Rep. Thaddeus Jones

Filed: 4/20/2021

AMENDMENT TO HOUSE BILL 1471

AMENDMENT NO. _____. Amend House Bill 1471 by replacing everything after the enacting clause with the following:

"Section 5. The Department of Insurance Law of the Civil Administrative Code of Illinois is amended by adding Section 1405-40 as follows:

(20 ILCS 1405/1405-40 new)

Sec. 1405-40. Transfer of the Illinois Comprehensive Health Insurance Plan. Upon entry of an Order of Rehabilitation or Liquidation against the Comprehensive Health Insurance Plan in accordance with Article XIII of the Illinois Insurance Code, all powers, duties, rights, and responsibilities of the Illinois Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board under the Comprehensive Health Insurance Plan Act shall be transferred to and vested in the Director of Insurance as

rehabilitator or liquidator as provided in the provisions of this amendatory Act of the 102nd General Assembly.

Section 10. The Comprehensive Health Insurance Plan Act is amended by changing Sections 1.1, 3, and 15 and by adding Sections 16 and 17 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 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.

With the implementation of the federal Patient Protection and Affordable Care Act, the Plan shall discontinue as the alternative market for health insurance for certain Illinois residents and discontinue as the alternative mechanism, as described in the federal Health Insurance Portability and Accountability Act of 1996, effective no later than January 1, 2022.

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

(215 ILCS 105/3) (from Ch. 73, par. 1303)

Sec. 3. Operation of the Plan.

a. There is hereby created an Illinois Comprehensive Health Insurance Plan.

b. The Plan shall operate subject to the supervision and control of the Board. The Board is created as a political subdivision and body politic and corporate and, as such, is not a State agency. The Board shall consist of 10 public members, appointed by the Governor with the advice and consent of the Senate.

Initial members shall be appointed to the Board by the Governor as follows: 2 members to serve until July 1, 1988, and until their successors are appointed and qualified; 2 members to serve until July 1, 1989, and until their successors are appointed and qualified; 3 members to serve until July 1, 1990, and until their successors are appointed and qualified; and 3 members to serve until July 1, 1991, and until their successors are appointed and qualified. As terms of initial members expire, their successors shall be appointed for terms to expire the first day in July 3 years thereafter, and until their successors are appointed and qualified.

Any vacancy in the Board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.

Any member of the Board may be removed by the Governor for neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

In addition, a representative of the Governor's Office of Management and Budget, a representative of the Office of the Attorney General and the Director or the Director's designated

representative shall be members of the Board. Four members of the General Assembly, one each appointed by the President and Minority Leader of the Senate and by the Speaker and Minority Leader of the House of Representatives, shall serve as nonvoting members of the Board. At least 2 of the public members shall be individuals reasonably expected to qualify for coverage under the Plan, the parent or spouse of such an individual, or a surviving family member of an individual who could have qualified for the Plan during his lifetime. The Director or Director's representative shall be the chairperson of the Board. Members of the Board shall receive no compensation, but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

c. The Board shall make an annual report in September and shall file the report with the Secretary of the Senate and the Clerk of the House of Representatives. The report shall summarize the activities of the Plan in the preceding calendar year, including net written and earned premiums, the expense of administration, the paid and incurred losses for the year and other information as may be requested by the General Assembly. The report shall also include analysis and recommendations regarding utilization review, quality assurance and access to cost effective quality health care.

d. In its plan of operation the Board shall:

(1) Establish procedures for selecting a Plan administrator in accordance with Section 5 of this Act.

(2) Establish procedures for the operation of the Board.

(3) Create a Plan fund, under management of the Board, to fund administrative, claim, and other expenses of the Plan.

(4) Establish procedures for the handling and accounting of assets and monies of the Plan.

(5) Develop and implement a program to publicize the existence of the Plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the Plan.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board. The grievances shall be reported to the Board immediately after completion of the review. The Department and the Board shall retain all written complaints regarding the Plan for at least 3 years. Oral complaints shall be reduced to written form and maintained for at least 3 years.

