HB5648

LRB095 19208 KBJ 45459 b

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB5648

by Rep. Frank J. Mautino

SYNOPSIS AS INTRODUCED:

215 ILCS 105/7 from Ch. 73, par. 1307

Amends the Comprehensive Health Insurance Plan Act. Provides that coverage under the Plan shall automatically terminate as of the effective date of any medical assistance, except in cases where the effective date of the medical assistance is the date that the application for medical assistance was submitted to the Department of Human Services and that date is different than the date that the applicant is determined to be eligible for medical assistance. Provides that in that circumstance, coverage under the plan shall terminate on the date that the applicant was determined to be eligible for medical assistance. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Comprehensive Health Insurance Plan Act is amended by changing Section 7 as follows:

(215 ILCS 105/7) (from Ch. 73, par. 1307)

Sec. 7. Eligibility.

a. Except as provided in subsection (e) of this Section or in Section 15 of this Act, any person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and who has been for a period of at least 180 days and continues to be a resident of this State shall be eligible for Plan coverage under this Section if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar individual health insurance coverage for health reasons by a health insurance issuer; or

(2) A refusal by a health insurance issuer to issue individual health insurance coverage except at a rate exceeding the applicable Plan rate for which the person is responsible.

A rejection or refusal by a group health plan or health insurance issuer offering only stop-loss or excess of loss

insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection.

b. The board shall promulgate a list of medical or health conditions for which a person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and a resident of this State would be eligible for Plan coverage without applying for health insurance coverage pursuant to subsection a. of this Section. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection a. of this Section. The list shall be effective on the first day of the operation of the Plan and may be amended from time to time as appropriate.

c. Family members of the same household who each are covered persons are eligible for optional family coverage under the Plan.

d. For persons qualifying for coverage in accordance with Section 7 of this Act, the board shall, if it determines that such appropriations as are made pursuant to Section 12 of this Act are insufficient to allow the board to accept all of the eligible persons which it projects will apply for enrollment under the Plan, limit or close enrollment to ensure that the Plan is not over-subscribed and that it has sufficient resources to meet its obligations to existing enrollees. The

board shall not limit or close enrollment for federally eligible individuals.

e. A person shall not be eligible for coverage under the Plan if:

(1) He or she has or obtains other coverage under a group health plan or health insurance coverage substantially similar to or better than a Plan policy as an insured or covered dependent or would be eligible to have that coverage if he or she elected to obtain it. Persons otherwise eligible for Plan coverage may, however, solely for the purpose of having coverage for a pre-existing condition, maintain other coverage only while satisfying any pre-existing condition waiting period under a Plan policy or a subsequent replacement policy of a Plan policy.

(1.1) His or her prior coverage under a group health plan or health insurance coverage, provided or arranged by an employer of more than 10 employees was discontinued for any reason without the entire group or plan being discontinued and not replaced, provided he or she remains an employee, or dependent thereof, of the same employer.

(2) He or she is a recipient of or is approved to receive medical assistance, except that a person may continue to receive medical assistance through the medical assistance no grant program, but only while satisfying the requirements for a preexisting condition under Section 8, subsection f. of this Act. Payment of premiums pursuant to

this Act shall be allocable to the person's spenddown for purposes of the medical assistance no grant program, but that person shall not be eligible for any Plan benefits while that person remains eligible for medical assistance. If the person continues to receive or be approved to receive medical assistance through the medical assistance no grant program at or after the time that requirements for a preexisting condition are satisfied, the person shall not be eligible for coverage under the Plan. In that circumstance, coverage under the plan shall terminate as of the expiration of the preexisting condition limitation period. Under all other circumstances, coverage under the Plan shall automatically terminate as of the effective date of any medical assistance, except in cases where the effective date of the medical assistance is the date that the application for medical assistance was submitted to the Department of Human Services and that date is different than the date that the applicant is determined to be eligible for medical assistance. In that circumstance, coverage under the plan shall terminate on the date that the applicant was determined to be eligible for medical assistance.

(3) Except as provided in Section 15, the person has previously participated in the Plan and voluntarily terminated Plan coverage, unless 12 months have elapsed since the person's latest voluntary termination of

coverage.

(4) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the Plan shall be limited to benefits incurred under the Plan for the time period for which premiums had been paid and the covered person remained eligible for Plan coverage.

(5) The Plan (i) until 3 years after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $2,000,000 in benefits on behalf of the covered person or (ii) 3 years or more after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $1,500,000 in benefits on behalf of the covered person.

(6) The person is a resident of a public institution.

(7) The person's premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of such employee, of a government agency or health care provider or, except when a person's premium is paid by the U.S. Treasury Department pursuant to the federal Trade Act of 2002.

(8) The person has or later receives other benefits or funds from any settlement, judgement, or award resulting from any accident or injury, regardless of the date of the

accident or injury, or any other circumstances creating a legal liability for damages due that person by a third party, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or assets remaining from those sources in an amount in excess of $300,000.

(9) Within the 5 years prior to the date a person's Plan application is received by the Board, the person's coverage under any health care benefit program as defined in 18 U.S.C. 24, including any public or private plan or contract under which any medical benefit, item, or service is provided, was terminated as a result of any act or practice that constitutes fraud under State or federal law or as a result of an intentional misrepresentation of material fact; or if that person knowingly and willfully obtained or attempted to obtain, or fraudulently aided or attempted to aid any other person in obtaining, any coverage or benefits under the Plan to which that person was not entitled.

f. The board or the administrator shall require verification of residency and may require any additional information or documentation, or statements under oath, when

necessary to determine residency upon initial application and for the entire term of the policy.

g. Coverage shall cease (i) on the date a person is no longer a resident of Illinois, (ii) on the date a person requests coverage to end, (iii) upon the death of the covered person, (iv) on the date State law requires cancellation of the policy, or (v) at the Plan's option, 30 days after the Plan makes any inquiry concerning a person's eligibility or place of residence to which the person does not reply.

h. Except under the conditions set forth in subsection g of this Section, the coverage of any person who ceases to meet the eligibility requirements of this Section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

(Source: P.A. 94-17, eff. 1-1-06; 94-737, eff. 5-3-06; 95-547, eff. 8-29-07.)

Section 99. Effective date. This Act takes effect upon becoming law.