

1 AN ACT to amend the Comprehensive Health Insurance Plan
2 Act by changing Sections 2 and 15.

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

5 Section 5. The Comprehensive Health Insurance Plan Act
6 is amended by changing Sections 2 and 15 as follows:

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

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

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

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

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

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

20 "Continuation coverage" means continuation of coverage
21 under a group health plan or other health insurance coverage
22 for former employees or dependents of former employees that
23 would otherwise have terminated under the terms of that
24 coverage pursuant to any continuation provisions under
25 federal or State law, including the Consolidated Omnibus
26 Budget Reconciliation Act of 1985 (COBRA), as amended,
27 Sections 367.2 and 367e of the Illinois Insurance Code, or
28 any other similar requirement in another State.

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

1 "Creditable coverage" means, with respect to a federally
2 eligible individual, coverage of the individual under any of
3 the following:

4 (A) A group health plan.

5 (B) Health insurance coverage (including group
6 health insurance coverage).

7 (C) Medicare.

8 (D) Medical assistance.

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

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

12 (G) A state health benefits risk pool.

13 (H) A health plan offered under Chapter 89 of title
14 5, United States Code.

15 (I) A public health plan (as defined in regulations
16 consistent with Section 104 of the Health Care
17 Portability and Accountability Act of 1996 that may be
18 promulgated by the Secretary of the U.S. Department of
19 Health and Human Services).

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

22 (K) Any other qualifying coverage required by the
23 federal Health Insurance Portability and Accountability
24 Act of 1996, as it may be amended, or regulations under
25 that Act.

26 "Creditable coverage" does not include coverage
27 consisting solely of coverage of excepted benefits, (as
28 defined in Section 2791(c) of title XXVII of the Public
29 Health Service Act (42 U.S.C. 300 gg-91), nor does it include
30 any period of coverage under any of items (A) through (K)
31 that occurred before a break of more than 90 63 days during
32 all of which the individual was not covered under any of
33 items (A) through (K) above. Any period that an individual
34 is in a waiting period for any coverage under a group health

1 plan (or for group health insurance coverage) or is in an
2 affiliation period under the terms of health insurance
3 coverage offered by a health maintenance organization shall
4 not be taken into account in determining if there has been a
5 break of more than ~~90~~ 63 days in any creditable ~~credible~~
6 coverage.

7 "Department" means the Illinois Department of Insurance.

8 "Dependent" means an Illinois resident: who is a spouse;
9 or who is claimed as a dependent by the principal insured for
10 purposes of filing a federal income tax return and resides in
11 the principal insured's household, and is a resident
12 unmarried child under the age of 19 years; or who is an
13 unmarried child who also is a full-time student under the age
14 of 23 years and who is financially dependent upon the
15 principal insured; or who is a child of any age and who is
16 disabled and financially dependent upon the principal
17 insured.

18 "Direct Illinois premiums" means, for Illinois business,
19 an insurer's direct premium income for the kinds of business
20 described in clause (b) of Class 1 or clause (a) of Class 2
21 of Section 4 of the Illinois Insurance Code, and direct
22 premium income of a health maintenance organization or a
23 voluntary health services plan, except it shall not include
24 credit health insurance as defined in Article IX 1/2 of the
25 Illinois Insurance Code.

26 "Director" means the Director of the Illinois Department
27 of Insurance.

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

30 "Employee" means a resident of this State who is employed
31 by an employer or has entered into the employment of or works
32 under contract or service of an employer including the
33 officers, managers and employees of subsidiary or affiliated
34 corporations and the individual proprietors, partners and

1 employees of affiliated individuals and firms when the
2 business of the subsidiary or affiliated corporations, firms
3 or individuals is controlled by a common employer through
4 stock ownership, contract, or otherwise.

5 "Employer" means any individual, partnership,
6 association, corporation, business trust, or any person or
7 group of persons acting directly or indirectly in the
8 interest of an employer in relation to an employee, for which
9 one or more persons is gainfully employed.

10 "Family" coverage means the coverage provided by the Plan
11 for the covered person and his or her eligible dependents who
12 also are covered persons.

