

1 AN ACT concerning regulation.

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

4 Section 1. Short title. This Act may be cited as the
5 Hospital Uninsured Patient Discount Act.

6 Section 5. Definitions. As used in this Act:

7 "Cost to charge ratio" means the ratio of a hospital's
8 costs to its charges taken from its most recently filed
9 Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS
10 Inpatient Ratios).

11 "Critical Access Hospital" means a hospital that is
12 designated as such under the federal Medicare Rural Hospital
13 Flexibility Program.

14 "Family income" means the sum of a family's annual earnings
15 and cash benefits from all sources before taxes, less payments
16 made for child support.

17 "Federal poverty income guidelines" means the poverty
18 guidelines updated periodically in the Federal Register by the
19 United States Department of Health and Human Services under
20 authority of 42 U.S.C. 9902(2).

21 "Health care services" means any medically necessary
22 inpatient or outpatient hospital service, including
23 pharmaceuticals or supplies provided by a hospital to a

1 patient.

2 "Hospital" means any facility or institution required to be
3 licensed pursuant to the Hospital Licensing Act or operated
4 under the University of Illinois Hospital Act.

5 "Illinois resident" means a person who lives in Illinois
6 and who intends to remain living in Illinois indefinitely.
7 Relocation to Illinois for the sole purpose of receiving health
8 care benefits does not satisfy the residency requirement under
9 this Act.

10 "Medically necessary" means any inpatient or outpatient
11 hospital service, including pharmaceuticals or supplies
12 provided by a hospital to a patient, covered under Title XVIII
13 of the federal Social Security Act for beneficiaries with the
14 same clinical presentation as the uninsured patient. A
15 "medically necessary" service does not include any of the
16 following:

17 (1) Non-medical services such as social and vocational
18 services.

19 (2) Elective cosmetic surgery, but not plastic surgery
20 designed to correct disfigurement caused by injury,
21 illness, or congenital defect or deformity.

22 "Rural hospital" means a hospital that is located outside a
23 metropolitan statistical area.

24 "Uninsured discount" means a hospital's charges multiplied
25 by the uninsured discount factor.

26 "Uninsured discount factor" means 1.0 less the product of a

1 hospital's cost to charge ratio multiplied by 1.35.

2 "Uninsured patient" means an Illinois resident who is a
3 patient of a hospital and is not covered under a policy of
4 health insurance and is not a beneficiary under a public or
5 private health insurance, health benefit, or other health
6 coverage program, including high deductible health insurance
7 plans, workers' compensation, accident liability insurance, or
8 other third party liability.

9 Section 10. Uninsured patient discounts.

10 (a) Eligibility.

11 (1) A hospital, other than a rural hospital or Critical
12 Access Hospital, shall provide a discount from its charges
13 to any uninsured patient who applies for a discount and has
14 family income of not more than 600% of the federal poverty
15 income guidelines for all medically necessary health care
16 services exceeding \$300 in any one inpatient admission or
17 outpatient encounter.

18 (2) A rural hospital or Critical Access Hospital shall
19 provide a discount from its charges to any uninsured
20 patient who applies for a discount and has annual family
21 income of not more than 300% of the federal poverty income
22 guidelines for all medically necessary health care
23 services exceeding \$300 in any one inpatient admission or
24 outpatient encounter.

25 (b) Discount. For all health care services exceeding \$300

1 in any one inpatient admission or outpatient encounter, a
2 hospital shall not collect from an uninsured patient, deemed
3 eligible under subsection (a), more than its charges less the
4 amount of the uninsured discount.

5 (c) Maximum Collectible Amount.

6 (1) The maximum amount that may be collected in a 12
7 month period for health care services provided by the
8 hospital from a patient determined by that hospital to be
9 eligible under subsection (a) is 25% of the patient's
10 family income, and is subject to the patient's continued
11 eligibility under this Act.

12 (2) The 12 month period to which the maximum amount
13 applies shall begin on the first date, after the effective
14 date of this Act, an uninsured patient receives health care
15 services that are determined to be eligible for the
16 uninsured discount at that hospital.

17 (3) To be eligible to have this maximum amount applied
18 to subsequent charges, the uninsured patient shall inform
19 the hospital in subsequent inpatient admissions or
20 outpatient encounters that the patient has previously
21 received health care services from that hospital and was
22 determined to be entitled to the uninsured discount.

