SB3210

LRB09617688RPM33050b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

SB3210

Introduced 2/9/2010, by Sen. Jeffrey M. Schoenberg

SYNOPSIS AS INTRODUCED:

215 ILCS 105/1.1	from Ch. 73, par. 1301.1
215 ILCS 105/2	from Ch. 73, par. 1302
215 ILCS 105/4	from Ch. 73, par. 1304
215 ILCS 105/7	from Ch. 73, par. 1307
215 ILCS 105/12	from Ch. 73, par. 1312

Amends the Comprehensive Health Insurance Plan Act. Deletes language that provides that the State may subsidize the cost of health insurance coverage offered by the Comprehensive Health Insurance Plan. Makes changes to the definition of "dependent". In the provisions concerning powers and authority of the board and eligibility, changes references of "appropriated funds" to "assessments". Deletes language that provides that any deficit incurred or expected to be incurred on behalf of eligible persons who qualify for plan coverage shall be recouped by an appropriation made by the General Assembly. Makes technical changes to update Section numbering. Makes other changes. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

Section 5. The Comprehensive Health Insurance Plan Act is amended by changing Sections 1.1, 2, 4, 7, and 12 as follows:

(215 ILCS 105/1.1) (from Ch. 73, par. 1301.1)

Sec. 1.1. The General Assembly hereby makes the following findings and declarations:

(a) The Comprehensive Health Insurance Plan is established as a State program that is intended to provide an alternate market for health insurance for certain uninsurable Illinois residents, and further is intended to provide an acceptable alternative mechanism as described in the federal Health Insurance Portability and Accountability Act of 1996 for providing portable and accessible individual health insurance coverage for federally eligible individuals as defined in this Act.

(b) The ~~State of Illinois may subsidize the cost of health insurance coverage offered by the Plan. However, since the State has only a limited amount of resources, the~~ General Assembly declares that it intends for this program to provide portable and accessible individual health insurance coverage for every federally eligible individual who qualifies for

coverage in accordance with Section 14.05 ~~15~~ of this Act, but does not intend for every eligible person who qualifies for Plan coverage in accordance with Section 7 of this Act to be guaranteed a right to be issued a policy under this Plan as a matter of entitlement.

(c) The Comprehensive Health Insurance Plan Board shall operate the Plan in a manner so that the estimated cost of the program during any fiscal year will not exceed the total income it expects to receive from policy premiums, investment income, assessments, or fees collected or received by the Board ~~and other funds which are made available from appropriations for the Plan by the General Assembly for that fiscal year~~.

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

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

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

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

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

"Board" means the Illinois Comprehensive Health Insurance Board.

"Church plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of

1996.

"Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or State law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2, 367e, and 367e.1 of the Illinois Insurance Code, or any other similar requirement in another State.

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

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

(A) A group health plan.

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

(C) Medicare.

(D) Medical assistance.

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

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

(G) A state health benefits risk pool.

(H) A health plan offered under Chapter 89 of title 5,

United States Code.

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

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

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

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 2791(c) of title XXVII of the Public Health Service Act (42 U.S.C. 300 gg-91), nor does it include any period of coverage under any of items (A) through (K) that occurred before a break of more than 90 days or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, a break of more than 63 days during all of which the individual was not covered under any of items (A) through (K) above.

Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in

determining if there has been a break of more than 90 days in any creditable coverage.

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is an ~~claimed as a dependent by the principal insured for purposes of filing a federal income tax return and resides in the principal insured's household, and is a resident~~ unmarried child under the age of 26 ~~19~~ years; ~~or who is an unmarried child who also is a full time student under the age of 23 years and who is financially dependent upon the principal insured;~~ or who is an unmarried child under the age of 30 years if the child (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

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

"Director" means the Director of the Illinois Department of

Insurance.

