Rep. Frank J. Mautino

Filed: 5/8/2007

AMENDMENT TO HOUSE BILL 1006

AMENDMENT NO. _____. Amend House Bill 1006 by replacing everything after the enacting clause with the following:

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

Section 5. Purpose. The General Assembly recognizes the need for individuals and small employers in this State to have access to health insurance policies that are more affordable and flexible than those currently available in the small group market. The General Assembly, therefore, seeks to increase the availability of health insurance coverage by requiring small employer carriers in this State to issue policies that are more affordable for employees of eligible employers. To accomplish its objective, the General Assembly also requires eligible employers to facilitate the offering of these policies to their employees.

Section 10. Definitions. For purposes of this Act:

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

"Eligible employer" means a small employer (1) that has not offered group health plans to its employees for at least 12 months before the employee applies for such coverage under a health insurance choice policy; and (2) whose average annual compensation paid to employees is less than 250% of the Federal poverty level.

"Employee" means an employee who is scheduled to work not less than 20 hours per week on a regular basis.

"Enrollee" means an individual covered under a health insurance choice policy, including both an employee and his or her dependents.

"Facilitate" means, with respect to an eligible employer, permitting one or more insurers to, without endorsement, publicize their health insurance choice policy or policies and alternative accident and health insurance policy or policies with all mandated benefits to the eligible employer's employees and collecting premiums through payroll deduction and remitting such premiums to the insurer.

"Federal poverty level" means the federal poverty level guidelines published annually by the United States Department of Health and Human Services.

"Group health plan" has the meaning given to such term in

the Illinois Health Insurance Portability and Accountability Act.

"Health insurance choice policy" or "policy" means a policy of accident and health insurance that provides standard required benefits as described in Section 20 of this Act and satisfies the additional requirements set forth in Section 25 of this Act.

"Insurer" means a small employer carrier as such term is defined in the Small Employer Health Insurer Rating Act.

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

"Small employer" has the meaning given that term in the Illinois Health Insurance Portability and Accountability Act.

"State-mandated health benefits" means coverage required under the laws of this State to be provided in a group major medical policy for accident and health insurance or a contract for a health-related condition that: (1) includes coverage for specific health care services or benefits; (2) places limitations or restrictions on deductibles, coinsurance, co-payments, or any annual or lifetime maximum benefit amounts; or (3) includes coverage for a specific category of licensed health practitioner from whom an insured is entitled to receive care.

Section 15. Authorization of health insurance choice policies.

(a) All insurers, as defined in Section 10 of this Act, shall offer one or more health insurance choice policies to employees of eligible employers in this State.

(b) An insurer that offers one or more health insurance choice policies under this Act to the employees of an eligible employer must also offer to all employees of such eligible employer at least one accident and health insurance policy that has been filed with and approved by the Department and includes coverage for all state-mandated health benefits.

(c) All eligible employers in this State shall facilitate insurers offering coverage under one or more health insurance choice policies for employees of such eligible employers and their dependents. Each employee may elect whether he or she wants to apply for coverage.

(d) All eligible employers in the State shall also offer to their employees at least one insured group health plan under a policy that has been filed with and approved by the Department and includes coverage for all state-mandated health benefits.

(e) An eligible employer whose employees elect coverage under a health insurance choice policy or group health plan under subsections (c) or (d) of this Section for themselves or their dependents is not required to make contributions to the cost of any policy or group health plan on behalf of its employees or their dependents.

(f) An insurer is not required to issue or renew coverage to the employees of an eligible employer under a health

insurance choice policy or group health plan unless (i) 75% of the eligible employer's employees, excluding employees covered by a group health plan of another employer, elect coverage under a health insurance choice policy or a group health plan of the small employer offered by the insurer and (ii) 50% of the eligible employer's total employees elect coverage under a health insurance choice policy or group health plan of the eligible employer offered by the insurer.

(g) This Act must not be interpreted to restrict the ability of any insurer or small employer to offer any health insurance coverage permitted by law.

Section 20. Standard required benefits. A health insurance choice policy must include a maximum aggregate benefit of not less than $50,000 per year for each enrollee and the policy must contain the following standard required benefits:

(1) physician services, including, primary care, consultation, referral, surgical, anesthesia, or other, as needed by the enrollee in any level of service delivery. Such services need not include organ transplants unless specifically authorized by a physician;

(2) outpatient diagnostic, imaging, and pathology services and radiation therapy;

(3) 120 days of non-mental-health inpatient services per year, including all professional services, medications, surgically implanted devices, and supplies

used by the enrollee while an inpatient;

(4) 45 days of inpatient serious mental illness treatment services per year and 60 office visits per year for outpatient serious mental illness treatment services, with the copayment to apply to the cost of treatment if the treatment occurs during the office visit;

(5) 30 days of other inpatient mental health and chemical dependency treatment services per year and 30 days of other outpatient mental health and chemical dependency treatment services per year, with a lifetime maximum of 100 visits;