23 (4) Hospitals may adopt policies to exclude an
24 uninsured patient from the application of subdivision
25 (c)(1) when the patient owns assets having a value in
26 excess of 600% of the federal poverty level for hospitals

1 in a metropolitan statistical area or owns assets having a
2 value in excess of 300% of the federal poverty level for
3 Critical Access Hospitals or hospitals outside a
4 metropolitan statistical area, not counting the following
5 assets: the uninsured patient's primary residence;
6 personal property exempt from judgment under Section
7 12-1001 of the Code of Civil Procedure; or any amounts held
8 in a pension or retirement plan, provided, however, that
9 distributions and payments from pension or retirement
10 plans may be included as income for the purposes of this
11 Act.

12 (d) Each hospital bill, invoice, or other summary of
13 charges to an uninsured patient shall include with it, or on
14 it, a prominent statement that an uninsured patient who meets
15 certain income requirements may qualify for an uninsured
16 discount and information regarding how an uninsured patient may
17 apply for consideration under the hospital's financial
18 assistance policy.

19 Section 15. Patient responsibility.

20 (a) Hospitals may make the availability of a discount and
21 the maximum collectible amount under this Act contingent upon
22 the uninsured patient first applying for coverage under public
23 programs, such as Medicare, Medicaid, AllKids, the State
24 Children's Health Insurance Program, or any other program, if
25 there is a reasonable basis to believe that the uninsured

1 patient may be eligible for such program.

2 (b) Hospitals shall permit an uninsured patient to apply
3 for a discount within 60 days of the date of discharge or date
4 of service.

5 (1) Income verification. Hospitals may require an
6 uninsured patient who is requesting an uninsured discount
7 to provide documentation of family income. Acceptable
8 family income documentation shall include any one of the
9 following:

10 (A) a copy of the most recent tax return;

11 (B) a copy of the most recent W-2 form and 1099
12 forms;

13 (C) copies of the 2 most recent pay stubs;

14 (D) written income verification from an employer
15 if paid in cash; or

16 (E) one other reasonable form of third party income
17 verification deemed acceptable to the hospital.

18 (2) Asset verification. Hospitals may require an
19 uninsured patient who is requesting an uninsured discount
20 to certify the existence of assets owned by the patient and
21 to provide documentation of the value of such assets.
22 Acceptable documentation may include statements from
23 financial institutions or some other third party
24 verification of an asset's value. If no third party
25 verification exists, then the patient shall certify as to
26 the estimated value of the asset.

1 (3) Illinois resident verification. Hospitals may
2 require an uninsured patient who is requesting an uninsured
3 discount to verify Illinois residency. Acceptable
4 verification of Illinois residency shall include any one of
5 the following:

6 (A) any of the documents listed in paragraph (1);

7 (B) a valid state-issued identification card;

8 (C) a recent residential utility bill;

9 (D) a lease agreement;

10 (E) a vehicle registration card;

11 (F) a voter registration card;

12 (G) mail addressed to the uninsured patient at an
13 Illinois address from a government or other credible
14 source;

15 (H) a statement from a family member of the
16 uninsured patient who resides at the same address and
17 presents verification of residency; or

18 (I) a letter from a homeless shelter, transitional
19 house or other similar facility verifying that the
20 uninsured patient resides at the facility.

21 (c) Hospital obligations toward an individual uninsured
22 patient under this Act shall cease if that patient unreasonably
23 fails or refuses to provide the hospital with information or
24 documentation requested under subsection (b) or to apply for
25 coverage under public programs when requested under subsection
26 (a) within 30 days of the hospital's request.

1 (d) In order for a hospital to determine the 12 month
2 maximum amount that can be collected from a patient deemed
3 eligible under Section 10, an uninsured patient shall inform
4 the hospital in subsequent inpatient admissions or outpatient
5 encounters that the patient has previously received health care
6 services from that hospital and was determined to be entitled
7 to the uninsured discount.

8 (e) Hospitals may require patients to certify that all of
9 the information provided in the application is true. The
10 application may state that if any of the information is untrue,
11 any discount granted to the patient is forfeited and the
12 patient is responsible for payment of the hospital's full
13 charges.

14 Section 20. Exemptions and limitations.

15 (a) Hospitals that do not charge for their services are
16 exempt from the provisions of this Act.

17 (b) Nothing in this Act shall be used by any private or
18 public health care insurer or plan as a basis for reducing its
19 payment or reimbursement rates or policies with any hospital.
20 Notwithstanding any other provisions of law, discounts
21 authorized under this Act shall not be used by any private or
22 public health care insurer or plan, regulatory agency,
23 arbitrator, court, or other third party to determine a
24 hospital's usual and customary charges for any health care
25 service.

