LRB09410015LJB40273b

94TH GENERAL ASSEMBLY

State of Illinois

2005 and 2006

HB3878

Introduced 2/28/2005, by Rep. Elizabeth Coulson

SYNOPSIS AS INTRODUCED:

New Act

Creates the Health Insurance Alliance Act. Establishes the Illinois Health Insurance Alliance as a nonprofit public corporation for the purpose of providing increased access to health insurance for small employers in Illinois. Provides that the members of the Alliance shall be insurance companies authorized to do business in this State as a condition of their authority to offer health insurance. Authorizes a board of directors elected by the members and including the Secretary of Financial and Professional Regulation as the chairperson and a nonvoting member. Requires the submission of a plan of operation by the board to the Secretary. Sets forth powers and duties of the board. Requires certain approved health plans to be approved by the board and offered by the Alliance. Provides that members offering approved health plans are to be reinsured for certain losses by the Alliance. Requires members to pay an assessment to the Alliance for net reinsurance and administrative losses and allows the board to defer the payment if the payment would endanger the ability of the member to fulfill contractual obligations. Requires all members to pay an initial assessment of $500. Provides for the selection and duties of an alliance administrator. Provides criteria for eligibility for an approved health plan for employers and individuals. Requires members to provide notice of the Alliance to certain small employers. Sets forth general benefits, deductible, co-insurance, and out-of-pocket payment guidelines. Requires renewability of the health plan except for nonpayment of premiums, fraud, or termination of the approved health plan (except that the individual has the right to transfer to another approved health plan in the case of termination). Requires the Secretary to adopt rules to provide for disclosure of the availability of health insurance from the Alliance and to carry out the provisions of the Act. Provides that the participation of members in carrying out the provisions of the Act may not be a basis of any legal action against the members. Requires the Alliance to determine a standard risk rate index. Provides that the Alliance is the last payor of benefits. Requires the Department of Financial and Professional Regulation, in cooperation with the Alliance, to develop a plan to provide health insurance coverage to uninsured children, individuals, and other employers.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

Section 1. Short title. This Act may be cited as the Health Insurance Alliance Act.

Section 5. Purpose. The purpose of the Health Insurance Alliance Act is to provide increased access to voluntary health insurance coverage for small employer groups in Illinois. An additional purpose of the Health Insurance Alliance Act is to provide for access to voluntary health insurance coverage for individuals in the individual market who have met eligibility criteria established by this Act.

Section 10. Definitions. As used in this Act, the following words have the following meanings:

"Alliance" means the Illinois Health Insurance Alliance.

"Approved health plan" means any arrangement for the provision of health insurance offered through and approved by the Alliance.

"Board" means the board of directors of the Alliance.

"Child" means a dependent unmarried individual who is less than 25 years of age.

"Creditable coverage" means, with respect to an individual, coverage of the individual pursuant to:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the federal Social Security Act;

(4) Title 19 of the federal Social Security Act, except coverage consisting solely of benefits pursuant to Section 1928 of that Title;

(5) Chapter 55 of Title 10 of the United States Code;

(6) a medical care program of the Indian Health Service or of an Indian nation or tribe;

(7) a health plan offered pursuant to Chapter 89 of Title 5 of the United States Code;

(8) a public health plan as defined in federal regulations; or

(9) a health benefit plan offered pursuant to subsection (e) of Section 5 of the federal Peace Corps Act.

"Department" means the Department of Financial and Professional Regulation.

"Director" means an individual who serves on the board.

"Earned premiums" means premiums paid or due during a calendar year for coverage under an approved health plan less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year.

"Eligible expenses" means the allowable charges for a health care service covered under an approved health plan.

"Eligible individual" means an individual who (i) as of the date of the individual's application for coverage under an approved health plan, has an aggregate of 18 or more months of creditable coverage, the most recent of which was under a group health plan, governmental plan, or church plan or health insurance offered in connection with any of those plans, but for the purposes of aggregating creditable coverage, a period of creditable coverage shall not be counted with respect to enrollment of an individual for coverage under an approved health plan if, after that period and before the enrollment date, there was a 63-day or longer period during all of which the individual was not covered under any creditable coverage, or (ii) is entitled to continuation coverage pursuant to Section 95 of this Act. "Eligible individual" does not include an individual who (A) has or is eligible for coverage under a group health plan, (B) is eligible for coverage under Medicare or a State plan under Title 19 of the federal Social Security Act or any successor program, (C) during the most recent

coverage within the coverage period described in item (i) of this definition, was terminated from coverage as a result of nonpayment of premium or fraud, or (D) has been offered the option of coverage under a COBRA continuation provision, as that term is defined under Section 5 of the Illinois Health Insurance Portability and Accountability Act, or under a similar State program and did not exhaust the coverage available under the offered program.

"Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for that enrollment.

"Gross earned premiums" means premiums paid or due during a calendar year for all health insurance written in the State less any unearned premiums at the end of that calendar year plus any unearned premiums from the end of the immediately preceding calendar year.

"Group health plan" means an employee welfare benefit plan to the extent the plan provides hospital, surgical, or medical expense benefits to employees or their dependents, as defined by the terms of the plan, directly through insurance, reimbursement, or otherwise.

"Health care service" means a service or product furnished to an individual for the purpose of preventing, alleviating, curing, or healing human illness or injury and includes services and products incidental to furnishing the described services or products.

"Health insurance" means any hospital and medical expense-incurred policy; nonprofit health care plan service contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity, specified disease policy or disability income insurance contracts, and limited health benefit or credit health insurance; coverage for health care services under uninsured arrangements of group or group-type contracts, including employer self-insured,

cost-plus, or other benefit methodologies not involving insurance; coverage for health care services under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; or coverage by Medicare or other governmental programs providing health care services. "Health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or a similar law, automobile medical payment insurance, or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy.

"Health maintenance organization" means a health maintenance organization as defined in Section 1-2 of the Health Maintenance Organization Act.

"Incurred claims" means claims paid during a calendar year plus claims incurred in the calendar year and paid prior to April 1 of the succeeding year, less claims incurred previous to the calendar year and paid prior to April 1 of the calendar year.

"Insured" means a small employer or its employee and an individual covered by an approved health plan, a former employee of a small employer who is covered by an approved health plan through conversion, or an individual covered by an approved health plan that allows individual enrollment.

"Medicare" means coverage under both Parts A and B of Title 18 of the federal Social Security Act.

"Member" means a member of the Alliance.

"Premiums" means the premiums received for coverage under an approved health plan during a calendar year.

"Small employer" means a person that is a resident of this State, has employees at least 50% of whom are residents of this State, is actively engaged in business and that on at least 50% of its working days during either of the 2 preceding calendar years, employed no fewer than 2 and no more than 50 eligible employees, provided that:

(1) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer's discretion, be counted as a separate employee;

(2) companies that are affiliated companies or that are eligible to file a combined tax return for purposes of State income taxation shall be considered one employer; and

(3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year.

"Secretary" means the Secretary of Financial and Professional Regulation.

"Total premiums" means the total premiums for business written in the State received during a calendar year.

"Unearned premiums" means the portion of a premium previously paid for which the coverage period is in the future.

Section 15. Alliance created; board created.

(a) The Illinois Health Insurance Alliance is created as a nonprofit public corporation for the purpose of providing increased access to health insurance in the State. All insurance companies authorized to transact health insurance business in this State, nonprofit health care plans, health maintenance organizations, and self-insurers not subject to federal preemption shall organize and be members of the Alliance as a condition of their authority to offer health insurance in this State, except for an insurance company that is organized under the Dental Service Plan Act or a company that is solely engaged in the sale of dental insurance and is licensed under a provision of the Illinois Insurance Code.

(b) The Alliance shall be governed by a board of directors constituted pursuant to the provisions of this Section. The board is a governmental entity for purposes of the Local Governmental and Governmental Employees Tort Immunity Act, but

neither the board nor the Alliance shall be considered a governmental entity for any other purpose.

(c) The Secretary shall, within 60 days after July 1, 2006, give notice to all members of the time and place for the initial organizational meeting of the Alliance. Each member shall be entitled to one vote in person or by proxy at the organizational meeting.

