



97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB3462

Introduced 2/24/2011, by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

215 ILCS 105/8

from Ch. 73, par. 1308

Amends the Comprehensive Health Insurance Plan Act. Deletes from the list of expenses that are not covered under the Plan, any expense or charge for routine physical examinations or tests.

LRB097 10590 RPM 50951 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning insurance.

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

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

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

7 Sec. 8. Minimum benefits.

8 a. Availability. The Plan shall offer in a periodically
9 renewable policy major medical expense coverage to every
10 eligible person who is not eligible for Medicare. Major medical
11 expense coverage offered by the Plan shall pay an eligible
12 person's covered expenses, subject to limit on the deductible
13 and coinsurance payments authorized under paragraph (4) of
14 subsection d of this Section, up to a lifetime benefit limit of
15 \$5,000,000. The maximum limit under this subsection shall not
16 be altered by the Board, and no actuarial equivalent benefit
17 may be substituted by the Board. Any person who otherwise would
18 qualify for coverage under the Plan, but is excluded because he
19 or she is eligible for Medicare, shall be eligible for any
20 separate Medicare supplement policy or policies which the Board
21 may offer.

22 b. Outline of benefits. Covered expenses shall be limited
23 to the usual and customary charge, including negotiated fees,

1 in the locality for the following services and articles when
2 prescribed by a physician and determined by the Plan to be
3 medically necessary for the following areas of services,
4 subject to such separate deductibles, co-payments, exclusions,
5 and other limitations on benefits as the Board shall establish
6 and approve, and the other provisions of this Section:

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

17 (2) Professional services for the diagnosis or
18 treatment of injuries, illnesses or conditions, other than
19 dental and mental and nervous disorders as described in
20 paragraph (17), which are rendered by a physician, or by
21 other licensed professionals at the physician's direction.
22 This includes reconstruction of the breast on which a
23 mastectomy was performed; surgery and reconstruction of
24 the other breast to produce a symmetrical appearance; and
25 prostheses and treatment of physical complications at all
26 stages of the mastectomy, including lymphedemas.

1 (2.5) Professional services provided by a physician to
2 children under the age of 16 years for physical
3 examinations and age appropriate immunizations ordered by
4 a physician licensed to practice medicine in all its
5 branches.

6 (3) (Blank).

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

13 (5) Skilled nursing services of a licensed skilled
14 nursing facility for not more than 120 days during a policy
15 year.

16 (6) Services of a home health agency in accord with a
17 home health care plan, up to a maximum of 270 visits per
18 year.

19 (7) Services of a licensed hospice for not more than
20 180 days during a policy year.

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

22 (9) Oxygen.

23 (10) Anesthetics.

24 (11) Orthoses and prostheses other than dental.

25 (12) Rental or purchase in accordance with Board
26 policies or procedures of durable medical equipment, other

1 than eyeglasses or hearing aids, for which there is no
2 personal use in the absence of the condition for which it
3 is prescribed.

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

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

14 (15) Physical, speech, and functional occupational
15 therapy as medically necessary and provided by appropriate
16 licensed professionals.

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

22 (17) Outpatient services for diagnosis and treatment
23 of mental and nervous disorders provided that a covered
24 person shall be required to make a copayment not to exceed
25 50% and that the Plan's payment shall not exceed such
26 amounts as are established by the Board.

1 (18) Human organ or tissue transplants specified by the
2 Board that are performed at a hospital designated by the
3 Board as a participating transplant center for that
4 specific organ or tissue transplant.

5 (19) Naprapathic services, as appropriate, provided by
6 a licensed naprapathic practitioner.

7 c. Exclusions. Covered expenses of the Plan shall not
8 include the following:

9 (1) Any charge for treatment for cosmetic purposes
10 other than for reconstructive surgery when the service is
11 incidental to or follows surgery resulting from injury,
12 sickness or other diseases of the involved part or surgery
13 for the repair or treatment of a congenital bodily defect
14 to restore normal bodily functions.

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

17 (3) Any charge for services in a private room to the
18 extent it is in excess of the institution's charge for its
19 most common semiprivate room, unless a private room is
20 prescribed as medically necessary by a physician.

21 (4) That part of any charge for room and board or for
22 services rendered or articles prescribed by a physician,
23 dentist, or other health care personnel that exceeds the
24 reasonable and customary charge in the locality or for any
25 services or supplies not medically necessary for the
26 diagnosed injury or illness.

1 (5) Any charge for services or articles the provision
2 of which is not within the scope of licensure of the
3 institution or individual providing the services or
4 articles.

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

8 (7) Dental care, dental surgery, dental treatment, any
9 other dental procedure involving the teeth or
10 periodontium, or any dental appliances, including crowns,
11 bridges, implants, or partial or complete dentures, except
12 as specifically provided in paragraph (14) of subsection b
13 of this Section.

14 (8) Eyeglasses, contact lenses, hearing aids or their
15 fitting.