1 (c) Nothing in this Act shall be construed to require a
2 hospital to provide an uninsured patient with a particular type
3 of health care service or other service.

4 (d) Nothing in this Act shall be deemed to reduce or
5 infringe upon the rights and obligations of hospitals and
6 patients under the Fair Patient Billing Act.

7 (e) The obligations of hospitals under this Act shall take
8 effect for health care services provided on or after the first
9 day of the month that begins 90 days after the effective date
10 of this Act or 90 days after the initial adoption of rules
11 authorized under subsection (a) of Section 25, whichever occurs
12 later.

13 Section 25. Enforcement.

14 (a) The Attorney General is responsible for administering
15 and ensuring compliance with this Act, including the
16 development of any rules necessary for the implementation and
17 enforcement of this Act.

18 (b) The Attorney General shall develop and implement a
19 process for receiving and handling complaints from individuals
20 or hospitals regarding possible violations of this Act.

21 (c) The Attorney General may conduct any investigation
22 deemed necessary regarding possible violations of this Act by
23 any hospital including, without limitation, the issuance of
24 subpoenas to:

25 (1) require the hospital to file a statement or report

1 or answer interrogatories in writing as to all information
2 relevant to the alleged violations;

3 (2) examine under oath any person who possesses
4 knowledge or information directly related to the alleged
5 violations; and

6 (3) examine any record, book, document, account, or
7 paper necessary to investigate the alleged violation.

8 (d) If the Attorney General determines that there is a
9 reason to believe that any hospital has violated this Act, the
10 Attorney General may bring an action in the name of the People
11 of the State against the hospital to obtain temporary,
12 preliminary, or permanent injunctive relief for any act,
13 policy, or practice by the hospital that violates this Act.
14 Before bringing such an action, the Attorney General may permit
15 the hospital to submit a Correction Plan for the Attorney
16 General's approval.

17 (e) This Section applies if:

18 (1) A court orders a party to make payments to the
19 Attorney General and the payments are to be used for the
20 operations of the Office of the Attorney General; or

21 (2) A party agrees in a Correction Plan under this Act
22 to make payments to the Attorney General for the operations
23 of the Office of the Attorney General.

24 (f) Moneys paid under any of the conditions described in
25 subsection (e) shall be deposited into the Attorney General
26 Court Ordered and Voluntary Compliance Payment Projects Fund.

1 Moneys in the Fund shall be used, subject to appropriation, for
2 the performance of any function, pertaining to the exercise of
3 the duties, to the Attorney General including, but not limited
4 to, enforcement of any law of this State and conducting public
5 education programs; however, any moneys in the Fund that are
6 required by the court to be used for a particular purpose shall
7 be used for that purpose.

8 (g) The Attorney General may seek the assessment of a civil
9 monetary penalty not to exceed \$500 per violation in any action
10 filed under this Act where a hospital, by pattern or practice,
11 knowingly violates Section 10 of this Act.

12 (h) In the event a court grants a final order of relief
13 against any hospital for a violation of this Act, the Attorney
14 General may, after all appeal rights have been exhausted, refer
15 the hospital to the Illinois Department of Public Health for
16 possible adverse licensure action under the Hospital Licensing
17 Act.

18 (i) Each hospital shall file Worksheet C Part I from its
19 most recently filed Medicare Cost Report with the Attorney
20 General within 60 days after the effective date of this Act and
21 thereafter shall file each subsequent Worksheet C Part I with
22 the Attorney General within 30 days of filing its Medicare Cost
23 Report with the hospital's fiscal intermediary.

24 Section 30. Home rule. A home rule unit may not regulate
25 hospitals in a manner inconsistent with the provisions of this

1 Act. This Section is a limitation under subsection (i) of
2 Section 6 of Article VII of the Illinois Constitution on the
3 concurrent exercise by home rule units of powers and functions
4 exercised by the State.

5 Section 90. The Comprehensive Health Insurance Plan Act is
6 amended by changing Section 2 as follows:

7 (215 ILCS 105/2) (from Ch. 73, par. 1302)

8 Sec. 2. Definitions. As used in this Act, unless the
9 context otherwise requires:

10 "Plan administrator" means the insurer or third party
11 administrator designated under Section 5 of this Act.

12 "Benefits plan" means the coverage to be offered by the
13 Plan to eligible persons and federally eligible individuals
14 pursuant to this Act.

15 "Board" means the Illinois Comprehensive Health Insurance
16 Board.

