SB1893

LRB09610117RPM20283b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

SB1893

Introduced 2/20/2009, by Sen. William R. Haine

SYNOPSIS AS INTRODUCED:

See Index

Sets forth the purpose of the Act. Creates the Health Insurance Choice Law. Sets forth requirements concerning policy offerings, choice, renewability, notice, disclosure, and rates. Creates the Illinois Healthcare Policy Task Force Law. Provides that the Task Force shall make recommendations regarding legislation. Amends the Illinois Income Tax Act to provide for certain contribution credits. Creates the Illinois Innovative Insurance Solutions Law as a new Article in the Illinois Insurance Code. Provides that health insurance carriers may submit plans that may not otherwise meet existing requirements. Creates the Illinois Health Insurance Premium Assistance Program as a new Article in the Illinois Insurance Code. Provides that the Department of Healthcare and Family Services shall administer the Program and issue rebates. Amends the Illinois Insurance Code. Provides assistance to small employers with certain provisions of the Code. Amends the Comprehensive Health Insurance Plan Act to set forth provisions concerning eligibility and small employer participation. Amends the Children's Health Insurance Program Act to set forth provisions concerning eligibility and health benefits for children. Amends the Managed Care Reform and Patients Rights Act to set forth requirements concerning the Office of Consumer Health Insurance. Amends the Covering ALL KIDS Health Insurance Act to set forth requirements concerning eligibility and enrollment. Amends the Illinois Public Aid Code. Sets forth provisions concerning eligibility, reporting, incentives, model programs, and enforcement. Makes other changes. Effective immediately.

LRB096 10117 RPM 20283 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

ARTICLE 5. PURPOSE

Section 5-5. Purpose. Increasing health care benefit and health insurance costs threaten our citizens from being able to afford and access quality healthcare services. To address these threats, the State of Illinois must establish a State policy on healthcare that relies on flexibility and innovativeness, focuses on quality, and reduces the number of uninsured.

It is the intent of this legislation to strategically address these issues by encouraging collaboration with consumers, private purchasers of insurance benefits, providers of medical services, insurance carriers, and State government to implement the following:

(1) Increased measurement, transparency, and disclosure of hospital and clinician performance.

(2) Information, tools, and, incentives for patients and other consumers to enable them to make informed health care decisions.

(3) Timely payment of hospitals and clinicians based on their performance.

(4) Enhanced health information technology, including

an electronic health record for each of Illinois' citizens.

(5) Preventive and wellness initiatives.

(6) Creation of health insurance plans that provide flexibility, affordability, and innovativeness.

(7) Review of current private and public health plan designs and requirements identifying elements of the plans that need elimination and implementation of new programs that are consistent with guidelines and protocols established by organizations representing medical professions and best practices of public and private payers of healthcare benefits; changes or expansion of current public programs must meet State budget plans.

(8) Prioritizing of State provided healthcare programs assuring that such programs are being accessed and meeting the needs of low-income individuals and families before State program eligibility for these programs are expanded to higher income levels.

ARTICLE 10. MAKING HEALTHCARE MORE ACCESSIBLE AND AFFORDABLE BY EXPANDING HEALTHCARE INSURANCE CHOICES TO CONSUMERS

Section 10-1. Short title. This Law may be cited as the Health Insurance Choice Law.

Section 10-5. Purpose. The General Assembly recognizes the

need for individuals and small employers in this State to have access to health insurance policies that are more affordable and flexible than those currently available in the small group market. The General Assembly, therefore, seeks to increase the availability of health insurance coverage by requiring small employer carriers in this State to issue policies that are more affordable for employees of eligible employers.

Section 10-10. Definitions. For purposes of this Act:

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

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

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

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

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

"Federal poverty level" means the federal poverty level guidelines published annually by the United States Department

of Health and Human Services.

"Group health plan" has the meaning given to such term in the Illinois Health Insurance Portability and Accountability Act.

"Health insurance choice policy" or "policy" means a policy of accident and health insurance that provides standard required benefits as described in Section 10-20 of this Law and satisfies the additional requirements set forth in Section 10-25 of this Law.

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

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

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

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

Section 10-15. Authorization of health insurance choice policies.

