Sen. Carol Ronen

Filed: 3/30/2007

AMENDMENT TO SENATE BILL 5

AMENDMENT NO. _____. Amend Senate Bill 5 by replacing everything after the enacting clause with the following:

"ARTICLE 1. SHORT TITLE; LEGISLATIVE INTENT

Section 1-1. Short title. This Act may be cited as the Illinois Covered Act.

Section 1-5. Legislative intent. The General Assembly finds that, for the economic and social benefit of all residents of the State, it is important to enable all Illinoisans to access affordable health insurance that provides comprehensive coverage and emphasizes preventive healthcare. Many working families are uninsured and numerous others struggle with the high cost of healthcare. Nationally, the cost of premiums for family coverage ($11,480) outpaced the earnings of a full-time, minimum wage worker ($10,712).

Those individuals and businesses that are paying for health insurance are paying more due to cost shifting from the uninsured. A Families USA study showed that family health insurance in Illinois was increased by $1,059 in 2006 due to cost shifting from the uninsured. Numerous studies, including the Institute of Medicine's report "Health Insurance Matters", demonstrate that lack of insurance negatively affects health status. Lack of insurance also decreases worker productivity and the long-term health of Illinois residents, therefore, negatively affecting the economy overall. It is, therefore, the intent of this legislation to provide access to affordable, comprehensive health insurance to all Illinoisans in a cost-effective manner maximizing federal support.

ARTICLE 5. MAKING HEALTH INSURANCE MORE AFFORDABLE THROUGH THE ILLINOIS COVERED REBATE PROGRAM

Section 5-1. Short title. This Article may be cited as the Illinois Covered Rebate Program Act. All references in this Article to "this Act" mean this Article.

Section 5-10. Definitions. In this Act:

"Department" means the Department of Healthcare and Family Services.

"Employer-sponsored insurance" means health insurance obtained as a benefit of employment that meets qualifying

criteria established by the Department by rule, including, but not limited to, amount of employer contribution.

"Federal poverty level" means the federal poverty level income guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

"Premium assistance" means payments made on behalf of an individual to offset the costs of paying premiums to secure health insurance for that individual or that individual's family under family coverage.

Section 5-15. Eligibility.

(a) To be eligible for premium assistance, a person must:

(1) be at least 19 years of age and no older than 64 years of age; and

(2) be a resident of Illinois; and

(3) reside legally in the United States as one of the following:

(A) a United States citizen; or

(B) a qualified immigrant as set forth in Section 1-11 of the Illinois Public Aid Code, except that those persons who are in categories set forth in items (6) and (7) of that Section and who enter the United States on or after August 22, 1996 shall not be excluded from eligibility for 5 years beginning on the date the person entered the United States; or

(C) a documented non-immigrant who is not a temporary visitor or in transit through the United States who is granted legal entry into the United States, as determined by the Department by rule; and

(4) have income below 400% of the federal poverty level.

(b) The Department shall adopt rules regarding eligibility that shall include but not be limited to coordinating eligibility for benefits available under the Illinois Covered Rebate Program with eligibility for medical assistance, other premium assistance, or healthcare benefits available under the Illinois Public Aid Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Program Act, or the Veterans' Health Insurance Program Act, as well as determining income, the method of applying for premium assistance, renewals, and reenrollment.

Section 5-20. Premium assistance.

(a) Effective July 1, 2008, or as soon as practicable thereafter as determined by the Department, the Department shall provide premium assistance for eligible persons under this Act.

(b) For those persons who have access to employer-sponsored insurance, the Department shall provide premium assistance to enable the person to enroll in the employer-sponsored plan.

(c) For those persons who do not have access to

employer-sponsored insurance, the Department shall provide premium assistance to enable the person to enroll in the Illinois Covered Choices program under the Illinois Covered Choices Act.

(d) The Department shall adopt rules regarding premium assistance that shall include, but not be limited to, defining qualifying employer-sponsored insurance, the threshold minimums for employer contributions, and the amount of premium assistance.

Section 5-30. Study.

(a) Subsequent to the implementation of the Illinois Covered Rebate Program, the Department shall conduct a study to determine whether the program should be made available to persons older than age 64.

(b) The results of the study shall be submitted to the Governor and the General Assembly no later than October 1, 2011.

Section 5-90. The Illinois Income Tax Act is amended by changing Section 917 as follows:

(35 ILCS 5/917) (from Ch. 120, par. 9-917)

Sec. 917. Confidentiality and information sharing.

(a) Confidentiality. Except as provided in this Section, all information received by the Department from returns filed

under this Act, or from any investigation conducted under the provisions of this Act, shall be confidential, except for official purposes within the Department or pursuant to official procedures for collection of any State tax or pursuant to an investigation or audit by the Illinois State Scholarship Commission of a delinquent student loan or monetary award or enforcement of any civil or criminal penalty or sanction imposed by this Act or by another statute imposing a State tax, and any person who divulges any such information in any manner, except for such purposes and pursuant to order of the Director or in accordance with a proper judicial order, shall be guilty of a Class A misdemeanor. However, the provisions of this paragraph are not applicable to information furnished to (i) the Department of Healthcare and Family Services (formerly Department of Public Aid), State's Attorneys, and the Attorney General for child support enforcement purposes and (ii) a licensed attorney representing the taxpayer where an appeal or a protest has been filed on behalf of the taxpayer. If it is necessary to file information obtained pursuant to this Act in a child support enforcement proceeding, the information shall be filed under seal.

(b) Public information. Nothing contained in this Act shall prevent the Director from publishing or making available to the public the names and addresses of persons filing returns under this Act, or from publishing or making available reasonable statistics concerning the operation of the tax wherein the

contents of returns are grouped into aggregates in such a way that the information contained in any individual return shall not be disclosed.

(c) Governmental agencies. The Director may make available to the Secretary of the Treasury of the United States or his delegate, or the proper officer or his delegate of any other state imposing a tax upon or measured by income, for exclusively official purposes, information received by the Department in the administration of this Act, but such permission shall be granted only if the United States or such other state, as the case may be, grants the Department substantially similar privileges. The Director may exchange information with the Department of Healthcare and Family Services and the Department of Human Services for the purpose of determining eligibility for health benefit programs administered by those departments, for verifying sources and amounts of income, and for other purposes directly connected with the administration of those programs. The Director may exchange information with the Department of Healthcare and Family Services and the Department of Human Services (acting as successor to the Department of Public Aid under the Department of Human Services Act) for the purpose of verifying sources and amounts of income and for other purposes directly connected with the administration of this Act and the Illinois Public Aid Code. The Director may exchange information with the Director of the Department of Employment Security for the purpose of

verifying sources and amounts of income and for other purposes directly connected with the administration of this Act and Acts administered by the Department of Employment Security. The Director may make available to the Illinois Workers' Compensation Commission information regarding employers for the purpose of verifying the insurance coverage required under the Workers' Compensation Act and Workers' Occupational Diseases Act. The Director may exchange information with the Illinois Department on Aging for the purpose of verifying sources and amounts of income for purposes directly related to confirming eligibility for participation in the programs of benefits authorized by the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.

The Director may make available to any State agency, including the Illinois Supreme Court, which licenses persons to engage in any occupation, information that a person licensed by such agency has failed to file returns under this Act or pay the tax, penalty and interest shown therein, or has failed to pay any final assessment of tax, penalty or interest due under this Act. The Director may make available to any State agency, including the Illinois Supreme Court, information regarding whether a bidder, contractor, or an affiliate of a bidder or contractor has failed to file returns under this Act or pay the tax, penalty, and interest shown therein, or has failed to pay any final assessment of tax, penalty, or interest due under this Act, for the limited purpose of enforcing bidder and

contractor certifications. For purposes of this Section, the term "affiliate" means any entity that (1) directly, indirectly, or constructively controls another entity, (2) is directly, indirectly, or constructively controlled by another entity, or (3) is subject to the control of a common entity. For purposes of this subsection (a), an entity controls another entity if it owns, directly or individually, more than 10% of the voting securities of that entity. As used in this subsection (a), the term "voting security" means a security that (1) confers upon the holder the right to vote for the election of members of the board of directors or similar governing body of the business or (2) is convertible into, or entitles the holder to receive upon its exercise, a security that confers such a right to vote. A general partnership interest is a voting security.

The Director may make available to any State agency, including the Illinois Supreme Court, units of local government, and school districts, information regarding whether a bidder or contractor is an affiliate of a person who is not collecting and remitting Illinois Use taxes, for the limited purpose of enforcing bidder and contractor certifications.

The Director may also make available to the Secretary of State information that a corporation which has been issued a certificate of incorporation by the Secretary of State has failed to file returns under this Act or pay the tax, penalty

and interest shown therein, or has failed to pay any final assessment of tax, penalty or interest due under this Act. An assessment is final when all proceedings in court for review of such assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted. For taxable years ending on or after December 31, 1987, the Director may make available to the Director or principal officer of any Department of the State of Illinois, information that a person employed by such Department has failed to file returns under this Act or pay the tax, penalty and interest shown therein. For purposes of this paragraph, the word "Department" shall have the same meaning as provided in Section 3 of the State Employees Group Insurance Act of 1971.

(d) The Director shall make available for public inspection in the Department's principal office and for publication, at cost, administrative decisions issued on or after January 1, 1995. These decisions are to be made available in a manner so that the following taxpayer information is not disclosed:

(1) The names, addresses, and identification numbers of the taxpayer, related entities, and employees.

(2) At the sole discretion of the Director, trade secrets or other confidential information identified as such by the taxpayer, no later than 30 days after receipt of an administrative decision, by such means as the Department shall provide by rule.

The Director shall determine the appropriate extent of the

deletions allowed in paragraph (2). In the event the taxpayer does not submit deletions, the Director shall make only the deletions specified in paragraph (1).

The Director shall make available for public inspection and publication an administrative decision within 180 days after the issuance of the administrative decision. The term "administrative decision" has the same meaning as defined in Section 3-101 of Article III of the Code of Civil Procedure. Costs collected under this Section shall be paid into the Tax Compliance and Administration Fund.

(e) Nothing contained in this Act shall prevent the Director from divulging information to any person pursuant to a request or authorization made by the taxpayer, by an authorized representative of the taxpayer, or, in the case of information related to a joint return, by the spouse filing the joint return with the taxpayer.

(Source: P.A. 93-25, eff. 6-20-03; 93-721, eff. 1-1-05; 93-835; 93-841, eff. 7-30-04; 94-1074, eff. 12-26-06.)

ARTICLE 7. EXPANDING ACCESS TO HEALTH INSURANCE THROUGH PUBLIC COVERAGE

Section 7-90. The Children's Health Insurance Program Act is amended by changing Section 40 as follows:

(215 ILCS 106/40)

Sec. 40. Waivers.

(a) If the ~~The~~ Department determines that it is advantageous to the State, it may initiate, modify, or terminate provisions of any State plans or ~~shall request any necessary~~ waivers of federal requirements in order to allow receipt of federal funding for:

(1) the coverage of any caretaker relative, as defined by the Department ~~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 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 7-95. The Illinois Public Aid Code is amended by changing Sections 1-11, 5-2, and 12-4.35 as follows:

(305 ILCS 5/1-11)

Sec. 1-11. Citizenship. Except as provided in Section 12-4.35 of this Code, to ~~To~~ the extent not otherwise provided in this Code or federal law, all individuals ~~clients~~ who receive cash or medical assistance under Article III, IV, V, or VI of this Code must meet the citizenship requirements as established in this Section. To be eligible for assistance an individual, who is otherwise eligible, must be either a United States citizen or included in one of the following categories of non-citizens:

(1) United States veterans honorably discharged and persons on active military duty, and the spouse and

unmarried dependent children of these persons;

(2) Refugees under Section 207 of the Immigration and Nationality Act;

(3) Asylees under Section 208 of the Immigration and Nationality Act;

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

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

(6) Persons lawfully admitted for permanent residence under the Immigration and Nationality Act;

(7) Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act;

(8) Nationals of Cuba or Haiti admitted on or after April 21, 1980;

(9) Amerasians from Vietnam, and their close family members, admitted through the Orderly Departure Program beginning on March 20, 1988;

(10) Persons identified by the federal Office of Refugee Resettlement (ORR) as victims of trafficking;

(11) Persons legally residing in the United States who were members of a Hmong or Highland Laotian tribe when the tribe helped United States personnel by taking part in a military or rescue operation during the Vietnam era

(between August 5, 1965 and May 7, 1975); this also includes the person's spouse, a widow or widower who has not remarried, and unmarried dependent children;

(12) American Indians born in Canada under Section 289 of the Immigration and Nationality Act and members of an Indian tribe as defined in Section 4e of the Indian Self-Determination and Education Assistance Act; and

(13) Persons who are a spouse, widow, or child of a U.S. citizen or a spouse or child of a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the U.S. citizen or LPR or a member of that relative's family who lived with them, who no longer live with the abuser or plan to live separately within one month of receipt of assistance and whose need for assistance is due, at least in part, to the abuse.

Those persons who are in the categories set forth in subdivisions 6 and 7 of this Section, who enter the United States on or after August 22, 1996, shall not be eligible for 5 years beginning on the date the person entered the United States unless they are eligible under one of the following paragraphs of Section 5-2: 1, 2, 5, 6, 8, 11, 15, or 16. Persons who are documented non-immigrants who are not temporary visitors or in transit through the United States who are granted legal entry into the United States as determined by the Department by rule are eligible for medical assistance if they are otherwise eligible under one of the following paragraphs of

Section 5-2: 1, 2, 5, 6, 8, 11, 15, or 16.

The Illinois Department may, by rule, cover prenatal care or emergency medical care for non-citizens who are not otherwise eligible under this Section. Local governmental units which do not receive State funds may impose their own citizenship requirements and are authorized to provide any benefits and impose any citizenship requirements as are allowed under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).