(6) emergency services for accidental injury or emergency illness 24 hours per day and 7 days per week. Such emergency treatment shall include outpatient visits and referrals for emergency mental health problems;

(7) maternity care, including prenatal and post-natal care, care for complications of pregnancy of the mother, and care with respect to a newborn child from the moment of birth, which shall include the necessary care and treatment of an illness, an injury, congenital defects, birth abnormalities, and a premature birth;

(8) blood transfusion services, processing, and the administration of whole blood and blood components and derivatives;

(9) preventive health services as appropriate for the patient population, including a health evaluation program

and immunizations to prevent or arrest the further manifestation of human illness or injury, including, but not limited to, allergy infections and allergy serum. Such health evaluation program shall include at least periodic physical examinations and medical history, hearing and vision testing or screening, routine laboratory testing or screening, blood pressure testing, uterine cervical-cytological testing, and low-dose mammography testing as required by Section 356g of the Illinois Insurance Code; and

(10) outpatient rehabilitative therapy (including, but not limited to, speech therapy, physical therapy, and occupational therapy directed at improving physical functioning of the member), up to 60 treatments per year for conditions that are expected to result in significant improvement within 2 months, as determined by the primary care physician.

The benefits under a health insurance choice policy may contain reasonable deductibles and co-payments subject to such limitations as the Department may prescribe pursuant to rule.

Section 25. Health insurance choice policy requirements.

(a) Any insurer, as defined in Section 10 of this Act, shall have the power to issue health insurance choice policies. No such policy may be issued or delivered in this State unless a copy of the form thereof has been filed with the Department

and approved by it in accordance with Section 355 of the Illinois Insurance Code, unless it contains in substance those provisions contained in Sections 357.1 through 357.30 of the Illinois Insurance Code as may be applicable to this Act and the provisions set forth in this Section.

(b) The policy must provide that the policy and the individual applications of the employees of the eligible employer shall constitute the entire contract between the parties, that all statements made by the employer or by the individual employees shall (in the absence of fraud) be deemed representations and not warranties, and that none of those statements may be used in defense to a claim under the policy unless it is contained in a written application.

(c) The policy must provide that the insurer will issue to the eligible employer, for delivery to the employee who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which the employee is entitled and to whom payable.

(d) The policy must provide that all new employees of the eligible employer shall be eligible to apply for coverage under any health insurance choice policies facilitated by such employer or the group health plan of the employer.

(e) Any health insurance choice policy may provide that all or any portion of any indemnities provided by the policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the health

care professional, health care provider, or the insured; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. Nothing in this subsection (e) shall prohibit an insurer from providing incentives for insureds to utilize the services of a particular hospital or person.

(f) Whenever the Department of Public Health finds that it has paid all or part of any hospital or medical expenses that an insurer is obligated to pay under a policy issued under this Act, the Department of Public Health shall be entitled to receive reimbursement for its payments from the insurer, provided that the Department of Public Health has notified the insurer of its claim before the carrier has paid the benefits to its insureds or the insureds' assignees.

(g) No group hospital, medical, or surgical expense policy under this Act may contain any provision whereby benefits otherwise payable thereunder are subject to reduction solely on account of the existence of similar benefits provided under other group or group-type accident and sickness insurance policies if the reduction would operate to reduce total benefits payable under the policies below an amount equal to 100% of total allowable expenses provided under the policies.

(h) If dependents of insureds are covered under 2 policies, both of which contain coordination of benefit provisions, benefits of the policy of the insured whose birthday falls

earlier in the year are determined before those of the policy of the insured whose birthday falls later in the year. "Birthday", as used in this subsection (h), refers only to the month and day in a calendar year, not the year in which the person was born. The Department shall promulgate rules defining the order of benefit determination under this subsection (h).

(i) Discrimination between individuals of the same class of risk in the issuance of policies, in the amount of premiums or rates charged for any insurance covered by this Act, in benefits payable thereon, in any of the terms or conditions of the policy, or in any other manner whatsoever is prohibited. Nothing in this subsection (i) prohibits an insurer from providing incentives for insureds to utilize the services of a particular hospital or person.

(j) No insurer may make or permit any distinction or discrimination against individuals solely because of handicaps or disabilities in (i) the amount of payment of premiums or rates charged for policies of insurance, (ii) the amount of any dividends or other benefits payable thereon, or (iii) any other terms and conditions of the contract it makes, except if the distinction or discrimination is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(k) No insurer may refuse to insure or refuse to continue to insure, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different

rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his or her eyesight. However, an insurer may exclude from coverage disability consisting solely of blindness or partial blindness when the condition existed at the time the policy was issued.

Section 30. Applicability of other Insurance Code provisions. All health insurance choice policies issued under this Act shall be subject to the provisions of Sections 356c, 356d, 356g, 356h, 356n, 367.2, 367.2-5, 367c, 367d, 367e, 367e.1, 367i, 368a, 370, 370a, and 370e of the Illinois Insurance Code even though such policies do not constitute group health plans.

