HB1006

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB1006

Introduced 2/8/2007, by Rep. Frank J. Mautino

SYNOPSIS AS INTRODUCED:

See Index

Amends the Children's Health Insurance Program Act and the Illinois Public Aid Code. Under the Children's Health Insurance Program, (i) provides for eligibility for children whose household income is at or below 300% (instead of 200%) of the federal poverty level and (ii) increases the income threshold in connection with eligibility under an approved waiver. Provides that on and after July 1, 2008, the Department of Healthcare and Family services shall implement a capitated managed care system for selected populations of persons persons under the Children's Health Insurance Program and the Medicaid program. Provides that under such a system, the State shall pay a fixed amount per individual per month to a third-party entity to manage the program of health care benefits and assume the risk associated with the payment of medical bills without regard to actual medical claims incurred. Provides that the Department shall implement the system in a manner that maximizes all available State and federal funds. Sets forth categories of Medicaid recipients who may withdraw from the managed care program and who may voluntarily opt to participate in the program, and provides that certain recipients are not eligible to participate in the managed care program. Provides for Medicaid eligibility for persons whose income is between zero and 100% of the federal poverty level. Provides that under the Medicaid program, the Department of Healthcare and Family Services shall provide health benefits coverage to eligible individuals by: (1) subsidizing the cost of privately sponsored health insurance, including employer-based health insurance, to assist individuals in taking advantage of available privately sponsored health insurance; and (2) purchasing or providing health care benefits for eligible individuals. Makes other changes.

LRB095 07756 DRJ 27915 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Children's Health Insurance Program Act is amended by changing Sections 20 and 40 and adding Section 27 as follows:

(215 ILCS 106/20)

Sec. 20. Eligibility.

(a) To be eligible for this Program, a person must be a person who has a child eligible under this Act and who is eligible under a waiver of federal requirements pursuant to an application made pursuant to subdivision (a)(1) of Section 40 of this Act or who is a child who:

(1) is a child who is not eligible for medical assistance;

(2) is a child whose annual household income, as determined by the Department, is above 133% of the federal poverty level and at or below <u>300%</u> ~~200%~~ of the federal poverty level;

(3) is a resident of the State of Illinois; and

(4) is a child who is either a United States citizen or included in one of the following categories of non-citizens:

1 (A) unmarried dependent children of either a
2 United States Veteran honorably discharged or a person
3 on active military duty;
4 (B) refugees under Section 207 of the Immigration
5 and Nationality Act;
6 (C) asylees under Section 208 of the Immigration
7 and Nationality Act;
8 (D) persons for whom deportation has been withheld
9 under Section 243(h) of the Immigration and
10 Nationality Act;
11 (E) persons granted conditional entry under
12 Section 203(a)(7) of the Immigration and Nationality
13 Act as in effect prior to April 1, 1980;
14 (F) persons lawfully admitted for permanent
15 residence under the Immigration and Nationality Act;
16 and
17 (G) parolees, for at least one year, under Section
18 212(d)(5) of the Immigration and Nationality Act.
19 Those children who are in the categories set forth in
20 subdivisions (4)(F) and (4)(G) of this subsection, who enter
21 the United States on or after August 22, 1996, shall not be
22 eligible for 5 years beginning on the date the child entered
23 the United States.
24 (b) A child who is determined to be eligible for assistance
25 may remain eligible for 12 months, provided the child maintains
26 his or her residence in the State, has not yet attained 19

1 years of age, and is not excluded pursuant to subsection (c). A
2 child who has been determined to be eligible for assistance
3 must reapply or otherwise establish eligibility at least
4 annually. An eligible child shall be required, as determined by
5 the Department by rule, to report promptly those changes in
6 income and other circumstances that affect eligibility. The
7 eligibility of a child may be redetermined based on the
8 information reported or may be terminated based on the failure
9 to report or failure to report accurately. A child's
10 responsible relative or caretaker may also be held liable to
11 the Department for any payments made by the Department on such
12 child's behalf that were inappropriate. An applicant shall be
13 provided with notice of these obligations.
14 (c) A child shall not be eligible for coverage under this
15 Program if:
16 (1) the premium required pursuant to Section 30 of this
17 Act has not been paid. If the required premiums are not
18 paid the liability of the Program shall be limited to
19 benefits incurred under the Program for the time period for
20 which premiums had been paid. If the required monthly
21 premium is not paid, the child shall be ineligible for
22 re-enrollment for a minimum period of 3 months.
23 Re-enrollment shall be completed prior to the next covered
24 medical visit and the first month's required premium shall
25 be paid in advance of the next covered medical visit. The
26 Department shall promulgate rules regarding grace periods,

