a federal income tax return and resides in

the principal insured's household, and is a resident unmarried child under the age of 19 years; or who is an unmarried child who also is a full-time student under the age of 23 years and who is financially dependent upon the principal insured; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

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

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

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

"Employee" means a resident of this State who is employed by an employer or has entered into the employment of or works under contract or service of an employer including the officers, managers and employees of subsidiary or affiliated corporations and the individual proprietors, partners and employees of affiliated individuals and firms when the business of the subsidiary or affiliated corporations, firms or individuals is controlled by a common employer through stock ownership, contract, or otherwise.

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

"Family" coverage means the coverage provided by the Plan

for the covered person and his or her eligible dependents who also are covered persons.

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

(1)(A) for whom, as of the date on which the individual seeks Plan coverage under Section 15 of this Act, the aggregate of the periods of creditable coverage is 18 or more months or, if the individual has ~~either (i)~~ been certified as eligible pursuant to the federal Trade Act of 2002, ~~(ii) initially been paid a benefit by the Pension Benefit Guaranty Corporation, or (iii) as of December 1, 2002, been receiving benefits from the Pension Benefit Guaranty Corporation and has qualified health insurance, as defined by the federal Trade Act of 2002,~~ 3 or more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) who is not eligible for coverage under (A) a group health plan (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), (B) part A or part B of Medicare due to age (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), or (C) medical assistance, and does not have other health insurance coverage (other than an individual who has been certified as eligible pursuant to the Federal Trade Act of 2002);

(3) with respect to whom (other than an individual

who has been certified as eligible pursuant to the federal Trade Act of 2002) the most recent coverage within the coverage period described in paragraph (1)(A) of this definition was not terminated based upon a factor relating to nonpayment of premiums or fraud;

(4) if the individual (other than an individual who has either (A) been certified as eligible pursuant to the federal Trade Act of 2002, (B) initially been paid a benefit by the Pension Benefit Guaranty Corporation, or (C) as of December 1, 2002, been receiving benefits from the Pension Benefit Guaranty Corporation and who has qualified health insurance, as defined by the federal Trade Act of 2002) had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

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

However, an individual who has either been certified as eligible pursuant to the federal Trade Act of 2002 or initially been paid a benefit by the Pension Benefit Guaranty Corporation shall not be required to elect continuation coverage under a COBRA continuation provision or under a similar state program.

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

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

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

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

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

Act.

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

"Insured" means any individual resident of this State who is eligible to receive benefits from any insurer (including health insurance coverage offered in connection with a group health plan) or health insurance issuer as defined in this Section.

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

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

"Medically necessary" means that a service, drug, or supply is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient. A service, drug, or supply shall not be medically necessary if it: (i) is investigational, experimental, or for research purposes; or (ii) is provided solely for the convenience of the patient, the patient's family, physician,

hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or (iv) could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or (v) involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration.

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

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

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

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

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

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

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

"Provider" means any hospital, skilled nursing facility,

hospice, home health agency, physician, registered pharmacist acting within the scope of that registration, or any other person or entity licensed in Illinois to furnish medical care.

"Qualified high risk pool" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

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

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

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

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

(Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03; 93-34, eff. 6-23-03; 93-477, eff. 8-8-03; revised 8-21-03.)

(215 ILCS 105/3) (from Ch. 73, par. 1303)

Sec. 3. Operation of the Plan.

a. There is hereby created an Illinois Comprehensive Health Insurance Plan.

b. The Plan shall operate subject to the supervision and control of the board. The board is created as a political

subdivision and body politic and corporate and, as such, is not a State agency. The board shall consist of 10 public members, appointed by the Governor with the advice and consent of the Senate.

Initial members shall be appointed to the Board by the Governor as follows: 2 members to serve until July 1, 1988, and until their successors are appointed and qualified; 2 members to serve until July 1, 1989, and until their successors are appointed and qualified; 3 members to serve until July 1, 1990, and until their successors are appointed and qualified; and 3 members to serve until July 1, 1991, and until their successors are appointed and qualified. As terms of initial members expire, their successors shall be appointed for terms to expire the first day in July 3 years thereafter, and until their successors are appointed and qualified.