Section 35. Means testing; authorized. For purposes of this Act, an employer shall perform means testing to determine eligibility requirements for the health insurance choice policy and shall provide a certification to the insurer

respecting the results of the means testing. A health insurance choice policy based on those eligibility requirements shall not be in violation of Section 364 of the Illinois Insurance Code or subsection (i) or (j) of Section 25 of this Act.

Section 40. Guaranteed renewability and availability.

(a) Subject to subsection (f) of Section 15 of this Act and subsections (b) and (c) of this Section, an insurer (i) must accept the application of every employee of an eligible employer that applies for coverage under subsections (c) or (d) of Section 15 of this Act and (ii) must renew or continue in force such coverage at the option of the covered employee as long as the employee continues as an employee of the eligible employer.

(b) An insurer is not obligated to renew or continue in force coverage under subsection (a) of this Section (i) if the coverage requirements of subsection (f) of Section 15 of this Act are not satisfied, (ii) if the insurer would not be obligated to renew or continue in force such coverage had subdivision (2), (4), or (5) of subsection (B) Section 30 of the Illinois Health Insurance Portability and Accountability Act applied to such policies, or (iii) with respect to an employee who has failed to pay premiums in accordance with the applicable policy or the insurer has not received timely premium payments from the employee.

(c) An insurer may modify the coverage offered under this

Act only at the time of coverage renewal and only if the modification is consistent with State law and effective on a uniform basis with respect to all employees of eligible employers.

(d) Subsection (a) of Section 15 of this Act and this Section shall apply with respect to an insurer as long as the insurer offers any health benefit plan to small employers in this State that is subject to the Small Employer Health Insurance Rating Act.

Section 45. Notice to policyholders and enrollees.

(a) Each written application for enrollment under a health insurance choice policy must contain the following language at the beginning of the application in bold type:

"You have the option to choose this health insurance choice policy that, either in whole or in part, does not provide state-mandated health insurance benefits normally required in accident and health insurance policies in Illinois. This health insurance choice policy may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health insurance benefits than those normally included as state-mandated health insurance benefits in policies in Illinois."

(b) Each health insurance choice policy must contain the following language at or near the beginning of the policy in

bold type:

"This health insurance choice policy, either in whole or in part, does not provide state-mandated health benefits normally required in accident and health insurance policies in Illinois. This health insurance choice policy may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health insurance benefits than those normally included as state-mandated health insurance benefits in policies in Illinois."

Section 50. Disclosure statement.

(a) When a health insurance choice policy is issued, the insurer providing such policy must provide an applicant with a written disclosure statement that does the following:

(1) acknowledges that the health insurance choice policy being purchased does not provide some or all state-mandated health benefits;

(2) lists those state-mandated health benefits not included under the health insurance choice policy; and

(3) includes a section that allows for a signature by the applicant attesting to the fact that the applicant has read and understands the disclosure statement and attesting to the fact that the applicant has in fact been given a choice between the health insurance choice policy that he or she has chosen and a health insurance policy

that includes all state-mandated health benefits.

(b) Each applicant for initial coverage must sign the disclosure statement provided by the insurer under subsection (a) of this Section and return the statement to the insurer.

(c) An insurer must:

(1) retain the signed disclosure statement in the insurer's records; and

(2) provide the signed disclosure statement to the Department upon request from the Secretary.

Section 55. Rates.

(a) Except as expressly provided in paragraphs (b) and (c) of this Section, the Small Employer Health Insurance Rating Act shall apply to each health insurance choice policy that is delivered, issued for delivery, renewed, or continued in this State.

(b) An insurer may establish one or more separate classes of business for purposes of the Small Employer Health Insurance Rating Act for health insurance choice policies delivered, issued for delivery, renewed, or continued in this State, and any such separate classes of business so established and including only health insurance choice policies shall not reduce the number of classes of business that an insurer may otherwise establish under the Small Employer Health Insurance Rating Act.

(c) Premium rates for health insurance choice policies

included in a separate class of business shall not be subject to subdivision (1) of subsection (a) of Section 25 of the Small Employer Health Insurance Rating Act.

Section 60. Rules. The Secretary shall adopt rules as necessary to implement this Act.

Section 905. The Illinois Insurance Code is amended by changing Section 352 and by adding Article XLVI as follows:

(215 ILCS 5/352) (from Ch. 73, par. 964)

Sec. 352. Scope of Article.

(a) Except as provided in subsections (b), (c), (d), and (e), this Article shall apply to all companies transacting in this State the kinds of business enumerated in clause (b) of Class 1 and clause (a) of Class 2 of section 4. Nothing in this Article shall apply to, or in any way affect policies or contracts described in clause (a) of Class 1 of Section 4; however, this Article shall apply to policies and contracts which contain benefits providing reimbursement for the expenses of long term health care which are certified or ordered by a physician including but not limited to professional nursing care, custodial nursing care, and non-nursing custodial care provided in a nursing home or at a residence of the insured.