1 notice requirements, and hearing procedures pursuant to
2 this subsection;
3 (2) the child is an inmate of a public institution or a
4 patient in an institution for mental diseases; or
5 (3) the child is a member of a family that is eligible
6 for health benefits covered under the State of Illinois
7 health benefits plan on the basis of a member's employment
8 with a public agency.
9 (Source: P.A. 92-597, eff. 6-28-02; 93-63, eff. 6-30-03.)

10 (215 ILCS 106/27 new)
11 Sec. 27. Transition to capitated managed care system.
12 (a) On and after July 1, 2008, the Department of Healthcare
13 and Family services shall implement a capitated managed care
14 system for selected populations of persons. Under the capitated
15 managed care system, the State shall pay a fixed amount per
16 individual per month to a third-party entity to manage the
17 program of health care benefits and assume the risk associated
18 with the payment of medical bills without regard to actual
19 medical claims incurred.
20 (b) The Department shall adopt rules establishing the
21 populations that must participate in the capitated managed care
22 system. At a minimum, those populations must include all
23 persons eligible for benefits under Sections 20 and 40. The
24 Department shall adopt rules providing for the implementation
25 and continued oversight of the capitated managed care system.

1 (c) The Department shall implement the capitated managed
2 care system in a manner that maximizes all available State and
3 federal funds, including those obtained through
4 intergovernmental transfers, supplemental Medicaid payments,
5 and the disproportionate share program.
6 (d) The Department shall implement actuarially sound,
7 risk-adjusted capitation rates for recipients in the capitated
8 managed care program which cover comprehensive care,
9 catastrophic care, and an Enhanced Benefits Account Program
10 that rewards recipients for taking part in activities that
11 improve their health.
12 (e) The Department shall promptly apply for all waivers of
13 federal law and regulations that are necessary to allow the
14 full implementation of this Section.

15 (215 ILCS 106/40)
16 Sec. 40. Waivers.
17 (a) The Department shall request any necessary waivers of
18 federal requirements in order to allow receipt of federal
19 funding for:
20 (1) the coverage of families with eligible children
21 under this Act; and
22 (2) for the coverage of children who would otherwise be
23 eligible under this Act, but who have health insurance.
24 (b) The failure of the responsible federal agency to
25 approve a waiver for children who would otherwise be eligible

under this Act but who have health insurance shall not prevent the implementation of any Section of this Act provided that there are sufficient appropriated funds.

(c) Eligibility of a person under an approved waiver due to the relationship with a child pursuant to Article V of the Illinois Public Aid Code or this Act shall be limited to such a person whose countable income is determined by the Department to be at or below such income eligibility standard as the Department by rule shall establish. The income level established by the Department shall not be below <u>200%</u> ~~90%~~ of the federal poverty level. Such persons who are determined to be eligible must reapply, or otherwise establish eligibility, at least annually. An eligible person shall be required, as determined by the Department by rule, to report promptly those changes in income and other circumstances that affect eligibility. The eligibility of a person may be redetermined based on the information reported or may be terminated based on the failure to report or failure to report accurately. A person may also be held liable to the Department for any payments made by the Department on such person's behalf that were inappropriate. An applicant shall be provided with notice of these obligations.

(Source: P.A. 92-597, eff. 6-28-02; 93-63, eff. 6-30-03.)