Any vacancy in the Board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.

Any member of the Board may be removed by the Governor for neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

In addition, a representative of the Governor's Office of Management and Budget ~~Bureau of the Budget~~, a representative of the Office of the Attorney General and the Director or the Director's designated representative shall be members of the board. Four members of the General Assembly, one each appointed by the President and Minority Leader of the Senate and by the Speaker and Minority Leader of the House of Representatives, shall serve as nonvoting members of the board. At least 2 of the public members shall be individuals reasonably expected to qualify for coverage under the Plan, the parent or spouse of such an individual, or a surviving

family member of an individual who could have qualified for the plan during his lifetime. The Director or Director's representative shall be the chairperson of the board. Members of the board shall receive no compensation, but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

c. The board shall make an annual report in September and shall file the report with the Secretary of the Senate and the Clerk of the House of Representatives. The report shall summarize the activities of the Plan in the preceding calendar year, including net written and earned premiums, the expense of administration, the paid and incurred losses for the year and other information as may be requested by the General Assembly. The report shall also include analysis and recommendations regarding utilization review, quality assurance and access to cost effective quality health care.

d. In its plan of operation the board shall:

(1) Establish procedures for selecting a plan administrator in accordance with Section 5 of this Act.

(2) Establish procedures for the operation of the board.

(3) Create a Plan fund, under management of the board, to fund administrative, claim, and other expenses of the Plan.

(4) Establish procedures for the handling and accounting of assets and monies of the Plan.

(5) Develop and implement a program to publicize the existence of the Plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the Plan.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board immediately after completion of

the review. The Department and the board shall retain all written complaints regarding the Plan for at least 3 years. Oral complaints shall be reduced to written form and maintained for at least 3 years.

(7) Provide for other matters as may be necessary and proper for the execution of its powers, duties and obligations under the Plan.

e. No later than 5 years after the Plan is operative the board and the Department shall conduct cooperatively a study of the Plan and the persons insured by the Plan to determine: (1) claims experience including a breakdown of medical conditions for which claims were paid; (2) whether availability of the Plan affected employment opportunities for participants; (3) whether availability of the Plan affected the receipt of medical assistance benefits by Plan participants; (4) whether a change occurred in the number of personal bankruptcies due to medical or other health related costs; (5) data regarding all complaints received about the Plan including its operation and services; (6) and any other significant observations regarding utilization of the Plan. The study shall culminate in a written report to be presented to the Governor, the President of the Senate, the Speaker of the House and the chairpersons of the House and Senate Insurance Committees. The report shall be filed with the Secretary of the Senate and the Clerk of the House of Representatives. The report shall also be available to members of the general public upon request.

f. The board may:

(1) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public in this State.

(2) Provide for reinsurance of risks incurred by the Plan and enter into reinsurance agreements with

insurers to establish a reinsurance plan for risks of coverage described in the Plan, or obtain commercial reinsurance to reduce the risk of loss through the Plan.

(3) Issue additional types of health insurance policies to provide optional coverages as are otherwise permitted by this Act including a Medicare supplement policy designed to supplement Medicare.

(4) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission certification, second surgical opinion, concurrent utilization review programs, and individual case management for the purpose of making the pool more cost effective.

(5) Design, utilize, contract, or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(6) Adopt bylaws, rules, regulations, policies and procedures as may be necessary or convenient for the implementation of the Act and the operation of the Plan.

(7) Administer separate pools, separate accounts, or other plans or arrangements as required by this Act to separate federally eligible individuals or groups of federally eligible individuals who qualify for plan coverage under Section 15 of this Act from eligible persons or groups of eligible persons who qualify for plan coverage under Section 7 of this Act and apportion the costs of the administration among such separate pools, separate accounts, or other plans or arrangements.

g. The Director may, by rule, establish additional powers and duties of the board and may adopt rules for any other purposes, including the operation of the Plan, as are necessary or proper to implement this Act.

h. The board is not liable for any obligation of the Plan. There is no liability on the part of any member or employee of the board or the Department, and no cause of action of any nature may arise against them, for any action taken or omission made by them in the performance of their powers and duties under this Act, unless the action or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

i. There is no liability on the part of any insurance producer for the failure of any applicant to be accepted by the Plan unless the failure of the applicant to be accepted by the Plan is due to an act or omission by the insurance producer which constitutes willful or wanton misconduct.