(d) The Alliance shall operate subject to the supervision and approval of the board. The board shall consist of:

(1) five directors, elected by the members, who shall be officers or employees of members and shall consist of one representative of a nonprofit health care plan, 2 representatives of health maintenance organizations, and 2 representatives of other types of members;

(2) five directors, appointed by the Governor, who shall be officers, general partners, or proprietors of small employers;

(3) four directors appointed by the Governor, who shall be employees of small employers; and

(4) the Secretary or his or her designee, who shall be a nonvoting member, except when his or her vote is necessary to break a tie.

(e) The Secretary shall serve as chairperson of the board unless he or she declines, in which event he or she shall appoint the chairperson.

(f) The directors elected by the members shall be elected for initial terms of 3 years or less, staggered so that the term of at least one director expires on June 30 of each year. The directors appointed by the Governor shall be appointed for initial terms of 3 years or less, staggered so that the term of at least one director expires on June 30 of each year. Following the initial terms, directors shall be elected or appointed for terms of 3 years. A director whose term has expired shall continue to serve until his or her successor is elected or appointed and qualified.

(g) Whenever a vacancy on the board occurs, the electing or

appointing authority of the position that is vacant shall fill the vacancy by electing or appointing an individual to serve the balance of the unexpired term, except that when a vacancy occurs in one of the director's positions elected by the members, the Secretary is authorized to appoint a temporary replacement director until the next scheduled election of directors elected by the members is held. The individual elected or appointed to fill a vacancy shall meet the requirements for initial election or appointment to that position.

(h) Directors shall serve without compensation, but shall be reimbursed for necessary travel expenses incurred in the performance of their duties.

Section 20. Plan of operation.

(a) The board shall submit a plan of operation to the Secretary and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the Alliance.

(b) The Secretary shall, after notice and hearing, approve the plan of operation if it is determined to assure the fair, reasonable, and equitable administration of the Alliance. The plan of operation shall become effective upon written approval of the Secretary consistent with the date on which health insurance coverage through the Alliance pursuant to the provisions of this Act is made available. A plan of operation adopted by the Secretary shall continue in force until modified by him or superseded by a subsequent plan of operation submitted by the board and approved by the Secretary.

(c) The plan of operation shall:

(1) establish procedures for the handling and accounting of assets of the Alliance;

(2) establish regular times and places for meetings of the board;

(3) establish procedures for records to be kept of all financial transactions and for annual fiscal reporting to

the Secretary;

(4) establish the amount of and the method for collecting assessments pursuant to Section 50 of this Act;

(5) establish a program to publicize the existence of the Alliance, the approved health plans, and the eligibility requirements and procedures for enrollment in an approved health plan and to maintain public awareness of the Alliance;

(6) establish penalties for nonpayment of assessments by members;

(7) establish procedures for alternative dispute resolution of disputes between members and insureds; and

(8) contain additional provisions necessary and proper for the execution of the powers and duties of the Alliance.

Section 25. Board; powers and duties.

(a) The board shall have the general powers and authority granted to insurance companies licensed to transact a health insurance business under the laws of this State.

(b) The board:

(1) May enter into contracts to carry out the provisions of this Act, including, with the approval of the Secretary, contracting with similar alliances of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) May sue and be sued.

(3) May conduct periodic audits of the members to assure the general accuracy of the financial data submitted to the Alliance.

(4) Shall establish maximum rate schedules, allowable rate adjustments, administrative allowances, reinsurance premiums and agent referral, servicing fees, or commissions subject to applicable provisions in the Illinois Insurance Code. In determining the initial year's rate for health insurance, the only rating factors that may

be used are age, gender, geographic area of the place of employment, and smoking practices. In any year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than 20% of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than 250% of the lower rate, except that the rates for children under the age of 19 may be lower than the bottom rates in the 250% band. The rating factor restrictions shall not prohibit a member from offering rates that differ depending upon family composition.

(5) May direct a member to issue policies or certificates of coverage of health insurance in accordance with the requirements of this Act.

(6) Shall establish procedures for alternative dispute resolution of disputes between members and insureds.

(7) Shall cause the Alliance to have an annual audit of its operations by an independent certified public accountant.

(8) Shall conduct all board meetings as if it were subject to the provisions of the Open Meetings Act.

(9) Shall draft one or more sample health insurance policies that are the prototype documents for the members.

(10) Shall determine the design criteria to be met for an approved health plan.