(Source: P.A. 93-342, eff. 7-24-03.)

(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.

Subject to federal approval and as defined by the Department by rule, persons who are eligible due to blindness or disability and who have access to employer-sponsored insurance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, may be offered and may choose to receive premium assistance as defined in Section 5-10 of the Illinois Covered Rebate Program Act and

under the terms and conditions, including amount of premium subsidy and cost sharing, set forth by the Department by rule.

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).

Subject to federal approval and as defined by the Department by rule, persons who are eligible due to blindness or disability and who have access to employer-sponsored insurance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, may be offered and may choose to receive premium assistance as defined in Section 5-10 of the Illinois Covered Rebate Program Act and under the terms and conditions, including amount of premium subsidy and cost sharing, set forth by the Department by rule.

(b) Effective January 1, 2009, or as soon as practicable thereafter as determined by the Department, persons otherwise eligible for basic maintenance under Article III due to blindness or disability, who are uninsured as determined by the Department by rule, whose income, as determined by the Department, is greater than 100% of the federal poverty

level but no greater than 300% shall be eligible for premium assistance as defined in Section 5-10 of the Illinois Covered Rebate Program Act and under the terms and conditions, including amount of premium subsidy and cost sharing, set forth by the Department by rule.

(i) If such person has access to employer-sponsored insurance but is not eligible for Medicare, the Department shall subsidize the premiums for that employer-sponsored insurance as defined by the Department by rule.

(ii) If such person does not have access to employer-sponsored insurance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, or Medicare, the Department shall subsidize the person's premiums for enrollment in the Illinois Covered Choices Program under the Illinois Covered Choices Act.

(iii) If such person is eligible for Medicare, the Department shall determine which coverage it shall subsidize for the individual.

If necessary to obtain federal funding for expenditures under this paragraph or for other budgetary concerns, the Department may modify these provisions through rulemaking, including opting to provide direct coverage rather than premium assistance. Those modifications shall occur only when

the Department determines those modifications to be cost effective.

(c) ~~(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. (Blank). ~~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. Effective January 1, 2008 and subject to federal approval, such persons shall be eligible if their income as determined by the Department is equal to or less than 350% of the Federal Poverty Level guideline.

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. Persons who are at least 19 years of age and younger than 65 years of age who are not otherwise eligible under this Section with income, as determined by the Department, at or below 100% of the federal poverty level as follows:

(a) Effective January 1, 2008, or as soon as practicable thereafter as determined by the Department, persons who do not have access to employer-sponsored insurance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, shall

be eligible for medical assistance. "Medical assistance" under this paragraph 15 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act, excluding coverage for long term care, non-emergency transportation, and chiropractic services. For hospital services provided to persons made eligible for medical assistance under this paragraph 15, the base payments for such services shall be no less than the base payments for existing recipients of medical assistance.

(b) Effective July 1, 2008, or as soon as practicable thereafter as determined by the Department, persons who have access to employer-sponsored insurance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, shall be eligible for premium assistance as defined in Section 5-10 of the Illinois Covered Rebate Program Act and under the terms and conditions, including amount of premium subsidy and cost sharing, set forth by the Department by rule to enroll in their employer's plan.

If necessary to obtain federal funding for coverage under this paragraph or for other budgetary concerns, the Department may modify these provisions through rulemaking or may initiate, modify, or terminate any provisions of state plans or waivers of federal requirements in order to

allow receipt of federal funding for coverage under this paragraph 15. Those modifications shall occur only when the Department determines the modifications to be cost effective.

16. Caretaker relatives, as defined by the Department by rule, who are not otherwise eligible under this Section, the Children's Health Insurance Program Act, or the Covering ALL KIDS Health Insurance Program who have income at or below 400% of the federal poverty level as follows:

(a) Effective January 1, 2008 or as soon as practicable thereafter, caretaker relatives who do not have access to employer-sponsored insurance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, shall be eligible for medical assistance.

(b) Effective July 1, 2008 or as soon as practicable thereafter, caretaker relatives who have access to employer-sponsored insurance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, shall be eligible for premium assistance as defined in Section 5-10 of the Illinois Covered Rebate Program Act and under the terms and conditions, including amount of premium subsidy and cost sharing, set forth by the Department by rule to enroll in the employer's plan.

The Department may by rule define criteria for eligibility of caretaker relatives that are comparable to

criteria established for children under the Covering ALL KIDS Health Insurance Act.

If the Department determines that it is advantageous to the State, it may initiate, modify, or terminate any provisions of State plans or waivers of federal requirements in order to allow receipt of federal funding for coverage under this paragraph.

If necessary to obtain federal funding for coverage under this paragraph or for other budgetary concerns, the Department may modify these provisions through rulemaking. Those modifications shall occur only when the Department determines the modifications to be cost effective.

17. Subject to federal approval, such other individuals and such coverage or premium assistance, as defined in Section 5-10 of the Illinois Covered Rebate Program Act, as may be defined by the Department by rule.

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 5/12-4.35)

Sec. 12-4.35. Medical services for certain noncitizens.

(a) Notwithstanding Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act, the Department of Healthcare and Family Services ~~Public Aid~~ may

provide medical services to noncitizens who have not yet attained 19 years of age and who are not eligible for medical assistance under Article V of this Code or under the Children's Health Insurance Program created by the Children's Health Insurance Program Act due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code or the Children's Health Insurance Program created by the Children's Health Insurance Program Act.

(b) The Department is authorized to take any action, including without limitation cessation of enrollment, reduction of available medical services, and changing standards for eligibility, that is deemed necessary by the Department during a State fiscal year to assure that payments under this Section do not exceed available funds.

(c) (Blank). ~~Continued enrollment of individuals into the program created under this Section in any fiscal year is contingent upon continued enrollment of individuals into the Children's Health Insurance Program during that fiscal year.~~

(d) (Blank).

(Source: P.A. 94-48, eff. 7-1-05; revised 12-15-05.)

Section 7-97. The Veterans' Health Insurance Program Act is amended by changing Section 85 as follows:

(330 ILCS 125/85)

(Section scheduled to be repealed on January 1, 2008)

Sec. 85. Repeal. This Act is repealed on January 1, 2010 ~~2008~~. The Department shall assist veterans to transition from Veterans Care to appropriate comparable coverage under the Illinois Covered Rebate Program Act or the Illinois Covered Choices Act, or both, prior to the repeal of this Act.

(Source: P.A. 94-816, eff. 5-30-06.)

ARTICLE 10. EXPANDING ACCESS TO HEALTH INSURANCE THROUGH THE ILLINOIS COVERED CHOICES PROGRAM

Section 10-1. Short title. This Article may be cited as the Illinois Covered Choices Act. All references in this Article to "this Act" mean this Article.

Section 10-5. Purpose. The General Assembly recognizes that individuals and small employers in this State struggle every day to pay the costs of meaningful health insurance coverage that allows for delivery of quality health care services. The General Assembly acknowledges that the high cost of health care for individuals and small groups can be driven

by unpredictable and high cost catastrophic medical events. Therefore, the General Assembly, in order to provide access to affordable health insurance for every Illinoisan, seeks to reduce the impact of high-cost medical events by enacting this Act.

Section 10-10. Definitions. In this Act:

"Department" means the Department of Healthcare and Family Services.

"Division" means the Division of Insurance within the Department of Financial and Professional Regulation.

"Federal poverty level" means the federal poverty level income guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

"Full-time employee" means a full-time employee as defined by Section 5-5 of the Economic Development for a Growing Economy Tax Credit Act.

"Health care plan" means a health care plan as defined by Section 1-2 of the Health Maintenance Organization Act.

"Health maintenance organization" means commmercial health maintenance organizations as defined by Section 1-2 of the Health Maintenance Organization Act and shall not include health maintenance organizations which participate solely in government-sponsored programs.

"Illinois Comprehensive Health Insurance Plan" means the

Illinois Comprehensive Health Insurance Plan established by the Comprehensive Health Insurance Plan Act.

"Illinois Covered Choices Program" means the program established under this Act.

"Insurer" means any carrier licensed in Illinois that sells group or individual policies of hospital, surgical, or major medical insurance coverage, or any combination thereof, that contains agreements or arrangements with providers relating to health care services that may be rendered to beneficiaries as defined by the Health Care Reimbursement Reform Act of 1985 in Sections 370f and following of the Illinois Insurance Code (215 ILCS 5/370f and following) and its accompanying regulation (50 Illinois Administrative Code 2051). This does not include insurers that sell only policies of hospital indemnity, accidental death and dismemberment, workers' compensation, credit accident and health, short-term accident and health, accident only, long term care, Medicare supplement, student blanket, stand-alone policies, dental, vision care, prescription drug benefits, disability income, specified disease, or similar supplementary benefits.

"Managed care entity" means any health maintenance organization or insurer as those terms are defined in this Section.

"Risk-based capital" means the minimum amount of required capital or net worth to be maintained by an insurer or managed care entity as prescribed by Article IIA of the Insurance Code

(215 ILCS 5/35A-1 and following).

"Suitable group managed care plan" means any group plan offered pursuant to Section 10-15 of this Act.

"Suitable individual managed care plan" means any individual plan offered pursuant to Section 10-15 of this Act.

"Veteran" means veteran as defined by Section 5 of the Veterans' Health Insurance Program Act.

Section 10-15. Suitable managed care plans for eligible small employers and individuals.

(a) The State hereby establishes a program for the purpose of making managed care plans affordable and accessible to small employers and individuals as defined in this Section. The program is designed to encourage small employers to offer affordable health insurance to employees and to make affordable health insurance available to eligible Illinoisans, including veterans and individuals whose employers do not offer or sponsor group health insurance.

(b) Participation in this program is limited to managed care entities as defined by Section 10-10 of this Act. Participation by all managed care entities is mandatory. On January 1, 2009, or as soon as practicable as determined by the Department, managed care entities offering health insurance coverage or a health care plan in the small group market shall offer one or more suitable group managed care plans. Managed care entities offering health insurance or a health care plan

in the individual market shall offer one or more suitable individual managed care plans. For purposes of this Section and Section 10-20 of this Act, all managed care entities that comply with the program requirements shall be eligible for reimbursement from the Illinois Covered Choices stop loss funds created pursuant to Section 10-20 of this Act.

(c) An eligible small employer is an employer that:

(1) employs not more than 25 eligible employees and contributes towards the suitable group managed care plan the minimum required percentage of an individual employee's premium and the minimum required percentage of an employee's family premium; and

(2) for the year prior to the first enrollment period for the program, employed employees at least two-thirds of whom earned less than 400% of the federal poverty level; for eligibility beginning in the second year of operation of the program, small employers may participate in the program regardless of employee income level; the Department shall thereafter possess authority to modify small employer eligibility; and

(3) uses Illinois as its principal place of business, management, and administration.

(d) For purposes of this Section, "eligible employee" shall include any individual who receives compensation from the eligible employer for at least 25 hours of work per week.

(e) A managed care entity may enter into an agreement with

an employer to offer a suitable managed care plan pursuant to this Section only if that employer offers that plan to all eligible employees.

(f) The employer contribution towards an individual employee's premium and an employee's family premium, measured as a percentage of premium, cannot vary by employee or class of employee.

(g) The Division shall determine pro-rated employer premium contribution levels for eligible employees who do not qualify as full-time employees. The pro-rated employer premium contribution levels shall be based upon employer premium contribution levels set pursuant to subsection (f) of this Section. An eligible small employer shall contribute at least the pro-rated premium contribution amount towards an individual part-time employee's premium. An eligible small employer shall contribute at least the pro-rated premium contribution amount towards an individual part-time employee's family premium. The pro-rated premium contribution must be the same percentage for all similarly situated employees and may not vary based on class of employee.

(h) If the Division determines that such action is in the best interests of the program, the Division may use rulemaking authority to alter the definition of eligible small employer and eligible employee.

(i) Subject to determination by the Division, including applicable eligibility standards, Illinois-based chambers of

commerce or other associations may participate in the program.

(j) An eligible small employer shall elect whether to make coverage under the suitable group managed care plan available to dependents of employees. Any employee or dependent who is enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare shall be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

(k) A suitable group managed care plan is a group contract purchased from a participating managed care entity by an eligible small employer which provides the benefits set forth in subsection (r) of this Section. The contract, independently or in combination with other suitable group managed care plans, must insure not less than 50% of the eligible employees. The Division may exempt by rule certain employees from this calculation.

(l) An eligible individual is an individual:

(1) who is unemployed, not an eligible employee as defined by subsection (d) of Section 10-15, or solely self-employed, or whose employer does not sponsor group health insurance and has not sponsored group health insurance with benefits on an expense-reimbursed or prepaid basis covering employees in effect during the 18-month period prior to the individual's application for health insurance under the program established by this Section;

(2) who for the first year of operation of the program resides in a household having a household income at or below 400% of the federal poverty level; in subsequent years of the program there shall be no income limit for eligible individuals; the Division shall thereafter possess authority to modify individual eligibility;

(3) who is ineligible for Medicare, except that the Department may determine that it shall require an individual who is eligible under subdivision 2(b) of Section 5-2 of the Illinois Public Aid Code to participate as an eligible individual; and

(4) who is a resident of Illinois.

(m) The requirements set forth in subdivision (l)(2) of this Section shall not be applicable to veterans who are not on active duty and who have not been dishonorably discharged from service.

(n) The requirements set forth in subdivision (l)(1) of this Section shall not be applicable to individuals who had health insurance coverage terminated due to:

(1) death of a family member that results in termination of coverage under a health insurance contract under which the individual is covered;

(2) change of residence so that no employer-based health insurance with benefits on an expense-reimbursed or prepaid basis is available; or

(3) legal separation, divorce, or annulment that

results in termination of coverage under a health insurance contract under which the individual is covered.

