HB5733

LRB09816201RPM51260b

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB5733

by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

New Act
30 ILCS 105/5.855 new
215 ILCS 5/155.44 new

Creates the Public Health Insurance Option Act. Creates the Health Insurance Connector Authority (the Connector) as a body politic and corporate and a public instrumentality, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency, or political subdivision of the State, except as specifically provided in law. Provides that the Health Insurance Connector Authority shall provide for the offering a public health benefits plan (the public option) to eligible individuals and groups, in order to ensure choice, competition, and stability of affordable, high quality coverage throughout the State. Sets forth provisions concerning availability, the executive director of the Connector, reporting, premium rates, payment rates, health care providers, and the creation of the Public Health Insurance Option Trust Fund. Amends the State Finance Act to create the Public Health Insurance Option Trust Fund as a special fund in the State treasury. Amends the Illinois Insurance Code. Authorizes the Director of Insurance to make an assessment against all health plans, health insurers, and health maintenance organizations in the State, as well as the public health insurance option established by the Public Health Insurance Option Act, if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all risk-adjusted. Makes other changes.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

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

Section 1. Short title. This Act may be cited as the Public Health Insurance Option Act.

Section 5. Definitions. Unless the context clearly requires otherwise, in this Act:

"Carrier" means an insurer licensed or otherwise authorized to transact accident and health insurance; a nonprofit hospital service corporation; a nonprofit medical service corporation; or a health maintenance organization.

"Connector" means the Health Insurance Connector Authority.

"Connector Board" means the board of the Health Insurance Connector Authority.

"Connector seal of approval" means the approval given by the Connector Board to indicate that a health benefit plan meets certain standards regarding quality and value.

"Eligible individual" means an individual who is a resident of this State; provided that the individual is not offered subsidized health insurance by an employer with more than 50 employees.

"Eligible large groups" means groups, any labor union,

educational, professional, civic, trade, church, not-for-profit, or social organizations or firms, corporations, or partnerships or associations actively engaged in business that on at least 50% of its working days during the preceding year employed at least 51 employees.

"Eligible small groups" means groups, any sole proprietorship, labor unions, educational, professional, civic, trade, church, not-for-profit, or social organizations or firms, corporations, or partnerships or associations actively engaged in business that on at least 50% of its working days during the preceding year employed at least one but not more than 50 employees.

"Health benefit plan" means any individual, general, blanket, or group policy of accident and health insurance issued by an insurer licensed under the Illinois Insurance Code; a group hospital service plan issued by a non-profit hospital service corporation; a group medical service plan issued by a non-profit medical service corporation; a group health maintenance contract issued by a health maintenance organization; or coverage for young adults health insurance plan. "Health benefit plan" does not include accident only, credit-only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies, if offered as independent, non-coordinated benefits, which, for the purposes of this Act, means policies that provide a benefit not to exceed $500 per day, to be paid to an insured or a

dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the Director of Insurance by rule may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; long-term care, if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55, if offered as a separate insurance policy, or any similar policies issued on a group basis; Medicare Advantage plans; or Medicare prescription drug plans. A health plan issued, renewed, or delivered after the effective date of this Act to an individual who is enrolled in a qualifying student health insurance program shall not be considered a health plan for the purposes of this Act. The Director of Insurance may by rule define other health coverage as a health benefit plan for the purposes of this Act.

"Public option" means the public health benefits plan offered through the Connector, established by Section 15 of this Act.

"Trust Fund" means the Public Health Insurance Trust Fund, established in Section 40 of this Act.

Section 10. Health Insurance Connector Authority. There shall be a body politic and corporate and a public instrumentality to be known as the Health Insurance Connector Authority, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency, or political subdivision of the State, except as specifically provided in law. The exercise by the Connector of the powers conferred by this Act shall be considered to be the performance of an essential public function.

Section 15. Public health insurance option. The Health Insurance Connector Authority shall provide for the offering a public health benefits plan (the public option) to eligible individuals and groups in order to ensure choice, competition, and stability of affordable, high quality coverage throughout this State. The public option shall:

(1) be made available exclusively through the Connector, alongside health benefit plans receiving the Connector seal of approval;

(2) meet all the requirements established for health benefit plans to receive the Connector seal of approval; and

(3) meet the Connector's standards for minimum creditable coverage.