(11) Shall review each proposed approved health plan to determine if it meets the Alliance designed criteria and, if it does meet the criteria, approve the plan, except that the board shall not permit more than one approved health plan per member for each set of plan design criteria.

(12) Shall review annually each approved health plan to determine if it still qualifies as an approved health plan based on the Alliance-designed criteria and, if the plan is no longer approved, arrange for the transfer of the insureds covered under the formerly approved plan to an

approved health plan.

(13) May terminate an approved health plan not operating as required by the board.

(14) Shall terminate an approved health plan if timely claim payments are not made pursuant to the plan.

(15) Shall engage in significant marketing activities, including a program of media advertising, to inform small employers and eligible individuals of the existence of the Alliance, its purpose, and the health insurance available or potentially available through the Alliance.

(c) The Alliance is subject to and responsible for examination by the Secretary. No later than March 1 of each year, the board shall submit to the Secretary an audited financial report for the preceding calendar year in a form approved by the Secretary.

Section 30. Policy forms. All policy forms of approved health plans shall conform in substance to prototype forms developed by the Alliance and shall be filed with and approved by the Secretary before they are issued.

Section 35. Approved health plan.

(a) An approved health plan shall conform to the Alliance's approved health plan design criteria. The board may allow more than one plan design for approved health plans. A member may provide one approved health plan for each plan design approved by the board.

(b) The board shall designate plan designs for approved health plans. The board may designate plan designs for an approved health plan that provides catastrophic coverage or other benefit plan designs.

(c) Each approved health plan shall offer a premium that is no greater than 15% over and no less than 15% under the average of the standard rate index for plans with the same characteristics.

(d) Each approved health plan offered to an eligible

individual shall offer a premium that is no more than 25% over and no less than 25% under the average of the standard risk rate index determined pursuant to Section 110 of this Act.

(e) Any member that provides or offers to renew a group health insurance contract providing health insurance benefits to employees of the State, a county, a municipality, or a school district for which public funds are contributed shall offer at least one approved health plan to small employers and eligible individuals, except that if a member does not offer anywhere in the United States a plan that meets substantially the design criteria of an approved health plan, the member shall not be required to offer an approved health plan.

(f) If a plan design approved by the board is not offered by any member already offering an approved health plan, but a member offers a substantially similar plan design outside the Alliance, the board may require the member to offer that plan design as an approved health plan through the Alliance.

(g) A member required to offer and offering an approved health plan pursuant to the requirement of subsection (e) shall continue to offer that plan for 5 consecutive years after the date the member was last required to offer the plan. A member offering an approved health plan but not required to offer it pursuant to subsection (e) may withdraw the plan but shall continue to offer it for 5 consecutive years after the date notice of future withdrawal is given to the board unless (i) the member substitutes another approved health plan for the plan withdrawn or (ii) the board allows the plan to be withdrawn because it imposes a serious hardship upon the member.

(h) No member may be required to offer an approved health plan if the member notifies the Secretary in writing that it will no longer offer health insurance, life insurance, or annuities in the State, except for renewal of existing contracts, if:

(1) the member does not offer or provide health insurance, life insurance, or annuities for a period of 5

years from the date of notification to the Secretary to any person in the State who is not covered by the member through a health insurance policy in effect on the date of the notification; and

(2) with respect to health or life insurance policies or annuities in effect on the date of notification to the Secretary, the member continues to comply with all applicable laws and rules governing the provision of insurance in this State, including the payment of applicable taxes, fees, and assessments.

Section 40. Reinsurance.

(a) A member offering an approved health plan shall be reinsured for certain losses by the Alliance. Within 6 months following the end of each calendar year in which the member offering the approved health plan paid more in incurred claims, plus the member's reinsurance premium pursuant to subsection (b), than 75% of earned premiums received by the member on all approved health plans issued by the member, the member shall receive from the Alliance the excess amount for the calendar year by which the incurred claims and reinsurance premium exceeded 75% percent of the earned premiums received by the Alliance or its administrator.

(b) The Alliance shall withhold from all premiums that it receives a reinsurance premium as established by the board:

(1) For insured small employer groups, the reinsurance premium shall not exceed 5% of premiums paid by insured groups in the first year of coverage and shall not exceed 10% of premiums for renewal years.