13 "Federally eligible individual" means an individual
14 resident of this State:

15 (1)(A) for whom, as of the date on which the
16 individual seeks Plan coverage under Section 15 of this
17 Act, the aggregate of the periods of creditable coverage
18 is 18 or more months, and (B) whose most recent prior
19 creditable coverage was under group health insurance
20 coverage offered by a health insurance issuer, a group
21 health plan, a governmental plan, or a church plan (or
22 health insurance coverage offered in connection with any
23 such plans) or any other type of creditable coverage that
24 may be required by the federal Health Insurance
25 Portability and Accountability Act of 1996, as it may be
26 amended, or the regulations under that Act;

27 (2) who is not eligible for coverage under (A) a
28 group health plan, (B) part A or part B of Medicare due
29 to age, or (C) medical assistance, and does not have
30 other health insurance coverage;

31 (3) with respect to whom the most recent coverage
32 within the coverage period described in paragraph (1)(A)
33 of this definition was not terminated based upon a factor
34 relating to nonpayment of premiums or fraud;

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

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

8 "Group health insurance coverage" means, in connection
9 with a group health plan, health insurance coverage offered
10 in connection with that plan.

11 "Group health plan" has the same meaning given that term
12 in the federal Health Insurance Portability and
13 Accountability Act of 1996.

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

17 "Health insurance coverage" means benefits consisting of
18 medical care (provided directly, through insurance or
19 reimbursement, or otherwise and including items and services
20 paid for as medical care) under any hospital and medical
21 expense-incurred policy, certificate, or contract provided by
22 an insurer, non-profit health care service plan contract,
23 health maintenance organization or other subscriber contract,
24 or any other health care plan or arrangement that pays for or
25 furnishes medical or health care services whether by
26 insurance or otherwise. Health insurance coverage shall not
27 include short term, accident only, disability income,
28 hospital confinement or fixed indemnity, dental only, vision
29 only, limited benefit, or credit insurance, coverage issued
30 as a supplement to liability insurance, insurance arising out
31 of a workers' compensation or similar law, automobile
32 medical-payment insurance, or insurance under which benefits
33 are payable with or without regard to fault and which is
34 statutorily required to be contained in any liability

1 insurance policy or equivalent self-insurance.

2 "Health insurance issuer" means an insurance company,
3 insurance service, or insurance organization (including a
4 health maintenance organization and a voluntary health
5 services plan) that is authorized to transact health
6 insurance business in this State. Such term does not include
7 a group health plan.

8 "Health Maintenance Organization" means an organization
9 as defined in the Health Maintenance Organization Act.

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

12 "Hospital" means a duly licensed institution as defined
13 in the Hospital Licensing Act, an institution that meets all
14 comparable conditions and requirements in effect in the state
15 in which it is located, or the University of Illinois
16 Hospital as defined in the University of Illinois Hospital
17 Act.

18 "Individual health insurance coverage" means health
19 insurance coverage offered to individuals in the individual
20 market, but does not include short-term, limited-duration
21 insurance.

22 "Insured" means any individual resident of this State who
23 is eligible to receive benefits from any insurer (including
24 health insurance coverage offered in connection with a group
25 health plan) or health insurance issuer as defined in this
26 Section.

27 "Insurer" means any insurance company authorized to
28 transact health insurance business in this State and any
29 corporation that provides medical services and is organized
30 under the Voluntary Health Services Plans Act or the Health
31 Maintenance Organization Act.

32 "Medical assistance" means the State medical assistance
33 or medical assistance no grant (MANG) programs provided under
34 Title XIX of the Social Security Act and Articles V (Medical

1 Assistance) and VI (General Assistance) of the Illinois
2 Public Aid Code (or any successor program) or under any
3 similar program of health care benefits in a state other than
4 Illinois.

5 "Medically necessary" means that a service, drug, or
6 supply is necessary and appropriate for the diagnosis or
7 treatment of an illness or injury in accord with generally
8 accepted standards of medical practice at the time the
9 service, drug, or supply is provided. When specifically
10 applied to a confinement it further means that the diagnosis
11 or treatment of the covered person's medical symptoms or
12 condition cannot be safely provided to that person as an
13 outpatient. A service, drug, or supply shall not be medically
14 necessary if it: (i) is investigational, experimental, or for
15 research purposes; or (ii) is provided solely for the
16 convenience of the patient, the patient's family, physician,
17 hospital, or any other provider; or (iii) exceeds in scope,
18 duration, or intensity that level of care that is needed to
19 provide safe, adequate, and appropriate diagnosis or
20 treatment; or (iv) could have been omitted without adversely
21 affecting the covered person's condition or the quality of
22 medical care; or (v) involves the use of a medical device,
23 drug, or substance not formally approved by the United States
24 Food and Drug Administration.