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

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

(c) Each employee may elect whether he or she wants to apply for coverage.

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

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

(f) An insurer is not required to issue or renew coverage

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

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

Section 10-20. Standard required benefits. A health insurance choice policy must include an annual maximum aggregate benefit for each enrollee and the policy must contain the following standard required benefits:

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

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

(3) 120 days of non-mental-health inpatient services per year, including all professional services,

medications, surgically implanted devices, and supplies used by the enrollee while an inpatient;

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

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

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

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

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

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

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

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

Section 10-25. Health insurance choice policy requirements.

(a) Any insurer, as defined in Section 10-10 of this Law,

shall have the power to issue health insurance choice policies. No such policy may be issued or delivered in this State unless a copy of the form thereof has been filed with the Department and approved by it in accordance with Section 355 of the Illinois Insurance Code, unless it contains in substance those provisions contained in Sections 357.1 through 357.30 of the Illinois Insurance Code as may be applicable to this Act and the provisions set forth in this Section.

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

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

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

(e) Whenever the Department of Public Health finds that it

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

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

(g) If dependents of insureds are covered under 2 policies, both of which contain coordination of benefit provisions, then benefits of the policy of the insured whose birthday falls earlier in the year are determined before those of the policy of the insured whose birthday falls later in the year. "Birthday", as used in this subsection (g), refers only to the month and day in a calendar year, not the year in which the person was born. The Department shall promulgate rules defining the order of benefit determination under this subsection (g).

(h) Discrimination between individuals of the same class of risk in the issuance of policies, in the amount of premiums or

rates charged for any insurance covered by this Law, in benefits payable thereon, in any of the terms or conditions of the policy, or in any other manner whatsoever is prohibited. Nothing in this subsection (h) prohibits an insurer from providing incentives for insureds to utilize the services of a particular hospital or person.

(i) No insurer may make or permit any distinction or discrimination against individuals solely because of handicaps or disabilities in (1) the amount of payment of premiums or rates charged for policies of insurance, (2) the amount of any dividends or other benefits payable thereon, or (3) any other terms and conditions of the contract it makes, except if the distinction or discrimination is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(j) No insurer may refuse to insure or refuse to continue to insure, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy

defines "disability" as being presumed in the event that the insured loses his or her eyesight. However, an insurer may exclude from coverage disability consisting solely of blindness or partial blindness when the condition existed at the time the policy was issued.

Section 10-30. Applicability of other Insurance Code provisions. All health insurance choice policies issued under this Law shall be subject to the provisions of Sections 356c, 356d, 356g, 356h, 356n, 367.2, 367.2-5, 367c, 367d, 367e, 367e.1, 367i, 368a, 370, 370a, and 370e of the Illinois Insurance Code even though such policies do not constitute group health plans.

Section 10-35. Means testing; authorized. For purposes of this Law, an employer shall perform means testing to determine eligibility requirements for the health insurance choice policy and shall provide a certification to the insurer respecting the results of the means testing. A health insurance choice policy based on those eligibility requirements shall not be in violation of Section 364 of the Illinois Insurance Code or subsection (i) or (j) of Section 10-25 of this Law.

Section 10-40. Guaranteed renewability and availability.

(a) Subject to subsection (f) of Section 10-15 of this Law and subsections (b) and (c) of this Section, an insurer (1)

must accept the application of every employee of an eligible employer that applies for coverage under subsections (c) or (d) of Section 10-15 of this Law and (2) must renew or continue in force such coverage at the option of the covered employee as long as the employee continues as an employee of the eligible employer.

(b) An insurer is not obligated to renew or continue in force coverage under subsection (a) of this Section (1) if the coverage requirements of subsection (f) of Section 10-15 of this Law are not satisfied, (2) if the insurer would not be obligated to renew or continue in force such coverage had subdivision (2), (4), or (5) of subsection (B) of Section 30 of the Illinois Health Insurance Portability and Accountability Act applied to such policies, or (3) with respect to an employee who has failed to pay premiums in accordance with the applicable policy or the insurer has not received timely premium payments from the employee.

(c) An insurer may modify the coverage offered under this Law only at the time of coverage renewal and only if the modification is consistent with State law and effective on a uniform basis with respect to all employees of eligible employers.