"Effective date of medical assistance" means the date that eligibility for medical assistance for a person is approved by the Department of Human Services or the Department of Healthcare and Family Services, except when the Department of Human Services or the Department of Healthcare and Family Services determines eligibility retroactively. In such circumstances, the effective date of the medical assistance is the date the Department of Human Services or the Department of Healthcare and Family Services determines the person to be eligible for medical assistance.

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

"Employee" means a resident of this State who is employed by an employer or has entered into the employment of or works under contract or service of an employer including the officers, managers and employees of subsidiary or affiliated corporations and the individual proprietors, partners and employees of affiliated individuals and firms when the business of the subsidiary or affiliated corporations, firms or individuals is controlled by a common employer through stock ownership, contract, or otherwise.

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

gainfully employed.

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

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

(1)(A) for whom, as of the date on which the individual seeks Plan coverage under Section 14.05 ~~15~~ of this Act, the aggregate of the periods of creditable coverage is 18 or more months or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, 3 or more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) who is not eligible for coverage under (A) a group health plan (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), (B) part A or part B of Medicare due to age (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), or (C) medical

assistance, and does not have other health insurance coverage (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002);

(3) with respect to whom (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) the most recent coverage within the coverage period described in paragraph (1)(A) of this definition was not terminated based upon a factor relating to nonpayment of premiums or fraud;

(4) if the individual (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

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

However, an individual who has been certified as eligible pursuant to the federal Trade Act of 2002 shall not be required to elect continuation coverage under a COBRA continuation provision or under a similar state program.

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

"Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability

Act of 1996.

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

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

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization and a voluntary health

services plan) that is authorized to transact health insurance business in this State. Such term does not include a group health plan.

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

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

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

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

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

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

"Medical assistance" means the State medical assistance or medical assistance no grant (MANG) programs provided under Title XIX of the Social Security Act and Articles V (Medical Assistance) and VI (General Assistance) of the Illinois Public Aid Code (or any successor program) or under any similar program of health care benefits in a state other than Illinois.

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

"Medical care" means the ordinary and usual professional

services rendered by a physician or other specified provider during a professional visit for treatment of an illness or injury.

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

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

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

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

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

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

"Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, registered pharmacist

acting within the scope of that registration, or any other person or entity licensed in Illinois to furnish medical care.

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

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

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

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

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

(Source: P.A. 95-965, eff. 9-23-08.)

(215 ILCS 105/4) (from Ch. 73, par. 1304)

Sec. 4. Powers and authority of the board. The board shall have the general powers and authority granted under the laws of this State to insurance companies licensed to transact health and accident insurance and in addition thereto, the specific authority to:

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Director, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions including, without limitation, utilization review and quality assurance programs, or with health maintenance organizations or preferred provider organizations for the provision of health care services.

b. Sue or be sued, including taking any legal actions necessary or proper.

c. Take such legal action as necessary to:

(1) avoid the payment of improper claims against the plan or the coverage provided by or through the plan;

(2) to recover any amounts erroneously or improperly paid by the plan;

(3) to recover any amounts paid by the plan as a result of a mistake of fact or law; or

(4) to recover or collect any other amounts, including assessments, that are due or owed the Plan or have been

billed on its or the Plan's behalf.

d. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves, and formulas and any other actuarial function appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

e. Issue policies of insurance in accordance with the requirements of this Act.

f. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the plan.

g. Borrow money to effect the purposes of the Illinois Comprehensive Health Insurance Plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets.

h. Establish rules, conditions and procedures for reinsuring risks under this Act.

i. Employ and fix the compensation of employees. Such employees may be paid on a warrant issued by the State Treasurer pursuant to a payroll voucher certified by the Board and drawn by the Comptroller against appropriations or trust

funds held by the State Treasurer.

j. Enter into intergovernmental cooperation agreements with other agencies or entities of State government for the purpose of sharing the cost of providing health care services that are otherwise authorized by this Act for children who are both plan participants and eligible for financial assistance from the Division of Specialized Care for Children of the University of Illinois.

