



## 97TH GENERAL ASSEMBLY

### State of Illinois

#### 2011 and 2012

#### SB1313

Introduced 2/8/2011, 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. Makes changes in the provisions concerning findings and definitions. Provides that assessments (instead of appropriated funds) and other revenues collected or received by the Comprehensive Health Insurance Board shall be included in the Comprehensive Health Insurance Plan Fund. Deletes a provision concerning eligibility. Makes changes to the provision concerning deficit or surplus. Effective immediately.

LRB097 06593 RPM 46678 b

FISCAL NOTE ACT  
MAY APPLY

1 AN ACT concerning insurance.

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

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

6 (215 ILCS 105/1.1) (from Ch. 73, par. 1301.1)

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

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

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

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

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

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

15 (215 ILCS 105/2) (from Ch. 73, par. 1302)

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

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

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

23 "Board" means the Illinois Comprehensive Health Insurance  
24 Board.

25 "Church plan" has the same meaning given that term in the

1 federal Health Insurance Portability and Accountability Act of  
2 1996.

3 "Continuation coverage" means continuation of coverage  
4 under a group health plan or other health insurance coverage  
5 for former employees or dependents of former employees that  
6 would otherwise have terminated under the terms of that  
7 coverage pursuant to any continuation provisions under federal  
8 or State law, including the Consolidated Omnibus Budget  
9 Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2,  
10 367e, and 367e.1 of the Illinois Insurance Code, or any other  
11 similar requirement in another State.

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

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

18 (A) A group health plan.

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

21 (C) Medicare.

22 (D) Medical assistance.

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

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

26 (G) A state health benefits risk pool.

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

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

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

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

14          "Creditable coverage" does not include coverage consisting  
15          solely of coverage of excepted benefits, as defined in Section  
16          2791(c) of title XXVII of the Public Health Service Act (42  
17          U.S.C. 300 gg-91), nor does it include any period of coverage  
18          under any of items (A) through (K) that occurred before a break  
19          of more than 90 days or, if the individual has been certified  
20          as eligible pursuant to the federal Trade Act of 2002, a break  
21          of more than 63 days during all of which the individual was not  
22          covered under any of items (A) through (K) above.

23          Any period that an individual is in a waiting period for  
24          any coverage under a group health plan (or for group health  
25          insurance coverage) or is in an affiliation period under the  
26          terms of health insurance coverage offered by a health

1 maintenance organization shall not be taken into account in  
2 determining if there has been a break of more than 90 days in  
3 any creditable coverage.

4 "Department" means the Illinois Department of Insurance.

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

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

1 "Director" means the Director of the Illinois Department of  
2 Insurance.

3 "Effective date of medical assistance" means the date that  
4 eligibility for medical assistance for a person is approved by  
5 the Department of Human Services or the Department of  
6 Healthcare and Family Services, except when the Department of  
7 Human Services or the Department of Healthcare and Family  
8 Services determines eligibility retroactively. In such  
9 circumstances, the effective date of the medical assistance is  
10 the date the Department of Human Services or the Department of  
11 Healthcare and Family Services determines the person to be  
12 eligible for medical assistance.

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

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

24 "Employer" means any individual, partnership, association,  
25 corporation, business trust, or any person or group of persons  
26 acting directly or indirectly in the interest of an employer in

1 relation to an employee, for which one or more persons is  
2 gainfully employed.

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

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

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

22 (2) who is not eligible for coverage under (A) a group  
23 health plan (other than an individual who has been  
24 certified as eligible pursuant to the federal Trade Act of  
25 2002), (B) part A or part B of Medicare due to age (other  
26 than an individual who has been certified as eligible



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

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

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

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

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

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

26          "Group health plan" has the same meaning given that term in

1 the federal Health Insurance Portability and Accountability  
2 Act of 1996.

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

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

25 "Health insurance issuer" means an insurance company,  
26 insurance service, or insurance organization (including a

1 health maintenance organization and a voluntary health  
2 services plan) that is authorized to transact health insurance  
3 business in this State. Such term does not include a group  
4 health plan.

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

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

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

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

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

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

1 Maintenance Organization Act.

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

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

1 "Medical care" means the ordinary and usual professional  
2 services rendered by a physician or other specified provider  
3 during a professional visit for treatment of an illness or  
4 injury.