17 "Church plan" has the same meaning given that term in the
18 federal Health Insurance Portability and Accountability Act of
19 1996.

20 "Continuation coverage" means continuation of coverage
21 under a group health plan or other health insurance coverage
22 for former employees or dependents of former employees that
23 would otherwise have terminated under the terms of that
24 coverage pursuant to any continuation provisions under federal

1 or State law, including the Consolidated Omnibus Budget
2 Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2,
3 367e, and 367e.1 of the Illinois Insurance Code, or any other
4 similar requirement in another State.

5 "Covered person" means a person who is and continues to
6 remain eligible for Plan coverage and is covered under one of
7 the benefit plans offered by the Plan.

8 "Creditable coverage" means, with respect to a federally
9 eligible individual, coverage of the individual under any of
10 the following:

11 (A) A group health plan.

12 (B) Health insurance coverage (including group health
13 insurance coverage).

14 (C) Medicare.

15 (D) Medical assistance.

16 (E) Chapter 55 of title 10, United States Code.

17 (F) A medical care program of the Indian Health Service
18 or of a tribal organization.

19 (G) A state health benefits risk pool.

20 (H) A health plan offered under Chapter 89 of title 5,
21 United States Code.

22 (I) A public health plan (as defined in regulations
23 consistent with Section 104 of the Health Care Portability
24 and Accountability Act of 1996 that may be promulgated by
25 the Secretary of the U.S. Department of Health and Human
26 Services).

1 (J) A health benefit plan under Section 5(e) of the
2 Peace Corps Act (22 U.S.C. 2504(e)).

3 (K) Any other qualifying coverage required by the
4 federal Health Insurance Portability and Accountability
5 Act of 1996, as it may be amended, or regulations under
6 that Act.

7 "Creditable coverage" does not include coverage consisting
8 solely of coverage of excepted benefits, as defined in Section
9 2791(c) of title XXVII of the Public Health Service Act (42
10 U.S.C. 300 gg-91), nor does it include any period of coverage
11 under any of items (A) through (K) that occurred before a break
12 of more than 90 days or, if the individual has been certified
13 as eligible pursuant to the federal Trade Act of 2002, a break
14 of more than 63 days during all of which the individual was not
15 covered under any of items (A) through (K) above.

16 Any period that an individual is in a waiting period for
17 any coverage under a group health plan (or for group health
18 insurance coverage) or is in an affiliation period under the
19 terms of health insurance coverage offered by a health
20 maintenance organization shall not be taken into account in
21 determining if there has been a break of more than 90 days in
22 any creditable coverage.

23 "Department" means the Illinois Department of Insurance.

24 "Dependent" means an Illinois resident: who is a spouse; or
25 who is claimed as a dependent by the principal insured for
26 purposes of filing a federal income tax return and resides in

1 the principal insured's household, and is a resident unmarried
2 child under the age of 19 years; or who is an unmarried child
3 who also is a full-time student under the age of 23 years and
4 who is financially dependent upon the principal insured; or who
5 is a child of any age and who is disabled and financially
6 dependent upon the principal insured.

7 "Direct Illinois premiums" means, for Illinois business,
8 an insurer's direct premium income for the kinds of business
9 described in clause (b) of Class 1 or clause (a) of Class 2 of
10 Section 4 of the Illinois Insurance Code, and direct premium
11 income of a health maintenance organization or a voluntary
12 health services plan, except it shall not include credit health
13 insurance as defined in Article IX 1/2 of the Illinois
14 Insurance Code.

15 "Director" means the Director of the Illinois Department of
16 Insurance.

17 "Effective date of medical assistance" means the date that
18 eligibility for medical assistance for a person is approved by
19 the Department of Human Services or the Department of
20 Healthcare and Family Services, except when the Department of
21 Human Services or the Department of Healthcare and Family
22 Services determines eligibility retroactively. In such
23 circumstances, the effective date of the medical assistance is
24 the date the Department of Human Services or the Department of
25 Healthcare and Family Services determines the person to be
26 eligible for medical assistance.

1 "Eligible person" means a resident of this State who
2 qualifies for Plan coverage under Section 7 of this Act.

3 "Employee" means a resident of this State who is employed
4 by an employer or has entered into the employment of or works
5 under contract or service of an employer including the
6 officers, managers and employees of subsidiary or affiliated
7 corporations and the individual proprietors, partners and
8 employees of affiliated individuals and firms when the business
9 of the subsidiary or affiliated corporations, firms or
10 individuals is controlled by a common employer through stock
11 ownership, contract, or otherwise.