(o) The 18-month period set forth in item (1) of subsection (l) of this Section may be adjusted by the Division from 18 months to an alternative duration if the Division determines that the alternative period sufficiently prevents inappropriate substitution of suitable individual managed care plans for other health insurance contracts.

(p) A suitable individual managed care plan is an individual contract issued directly to an eligible individual and that provides the benefits set forth in subsection (r) of this Section. At the option of the eligible individual, such contract may include coverage for dependents of the eligible individual.

(q) The contracts issued pursuant to this Section by participating managed care entities and approved by the Department shall provide only in-plan benefits, except for emergency care or where services are not available through a plan provider. Dental and vision coverage shall be made available at the option and expense of the eligible individual. Any claim paid for a benefit not included in the benefits defined by the Department, including claims paid pursuant to dental and vision coverage contracts, shall not be submitted and shall not be eligible for or in any way credited toward stop loss funds provided by Section 10-20 of this Act.

(r) The Department shall determine the following by rule:

(1) Benefits provided in plans created by this Section. The benefits may be designed to decrease adverse selection and avoid improper manipulation of eligibility. These benefits shall include major medical benefits. Mental health benefits shall be provided as described by subdivision (c)(2) of Section 370c of the Illinois Insurance Code. No plan shall provide coverage for infertility treatment or long-term care.

(2) Co-pays and deductible amounts applicable to plans created by this Section, which shall not exceed the maximum allowable amount under the Illinois Insurance Code.

(3) The Department may determine rates for providers of services, but such rates shall in aggregate be no lower than base Medicare. Hospitals shall be reimbursed under the Illinois Covered Choices Program in an amount that equals the actuarial equivalent of 105% of base Medicare for critical access hospitals and equals the actuarial equivalent of 112% of base Medicare for all other hospitals. The Department shall define what constitutes "base Medicare" by rule, which shall include the weighting factors used by Medicare, the wage index adjustment, capital costs, and outlier adjustments. For hospital services provided for which a Medicare rate is not prescribed or cannot be calculated, the hospital shall be reimbursed 90% of the lowest rate paid by the applicable insurer under its contract with that hospital for that same

service. The Department may by rule extend the 112% rate ceiling for hospitals engaged in medical research, medical education, and highly complex medical care and for hospitals that serve a disproportionate share of patients covered by governmental sponsored programs and uninsured patients.

(r-5) Nothing in this Act shall be used by any private or public managed care entity or health care plan as a basis for reducing the managed care entity's or health care plan's rates or policies with any hospital. Notwithstanding any other provision of law, rates authorized under this Act shall not be used by any private or public managed care entities or health care plans to determine a hospital's usual and customary charges for any health care service.

(s) Eligible small employers shall be issued the benefit package in a suitable group managed care plan. Eligible individuals shall be issued the benefit package in a suitable individual managed care plan.

(t) No managed care entity shall issue a suitable group managed care plan or suitable individual managed care plan until the plan has been certified as such by the Department.

(u) A participating managed care plan shall obtain from the employer or individual written certification at the time of initial application and annually thereafter 90 days prior to the contract renewal date that the employer or individual meets and expects to continue to meet the requirements of an eligible

small employer or an eligible individual pursuant to this Section. A participating managed care plan may require the submission of appropriate documentation in support of the certification, including proof of income status. The Division may modify application requirements in order to ensure full and complete disclosure in the application process.

(v) Applications to enroll in suitable group managed care plans and suitable individual managed care plans must be received and processed from any eligible individual and any eligible small employer during the open enrollment period each year. Exceptions to the open enrollment period shall be determined by the Division by rule. This provision does not restrict open enrollment guidelines set by suitable managed care plan contracts, but every such contract must include standard employer group open enrollment guidelines.

(w) All coverage under suitable group managed care plans and suitable individual managed care plans must be subject to a pre-existing condition limitation provision, including the crediting requirements thereunder. Pre-existing conditions may be evaluated and considered by the Department when determining appropriate co-pay amounts, deductible levels, and benefit levels. Prenatal care shall be available without consideration of pregnancy as a preexisting condition. Waiver of deductibles and other cost-sharing payments by insurer may be made for individuals participating in chronic care management or wellness and prevention programs.

(x) Premium rate calculations for suitable group managed care plans and suitable individual managed care plans shall be subject to the following, all of which are subject to modification if the Division determines modification is necessary:

(1) In order to arrive at the actual premium charged to any particular group or individual, a participating managed care plan may adjust its base rate using only the following factors:

(A) geographic area;

(B) age;

(C) smoking or non-smoking status; and

(D) participation in wellness or chronic disease management activities.

(2) The adjustment for age in item (1) of this subsection (x) may not use age brackets smaller than 5-year increments, which shall begin with age 20 and end with age 65. Eligible individuals, sole proprietors, and employees under the age of 20 shall be treated as those age 20.

(3) Permitted rates for any age group shall be no more than 25% of the lowest rate for any age group on January 1, 2009. If necessary, the Department shall thereafter and at any time modify permitted age-based rate factors.

(4) If geographic rating areas are utilized, such geographic areas must be reasonable and in a given case may include a single county. The geographic areas utilized must

be the same for the contracts issued to eligible small employers and to eligible individuals. The Division shall not require the inclusion of any specific geographic region within the proposed region selected by the participating managed care entity, but the participating managed care entity's proposed regions shall not contain configurations designed to avoid or segregate particular areas within a county covered by the participating managed care plan's community rates. Rates from one geographic region to another may not vary by more than 30% and must be actuarially supported.

(5) Small employer premium rates shall not exceed by more than 25% the lowest rate for any small employer groups.

(6) A discount of up to 10% for participation in wellness or chronic disease management activities shall be permitted if based upon actuarially justified differences in utilization or cost attributed to such programs.

(7) Claims experience under contracts issued to eligible small employers and to eligible individuals must be combined for rate setting purposes.

(y) Participating managed care entities shall submit reports to the Department or the Division in such form and at times as may be reasonably required by the Department or the Division in order to evaluate the operations and results of suitable managed care plans established by this Section.

(z) All managed care entities must ensure that all networks available through other policies or plans to individuals and groups in established service areas must be available to suitable managed care plans in those areas.

(aa) The Department shall conduct public education and outreach to facilitate enrollment of small employers, eligible employees, and eligible individuals in the Illinois Covered Choices Program.

Section 10-20. Stop loss funding for suitable health insurance contracts issued to eligible small employers and eligible individuals.

(a) The Department shall provide a claims reimbursement program for participating managed care entities and shall annually seek appropriations to support the program.

(b) The claims reimbursement program, also known as "Illinois Covered Stop Loss Protection", shall operate as a stop loss program for participating managed care entities and shall reimburse participating managed care entities for a certain percentage of health care claims above a certain attachment amount or within certain attachment amounts. The attachment amount or amounts shall be determined by the Department.

(c) Commencing on January 1, 2009, participating managed care entities shall be eligible to receive reimbursement for 80% of claims paid in a calendar year in excess of the

attachment point for any member covered under a contract issued pursuant to Section 10-15 of this Act after the participating managed care entity pays claims for that same member in the same calendar year. Based on pre-determined attachment amounts, verified claims paid for members covered under suitable group and individual managed care plans shall be reimbursable from the Illinois Covered Stop Loss Protection Program. For purposes of this Section, claims shall include health care claims paid by or on behalf of a covered member pursuant to such suitable contracts.

(d) The Department shall adopt rules that set forth procedures for the operation of the Illinois Covered Stop Loss Protection Program and distribution of monies therefrom.

(e) Claims shall be reported and funds shall be distributed by the Department on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid.

(f) Each participating managed care entity shall submit a request for reimbursement from the Illinois Covered Stop Loss Protection Program on forms prescribed by the Department. Each request for reimbursement shall be submitted no later than April 1 following the end of the calendar year for which the reimbursement requests are being made. In connection with reimbursement requests, the Department may require participating managed care entities to submit such claims data deemed necessary to enable proper distribution of funds and to

oversee the effective operation of the Illinois Covered Stop Loss Protection Program. The Department may require that such data be submitted on a per-member, aggregate, or categorical basis, or any combination of those. Data shall be reported separately for suitable group managed care plans and suitable individual managed care plans issued pursuant to Section 10-15 of this Act.

(f-5) In each request for reimbursement from the Illinois Covered Stop Loss Protection Program, managed care entities shall certify that provider reimbursement rates are consistent with the reimbursement rates as defined by subdivision (r)(3) of Section 10-15 of this Act. The Department, in collaboration with the Division, shall audit, as necessary, claims data submitted pursuant to subsection (f) of this Section to ensure that reimbursement rates paid by managed care entities are consistent with reimbursement rates as defined by subsection (r) of Section 10-15.

(g) The Department shall calculate the total claims reimbursement amount for all participating managed care entities for the calendar year for which claims are being reported. In the event that the total amount requested for reimbursement for a calendar year exceeds appropriations available for distribution for claims paid during that same calendar year, the Department shall provide for the pro-rata distribution of the available funds. Each participating managed care entity shall be eligible to receive only such

proportionate amount of the available appropriations as the individual participating managed care entity's total eligible claims paid bears to the total eligible claims paid by all participating managed care entities.

(h) Each participating managed care entity shall provide the Department with monthly reports of the total enrollment under the suitable group managed care plans and suitable individual managed care plans issued pursuant to Section 10-15 of this Act. The reports shall be in a form prescribed by the Department.

(i) The Department shall separately estimate the per member annual cost of total claims reimbursement from each stop loss program for suitable group managed care plans and suitable individual managed care plans based upon available data and appropriate actuarial assumptions. Upon request, each participating managed care plan shall furnish to the Department claims experience data for use in such estimations.

(j) Every participating managed care entity shall file with the Division the base rates and rating schedules it uses to provide suitable group managed care plans and suitable individual managed care plans. All rates proposed for suitable managed care plans are subject to the prior regulatory review of the Division and shall be effective only upon approval by the Division. The Division has authority to approve, reject, or modify the proposed base rate subject to the following:

(1) Rates for suitable managed care plans must account

for the availability of reimbursement pursuant to this Section.

(2) Rates must not be excessive or inadequate nor shall the rates be unfairly discriminatory.

(3) Consideration shall be given, to the extent applicable and among other factors, to the managed care entity's past and prospective loss experience within the State for the product for which the base rate is proposed, to past and prospective expenses both countrywide and those especially applicable to this State, and to all other factors, including judgment factors, deemed relevant within and outside the State.

(4) Consideration shall be given to the managed care entity's actuarial support, enrollment levels, premium volume, risk-based capital, and the ratio of incurred claims to earned premiums.

(k) If the Department deems it appropriate for the proper administration of the program, the Department shall be authorized to purchase stop loss insurance or reinsurance, or both, from an insurance company licensed to write such type of insurance in Illinois.

(k-5) Nothing in this Section 10-20 shall require modification of stop loss provisions of an existing contract between the managed care entity and a healthcare provider.

(l) The Division shall assess insurers as defined in Section 12 of the Comprehensive Health Insurance Plan Act in

accordance with the provisions of this subsection:

(1) By March 1, 2009, the Illinois Comprehensive Health Insurance Plan shall report to the Division the total assessment paid pursuant to subsection d of Section 12 of the Comprehensive Health Insurance Plan Act for fiscal years 2004 through 2008. By March 1, 2009, the Division shall determine the total direct Illinois premiums for calendar years 2004 through 2008 for the kinds of business described in clause (b) of Class 1 or clause (a) of Class 2 of Section 4 of the Illinois Insurance Code, and direct premium income of a health maintenance organization or a voluntary health services plan, except that it shall not include credit health insurance as defined in Article IX 1/2 of the Illinois Insurance Code. The Division shall create a fraction, the numerator of which equals the total assessment as reported by the Illinois Comprehensive Health Insurance Plan pursuant to this subsection, and the denominator of which equals the total direct Illinois premiums determined by the Division pursuant to this subsection. The resulting percentage shall be the "baseline percentage assessment".

(2) For purposes of the program, and to the extent that in any fiscal year the Illinois Comprehensive Health Insurance Plan does not collect an amount equal to or greater than the equivalent dollar amount of the baseline percentage assessment to cover deficits established

pursuant to subsection d of Section 12 of the Comprehensive Health Insurance Plan Act, the Division shall impose the "baseline assessment" in accordance with paragraph (3) of this subsection.

(3) An insurer's assessment shall be determined by multiplying the equivalent dollar amount of the baseline percentage assessment, as determined by paragraph (1), by a fraction, the numerator of which equals that insurer's direct Illinois premiums during the preceding calendar year and the denominator of which equals the total of all insurers' direct Illinois premiums for the preceding calendar year. The Division may exempt those insurers whose share as determined under this subsection would be so minimal as to not exceed the estimated cost of levying the assessment.

(4) The Division shall charge and collect from each insurer the amounts determined to be due under this subsection.

(5) The difference between the total assessments paid pursuant to imposition of the baseline assessment and the total assessments paid to cover deficits established pursuant to subsection d of Section 12 of the Comprehensive Health Insurance Plan Act shall be paid to the fund.

(6) When used in this subsection (l), "insurer" means "insurer" as defined in Section 2 of the Comprehensive Health Insurance Plan Act.

Section 10-25. Program publicity duties of managed care entities and Department.

(a) In conjunction with the Department, all managed care entities shall participate in and share the cost of annually publishing and disseminating a consumer's shopping guide or guides for suitable group managed care plans and suitable individual managed care plans issued pursuant to Section 10-15 of this Act. The contents of all consumer shopping guides published pursuant to this Section shall be subject to review and approval by the Department.

(b) Participating managed care entities may distribute additional sales or marketing brochures describing suitable group managed care plans and suitable individual managed care plans subject to review and approval by the Department.

(c) Commissions available to insurance producers from managed care entities for sales of plans under the Illinois Covered Choices Program shall not be less than those available for sale of plans other than plans issued pursuant to the Illinois Covered Choices Program. Information on such commissions shall be reported to the Division in the rate approval process.