(b) This Article does not apply to policies of accident and

health insurance issued in compliance with Article XIXB of this Code or the Health Insurance Choice Act.

(c) A policy issued and delivered in this State that provides coverage under that policy for certificate holders who are neither residents of nor employed in this State does not need to provide to those nonresident certificate holders who are not employed in this State the coverages or services mandated by this Article.

(d) Stop-loss insurance is exempt from all Sections of this Article, except this Section and Sections 353a, 354, 357.30, and 370. For purposes of this exemption, stop-loss insurance is further defined as follows:

(1) The policy must be issued to and insure an employer, trustee, or other sponsor of the plan, or the plan itself, but not employees, members, or participants.

(2) Payments by the insurer must be made to the employer, trustee, or other sponsors of the plan, or the plan itself, but not to the employees, members, participants, or health care providers.

(e) A policy issued or delivered in this State to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) and providing coverage, under clause (b) of Class 1 or clause (a) of Class 2 as described in Section 4, to persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act is exempt from all

restrictions, limitations, standards, rules, or regulations respecting benefits imposed by or under authority of this Code, except those specified by subsection (1) of Section 143. Nothing in this subsection, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(Source: P.A. 92-370, eff. 8-15-01; revised 12-15-05.)

(215 ILCS 5/Art. XLVI heading new)

ARTICLE XLVI. ILLINOIS HEALTH INSURANCE PREMIUM ASSISTANCE

(215 ILCS 5/1600 new)

Sec. 1600. Short title. This Article may be cited as the Illinois Health Insurance Premium Assistance Program.

(215 ILCS 5/1605 new)

Sec. 1605. Legislative intent. The General Assembly finds that, for the economic and social benefit of all residents of this State, it is important to enable all State residents to access affordable health insurance coverage.

(215 ILCS 5/1610 new)

Sec. 1610. Definitions. In this Article:

"Carrier" is defined as in the Small Employer Health Insurance Rating Act.

"Department" means the Department of Healthcare and Family

Services.

"Employee" has the same meaning as provided in the Illinois Health Insurance Portability and Accountability Act.

"Eligible individual" means an individual who:

(1) is a resident of the State of Illinois;

(2) is not eligible for Medicare;

(3) except as otherwise provided by the Department, has family income less than 300% of the federal poverty level or, if the individual is not married, has income less than 100% of the federal poverty level;

(4) has investments, savings or other assets less than the limit established by the Department; and

(5) Meets other eligibility criteria established by the Department.

"Family" means:

(1) a single individual;

(2) an adult and the adult's spouse;

(3) an adult and the adult's spouse, all unmarried, dependent children less than 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse;

(4) an adult and the adult's unmarried, dependent children less than 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult; or

(5) a dependent elderly relative or a dependent adult disabled child who meets criteria established by the Department and who lives in the home of the adult described in paragraph (1), (2), (3), or (4) of this definition.

"Federal poverty level" means the federal poverty level guidelines published annually by the United States Department of Health and Human Services.

"Family member" means an employee's spouse, any unmarried child or stepchild within age limits and other conditions imposed by the Department of Professional and Financial Regulation's Division of Insurance with regard to unmarried children or stepchildren or any other dependents eligible under the terms of the health benefit plan selected by the employee's employer.

"Health benefit plan" has the same meaning as provided in the Small Employer Health Insurance Rating Act. "Health benefit plan" includes the Illinois Comprehensive Health Insurance Plan and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended. "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital

indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Illinois.

"Income" means gross income in cash or kind available to the applicant or the applicant's family. "Income" does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

"Premium" means the monthly or other periodic charge for a health benefit plan.

"Program" means the Illinois Health Insurance Premium Assistance Program.

"Rebate" means payment or reimbursement to an eligible individual toward the eligible individual's purchase or contribution of premium towards a health benefit plan for the eligible individual and the eligible individual's family and may include co-payments or deductible expenses that are the responsibility of the eligible individual.

"Small employer" has the same meaning as provided in the Illinois Health Insurance Portability and Accountability Act.

"Third-party administrator" means any insurance company or other entity licensed under the Illinois Insurance Code to

administer health insurance benefit programs.

(215 ILCS 5/1615 new)

Sec. 1615. Program Operation. The Illinois Health Insurance Premium Assistance Program is created. The Program shall be administered by the Department of Healthcare and Family Services. The Department shall have the same powers and authority to administer the Program as are provided to the Department in connection with the Department's administration of the Illinois Public Aid Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Program.

(215 ILCS 5/1620 new)

Sec. 1620. Additional duties of Department; rules.