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

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

20 (11) Personal supplies or services provided by a
21 hospital or nursing home, or any other nonmedical or
22 nonprescribed supply or service.

23 (12) Routine maternity charges for a pregnancy, except
24 where added as optional coverage with payment of an
25 additional premium for pregnancy resulting from conception
26 occurring after the effective date of the optional

1 coverage.

2 (13) (Blank).

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

11 (15) ~~(Blank) Any expense or charge for routine physical~~
12 ~~examinations or tests except as provided in item (2.5) of~~
13 ~~subsection b of this Section.~~

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

17 (17) Any expense incurred for benefits provided under
18 the laws of the United States and this State, including
19 Medicare, Medicaid, and other medical assistance, maternal
20 and child health services and any other program that is
21 administered or funded by the Department of Human Services,
22 Department of Healthcare and Family Services, or
23 Department of Public Health, military service-connected
24 disability payments, medical services provided for members
25 of the armed forces and their dependents or employees of
26 the armed forces of the United States, and medical services

1 financed on behalf of all citizens by the United States.

2 (18) Any expense or charge for in vitro fertilization,
3 artificial insemination, or any other artificial means
4 used to cause pregnancy.

5 (19) Any expense or charge for oral contraceptives used
6 for birth control or any other temporary birth control
7 measures.

8 (20) Any expense or charge for sterilization or
9 sterilization reversals.

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

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

16 (23) Any expense or charge for or related to organ or
17 tissue transplants other than those performed at a hospital
18 with a Board approved organ transplant program that has
19 been designated by the Board as a preferred or exclusive
20 provider organization for that specific organ or tissue
21 transplant.

22 (24) Any expense or charge for procedures, treatments,
23 equipment, or services that are provided in special
24 settings for research purposes or in a controlled
25 environment, are being studied for safety, efficiency, and
26 effectiveness, and are awaiting endorsement by the

1 appropriate national medical speciality college for
2 general use within the medical community.

3 d. Deductibles and coinsurance.

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

22 e. Scope of coverage.

23 (1) In approving any of the benefit plans to be offered
24 by the Plan, the Board shall establish such benefit levels,
25 deductibles, coinsurance factors, exclusions, and
26 limitations as it may deem appropriate and that it believes

1 to be generally reflective of and commensurate with health
2 insurance coverage that is provided in the individual
3 market in this State.

4 (2) The benefit plans approved by the Board may also
5 provide for and employ various cost containment measures
6 and other requirements including, but not limited to,
7 preadmission certification, prior approval, second
8 surgical opinions, concurrent utilization review programs,
9 individual case management, preferred provider
10 organizations, health maintenance organizations, and other
11 cost effective arrangements for paying for covered
12 expenses.

13 f. Preexisting conditions.

14 (1) Except for federally eligible individuals
15 qualifying for Plan coverage under Section 15 of this Act
16 or eligible persons who qualify for the waiver authorized
17 in paragraph (3) of this subsection, plan coverage shall
18 exclude charges or expenses incurred during the first 6
19 months following the effective date of coverage as to any
20 condition for which medical advice, care or treatment was
21 recommended or received during the 6 month period
22 immediately preceding the effective date of coverage.

23 (2) (Blank).

24 (3) Waiver: The preexisting condition exclusions as
25 set forth in paragraph (1) of this subsection shall be
26 waived to the extent to which the eligible person (a) has

1 satisfied similar exclusions under any prior individual
2 health insurance policy that was involuntarily terminated
3 because of the insolvency of the issuer of the policy and
4 (b) has applied for Plan coverage within 90 days following
5 the involuntary termination of that individual health
6 insurance coverage.

7 (4) Waiver: The preexisting condition exclusions as
8 set forth in paragraph (1) of this subsection shall be
9 waived to the extent to which the eligible person (a) has
10 satisfied the exclusion under prior Comprehensive Health
11 Insurance Plan coverage that was involuntarily terminated
12 because of meeting a lower lifetime benefit limit and (b)
13 has reapplied for Plan coverage within 90 days following an
14 increase in the lifetime benefit limit set forth in Section
15 8 of this Act.

16 g. Other sources primary; nonduplication of benefits.

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

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

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

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

1 of the sickness or injury or the date of any settlement,
2 judgment, or award resulting from that sickness or injury.

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

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

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

22 h. Right of subrogation; recoveries.

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

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

26 (2) If any action or claim is brought by or on behalf

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

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

1 right to recovery. The Plan shall pay to the covered person
2 or his personal representative all sums collected from any
3 third party by judgment or otherwise in excess of amounts
4 paid in benefits under the Plan and amounts paid or to be
5 paid as costs, attorneys fees, and reasonable expenses
6 incurred by the Plan in making the collection or enforcing
7 the judgment.

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

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

1 settlement.

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

1 exception of any attorney liens filed under the Attorneys
2 Lien Act.

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

9 (Source: P.A. 95-547, eff. 8-29-07; 96-791, eff. 9-25-09;
10 96-938, eff. 6-24-10.)