Section 10-30. Evaluation. The Division, with the consultation and collaboration of the Department, shall order a study of the program established pursuant to Sections 10-15 and

10-20 of this Act including an examination of employer participation, an income profile of covered employees and individuals, claims experience, and the impact of the program on the uninsured population. The study shall be completed and a report submitted by October 1, 2012 to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 10-35. Duties assigned to the Department. Unless otherwise specified, all duties assigned to the Department by this Act shall be carried out in consultation with the Division.

Section 10-40. Applicability of other Illinois Insurance Code provisions. Unless otherwise specified in this Section, policies for all suitable group managed care plans and suitable individual managed care plans must meet all other applicable provisions of the Illinois Insurance Code, including cafeteria plans under Section 352c.

Section 10-90. The Illinois Insurance Code is amended by changing Section 368b as follows:

(215 ILCS 5/368b)

Sec. 368b. Contracting procedures.

(a) A health care professional or health care provider

offered a contract by an insurer, health maintenance organization, independent practice association, or physician hospital organization for signature after the effective date of this amendatory Act of the 93rd General Assembly shall be provided with a proposed health care professional or health care provider services contract including, if any, exhibits and attachments that the contract indicates are to be attached. Within 35 days after a written request, the health care professional or health care provider offered a contract shall be given the opportunity to review and obtain a copy of the following: a specialty-specific fee schedule sample based on a minimum of the 50 highest volume fee schedule codes with the rates applicable to the health care professional or health care provider to whom the contract is offered, the network provider administration manual, and a summary capitation schedule, if payment is made on a capitation basis. If 50 codes do not exist for a particular specialty, the health care professional or health care provider offered a contract shall be given the opportunity to review or obtain a copy of a fee schedule sample with the codes applicable to that particular specialty. This information may be provided electronically. An insurer, health maintenance organization, independent practice association, or physician hospital organization may substitute the fee schedule sample with a document providing reference to the information needed to calculate the fee schedule that is available to the public at no charge and the percentage or

conversion factor at which the insurer, health maintenance organization, preferred provider organization, independent practice association, or physician hospital organization sets its rates.

(b) The fee schedule, the capitation schedule, and the network provider administration manual constitute confidential, proprietary, and trade secret information and are subject to the provisions of the Illinois Trade Secrets Act. The health care professional or health care provider receiving such protected information may disclose the information on a need to know basis and only to individuals and entities that provide services directly related to the health care professional's or health care provider's decision to enter into the contract or keep the contract in force. Any person or entity receiving or reviewing such protected information pursuant to this Section shall not disclose the information to any other person, organization, or entity, unless the disclosure is requested pursuant to a valid court order or required by a state or federal government agency. Individuals or entities receiving such information from a health care professional or health care provider as delineated in this subsection are subject to the provisions of the Illinois Trade Secrets Act.

(c) The health care professional or health care provider shall be allowed at least 30 days to review the health care professional or health care provider services contract,

including exhibits and attachments, if any, before signing. The 30-day review period begins upon receipt of the health care professional or health care provider services contract, unless the information available upon request in subsection (a) is not included. If information is not included in the professional services contract and is requested pursuant to subsection (a), the 30-day review period begins on the date of receipt of the information. Nothing in this subsection shall prohibit a health care professional or health care provider from signing a contract prior to the expiration of the 30-day review period.

(d) The insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide all contracted health care professionals or health care providers with any changes to the fee schedule provided under subsection (a) not later than 35 days after the effective date of the changes, unless such changes are specified in the contract and the health care professional or health care provider is able to calculate the changed rates based on information in the contract and information available to the public at no charge. For the purposes of this subsection, "changes" means an increase or decrease in the fee schedule referred to in subsection (a). This information may be made available by mail, e-mail, newsletter, website listing, or other reasonable method. Upon request, a health care professional or health care provider may request an updated copy of the fee schedule referred to in

subsection (a) every calendar quarter.

(e) Upon termination of a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization and at the request of the patient, a health care professional or health care provider shall transfer copies of the patient's medical records. Any other provision of law notwithstanding, the costs for copying and transferring copies of medical records shall be assigned per the arrangements agreed upon, if any, in the health care professional or health care provider services contract.

(f) All providers that contract with a managed care entity as defined by the Illinois Covered Choices Act must participate as a network provider under the same managed care entity's suitable managed care plan or plans.

(Source: P.A. 93-261, eff. 1-1-04.)

ARTICLE 15. EXPANDING ACCESS TO HEALTH INSURANCE FOR YOUNG ILLINOISANS

Section 15-5. The Illinois Insurance Code is amended by adding Section 367.4 as follows:

(215 ILCS 5/367.4 new)

Sec. 367.4. Coverage of dependents until age 30.

(a) A group health insurance policy that provides coverage for an insured's dependents under which coverage of a dependent

terminates at a specific age before the dependent's 30th birthday, and is delivered, issued, executed, or renewed in this State after the effective date of this amendatory Act of the 95th General Assembly, shall, upon application of the dependent as set forth in subsection (c) of this Section, provide coverage to the dependent after that specific age, until the dependent's 30th birthday. As used in this Section, "dependents" means any insured's children by blood or by law who:

(1) are less than 30 years of age;

(2) are unmarried;

(3) have no dependents of their own;

(4) are residents of this State or are enrolled as full-time students at an accredited public or private institution of higher education; and

(5) are not actually provided coverage as named subscribers, insureds, enrollees, or covered persons under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97 (42 U.S.C. 1395 et seq.).

(b) Nothing herein shall be construed to require that: (1) coverage for services be provided to dependents before the effective date of this amendatory Act of the 95th General Assembly; or (2) an employer pay all or part of the cost of coverage for dependents as provided pursuant to this Section.

(c) Application for dependent coverage.

(1) A dependent covered by an insured's policy, which coverage under the policy terminates at a specific age before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this Section, until the dependent's 30th birthday, at any of the following times:

(A) within 30 days prior to the termination of coverage at the specific age provided in the policy;

(B) within 30 days after meeting the requirements for dependent status as set forth in subsection (a) of this Section, when coverage for the dependent under the policy previously terminated; or

(C) during an open enrollment period, as provided pursuant to the policy, if the dependent meets the requirements for dependent status as set forth in subsection (a) of this Section during the open enrollment period.

(2) For 12 months after the effective date of this amendatory Act of the 95th General Assembly, a dependent who qualifies for dependent status as set forth in subsection (a) of this Section, but whose coverage as a dependent under an insured's policy terminated under the terms of the policy prior to the effective date of this amendatory Act of the 95th General Assembly, may make a written election to reinstate coverage under that policy as

a dependent pursuant to this Section.

(3) Coverage for a dependent who makes a written election for coverage pursuant to this subsection shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the policy. If coverage was modified under the policy for any similarly situated dependents prior to their termination of coverage at the specific age provided in the policy, the coverage shall also be modified in the same manner for the dependent seeking reinstatement.

(4) Coverage for a dependent who makes a written election for coverage pursuant to this subsection shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

(d) Premium adjustments and payments.

(1) A policy of insurance may require payment of a premium by the insured or dependent, as appropriate, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection (c). The premium shall not exceed 105% of the applicable portion of the premium previously paid for that dependent's coverage under the policy prior to the termination of coverage at the specific age provided in the policy.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the policy shall be

based upon the difference between the policy's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the Director which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payer, be made in monthly installments.

(e) Coverage for a dependent provided pursuant to this Section shall be provided until the earlier of the following:

(1) the dependent is disqualified for dependent status as set forth in subsection (a) of this Section;

(2) the date on which coverage ceases under the policy by reason of a failure to make a timely payment of any premium required under the policy by the insured or dependent for coverage provided pursuant to this Section; the payment of any premium shall be considered to be timely if made within 30 days after the due date or within a longer period as may be provided for by the policy; or

(3) the date upon which the employer under whose policy coverage is provided to a dependent ceases to provide coverage to the insured; nothing herein shall be construed to permit an insurer to refuse a written election for coverage by a dependent pursuant to subsection (c) of this Section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection.

(f) Notice regarding coverage for a dependent as provided

pursuant to this Section shall be provided to an insured:

(1) in the certificate of coverage prepared for insureds by the insurer on or about the date of commencement of coverage; and

(2) by the insured's employer:

(A) on or before the coverage of an insured's dependent terminates at the specific age as provided in the policy;

(B) at the time coverage of the dependent is no longer provided pursuant to this Section because the dependent is disqualified for dependent status as set forth in subsection (a) of this Section, except that this employer notice shall not be required when a dependent no longer qualifies based upon paragraph (1) or (3) of subsection (a) of this Section;

(C) before any open enrollment period permitting a dependent to make a written election for coverage pursuant to subsection (c) of this Section; and

(D) immediately following the effective date of this amendatory Act of the 95th General Assembly, with respect to information concerning a dependent's opportunity, for 12 months after the effective date of this amendatory Act of the 95th General Assembly, to make a written election to reinstate coverage under a policy pursuant to paragraph (2) of subsection (c) of this Section.

Section 15-10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 364.01, 367.2, 367.2-5, 367.4, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents

of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and

the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on

competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable

or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 93-102, eff. 1-1-04; 93-261, eff. 1-1-04; 93-477, eff. 8-8-03; 93-529, eff. 8-14-03; 93-853, eff. 1-1-05; 93-1000, eff. 1-1-05; 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; revised 1-5-07.)

ARTICLE 16. EXPANDING ACCESS TO AFFORDABLE HEALTH INSURANCE FOR EMPLOYEES

Section 16-5. The Illinois Insurance Code is amended by adding Sections 352b and 352c as follows:

(215 ILCS 5/352b new)

Sec. 352b. Group health plan non-discrimination requirement. No group policy or certificate of accident and health insurance shall be delivered or issued for delivery to an employer group in this State unless such policy or certificate is offered by that employer to all full-time employees; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount on behalf of an employee or class of employees than the employer makes on behalf of any other employee or class. Notwithstanding any provision of this Section, an insurer may deliver or issue a group policy or certificate of accident and health insurance to an employer group that establishes separate contribution percentages for employees covered by collective bargaining agreements as negotiated in those agreements.

(215 ILCS 5/352c new)

Sec. 352c. Cafeteria plans. No later than January 1, 2009, each employer with more than 10 employees shall adopt and maintain a cafeteria plan that satisfies 26 U.S.C. 125 and the rules adopted by the Department of Revenue in collaboration with the Department of Financial and Professional Regulation.

The Department of Revenue in collaboration with the Department of Financial and Professional Regulation shall develop a standard set of documents that may be used by businesses to establish such a plan and shall provide technical assistance to businesses to so establish such plans.

Section 16-10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 352b, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service

Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take

into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the

Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 93-102, eff. 1-1-04; 93-261, eff. 1-1-04; 93-477, eff. 8-8-03; 93-529, eff. 8-14-03; 93-853, eff. 1-1-05;

93-1000, eff. 1-1-05; 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; revised 1-5-07.)

ARTICLE 18. ENSURING ACCOUNTABILITY OF HEALTH INSURERS; ESTABLISHMENT OF THE OFFICE OF PATIENT PROTECTION AND IMPROVEMENTS IN PROTECTIONS FOR CONSUMERS GENERALLY

Section 18-5. The Illinois Insurance Code is amended by changing Sections 155.36, 359a, and 370c and by adding the heading of Article XLV and Sections 1500-5, 1500-10, 1500-15, 1500-20, and 1500-25 as follows:

(215 ILCS 5/155.36)

Sec. 155.36. Managed Care Reform and Patient Rights Act. Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code shall comply with Section 45, Section 55, Section 85, and the definition of the term "emergency medical condition" in Section 10 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 5/359a) (from Ch. 73, par. 971a)

Sec. 359a. Application.

(1) No individual or group policy or certificate of insurance except an Industrial Accident and Health Policy provided for by this article shall be issued, except upon the

signed application of the person or persons sought to be insured. Any information or statement of the applicant shall plainly appear upon such application in the form of interrogatories by the insurer and answers by the applicant. The insured shall not be bound by any statement made in an application for any policy, including an Industrial Accident and Health Policy, unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within fifteen days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal. All individual and group applications for insurance that require health information or questions shall comply with the following standards:

(A) Insurers may ask diagnostic questions on applications for insurance.

(B) Application questions shall be formed in a manner

designed to elicit specific medical information and not lifestyle or other inferential information.

(C) Questions which are vague, subjective, unfairly discriminatory, or so technical as to inhibit a clear understanding by the applicant are prohibited.

(D) Questions must be designed to elicit a "yes" or "no" answer, or to require an applicant to check one or more boxes for specific medical information. Any one question must specify a single, unique, and specific medical condition.

(E) Questions that ask an applicant to verify diagnosis or treatment for specific diseases or conditions must stipulate that such diagnoses must have been made and such treatment must have been performed by an appropriately licensed health care service provider.

(F) All underwriting shall be based on individual review of specific health information furnished on the application, any reports provided as a result of medical examinations performed at the company's request, medical record information obtained from the applicant's health care providers, or any combination of the foregoing. Adverse underwriting decisions shall not be based on ambiguous responses to application questions.

(G) Preexisting condition exclusions imposed based solely on responses to an application question may exclude only a condition that was specifically elicited in the

application and may not be broadened to similar, but separate conditions that were not specifically identified by an application question.

(2) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(3) The falsity of any statement in the application for any policy covered by this act may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(Source: Laws 1951, p. 611.)

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this Section, every insurer which delivers, issues for delivery or renews or modifies group A&H policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or

conditions, other than serious mental illnesses as defined in item (2) of subsection (b), up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, or licensed clinical professional counselor is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers and licensed clinical professional counselors, those persons who may provide services to

individuals shall do so after the licensed clinical social worker or licensed clinical professional counselor has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker or licensed clinical professional counselor has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker or licensed clinical professional counselor for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following

psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence;

(I) panic disorder; and

(J) post-traumatic stress disorders (acute, chronic, or with delayed onset).

