



Rep. Karen May

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LRB095 04988 KBJ 36610 a

1 AMENDMENT TO SENATE BILL 144

2 AMENDMENT NO. _____. Amend Senate Bill 144, AS AMENDED, by
3 replacing everything after the enacting clause with the
4 following:

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

7 (215 ILCS 105/8) (from Ch. 73, par. 1308)

8 Sec. 8. Minimum benefits.

9 a. Availability. The Plan shall offer in an annually
10 renewable policy major medical expense coverage to every
11 eligible person who is not eligible for Medicare. Major medical
12 expense coverage offered by the Plan shall pay an eligible
13 person's covered expenses, subject to limit on the deductible
14 and coinsurance payments authorized under paragraph (4) of
15 subsection d of this Section, up to a lifetime benefit limit of
16 \$1,500,000 per covered individual. The maximum limit under this

1 subsection shall not be altered by the Board, and no actuarial
2 equivalent benefit may be substituted by the Board. Any person
3 who otherwise would qualify for coverage under the Plan, but is
4 excluded because he or she is eligible for Medicare, shall be
5 eligible for any separate Medicare supplement policy or
6 policies which the Board may offer.

7 b. Outline of benefits. Covered expenses shall be limited
8 to the usual and customary charge, including negotiated fees,
9 in the locality for the following services and articles when
10 prescribed by a physician and determined by the Plan to be
11 medically necessary for the following areas of services,
12 subject to such separate deductibles, co-payments, exclusions,
13 and other limitations on benefits as the Board shall establish
14 and approve, and the other provisions of this Section:

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

25 (2) Professional services for the diagnosis or
26 treatment of injuries, illnesses or conditions, other than

1 dental and mental and nervous disorders as described in
2 paragraph (17), which are rendered by a physician, or by
3 other licensed professionals at the physician's direction.
4 This includes reconstruction of the breast on which a
5 mastectomy was performed; surgery and reconstruction of
6 the other breast to produce a symmetrical appearance; and
7 prostheses and treatment of physical complications at all
8 stages of the mastectomy, including lymphedemas.

9 (2.5) Professional services provided by a physician to
10 children under the age of 16 years for physical
11 examinations and age appropriate immunizations ordered by
12 a physician licensed to practice medicine in all its
13 branches.

14 (3) (Blank).

15 (4) Outpatient prescription drugs that by law require a
16 prescription written by a physician licensed to practice
17 medicine in all its branches subject to such separate
18 deductible, copayment, and other limitations or
19 restrictions as the Board shall approve, including the use
20 of a prescription drug card or any other program, or both.

21 (5) Skilled nursing services of a licensed skilled
22 nursing facility for not more than 120 days during a policy
23 year.

24 (6) Services of a home health agency in accord with a
25 home health care plan, up to a maximum of 270 visits per
26 year.

1 (7) Services of a licensed hospice for not more than
2 180 days during a policy year.

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

4 (9) Oxygen.

5 (10) Anesthetics.

6 (11) Orthoses and prostheses other than dental.

7 (12) Rental or purchase in accordance with Board
8 policies or procedures of durable medical equipment, other
9 than eyeglasses or hearing aids, for which there is no
10 personal use in the absence of the condition for which it
11 is prescribed.

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

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

22 (15) Physical, speech, and functional occupational
23 therapy as medically necessary and provided by appropriate
24 licensed professionals.

25 (16) Emergency and other medically necessary
26 transportation provided by a licensed ambulance service to

1 the nearest health care facility qualified to treat a
2 covered illness, injury, or condition, subject to the
3 provisions of the Emergency Medical Systems (EMS) Act.

4 (17) Outpatient services for diagnosis and treatment
5 of mental and nervous disorders provided that a covered
6 person shall be required to make a copayment not to exceed
7 50% and that the Plan's payment shall not exceed such
8 amounts as are established by the Board.

9 (18) Human organ or tissue transplants specified by the
10 Board that are performed at a hospital designated by the
11 Board as a participating transplant center for that
12 specific organ or tissue transplant.

13 (19) Naprapathic services, as appropriate, provided by
14 a licensed naprapathic practitioner.

15 (20) Coverage for benefits as required under Sections
16 356g, 356u, 356x, and 356z.4 of the Illinois Insurance
17 Code.