k. Establish conditions and procedures under which the plan may, if funds permit, discount or subsidize premium rates that are paid directly by senior citizens, as defined by the Board, and other plan participants, who are retired or unemployed and meet other qualifications.

l. Establish and maintain the Plan Fund authorized in Section 3 of this Act, which shall be divided into separate accounts, as follows:

(1) accounts to fund the administrative, claim, and other expenses of the Plan associated with eligible persons who qualify for Plan coverage under Section 7 of this Act, which shall consist of:

(A) premiums paid on behalf of covered persons;

(B) assessments ~~appropriated funds~~ and other revenues collected or received by the Board;

(C) reserves for future losses maintained by the Board; and

(D) interest earnings from investment of the funds

in the Plan Fund or any of its accounts other than the funds in the account established under item 2 of this subsection;

(2) an account, to be denominated the federally eligible individuals account, to fund the administrative, claim, and other expenses of the Plan associated with federally eligible individuals who qualify for Plan coverage under Section 14.05 ~~15~~ of this Act, which shall consist of:

(A) premiums paid on behalf of covered persons;

(B) assessments and other revenues collected or received by the Board;

(C) reserves for future losses maintained by the Board; and

(D) interest earnings from investment of the federally eligible individuals account funds; and

(E) grants provided pursuant to the federal Trade Act of 2002; and

(3) such other accounts as may be appropriate.

m. Charge and collect assessments paid by insurers pursuant to Section 12 of this Act and recover any assessments for, on behalf of, or against those insurers.

(Source: P.A. 93-33, eff. 6-23-03; 93-34, eff. 6-23-03.)

(215 ILCS 105/7) (from Ch. 73, par. 1307)

Sec. 7. Eligibility.

a. Except as provided in subsection (e) of this Section or in Section 14.05 ~~15~~ of this Act, any person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and who has been for a period of at least 180 days and continues to be a resident of this State shall be eligible for Plan coverage under this Section if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar individual health insurance coverage for health reasons by a health insurance issuer; or

(2) A refusal by a health insurance issuer to issue individual health insurance coverage except at a rate exceeding the applicable Plan rate for which the person is responsible.

A rejection or refusal by a group health plan or health insurance issuer offering only stop-loss or excess of loss insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection.

b. The board shall promulgate a list of medical or health conditions for which a person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and a resident of this State would be eligible for Plan coverage without applying for health insurance coverage pursuant to subsection a. of this Section. Persons who can demonstrate the existence or history of any medical or health

conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection a. of this Section. The list shall be effective on the first day of the operation of the Plan and may be amended from time to time as appropriate.

c. Family members of the same household who each are covered persons are eligible for optional family coverage under the Plan.

d. For persons qualifying for coverage in accordance with Section 7 of this Act, the board shall, if it determines that such assessments ~~appropriations~~ as are made pursuant to Section 12 of this Act are insufficient to allow the board to accept all of the eligible persons which it projects will apply for enrollment under the Plan, limit or close enrollment to ensure that the Plan is not over-subscribed and that it has sufficient resources to meet its obligations to existing enrollees. The board shall not limit or close enrollment for federally eligible individuals.

e. A person shall not be eligible for coverage under the Plan if:

(1) He or she has or obtains other coverage under a group health plan or health insurance coverage substantially similar to or better than a Plan policy as an insured or covered dependent or would be eligible to have that coverage if he or she elected to obtain it. Persons otherwise eligible for Plan coverage may, however, solely

for the purpose of having coverage for a pre-existing condition, maintain other coverage only while satisfying any pre-existing condition waiting period under a Plan policy or a subsequent replacement policy of a Plan policy.

(1.1) His or her prior coverage under a group health plan or health insurance coverage, provided or arranged by an employer of more than 10 employees was discontinued for any reason without the entire group or plan being discontinued and not replaced, provided he or she remains an employee, or dependent thereof, of the same employer.