(a) In carrying out its duties under this Article, the Department may:

(1) enter into contracts for administration of this Article that include, but are not limited to:

(a) distribution of rebate payments;

(b) eligibility determination;

(c) data collection;

(d) financial tracking and reporting; and

(e) such other services as the Department may deem necessary for the administration of the Program; and

(2) retain consultants and employ staff.

(b) The Department shall adopt rules reasonably necessary to carry out the purposes of this Article. If the Department decides to enter into any contract pursuant to this subsection, the Department shall engage in competitive bidding.

(215 ILCS 5/1625 new)

Sec. 1625. Application to participate in Program; issuance of rebates; restrictions; health benefit plan enrollment.

(a) To enroll in the Program, an applicant shall submit a written application to the Department in the form and manner prescribed by the Department. If the applicant qualifies as an eligible individual, the applicant shall either be enrolled in the Program or placed on a waiting list for enrollment.

(b) After an eligible individual has enrolled in the Program, the individual shall remain eligible for enrollment for the period of time established by the Department.

(c) After an eligible individual has enrolled in the Program, the Department shall issue rebates as provided in accordance with the restrictions in Section 25 of the Children's Health Insurance Program Act and available appropriations.

(d) Rebates may not be issued to an eligible individual unless all eligible children, if any, in the eligible individual's family are covered under a health benefit plan, Medicaid, or the Covering ALL KIDS Health Insurance Act.

(e) Rebates may not be used to subsidize premiums on a

health benefit plan whose premiums are wholly paid by the eligible individual's employer.

(f) The Department may issue rebates to an eligible individual in advance of a purchase of a health benefit plan.

(g) An eligible individual must enroll in a health benefit plan if such a plan is available to the eligible individual through the individual's employment.

(h) Notwithstanding Section 1610, if an eligible individual is enrolled in a group health benefit plan available to the eligible individual through the individual's employment, and the employer requires enrollment in both a health benefit plan and a dental plan, the individual is eligible for a rebate for both the health benefit plan and the dental plan.

(215 ILCS 5/1630 new)

Sec. 1630. Level of assistance determinations.

(a) The Department shall determine the level of assistance to be granted under Section 1625 based on a sliding scale that considers:

(1) family size;

(2) family income;

(3) the number of members of a family who will receive health benefit plan coverage subsidized through the Program; and

(4) such other factors as the Department may establish.

(b) Notwithstanding the sliding scale established in subsection (a) of this Section, the Department may establish different assistance levels for otherwise similarly situated eligible individuals based on factors including but not limited to whether the individual is enrolled in an employer-sponsored group health benefit plan or an individual health benefit plan.

(215 ILCS 5/1635 new)

Sec. 1635. Rebates limited to funds appropriated; enrollment restrictions.

(a) Notwithstanding eligibility criteria and rebate amounts established in this Article, rebates shall be provided only to the extent the General Assembly specifically appropriates funds to provide such assistance.

(b) The Department may prohibit or limit enrollment in the Program to ensure that Program expenditures are within legislatively appropriated amounts. Prohibitions or limitations allowed under this Section may include but are not limited to:

(1) lowering the allowable income level necessary to qualify as an eligible individual; and

(2) establishing a waiting list of eligible individuals who shall receive rebates only when sufficient funds are available.

(215 ILCS 5/1640 new)

Sec. 1640. Emergency rulemaking. The Department may adopt rules necessary to establish and implement this Article through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For the purposes of that Act, the General Assembly finds that the adoption of rules to implement this Article is deemed an emergency and necessary for the public interest, safety, and welfare. This Section is repealed on July 1, 2008.

(215 ILCS 5/1645 new)

Sec. 1645. Funding. This Article shall only take effect upon the approval of a federal waiver by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services for the funding for the rebates provided under this Article.

(215 ILCS 5/1650 new)

Sec. 1650. Severability. If any provision of this Article or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Article that can be given effect without the invalid provision or application, and to this end the provisions of this Article are severable.

(215 ILCS 5/1655 new)

Sec. 1655. Repealer. This Article is repealed on December 31, 2017.

Section 910. 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 300% ~~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:

(A) unmarried dependent children of either a United States Veteran honorably discharged or a person

on active military duty;

(B) refugees under Section 207 of the Immigration and Nationality Act;

(C) asylees under Section 208 of the Immigration and Nationality Act;

(D) persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act;

(E) persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980;

(F) persons lawfully admitted for permanent residence under the Immigration and Nationality Act; and

(G) parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.

Those children who are in the categories set forth in subdivisions (4)(F) and (4)(G) of this subsection, who enter the United States on or after August 22, 1996, shall not be eligible for 5 years beginning on the date the child entered the United States.

(b) A child who is determined to be eligible for assistance may remain eligible for 12 months, provided the child maintains his or her residence in the State, has not yet attained 19 years of age, and is not excluded pursuant to subsection (c). A child who has been determined to be eligible for assistance

must reapply or otherwise establish eligibility at least annually. An eligible child 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 child may be redetermined based on the information reported or may be terminated based on the failure to report or failure to report accurately. A child's responsible relative or caretaker may also be held liable to the Department for any payments made by the Department on such child's behalf that were inappropriate. An applicant shall be provided with notice of these obligations.