18 c. Exclusions. Covered expenses of the Plan shall not
19 include the following:

20 (1) Any charge for treatment for cosmetic purposes
21 other than for reconstructive surgery when the service is
22 incidental to or follows surgery resulting from injury,
23 sickness or other diseases of the involved part or surgery
24 for the repair or treatment of a congenital bodily defect
25 to restore normal bodily functions.

26 (2) Any charge for care that is primarily for rest,

1 custodial, educational, or domiciliary purposes.

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

6 (4) That part of any charge for room and board or for
7 services rendered or articles prescribed by a physician,
8 dentist, or other health care personnel that exceeds the
9 reasonable and customary charge in the locality or for any
10 services or supplies not medically necessary for the
11 diagnosed injury or illness.

12 (5) Any charge for services or articles the provision
13 of which is not within the scope of licensure of the
14 institution or individual providing the services or
15 articles.

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

19 (7) Dental care, dental surgery, dental treatment, any
20 other dental procedure involving the teeth or
21 periodontium, or any dental appliances, including crowns,
22 bridges, implants, or partial or complete dentures, except
23 as specifically provided in paragraph (14) of subsection b
24 of this Section.

25 (8) Eyeglasses, contact lenses, hearing aids or their
26 fitting.

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

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

5 (11) Personal supplies or services provided by a
6 hospital or nursing home, or any other nonmedical or
7 nonprescribed supply or service.

8 (12) Routine maternity charges for a pregnancy, except
9 where added as optional coverage with payment of an
10 additional premium for pregnancy resulting from conception
11 occurring after the effective date of the optional
12 coverage.

13 (13) (Blank).

14 (14) Any expense or charge for services, drugs, or
15 supplies that are: (i) not provided in accord with
16 generally accepted standards of current medical practice;
17 (ii) for procedures, treatments, equipment, transplants,
18 or implants, any of which are investigational,
19 experimental, or for research purposes; (iii)
20 investigative and not proven safe and effective; or (iv)
21 for, or resulting from, a gender transformation operation.

22 (15) Any expense or charge for routine physical
23 examinations or tests except as provided in items ~~item~~
24 (2.5) and (20) of subsection b of this Section.

25 (16) Any expense for which a charge is not made in the
26 absence of insurance or for which there is no legal

1 obligation on the part of the patient to pay.

2 (17) Any expense incurred for benefits provided under
3 the laws of the United States and this State, including
4 Medicare, Medicaid, and other medical assistance, maternal
5 and child health services and any other program that is
6 administered or funded by the Department of Human Services,
7 Department of Healthcare and Family Services, or
8 Department of Public Health, military service-connected
9 disability payments, medical services provided for members
10 of the armed forces and their dependents or employees of
11 the armed forces of the United States, and medical services
12 financed on behalf of all citizens by the United States.

13 (18) Any expense or charge for in vitro fertilization,
14 artificial insemination, or any other artificial means
15 used to cause pregnancy.

16 (19) (Blank). ~~Any expense or charge for oral~~
17 ~~contraceptives used for birth control or any other~~
18 ~~temporary birth control measures.~~

19 (20) Any expense or charge for sterilization or
20 sterilization reversals.

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

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

1 (23) Any expense or charge for or related to organ or
2 tissue transplants other than those performed at a hospital
3 with a Board approved organ transplant program that has
4 been designated by the Board as a preferred or exclusive
5 provider organization for that specific organ or tissue
6 transplant.

7 (24) Any expense or charge for procedures, treatments,
8 equipment, or services that are provided in special
9 settings for research purposes or in a controlled
10 environment, are being studied for safety, efficiency, and
11 effectiveness, and are awaiting endorsement by the
12 appropriate national medical speciality college for
13 general use within the medical community.

14 d. Deductibles and coinsurance.

15 The Plan coverage defined in Section 6 shall provide for a
16 choice of deductibles per individual as authorized by the
17 Board. If 2 individual members of the same family household,
18 who are both covered persons under the Plan, satisfy the same
19 applicable deductibles, no other member of that family who is
20 also a covered person under the Plan shall be required to meet
21 any deductibles for the balance of that calendar year. The
22 deductibles must be applied first to the authorized amount of
23 covered expenses incurred by the covered person. A mandatory
24 coinsurance requirement shall be imposed at the rate authorized
25 by the Board in excess of the mandatory deductible, the
26 coinsurance in the aggregate not to exceed such amounts as are

1 authorized by the Board per annum. At its discretion the Board
2 may, however, offer catastrophic coverages or other policies
3 that provide for larger deductibles with or without coinsurance
4 requirements. The deductibles and coinsurance factors may be
5 adjusted annually according to the Medical Component of the
6 Consumer Price Index.