Section 10. The Illinois Public Aid Code is amended by changing Section 5-2 and by adding Sections 5-3.5 and 5-16.14

1 as follows:

2 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)
3 Sec. 5-2. Classes of Persons Eligible. Medical assistance
4 under this Article shall be available to any of the following
5 classes of persons in respect to whom a plan for coverage has
6 been submitted to the Governor by the Illinois Department and
7 approved by him:
8 1. Recipients of basic maintenance grants under
9 Articles III and IV.
10 2. Persons otherwise eligible for basic maintenance
11 under Articles III and IV but who fail to qualify
12 thereunder on the basis of need, and who have insufficient
13 income and resources to meet the costs of necessary medical
14 care, including but not limited to the following:
15 (a) All persons otherwise eligible for basic
16 maintenance under Article III but who fail to qualify
17 under that Article on the basis of need and who meet
18 either of the following requirements:
19 (i) their income, as determined by the
20 Illinois Department in accordance with any federal
21 requirements, is equal to or less than 70% in
22 fiscal year 2001, equal to or less than 85% in
23 fiscal year 2002 and until a date to be determined
24 by the Department by rule, and equal to or less
25 than 100% beginning on the date determined by the

1 Department by rule, of the nonfarm income official
2 poverty line, as defined by the federal Office of
3 Management and Budget and revised annually in
4 accordance with Section 673(2) of the Omnibus
5 Budget Reconciliation Act of 1981, applicable to
6 families of the same size; or
7 (ii) their income, after the deduction of
8 costs incurred for medical care and for other types
9 of remedial care, is equal to or less than 70% in
10 fiscal year 2001, equal to or less than 85% in
11 fiscal year 2002 and until a date to be determined
12 by the Department by rule, and equal to or less
13 than 100% beginning on the date determined by the
14 Department by rule, of the nonfarm income official
15 poverty line, as defined in item (i) of this
16 subparagraph (a).
17 (b) All persons who would be determined eligible
18 for such basic maintenance under Article IV by
19 disregarding the maximum earned income permitted by
20 federal law.
21 3. Persons who would otherwise qualify for Aid to the
22 Medically Indigent under Article VII.
23 4. Persons not eligible under any of the preceding
24 paragraphs who fall sick, are injured, or die, not having
25 sufficient money, property or other resources to meet the
26 costs of necessary medical care or funeral and burial

1 expenses.
2 5.(a) Women during pregnancy, after the fact of
3 pregnancy has been determined by medical diagnosis, and
4 during the 60-day period beginning on the last day of the
5 pregnancy, together with their infants and children born
6 after September 30, 1983, whose income and resources are
7 insufficient to meet the costs of necessary medical care to
8 the maximum extent possible under Title XIX of the Federal
9 Social Security Act.
10 (b) The Illinois Department and the Governor shall
11 provide a plan for coverage of the persons eligible under
12 paragraph 5(a) by April 1, 1990. Such plan shall provide
13 ambulatory prenatal care to pregnant women during a
14 presumptive eligibility period and establish an income
15 eligibility standard that is equal to 133% of the nonfarm
16 income official poverty line, as defined by the federal
17 Office of Management and Budget and revised annually in
18 accordance with Section 673(2) of the Omnibus Budget
19 Reconciliation Act of 1981, applicable to families of the
20 same size, provided that costs incurred for medical care
21 are not taken into account in determining such income
22 eligibility.
23 (c) The Illinois Department may conduct a
24 demonstration in at least one county that will provide
25 medical assistance to pregnant women, together with their
26 infants and children up to one year of age, where the

1 income eligibility standard is set up to 185% of the
2 nonfarm income official poverty line, as defined by the
3 federal Office of Management and Budget. The Illinois
4 Department shall seek and obtain necessary authorization
5 provided under federal law to implement such a
6 demonstration. Such demonstration may establish resource
7 standards that are not more restrictive than those
8 established under Article IV of this Code.

9 6. Persons under the age of 18 who fail to qualify as
10 dependent under Article IV and who have insufficient income
11 and resources to meet the costs of necessary medical care
12 to the maximum extent permitted under Title XIX of the
13 Federal Social Security Act.