(d) Subsection (a) of Section 10-15 of this Law and this Section shall apply with respect to an insurer as long as the insurer offers any health benefit plan to small employers in this State that is subject to the Small Employer Health

Insurance Rating Act.

Section 10-45. Notice to policyholders and enrollees.

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

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

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

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

included as State-mandated health insurance benefits in policies in Illinois."

Section 10-50. Disclosure statement.

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

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

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

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

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

(c) An insurer must:

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

(2) provide the signed disclosure statement to the

Department upon request from the Secretary.

Section 10-55. Rates.

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

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

(c) Premium rates for health insurance choice policies included in a separate class of business shall not be subject to subdivision (1) of subsection (a) of Section 25 of the Small Employer Health Insurance Rating Act.

Section 10-60. Department and Director authority. The Director shall adopt rules as necessary to implement this Law. Rulemaking authority to implement this Law, if any, is conditioned on the rules being adopted in accordance with all

provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

It shall be the duty of the Director to withhold approval of any such policy, certificate, endorsement, rider, bylaw or other matter incorporated by reference or application blank filed with the Director under this Law if it contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, contrary to law or to the public policy of this State, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy.

ARTICLE 15. HELPING IMPROVE ILLINOIS HEALTHCARE POLICY BY CREATING THE ILLINOIS HEALTHCARE POLICY TASK FORCE LAW

Section 15-1. Short title. This Law may be cited as the Illinois Healthcare Policy Task Force Law.

Section 15-5. Illinois Healthcare Policy Task Force.

(a) The purpose of the Task Force is to annually review and make recommendations to the General Assembly and the Governor regarding legislative changes needed to meet and implement the

following healthcare policies and objectives:

(1) increased measurement, transparency, and disclosure of hospital and clinician performance;

(2) information, tools, and incentives for patients and other consumers to enable them to make informed healthcare decisions;

(3) payment of hospitals and clinicians based on their performance;

(4) health information technology, including an electronic health record for all Illinois citizens;

(5) preventative and wellness initiatives; and

(6) review of current health plan design and requirements, identifying elements of the plans that need elimination, and implementation of new provisions that are consistent with guidelines and protocols established by organizations representing medical professions and organizations with affordable budget guidelines.

The task force must report by January 1, 2010 to the Governor and the General Assembly and by January 1 of each year thereafter.

(b) The Task Force shall consist of 14 voting members, as follows: 6 persons, who are not currently employed by a State agency, appointed by the Director of Public Health, 3 of whom shall be persons with knowledge and experience in the delivery of health care services, including at least one person representing organized health service workers, 2 of whom shall

be persons with professional experience in the administration or management of health care facilities, and one of whom shall be a person with experience in health planning; 6 persons, who are not currently employed by a State agency, appointed by the Director of Insurance, one of whom shall be an employer of less than 50 employees, one of whom shall be an employer of more than 50 employees, 2 of whom shall be health care insurers, 1 of whom shall be a licensed health insurance agent, 1 of whom shall be a consumer of an individual health insurance plan; the Director of Insurance shall appoint a representative from the Illinois Comprehensive Health Insurance Plan; and a representative of the Department of Healthcare and Family Services responsible for programs under Medicaid and the children's health insurance programs.

(c) The Directors of Public Health and the Division of Insurance shall serve as co-chairpersons of the Task Force.

(d) The Department may accept gifts and grants from any party, including a health benefit plan issuer or a foundation associated with a health benefit plan issuer, to assist with funding the programs established in Section 90 of the Managed Care Reform and Patients Rights Act. The Department of Financial and Professional Regulation, Division of Insurance shall adopt rules governing acceptance of donations that are consistent with the Illinois Governmental Ethics Act. Before adopting rules under this subsection (d), the Department shall:

(1) submit the proposed rules to the Illinois Board of

Ethics for review; and

(2) consider the Board's recommendations regarding the regulations.

Rulemaking authority to implement this Law, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

Section 15-10. Repeal of Task Force. The Task Force is abolished on July 1, 2014.

ARTICLE 90. AMENDATORY PROVISIONS

Section 90-5. The Illinois Income Tax Act is amended by adding Section 218 as follows:

(35 ILCS 5/218 new)

Sec. 218. Health insurance contribution credit.