(2) He or she is a recipient of or is approved to receive medical assistance, except that a person may continue to receive medical assistance through the medical assistance no grant program, but only while satisfying the requirements for a preexisting condition under Section 8, subsection f. of this Act. Payment of premiums pursuant to this Act shall be allocable to the person's spenddown for purposes of the medical assistance no grant program, but that person shall not be eligible for any Plan benefits while that person remains eligible for medical assistance. If the person continues to receive or be approved to receive medical assistance through the medical assistance no grant program at or after the time that requirements for a preexisting condition are satisfied, the person shall not be eligible for coverage under the Plan. In that circumstance, coverage under the plan shall terminate as of

the expiration of the preexisting condition limitation period. Under all other circumstances, coverage under the Plan shall automatically terminate as of the effective date of any medical assistance.

(3) Except as provided in Section 14.05 ~~15~~, the person has previously participated in the Plan and voluntarily terminated Plan coverage, unless 12 months have elapsed since the person's latest voluntary termination of coverage.

(4) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the Plan shall be limited to benefits incurred under the Plan for the time period for which premiums had been paid and the covered person remained eligible for Plan coverage.

(5) The Plan (i) until 3 years after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $2,000,000 in benefits on behalf of the covered person or (ii) 3 years or more after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $1,500,000 in benefits on behalf of the covered person.

(6) The person is a resident of a public institution.

(7) The person's premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise

qualifying full-time employee, or dependent of such employee, of a government agency or health care provider or, except when a person's premium is paid by the U.S. Treasury Department pursuant to the federal Trade Act of 2002.

(8) The person has or later receives other benefits or funds from any settlement, judgement, or award resulting from any accident or injury, regardless of the date of the accident or injury, or any other circumstances creating a legal liability for damages due that person by a third party, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or assets remaining from those sources in an amount in excess of $300,000.

(9) Within the 5 years prior to the date a person's Plan application is received by the Board, the person's coverage under any health care benefit program as defined in 18 U.S.C. 24, including any public or private plan or contract under which any medical benefit, item, or service is provided, was terminated as a result of any act or practice that constitutes fraud under State or federal law or as a result of an intentional misrepresentation of

material fact; or if that person knowingly and willfully obtained or attempted to obtain, or fraudulently aided or attempted to aid any other person in obtaining, any coverage or benefits under the Plan to which that person was not entitled.

f. The board or the administrator shall require verification of residency and may require any additional information or documentation, or statements under oath, when necessary to determine residency upon initial application and for the entire term of the policy.

g. Coverage shall cease (i) on the date a person is no longer a resident of Illinois, (ii) on the date a person requests coverage to end, (iii) upon the death of the covered person, (iv) on the date State law requires cancellation of the policy, or (v) at the Plan's option, 30 days after the Plan makes any inquiry concerning a person's eligibility or place of residence to which the person does not reply.

h. Except under the conditions set forth in subsection g of this Section, the coverage of any person who ceases to meet the eligibility requirements of this Section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

(Source: P.A. 94-17, eff. 1-1-06; 94-737, eff. 5-3-06; 95-547, eff. 8-29-07.)

(215 ILCS 105/12) (from Ch. 73, par. 1312)

Sec. 12. Deficit or surplus.

a. If premiums or other receipts by the Board exceed the amount required for the operation of the Plan, including actual losses and administrative expenses of the Plan, the Board shall direct that the excess be held at interest, in a bank designated by the Board, or used to offset future losses or to reduce Plan premiums. In this subsection, the term "future losses" includes reserves for incurred but not reported claims.

b. (Blank). ~~Any deficit incurred or expected to be incurred on behalf of eligible persons who qualify for plan coverage under Section 7 of this Act shall be recouped by an appropriation made by the General Assembly.~~

c. For the purposes of this Section, a deficit shall be incurred when anticipated losses and incurred but not reported claims expenses exceed anticipated income from earned premiums net of administrative expenses.

