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Rep. Karen May

Filed: 3/15/2005

1 AMENDMENT TO HOUSE BILL 1603

2 AMENDMENT NO. ______. Amend House Bill 1603 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Comprehensive Health Insurance Plan Act is
5 amended by changing Sections 2 and 4 and by adding Section 16
6 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 of
19 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 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 the individual has been certified as eligible pursuant to the federal Trade Act of 2002, a break of more than 63 days during all of which the individual was not covered under any of items (A) through (K) above.

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.

1 "Eligible person" means a resident of this State who
2 qualifies for Plan coverage under Section 7 of this Act.
3 "Employee" means a resident of this State who is employed
4 by an employer or has entered into the employment of or works
5 under contract or service of an employer including the
6 officers, managers and employees of subsidiary or affiliated
7 corporations and the individual proprietors, partners and
8 employees of affiliated individuals and firms when the business
9 of the subsidiary or affiliated corporations, firms or
10 individuals is controlled by a common employer through stock
11 ownership, contract, or otherwise.
12 "Employer" means any individual, partnership, association,
13 corporation, business trust, or any person or group of persons
14 acting directly or indirectly in the interest of an employer in
15 relation to an employee, for which one or more persons is
16 gainfully employed.
17 "Family" coverage means the coverage provided by the Plan
18 for the covered person and his or her eligible dependents who
19 also are covered persons.
20 "Federally eligible individual" means an individual
21 resident of this State:
22 (1)(A) for whom, as of the date on which the individual
23 seeks Plan coverage under Section 15 of this Act, the
24 aggregate of the periods of creditable coverage is 18 or
25 more months or, if the individual has been certified as
26 eligible pursuant to the federal Trade Act of 2002, 3 or
27 more months, and (B) whose most recent prior creditable
28 coverage was under group health insurance coverage offered
29 by a health insurance issuer, a group health plan, a
30 governmental plan, or a church plan (or health insurance
31 coverage offered in connection with any such plans) or any
32 other type of creditable coverage that may be required by
33 the federal Health Insurance Portability and
34 Accountability Act of 1996, as it may be amended, or the

1 regulations under that Act;
2 (2) who is not eligible for coverage under (A) a group
3 health plan (other than an individual who has been
4 certified as eligible pursuant to the federal Trade Act of
5 2002), (B) part A or part B of Medicare due to age (other
6 than an individual who has been certified as eligible
7 pursuant to the federal Trade Act of 2002), or (C) medical
8 assistance, and does not have other health insurance
9 coverage (other than an individual who has been certified
10 as eligible pursuant to the federal Trade Act of 2002);
11 (3) with respect to whom (other than an individual who
12 has been certified as eligible pursuant to the federal
13 Trade Act of 2002) the most recent coverage within the
14 coverage period described in paragraph (1)(A) of this
15 definition was not terminated based upon a factor relating
16 to nonpayment of premiums or fraud;
17 (4) if the individual (other than an individual who has
18 been certified as eligible pursuant to the federal Trade
19 Act of 2002) had been offered the option of continuation
20 coverage under a COBRA continuation provision or under a
21 similar State program, who elected such coverage; and
22 (5) who, if the individual elected such continuation
23 coverage, has exhausted such continuation coverage under
24 such provision or program.
25 However, an individual who has been certified as eligible
26 pursuant to the federal Trade Act of 2002 shall not be required
27 to elect continuation coverage under a COBRA continuation
28 provision or under a similar state program.
29 "Group health insurance coverage" means, in connection
30 with a group health plan, health insurance coverage offered in
31 connection with that plan.
32 "Group health plan" has the same meaning given that term in
33 the federal Health Insurance Portability and Accountability
34 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