(a) For those taxable years ending on or after December 31, 2007 and ending on or before December 30, 2012, each taxpayer that is an employer with 10 or fewer employees and whose average annual compensation paid to employees is less than 250% of the Federal poverty level is entitled to a credit against the tax imposed by subsections (a) and (b) of Section 201 in an

amount equal to 33% of the amount of any contribution made by the taxpayer during the taxable year towards the premium of a health insurance policy authorized for sale in the State by the Department of Financial and Professional Regulation.

(b) For partners, shareholders of Subchapter S corporations, and owners of limited liability companies, if the liability company is treated as a partnership for purposes of federal and State income taxation, there shall be allowed a credit under this Section to be determined in accordance with the determination of income and distributive share of income under Sections 702 and 704 and Subchapter S of the Internal Revenue Code.

(c) The credit under this Section may not be carried forward or back and may not reduce the taxpayer's liability to less than zero.

Section 90-10. The Illinois Insurance Code is amended by adding Articles XLV and XLVI and Section 352b and by changing Section 352 as follows:

(215 ILCS 5/Art. XLV heading new)

ARTICLE XLV. ILLINOIS INNOVATIVE INSURANCE SOLUTIONS

(215 ILCS 5/10-1500 new)

Sec. 10-1500. Short title. This Article may be cited as the Illinois Innovative Insurance Solutions Law.

(215 ILCS 5/10-1505 new)

Sec. 10-1505. Purpose. It is hereby determined and declared that the purpose of this Article is to establish a program, called the Illinois Innovative Insurance Solutions Program, whereby authorized health insurance carriers may develop and submit to the Director of the Division of Insurance for consideration and approval, policies or plans of individual major medical, blanket, or group major medical accident and health insurance having the potential to increase Illinois residents' access to health care coverage, but which may not otherwise meet existing regulatory requirements. The Director of the Division of Insurance is authorized by this Section to grant approval of such innovative health insurance products on a limited, pilot program basis in order that any overriding potential to increase access to health care may be assessed on a limited trial basis. The purpose of this program is to encourage private health insurance market innovation and creativity in order to arrive at viable solutions for providing health insurance coverage and access to previously uninsured Illinois residents.

(215 ILCS 5/10-1510 new)

Sec. 10-1510. Duties of Director. It shall be the duty of the Director to withhold approval of any such policy, certificate, endorsement, rider, bylaw, or other matter

incorporated by reference or application blank filed with the Director under this Law if it contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, contrary to law or to the public policy of this State, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy.

Rulemaking authority to implement this Law, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(215 ILCS 5/Art. XLVI heading new)

ARTICLE XLVI. ILLINOIS HEALTH INSURANCE PREMIUM ASSISTANCE PROGRAM

(215 ILCS 5/10-1600 new)

Sec. 10-1600. Short title. This Article may be cited as the Illinois Health Insurance Premium Assistance Program.

(215 ILCS 5/10-1605 new)

Sec. 10-1605. Legislative intent. The General Assembly finds that, for the economic and social benefit of all

residents of this State, it is important to enable all State residents to access affordable health insurance coverage.

(215 ILCS 5/10-1610 new)

Sec. 10-1610. Definitions. In this Law:

"Carrier" has the same meaning as defined in the Small Employer Health Insurance Rating Act.

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

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

"Eligible individual" means an individual who:

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

(2) is not eligible for Medicare;

(3) except as otherwise provided by the Department, has family income less than 200% of the federal poverty level or, if the individual is not married, has income less than 100% of the federal poverty level;

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

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

"Family" means:

(1) a single individual;

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

(3) an adult and the adult's spouse, all unmarried,

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

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

(5) a dependent elderly relative or a dependent adult disabled child who meets criteria established by the Department and who lives in the home of the adult described in items (1) through (4) of this definition of "family".

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

"Family member" means an employee's spouse, any unmarried child, stepchild or dependent within age limits and other conditions under the terms of the health benefit plan selected by the employee or the employee's employer.

"Health benefit plan" has the same meaning as provided in the Small Employer Health Insurance Rating Act.