(3) (Blank). ~~Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's~~

~~provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.~~

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921) ~~this amendatory Act of the 94th General Assembly~~, 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for

delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906) ~~this amendatory Act of the 94th General Assembly~~, 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A);

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(7) This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(A) an addiction to a controlled substance or cannabis that is used in violation of law; or

(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.

(8) (Blank).

(c)(1) Coverage for the treatment of mental and emotional disorders as provided by subsections (a) and (b) shall not be denied under the policy provided that services are medically necessary as determined by the insured's treating physician. For purposes of this subsection, "medically necessary" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must be intended to either help restore or maintain the enrollee's health or prevent deterioration of the enrollee's condition. Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary.

(2) All of the provisions for the treatment of and services for mental, emotional, or nervous disorders or conditions, including the treatment of serious mental illness, contained in subsections (a) and (b), and the requirements relating to determinations based on medical necessity contained in

subdivision (c)(1) of this Section must be contained in all group and individual suitable managed care plans as defined by the Illinois Covered Choices Act.

(3) The requirements of subdivision (c)(1) shall apply to any policy of individual accident and health insurance issued in this State that provides coverage for any form of mental and emotional disorder.

(Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05; 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; revised 8-3-06.)

(215 ILCS 5/Art. XLV heading new)

ARTICLE XLV.

(215 ILCS 5/1500-5 new)

Sec. 1500-5. Office of Patient Protection. There is hereby established within the Division of Insurance an Office of Patient Protection to ensure that persons covered by health insurance companies or health care plans are provided the benefits due them under this Code and related statutes and are protected from health insurance company and health care plan actions or policy provisions that are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, or contrary to law or to the public policy of this State or that unreasonably or deceptively affect the risk purported to be assumed.

(215 ILCS 5/1500-10 new)

Sec. 1500-10. Powers of Office of Patient Protection. Acting under the authority of the Director, the Office of Patient Protection shall: (1) have the power as established by Section 401 of this Code to institute such actions or other lawful proceedings as may be necessary for the enforcement of this Code; and (2) oversee the responsibilities of the Office of Consumer Health, including, but not limited to, responding to consumer questions relating to health insurance.

(215 ILCS 5/1500-15 new)

Sec. 1500-15. Responsibility of Office of Patient Protection. The Office of Patient Protection shall assist health insurance company consumers and health care plan consumers with respect to the exercise of the grievance and appeals rights established by Section 45 of the Managed Care Reform and Patient Rights Act.

(215 ILCS 5/1500-20 new)

Sec. 1500-20. Health insurance oversight. The responsibilities of the Office of Patient Protection shall include, but not be limited to, the oversight of health insurance companies and health care plans with respect to:

(1) Improper claims practices (Sections 154.5 and 154.6 of this Code).

(2) Emergency services.

(3) Compliance with the Managed Care Reform and Patient Rights Act.

(4) Requiring health insurance companies and health care plans to pay claims when internal appeal time frames exceed requirements established by the Managed Care Reform and Patient Rights Act.

(5) Ensuring coverage for mental health treatment, including insurance company and health care plan procedures for internal and external review of denials for mental health coverage as provided by Section 370c of this Code.

(6) Reviewing health insurance company and health care plan eligibility, underwriting, and claims practices.

(215 ILCS 5/1500-25 new)

Sec. 1500-25. Powers of the Director.

(a) The Director, in his or her discretion, may issue a Notice of Hearing requiring a health insurance company or health care plan to appear at a hearing for the purpose of determining the health insurance company or health care plan's compliance with the duties and responsibilities listed in Section 1500-15.

(b) Nothing in this Article XLV shall diminish or affect the powers and authority of the Director of Insurance otherwise set forth in this Code.

Section 18-10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 359a, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to

substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be

acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into

account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 93-102, eff. 1-1-04; 93-261, eff. 1-1-04; 93-477, eff. 8-8-03; 93-529, eff. 8-14-03; 93-853, eff. 1-1-05; 93-1000, eff. 1-1-05; 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; revised 1-5-07.)

Section 18-15. The Managed Care Reform and Patient Rights Act is amended by changing Section 45 as follows:

(215 ILCS 134/45)

Sec. 45. Health care services appeals, complaints, and external independent reviews.

(a) A health care plan shall establish and maintain an appeals procedure as outlined in this Act. Compliance with this Act's appeals procedures shall satisfy a health care plan's obligation to provide appeal procedures under any other State law or rules. All appeals of a health care plan's administrative determinations and complaints regarding its administrative decisions shall be handled as required under Section 50.

(b) Internal appeals.

(1) When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the health care plan must allow for the filing of an appeal either orally or in writing.

(2) A health plan must prominently display a brief summary of its appeal requirements as established by this

Section, including the manner in which an enrollee may initiate such appeals, in all of its printed material sent to the enrollee as well as on its website.

(3) Upon submission of the appeal, a health care plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal.

(4) The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information.

(5) The health care plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(6) For all denials of treatment for mental and emotional disorders the following requirements shall apply:

(A) A plan's determination that care rendered or to be rendered is inappropriate shall not be made until the plan has communicated with the enrollee's attending mental health professional concerning that medical care. The review shall be made prior to or concurrent with the treatment.

(B) A determination that care rendered or to be rendered is inappropriate shall include the written evaluation and findings of the mental health professional whose training and expertise is at least comparable to that of the treating clinician.

(C) Any determination regarding services rendered or to be rendered for the treatment of mental and emotional disorders for an enrollee which may result in a denial of reimbursement or a denial of pre-certification for that service shall, at the request of the affected enrollee or provider as defined by Section 370c of the Illinois Insurance Code, include the specific review criteria, the procedures and methods used in evaluating proposed or delivered mental health care services, and the credentials of the peer reviewer.

(D) In making any communication, a plan shall ensure that all applicable State and federal laws to protect the confidentiality of individual mental health records are followed.

(E) A plan shall ensure that it provides appropriate notification to and receives concurrence from enrollees and their attending mental health professional before any enrollee interviews are conducted by the plan.

(7) If the enrollee, the enrollee's treating

physician, and the health care plan agree, or if the Office of Patient Protection established under Section 1500-5 of the Illinois Insurance Code explicitly allows, the claim determination may be appealed directly to the external independent review as described under subsection (f).

(8) Except as provided in paragraph (7), an enrollee must exhaust the internal appeal process prior to requesting an external independent review.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health care plan must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A health care plan shall designate a clinical

peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review under subsection (f).

(e) If an appeal filed under subsection (b) or (c) is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or length of stay requests, and if the amount of the denial exceeds $250, any involved party may request an external independent review under subsection (f) of the adverse determination.

(f) External independent review.

(1) The party seeking an external independent review shall so notify the health care plan. The health care plan shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination

and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.

(2) Within 180 ~~30~~ days after the enrollee receives written notice of an adverse determination, if the enrollee decides to initiate an external independent review, the enrollee shall send to the health care plan a written request for an external independent review, including any information or documentation to support the enrollee's request for the covered service or claim for a covered service.

(3) Within 30 days after the health care plan receives a request for an external independent review from an enrollee, the health care plan shall:

(A) provide a mechanism for joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the health care plan; and

(B) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the health care plan's decision, the criteria used, and the

medical and clinical reasons for that decision.

(4) Within 5 days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the health care service or claim for the health care service is medically appropriate. The decision by the independent reviewer is final and binding on the health plan. If the external independent reviewer determines the health care service to be medically appropriate, the health care plan shall pay for the health care service. If an external independent review upholds the health plan's determination, the enrollee has the right to appeal the final decision to the Office of Patient Protection established under Section 1500-5 of the Illinois Insurance Code. In cases in which the external independent review determination is found by the Director, through the Office of Patient Protection, to have been made in an arbitrary and capricious manner or to have demonstrated disregard for patient well-being or contracted terms, the Director may overturn the external independent review determination and require the health care plan to pay for the health care service.

(5) The health care plan shall be solely responsible for paying the fees of the external independent reviewer who is selected to perform the review.

(6) An external independent reviewer who acts in good

faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute willful ~~wilful~~ and wanton misconduct. For purposes of any proceeding, the good faith of the person participating shall be presumed.

(7) Future contractual or employment action by the health care plan regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in this procedure.

(8) For the purposes of this Section, an external independent reviewer shall:

(A) be a clinical peer;

(B) have no direct financial interest in connection with the case; and

(C) have not been informed of the specific identity of the enrollee.

(g) Nothing in this Section shall be construed to require a health care plan to pay for a health care service not covered under the enrollee's certificate of coverage or policy.

(Source: P.A. 91-617, eff. 1-1-00.)

ARTICLE 20. BUILDING HEALTHCARE CAPACITY THROUGH COMPREHENSIVE HEALTHCARE WORKFORCE PLANNING

Section 20-1. Short title. This Article may be cited as the Comprehensive Healthcare Workforce Planning Act. All references in this Article to "this Act" mean this Article.

Section 20-5. Definitions. As used in this Act:

"Council" means the State Healthcare Workforce Council created by this Act.

"Department" means the Department of Public Health.

"Executive Committee" means the Executive Committee of the State Healthcare Workforce Council, which shall consist of 13 members of the State Healthcare Workforce Council: the Chair, the Vice-Chair, a representative of the Governor's Office, the Director of Commerce and Economic Opportunity or his or her designee, the Director of Financial and Professional Regulation or his or her designee, the Secretary of Human Services or his or her designee, the Director of Healthcare and Family Services or his or her designee, and 6 health care workforce experts from the State Healthcare Workforce Council as designated by the Governor.

"Interagency Subcommittee" means the Interagency Subcommittee of the State Healthcare Workforce Council, which shall consist of the following members or their designees: the Director of the Department; a representative of the Governor's Office; the Secretary of Human Services; the Directors of the Departments of Commerce and Economic Opportunity, Employment Security, Financial and Professional Regulation, and

Healthcare and Family Services; and the executive director of the Illinois Board of Higher Education, the President of the Illinois Community College Board, and the State Superintendent of Education.

Section 20-10. Purpose. The State Healthcare Workforce Council is hereby established to provide an ongoing assessment of health care workforce trends, training issues, and financing policies, and to recommend appropriate State government and private sector efforts to address identified needs. The work of the Council shall focus on: health care workforce supply and distribution; cultural competence and minority participation in health professions education; primary care training and practice; and data evaluation and analysis.

Section 20-15. Members.

(a) The following 10 persons or their designees shall be members of the Council: the Director of the Department; a representative of the Governor's Office; the Secretary of Human Services; the Directors of the Departments of Commerce and Economic Opportunity, Employment Security, Financial and Professional Regulation, and Healthcare and Family Services; and the executive director of the Illinois Board of Higher Education, the President of the Illinois Community College Board, and the State Superintendent of Education.

(b) The Governor shall appoint 16 additional members, who

shall be health care workforce experts, including representatives of practicing physicians, nurses, and dentists, State and local health professions organizations, schools of medicine and osteopathy, nursing, dental, allied health, and public health; public and private teaching hospitals; health insurers, business; and labor. The Speaker of the Illinois House of Representatives, the President of the Illinois Senate, the Minority Leader of the Illinois House of Representatives, and the Minority Leader of the Illinois Senate may each appoint one representative to the Council. Members appointed under this subsection (b) shall serve 4-year terms and may be reappointed.

(c) The Director of the Department shall serve as Chair of the Council. The Governor shall appoint a health care workforce expert from the non-governmental sector to serve as Vice-Chair.

Section 20-20. Five-year comprehensive health care workforce plan.

(a) Every 5 years, the State of Illinois shall prepare a comprehensive healthcare workforce plan.

(b) The comprehensive healthcare workforce plan shall include, but need not be limited to, the following:

(1) 25-year projections of the demand and supply of health professionals to meet the needs of healthcare within the State.

(2) The identification of all funding sources for which

the State has administrative control that are available for health professions training.

(3) Recommendations on how to rationalize and coordinate the State-supported programs for health professions training.

(4) Recommendations on actions needed to meet the projected demand for health professionals over the 25 years of the plan.

(c) The Interagency Subcommittee, with staff support and coordination assistance from the Department, shall develop the Comprehensive Healthcare Workforce Plan. The State Healthcare Workforce Council shall provide advice and guidance to the Interagency Subcommittee in developing the plan. The Interagency Subcommittee shall deliver the Comprehensive Healthcare Workforce Plan to the Governor and the General Assembly by July 1 of each fifth year, beginning July 1, 2008, or the first business day thereafter.

(d) Each year in which a comprehensive healthcare workforce plan is not due, the Department, on behalf of the Interagency Subcommittee, shall prepare a report by July 1 of that year to the Governor and the General Assembly on the progress made toward achieving the projected goals of the current comprehensive healthcare workforce plan during the previous calendar year.

(e) The Department shall provide staffing to the Interagency Subcommittee, the Council, and the Executive

Committee of the Council. It shall also provide the staff support needed to help coordinate the implementation of the comprehensive healthcare workforce plan.

Section 20-25. Executive Committee. The Executive Committee shall:

(1) oversee and structure the operations of the Council;

(2) create necessary subcommittees and appoint subcommittee members, with the advice of the Council and the Interagency Subcommittee, as the Executive Committee deems necessary;

(3) ensure adequate public input into the comprehensive healthcare workforce plan;

(4) involve, to the extent possible, appropriate representatives of the federal government, local governments, municipalities, and education; and

(5) have input into the development of the comprehensive healthcare workforce plan and the annual report prepared by the Department before the Department submits them to the Council.