(7) Provide for other matters as may be necessary and proper for the execution of its powers, duties and obligations under the Plan.

e. No later than 5 years after the Plan is operative the Board and the Department shall conduct cooperatively a study of the Plan and the persons insured by the Plan to determine: (1) claims experience including a breakdown of medical

conditions for which claims were paid; (2) whether availability of the Plan affected employment opportunities for participants; (3) whether availability of the Plan affected the receipt of medical assistance benefits by Plan participants; (4) whether a change occurred in the number of personal bankruptcies due to medical or other health related costs; (5) data regarding all complaints received about the Plan including its operation and services; (6) and any other significant observations regarding utilization of the Plan. The study shall culminate in a written report to be presented to the Governor, the President of the Senate, the Speaker of the House and the chairpersons of the House and Senate Insurance Committees. The report shall be filed with the Secretary of the Senate and the Clerk of the House of Representatives. The report shall also be available to members of the general public upon request.

(e-5) The Board shall conduct a feasibility study of establishing a small employer health insurance pool in which employers may provide affordable health insurance coverage to their employees. The Board may contract with a private entity or enter into intergovernmental agreements with State agencies for the completion of all or part of the study. The study shall:

(i) Analyze other states' experience in establishing small employer health insurance pools;

(ii) Assess the need for a small employer health

insurance pool, including the number of individuals who might benefit from it;

(iii) Recommend means of establishing a small employer health insurance pool; and

(iv) Estimate the cost of providing a small employer health insurance pool through the Illinois Comprehensive Health Insurance Plan or another, public or private entity.

The Board may accept donations, in trust, from any legal source, public or private, for deposit into a trust account specifically created for expenditure, without the necessity of being appropriated, solely for the purpose of conducting all or part of the study. The Board shall issue a report with recommendations to the Governor and the General Assembly by January 1, 2005. As used in this subsection e-5, "small employer" means an employer having between one and 50 employees.

f. The Board may:

(1) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public in this State.

(2) Provide for reinsurance of risks incurred by the Plan and enter into reinsurance agreements with insurers to establish a reinsurance plan for risks of coverage described in the Plan, or obtain commercial reinsurance to reduce the risk of loss through the Plan.

(3) Issue additional types of health insurance policies to provide optional coverages as are otherwise permitted by this Act including a Medicare supplement policy designed to supplement Medicare.

(4) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission certification, second surgical opinion, concurrent utilization review programs, and individual case management for the purpose of making the pool more cost effective.

(5) Design, utilize, contract, or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(6) Adopt bylaws, rules, regulations, policies and procedures as may be necessary or convenient for the implementation of the Act and the operation of the Plan.

(7) Administer separate pools, separate accounts, or other plans or arrangements as required by this Act to separate federally eligible individuals or groups of federally eligible individuals who qualify for Plan coverage under Section 15 of this Act from eligible persons or groups of eligible persons who qualify for Plan coverage under Section 7 of this Act and apportion the costs of the administration among such separate pools,

separate accounts, or other plans or arrangements.

g. The Director may, by rule, establish additional powers and duties of the Board and may adopt rules for any other purposes, including the operation of the Plan, as are necessary or proper to implement this Act.

h. The Board is not liable for any obligation of the Plan. There is no liability on the part of any member or employee of the Board, ~~or~~ the Department, or the Director, both as regulator and as rehabilitator or liquidator, and no cause of action of any nature may arise against them, for any action taken or omission made by them in the performance of their powers and duties under this Act, unless the action or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

i. There is no liability on the part of any insurance producer for the failure of any applicant to be accepted by the Plan unless the failure of the applicant to be accepted by the Plan is due to an act or omission by the insurance producer which constitutes willful or wanton misconduct.

j. Not later than 60 days after the effective date of this amendatory Act of the 102nd General Assembly, the Board shall develop a plan of rehabilitation or liquidation and dissolution, including the consent of a majority of the Board to the entry of an order of rehabilitation or liquidation, to wind down the affairs of the Plan, including details for the

transition to other health plans of any persons currently enrolled in the Plan, for presentation to and approval by the Director. Upon the Director's approval of the plan of rehabilitation or liquidation and dissolution, the Director shall thereafter report to the Attorney General of this State, whose duty it shall be to file a complaint for rehabilitation or liquidation of the Plan pursuant to the provisions of Article XIII of the Illinois Insurance Code. Upon entry of a final Order of Rehabilitation or Liquidation and the Director's appointment as statutory rehabilitator or liquidator, the Director shall begin to administer and oversee the wind-down and dissolution of the Plan in accordance with the provisions of Article XIII.