14 7. Persons who are under 21 years of age and would
15 qualify as disabled as defined under the Federal
16 Supplemental Security Income Program, provided medical
17 service for such persons would be eligible for Federal
18 Financial Participation, and provided the Illinois
19 Department determines that:

20 (a) the person requires a level of care provided by
21 a hospital, skilled nursing facility, or intermediate
22 care facility, as determined by a physician licensed to
23 practice medicine in all its branches;

24 (b) it is appropriate to provide such care outside
25 of an institution, as determined by a physician
26 licensed to practice medicine in all its branches;

1 (c) the estimated amount which would be expended
2 for care outside the institution is not greater than
3 the estimated amount which would be expended in an
4 institution.
5 8. Persons who become ineligible for basic maintenance
6 assistance under Article IV of this Code in programs
7 administered by the Illinois Department due to employment
8 earnings and persons in assistance units comprised of
9 adults and children who become ineligible for basic
10 maintenance assistance under Article VI of this Code due to
11 employment earnings. The plan for coverage for this class
12 of persons shall:
13 (a) extend the medical assistance coverage for up
14 to 12 months following termination of basic
15 maintenance assistance; and
16 (b) offer persons who have initially received 6
17 months of the coverage provided in paragraph (a) above,
18 the option of receiving an additional 6 months of
19 coverage, subject to the following:
20 (i) such coverage shall be pursuant to
21 provisions of the federal Social Security Act;
22 (ii) such coverage shall include all services
23 covered while the person was eligible for basic
24 maintenance assistance;
25 (iii) no premium shall be charged for such
26 coverage; and

(iv) such coverage shall be suspended in the event of a person's failure without good cause to file in a timely fashion reports required for this coverage under the Social Security Act and coverage shall be reinstated upon the filing of such reports if the person remains otherwise eligible.

9. Persons with acquired immunodeficiency syndrome (AIDS) or with AIDS-related conditions with respect to whom there has been a determination that but for home or community-based services such individuals would require the level of care provided in an inpatient hospital, skilled nursing facility or intermediate care facility the cost of which is reimbursed under this Article. Assistance shall be provided to such persons to the maximum extent permitted under Title XIX of the Federal Social Security Act.

10. Participants in the long-term care insurance partnership program established under the Partnership for Long-Term Care Act who meet the qualifications for protection of resources described in Section 25 of that Act.

11. Persons with disabilities who are employed and eligible for Medicaid, pursuant to Section 1902(a)(10)(A)(ii)(xv) of the Social Security Act, as provided by the Illinois Department by rule.

12. Subject to federal approval, persons who are eligible for medical assistance coverage under applicable provisions of the federal Social Security Act and the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. Those eligible persons are defined to include, but not be limited to, the following persons:

(1) persons who have been screened for breast or cervical cancer under the U.S. Centers for Disease Control and Prevention Breast and Cervical Cancer Program established under Title XV of the federal Public Health Services Act in accordance with the requirements of Section 1504 of that Act as administered by the Illinois Department of Public Health; and

(2) persons whose screenings under the above program were funded in whole or in part by funds appropriated to the Illinois Department of Public Health for breast or cervical cancer screening.

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after the effective date of this amendatory Act of the 92nd General Assembly.

13. Subject to appropriation and to federal approval,

1 persons living with HIV/AIDS who are not otherwise eligible
2 under this Article and who qualify for services covered
3 under Section 5-5.04 as provided by the Illinois Department
4 by rule.

5 14. Subject to the availability of funds for this
6 purpose, the Department may provide coverage under this
7 Article to persons who reside in Illinois who are not
8 eligible under any of the preceding paragraphs and who meet
9 the income guidelines of paragraph 2(a) of this Section and
10 (i) have an application for asylum pending before the
11 federal Department of Homeland Security or on appeal before
12 a court of competent jurisdiction and are represented
13 either by counsel or by an advocate accredited by the
14 federal Department of Homeland Security and employed by a
15 not-for-profit organization in regard to that application
16 or appeal, or (ii) are receiving services through a
17 federally funded torture treatment center. Medical
18 coverage under this paragraph 14 may be provided for up to
19 24 continuous months from the initial eligibility date so
20 long as an individual continues to satisfy the criteria of
21 this paragraph 14. If an individual has an appeal pending
22 regarding an application for asylum before the Department
23 of Homeland Security, eligibility under this paragraph 14
24 may be extended until a final decision is rendered on the
25 appeal. The Department may adopt rules governing the
26 implementation of this paragraph 14.