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

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

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

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

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

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

26 "Provider" means any hospital, skilled nursing facility,

1 hospice, home health agency, physician, registered pharmacist  
2 acting within the scope of that registration, or any other  
3 person or entity licensed in Illinois to furnish medical care.

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

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

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

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

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

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

1 (215 ILCS 105/4) (from Ch. 73, par. 1304)

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

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

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

19 c. Take such legal action as necessary to:

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

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

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

26 (4) to recover or collect any other amounts, including

1 assessments, that are due or owed the Plan or have been  
2 billed on its or the Plan's behalf.

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

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

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

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

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

24 i. Employ and fix the compensation of employees. Such  
25 employees may be paid on a warrant issued by the State  
26 Treasurer pursuant to a payroll voucher certified by the Board



1 and drawn by the Comptroller against appropriations or trust  
2 funds held by the State Treasurer.

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

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

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

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

22 (A) premiums paid on behalf of covered persons;

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

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

1 (D) interest earnings from investment of the funds  
2 in the Plan Fund or any of its accounts other than the  
3 funds in the account established under item 2 of this  
4 subsection;

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

11 (A) premiums paid on behalf of covered persons;

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

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

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

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

20 (3) such other accounts as may be appropriate.

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

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

25 (215 ILCS 105/7) (from Ch. 73, par. 1307)

1           Sec. 7. Eligibility.

2           a. Except as provided in subsection (e) of this Section or  
3 in Section 15 of this Act, any person who is either a citizen  
4 of the United States or an alien lawfully admitted for  
5 permanent residence and who has been for a period of at least  
6 180 days and continues to be a resident of this State shall be  
7 eligible for Plan coverage under this Section if evidence is  
8 provided of:

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

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

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

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

1 demonstrate the existence or history of any medical or health  
2 conditions on the list promulgated by the board shall not be  
3 required to provide the evidence specified in subsection a. of  
4 this Section. The list shall be effective on the first day of  
5 the operation of the Plan and may be amended from time to time  
6 as appropriate.

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

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

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

22 (1) He or she has or obtains other coverage under a  
23 group health plan or health insurance coverage  
24 substantially similar to or better than a Plan policy as an  
25 insured or covered dependent or would be eligible to have  
26 that coverage if he or she elected to obtain it. Persons

1 otherwise eligible for Plan coverage may, however, solely  
2 for the purpose of having coverage for a pre-existing  
3 condition, maintain other coverage only while satisfying  
4 any pre-existing condition waiting period under a Plan  
5 policy or a subsequent replacement policy of a Plan policy.

6 (1.1) His or her prior coverage under a group health  
7 plan or health insurance coverage, provided or arranged by  
8 an employer of more than 10 employees was discontinued for  
9 any reason without the entire group or plan being  
10 discontinued and not replaced, provided he or she remains  
11 an employee, or dependent thereof, of the same employer.

12 (2) He or she is a recipient of or is approved to  
13 receive medical assistance, except that a person may  
14 continue to receive medical assistance through the medical  
15 assistance no grant program, but only while satisfying the  
16 requirements for a preexisting condition under Section 8,  
17 subsection f. of this Act. Payment of premiums pursuant to  
18 this Act shall be allocable to the person's spenddown for  
19 purposes of the medical assistance no grant program, but  
20 that person shall not be eligible for any Plan benefits  
21 while that person remains eligible for medical assistance.  
22 If the person continues to receive or be approved to  
23 receive medical assistance through the medical assistance  
24 no grant program at or after the time that requirements for  
25 a preexisting condition are satisfied, the person shall not  
26 be eligible for coverage under the Plan. In that

1           circumstance, coverage under the plan shall terminate as of  
2           the expiration of the preexisting condition limitation  
3           period. Under all other circumstances, coverage under the  
4           Plan shall automatically terminate as of the effective date  
5           of any medical assistance.

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

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

17          (5) The Plan has paid a total of \$5,000,000 in benefits  
18          on behalf of the covered person.

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

20          (7) The person's premium is paid for or reimbursed  
21          under any government sponsored program or by any government  
22          agency or health care provider, except as an otherwise  
23          qualifying full-time employee, or dependent of such  
24          employee, of a government agency or health care provider  
25          or, except when a person's premium is paid by the U.S.  
26          Treasury Department pursuant to the federal Trade Act of

1           2002.