1 comparable conditions and requirements in effect in the state
2 in which it is located, or the University of Illinois Hospital
3 as defined in the University of Illinois Hospital Act.
4 "Individual health insurance coverage" means health
5 insurance coverage offered to individuals in the individual
6 market, but does not include short-term, limited-duration
7 insurance.
8 "Insured" means any individual resident of this State who
9 is eligible to receive benefits from any insurer (including
10 health insurance coverage offered in connection with a group
11 health plan) or health insurance issuer as defined in this
12 Section.
13 "Insurer" means any insurance company authorized to
14 transact health insurance business in this State and any
15 corporation that provides medical services and is organized
16 under the Voluntary Health Services Plans Act or the Health
17 Maintenance Organization Act.
18 "Medical assistance" means the State medical assistance or
19 medical assistance no grant (MANG) programs provided under
20 Title XIX of the Social Security Act and Articles V (Medical
21 Assistance) and VI (General Assistance) of the Illinois Public
22 Aid Code (or any successor program) or under any similar
23 program of health care benefits in a state other than Illinois.
24 "Medically necessary" means that a service, drug, or supply
25 is necessary and appropriate for the diagnosis or treatment of
26 an illness or injury in accord with generally accepted
27 standards of medical practice at the time the service, drug, or
28 supply is provided. When specifically applied to a confinement
29 it further means that the diagnosis or treatment of the covered
30 person's medical symptoms or condition cannot be safely
31 provided to that person as an outpatient. A service, drug, or
32 supply shall not be medically necessary if it: (i) is
33 investigational, experimental, or for research purposes; or
34 (ii) is provided solely for the convenience of the patient, the

1 patient's family, physician, hospital, or any other provider;
2 or (iii) exceeds in scope, duration, or intensity that level of
3 care that is needed to provide safe, adequate, and appropriate
4 diagnosis or treatment; or (iv) could have been omitted without
5 adversely affecting the covered person's condition or the
6 quality of medical care; or (v) involves the use of a medical
7 device, drug, or substance not formally approved by the United
8 States Food and Drug Administration.
9 "Medical care" means the ordinary and usual professional
10 services rendered by a physician or other specified provider
11 during a professional visit for treatment of an illness or
12 injury.
13 "Medicare" means coverage under both Part A and Part B of
14 Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395, et
15 seq.
16 "Minimum premium plan" means an arrangement whereby a
17 specified amount of health care claims is self-funded, but the
18 insurance company assumes the risk that claims will exceed that
19 amount.
20 "Participating transplant center" means a hospital
21 designated by the Board as a preferred or exclusive provider of
22 services for one or more specified human organ or tissue
23 transplants for which the hospital has signed an agreement with
24 the Board to accept a transplant payment allowance for all
25 expenses related to the transplant during a transplant benefit
26 period.
27 "Physician" means a person licensed to practice medicine
28 pursuant to the Medical Practice Act of 1987.
29 "Plan" means the Comprehensive Health Insurance Plan
30 established by this Act.
31 "Plan of operation" means the plan of operation of the
32 Plan, including articles, bylaws and operating rules, adopted
33 by the board pursuant to this Act.
34 "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.

"Qualifying small employer" means an employer with at least 2 but not more than 50 employees. A qualifying small employer (i) shall not have had group health insurance coverage in effect during the 12-month period prior to application for a qualifying group health insurance contract and (ii) shall have at least 30% of its eligible employees receiving annual wages from the employer at a level equal to or less than $30,000. The wage requirement set forth in item (ii) shall be adjusted periodically by the board.

"Qualifying group health insurance contract" means a group health insurance contract purchased from a health insurance issuer by a qualifying small employer. The contract shall cover the benefits determined by the board in accordance with subsection (b) of Section 16 of this Act and shall insure not fewer than 75% of the employees eligible for coverage. At the option of the qualifying small employer, the benefits of the qualifying group health insurance contract may exclude outpatient prescription drugs that by law require a prescription written by a physician licensed to practice medicine in all its branches.

"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; 93-622, eff. 12-18-03.)

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

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

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Director, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions including, without limitation, utilization review and quality assurance programs, or with health maintenance organizations or preferred provider organizations for the provision of health care services.

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

c. Take such legal action as necessary to:

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

1 (2) to recover any amounts erroneously or improperly
2 paid by the plan;
3 (3) to recover any amounts paid by the plan as a result
4 of a mistake of fact or law; or
5 (4) to recover or collect any other amounts, including
6 assessments, that are due or owed the Plan or have been
7 billed on its or the Plan's behalf.
8 d. Establish appropriate rates, rate schedules, rate
9 adjustments, expense allowances, agents' referral fees, claim
10 reserves, and formulas and any other actuarial function
11 appropriate to the operation of the plan. Rates and rate
12 schedules may be adjusted for appropriate risk factors such as
13 age and area variation in claim costs and shall take into
14 consideration appropriate risk factors in accordance with
15 established actuarial and underwriting practices.
16 e. Issue policies of insurance in accordance with the
17 requirements of this Act.
18 f. Appoint appropriate legal, actuarial and other
19 committees as necessary to provide technical assistance in the
20 operation of the plan, policy and other contract design, and
21 any other function within the authority of the plan.
22 g. Borrow money to effect the purposes of the Illinois
23 Comprehensive Health Insurance Plan. Any notes or other
24 evidence of indebtedness of the plan not in default shall be
25 legal investments for insurers and may be carried as admitted
26 assets.
27 h. Establish rules, conditions and procedures for
28 reinsuring risks under this Act.
29 i. Employ and fix the compensation of employees. Such
30 employees may be paid on a warrant issued by the State
31 Treasurer pursuant to a payroll voucher certified by the Board
32 and drawn by the Comptroller against appropriations or trust
33 funds held by the State Treasurer.
34 j. Enter into intergovernmental cooperation agreements

with other agencies or entities of State government for the purpose of sharing the cost of providing health care services that are otherwise authorized by this Act for children who are both plan participants and eligible for financial assistance from the Division of Specialized Care for Children of the University of Illinois.

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

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

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

(A) premiums paid on behalf of covered persons;

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

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

(D) interest earnings from investment of the funds in the Plan Fund or any of its accounts other than the funds in the account established under item 2 of this subsection;

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

(A) premiums paid on behalf of covered persons;

1 (B) assessments and other revenues collected or
2 received by the Board;
3 (C) reserves for future losses maintained by the
4 Board; and
5 (D) interest earnings from investment of the
6 federally eligible individuals account funds; and
7 (E) grants provided pursuant to the federal Trade
8 Act of 2002; and
9 (3) such other accounts as may be appropriate,
10 including, but not limited to, accounts to fund the
11 administrative, claim, and other expenses of the Plan
12 associated with the Small Employer Group Health Insurance
13 Program established in accordance with Section 16 of this
14 Act.
15 m. Charge and collect assessments paid by insurers pursuant
16 to Section 12 of this Act and recover any assessments for, on
17 behalf of, or against those insurers.
18 (Source: P.A. 93-33, eff. 6-23-03; 93-34, eff. 6-23-03.)

19 (215 ILCS 105/16 new)
20 Sec. 16. Small Employer Group Health Insurance Program.
21 (a) On or after July 1, 2007 and subject to appropriation,
22 the board shall establish the Small Employer Group Health
23 Insurance Program. The purpose of the Program is to make
24 qualifying group health insurance contracts available to
25 qualifying small employers. The Program is designed to
26 encourage small employers to offer health insurance coverage to
27 their employees.
28 Participation in the Program by insurers is limited to
29 health insurance issuers offering qualifying group health
30 insurance contracts. Agents for health insurance issuers shall
31 receive a referral fee of $50 for each qualifying group health
32 insurance contract issued.
33 (b) For qualifying group health insurance contracts made

1 available under the Program, the board shall determine
2 benefits, limitations, exclusions, deductibles, coinsurance
3 payments, and other policy terms and conditions in accordance
4 with appropriate actuarial principles and the requirements of
5 this Act.
6 (c) The board shall establish a fund from which a health
7 insurance issuer may receive reimbursement for claims paid by
8 the health insurance issuer for persons covered under
9 qualifying group health insurance contracts to the extent funds
10 are available therefor. The fund shall be known as the "small
11 employer stop loss fund".
12 (d) Beginning on July 1, 2007, health insurance issuers
13 shall be eligible to receive reimbursement for 90% of the value
14 of claims paid between $30,000 and $100,000 in a calendar year
15 for any person covered under a qualifying group health
16 insurance contract to the extent funds are available therefor.
17 Claims paid for persons covered under qualifying group
18 health insurance contracts shall be reimbursable from the small
19 employer stop loss fund. Claims shall be reported and funds
20 shall be distributed from the small employer stop loss fund on
21 a calendar year basis. Claims shall be eligible for
22 reimbursement only for the calendar year in which the claims
23 are paid. Once claims paid on behalf of a claimant reach or
24 exceed $100,000 in a given calendar year, no further claims
25 paid on behalf of the claimant in that calendar year shall be
26 eligible for reimbursement.
27 (e) The board shall adopt rules that set forth procedures
28 for the operation of the small employer stop loss fund.".