



**94TH GENERAL ASSEMBLY**  
**State of Illinois**  
**2005 and 2006**  
**HB0197**

Introduced 01/13/05, by Rep. Carolyn H. Krause

**SYNOPSIS AS INTRODUCED:**

215 ILCS 105/7

from Ch. 73, par. 1307

Amends the Comprehensive Health Insurance Plan Act. Provides that a person is not eligible for coverage under the Comprehensive Health Insurance Plan if the person has or later receives benefits or funds from a settlement, judgment, or award resulting from an accident or injury and the remaining amount exceeds \$500,000 (rather than \$100,000).

LRB094 05352 LJB 35397 b

FISCAL NOTE ACT  
MAY APPLY

1 AN ACT concerning insurance.

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

4 Section 5. The Comprehensive Health Insurance Plan Act is  
5 amended by changing Section 7 as follows:

6 (215 ILCS 105/7) (from Ch. 73, par. 1307)

7 Sec. 7. Eligibility.

8 a. Except as provided in subsection (e) of this Section or  
9 in Section 15 of this Act, any person who is either a citizen  
10 of the United States or an alien lawfully admitted for  
11 permanent residence and who has been for a period of at least  
12 180 days and continues to be a resident of this State shall be  
13 eligible for Plan coverage under this Section if evidence is  
14 provided of:

15 (1) A notice of rejection or refusal to issue  
16 substantially similar individual health insurance coverage  
17 for health reasons by a health insurance issuer; or

18 (2) A refusal by a health insurance issuer to issue  
19 individual health insurance coverage except at a rate  
20 exceeding the applicable Plan rate for which the person is  
21 responsible.

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

27 b. The board shall promulgate a list of medical or health  
28 conditions for which a person who is either a citizen of the  
29 United States or an alien lawfully admitted for permanent  
30 residence and a resident of this State would be eligible for  
31 Plan coverage without applying for health insurance coverage  
32 pursuant to subsection a. of this Section. Persons who can

1 demonstrate the existence or history of any medical or health  
2 conditions on the list promulgated by the board shall not be  
3 required to provide the evidence specified in subsection a. of  
4 this Section. The list shall be effective on the first day of  
5 the operation of the Plan and may be amended from time to time  
6 as appropriate.

7 c. Family members of the same household who each are  
8 covered persons are eligible for optional family coverage under  
9 the Plan.

10 d. For persons qualifying for coverage in accordance with  
11 Section 7 of this Act, the board shall, if it determines that  
12 such appropriations as are made pursuant to Section 12 of this  
13 Act are insufficient to allow the board to accept all of the  
14 eligible persons which it projects will apply for enrollment  
15 under the Plan, limit or close enrollment to ensure that the  
16 Plan is not over-subscribed and that it has sufficient  
17 resources to meet its obligations to existing enrollees. The  
18 board shall not limit or close enrollment for federally  
19 eligible individuals.

20 e. A person shall not be eligible for coverage under the  
21 Plan if:

22 (1) He or she has or obtains other coverage under a  
23 group health plan or health insurance coverage  
24 substantially similar to or better than a Plan policy as an  
25 insured or covered dependent or would be eligible to have  
26 that coverage if he or she elected to obtain it. Persons  
27 otherwise eligible for Plan coverage may, however, solely  
28 for the purpose of having coverage for a pre-existing  
29 condition, maintain other coverage only while satisfying  
30 any pre-existing condition waiting period under a Plan  
31 policy or a subsequent replacement policy of a Plan policy.

32 (1.1) His or her prior coverage under a group health  
33 plan or health insurance coverage, provided or arranged by  
34 an employer of more than 10 employees was discontinued for  
35 any reason without the entire group or plan being  
36 discontinued and not replaced, provided he or she remains

1 an employee, or dependent thereof, of the same employer.

2 (2) He or she is a recipient of or is approved to  
3 receive medical assistance, except that a person may  
4 continue to receive medical assistance through the medical  
5 assistance no grant program, but only while satisfying the  
6 requirements for a preexisting condition under Section 8,  
7 subsection f. of this Act. Payment of premiums pursuant to  
8 this Act shall be allocable to the person's spenddown for  
9 purposes of the medical assistance no grant program, but  
10 that person shall not be eligible for any Plan benefits  
11 while that person remains eligible for medical assistance.  
12 If the person continues to receive or be approved to  
13 receive medical assistance through the medical assistance  
14 no grant program at or after the time that requirements for  
15 a preexisting condition are satisfied, the person shall not  
16 be eligible for coverage under the Plan. In that  
17 circumstance, coverage under the plan shall terminate as of  
18 the expiration of the preexisting condition limitation  
19 period. Under all other circumstances, coverage under the  
20 Plan shall automatically terminate as of the effective date  
21 of any medical assistance.

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

27 (4) The person fails to pay the required premium under  
28 the covered person's terms of enrollment and  
29 participation, in which event the liability of the Plan  
30 shall be limited to benefits incurred under the Plan for  
31 the time period for which premiums had been paid and the  
32 covered person remained eligible for Plan coverage.

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

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

36 (7) The person's premium is paid for or reimbursed

1 under any government sponsored program or by any government  
2 agency or health care provider, except as an otherwise  
3 qualifying full-time employee, or dependent of such  
4 employee, of a government agency or health care provider  
5 or, except when a person's premium is paid by the U.S.  
6 Treasury Department pursuant to the federal Trade Act of  
7 2002.

8 (8) The person has or later receives other benefits or  
9 funds from any settlement, judgement, or award resulting  
10 from any accident or injury, regardless of the date of the  
11 accident or injury, or any other circumstances creating a  
12 legal liability for damages due that person by a third  
13 party, whether the settlement, judgment, or award is in the  
14 form of a contract, agreement, or trust on behalf of a  
15 minor or otherwise and whether the settlement, judgment, or  
16 award is payable to the person, his or her dependent,  
17 estate, personal representative, or guardian in a lump sum  
18 or over time, so long as there continues to be benefits or  
19 assets remaining from those sources in an amount in excess  
20 of \$500,000 ~~\$100,000~~.

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

34 f. The board or the administrator shall require  
35 verification of residency and may require any additional  
36 information or documentation, or statements under oath, when

1 necessary to determine residency upon initial application and  
2 for the entire term of the policy.

3 g. Coverage shall cease (i) on the date a person is no  
4 longer a resident of Illinois, (ii) on the date a person  
5 requests coverage to end, (iii) upon the death of the covered  
6 person, (iv) on the date State law requires cancellation of the  
7 policy, or (v) at the Plan's option, 30 days after the Plan  
8 makes any inquiry concerning a person's eligibility or place of  
9 residence to which the person does not reply.

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

15 (Source: P.A. 93-33, eff. 6-23-03; 93-34, eff. 6-23-03.)