7 e. Scope of coverage.

8 (1) In approving any of the benefit plans to be offered
9 by the Plan, the Board shall establish such benefit levels,
10 deductibles, coinsurance factors, exclusions, and
11 limitations as it may deem appropriate and that it believes
12 to be generally reflective of and commensurate with health
13 insurance coverage that is provided in the individual
14 market in this State.

15 (2) The benefit plans approved by the Board may also
16 provide for and employ various cost containment measures
17 and other requirements including, but not limited to,
18 preadmission certification, prior approval, second
19 surgical opinions, concurrent utilization review programs,
20 individual case management, preferred provider
21 organizations, health maintenance organizations, and other
22 cost effective arrangements for paying for covered
23 expenses.

24 f. Preexisting conditions.

25 (1) Except for federally eligible individuals
26 qualifying for Plan coverage under Section 15 of this Act

1 or eligible persons who qualify for the waiver authorized
2 in paragraph (3) of this subsection, plan coverage shall
3 exclude charges or expenses incurred during the first 6
4 months following the effective date of coverage as to any
5 condition for which medical advice, care or treatment was
6 recommended or received during the 6 month period
7 immediately preceding the effective date of coverage.

8 (2) (Blank).

9 (3) Waiver: The preexisting condition exclusions as
10 set forth in paragraph (1) of this subsection shall be
11 waived to the extent to which the eligible person (a) has
12 satisfied similar exclusions under any prior individual
13 health insurance policy that was involuntarily terminated
14 because of the insolvency of the issuer of the policy and
15 (b) has applied for Plan coverage within 90 days following
16 the involuntary termination of that individual health
17 insurance coverage.

18 g. Other sources primary; nonduplication of benefits.

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

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

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

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

1 may be payable by the amount of damages that the covered
2 person has recovered or may recover regardless of the date
3 of the sickness or injury or the date of any settlement,
4 judgment, or award resulting from that sickness or injury.

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

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

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

24 h. Right of subrogation; recoveries.

25 (1) Whenever the Plan has paid benefits because of
26 sickness or an injury to any covered person resulting from

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

1 guardian, conservator, estate, dependents, or survivors.

2 (2) If any action or claim is brought by or on behalf
3 of a covered person against a third party or the third
4 party's insurer, the covered person or his personal
5 representative, including his guardian, conservator,
6 estate, dependents, or survivors, shall notify the Plan by
7 personal service or registered mail of the action or claim
8 and of the name of the court in which the action or claim
9 is brought, filing proof thereof in the action or claim.

10 The Plan may, at any time thereafter, join in the action or
11 claim upon its motion so that all orders of court after
12 hearing and judgment shall be made for its protection. No
13 release or settlement of a claim for damages and no
14 satisfaction of judgment in the action shall be valid
15 without the written consent of the Plan to the extent of
16 its interest in the settlement or judgment and of the
17 covered person or his personal representative.

18 (3) In the event that the covered person or his
19 personal representative fails to institute a proceeding
20 against any appropriate third party before the fifth month
21 before the action would be barred, the Plan may, in its own
22 name or in the name of the covered person or personal
23 representative, commence a proceeding against any
24 appropriate third party for the recovery of damages on
25 account of any sickness, injury, or death to the covered
26 person. The covered person shall cooperate in doing what is

1 reasonably necessary to assist the Plan in any recovery and
2 shall not take any action that would prejudice the Plan's
3 right to recovery. The Plan shall pay to the covered person
4 or his personal representative all sums collected from any
5 third party by judgment or otherwise in excess of amounts
6 paid in benefits under the Plan and amounts paid or to be
7 paid as costs, attorneys fees, and reasonable expenses
8 incurred by the Plan in making the collection or enforcing
9 the judgment.

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

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

1 by multiplying by the ratio of the full amount of the
2 expenditures to the full amount of the judgement, award, or
3 settlement.

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

1 the Plan shall take priority over all other liens and
2 charges existing under the laws of this State with the
3 exception of any attorney liens filed under the Attorneys
4 Lien Act.

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

11 (Source: P.A. 94-737, eff. 5-3-06.)".