



## 95TH GENERAL ASSEMBLY

### State of Illinois

2007 and 2008

HB4390

by Rep. Karen May

#### SYNOPSIS AS INTRODUCED:

215 ILCS 105/8

from Ch. 73, par. 1308

Amends the Comprehensive Health Insurance Plan Act. Adds a provision requiring that the Plan provide coverage for mammograms and prosthetic devices or reconstructive surgery incident to a mastectomy, Pap tests, prostate-specific antigen tests, colorectal cancer examination and screening, and contraceptives as required under certain Sections of the Illinois Insurance Code. Provides that any expense or charge for routine physical examinations or tests related to certain covered benefits are not excluded from coverage under the Plan. Deletes a provision excluding any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures from coverage under the Plan.

LRB095 15208 KBJ 41188 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Comprehensive Health Insurance Plan Act is  
5 amended by changing Section 8 as follows:

6 (215 ILCS 105/8) (from Ch. 73, par. 1308)

7 Sec. 8. Minimum benefits.

8 a. Availability. The Plan shall offer in an annually  
9 renewable policy major medical expense coverage to every  
10 eligible person who is not eligible for Medicare. Major medical  
11 expense coverage offered by the Plan shall pay an eligible  
12 person's covered expenses, subject to limit on the deductible  
13 and coinsurance payments authorized under paragraph (4) of  
14 subsection d of this Section, up to a lifetime benefit limit of  
15 \$2,000,000 until 3 years after the effective date of this  
16 amendatory Act of the 95th General Assembly, and \$1,500,000 in  
17 benefits 3 years or more after the effective date of this  
18 amendatory Act of the 95th General Assembly per covered  
19 individual. The maximum limit under this subsection shall not  
20 be altered by the Board, and no actuarial equivalent benefit  
21 may be substituted by the Board. Any person who otherwise would  
22 qualify for coverage under the Plan, but is excluded because he  
23 or she is eligible for Medicare, shall be eligible for any

1 separate Medicare supplement policy or policies which the Board  
2 may offer.

3 b. Outline of benefits. Covered expenses shall be limited  
4 to the usual and customary charge, including negotiated fees,  
5 in the locality for the following services and articles when  
6 prescribed by a physician and determined by the Plan to be  
7 medically necessary for the following areas of services,  
8 subject to such separate deductibles, co-payments, exclusions,  
9 and other limitations on benefits as the Board shall establish  
10 and approve, and the other provisions of this Section:

11 (1) Hospital services, except that any services  
12 provided by a hospital that is located more than 75 miles  
13 outside the State of Illinois shall be covered only for a  
14 maximum of 45 days in any calendar year. With respect to  
15 covered expenses incurred during any calendar year ending  
16 on or after December 31, 1999, inpatient hospitalization of  
17 an eligible person for the treatment of mental illness at a  
18 hospital located within the State of Illinois shall be  
19 subject to the same terms and conditions as for any other  
20 illness.

21 (2) Professional services for the diagnosis or  
22 treatment of injuries, illnesses or conditions, other than  
23 dental and mental and nervous disorders as described in  
24 paragraph (17), which are rendered by a physician, or by  
25 other licensed professionals at the physician's direction.  
26 This includes reconstruction of the breast on which a

1 mastectomy was performed; surgery and reconstruction of  
2 the other breast to produce a symmetrical appearance; and  
3 prostheses and treatment of physical complications at all  
4 stages of the mastectomy, including lymphedemas.

5 (2.5) Professional services provided by a physician to  
6 children under the age of 16 years for physical  
7 examinations and age appropriate immunizations ordered by  
8 a physician licensed to practice medicine in all its  
9 branches.

10 (3) (Blank).

11 (4) Outpatient prescription drugs that by law require a  
12 prescription written by a physician licensed to practice  
13 medicine in all its branches subject to such separate  
14 deductible, copayment, and other limitations or  
15 restrictions as the Board shall approve, including the use  
16 of a prescription drug card or any other program, or both.

17 (5) Skilled nursing services of a licensed skilled  
18 nursing facility for not more than 120 days during a policy  
19 year.

20 (6) Services of a home health agency in accord with a  
21 home health care plan, up to a maximum of 270 visits per  
22 year.

23 (7) Services of a licensed hospice for not more than  
24 180 days during a policy year.

25 (8) Use of radium or other radioactive materials.

26 (9) Oxygen.

1 (10) Anesthetics.

2 (11) Orthoses and prostheses other than dental.