1 15. Subject to appropriations and federal approval,
2 any individual who resides in Illinois and has an income
3 level, as determined by the Illinois Department in
4 accordance with any federal requirements, that is between
5 zero and 100% of the federal poverty guidelines as
6 published annually by the United States Department of
7 Health and Human Services. The Department shall promptly
8 apply for all waivers of federal law and regulations that
9 are necessary to allow the full implementation of this
10 paragraph 15.
11 The Illinois Department and the Governor shall provide a
12 plan for coverage of the persons eligible under paragraph 7 as
13 soon as possible after July 1, 1984.
14 The eligibility of any such person for medical assistance
15 under this Article is not affected by the payment of any grant
16 under the Senior Citizens and Disabled Persons Property Tax
17 Relief and Pharmaceutical Assistance Act or any distributions
18 or items of income described under subparagraph (X) of
19 paragraph (2) of subsection (a) of Section 203 of the Illinois
20 Income Tax Act. The Department shall by rule establish the
21 amounts of assets to be disregarded in determining eligibility
22 for medical assistance, which shall at a minimum equal the
23 amounts to be disregarded under the Federal Supplemental
24 Security Income Program. The amount of assets of a single
25 person to be disregarded shall not be less than $2,000, and the
26 amount of assets of a married couple to be disregarded shall

1 not be less than $3,000.
2 To the extent permitted under federal law, any person found
3 guilty of a second violation of Article VIIIA shall be
4 ineligible for medical assistance under this Article, as
5 provided in Section 8A-8.
6 The eligibility of any person for medical assistance under
7 this Article shall not be affected by the receipt by the person
8 of donations or benefits from fundraisers held for the person
9 in cases of serious illness, as long as neither the person nor
10 members of the person's family have actual control over the
11 donations or benefits or the disbursement of the donations or
12 benefits.
13 (Source: P.A. 93-20, eff. 6-20-03; 94-629, eff. 1-1-06;
14 94-1043, eff. 7-24-06.)

15 (305 ILCS 5/5-3.5 new)
16 Sec. 5-3.5. Method of providing health benefits coverage.
17 (a) Subject to appropriation and federal approval, the
18 Department of Healthcare and Family Services shall provide
19 health benefits coverage to eligible individuals by:
20 (1) subsidizing the cost of privately sponsored health
21 insurance, including employer-based health insurance, to
22 assist individuals in taking advantage of available
23 privately sponsored health insurance; and
24 (2) purchasing or providing health care benefits for
25 eligible individuals.

1 For individuals eligible for Medicaid under a mandatory
2 eligibility group who have access to privately sponsored health
3 insurance, the health benefits provided under subdivision
4 (a)(2) shall continue to be the benefit package specified in
5 the State Medicaid plan. In addition, such individuals shall be
6 subject to nominal cost-sharing only, in accordance with the
7 State Medicaid plan.

8 (b) The subsidization provided pursuant to subdivision
9 (a)(1) shall be credited to the eligible individual.

10 (c) For an eligible individual who is not included in a
11 mandatory Medicaid eligibility group, the Department is
12 prohibited from denying coverage to an individual who is
13 enrolled in a privately sponsored health insurance plan
14 pursuant to subdivision (a)(1) because the plan does not meet
15 federal benchmarking standards or cost-sharing and
16 contribution requirements. To be eligible for inclusion in the
17 Program, the plan shall contain comprehensive major medical
18 coverage which shall consist of physician and hospital
19 inpatient services. The Department is prohibited from denying
20 coverage to an individual who is enrolled in a privately
21 sponsored health insurance plan pursuant to subdivision (a)(1)
22 because the plan offers benefits in addition to physician and
23 hospital inpatient services.

24 (d) For all eligible individuals, provisions related to
25 benefits, cost-sharing, and premium assistance benefit costs
26 shall be consistent with federal law and regulations.

1 (e) The Department shall promptly apply for all waivers of
2 federal law and regulations that are necessary to allow the
3 full implementation of this Section.