Section 20-30. Interagency Subcommittee. The Interagency Subcommittee and its member agencies shall:

(1) be responsible for providing the information needed to develop the comprehensive healthcare workforce

plan as well as the plan reports;

(2) develop the comprehensive healthcare workforce plan; and

(3) oversee the implementation of the plan by coordinating, streamlining, and prioritizing the allocation of resources.

Section 20-35. Reimbursement. The members of the Council shall receive no compensation but shall be entitled to reimbursement for any necessary expenses incurred in connection with the performance of their duties.

ARTICLE 25. AMENDATORY PROVISIONS

Section 25-5. The Loan Repayment Assistance for Physicians Act is amended by changing the title of the Act and Sections 1, 5, 10, 15, 20, 25, 30, and 35 as follows:

(110 ILCS 949/Act title)

An Act concerning loan repayment assistance for physicians <u>and dentists</u>.

(110 ILCS 949/1)

Sec. 1. Short title. This Act may be cited as the <u>Targeted</u> Loan Repayment Assistance for Physicians <u>and Dentists</u> Act.

(Source: P.A. 94-368, eff. 7-29-05.)

(110 ILCS 949/5)

Sec. 5. Purpose. The purpose of this Act is to establish a program in the Department of Public Health to increase the total number of physicians and dentists in this State serving targeted populations by providing educational loan repayment assistance grants to physicians and dentists.

(Source: P.A. 94-368, eff. 7-29-05.)

(110 ILCS 949/10)

Sec. 10. Definitions. In this Act, unless the context otherwise requires:

"Dentist" means a person who has received a general license pursuant to paragraph (a) of Section 11 of the Illinois Dental Practice Act, who may perform any intraoral and extraoral procedure required in the practice of dentistry, and to whom is reserved the responsibilities specified in Section 17 of the Illinois Dental Practice Act.

"Department" means the Department of Public Health.

"Educational loans" means higher education student loans that a person has incurred in attending a registered professional physician education program or a registered professional dentist education program.

"Medical payments" means compensation provided to physicians or dentists for services rendered under means-tested healthcare programs administered by the

Department of Healthcare and Family Services.

"Medically underserved area" means an urban or rural area designated by the Secretary of the United States Department of Health and Human Services as an area with a shortage of personal health services or as otherwise designated by the Department of Public Health.

"Medically underserved population" means (i) the population of an urban or rural area designated by the Secretary of the United States Department of Health and Human Services as an area with a shortage of personal health services or (ii) a population group designated by the Secretary as having a shortage of those services or as otherwise designated by the Department of Public Health.

"Physician" means a person licensed under the Medical Practice Act of 1987 to practice medicine in all of its branches.

"Program" means the educational loan repayment assistance program for physicians and dentists established by the Department under this Act.

"Targeted populations" means one or more of the following: the medically underserved population, persons in a medically underserved area, the uninsured population of this State and persons enrolled in means-tested healthcare programs administered by the Department of Healthcare and Family Services.

"Uninsured population" means persons who do not own private

health care insurance, are not part of a group insurance plan, and are not enrolled in any State or federal government-sponsored means-tested healthcare program.

(Source: P.A. 94-368, eff. 7-29-05.)

(110 ILCS 949/15)

Sec. 15. Establishment of program.

(a) The Department shall establish an educational loan repayment assistance program for physicians and dentists who practice in Illinois and serve targeted populations. The Department shall administer the program and make all necessary and proper rules not inconsistent with this Act for the program's effective implementation. The Department may use up to 5% of the appropriation for this program for administration ~~and promotion of physician incentive programs~~.

(b) The Department shall consult with the Department of Healthcare and Family Services and the Department of Human Services to identify geographic areas of the State in need of health care services, including dental services, for one or more targeted populations. The Department may target grants to physicians and dentists in accordance with those identified needs, with respect to geographic areas, categories of services or quantity of service to targeted populations.

(Source: P.A. 94-368, eff. 7-29-05.)

(110 ILCS 949/20)

Sec. 20. Application. Beginning July 1, 2008 ~~2005~~, the Department shall, each year, consider applications for assistance under the program. The form of application and the information required to be set forth in the application shall be determined by the Department, and the Department shall require applicants to submit with their applications such supporting documents as the Department deems necessary.

(Source: P.A. 94-368, eff. 7-29-05.)

(110 ILCS 949/25)

Sec. 25. Eligibility. To be eligible for assistance under the program, an applicant must meet all of the following qualifications:

(1) He or she must be a citizen or permanent resident of the United States.

(2) He or she must be a resident of Illinois.

(3) He or she must be practicing full-time in Illinois as a physician or dentist.

(4) He or she must currently be repaying educational loans.

(5) He or she must agree to continue full-time practice in Illinois for 3 years servicing targeted populations.

(6) He or she must accept medical payments as defined in this Act.

(Source: P.A. 94-368, eff. 7-29-05.)

(110 ILCS 949/30)

Sec. 30. The award of grants. Under the program, for each year that a qualified applicant practices full-time in Illinois as a physician or dentist serving targeted populations, the Department shall, subject to appropriation, award a grant to that person in an amount not to exceed ~~equal to~~ the amount in educational loans that the person must repay that year. The ~~However, the~~ total amount in grants that a person may be awarded under the program shall not exceed $200,000 ~~$25,000~~. The Department shall require recipients to use the grants to pay off their educational loans.

(Source: P.A. 94-368, eff. 7-29-05.)

(110 ILCS 949/35)

Sec. 35. Penalty for failure to fulfill obligation. Loan repayment recipients who fail to practice full-time in Illinois for 3 years and meet the grant requirement of serving targeted populations shall repay the Department a sum equal to 3 times the amount received under the program.

(Source: P.A. 94-368, eff. 7-29-05.)

ARTICLE 30. BUILDING HEALTHCARE CAPACITY THROUGH COMMUNITY HEALTH CENTER TARGETED EXPANSION

Section 30-1. Short title. This Article may be cited as the Community Health Center Targeted Expansion Act. All references

in this Article to "this Act" mean this Article.

Section 30-5. Definitions. In this Act:

"Community health center site" means a site where a community health center provides or will provide primary health care services (and, if applicable, specialty health care services) to targeted populations.

"Department" means the Department of Public Health.

"Medically underserved area" means an urban or rural area designated by the Secretary of the United States Department of Health and Human Services as an area with a shortage of personal health services or as otherwise designated by the Department of Public Health.

"Medically underserved population" means (i) the population of an urban or rural area designated by the Secretary of the United States Department of Health and Human Services as an area with a shortage of personal health services or (ii) a population group designated by the Secretary as having a shortage of those services or as otherwise designated by the Department of Public Health.

"Primary health care services" means the following:

(1) Basic health services consisting of the following:

(A) Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and, if appropriate, physician assistants, nurse

practitioners, and nurse midwives.

(B) Diagnostic laboratory and radiologic services.

(C) Preventive health services, including the following:

(i) Prenatal and perinatal services.

(ii) Screenings for breast and cervical cancer.

(iii) Well-child services.

(iv) Immunizations against vaccine-preventable diseases.

(v) Screenings for elevated blood lead levels, communicable diseases, and cholesterol.

(vi) Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care.

(vii) Voluntary family planning services.

(viii) Preventive dental services.

(D) Emergency medical services.

(E) Pharmaceutical services as appropriate for particular health centers.

(2) Referrals to providers of medical services and other health-related services (including addiction treatment and mental health services).

(3) Patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in

establishing eligibility for and gaining access to federal, State, and local programs that provide or financially support the provision of medical, social, educational, or other related services.

(4) Services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of those individuals).

(5) Education of patients and the general population served by the health center regarding the availability and proper use of health services.

(6) Additional health services consisting of services that are appropriate to meet the health needs of the population served by the health center involved and that may include the following:

(A) Environmental health services, including the following:

(i) Detection and alleviation of unhealthful conditions associated with water supply.

(ii) Sewage treatment.

(iii) Solid waste disposal.

(iv) Detection and alleviation of rodent and parasite infestation.

(v) Field sanitation.

(vi) Housing.

(vii) Other environmental factors related to health.

(B) Special occupation-related health services for migratory and seasonal agricultural workers, including the following:

(i) Screening for and control of infectious diseases, including parasitic diseases.

(ii) Injury prevention programs, which may include prevention of exposure to unsafe levels of agricultural chemicals, including pesticides.

"Specialty health care services" means health care services, other than primary health care services, provided by such specialists, as the Department may determine by rule. "Specialty health care services" may include, without limitation, dental services, mental health services, behavioral health services, and optometry services.

"Targeted populations" means one or more of the following: the medically underserved population, persons in a medically underserved area, the uninsured population of this State and persons enrolled in a means-tested healthcare program administered by the Department of Healthcare and Family Services.

"Uninsured population" means persons who do not own private health care insurance, are not part of a group insurance plan,

and are not enrolled in any State or federal government-sponsored means-tested healthcare program.

Section 30-10. Grants.

(a) The Department shall establish a community health center targeted expansion grant program and may make grants subject to appropriations. The grants shall be for the purpose of (i) establishing new community health center sites, (ii) expanding primary health care services at existing community health center sites, or (iii) adding or expanding specialty health care services at existing community health center sites, in each case to serve one or more of the targeted populations in this State. The Department may use up to 5% of the appropriation for this program for administration of the program.

(b) Grants under this Section shall be for a period not to exceed 3 years. The Department may make new grants whenever the total amount appropriated for grants is sufficient to fund both the new grants and the grants already in effect.

(c) The Department shall consult with the Department of Healthcare and Family Services and the Department of Human Services to identify geographic areas of the State in need of primary health services and specialty care services for one or more targeted populations. The Department may target grants in accordance with those identified needs, with respect to geographic areas, categories of services or targeted

populations.

Section 30-15. Use of grant moneys. In accordance with grant agreements respecting grants awarded under this Act, a recipient of a grant may use the grant moneys to do any one or more of the following:

(1) Purchase equipment.

(2) Acquire a new physical location for the purpose of delivering primary health care services or specialty health care services.

(3) Hire and train staff.

(4) Develop new practice networks.

(5) Purchase services or products that shall facilitate the provision of health care services at a community health center site.

Section 30-20. Reporting. Within 60 days after the first and second years of a grant under this Act, the grant recipient must submit a progress report to the Department demonstrating that the recipient is meeting the goals and objectives stated in the grant, that grant moneys are being used for appropriate purposes, and that residents of the community are being served by the targeted expansions established with grant moneys. Within 60 days after the final year of a grant under this Act, the grant recipient must submit a final report to the Department demonstrating that the recipient has met the goals

and objectives stated in the grant, that grant moneys were used for appropriate purposes, and that residents of the community are being served by the targeted expansions established with grant moneys.

Section 30-25. Rules. The Department shall adopt rules it deems necessary for the efficient administration of this Act.

ARTICLE 33. ILLINOIS ROADMAP TO HEALTH

Section 33-1. Short title. This Article may be cited as the Illinois Roadmap to Health Act. All references in this Article to "this Act" mean this Article.

Section 33-5. Definitions. In this Act:

"Chronic care" means health services provided by a healthcare professional for an established chronic condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, asthma, pulmonary disease, substance abuse, mental illness, and hyperlipidemia.

"Chronic care information system" means the electronic database developed under the Illinois Roadmap to Health that

shall include information on all cases of a particular disease or health condition in a defined population of individuals. Such a database may be developed in collaboration between the Department of Healthcare and Family Services and the Department of Public Health building upon and integrating current State databases.

"Chronic care management" means a system of coordinated healthcare interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

"Health risk assessment" means screening by a healthcare professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a screening.

"Illinois Roadmap to Health" means the State's plan for chronic care infrastructure, prevention of chronic conditions, and chronic care management program, and includes an integrated approach to patient self-management, community development, healthcare system and professional practice change, and

information technology initiatives.

Section 33-10. Illinois Roadmap to Health.

(a) In coordination with the Director of Healthcare and Family Services or his or her designee and the Secretary of Human Services or his or her designee, the Director of Public Health shall be responsible for the development and implementation of the Illinois Roadmap to Health, including the 5-year strategic plan.

(b)(1) The Director of Public Health shall establish an executive committee to advise him or her on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention described under this Section. The executive committee shall consist of no fewer than 16 individuals, including representatives from the Department of Financial and Professional Regulation, the Department of Healthcare and Family Services Division of Medical Programs, the Department of Healthcare and Family Services Office of Healthcare Purchasing, the Department of Human Services, 2 representatives of Illinois physician organizations, a representative of Illinois hospitals, a representative from Illinois nurses, a representative from Illinois community health centers, a representative from community mental health providers, a representative from substance abuse providers, 2 representatives of private health insurers, and at least 2 consumer advocates.

(2) The executive committee shall engage a broad range of healthcare professionals who provide services and have expertise in specific areas addressed by the Illinois Roadmap to Health. Such professionals shall be representative of practice in both private insurance and public health and in care for those served by State medical programs including, but not limited to, the Covering ALL KIDS Health Insurance Program, the Children's Health Insurance Program Act, and medical assistance under Article V of the Illinois Public Aid Code generally.

(c)(1) The strategic plan shall include:

(A) A description of the Illinois Roadmap to Health, which includes general, standard elements, patient self-management, community initiatives, and health system and information technology reform, to be used uniformly statewide by private insurers, third party administrators, and State healthcare programs.

(B) A description of prevention programs and how these programs are integrated into communities, with chronic care management, and the Illinois Roadmap to Health model.

(C) A plan to develop an appropriate payment methodology that aligns with and rewards health professionals who manage the care for individuals with or at risk for conditions in order to improve outcomes and the quality of care.

(D) The involvement of public and private groups,

healthcare professionals, insurers, third party administrators, hospitals, community health centers, and businesses to facilitate and ensure the sustainability of a new system of care.

(E) The involvement of community and consumer groups to facilitate and ensure the sustainability of health services supporting healthy behaviors and good patient self-management for the prevention and management of chronic conditions.

(F) Alignment of any information technology needs with other healthcare information technology initiatives.