(2) For eligible individuals, the reinsurance premium shall not exceed 10% of premiums paid by individuals in the first year of coverage or continuation coverage and shall not exceed 15% of premiums paid by individuals for renewal years. In determining the reinsurance premium for a particular calendar year, the board shall set the reinsurance premium at a rate that will recover the total

reinsurance loss for the preceding year over a reasonable number of years in accordance with sound actuarial principles.

Section 45. Administration. The Alliance shall deduct from premiums collected for approved health plans an administrative charge as set by the board. The administrative charge shall be determined before the beginning of each calendar year:

(1) for insured small employer groups, the maximum administrative charge the Alliance may charge is 10% of premiums in the first year and 5% of premiums in renewal years; and

(2) for eligible individuals, the maximum administrative charge the Alliance may charge in any year is 10% of premiums.

Section 50. Assessments.

(a) After the completion of each calendar year, the Alliance shall assess all its members for the net reinsurance loss in the previous calendar year and for the net administrative loss that occurred in the previous calendar year, taking into account investment income for the period and other appropriate gains and losses using the following definitions:

(1) Net reinsurance losses shall be the amount determined for the previous calendar year in accordance with subsection (a) of Section 40 of this Act for all members offering an approved health plan reduced by reinsurance premiums charged by the Alliance in the previous calendar year. Net reinsurance losses shall be calculated separately for group and individual coverage. If the reinsurance premiums for either category of coverage exceed the amount calculated in accordance with subsection (a) of Section 40 of this Act, the premiums shall be applied first to offset the net reinsurance losses incurred in the other category of coverage and second to offset

administrative losses.

(2) Net administrative losses shall be the administrative expenses incurred by the Alliance in the previous calendar year and projected for the current calendar year less the sum of administrative allowances received by the Alliance, but in the event of an administrative gain, net administrative losses for the purpose of assessments shall be considered zero and the gain shall be carried forward to the administrative fund for the next calendar year as an additional allowance.

(b) The assessment for each member shall be determined by multiplying the total losses of the Alliance's operation, as defined in subsection (a) of this Section, by a fraction, the numerator of which is an amount equal to that member's total premiums or the equivalent, exclusive of premiums received by the member for an approved health plan for health insurance written in the State during the preceding calendar year, and the denominator of which equals the total premiums of all health insurance written in the State during the preceding calendar year exclusive of premiums for approved health plans, except that total premiums shall not include payments by the Secretary of Human Services pursuant to a contract issued under Section 1876 of the federal Social Security Act, total premiums exempted by the federal Employee Retirement Income Security Act of 1974, or federal government programs.

(c) If assessments exceed actual reinsurance losses and administrative losses of the Alliance, the excess shall be held at interest by the board to offset future losses.

(d) To enable the board to properly determine the net reinsurance amount and its responsibility for reinsurance to each member, (i) by April 15 of each year, each member offering an approved health plan shall submit a listing of all incurred claims for the previous year and (ii) by April 15 of each year, each member shall submit a report that includes the total earned premiums received during the prior year less the total earned premiums exempted by federal government programs.

(e) The Alliance shall notify each member of the amount of its assessment due by May 15 of each year. The assessment shall be paid by the member by June 15 of each year.

(f) The proportion of participation of each member in the Alliance shall be determined annually by the board, based on annual statements filed by each member and other reports deemed necessary by the board. Any deficit incurred by the Alliance shall be recouped by assessments apportioned among the members pursuant to the formula provided in subsection (b) of this Section.

(g) The board may defer, in whole or in part, the payment of an assessment of a member if, in the opinion of the board, after approval of the Secretary, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event payment of an assessment against a member is deferred, the amount deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (a) of this Section. The member receiving the deferment shall pay the assessment in full plus interest at the prevailing rate as determined by rule of the Secretary within 4 years from the date payment is deferred. After 4 years but within 5 years of the date of the deferment, the board may sue to recover the amount of the deferred payment plus interest and costs. Board actions to recover deferred payments brought after 5 years of the date of deferment are barred. Any amount received shall be deducted from future assessments or reimbursed pro rata to the members paying the deferred assessment.