(Source: P.A. 92-597, eff. 6-28-02; 93-622, eff. 12-18-03; 93-824, eff. 7-28-04.)

(215 ILCS 105/15)

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

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

Section.

A federally eligible person who has been certified as eligible pursuant to the federal Trade Act of 2002 and whose Plan application and enclosures and supporting documentation as the Board may require is received by the Board within 63 days after the termination of previous creditable coverage shall qualify to enroll in the Plan under the portability provisions of this Section.

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

(c) Except as otherwise provided in this Section, a period of creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 90-day period during all of which the individual was not covered under any creditable coverage.

For a federally eligible person who has been certified as eligible pursuant to the federal Trade Act of 2002, a period of

creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 63-day period during all of which the individual was not covered under any creditable coverage.

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

(e) The Board shall offer a choice of health care coverages consistent with major medical coverage under the alternative health benefit plans authorized by this Section to every federally eligible individual. The coverages to be offered under the plans, the schedule of benefits, deductibles, co-payments, exclusions, and other limitations shall be approved by the Board. One optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this State or a standard option of coverage available under the group or individual health insurance laws of the State. The standard benefit plan that is authorized by Section 8 of this Act may be used for this purpose. The Board may also offer a preferred provider

option and such other options as the Board determines may be appropriate for these federally eligible individuals who qualify for Plan coverage pursuant to this Section.

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

(g) Federally eligible individuals who qualify and enroll in the Plan pursuant to this Section shall be required to pay such premium rates as the Board shall establish and approve in accordance with the requirements of Section 7.1 of this Act.

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

(i) New enrollment and policy renewals are discontinued on December 31, 2021.

(Source: P.A. 100-201, eff. 8-18-17.)

(215 ILCS 105/16 new)

Sec. 16. Cessation of operations.

(a) Except as otherwise provided in this Section, the insurance operations of the Plan authorized by this Act shall cease on December 31, 2021.

(b) Coverage under the Plan does not apply to services provided on or after January 1, 2022.

(c) The Plan shall cease providing coverage for participants enrolled prior to January 1, 2022 at 11:59 p.m. on December 31, 2021.

(d) A claim for payment under the Plan must be submitted within 180 days after January 1, 2022 and paid in accordance with the provisions of Article XIII of the Illinois Insurance Code.

(e) Any claim or grievance shall be resolved by the court supervising the Plan's Article XIII rehabilitation or liquidation proceedings.

(f) Balance billing by a health care provider that is not a member of the provider network used by the Plan is prohibited.

(g) The Board shall, not later than 60 days after the effective date of this amendatory Act of the 102nd General Assembly, submit to the Director a plan of rehabilitation or liquidation and dissolution, which must provide for, but shall not be limited to, the following:

(1) continuity of care for an individual who is covered under the Plan and is an inpatient on January 1, 2022;

(2) a final accounting of assessments;

(3) resolution of any net asset deficiency;

(4) cessation of all liability of the Plan; and

(5) final dissolution of the Plan.

(h) The plan of rehabilitation or liquidation and dissolution may provide that, with the approval of the Director, a power or duty of the Plan may be delegated to a person that is to perform functions similar to the functions of the Plan.

(i) Upon entry of an Order of Rehabilitation or Liquidation against the Plan, the court supervising the rehabilitation or liquidation proceedings shall have the jurisdiction to issue injunctions as set forth in Section 189 of the Illinois Insurance Code, including, but not limited to, the restraining of all persons, companies, and entities from bringing or further prosecuting all actions and proceedings at law or in equity or otherwise, whether in this State or elsewhere, against the Plan or its assets or property or the Director except insofar as those actions or proceedings arise in or are brought in the rehabilitation or liquidation proceedings.

(j) Upon the entry of an order of rehabilitation or liquidation, the rights and liabilities of the Plan and of its policyholders and all other persons interested in its assets shall be fixed as of the date of entry of the order directing rehabilitation or liquidation, or such later date as may be provided by order of the court supervising the rehabilitation

or liquidation proceedings.