"Health benefit plan" includes the Illinois Comprehensive Health Insurance Plan and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended. Health

benefit plan does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Illinois.

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

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

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

"Rebate" means payment or reimbursement to an eligible individual toward the eligible individual's purchase or contribution of premium towards a health benefit plan for the eligible individual and the eligible individual's family and

may include co-payments or deductible expenses that are the responsibility of the eligible individual.

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

"Third-party administrator" means any insurance company or other entity licensed under the Illinois Insurance Code to administer health insurance benefit programs.

(215 ILCS 5/10-1615 new)

Sec. 10-1615. Program operation. The Illinois Health Insurance Premium Assistance Program is created. The Program shall be administered by the Department of Healthcare and Family Services. The Department shall have the same powers and authority to administer the Program as are provided to the Department in connection with the Department's administration of the Illinois Public Aid Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Program.

(215 ILCS 5/10-1620 new)

Sec. 10-1620. Additional duties of Department; rules.

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

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

(a) distribution of rebate payments;

(b) eligibility determination;

(c) data collection;

(d) financial tracking and reporting; and

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

(2) retain consultants and employ staff.

(b) The Department shall adopt rules reasonably necessary to carry out the purposes of this Law. If the Department decides to enter into any contract pursuant to this subsection (b), the Department shall engage in competitive bidding. Rulemaking authority to implement this Law, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(215 ILCS 5/10-1625 new)

Sec. 10-1625. Application to participate in the Program; issuance of rebates; restrictions; health benefit plan enrollment.

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

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

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

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

(e) Rebates may not be used to subsidize premiums on a health benefit plan whose premiums are wholly paid by the eligible individual's employer. However, rebates may be used to pay for any copayments or deductibles required under the policy for the eligible individual or a covered family member and paid by the eligible individual.

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

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

(h) Notwithstanding Section 1610, if an eligible individual is enrolled in a group health benefit plan available to the eligible individual through the individual's

employment, and the employer requires enrollment in both a health benefit plan and a dental plan, the individual is eligible for a rebate for both the health benefit plan and the dental plan.

(215 ILCS 5/10-1630 new)

Sec. 10-1630. Level of assistance determinations.

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

(1) family size;

(2) family income;

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

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

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

(215 ILCS 5/10-1635 new)

Sec. 10-1635. Rebates limited to funds appropriated; enrollment restrictions.

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

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

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

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

(215 ILCS 5/10-1640 new)

Sec. 10-1640. Repeal. This Article is repealed on December 31, 2019.

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

Sec. 352. Scope of Article.

(a) Except as provided in subsections (b), (c), (d), and (e), this Article shall apply to all companies transacting in this State the kinds of business enumerated in clause (b) of Class 1 and clause (a) of Class 2 of section 4. Nothing in this Article shall apply to, or in any way affect policies or

contracts described in clause (a) of Class 1 of Section 4; however, this Article shall apply to policies and contracts which contain benefits providing reimbursement for the expenses of long term health care which are certified or ordered by a physician including but not limited to professional nursing care, custodial nursing care, and non-nursing custodial care provided in a nursing home or at a residence of the insured.

(b) This Article does not apply to policies of accident and health insurance issued in compliance with Article XIXB of this Code or the Health Insurance Choice Law.

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

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

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

(2) Payments by the insurer must be made to the employer, trustee, or other sponsors of the plan, or the

plan itself, but not to the employees, members, participants, or health care providers.

(e) A policy issued or delivered in this State to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) and providing coverage, under clause (b) of Class 1 or clause (a) of Class 2 as described in Section 4, to persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act is exempt from all restrictions, limitations, standards, rules, or regulations respecting benefits imposed by or under authority of this Code, except those specified by subsection (1) of Section 143. Nothing in this subsection, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/352b new)

Sec. 352b. Small employer assistance. The Director shall assist employers with 25 or fewer employees with implementing and administering plans under Section 125 of the Internal Revenue Code, including medical expense reimbursement accounts and dependent care accounts. The Director shall provide information about the assistance available to small employers on the Insurance Division's website.