Section 55. Initial administrative assessment. Following the Secretary's approval or adoption of the plan of operations, the board may impose an initial assessment of $500 on each member. New members shall also be subject to the initial assessment. These funds shall not be considered as income to offset any administrative expenses in future assessments. Additional expenses to establish and to operate the Alliance

shall first be assessed following the first calendar year of operation of the Alliance.

Section 60. Alliance administrator.

(a) The board may select an Alliance administrator through a competitive request for proposal process. The board shall evaluate proposals based on criteria established by the board, which shall include (i) proven ability to administer health insurance programs, (ii) an estimate of total charges for administering the Alliance for the proposed contract period, and (iii) the ability to administer the Alliance in a cost-efficient manner.

(b) The Alliance administrator contract shall be for a period of up to 4 years, subject to annual renegotiation of the fees and services, and shall provide for cancellation of the contract for cause, termination of the Alliance by law of the General Assembly, or the combining of the Alliance with a governmental body.

(c) At least one year prior to the expiration of an Alliance administrator contract, the board may invite all interested parties, including the current administrator, to submit proposals to serve as Alliance administrator for a succeeding contract period. Selection of the administrator for a succeeding contract period shall be made at least 6 months prior to the expiration of the current contract.

(d) The Alliance administrator shall:

(1) Take applications for an approved health plan from small employers or a referring agent.

(2) Establish a premium billing procedure for collection of premiums from insureds. Billings shall be made on a periodic basis, not less than monthly, as determined by the board.

(3) Pay the member that offers an approved health plan the net premium due after deduction of reinsurance and administrative allowances.

(4) Provide each member with any changes in the status

of insureds.

(5) Perform all necessary functions to ensure that each member is providing timely payment of benefits to individuals covered under an approved health plan, including, but not limited to:

(A) making information available to insureds relating to the proper manner of submitting a claim for benefits to the member offering the approved health plan and distributing forms on which submissions shall be made; and

(B) making information available on approved health plan benefits and rates to insureds.

(6) Submit regular reports to the board regarding the operation of the Alliance, the frequency, content, and form of which shall be determined by the board.

(7) Following the close of each fiscal year, determine premiums of members, the expense of administration, and the paid and incurred health care service charges for the year and report this information to the board and the Secretary on a form prescribed by the Secretary.

(8) Establish the premiums for reinsurance and the administrative charges, subject to approval of the board.

(e) The board may require members issuing policies through the Alliance to perform, subject to the oversight of the board, any or all of the administrative functions of the Alliance related to enrollment, billing, or other activity that members regularly perform in the normal course of business. Members shall be required to submit regular reports to the board of such activities, as specified by the board. Members performing these functions shall not be entitled to receive any portion of the administrative assessment or any other payment from the Alliance for performing the services.

Section 65. Eligibility; guaranteed issue; plan provisions.

(a) A small employer is eligible for an approved health

plan if on the effective date of coverage or renewal (i) at least 50% of its employees not otherwise insured elect to be covered under the approved health plan, (ii) the small employer has not terminated coverage with an approved health plan within 3 years of the date of application for coverage except to change to another approved health plan, and (iii) the small employer does not offer other general group health insurance coverage to its employees. For the purposes of this paragraph, general group health insurance coverage excludes coverage providing only a specific limited form of health insurance such as accident or disability income insurance coverage or a specific health care service such as dental care.

(b) An individual is eligible for an approved health plan if on the effective date of coverage or renewal he or she meets the definition of an eligible individual under Section 10 of this Act.

(c) An approved health plan shall provide in substance that attainment of the limiting age by an unmarried dependent individual does not operate to terminate coverage when the individual continues to be incapable of self-sustaining employment by reason of developmental disability or physical handicap and the individual is primarily dependent for support and maintenance upon the employee. Proof of incapacity and dependency shall be furnished to the Alliance and the member that offered the approved health plan within 120 days of attainment of the limiting age. The board may require subsequent proof annually after a 2-year period following attainment of the limiting age.

(d) An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable with respect to a newly born child of the family member or the individual in whose name the contract is issued from the moment of birth, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that

notification of the birth of a child and payment of the required premium shall be furnished to the member within 31 days after the date of birth in order to have the coverage from birth. An approved health plan shall provide that the health insurance benefits applicable for eligible dependents are payable for an adopted child in accordance with the provisions of Section 356h of the Illinois Insurance Code.