(G) The use and development of outcomes measures and reporting requirements, aligned with existing outcome measures within the Departments of Public Health and Healthcare and Family Services, to assess and evaluate the system of chronic care.

(H) Target timelines for inclusion of specific chronic conditions to be included in the chronic care infrastructure and for statewide implementation of the Illinois Roadmap to Health.

(I) Identification of resource needs for implementing and sustaining the blueprint for health, and strategies to meet the needs.

(J) A strategy for ensuring statewide participation no later than January 1, 2011 by insurers, third-party administrators, State healthcare programs, healthcare

professionals, hospitals and other professionals, and consumers in the chronic care management plan, including common outcome measures, best practices and protocols, data reporting requirements, reimbursement methodologies incentivizing chronic care management and prevention or early detection of chronic illnesses and other standards.

(2) The strategic plan shall be reviewed biennially and amended as necessary to reflect changes in priorities. Amendments to the plan shall be reported to the General Assembly and the Office of the Governor in the report established under subsection (d) of this Section.

(d)(1) The Director of Public Health in collaboration with the Director of Healthcare and Family Services and the Secretary of Human Services shall report annually to members of the General Assembly and the Office of the Governor on the status of implementation of the Illinois Roadmap to Health. The report shall include: the number of participating insurers, healthcare professionals, and patients; the progress for achieving statewide participation in the chronic care management plan, including the measures established under subsection (c) of this Section; the expenditures and savings for the period; and the results of healthcare professional and patient satisfaction surveys. The surveys shall be developed in collaboration with the executive committee established under subsection (b) of this Section.

(2) If statewide participation in the Illinois Roadmap to

Health is not achieved by January 1, 2011, the Director of Public Health shall evaluate the Illinois Roadmap to Health and recommend to the General Assembly changes necessary to create alternative measures to ensure statewide participation by health insurers, third party administrators, State healthcare programs, and healthcare professionals.

Section 33-15. Chronic Care Management Program.

(a) The Director of Healthcare and Family Services shall ensure that chronic care management programs, including disease management programs established for those enrolled in medical programs administered by the Department, including both State employee health insurance programs and means-tested healthcare programs administered by the Department, are modified over time to comply with the Illinois Roadmap to Health strategic plan and to the extent feasible collaborate in its initiatives.

(b) The programs described in subsection (a) shall be designed or modified as necessary to:

(1) Include a broad range of chronic conditions in the chronic care management program.

(2) Utilize the chronic care information system established under this Act.

(3) Include an enrollment process which provides incentives and strategies for maximum patient participation, and a standard statewide health risk

assessment for each individual.

(4) Include methods of increasing communications among healthcare professionals and patients, including patient education, self-management, and follow-up plans.

(5) Include process and outcome measures to provide performance feedback for healthcare professionals and information on the quality of care, including patient satisfaction and health status outcomes.

(6) Include payment methodologies to align reimbursements and create financial incentives and rewards for healthcare professionals to establish management systems for chronic conditions, to improve health outcomes, and to improve the quality of care, including case management fees, payment for technical support and data entry associated with patient registries, and any other appropriate payment for achievement of chronic care goals.

(7) Include a requirement that the data on enrollees be shared, to the extent allowable under federal law, with the Department in order to inform the healthcare reform initiatives under the Illinois Roadmap to Health.

Section 33-20. Promoting Wellness under the Illinois Roadmap to Health. The Director of Healthcare and Family Services, in collaboration with the Director of Public Health, the Secretary of Human Services, and the Department of Central

Management Services, shall develop new strategies to:

(1) Promote wellness and the adoption of healthy lifestyle choices and prevent chronic illness in the State's means-tested healthcare programs. The Department of Healthcare and Family Services shall analyze whether any federal waivers or waiver modifications are needed or desirable to integrate such programs into the State's means-tested healthcare programs.

(2) Promote wellness and the adoption of healthy lifestyle choices and prevent chronic illness in the State employee's health insurance programs. Such initiatives shall involve consultation with the State of Illinois employees' representatives.

ARTICLE 35. IMPROVING PATIENT SAFETY AND PROMOTING ELECTRONIC HEALTH RECORDS

Section 35-1. Short title. This Article may be cited as the Health Information Exchange and Technology Act. All references in this Article to "this Act" mean this Article.

Section 35-5. Purpose. Health information technology improves the quality of patient care, increases the efficiency of health care practices, improves safety, and reduces health care errors. These benefits are realized through the sharing of vital health information among health care providers who have

adopted electronic health record systems. To ensure the benefits of health information technology are available to the citizens of Illinois, the State must provide a framework for the exchange of health information and encourage the widespread adoption of electronic health record (EHR) systems among health care providers.

Section 35-7. Definition. As used in this Article, "Department" means the Department of Public Health.

Section 35-10. Implementation of health information technology initiatives. In order to advance the effective implementation of health information technology, the Department of Public Health shall, subject to appropriation, establish a program to promote, through public-private partnerships, the development of a health information exchange framework and foster the adoption of electronic health record systems.

Section 35-15. Establishment of the Illinois Health Information Network.

(a) As part of its program to promote health information technology through public-private partnerships, the Department of Public Health is authorized in accordance with Section 10 of the State Agency Entity Creation Act to create a not for profit organization that shall be known as the Illinois Health

Information Network, or ILHIN. The Department shall file articles of incorporation and bylaws as required under the General Not For Profit Corporation Act of 1986 to create the ILHIN.

(b) The primary mission of the ILHIN shall be the following:

(1) to establish a State-level health information exchange to facilitate the sharing of health information among health care providers within Illinois and beyond in other states; and

(2) to foster the widespread adoption of electronic health records, personal health records, and health information exchange by health care providers and the general public.

(c) The ILHIN shall be governed by a board of directors as specified in Section 35-25 of this Act, with the rights, titles, powers, privileges, and obligations provided for in the General Not For Profit Corporation Act of 1986.

(d) The board of directors may employ staff under the direction of the executive director appointed pursuant to Section 35-25, or independent contractors necessary to perform its duties as specified in this Section and to fix their compensation, benefits, terms, and conditions of their employment. Employees of the department may be deployed by the director to support the activities of the ILHIN.

(e) Funds collected by the ILHIN shall be considered

private funds and shall be held in an appropriate account outside of the State Treasury. The treasurer of the ILHIN shall be custodian of all ILHIN funds. The ILHIN's accounts and books shall be set up and maintained in a manner approved by the Auditor General and the ILHIN and its officers shall be responsible for the approval of recording of receipts, approval of payments, and the proper filing of required reports. The ILHIN may be assisted in carrying out its functions by personnel of the department with respect to matters falling within their scope and function. The ILHIN shall cooperate fully with the boards, commissions, agencies, departments and institutions of the State. The funds held and made available by ILHIN shall be subject to financial and compliance audits by the Auditor General in compliance with the Illinois State Auditing Act.

Section 35-20. Powers and duties of the Illinois Health Information Network.

(a) The ILHIN shall create a State-level health information exchange using modern up-to-date communications technology and software that is both secure and cost effective, meets all other relevant privacy and security requirements both at the State and federal level, and conforms to appropriate existing or developing federal electronic communications standards. The ILHIN shall consult with other states and federal agencies to better understand the technologies in use as well as the kinds

of patient data that is being collected and utilized in similar programs.

(b) The ILHIN shall establish, by January 1, 2010, minimum standards for accessing the State-level health information exchange by health care providers and researchers in order to ensure security and confidentiality protections for patient information, consistent with applicable federal and State standards. The ILHIN shall have the authority to suspend or terminate rights to participate in the health information exchange in case of non-compliance or failure to act, with respect to applicable standards, in the best interests of patients, participants of the ILHIN, and the public.

(c) The ILHIN shall identify barriers to the adoption of electronic health record systems by health care providers, including conducting, facilitating, or coordinating research on the rates and patterns of dissemination and use of electronic health record systems throughout the State. To address gaps in statewide implementation, the ILHIN may, through staff or consultant support, contracts, grants, or loans, offer technical assistance, training, and financial assistance, as available, to health care providers, with priority given to providers serving a significant percentage of uninsured patients and patients in medically underserved or rural areas.

(d) The ILHIN shall educate the general public on the benefits of electronic health records, personal health

records, and the safeguards available to prevent disclosure of personal health information.

(e) The ILHIN may appoint or designate a federally qualified institutional review board to review and approve requests for research in order to ensure compliance with standards and patient privacy protections as specified in subsection (b) of this Section.

(f) The ILHIN may solicit grants, loans, contributions, or appropriations from public or private source and may enter into any contracts, grants, loans, or agreements with respect to the use of such funds to fulfill its duties under this Act. No debt or obligation of the ILHIN shall become the debt or obligation of the State.

(g) The ILHIN may determine, charge, and collect any fees, charges, costs, and expenses from any person or provider in connection with its duties under this Act.

(h) The Department of Public Health may authorize ILHIN to collect protected health data from health care providers in a central repository for public health purposes and identified data for the use of the Department or other State agencies specifically to fulfill their state responsibilities. Any identified data so collected shall be privileged and confidential in accordance with Sections 8-2101, 8-2102, 8-2103, 8-2104, and 8-2105 of the Code of Civil Procedure and shall be exempt from the provisions of the Freedom of Information Act.

(i) The Department may authorize the ILHIN to make protected data available to health care providers and other organizations for the purpose of analyzing data related to health disparities, chronic illnesses, quality performance measurers, and other health care related issues.

(j) The ILHIN shall coordinate with the Department of Public Health with respect to the Governor's 2006 Executive Order 8 that, among other matters, encourages all health care providers to use electronic prescribing programs by 2011, to evaluate areas in need of enhanced technology to support e-prescribing programs, and to determine the technology needed to implement e-prescribing programs.

Section 35-25. Governance of the Illinois Health Information Network.

(a) The ILHIN shall be governed by a board of directors appointed to 3-year staggered terms by the Director of Public Health. The directors shall be representative of a broad spectrum of health care providers and may include among others: hospitals; physicians; nurses; consumers; third-party payers; pharmacists; federally qualified health centers as defined in Section 1905(l)(2)(B) of the Social Security Act; long-term care facilities, laboratories, mental health facilities, and home health agency organizations. The directors shall include representatives of the public and health care consumers.

(b) The Director of Public Health, the Director of

Healthcare and Family Services, and the Secretary of Human Services, or their designees, shall be ex-officio members of the board of directors.

(c) The Director of Public Health shall designate the ILHIN's presiding officer from among the members appointed.

(d) The Director of Public Health shall appoint the executive director for the ILHIN. The executive director may be an employee of the Department of Public Health.

(e) The board of directors may elect or appoint an executive committee, other committees, and subcommittees to conduct the business of the organization.

Section 35-30. Health information systems maintained by State agencies.

(a) By no later than January 1, 2015, each State agency that implements, acquires, or upgrades health information technology systems used for the direct exchange of health information between agencies and with non-State entities shall use health information technology systems and products that meet minimum standards adopted by the ILHIN for accessing the State-level health information exchange.

(b) In order to provide the ILHIN with operational capabilities to assist in the development of the State-level health information exchange, the Department of Public Health is authorized to transfer or license the assets of the Illinois Health Network to the ILHIN as soon as is practicable.

ARTICLE 40. REDUCING ADMINISTRATIVE COSTS IN THE OVERALL HEALTHCARE SYSTEM THROUGH ADMINISTRATIVE SIMPLIFICATION

Section 40-5. Common claims and procedures work group.

(a) No later than January 1, 2008, a common claims and procedures work group shall form, composed of:

(1) Two representatives of Illinois hospitals.

(2) Two representatives of Illinois physicians organizations.

(3) One representative of a nursing organization.

(4) One representative of a community health center.

(5) The Director of Healthcare and Family Services or his or her designee.

(6) Two representatives from business groups appointed by the Governor.

(7) The Director of Professional and Financial Regulation or his or her designee.

(8) Two representatives of the insurance industry appointed by the Governor.

(b) The group shall design, recommend, and implement steps to achieve the following goals:

(1) Simplifying the claims administration process for consumers, healthcare providers, and others so that the process is more understandable, and less time-consuming.

(2) Lowering administrative costs in the healthcare

financing system.

(3) Where possible, harmonizing the claims processing system for State healthcare programs with the process utilized by private insurers.

(c) On or before July 1, 2008, the work group shall present a 2-year work plan and budget to the General Assembly and Office of the Governor. This work plan may include the elements of the claims administration process, including claims forms, patient invoices, and explanation of benefits forms, payment codes, claims submission and processing procedures, including electronic claims processing, issues relating to the prior authorization process, and reimbursement for services provided prior to being credentialed.

(d) The Department of Healthcare and Family Services may procure a vendor or external expertise to assist the work group in its activities. Such a vendor shall have broad knowledge of claims processing and benefit management across both public and private payors. Particular attention may be paid to harmonizing claims processing system for State healthcare programs with the processes utilized by private insurers.

ARTICLE 45. PROMOTING PERSONAL AND BUSINESS RESPONSIBILITY FOR HEALTH INSURANCE AND HEALTHCARE COSTS

Section 45-5. Findings. A majority of Illinoisans receive their healthcare through employer sponsored health insurance.

The cost of such healthcare has been rising faster than wage inflation. A majority of businesses offer and subsidize such health insurance. However, a growing number of businesses are not offering health insurance. When a business does not offer subsidized health insurance, employees are far more likely to be uninsured and the costs of their healthcare are borne by other payors including other businesses. Likewise, when individuals choose to forgo paying for health insurance, they may still experience illness or be involved in an accident resulting in high medical costs that are borne by others. This cost shifting is driving up the cost of insurance for responsible businesses who are offering health insurance and other individuals who are purchasing health insurance in the non-group market. It is also shifting costs to State government, and therefore taxpayers, by expanding the costs of current State healthcare programs. Therefore, the General Assembly finds that it is equitable to assess businesses a fee to offset such costs when such a business is not contributing adequately to the cost of healthcare insurance and services for its employees. It is also appropriate to consider whether individuals should be required to contribute to the purchase of affordable health insurance coverage for themselves and their families.