Section 90-15. The Comprehensive Health Insurance Plan Act is amended by adding Sections 16 and 17 as follows:

(215 ILCS 105/16 new)

Sec. 16. No eligibility groups added or expanded. Notwithstanding any other provision of this Act to the contrary, no eligibility group may be added or expanded under this Act without authorization by the General Assembly.

(215 ILCS 105/17 new)

Sec. 17. Small employer participation. Notwithstanding Section 7 of this Act, an employer of 10 or less employees contributing at least 50% of the cost of premiums for health insurance coverage for its employees may enroll any covered employee or covered dependent into the Plan, if: (i) the employee or dependent meets a presumptive condition of the Plan; (ii) the employer continues to contribute at least 50% of the cost of the premium to the Plan on behalf of the employee or dependent; (iii) the employer has experienced an average increase in cost of its health insurance plan of 15% or more over the previous consecutive three years; and (iv) maintains coverage for its remaining employees and dependents.

Section 90-20. The Children's Health Insurance Program Act is amended by adding Section 7 and by changing Section 25 as follows:

(215 ILCS 106/7 new)

Sec. 7. No eligibility groups added or expanded. Notwithstanding any other provision of this Act to the contrary, no eligibility group may be added or expanded under this Act without authorization by the General Assembly.

(215 ILCS 106/25)

Sec. 25. Health benefits for children.

(a) The Department shall, subject to appropriation, provide health benefits coverage to eligible children by:

(1) Subsidizing the cost of privately sponsored health insurance, including employer based health insurance, to assist families to take advantage of available privately sponsored health insurance for their eligible children; and

(2) Purchasing or providing health care benefits for eligible children. The health benefits provided under this subdivision (a)(2) shall, subject to appropriation and without regard to any applicable cost sharing under Section 30, be identical to the benefits provided for children under the State's approved plan under Title XIX of the Social Security Act. Providers under this subdivision (a)(2) shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code and shall be reimbursed at the same rate as providers under the

State's approved plan under Title XIX of the Social Security Act. In addition, providers may retain co-payments when determined appropriate by the Department.

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

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

(d) The total dollar amount of subsidizing coverage per child per month pursuant to subdivision (a)(1) shall be equal to the average dollar payments, less premiums incurred, per child per month pursuant to subdivision (a)(2). The Department shall set this amount prospectively based upon the prior fiscal year's experience adjusted for incurred but not reported claims and estimated increases or decreases in the cost of medical care. Payments obligated before July 1, 1999, will be computed using State Fiscal Year 1996 payments for children eligible for

Medical Assistance and income assistance under the Aid to Families with Dependent Children Program, with appropriate adjustments for cost and utilization changes through January 1, 1999. The Department is prohibited from providing a subsidy pursuant to subdivision (a)(1) that is more than the individual's monthly portion of the premium.

(e) An eligible child may obtain immediate coverage under this Program only once during a medical visit. If coverage lapses, re-enrollment shall be completed in advance of the next covered medical visit and the first month's required premium shall be paid in advance of any covered medical visit.

(f) In order to accelerate and facilitate the development of networks to deliver services to children in areas outside counties with populations in excess of 3,000,000, in the event less than 25% of the eligible children in a county or contiguous counties has enrolled with a Health Maintenance Organization pursuant to Section 5-11 of the Illinois Public Aid Code, the Department may develop and implement demonstration projects to create alternative networks designed to enhance enrollment and participation in the program. The Department shall prescribe by rule the criteria, standards, and procedures for effecting demonstration projects under this Section.

(g) The Department or any person acting on behalf of the Department is prohibited from encouraging any individual to drop or otherwise discontinue privately sponsored health

insurance, including employer based health insurance that is available to an eligible child. Any person violating this Section shall be guilty of a petty offense.

(Source: P.A. 90-736, eff. 8-12-98.)

Section 90-25. The Managed Care Reform and Patient Rights Act is amended by changing Section 90 as follows:

(215 ILCS 134/90)

Sec. 90. Office of Consumer Health Insurance.