(e) Except as provided in subsections (g), (h), and (i) of this Section, an approved health plan offered to a small employer may contain a preexisting condition exclusion only if:

(1) the exclusion relates to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) the exclusion extends for a period of not more than 6 months after the enrollment date; and

(3) the period of the exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

(f) As used in this Section, "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage for the benefits, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date, but genetic information is not included as a preexisting condition for the purposes of limiting or excluding benefits in the absence of a diagnosis of the condition related to the genetic information.

(g) An insurer shall not impose a preexisting condition exclusion:

(1) in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage;

(2) that excludes a child who is adopted or placed for adoption before his eighteenth birthday and who, as of the last day of the 30-day period beginning on and following the date of the adoption or placement for adoption, is covered under creditable coverage; or

(3) that relates to or includes pregnancy as a preexisting condition.

(h) The provisions of paragraphs (1) and (2) of subsection (g) of this Section do not apply to any individual after the end of the first continuous 63-day period during which the individual was not covered under any creditable coverage.

(i) The preexisting condition exclusions described in subsection (e) of this Section shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the effective date of coverage for health insurance through the Alliance is made not later than 63 days following the termination of the prior coverage. In that case, coverage through the Alliance shall be effective from the date on which the prior coverage was terminated. This subsection (i) does not prohibit preexisting conditions coverage in an approved health plan that is more favorable to the covered individual than that specified in this subsection (i).

(j) An approved health plan issued to an eligible individual shall not contain any preexisting condition exclusion.

(k) An individual is not eligible for coverage by the Alliance under an approved health plan issued to a small employer if he or she:

(1) is eligible for Medicare, except that if an individual has health insurance coverage from an employer whose group includes 20 or more individuals, an individual eligible for Medicare who continues to be employed may choose to be covered through an approved health plan;

(2) has voluntarily terminated health insurance issued through the Alliance within the past 12 months unless it

was due to a change in employment; or

(3) is an inmate of a public institution.

(l) The Alliance shall provide for an open enrollment period of 60 days from the initial offering of an approved health plan. Individuals enrolled during the open enrollment period shall not be subject to the preexisting conditions limitation.

(m) If an insured covered by an approved health plan switches to another approved health plan that provides increased or additional benefits such as lower deductible or co-payment requirements, the member offering the approved health plan with increased or additional benefits may require the 6-month period for preexisting conditions provided in subsection (e) of this Section to be satisfied prior to receipt of the additional benefits.

Section 70. Notice of Alliance by members.

(a) By January 1, 2007, members shall provide notice and applications for coverage through the Alliance to a small employer that receives:

(1) a rejection of coverage for health insurance;

(2) a notice that the rate for health insurance similar to coverage through the Alliance will exceed the maximum rate of health insurance through the Alliance; or

(3) a notice of reduction or limitation of coverage, including a restrictive rider, from a provider of health insurance, if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a small group considered a standard risk for the type of coverage provided by an approved health plan.

(b) The notice shall state that the small employer is eligible but is not required to apply for health insurance provided through the Alliance. Application for the health insurance shall be on forms prescribed by the board and made available to all members.

Section 75. Enrollment.

(a) New employees and their dependents may enroll in their small employer's approved health plan within 31 days of completion of their employer's eligibility period. If application for enrollment is not made during this period, the employee and dependents may be required to submit evidence of insurability.

(b) Insureds shall notify the Alliance at least 31 days prior to the anniversary date of the approved health plan of their intent to switch coverage to another approved health plan.

Section 80. Benefits.

(a) An approved health plan shall pay for medically necessary eligible expenses that exceed the deductible, co-payment, and co-insurance amounts applicable under the provisions of Section 85 of this Act and are not otherwise limited or excluded. This Act does not prohibit the board from approving additional types of health plan designs with similar cost-benefit structures or other types of health plan designs. An approved health plan for small employers shall, at a minimum, reflect the levels of health insurance coverage generally available in Illinois for small employer group policies, but an approved health plan for small employers may also offer health plan designs that are not generally available in Illinois for small employer group policies.

(b) The board may design and require an approved health plan to contain cost-containment measures and requirements, including managed care, pre-admission certification and concurrent inpatient review, and the use of fee schedules for health care providers, including the diagnosis-related grouping system and the resource-based relative value system.