3 (12) Rental or purchase in accordance with Board  
4 policies or procedures of durable medical equipment, other  
5 than eyeglasses or hearing aids, for which there is no  
6 personal use in the absence of the condition for which it  
7 is prescribed.

8 (13) Diagnostic x-rays and laboratory tests.

9 (14) Oral surgery (i) for excision of partially or  
10 completely unerupted impacted teeth when not performed in  
11 connection with the routine extraction or repair of teeth;  
12 (ii) for excision of tumors or cysts of the jaws, cheeks,  
13 lips, tongue, and roof and floor of the mouth; (iii)  
14 required for correction of cleft lip and palate and other  
15 craniofacial and maxillofacial birth defects; or (iv) for  
16 treatment of injuries to natural teeth or a fractured jaw  
17 due to an accident.

18 (15) Physical, speech, and functional occupational  
19 therapy as medically necessary and provided by appropriate  
20 licensed professionals.

21 (16) Emergency and other medically necessary  
22 transportation provided by a licensed ambulance service to  
23 the nearest health care facility qualified to treat a  
24 covered illness, injury, or condition, subject to the  
25 provisions of the Emergency Medical Systems (EMS) Act.

26 (17) Outpatient services for diagnosis and treatment

1 of mental and nervous disorders provided that a covered  
2 person shall be required to make a copayment not to exceed  
3 50% and that the Plan's payment shall not exceed such  
4 amounts as are established by the Board.

5 (18) Human organ or tissue transplants specified by the  
6 Board that are performed at a hospital designated by the  
7 Board as a participating transplant center for that  
8 specific organ or tissue transplant.

9 (19) Naprapathic services, as appropriate, provided by  
10 a licensed naprapathic practitioner.

11 (20) Coverage for benefits as required under Sections  
12 356g, 356u, 356x, and 356z.4 of the Illinois Insurance  
13 Code.

14 c. Exclusions. Covered expenses of the Plan shall not  
15 include the following:

16 (1) Any charge for treatment for cosmetic purposes  
17 other than for reconstructive surgery when the service is  
18 incidental to or follows surgery resulting from injury,  
19 sickness or other diseases of the involved part or surgery  
20 for the repair or treatment of a congenital bodily defect  
21 to restore normal bodily functions.

22 (2) Any charge for care that is primarily for rest,  
23 custodial, educational, or domiciliary purposes.

24 (3) Any charge for services in a private room to the  
25 extent it is in excess of the institution's charge for its  
26 most common semiprivate room, unless a private room is

1 prescribed as medically necessary by a physician.

2 (4) That part of any charge for room and board or for  
3 services rendered or articles prescribed by a physician,  
4 dentist, or other health care personnel that exceeds the  
5 reasonable and customary charge in the locality or for any  
6 services or supplies not medically necessary for the  
7 diagnosed injury or illness.

8 (5) Any charge for services or articles the provision  
9 of which is not within the scope of licensure of the  
10 institution or individual providing the services or  
11 articles.

12 (6) Any expense incurred prior to the effective date of  
13 coverage by the Plan for the person on whose behalf the  
14 expense is incurred.

15 (7) Dental care, dental surgery, dental treatment, any  
16 other dental procedure involving the teeth or  
17 periodontium, or any dental appliances, including crowns,  
18 bridges, implants, or partial or complete dentures, except  
19 as specifically provided in paragraph (14) of subsection b  
20 of this Section.

21 (8) Eyeglasses, contact lenses, hearing aids or their  
22 fitting.

23 (9) Illness or injury due to acts of war.

24 (10) Services of blood donors and any fee for failure  
25 to replace the first 3 pints of blood provided to a covered  
26 person each policy year.

1           (11) Personal supplies or services provided by a  
2 hospital or nursing home, or any other nonmedical or  
3 nonprescribed supply or service.

4           (12) Routine maternity charges for a pregnancy, except  
5 where added as optional coverage with payment of an  
6 additional premium for pregnancy resulting from conception  
7 occurring after the effective date of the optional  
8 coverage.

9           (13) (Blank).

10          (14) Any expense or charge for services, drugs, or  
11 supplies that are: (i) not provided in accord with  
12 generally accepted standards of current medical practice;  
13 (ii) for procedures, treatments, equipment, transplants,  
14 or implants, any of which are investigational,  
15 experimental, or for research purposes; (iii)  
16 investigative and not proven safe and effective; or (iv)  
17 for, or resulting from, a gender transformation operation.