(Source: P.A. 92-597, eff. 6-28-02; revised 8-23-03.)

(215 ILCS 105/15)

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

(a) Notwithstanding the requirements of subsection a. of Section 7 and except as otherwise provided in this Section, any federally eligible individual for whom a Plan application, and such enclosures and supporting documentation as the Board may require, is received by the Board within 90 days after the termination of prior creditable coverage shall qualify to enroll in the Plan under the portability provisions of this Section.

~~A federally eligible person who between December 1, 2002 and September 30, 2003 has either (1) been certified as eligible pursuant to the federal Trade Act of 2002, (2) initially been paid a benefit by the Pension Benefit Guaranty Corporation, or (3) as of December 1, 2002, been receiving benefits from the Pension Benefit Guaranty Corporation, who has qualified health insurance, as defined by the federal~~

~~Trade Act of 2002, and whose Plan application and enclosures and supporting documentation, as the Board may require, is received by the Board after the termination of previous creditable coverage shall qualify to enroll in the Plan under the portability provisions of this Section.~~

A federally eligible person who~~, after September 30, 2003,~~ has ~~either~~ been certified as eligible pursuant to the federal Trade Act of 2002 ~~or initially been paid a benefit by the Pension Benefit Guaranty Corporation~~ and whose Plan application and enclosures and supporting documentation as the Board may require is received by the Board within 63 days after the termination of previous creditable coverage shall qualify to enroll in the Plan under the portability provisions of this Section.

(b) Any federally eligible individual seeking Plan coverage under this Section must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the Board's satisfaction, that he or she meets all of the requirements to be a federally eligible individual and is currently and permanently residing in this State (as of the date his or her application was received by the Board).

(c) Except as otherwise provided in this Section, a period of creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 90 day period during all of which the individual was not covered under any creditable coverage.

~~For a federally eligible person who between December 1, 2002 and September 30, 2003 has either (1) been certified as eligible pursuant to the federal Trade Act of 2002, (2)~~

initially-been-paid-a-benefit-by-the-Pension-Benefit-Guaranty Corporation,-or-(3)-as-of-December-1,--2002,--been--receiving benefits--from--the--Pension-Benefit-Guaranty-Corporation-and who-has-qualified-health-insurance,-as-defined-by-the-federal Trade-Act-of-2002,-a-period-of-creditable-coverage--shall--be counted,--with--respect--to--qualifying-an-applicant-for-Plan coverage--as--a--federally--eligible--individual--under--this Section,-when-the-application-for-Plan-coverage-was--received by-the-Board.

For a federally eligible person who,-after-September-30, 2003, has either been certified as eligible pursuant to the federal Trade Act of 2002 or-initially-been-paid-a-benefit-by the---Pension--Benefit--Guaranty--Corporation, a period of creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 63 day period during all of which the individual was not covered under any creditable coverage.

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

(e) The Board shall offer a choice of health care coverages consistent with major medical coverage under the alternative health benefit plans authorized by this Section to every federally eligible individual. The coverages to be offered under the plans, the schedule of benefits, deductibles, co-payments, exclusions, and other limitations shall be approved by the Board. One optional form of coverage shall be comparable to comprehensive health

insurance coverage offered in the individual market in this State or a standard option of coverage available under the group or individual health insurance laws of the State. The standard benefit plan that is authorized by Section 8 of this Act may be used for this purpose. The Board may also offer a preferred provider option and such other options as the Board determines may be appropriate for these federally eligible individuals who qualify for Plan coverage pursuant to this Section.

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

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

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

(Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03; 93-34, eff. 6-23-03.)

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