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

15           (9) Within the 5 years prior to the date a person's  
16 Plan application is received by the Board, the person's  
17 coverage under any health care benefit program as defined  
18 in 18 U.S.C. 24, including any public or private plan or  
19 contract under which any medical benefit, item, or service  
20 is provided, was terminated as a result of any act or  
21 practice that constitutes fraud under State or federal law  
22 or as a result of an intentional misrepresentation of  
23 material fact; or if that person knowingly and willfully  
24 obtained or attempted to obtain, or fraudulently aided or  
25 attempted to aid any other person in obtaining, any  
26 coverage or benefits under the Plan to which that person

1 was not entitled.

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

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

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

19 (Source: P.A. 95-547, eff. 8-29-07; 96-938, eff. 6-24-10.)

20 (215 ILCS 105/12) (from Ch. 73, par. 1312)

21 Sec. 12. Deficit or surplus.

22 a. If premiums or other receipts by the Board exceed the  
23 amount required for the operation of the Plan, including actual  
24 losses and administrative expenses of the Plan, the Board shall  
25 direct that the excess be held at interest, in a bank



1 designated by the Board, or used to offset future losses or to  
2 reduce Plan premiums. In this subsection, the term "future  
3 losses" includes reserves for incurred but not reported claims.

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

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

12 d. Any deficit incurred or expected to be incurred on  
13 behalf of ~~federally~~ eligible persons ~~individuals~~ who qualify  
14 for Plan coverage under Section 7 of this Act and any deficit  
15 incurred or expected to be incurred on behalf of federally  
16 eligible individuals who qualify for Plan coverage under  
17 Section 15 of this Act shall be recouped by an assessment of  
18 all insurers made in accordance with the provisions of this  
19 Section. The Board shall ~~within 90 days of the effective date~~  
20 ~~of this amendatory Act of 1997 and~~ within the first quarter of  
21 each fiscal year ~~thereafter~~ assess all insurers for the  
22 anticipated deficit in accordance with the provisions of this  
23 Section. The Board ~~board~~ may also make additional assessments  
24 no more than 4 times a year to fund unanticipated deficits,  
25 implementation expenses, and cash flow needs.

26 e. An insurer's assessment shall be determined by

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

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

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

21 h. Amounts collected under this Section shall be paid to  
22 the Board for deposit into the Plan Fund authorized by Section  
23 3 of this Act.

24 i. An insurer may petition the Director for an abatement or  
25 deferment of all or part of an assessment imposed by the Board.  
26 The Director may abate or defer, in whole or in part, the

1 assessment if, in the opinion of the Director, payment of the  
2 assessment would endanger the ability of the insurer to fulfill  
3 its contractual obligations. In the event an assessment against  
4 an insurer is abated or deferred in whole or in part, the  
5 amount by which the assessment is abated or deferred shall be  
6 assessed against the other insurers in a manner consistent with  
7 the basis for assessments set forth in this subsection. The  
8 insurer receiving a deferment shall remain liable to the plan  
9 for the deficiency for 4 years.

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

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

24 (2) Within 90 days following the payment of an  
25 assessment under appeal by any insurer, the board shall  
26 notify the insurer or representative designated by the

1 insurer in writing of its determination with respect to the  
2 appeal and the basis or bases for that determination unless  
3 the Board notifies the insurer that a reasonable amount of  
4 additional time is required to resolve the issues raised by  
5 the appeal.

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

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

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

25 (6) The board's determination with respect to any  
26 appeal received pursuant to this subsection shall be a

1 final administrative decision as defined in Section 3-101  
2 of the Code of Civil Procedure. The provisions of the  
3 Administrative Review Law shall apply to and govern all  
4 proceedings for the judicial review of final  
5 administrative decisions of the board.

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

9 The provisions of this subsection apply to all assessments  
10 made in any calendar year ending on or after December 31, 1997.

11 k. An insurer shall not pass through to its insureds or  
12 members any portion of an assessment made in accordance with  
13 the provisions of this Section.

14 (Source: P.A. 90-30, eff. 7-1-97; 90-567, eff. 1-23-98.)

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