18          (15) Any expense or charge for routine physical  
19 examinations or tests except as provided in items ~~item~~  
20 (2.5) and (20) of subsection b of this Section.

21          (16) Any expense for which a charge is not made in the  
22 absence of insurance or for which there is no legal  
23 obligation on the part of the patient to pay.

24          (17) Any expense incurred for benefits provided under  
25 the laws of the United States and this State, including  
26 Medicare, Medicaid, and other medical assistance, maternal



1 and child health services and any other program that is  
2 administered or funded by the Department of Human Services,  
3 Department of Healthcare and Family Services, or  
4 Department of Public Health, military service-connected  
5 disability payments, medical services provided for members  
6 of the armed forces and their dependents or employees of  
7 the armed forces of the United States, and medical services  
8 financed on behalf of all citizens by the United States.

9 (18) Any expense or charge for in vitro fertilization,  
10 artificial insemination, or any other artificial means  
11 used to cause pregnancy.

12 (19) (Blank). ~~Any expense or charge for oral~~  
13 ~~contraceptives used for birth control or any other~~  
14 ~~temporary birth control measures.~~

15 (20) Any expense or charge for sterilization or  
16 sterilization reversals.

17 (21) Any expense or charge for weight loss programs,  
18 exercise equipment, or treatment of obesity, except when  
19 certified by a physician as morbid obesity (at least 2  
20 times normal body weight).

21 (22) Any expense or charge for acupuncture treatment  
22 unless used as an anesthetic agent for a covered surgery.

23 (23) Any expense or charge for or related to organ or  
24 tissue transplants other than those performed at a hospital  
25 with a Board approved organ transplant program that has  
26 been designated by the Board as a preferred or exclusive

1 provider organization for that specific organ or tissue  
2 transplant.

3 (24) Any expense or charge for procedures, treatments,  
4 equipment, or services that are provided in special  
5 settings for research purposes or in a controlled  
6 environment, are being studied for safety, efficiency, and  
7 effectiveness, and are awaiting endorsement by the  
8 appropriate national medical speciality college for  
9 general use within the medical community.

10 d. Deductibles and coinsurance.

11 The Plan coverage defined in Section 6 shall provide for a  
12 choice of deductibles per individual as authorized by the  
13 Board. If 2 individual members of the same family household,  
14 who are both covered persons under the Plan, satisfy the same  
15 applicable deductibles, no other member of that family who is  
16 also a covered person under the Plan shall be required to meet  
17 any deductibles for the balance of that calendar year. The  
18 deductibles must be applied first to the authorized amount of  
19 covered expenses incurred by the covered person. A mandatory  
20 coinsurance requirement shall be imposed at the rate authorized  
21 by the Board in excess of the mandatory deductible, the  
22 coinsurance in the aggregate not to exceed such amounts as are  
23 authorized by the Board per annum. At its discretion the Board  
24 may, however, offer catastrophic coverages or other policies  
25 that provide for larger deductibles with or without coinsurance  
26 requirements. The deductibles and coinsurance factors may be

1 adjusted annually according to the Medical Component of the  
2 Consumer Price Index.

3 e. Scope of coverage.

4 (1) In approving any of the benefit plans to be offered  
5 by the Plan, the Board shall establish such benefit levels,  
6 deductibles, coinsurance factors, exclusions, and  
7 limitations as it may deem appropriate and that it believes  
8 to be generally reflective of and commensurate with health  
9 insurance coverage that is provided in the individual  
10 market in this State.

11 (2) The benefit plans approved by the Board may also  
12 provide for and employ various cost containment measures  
13 and other requirements including, but not limited to,  
14 preadmission certification, prior approval, second  
15 surgical opinions, concurrent utilization review programs,  
16 individual case management, preferred provider  
17 organizations, health maintenance organizations, and other  
18 cost effective arrangements for paying for covered  
19 expenses.

20 f. Preexisting conditions.

21 (1) Except for federally eligible individuals  
22 qualifying for Plan coverage under Section 15 of this Act  
23 or eligible persons who qualify for the waiver authorized  
24 in paragraph (3) of this subsection, plan coverage shall  
25 exclude charges or expenses incurred during the first 6  
26 months following the effective date of coverage as to any

1 condition for which medical advice, care or treatment was  
2 recommended or received during the 6 month period  
3 immediately preceding the effective date of coverage.

4 (2) (Blank).