4 (305 ILCS 5/5-16.14 new)
5 Sec. 5-16.14. Transition to capitated managed care system.
6 (a) On and after July 1, 2008, the Department of Healthcare
7 and Family Services shall implement a capitated managed care
8 system for selected populations of persons. Under the capitated
9 managed care system, the State shall pay a fixed amount per
10 individual per month to a third-party entity to manage the
11 program of health care benefits and assume the risk associated
12 with the payment of medical bills without regard to actual
13 medical claims incurred. The Department shall adopt rules
14 establishing the populations that must participate in the
15 capitated managed care system.
16 (b) A medical assistance recipient shall not be required to
17 participate in, and shall be permitted to withdraw from, the
18 managed care program under the following circumstances:
19 (1) A pregnant woman with an established relationship,
20 as defined by the Department, with a comprehensive prenatal
21 primary care provider that is not associated with the
22 managed care provider in the participant's service area may
23 defer participation in the managed care program while
24 pregnant and for 60 days post-partum.
25 (ii) An individual with a chronic medical condition

being treated by a specialist physician who is not associated with a managed care provider in the participant's service area may defer participation in the managed care program until the course of treatment is complete.

(c) The following medical assistance recipients shall not be required to participate in a managed care program established pursuant to this Section, but may voluntarily opt to do so:

(i) A person receiving services provided by a residential alcohol or substance abuse program or facility for the mentally retarded.

(ii) A person receiving services provided by an intermediate care facility for the mentally retarded or who has characteristics and needs similar to such persons.

(iii) A person with a developmental or physical disability who receives home and community-based services or care-at-home services through existing waivers under section 1915(c) of the Social Security Act or who has characteristics and needs similar to such persons.

(iv) Native Americans.

(v) Medicare/Medicaid dually eligible individuals not enrolled in a Medicare TEFRA plan.

(d) The following medical assistance recipients shall not be eligible to participate in a managed care program established pursuant to this Section:

1 (i) A person receiving services provided by a long term
2 home health care program, or a person receiving inpatient
3 services in a State-operated psychiatric facility or a
4 residential treatment facility for children and youth.
5 (ii) A person eligible for Medicare participating in a
6 capitated demonstration program for long-term care.
7 (iii) An infant living with an incarcerated mother in a
8 county jail or in a correctional facility as defined in
9 Section 3-1-2 of the Unified Code of Corrections.
10 (iv) A person who is expected to be eligible for
11 medical assistance for less than 6 months.
12 (v) A person who is eligible for medical assistance
13 benefits only with respect to tuberculosis-related
14 services.
15 (vi) A certified blind or disabled child living or
16 expected to be living separate and apart from his or her
17 parent for 30 days or more.
18 (vii) A resident of a nursing facility at the time of
19 enrollment.
20 (viii) An individual receiving hospice services at the
21 time of enrollment.
22 (ix) A person who has primary medical or health care
23 coverage available from or under a third-party payor which
24 may be maintained by payment, or part payment, of the
25 premium or cost-sharing amounts, when payment of such
26 premium or cost-sharing amounts would be cost-effective,

1 as determined by the Department.
2 (x) A foster child in the placement of a voluntary
3 agency.
4 (e) The Department shall adopt rules providing for the
5 implementation and continued oversight of the capitated
6 managed care system. The rules shall provide for the
7 implementation of the system in a manner consistent with the
8 Department's implementation of a capitated managed care system
9 under subsection (a) of Section 27 of the Children's Health
10 Insurance Program Act.
11 (f) The Department shall implement the capitated managed
12 care system in a manner that maximizes all available State and
13 federal funds, including those obtained through
14 intergovernmental transfers, supplemental Medicaid payments,
15 and the disproportionate share program.
16 (g) The Department shall implement actuarially sound,
17 risk-adjusted capitation rates for recipients in the capitated
18 managed care program which cover comprehensive care,
19 catastrophic care, and an Enhanced Benefits Account Program
20 that rewards recipients for taking part in activities that
21 improve their health.
22 (h) The Department shall promptly apply for all waivers of
23 federal law and regulations that are necessary to allow the
24 full implementation of this Section.

1 INDEX

2 Statutes amended in order of appearance

3 215 ILCS 106/20
4 215 ILCS 106/27 new
5 215 ILCS 106/40
6 305 ILCS 5/5-2 from Ch. 23, par. 5-2
7 305 ILCS 5/5-3.5 new
8 305 ILCS 5/5-16.14 new