12 "Employer" means any individual, partnership, association,
13 corporation, business trust, or any person or group of persons
14 acting directly or indirectly in the interest of an employer in
15 relation to an employee, for which one or more persons is
16 gainfully employed.

17 "Family" coverage means the coverage provided by the Plan
18 for the covered person and his or her eligible dependents who
19 also are covered persons.

20 "Federally eligible individual" means an individual
21 resident of this State:

22 (1) (A) for whom, as of the date on which the individual
23 seeks Plan coverage under Section 15 of this Act, the
24 aggregate of the periods of creditable coverage is 18 or
25 more months or, if the individual has been certified as
26 eligible pursuant to the federal Trade Act of 2002, 3 or

1 more months, and (B) whose most recent prior creditable
2 coverage was under group health insurance coverage offered
3 by a health insurance issuer, a group health plan, a
4 governmental plan, or a church plan (or health insurance
5 coverage offered in connection with any such plans) or any
6 other type of creditable coverage that may be required by
7 the federal Health Insurance Portability and
8 Accountability Act of 1996, as it may be amended, or the
9 regulations under that Act;

10 (2) who is not eligible for coverage under (A) a group
11 health plan (other than an individual who has been
12 certified as eligible pursuant to the federal Trade Act of
13 2002), (B) part A or part B of Medicare due to age (other
14 than an individual who has been certified as eligible
15 pursuant to the federal Trade Act of 2002), or (C) medical
16 assistance, and does not have other health insurance
17 coverage (other than an individual who has been certified
18 as eligible pursuant to the federal Trade Act of 2002);

19 (3) with respect to whom (other than an individual who
20 has been certified as eligible pursuant to the federal
21 Trade Act of 2002) the most recent coverage within the
22 coverage period described in paragraph (1)(A) of this
23 definition was not terminated based upon a factor relating
24 to nonpayment of premiums or fraud;

25 (4) if the individual (other than an individual who has
26 been certified as eligible pursuant to the federal Trade

1 Act of 2002) had been offered the option of continuation
2 coverage under a COBRA continuation provision or under a
3 similar State program, who elected such coverage; and

4 (5) who, if the individual elected such continuation
5 coverage, has exhausted such continuation coverage under
6 such provision or program.

7 However, an individual who has been certified as eligible
8 pursuant to the federal Trade Act of 2002 shall not be required
9 to elect continuation coverage under a COBRA continuation
10 provision or under a similar state program.

11 "Group health insurance coverage" means, in connection
12 with a group health plan, health insurance coverage offered in
13 connection with that plan.

14 "Group health plan" has the same meaning given that term in
15 the federal Health Insurance Portability and Accountability
16 Act of 1996.

17 "Governmental plan" has the same meaning given that term in
18 the federal Health Insurance Portability and Accountability
19 Act of 1996.

20 "Health insurance coverage" means benefits consisting of
21 medical care (provided directly, through insurance or
22 reimbursement, or otherwise and including items and services
23 paid for as medical care) under any hospital and medical
24 expense-incurred policy, certificate, or contract provided by
25 an insurer, non-profit health care service plan contract,
26 health maintenance organization or other subscriber contract,

1 or any other health care plan or arrangement that pays for or
2 furnishes medical or health care services whether by insurance
3 or otherwise. Health insurance coverage shall not include short
4 term, accident only, disability income, hospital confinement
5 or fixed indemnity, dental only, vision only, limited benefit,
6 or credit insurance, coverage issued as a supplement to
7 liability insurance, insurance arising out of a workers'
8 compensation or similar law, automobile medical-payment
9 insurance, or insurance under which benefits are payable with
10 or without regard to fault and which is statutorily required to
11 be contained in any liability insurance policy or equivalent
12 self-insurance.

13 "Health insurance issuer" means an insurance company,
14 insurance service, or insurance organization (including a
15 health maintenance organization and a voluntary health
16 services plan) that is authorized to transact health insurance
17 business in this State. Such term does not include a group
18 health plan.

19 "Health Maintenance Organization" means an organization as
20 defined in the Health Maintenance Organization Act.

21 "Hospice" means a program as defined in and licensed under
22 the Hospice Program Licensing Act.

23 "Hospital" means a duly licensed institution as defined in
24 the Hospital Licensing Act, an institution that meets all
25 comparable conditions and requirements in effect in the state
26 in which it is located, or the University of Illinois Hospital

1 as defined in the University of Illinois Hospital Act.