5 (3) Waiver: The preexisting condition exclusions as  
6 set forth in paragraph (1) of this subsection shall be  
7 waived to the extent to which the eligible person (a) has  
8 satisfied similar exclusions under any prior individual  
9 health insurance policy that was involuntarily terminated  
10 because of the insolvency of the issuer of the policy and  
11 (b) has applied for Plan coverage within 90 days following  
12 the involuntary termination of that individual health  
13 insurance coverage.

14 g. Other sources primary; nonduplication of benefits.

15 (1) The Plan shall be the last payor of benefits  
16 whenever any other benefit or source of third party payment  
17 is available. Subject to the provisions of subsection e of  
18 Section 7, benefits otherwise payable under Plan coverage  
19 shall be reduced by all amounts paid or payable by Medicare  
20 or any other government program or through any health  
21 insurance coverage or group health plan, whether by  
22 insurance, reimbursement, or otherwise, or through any  
23 third party liability, settlement, judgment, or award,  
24 regardless of the date of the settlement, judgment, or  
25 award, whether the settlement, judgment, or award is in the  
26 form of a contract, agreement, or trust on behalf of a

1 minor or otherwise and whether the settlement, judgment, or  
2 award is payable to the covered person, his or her  
3 dependent, estate, personal representative, or guardian in  
4 a lump sum or over time, and by all hospital or medical  
5 expense benefits paid or payable under any worker's  
6 compensation coverage, automobile medical payment, or  
7 liability insurance, whether provided on the basis of fault  
8 or nonfault, and by any hospital or medical benefits paid  
9 or payable under or provided pursuant to any State or  
10 federal law or program.

11 (2) The Plan shall have a cause of action against any  
12 covered person or any other person or entity for the  
13 recovery of any amount paid to the extent the amount was  
14 for treatment, services, or supplies not covered in this  
15 Section or in excess of benefits as set forth in this  
16 Section.

17 (3) Whenever benefits are due from the Plan because of  
18 sickness or an injury to a covered person resulting from a  
19 third party's wrongful act or negligence and the covered  
20 person has recovered or may recover damages from a third  
21 party or its insurer, the Plan shall have the right to  
22 reduce benefits or to refuse to pay benefits that otherwise  
23 may be payable by the amount of damages that the covered  
24 person has recovered or may recover regardless of the date  
25 of the sickness or injury or the date of any settlement,  
26 judgment, or award resulting from that sickness or injury.

1           During the pendency of any action or claim that is  
2 brought by or on behalf of a covered person against a third  
3 party or its insurer, any benefits that would otherwise be  
4 payable except for the provisions of this paragraph (3)  
5 shall be paid if payment by or for the third party has not  
6 yet been made and the covered person or, if incapable, that  
7 person's legal representative agrees in writing to pay back  
8 promptly the benefits paid as a result of the sickness or  
9 injury to the extent of any future payments made by or for  
10 the third party for the sickness or injury. This agreement  
11 is to apply whether or not liability for the payments is  
12 established or admitted by the third party or whether those  
13 payments are itemized.

14           Any amounts due the plan to repay benefits may be  
15 deducted from other benefits payable by the Plan after  
16 payments by or for the third party are made.

17           (4) Benefits due from the Plan may be reduced or  
18 refused as an offset against any amount otherwise  
19 recoverable under this Section.

20           h. Right of subrogation; recoveries.

21           (1) Whenever the Plan has paid benefits because of  
22 sickness or an injury to any covered person resulting from  
23 a third party's wrongful act or negligence, or for which an  
24 insurer is liable in accordance with the provisions of any  
25 policy of insurance, and the covered person has recovered  
26 or may recover damages from a third party that is liable

1 for the damages, the Plan shall have the right to recover  
2 the benefits it paid from any amounts that the covered  
3 person has received or may receive regardless of the date  
4 of the sickness or injury or the date of any settlement,  
5 judgment, or award resulting from that sickness or injury.  
6 The Plan shall be subrogated to any right of recovery the  
7 covered person may have under the terms of any private or  
8 public health care coverage or liability coverage,  
9 including coverage under the Workers' Compensation Act or  
10 the Workers' Occupational Diseases Act, without the  
11 necessity of assignment of claim or other authorization to  
12 secure the right of recovery. To enforce its subrogation  
13 right, the Plan may (i) intervene or join in an action or  
14 proceeding brought by the covered person or his personal  
15 representative, including his guardian, conservator,  
16 estate, dependents, or survivors, against any third party  
17 or the third party's insurer that may be liable or (ii)  
18 institute and prosecute legal proceedings against any  
19 third party or the third party's insurer that may be liable  
20 for the sickness or injury in an appropriate court either  
21 in the name of the Plan or in the name of the covered  
22 person or his personal representative, including his  
23 guardian, conservator, estate, dependents, or survivors.

