HB3626

LRB09710887JDS51412b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB3626

Introduced 2/24/2011, by Rep. Patrick J. Verschoore

SYNOPSIS AS INTRODUCED:

5 ILCS 375/8 from Ch. 127, par. 528

Amends the State Employees Group Insurance Act of 1971. Requires the Director of Central Management Services, beginning July 1, 2011, to reimburse on a monthly basis each eligible member who has elected not to participate in the program of health benefits under the Act for premiums paid under the eligible member's health benefit coverage. Prohibits the reimbursed amount from exceeding the amount that would otherwise be paid by the State for the program of health benefits under the Act. Effective July 1, 2011.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning government.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 8 as follows:

(5 ILCS 375/8) (from Ch. 127, par. 528)

Sec. 8. Eligibility.

(a) Each member eligible under the provisions of this Act and any rules and regulations promulgated and adopted hereunder by the Director shall become immediately eligible and covered for all benefits available under the programs. Members electing coverage for eligible dependents shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and procedures specified by the Director.

(1) Every member originally eligible to elect dependent coverage, but not electing it during the original eligibility period, may subsequently obtain dependent coverage only in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

(2) Members described above being transferred from

previous coverage towards which the State has been contributing shall be transferred regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled.

(3) Eligible and covered members that are eligible for coverage as dependents except for the fact of being members shall be transferred to, and covered under, dependent status regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled upon cessation of member status and the election of dependent coverage by a member eligible to elect that coverage.

(b) New employees shall be immediately insured for the basic group life insurance and covered by the program of health benefits on the first day of active State service. Optional life insurance coverage one to 4 times the basic amount, if elected during the relevant eligibility period, will become effective on the date of employment. Optional life insurance coverage exceeding 4 times the basic amount and all life insurance amounts applied for after the eligibility period will be effective, subject to satisfactory evidence of insurability when applicable, or other necessary qualifications, pursuant to the requirements of the applicable benefit program, unless there is a change in status that would confer new eligibility

for change of enrollment under rules established supplementing this Act, in which event application must be made within the new eligibility period.

(c) As to the group health benefits program contracted to begin or continue after June 30, 1973, each retired employee shall become immediately eligible and covered for all benefits available under that program. Retired employees may elect coverage for eligible dependents and shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and procedures specified by the Director.

Except as otherwise provided in this Act, where husband and wife are both eligible members, each shall be enrolled as a member and coverage on their eligible dependent children, if any, may be under the enrollment and election of either.

Regardless of other provisions herein regarding late enrollment or other qualifications, as appropriate, the Director may periodically authorize open enrollment periods for each of the benefit programs at which time each member may elect enrollment or change of enrollment without regard to age, sex, health, or other qualification under the conditions as may be prescribed in rules and regulations supplementing this Act. Special open enrollment periods may be declared by the Director for certain members only when special circumstances occur that affect only those members.

(d) Beginning with fiscal year 2003 and for all subsequent

years, eligible members may elect not to participate in the program of health benefits as defined in this Act. The election must be made during the annual benefit choice period, subject to the conditions in this subsection.

(1) Members must furnish proof of health benefit coverage, either comprehensive major medical coverage or comprehensive managed care plan, from a source other than the Department of Central Management Services in order to elect not to participate in the program.

(2) Members may re-enroll in the Department of Central Management Services program of health benefits upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions, provided that there was not a break in coverage of more than 63 days.

(3) Members may also re-enroll in the program of health benefits during any annual benefit choice period, without evidence of insurability.

(4) Members who elect not to participate in the program of health benefits shall be furnished a written explanation of the requirements and limitations for the election not to participate in the program and for re-enrolling in the program. The explanation shall also be included in the annual benefit choice options booklets furnished to members.

(d-5) Beginning July 1, 2005, the Director may establish a program of financial incentives to encourage annuitants receiving a retirement annuity from the State Employees Retirement System, but who are not eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97) to elect not to participate in the program of health benefits provided under this Act. The election by an annuitant not to participate under this program must be made in accordance with the requirements set forth under subsection (d). The financial incentives provided to these annuitants under the program may not exceed $150 per month for each annuitant electing not to participate in the program of health benefits provided under this Act.

(d-10) Beginning July 1, 2011, the Director shall reimburse on a monthly basis each eligible member who has elected pursuant to subsection (d) not to participate in the program of health benefits under this Act for premiums paid under the eligible member's health benefit coverage. The reimbursed amount shall not be in excess of the amount that would otherwise be paid by the State for the program of health benefits under the Act.

(e) Notwithstanding any other provision of this Act or the rules adopted under this Act, if a person participating in the program of health benefits as the dependent spouse of an eligible member becomes an annuitant, the person may elect, at

the time of becoming an annuitant or during any subsequent annual benefit choice period, to continue participation as a dependent rather than as an eligible member for as long as the person continues to be an eligible dependent.

An eligible member who has elected to participate as a dependent may re-enroll in the program of health benefits as an eligible member (i) during any subsequent annual benefit choice period or (ii) upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions.

A person who elects to participate in the program of health benefits as a dependent rather than as an eligible member shall be furnished a written explanation of the consequences of electing to participate as a dependent and the conditions and procedures for re-enrolling as an eligible member. The explanation shall also be included in the annual benefit choice options booklet furnished to members.

(Source: P.A. 94-95, eff. 7-1-05; 94-109, eff. 7-1-05; 95-331, eff. 8-21-07.)

Section 99. Effective date. This Act takes effect July 1, 2011.