(a) The Director of Insurance shall establish the Office of Consumer Health Insurance within the Department of Financial and Professional Regulation, Division of Insurance to provide assistance and information to all health care consumers within the State. Within the appropriation allocated, the Office shall provide information and assistance to all health care consumers by:

(1) assisting consumers in understanding health insurance marketing materials and the coverage provisions of individual plans;

(2) educating enrollees about their rights within individual plans;

(3) assisting enrollees with the process of filing formal grievances and appeals;

(4) establishing and operating a toll-free "800" telephone number line to handle consumer inquiries;

(5) making related information available in languages other than English that are spoken as a primary language by a significant portion of the State's population, as determined by the Department;

(6) analyzing, commenting on, monitoring, and making publicly available reports on the development and implementation of federal, State, and local laws, regulations, and other governmental policies and actions that pertain to the adequacy of health care plans, facilities, and services in the State;

(7) filing an annual report with the Governor, the Director, and the General Assembly, which shall contain recommendations for improvement of the regulation of health insurance plans, including recommendations on improving health care consumer assistance and patterns, abuses, and progress that it has identified from its interaction with health care consumers; and

(8) performing all duties assigned to the Office by the Director.

(b) The report required under subsection (a)(7) shall be filed by January 31, 2001 and each January 31 thereafter.

(c) Nothing in this Section shall be interpreted to authorize access to or disclosure of individual patient or health care professional or provider records.

(d) The Office of Consumer Health Insurance shall:

(1) Develop and implement a health coverage public

awareness and education program by:

(i) increasing public awareness of health coverage options available in this State;

(ii) educating the public on the value of health insurance coverage; and

(iii) providing information on health insurance coverage options, including explanations of deductibles and copayments and the differences between health maintenance organizations, preferred provider organizations, point of service plans, health savings accounts and compatible high deductible health benefit plans, and other forms of health insurance coverage.

(2) Provide information, including financial ratings about specific health insurance coverage insurers, but the Office may not favor or endorse one particular insurer over another.

(3) Develop and release public service announcements to educate consumers and employers about the types of policies and availability of health coverage in this State.

(4) Develop an Internet website designed to educate the public about the types of policies and availability of health coverage in this State.

(5) Provide other appropriate education to the public regarding the value of health insurance coverage.

(6) Consult the Illinois Healthcare Policy Task Force regarding the content of the public service announcements,

Internet website, and educational materials. The Director has authority to make final decisions as to what the Program's materials will contain.

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

Section 90-30. The Covering ALL KIDS Health Insurance Act is amended by adding Section 7 and by changing Section 25 as follows:

(215 ILCS 170/7 new)

Sec. 7. No eligibility groups added or expanded. Notwithstanding any other provision of this Act to the contrary, no eligibility group may be added or expanded under this Act without authorization by the General Assembly.

(215 ILCS 170/25)

(Section scheduled to be repealed on July 1, 2011)

Sec. 25. Enrollment in Program. The Department shall develop procedures to allow application agents to assist in enrolling children in the Program or other children's health programs operated by the Department. At the Department's discretion, technical assistance payments may be made available for approved applications facilitated by an application agent. The Department or any person acting on behalf of the Department is prohibited from encouraging any individual to drop or otherwise discontinue privately

sponsored health insurance, including employer based health insurance. Any person violating this Section shall be guilty of a petty offense.

(Source: P.A. 94-693, eff. 7-1-06.)

Section 90-35. The Illinois Public Aid Code is amended by adding Sections 1-12, 5-27, 5-28, 5-29, and 5-30 and by changing Section 5A-7 as follows:

(305 ILCS 5/1-12 new)

Sec. 1-12. No programs or eligibility groups added or expanded. Notwithstanding any other provision of this Code to the contrary, no program or eligibility group may be added or expanded under this Code without authorization by the General Assembly.

(305 ILCS 5/5-27 new)

Sec. 5-27. Incentive payments to providers.

(a) Subject to appropriation, the Illinois Department shall establish incentive payments to eligible providers based on a quality reporting system using quality measures consistent with criteria established by the Centers for Medicare and Medicaid Services to implement the physician quality reporting system established under the federal Tax Relief and Health Care Act of 2006.

(b) Subject to appropriation, the Illinois Department

shall establish incentive payments to eligible providers who make health information technology investments that lead to administrative and benefit delivery cost savings to the Department in its administration and enforcement of the Act.

(305 ILCS 5/5-28 new)

Sec. 5-28. Incentive program for recipients.