24 (2) If any action or claim is brought by or on behalf  
25 of a covered person against a third party or the third  
26 party's insurer, the covered person or his personal

1 representative, including his guardian, conservator,  
2 estate, dependents, or survivors, shall notify the Plan by  
3 personal service or registered mail of the action or claim  
4 and of the name of the court in which the action or claim  
5 is brought, filing proof thereof in the action or claim.  
6 The Plan may, at any time thereafter, join in the action or  
7 claim upon its motion so that all orders of court after  
8 hearing and judgment shall be made for its protection. No  
9 release or settlement of a claim for damages and no  
10 satisfaction of judgment in the action shall be valid  
11 without the written consent of the Plan to the extent of  
12 its interest in the settlement or judgment and of the  
13 covered person or his personal representative.

14 (3) In the event that the covered person or his  
15 personal representative fails to institute a proceeding  
16 against any appropriate third party before the fifth month  
17 before the action would be barred, the Plan may, in its own  
18 name or in the name of the covered person or personal  
19 representative, commence a proceeding against any  
20 appropriate third party for the recovery of damages on  
21 account of any sickness, injury, or death to the covered  
22 person. The covered person shall cooperate in doing what is  
23 reasonably necessary to assist the Plan in any recovery and  
24 shall not take any action that would prejudice the Plan's  
25 right to recovery. The Plan shall pay to the covered person  
26 or his personal representative all sums collected from any



1 third party by judgment or otherwise in excess of amounts  
2 paid in benefits under the Plan and amounts paid or to be  
3 paid as costs, attorneys fees, and reasonable expenses  
4 incurred by the Plan in making the collection or enforcing  
5 the judgment.

6 (4) In the event that a covered person or his personal  
7 representative, including his guardian, conservator,  
8 estate, dependents, or survivors, recovers damages from a  
9 third party for sickness or injury caused to the covered  
10 person, the covered person or the personal representative  
11 shall pay to the Plan from the damages recovered the amount  
12 of benefits paid or to be paid on behalf of the covered  
13 person.

14 (5) When the action or claim is brought by the covered  
15 person alone and the covered person incurs a personal  
16 liability to pay attorney's fees and costs of litigation,  
17 the Plan's claim for reimbursement of the benefits provided  
18 to the covered person shall be the full amount of benefits  
19 paid to or on behalf of the covered person under this Act  
20 less a pro rata share that represents the Plan's reasonable  
21 share of attorney's fees paid by the covered person and  
22 that portion of the cost of litigation expenses determined  
23 by multiplying by the ratio of the full amount of the  
24 expenditures to the full amount of the judgement, award, or  
25 settlement.

26 (6) In the event of judgment or award in a suit or

1 claim against a third party or insurer, the court shall  
2 first order paid from any judgement or award the reasonable  
3 litigation expenses incurred in preparation and  
4 prosecution of the action or claim, together with  
5 reasonable attorney's fees. After payment of those  
6 expenses and attorney's fees, the court shall apply out of  
7 the balance of the judgment or award an amount sufficient  
8 to reimburse the Plan the full amount of benefits paid on  
9 behalf of the covered person under this Act, provided the  
10 court may reduce and apportion the Plan's portion of the  
11 judgement proportionate to the recovery of the covered  
12 person. The burden of producing evidence sufficient to  
13 support the exercise by the court of its discretion to  
14 reduce the amount of a proven charge sought to be enforced  
15 against the recovery shall rest with the party seeking the  
16 reduction. The court may consider the nature and extent of  
17 the injury, economic and non-economic loss, settlement  
18 offers, comparative negligence as it applies to the case at  
19 hand, hospital costs, physician costs, and all other  
20 appropriate costs. The Plan shall pay its pro rata share of  
21 the attorney fees based on the Plan's recovery as it  
22 compares to the total judgment. Any reimbursement rights of  
23 the Plan shall take priority over all other liens and  
24 charges existing under the laws of this State with the  
25 exception of any attorney liens filed under the Attorneys  
26 Lien Act.

1           (7) The Plan may compromise or settle and release any  
2           claim for benefits provided under this Act or waive any  
3           claims for benefits, in whole or in part, for the  
4           convenience of the Plan or if the Plan determines that  
5           collection would result in undue hardship upon the covered  
6           person.

7           (Source: P.A. 94-737, eff. 5-3-06; 95-547, eff. 8-29-07.)