Section 85. Deductibles; co-insurance; maximum out-of-pocket payments.

(a) Subject to the limitations provided in subsection (c)

of this Section, an approved health plan offered through the Alliance may impose a deductible on a per-person calendar year basis. An approved health plan offered by a health maintenance organization shall provide equivalent cost-benefit structures. The board may authorize deductibles in other amounts and equivalent cost-benefit structures.

(b) Subject to the limitations provided in subsection (c) of this Section, a mandatory co-insurance requirement for an approved health plan may be imposed as a percentage of eligible expenses in excess of a deductible. Health maintenance organizations shall impose equivalent cost-benefit structures.

(c) The maximum aggregate out-of-pocket payments for eligible expenses by the covered individual shall be determined by the board.

Section 90. Dependent family member required coverage; small employer responsibility.

(a) A small employer shall collect or make a payroll deduction from the compensation of an employee for the portion of the approved health plan cost that the employee is responsible for paying. The small employer may contribute to the cost of that plan on behalf of the employee.

(b) A small employer shall make available to dependent family members of an employee covered by an approved health plan the same approved health plan. The small employer may contribute to the cost of group coverage.

(c) All premiums collected, deducted from the compensation of employees, or paid on their behalf by the small employer shall be promptly remitted to the Alliance.

Section 95. Renewability.

(a) An approved health plan shall contain provisions under which the member offering the plan is obligated to renew the health insurance if premiums are paid until the day the plan is replaced by another plan or the small employer terminates coverage.

(b) An approved health plan issued to an eligible individual shall contain provisions under which the member offering the plan is obligated to renew the health insurance except for:

(1) nonpayment of premium;

(2) fraud; or

(3) termination of the approved health plan, except that the individual has the right to transfer to another approved health plan.

(c) If an approved health plan ceases to exist, the Alliance shall provide an alternate approved health plan.

(d) An approved health plan shall provide covered individuals the right to continue health insurance coverage through an approved health plan as individual health insurance provided by the same member upon the death of the employee or upon the divorce, annulment, or dissolution of marriage or legal separation of the spouse from the employee or by termination of employment by electing to do so within a period of time specified in the health insurance if the employee was covered under an approved health plan while employed for at least 6 consecutive months. The individual may be charged an additional administrative charge for the individual health insurance.

(e) The right to continue health insurance coverage provided in this Section terminates if the covered individual resides outside the United States for more than 6 consecutive months.

Section 100. Rules. The Secretary shall adopt rules that provide for disclosure by members of the availability of health insurance from the Alliance and adopt rules to carry out the provisions of this Act.

Section 105. Collective action. Neither the participation by insurers in the Alliance, the establishment of rates, forms, or procedures for coverages issued by the Alliance, nor any

other joint or collective action required by the provisions of this Act shall be the basis of any legal action, civil or criminal liability, or penalty against the members either jointly or separately.

Section 110. Rates; standard risk rate; experience rating prohibited.

(a) The Alliance shall determine a standard risk rate index by actuarially calculating the average index rates that the insurer has filed under the requirements of the Small Employer Health Insurance Rating Act with the benefits similar to the Alliance's standard approved health plan. A standard risk rate based on age and other appropriate demographic characteristics may be used. No standard risk rate shall be more than 15% higher or 15% lower than the average index rate. In determining the standard risk rate, the Alliance shall consider the benefits provided by the approved health plan.

(b) Experience rating is not allowed other than for reinsurance purposes.

(c) All rates and rate schedules shall be submitted to the Secretary for approval prior to use.

Section 115. Benefit payment reductions.

(a) An approved health plan shall be the last payor of benefits whenever any other benefit is available. Benefits otherwise payable under the approved health plan shall be reduced by all amounts paid or payable through any other health insurance and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal program, excluding Medicaid.

(b) The administrator or the Alliance shall have a cause of action against any person covered by an approved health plan for the recovery of the amount of benefits paid that are not

for eligible expenses. Benefits due from the approved health plan may be reduced or refused as a set-off against any amount recoverable under this Section.

Section 120. Expanded service development. The Department of Financial and Professional Regulation, in cooperation with the Alliance, shall develop a plan to provide health insurance coverage for uninsured children, individuals, and other employers.