2 "Individual health insurance coverage" means health
3 insurance coverage offered to individuals in the individual
4 market, but does not include short-term, limited-duration
5 insurance.

6 "Insured" means any individual resident of this State who
7 is eligible to receive benefits from any insurer (including
8 health insurance coverage offered in connection with a group
9 health plan) or health insurance issuer as defined in this
10 Section.

11 "Insurer" means any insurance company authorized to
12 transact health insurance business in this State and any
13 corporation that provides medical services and is organized
14 under the Voluntary Health Services Plans Act or the Health
15 Maintenance Organization Act.

16 "Medical assistance" means the State medical assistance or
17 medical assistance no grant (MANG) programs provided under
18 Title XIX of the Social Security Act and Articles V (Medical
19 Assistance) and VI (General Assistance) of the Illinois Public
20 Aid Code (or any successor program) or under any similar
21 program of health care benefits in a state other than Illinois.

22 "Medically necessary" means that a service, drug, or supply
23 is necessary and appropriate for the diagnosis or treatment of
24 an illness or injury in accord with generally accepted
25 standards of medical practice at the time the service, drug, or
26 supply is provided. When specifically applied to a confinement

1 it further means that the diagnosis or treatment of the covered
2 person's medical symptoms or condition cannot be safely
3 provided to that person as an outpatient. A service, drug, or
4 supply shall not be medically necessary if it: (i) is
5 investigational, experimental, or for research purposes; or
6 (ii) is provided solely for the convenience of the patient, the
7 patient's family, physician, hospital, or any other provider;
8 or (iii) exceeds in scope, duration, or intensity that level of
9 care that is needed to provide safe, adequate, and appropriate
10 diagnosis or treatment; or (iv) could have been omitted without
11 adversely affecting the covered person's condition or the
12 quality of medical care; or (v) involves the use of a medical
13 device, drug, or substance not formally approved by the United
14 States Food and Drug Administration.

15 "Medical care" means the ordinary and usual professional
16 services rendered by a physician or other specified provider
17 during a professional visit for treatment of an illness or
18 injury.

19 "Medicare" means coverage under both Part A and Part B of
20 Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395, et
21 seq.

22 "Minimum premium plan" means an arrangement whereby a
23 specified amount of health care claims is self-funded, but the
24 insurance company assumes the risk that claims will exceed that
25 amount.

26 "Participating transplant center" means a hospital

1 designated by the Board as a preferred or exclusive provider of
2 services for one or more specified human organ or tissue
3 transplants for which the hospital has signed an agreement with
4 the Board to accept a transplant payment allowance for all
5 expenses related to the transplant during a transplant benefit
6 period.

7 "Physician" means a person licensed to practice medicine
8 pursuant to the Medical Practice Act of 1987.

9 "Plan" means the Comprehensive Health Insurance Plan
10 established by this Act.

11 "Plan of operation" means the plan of operation of the
12 Plan, including articles, bylaws and operating rules, adopted
13 by the board pursuant to this Act.

14 "Provider" means any hospital, skilled nursing facility,
15 hospice, home health agency, physician, registered pharmacist
16 acting within the scope of that registration, or any other
17 person or entity licensed in Illinois to furnish medical care.

18 "Qualified high risk pool" has the same meaning given that
19 term in the federal Health Insurance Portability and
20 Accountability Act of 1996.

21 "Resident" means a person who is and continues to be
22 legally domiciled and physically residing on a permanent and
23 full-time basis in a place of permanent habitation in this
24 State that remains that person's principal residence and from
25 which that person is absent only for temporary or transitory
26 purpose.

1 "Skilled nursing facility" means a facility or that portion
2 of a facility that is licensed by the Illinois Department of
3 Public Health under the Nursing Home Care Act or a comparable
4 licensing authority in another state to provide skilled nursing
5 care.

6 "Stop-loss coverage" means an arrangement whereby an
7 insurer insures against the risk that any one claim will exceed
8 a specific dollar amount or that the entire loss of a
9 self-insurance plan will exceed a specific amount.

10 "Third party administrator" means an administrator as
11 defined in Section 511.101 of the Illinois Insurance Code who
12 is licensed under Article XXXI 1/4 of that Code.

13 (Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03; 93-34,
14 eff. 6-23-03; 93-477, eff. 8-8-03; 93-622, eff. 12-18-03.)

15 Section 99. Effective date. This Act takes effect upon
16 becoming law, except that Sections 1 through 30 take effect 90
17 days after becoming law.