(a) Subject to appropriation, the Illinois Department shall establish a pilot program that allows recipients to select a healthcare savings account option to meet their coverage needs.

(b) The Department shall create a healthcare savings account for each individual eligible for coverage under this Act that volunteers to participate in the pilot program. The Department shall contribute annually to each savings account the maximum contribution provided under federal law for a healthcare savings account.

(c) Any healthcare services provided to the recipient shall be paid from the healthcare savings account until exhausted. If the healthcare savings account is exhausted the Department shall continue to pay benefits as provided under this Act. If there is a balance at the end of the calendar year in the savings account that amount shall be rolled over for future use by the recipient.

(d) If the participating recipient is no longer eligible for benefits under this Act due to income eligibility, the

individual may retain the balance of the healthcare savings account for the purpose of continuing the healthcare savings account to pay for future healthcare expenses subject to any and all federal and state tax law.

(e) The Department shall adopt rules to implement this Section within 180 days of the effective date of these changes.

(f) The Department shall issue a report to the General Assembly on the status and success of the pilot project by July 1, 2009.

(305 ILCS 5/5-29 new)

Sec. 5-29. Model program for enhanced primary care case management.

(a) On or before January 1, 2010, the Department of Healthcare and Family Services shall implement a model program for enhanced primary care case management program for selected populations of persons.

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

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

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

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

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

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

(g) On or before January 1, 2010 and every year thereafter, the Department shall report to the General Assembly concerning the effectiveness, the progress of implementation, and the results of the primary care case management program.

(305 ILCS 5/5-30 new)

Sec. 5-30. Model program for auto-assignment to quality care. The Department shall work with the PCCM Administrator and MCOs to develop a model program for an auto-assignment algorithm following CMS regulations which equitably distributes those recipients that do not choose an MCO or PCCM during their enrollment process to a provider. Consistent with current Medicaid enrollment procedure, recipients may opt out of the plan to which they have been auto-assigned once a month.

(305 ILCS 5/5A-7) (from Ch. 23, par. 5A-7)

Sec. 5A-7. Administration; enforcement provisions.

(a) The Illinois Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Illinois Department of Public Health, which shall show each provider's name and principal place of business and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The Illinois Department shall administer and enforce this Article and collect the assessments and penalty assessments imposed under this Article using procedures employed in its administration of this Code generally. The Illinois Department, its Director, and every hospital provider subject to assessment under this Article shall have the following powers, duties, and rights:

(1) The Illinois Department may initiate either

administrative or judicial proceedings, or both, to enforce provisions of this Article. Administrative enforcement proceedings initiated hereunder shall be governed by the Illinois Department's administrative rules. Judicial enforcement proceedings initiated hereunder shall be governed by the rules of procedure applicable in the courts of this State.

(2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than 3 years after the due date of the assessment, except in the case of an extended period agreed to in writing by the Illinois Department and the hospital provider before the expiration of this limitation period.

(3) Any unpaid assessment under this Article shall become a lien upon the assets of the hospital upon which it was assessed. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of (A) the real property and improvements, (B) the machinery and equipment, or (C) the furniture or fixtures, of any hospital that is subject to the provisions of this Article, the seller or transferor shall pay the Illinois Department the amount of any assessment, assessment penalty, and interest (if any) due from it under this Article up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due,

the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Illinois Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Illinois Department showing that no assessment, penalty, or interest is due from the seller or transferor under this Article.

(4) Payments under this Article are not subject to the Illinois Prompt Payment Act. The Department shall by rule implement an expedited claims rejection process and within 30 days of the effective date of this Act shall provide monthly reports to the General Assembly regarding payments to providers under this Code including what policies, procedures, schedules and actions undertaken by the Department to make timely payments to providers. Rulemaking authority to implement this amendatory Act of the 96th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of

the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized ~~Credits or refunds shall not bear interest~~.

(b) In addition to any other remedy provided for and without sending a notice of assessment liability, the Illinois Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Illinois Department to the hospital provider.

(Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04; 94-242, eff. 7-18-05.)

ARTICLE 97. SEVERABILITY

Section 97-97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

ARTICLE 99. EFFECTIVE DATE

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

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