(c) A child shall not be eligible for coverage under this Program if:

(1) the premium required pursuant to Section 30 of this Act has not been paid. If the required premiums are not paid the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums had been paid. If the required monthly premium is not paid, the child shall be ineligible for re-enrollment for a minimum period of 3 months. Re-enrollment shall be completed prior to the next covered medical visit and the first month's required premium shall be paid in advance of the next covered medical visit. The Department shall promulgate rules regarding grace periods, notice requirements, and hearing procedures pursuant to this subsection;

(2) the child is an inmate of a public institution or a patient in an institution for mental diseases; or

(3) the child is a member of a family that is eligible for health benefits covered under the State of Illinois health benefits plan on the basis of a member's employment with a public agency.

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

(215 ILCS 106/27 new)

Sec. 27. Transition to enhanced primary care case management program.

(a) On and after July 1, 2008, the Department of Healthcare and Family Services shall implement an enhanced primary care case management program for selected populations of persons. The enhanced primary care case management program is a non-capitated model of Medicaid managed care with enhanced components to:

(1) improve patient health and social outcomes;

(2) improve access to care;

(3) ensure the efficient and cost effective delivery of health care; and

(4) integrate the spectrum of acute care and long-term care services and supports.

(b) In developing the enhanced primary care case management program, the Department shall ensure that the program utilizes managed care principles and strategies to ensure proper

utilization of acute care and long-term care services and supports. The components of the model must include all of the following:

(1) The assignment of enrollees to a medical home.

(2) Utilization management to ensure appropriate access and utilization of services, including prescription drugs.

(3) Health risk or functional needs assessment.

(4) A method for reporting to medical homes and other appropriate health care providers on the utilization by recipients of health care services and the associated cost of utilization of those services.

(5) Mechanisms to reduce inappropriate emergency department utilization by recipients, including the provision of after-hours primary care.

(6) Mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating, and monitoring recipients with complex, chronic, or high-cost health care or social support needs, including attendant care and other services needed to remain in the community.

(7) Implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system.

(8) Strategies to prevent or delay institutionalization of recipients through the effective utilization of home and community-based support services.

(9) Any other components the Department determines will improve a recipient's health outcomes and are cost-effective.

(c) The Department shall adopt rules establishing the populations that must participate in the enhanced primary care case management program. At a minimum, those populations must include all persons eligible for benefits under Sections 20 and 40. The Department shall adopt rules providing for the implementation and continued oversight of the enhanced primary care case management program.

(d) Every person eligible for or receiving assistance under this Act shall participate in the program authorized by this Section. A recipient shall not be required to participate in, and shall be permitted to withdraw from, the enhanced primary care case management program upon showing that an individual with a chronic medical condition being treated by a specialist physician that is not associated with a provider in the participant's service area may defer participation in the enhanced primary care case management program until the course of treatment is complete.

(e) The following medical assistance recipients shall not be required to participate in the enhanced primary care case management program established pursuant to this Section, but may voluntarily opt to do so:

(1) A person receiving services provided by a residential alcohol or substance abuse program or facility

for the developmentally disabled.

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

(3) 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 federal Social Security Act or who has characteristics and needs similar to such persons.

(4) Native Americans.

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

(f) The following medical assistance recipients shall not be eligible to participate in the enhanced primary care case management program established pursuant to this Section:

(1) A person receiving services provided by a long term home health care program, or a person receiving inpatient services in a State-operated psychiatric facility or a residential treatment facility for children and youth.

(2) A person eligible for Medicare participating in a capitated demonstration program for long term care.

(3) An infant living with an incarcerated mother in a State or local correctional facility as defined in Section 3-1-2 of the Unified Code of Corrections.

(4) A person who is expected to be eligible for medical

assistance for less than 6 months.

(5) A person who is eligible for medical assistance benefits only with respect to tuberculosis-related services.

(6) Certified blind or disabled children living or expected to be living separate and apart from the parent for 30 days or more.

(7) Residents of nursing facilities at the time of enrollment in the program.

(8) Individuals receiving hospice services at the time of enrollment in the program.

(9) A person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost-sharing amounts, when payment of such premium or cost-sharing amounts would be cost-effective, as determined by the Department.

(10) A foster child in the placement of a voluntary agency.

(g) The Department shall adopt rules providing for the implementation and continued oversight of the enhanced primary care case management program.

(h) The Department shall implement the enhanced primary care case management program in a manner that maximizes all available State and federal funds, including those obtained through intergovernmental transfers, supplemental Medicaid

payments, and the disproportionate share program.

(i) Waivers. The Department of Healthcare and Family Services shall promptly apply for all waivers of federal law and regulations that are necessary to allow the full implementation of this Section.