(k) Upon the satisfaction of all claims allowed in the rehabilitation or liquidation proceedings, including the costs and expenses of administering the rehabilitation or liquidation, any remaining funds shall be distributed as follows:

(1) for the accounts described in paragraph (2) of subsection (l) of Section 4, all funds shall be refunded on a pro rata basis to the insurers that were assessed based on the most recent deficit projections of the Plan's operation pursuant to Section 12 and to covered persons where appropriate; and

(2) for all other accounts, all remaining funds shall be released and deposited into the Insurance Producer Administration Fund for use by the Department for initiatives to support the Illinois Health Benefits Exchange.

(l) Upon the entry of an Order of Rehabilitation or Liquidation against the Plan, if the Director determines the Plan is holding any surplus funds in a segregated account associated with persons who qualified for coverage under Section 7 that are no longer required for the purposes for which they were acquired and are restricted from any other use, the Director may petition the court for such funds to be released and placed as follows:

(1) the first $10,000,000 shall be deposited into the

Insurance Producer Administration Fund for use by the Department for initiatives to support the Illinois Health Benefits Exchange; and

(2) the remainder shall be deposited into the Parity Advancement Fund.

(215 ILCS 105/17 new)

Sec. 17. Transfer of the Illinois Comprehensive Health Insurance Plan.

(a) Upon entry of an Order of Rehabilitation or Liquidation against the Plan all powers, duties, rights, and responsibilities of the Plan and the Board shall be transferred to and vested in the Director, as rehabilitator or liquidator, who is authorized to wind down the affairs of the Plan in accordance with Article XIII of the Illinois Insurance Code.

(b) The Director, as rehabilitator or liquidator, shall act on behalf of the Plan and the Board and shall have the power and duty to receive and answer correspondence, and shall evaluate all claims that are timely filed in the rehabilitation or liquidation proceedings and is authorized to make distribution from any unencumbered funds of the Plan's rehabilitation or liquidation estate upon all such claims as are allowed in the proceedings consistent with subsection (1) of Section 205 of the Illinois Insurance Code. Timely filed claims of vendors allowed in the rehabilitation or liquidation

proceedings that are not capable of being discharged, in full, from the assets of the rehabilitation or liquidation estate may be presented to the Court of Claims.

(c) All books, records, papers, documents, property (real and personal), contracts, causes of action, and pending business pertaining to the powers, duties, rights, and responsibilities transferred by this amendatory Act of the 102nd General Assembly from the Plan and the Board to the Director, as rehabilitator or liquidator, including, but not limited to, material in electronic or magnetic format and necessary computer hardware and software, shall be transferred to the Director, as rehabilitator or liquidator. Records shall be maintained as required by the federal Health Insurance Portability and Accountability Act of 1996, as now or hereafter amended, unless otherwise ordered by the court supervising the rehabilitation or liquidation proceedings.

(d) The rights of the employees in the State of Illinois and its agencies under the Personnel Code and applicable collective bargaining agreements or under any pension, retirement, or annuity plan shall not be affected by this amendatory Act of the 102nd General Assembly.

(e) Upon entry of an Order of Rehabilitation or Liquidation against the Plan, all unexpended appropriations and balances and other funds available for use by the Plan and the Board shall be transferred to and vested in the Director, as rehabilitator or liquidator. Except as provided in

subsection (l) of Section 16, unexpended balances so transferred shall be distributed in accordance with Article XIII of the Illinois Insurance Code for paying the Director's administrative expenses incurred in connection with winding down the affairs of the Plan.

(f) Whenever reports or notices are, on the effective date of this amendatory Act of the 102nd General Assembly, required to be made or given or papers or documents furnished or served by any person to or upon the Plan or the Board in connection with any of the powers, duties, rights, and responsibilities transferred by this amendatory Act of the 102nd General Assembly, the same shall be made, given, furnished, or served in the same manner to or upon the Director, as rehabilitator or liquidator.

(g) This amendatory Act of the 102nd General Assembly does not affect any act done, ratified, or canceled or any right occurring or established or any action or proceeding had or commenced in the administrative, civil, or criminal cause by the Plan or the Board prior to the entry of an Order of Rehabilitation or Liquidation against the Plan; such actions or proceedings may be prosecuted and continued by the Director, as rehabilitator or liquidator.

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