Section 20. Availability. The public option shall be made available to eligible individuals and eligible small groups through the Connector no later than January 1, 2016. The public option shall be made available to eligible large groups no later than July 1, 2016.

Section 25. Executive director. The executive director of the Connector may contract with managed care organizations or other such health benefits administrators to administer aspects of plans offered under the public option. Notwithstanding any general or special law to the contrary, the executive director shall collaborate with the Director of Healthcare and Family Services and the Director of Insurance to ensure that only Medicaid managed care organizations that have contracted with the State as of January 1, 2015 to deliver such managed care services are so contracted with to administer aspects of the public option. The executive director may accept applications from non-Medicaid managed care organizations for the provision of such services after January 1, 2017. The executive director may adopt rules to implement this Act.

Section 30. Reporting. A report on the activities, receipts, expenditures, and enrollments of the public option shall be included in the Connector's annual reports and shall be subject to the prescription and oversight of the Connector

Board and Auditor General.

Section 35. Premium rates. The Connector Board shall establish premium rates for the public health insurance option at a level sufficient to fully finance the costs of:

(1) health benefits provided by the public option; and

(2) administrative costs related to operating the public option.

Section 40. Payment rates. The Connector Board shall establish payment rates for the public option for services and providers based on parts A and B of Medicare. The Connector Board may determine the extent to which adjustments to base Medicare payment rates shall be made in order to fairly reimburse providers and medical goods and device makers, as well as to maintain a strong provider network.

Section 45. Health care providers. Health care providers, including physicians and hospitals, participating in Medicare are participating providers in the public option unless they opt out through a process to be established by the Connector Board. This opt-out process must ensure that:

(1) no provider shall be subject to a penalty for not participating in the public option;

(2) the Connector shall include information on how providers participating in Medicare who chose to opt out of

participating in the public option may opt back in; and

(3) there shall be an annual enrollment period in which providers may decide whether to participate in the public option.

Section 50. Fund. There is hereby created as special fund in the State treasury the Public Health Insurance Option Trust Fund (the Trust Fund). Amounts credited to the Trust Fund shall be expended without further appropriation for the operation of the public option. Not later than January 1, 2017, the State Comptroller shall report an update of revenues for the current fiscal year.

Section 900. The State Finance Act is amended by adding Section 5.855 as follows:

(30 ILCS 105/5.855 new)

Sec. 5.855. The Public Health Insurance Option Trust Fund.

Section 905. The Illinois Insurance Code is amended by adding Section 155.44 as follows:

(215 ILCS 5/155.44 new)

Sec. 155.44. Assessments.

(a) The Director is hereby authorized to make an assessment against all health plans, health insurers, and health

maintenance organizations in the State, as well as the public health insurance option established by the Public Health Insurance Option Act (which shall be referred to as risk-adjusted health plans), if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all risk-adjusted health plans for such year. Self-insured group health plans subject to the provisions of the Employee Retirement Income Security Act of 1974 are exempted from the risk adjustment.

(b) Using the criteria and methods developed under subsection (c) of this Section, the Director shall provide a payment to risk-adjusted health plans (with respect to health insurance coverage) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all risk-adjusted health plans for such year that are not self-insured group health plans subject to the provisions of the Employee Retirement Income Security Act of 1974.

(c) The Director shall establish criteria and methods to be used in carrying out the risk adjustment activities under this Section. In calculating the actuarial risk of risk-adjusted health plans, the Director may utilize data, including, but not limited to, enrollee demographics, inpatient and outpatient diagnoses (in similar fashion as such data are used under parts C and D of Title XVIII of the Social Security Act), and such other information as the Director determines may be necessary,

such as the actual medical costs of enrollees during the previous year. Upon request, the risk-adjusted health plans shall make information available to the Department of Insurance for the purposes of risk adjustment under this Section. The information shall be limited to the minimum amount of personal information necessary, shall be confidential, and shall not constitute a public record.