ARTICLE 50. ILLINOIS COVERED ASSESSMENT ACT

PART 1. SHORT TITLE AND CONSTRUCTION

Section 50-101. Short title. This Article may be cited as the Illinois Covered Assessment Act. All references in this Article to "this Act" mean this Article.

Section 50-105. Construction. Except as otherwise expressly provided or clearly appearing from the context, any term used in this Act shall have the same meaning as when used in a comparable context in the Illinois Income Tax Act as in effect for the taxable year.

PART 2. DEFINITIONS

Section 50-201. Definitions. When used in this Act, where not otherwise distinctly expressed or manifestly incompatible with the intent thereof:

"Employer" means any person who employs 10 or more full-time equivalent employees during the taxable year. The term "employer" does not include the government of the United States, of any foreign country, or of any of the states, or of any agency, instrumentality, or political subdivision of any such government. In the case of a unitary business group, as defined in Section 1501(a)(27) of the Illinois Income Tax Act, the employer is the unitary business group.

"Expenditures for health care" means any amount paid by an

employer to provide health care to its employees or their families or reimburse its employees or their families for health care, including but not limited to amounts paid or reimbursed for health insurance premiums where the underlying policy provides or has provided coverage to employees of such employer or their families. Such expenditures include but are not limited to payment or reimbursement for medical care, prescription drugs, vision care, medical savings accounts, and any other costs to provide health care to an employer's employees or their families.

"Full-time equivalent employees". The number of "full-time equivalent employees" employed by an employer during a taxable year shall be the lesser of (i) the number of persons who were employees of the employer at any time during the taxable year and (ii) the total number of hours worked by all employees of the employer during the taxable year, divided by 1500.

"Illinois employee" means an employee who is an Illinois resident during the time he or she is performing services for the employer or who has compensation from the employer that is "paid in this State" during the taxable year within the meaning of Section 304(a)(2)(B) of the Illinois Income Tax Act.

"Wages" means wages as defined in Section 3401(a) of the Internal Revenue Code, without regard to the exceptions contained in that Section and without reduction for exemptions allowed in computing withholding.

PART 3. TAX IMPOSED

Section 50-301. Tax imposed.

(a) A tax is hereby imposed on each employer for the privilege of doing business in this State at the rate of 3% of the wages paid to Illinois employees by the employer during the taxable year, provided that the tax on wages paid by the employer to any single employee shall not exceed $7,500 for the taxable year.

(b) The tax imposed under this Act shall apply to wages paid on or after July 1, 2008.

(c) The tax imposed under this Act is a tax on the employer, and shall not be withheld from wages paid to employees or otherwise be collected from employees or reduce the compensation paid to employees.

Section 50-302. Credits.

(a) For each taxable year, an employer whose total expenditures for health care for Illinois employees exceed 4% of the wages paid to Illinois employees for that taxable year shall be entitled to a credit equal to 3% of the wages paid to Illinois employees for that taxable year.

(b) For each taxable year, an employer whose expenditures for health care for Illinois employees exceed 2.5% of the wages paid to Illinois employees for that taxable year, but are less than 4%, shall be entitled to a credit equal to the wages paid

to Illinois employees times a percentage equal to 3% minus the excess of the percentage of wages paid to Illinois employees expended on health care for Illinois employees over 2.5%.

PART 4. PAYMENT OF ESTIMATED TAX

Section 50-401. Payment of estimated tax.

(a) Each taxpayer is required to pay estimated tax in installments for each taxable year in the form and manner that the Department requires by rule.

(b) Payment of an installment of estimated tax is due no later than each due date during the taxable year under Article 7 of the Illinois Income Tax Act for payment of amounts withheld from employee compensation by the employer.

(c) The amount of each installment shall be: (1) 3% of the wages paid to Illinois employees during the period during which the employer withheld the amount of Illinois income withholding that is due on the same date as the installment, minus (2) the credit allowed for the taxable year under Section 50-302 of this Act, multiplied by the number of days during the period in clause (1), divided by 365.

(d) No payment of estimated tax is due under this Section for a taxable year if, during the 12 months preceding the taxable year, the employer employed fewer than 10 full-time equivalent employees. For purposes of this subsection, in the case of an employer that is a corporation, the employees for

the 12 months immediately preceding the taxable year shall include the employees of any corporations whose assets were acquired by the employer in a transaction described in Section 381(a) of the Internal Revenue Code during that 12-month period.

(e) For purposes of Section 3-3 of the Uniform Penalty and Interest Act, a taxpayer shall be deemed to have failed to make timely payment of an installment of estimated taxes due under this Section only if the amount timely paid for that installment is less than 90% of the amount due under subsection (c) of this Section.

PART 5. INDIVIDUAL RESPONSIBILITY

Section 50-501. Individual responsibility.

(a) No later than January 1, 2008, the Department of Healthcare and Family Services, in collaboration with the Department of Public Health, shall establish the Promoting Individual Responsibility in Health Insurance Task Force. The task force shall be appointed by the Governor and shall consist at a minimum of:

(1) Three consumer advocates including an advocate for persons with disabilities.

(2) Three representatives of businesses.

(3) Two representatives of healthcare professionals.

(4) Two individuals with expertise in health policy.

(5) One representative of hospitals.

(6) One individual with expertise in economics.

(b) The task force shall analyze the effects of establishing an individual mandate to purchase health insurance, including but not limited to the following topics:

(1) The effect on current insurance premiums paid for by businesses and individuals of the presence or absence of such a mandate.

(2) The effect on lifetime healthcare costs of lack of health insurance or intermittent coverage.

(3) What constitutes affordability of health insurance for individuals and families.

(4) What are the barriers to insurance that exist today, and what would be appropriate remedies for such barriers.

(5) What entities currently incur costs due to individuals being uninsured, and the extent of such costs here in Illinois.

(6) What an appropriate enforcement mechanism would be if such a mandate were to be established.

(7) What the effect on the level of insurance would be if such a mandate were to be established.

(c) The task force shall prepare a report for the General Assembly and the Office of the Governor no later than December 31, 2009 with recommendations as to whether an individual mandate should be enacted and, if so, the mechanism for so

doing.

(d) No later than December 31, 2010, the Department of Healthcare and Family Services shall estimate the reduction in the number of uninsured persons due to implementation of the Illinois Covered Act. If the number of uninsured adults between the ages of 19 and 64 is estimated to be above 500,000 individuals, then the Department shall review the recommendations of the task force and make a recommendation to the General Assembly regarding a requirement for purchase of health insurance.

PART 6. HEALTH INSURER RESPONSIBILITY

Section 50-601. Health insurer responsibility. Within 30 days after the conclusion of 2 years from the effective date of the Illinois Covered Choices Program, the Governor shall designate a 9-person task force to determine the propriety of regulatory reform requiring prior approval of premium rates charged by health insurers for group and individual contracts. The task force shall be composed of a designee of the Governor, the Speaker of the House of Representatives, the President of the Senate, the Director of the Department of Healthcare and Family Services, the Director of the Division of Insurance, a representative of the health insurance industry, a representative of health care providers, and 2 representatives of labor groups or employee associations. Within 270 days after

the conclusion of 2 years from the effective date of the Illinois Covered Choices Program, the task force shall issue a written report to the Governor, including a description of findings, analyses, conclusions, and recommendations, regarding whether additional health insurance rate regulation is appropriate. If necessary, the Governor shall thereafter take action appropriate to implement the recommendations of the task force.

PART 7. SEVERABILITY

Section 50-701. Severability. It is the purpose of Section 50-301 of this Act to impose a tax upon the privilege of doing business in this State, so far as the same may be done under the Constitution and statutes of the United States and the Constitution of the State of Illinois. If any clause, sentence, Section, provision, part, or credit included in this Act, or the application thereof to any person or circumstance, is adjudged to be unconstitutional, then it is the intent of the General Assembly that the tax imposed and the remainder of this Act, or its application to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

ARTICLE 95. MISCELLANEOUS PROVISIONS

Section 95-5. The Illinois Administrative Procedure Act is amended by changing Section 5-45 as follows:

(5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

Sec. 5-45. Emergency rulemaking.

(a) "Emergency" means the existence of any situation that any agency finds reasonably constitutes a threat to the public interest, safety, or welfare.

(b) If any agency finds that an emergency exists that requires adoption of a rule upon fewer days than is required by Section 5-40 and states in writing its reasons for that finding, the agency may adopt an emergency rule without prior notice or hearing upon filing a notice of emergency rulemaking with the Secretary of State under Section 5-70. The notice shall include the text of the emergency rule and shall be published in the Illinois Register. Consent orders or other court orders adopting settlements negotiated by an agency may be adopted under this Section. Subject to applicable constitutional or statutory provisions, an emergency rule becomes effective immediately upon filing under Section 5-65 or at a stated date less than 10 days thereafter. The agency's finding and a statement of the specific reasons for the finding shall be filed with the rule. The agency shall take reasonable and appropriate measures to make emergency rules known to the persons who may be affected by them.

(c) An emergency rule may be effective for a period of not

longer than 150 days, but the agency's authority to adopt an identical rule under Section 5-40 is not precluded. No emergency rule may be adopted more than once in any 24 month period, except that this limitation on the number of emergency rules that may be adopted in a 24 month period does not apply to (i) emergency rules that make additions to and deletions from the Drug Manual under Section 5-5.16 of the Illinois Public Aid Code or the generic drug formulary under Section 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii) emergency rules adopted by the Pollution Control Board before July 1, 1997 to implement portions of the Livestock Management Facilities Act, or (iii) emergency rules adopted by the Illinois Department of Public Health under subsections (a) through (i) of Section 2 of the Department of Public Health Act when necessary to protect the public's health. Two or more emergency rules having substantially the same purpose and effect shall be deemed to be a single rule for purposes of this Section.

(d) In order to provide for the expeditious and timely implementation of the State's fiscal year 1999 budget, emergency rules to implement any provision of Public Act 90-587 or 90-588 or any other budget initiative for fiscal year 1999 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125

do not apply to rules adopted under this subsection (d). The adoption of emergency rules authorized by this subsection (d) shall be deemed to be necessary for the public interest, safety, and welfare.

(e) In order to provide for the expeditious and timely implementation of the State's fiscal year 2000 budget, emergency rules to implement any provision of this amendatory Act of the 91st General Assembly or any other budget initiative for fiscal year 2000 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (e). The adoption of emergency rules authorized by this subsection (e) shall be deemed to be necessary for the public interest, safety, and welfare.

(f) In order to provide for the expeditious and timely implementation of the State's fiscal year 2001 budget, emergency rules to implement any provision of this amendatory Act of the 91st General Assembly or any other budget initiative for fiscal year 2001 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (f). The adoption of emergency rules authorized by

this subsection (f) shall be deemed to be necessary for the public interest, safety, and welfare.

(g) In order to provide for the expeditious and timely implementation of the State's fiscal year 2002 budget, emergency rules to implement any provision of this amendatory Act of the 92nd General Assembly or any other budget initiative for fiscal year 2002 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (g). The adoption of emergency rules authorized by this subsection (g) shall be deemed to be necessary for the public interest, safety, and welfare.

(h) In order to provide for the expeditious and timely implementation of the State's fiscal year 2003 budget, emergency rules to implement any provision of this amendatory Act of the 92nd General Assembly or any other budget initiative for fiscal year 2003 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (h). The adoption of emergency rules authorized by this subsection (h) shall be deemed to be necessary for the public interest, safety, and welfare.

(i) In order to provide for the expeditious and timely implementation of the State's fiscal year 2004 budget, emergency rules to implement any provision of this amendatory Act of the 93rd General Assembly or any other budget initiative for fiscal year 2004 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (i). The adoption of emergency rules authorized by this subsection (i) shall be deemed to be necessary for the public interest, safety, and welfare.

(j) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2005 budget as provided under the Fiscal Year 2005 Budget Implementation (Human Services) Act, emergency rules to implement any provision of the Fiscal Year 2005 Budget Implementation (Human Services) Act may be adopted in accordance with this Section by the agency charged with administering that provision, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (j). The Department of Public Aid may also adopt rules under this subsection (j) necessary to administer the Illinois Public Aid Code and the Children's Health Insurance Program Act. The adoption of emergency rules

authorized by this subsection (j) shall be deemed to be necessary for the public interest, safety, and welfare.

(k) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2006 budget, emergency rules to implement any provision of this amendatory Act of the 94th General Assembly or any other budget initiative for fiscal year 2006 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (k). The Department of Healthcare and Family Services may also adopt rules under this subsection (k) necessary to administer the Illinois Public Aid Code, the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act, the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act (now the Illinois Prescription Drug Discount Program Act), and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (k) shall be deemed to be necessary for the public interest, safety, and welfare.

(l) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2007 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2007, including

rules effective July 1, 2007, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (l) shall be deemed to be necessary for the public interest, safety, and welfare.

(m) In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 95th General Assembly, the Departments of Healthcare and Family Services, Revenue, Public Health, and Financial and Professional Regulation may adopt rules necessary to establish and implement this amendatory Act of the 95th General Assembly through the use of emergency rulemaking in accordance with this Section. For the purposes of this Act, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 95th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

(Source: P.A. 93-20, eff. 6-20-03; 93-829, eff. 7-28-04; 93-841, eff. 7-30-04; 94-48, eff. 7-1-05; 94-838, eff. 6-6-06; revised 10-19-06.)

Section 95-97. Severability. If any provision of this Act or its application to any person or circumstance is held

invalid, the invalidity of that provision of application does not affect other provisions or applications of this Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

ARTICLE 99. EFFECTIVE DATE

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