(215 ILCS 106/40)

Sec. 40. Waivers.

(a) The Department shall request any necessary waivers of federal requirements in order to allow receipt of federal funding for:

(1) the coverage of families with eligible children under this Act; and

(2) for the coverage of children who would otherwise be eligible under this Act, but who have health insurance.

(b) The failure of the responsible federal agency to 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 200% ~~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 915. The Illinois Public Aid Code is amended by changing Section 5-2 and by adding Sections 5-3.5, 5-16.14, and 5-16.15 as follows:

(305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

Sec. 5-2. Classes of Persons Eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and approved by him:

1. Recipients of basic maintenance grants under

Articles III and IV.

2. Persons otherwise eligible for basic maintenance under Articles III and IV but who fail to qualify thereunder on the basis of need, and who have insufficient income and resources to meet the costs of necessary medical care, including but not limited to the following:

(a) All persons otherwise eligible for basic maintenance under Article III but who fail to qualify under that Article on the basis of need and who meet either of the following requirements:

(i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size; or

(ii) their income, after the deduction of costs incurred for medical care and for other types of remedial care, is equal to or less than 70% in

fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined in item (i) of this subparagraph (a).

(b) All persons who would be determined eligible for such basic maintenance under Article IV by disregarding the maximum earned income permitted by federal law.

3. Persons who would otherwise qualify for Aid to the Medically Indigent under Article VII.

4. Persons not eligible under any of the preceding paragraphs who fall sick, are injured, or die, not having sufficient money, property or other resources to meet the costs of necessary medical care or funeral and burial expenses.

5.(a) Women during pregnancy, after the fact of pregnancy has been determined by medical diagnosis, and during the 60-day period beginning on the last day of the pregnancy, together with their infants and children born after September 30, 1983, whose income and resources are insufficient to meet the costs of necessary medical care to the maximum extent possible under Title XIX of the Federal Social Security Act.

(b) The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 5(a) by April 1, 1990. Such plan shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 133% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size, provided that costs incurred for medical care are not taken into account in determining such income eligibility.

(c) The Illinois Department may conduct a demonstration in at least one county that will provide medical assistance to pregnant women, together with their infants and children up to one year of age, where the income eligibility standard is set up to 185% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget. The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a demonstration. Such demonstration may establish resource standards that are not more restrictive than those established under Article IV of this Code.

6. Persons under the age of 18 who fail to qualify as

dependent under Article IV and who have insufficient income and resources to meet the costs of necessary medical care to the maximum extent permitted under Title XIX of the Federal Social Security Act.

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

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

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

(c) the estimated amount which would be expended for care outside the institution is not greater than the estimated amount which would be expended in an institution.

8. Persons who become ineligible for basic maintenance assistance under Article IV of this Code in programs administered by the Illinois Department due to employment earnings and persons in assistance units comprised of adults and children who become ineligible for basic

maintenance assistance under Article VI of this Code due to employment earnings. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage for up to 12 months following termination of basic maintenance assistance; and

(b) offer persons who have initially received 6 months of the coverage provided in paragraph (a) above, the option of receiving an additional 6 months of coverage, subject to the following:

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

(ii) such coverage shall include all services covered while the person was eligible for basic maintenance assistance;

(iii) no premium shall be charged for such 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, persons living with HIV/AIDS who are not otherwise eligible under this Article and who qualify for services covered under Section 5-5.04 as provided by the Illinois Department by rule.

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and

(i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Subject to appropriations and federal approval, any individual who resides in Illinois and has an income level, as determined by the Illinois Department in accordance with any federal requirements, that is between zero and 100% of the federal poverty guidelines as published annually by the United States Department of Health and Human Services. The Department shall promptly apply for all waivers of federal law and regulations that are necessary to allow the full implementation of this

paragraph 15.

The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 7 as soon as possible after July 1, 1984.

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

To the extent permitted under federal law, any person found guilty of a second violation of Article VIIIA shall be ineligible for medical assistance under this Article, as provided in Section 8A-8.

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor

members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

(Source: P.A. 93-20, eff. 6-20-03; 94-629, eff. 1-1-06; 94-1043, eff. 7-24-06.)

(305 ILCS 5/5-3.5 new)

Sec. 5-3.5. Method of providing health benefits coverage.

(a) Subject to appropriation and federal approval, 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.

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

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

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

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

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

(305 ILCS 5/5-16.14 new)

Sec. 5-16.14. Transition to enhanced primary care case management program.

(a) On and after July 1, 2008, the Department of Healthcare and Family Services shall implement an enhanced primary care

case management program for selected populations of persons. The enhanced primary care case management program is a non-capitated model of Medicaid managed care with enhanced components to:

(1) improve patient health and social outcomes;

(2) improve access to care;

(3) ensure the efficient and cost effective delivery of health care; and

(4) integrate the spectrum of acute care and long-term care services and supports.