d. Any deficit incurred or expected to be incurred on behalf of covered persons ~~federally eligible individuals~~ who qualify for Plan coverage under Section 7 or Section 14.05 ~~15~~ of this Act shall be recouped by an assessment of all insurers made in accordance with the provisions of this Section. The Board shall within 90 days of the effective date of this amendatory Act of 1997 and within the first quarter of each fiscal year thereafter assess all insurers for the anticipated deficit in accordance with the provisions of this Section. The board may also make additional assessments no more than 4 times

a year to fund unanticipated deficits, implementation expenses, and cash flow needs.

e. An insurer's assessment shall be determined by multiplying the total assessment, as determined in subsection d. of this Section, by a fraction, the numerator of which equals that insurer's direct Illinois premiums during the preceding calendar year and the denominator of which equals the total of all insurers' direct Illinois premiums. The Board may exempt those insurers whose share as determined under this subsection would be so minimal as to not exceed the estimated cost of levying the assessment.

f. The Board shall charge and collect from each insurer the amounts determined to be due under this Section. The assessment shall be billed by Board invoice based upon the insurer's direct Illinois premium income as shown in its annual statement for the preceding calendar year as filed with the Director. The invoice shall be due upon receipt and must be paid no later than 30 days after receipt by the insurer.

g. When an insurer fails to pay the full amount of any assessment of $100 or more due under this Section there shall be added to the amount due as a penalty the greater of $50 or an amount equal to 5% of the deficiency for each month or part of a month that the deficiency remains unpaid.

h. Amounts collected under this Section shall be paid to the Board for deposit into the Plan Fund authorized by Section 3 of this Act.

i. An insurer may petition the Director for an abatement or deferment of all or part of an assessment imposed by the Board. The Director may abate or defer, in whole or in part, the assessment if, in the opinion of the Director, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection. The insurer receiving a deferment shall remain liable to the plan for the deficiency for 4 years.

j. The board shall establish procedures for appeal by any insurer subject to assessment pursuant to this Section. Such procedures shall require that:

(1) Any insurer that wishes to appeal all or any part of an assessment made pursuant to this Section shall first pay the amount of the assessment as set forth in the invoice provided by the board within the time provided in subsection f. of this Section. The board shall hold such payments in a separate interest-bearing account. The payments shall be accompanied by a statement in writing that the payment is made under appeal. The statement shall specify the grounds for the appeal. The insurer may be represented in its appeal by counsel or other representative of its choosing.

(2) Within 90 days following the payment of an assessment under appeal by any insurer, the board shall notify the insurer or representative designated by the insurer in writing of its determination with respect to the appeal and the basis or bases for that determination unless the Board notifies the insurer that a reasonable amount of additional time is required to resolve the issues raised by the appeal.

(3) The board shall refer to the Director any question concerning the amount of direct Illinois premium income as shown in an insurer's annual statement for the preceding calendar year on file with the Director on the invoice date of the assessment. Unless additional time is required to resolve the question, the Director shall within 60 days report to the board in writing his determination respecting the amount of direct Illinois premium income on file on the invoice date of the assessment.

(4) In the event the board determines that the insurer is entitled to a refund, the refund shall be paid within 30 days following the date upon which the board makes its determination, together with the accrued interest. Interest on any refund due an insurer shall be paid at the rate actually earned by the Board on the separate account.

(5) The amount of any such refund shall then be assessed against all insurers in a manner consistent with the basis for assessment as otherwise authorized by this

Section.

(6) The board's determination with respect to any appeal received pursuant to this subsection shall be a final administrative decision as defined in Section 3-101 of the Code of Civil Procedure. The provisions of the Administrative Review Law shall apply to and govern all proceedings for the judicial review of final administrative decisions of the board.

(7) If an insurer fails to appeal an assessment in accordance with the provisions of this subsection, the insurer shall be deemed to have waived its right of appeal.

The provisions of this subsection apply to all assessments made in any calendar year ending on or after December 31, 1997. (Source: P.A. 90-30, eff. 7-1-97; 90-567, eff. 1-23-98.)

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