25 "Medical care" means the ordinary and usual professional
26 services rendered by a physician or other specified provider
27 during a professional visit for treatment of an illness or
28 injury.

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

32 "Minimum premium plan" means an arrangement whereby a
33 specified amount of health care claims is self-funded, but
34 the insurance company assumes the risk that claims will

1 exceed that amount.

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

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

11 "Plan" means the Comprehensive Health Insurance Plan
12 established by this Act.

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

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

21 "Qualified high risk pool" has the same meaning given
22 that term in the federal Health Insurance Portability and
23 Accountability Act of 1996.

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

30 "Skilled nursing facility" means a facility or that
31 portion of a facility that is licensed by the Illinois
32 Department of Public Health under the Nursing Home Care Act
33 or a comparable licensing authority in another state to
34 provide skilled nursing care.

1 "Stop-loss coverage" means an arrangement whereby an
2 insurer insures against the risk that any one claim will
3 exceed a specific dollar amount or that the entire loss of a
4 self-insurance plan will exceed a specific amount.

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

8 (Source: P.A. 90-30, eff. 7-1-97; 91-357, eff. 7-29-99;
9 91-735, eff. 6-2-00.)

10 (215 ILCS 105/15)

11 Sec. 15. Alternative portable coverage for federally
12 eligible individuals.

13 (a) Notwithstanding the requirements of subsection a. of
14 Section 7, any federally eligible individual for whom a Plan
15 application, and such enclosures and supporting documentation
16 as the Board may require, is received by the Board within 90
17 63 days after the termination of prior creditable coverage
18 shall qualify to enroll in the Plan under the portability
19 provisions of this Section.

20 (b) Any federally eligible individual seeking Plan
21 coverage under this Section must submit with his or her
22 application evidence, including acceptable written
23 certification of previous creditable coverage, that will
24 establish to the Board's satisfaction, that he or she meets
25 all of the requirements to be a federally eligible individual
26 and is currently and permanently residing in this State (as
27 of the date his or her application was received by the
28 Board).

29 (c) A period of creditable coverage shall not be
30 counted, with respect to qualifying an applicant for Plan
31 coverage as a federally eligible individual under this
32 Section, if after such period and before the application for
33 Plan coverage was received by the Board, there was at least a

1 90 63 day period during all of which the individual was not
2 covered under any creditable coverage.

3 (d) Any federally eligible individual who the Board
4 determines qualifies for Plan coverage under this Section
5 shall be offered his or her choice of enrolling in one of
6 alternative portability health benefit plans which the Board
7 is authorized under this Section to establish for these
8 federally eligible individuals and their dependents.

9 (e) The Board shall offer a choice of health care
10 coverages consistent with major medical coverage under the
11 alternative health benefit plans authorized by this Section
12 to every federally eligible individual. The coverages to be
13 offered under the plans, the schedule of benefits,
14 deductibles, co-payments, exclusions, and other limitations
15 shall be approved by the Board. One optional form of
16 coverage shall be comparable to comprehensive health
17 insurance coverage offered in the individual market in this
18 State or a standard option of coverage available under the
19 group or individual health insurance laws of the State. The
20 standard benefit plan that is authorized by Section 8 of this
21 Act may be used for this purpose. The Board may also offer a
22 preferred provider option and such other options as the Board
23 determines may be appropriate for these federally eligible
24 individuals who qualify for Plan coverage pursuant to this
25 Section.

26 (f) Notwithstanding the requirements of subsection f. of
27 Section 8, any plan coverage that is issued to federally
28 eligible individuals who qualify for the Plan pursuant to the
29 portability provisions of this Section shall not be subject
30 to any preexisting conditions exclusion, waiting period, or
31 other similar limitation on coverage.

32 (g) Federally eligible individuals who qualify and
33 enroll in the Plan pursuant to this Section shall be required
34 to pay such premium rates as the Board shall establish and

1 approve in accordance with the requirements of Section 7.1 of
2 this Act.

3 (h) A federally eligible individual who qualifies and
4 enrolls in the Plan pursuant to this Section must satisfy on
5 an ongoing basis all of the other eligibility requirements of
6 this Act to the extent not inconsistent with the federal
7 Health Insurance Portability and Accountability Act of 1996
8 in order to maintain continued eligibility for coverage under
9 the Plan.

10 (Source: P.A. 90-30, eff. 7-1-97.)

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