(b) In developing the enhanced primary care case management program, the Department shall ensure that the program utilizes managed care principles and strategies to ensure proper utilization of acute care and long-term care services and supports. The components of the model must include all of the following:

(1) The assignment of enrollees to a medical home.

(2) Utilization management to ensure appropriate access and utilization of services, including prescription drugs.

(3) Health risk or functional needs assessment.

(4) A method for reporting to medical homes and other appropriate health care providers on the utilization by recipients of health care services and the associated cost of utilization of those services.

(5) Mechanisms to reduce inappropriate emergency

department utilization by recipients, including the provision of after-hours primary care.

(6) Mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating, and monitoring recipients with complex, chronic, or high-cost health care or social support needs, including attendant care and other services needed to remain in the community.

(7) Implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system.

(8) Strategies to prevent or delay institutionalization of recipients through the effective utilization of home and community-based support services.

(9) Any other components the Department determines will improve a recipient's health outcomes and are cost-effective.

(c) The Department shall adopt rules establishing the populations that must participate in the enhanced primary care case management program.

(d) Every person eligible for or receiving medical assistance under this Article shall participate in the program authorized by this Section. A medical assistance recipient shall not be required to participate in, and shall be permitted to withdraw from, the enhanced primary care case management program upon showing that:

(1) a pregnant woman with an established relationship,

as defined by the Department, with a comprehensive prenatal primary care provider that is not associated with the physician and provider network in the participant's service area, may defer participation in the enhanced primary care case management program while pregnant and for 60 days post-partum; or

(2) an individual with a chronic medical condition being treated by a specialist physician that is not associated with a provider in the participant's service area may defer participation in the enhanced primary care case management program until the course of treatment is complete.

(e) The following medical assistance recipients shall not be required to participate in the enhanced primary care case management program established pursuant to this Section, but may voluntarily opt to do so:

(1) A person receiving services provided by a residential alcohol or substance abuse program or facility for the developmentally disabled.

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

(3) 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 federal Social Security Act or who has characteristics and needs similar to such persons.

(4) Native Americans.

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

(f) The following medical assistance recipients shall not be eligible to participate in the enhanced primary care case management program established pursuant to this Section:

(1) A person receiving services provided by a long term home health care program, or a person receiving inpatient services in a State-operated psychiatric facility or a residential treatment facility for children and youth.

(2) A person eligible for Medicare participating in a capitated demonstration program for long term care.

(3) An infant living with an incarcerated mother in a State or local correctional facility as defined in Section 3-1-2 of the Unified Code of Corrections.

(4) A person who is expected to be eligible for medical assistance for less than 6 months.

(5) A person who is eligible for medical assistance benefits only with respect to tuberculosis-related services.

(6) Certified blind or disabled children living or expected to be living separate and apart from the parent for 30 days or more.

(7) Residents of nursing facilities at the time of

enrollment in the program.

(8) Individuals receiving hospice services at the time of enrollment in the program.

(9) A person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost-sharing amounts, when payment of such premium or cost-sharing amounts would be cost-effective, as determined by the Department.

(10) A foster child in the placement of a voluntary agency.

(g) The Department shall adopt rules providing for the implementation and continued oversight of the enhanced primary care case management program.

(h) The Department shall implement the enhanced primary care case management program in a manner that maximizes all available State and federal funds, including those obtained through intergovernmental transfers, supplemental Medicaid payments, and the disproportionate share program.

(i) Waivers. The Department of Healthcare and Family Services shall promptly apply for all waivers of federal law and regulations that are necessary to allow the full implementation of this Section.

(305 ILCS 5/5-16.15 new)

Sec. 5-16.15. Contracts with administrative services

organizations.

(a) In this Section, "administrative services organization" means an entity that performs administrative and management functions, such as the development of a physician and provider network, care coordination, disease management, service coordination, utilization review and management, quality management, and patient and provider education, for a non-capitated system of health care services, medical services, or long-term care services and supports.

(b) Under the enhanced primary care case management program, the Department may contract with one or more administrative services organizations to perform the coordination of care and other services and functions of the enhanced primary care case management program.

(c) The Department may require that each administrative services organization contracting with the Department under this Section assume responsibility for exceeding administrative costs and not meeting performance standards in connection with the provision of acute care and long-term care services and supports under the terms of the contract.

(d) The Department may include in a contract awarded under this Section a written guarantee of State savings on Medicaid expenditures for the recipients receiving services provided under the enhanced primary care case management program developed under Section 5-16.14.

(e) The Department may require that each administrative

services organization contracting with the Department under this Section establish pay-for-performance incentives for providers to improve patient outcomes.

(f) The Department may require each administrative services organization contracting with the Department to perform services under this Code to incorporate disease management into the enhanced primary care case management program utilizing the Medicaid disease management contractor operating in the State until the date the disease management contract expires.".