1 AMENDMENT TO HOUSE BILL 3298

2 AMENDMENT NO. _____. Amend House Bill 3298 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Comprehensive Health Insurance Plan Act
5 is amended by changing Sections 2, 4, 7, and 15 as follows:

6 (215 ILCS 105/2) (from Ch. 73, par. 1302)
7 Sec. 2. Definitions. As used in this Act, unless the
8 context otherwise requires:
9 "Plan administrator" means the insurer or third party
10 administrator designated under Section 5 of this Act.
11 "Benefits plan" means the coverage to be offered by the
12 Plan to eligible persons and federally eligible individuals
13 pursuant to this Act.
14 "Board" means the Illinois Comprehensive Health Insurance
15 Board.
16 "Church plan" has the same meaning given that term in the
17 federal Health Insurance Portability and Accountability Act
18 of 1996.
19 "Continuation coverage" means continuation of coverage
20 under a group health plan or other health insurance coverage
21 for former employees or dependents of former employees that
22 would otherwise have terminated under the terms of that

1 coverage pursuant to any continuation provisions under
2 federal or State law, including the Consolidated Omnibus
3 Budget Reconciliation Act of 1985 (COBRA), as amended,
4 Sections 367.2 and 367e of the Illinois Insurance Code, or
5 any other similar requirement in another State.
6 "Covered person" means a person who is and continues to
7 remain eligible for Plan coverage and is covered under one of
8 the benefit plans offered by the Plan.
9 "Creditable coverage" means, with respect to a federally
10 eligible individual, coverage of the individual under any of
11 the following:
12 (A) A group health plan.
13 (B) Health insurance coverage (including group
14 health insurance coverage).
15 (C) Medicare.
16 (D) Medical assistance.
17 (E) Chapter 55 of title 10, United States Code.
18 (F) A medical care program of the Indian Health
19 Service or of a tribal organization.
20 (G) A state health benefits risk pool.
21 (H) A health plan offered under Chapter 89 of title
22 5, United States Code.
23 (I) A public health plan (as defined in regulations
24 consistent with Section 104 of the Health Care
25 Portability and Accountability Act of 1996 that may be
26 promulgated by the Secretary of the U.S. Department of
27 Health and Human Services).
28 (J) A health benefit plan under Section 5(e) of the
29 Peace Corps Act (22 U.S.C. 2504(e)).
30 (K) Any other qualifying coverage required by the
31 federal Health Insurance Portability and Accountability
32 Act of 1996, as it may be amended, or regulations under
33 that Act.
34 "Creditable coverage" does not include coverage

1 consisting solely of coverage of excepted benefits, as
2 defined in Section 2791(c) of title XXVII of the Public
3 Health Service Act (42 U.S.C. 300 gg-91), nor does it include
4 any period of coverage under any of items (A) through (K)
5 that occurred before a break of more than 90 days or, if the
6 individual has been certified as an eligible person pursuant
7 to the federal Trade Adjustment Act of 2002, a break of more
8 than 63 days during all of which the individual was not
9 covered under any of items (A) through (K) above. Any period
10 that an individual is in a waiting period for any coverage
11 under a group health plan (or for group health insurance
12 coverage) or is in an affiliation period under the terms of
13 health insurance coverage offered by a health maintenance
14 organization shall not be taken into account in determining
15 if there has been a break of more than 90 days in any
16 creditable coverage.
17 "Department" means the Illinois Department of Insurance.
18 "Dependent" means an Illinois resident: who is a spouse;
19 or who is claimed as a dependent by the principal insured for
20 purposes of filing a federal income tax return and resides in
21 the principal insured's household, and is a resident
22 unmarried child under the age of 19 years; or who is an
23 unmarried child who also is a full-time student under the age
24 of 23 years and who is financially dependent upon the
25 principal insured; or who is a child of any age and who is
26 disabled and financially dependent upon the principal
27 insured.
28 "Direct Illinois premiums" means, for Illinois business,
29 an insurer's direct premium income for the kinds of business
30 described in clause (b) of Class 1 or clause (a) of Class 2
31 of Section 4 of the Illinois Insurance Code, and direct
32 premium income of a health maintenance organization or a
33 voluntary health services plan, except it shall not include
34 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.

"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 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 an eligible person pursuant to the federal Trade Adjustment 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, (B) part A or part B of Medicare due to age, or (C) medical assistance, and does not have other health insurance coverage;

(3) with respect to whom 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 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.

"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

1 an insurer, non-profit health care service plan contract,
2 health maintenance organization or other subscriber contract,
3 or any other health care plan or arrangement that pays for or
4 furnishes medical or health care services whether by
5 insurance or otherwise. Health insurance coverage shall not
6 include short term, accident only, disability income,
7 hospital confinement or fixed indemnity, dental only, vision
8 only, limited benefit, or credit insurance, coverage issued
9 as a supplement to liability insurance, insurance arising out
10 of a workers' compensation or similar law, automobile
11 medical-payment insurance, or insurance under which benefits
12 are payable with or without regard to fault and which is
13 statutorily required to be contained in any liability
14 insurance policy or equivalent self-insurance.
15 "Health insurance issuer" means an insurance company,
16 insurance service, or insurance organization (including a
17 health maintenance organization and a voluntary health
18 services plan) that is authorized to transact health
19 insurance business in this State. Such term does not include
20 a group health plan.
21 "Health Maintenance Organization" means an organization
22 as defined in the Health Maintenance Organization Act.
23 "Hospice" means a program as defined in and licensed
24 under the Hospice Program Licensing Act.
25 "Hospital" means a duly licensed institution as defined
26 in the Hospital Licensing Act, an institution that meets all
27 comparable conditions and requirements in effect in the state
28 in which it is located, or the University of Illinois
29 Hospital as defined in the University of Illinois Hospital
30 Act.
31 "Individual health insurance coverage" means health
32 insurance coverage offered to individuals in the individual
33 market, but does not include short-term, limited-duration
34 insurance.

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

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

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

18 "Medically necessary" means that a service, drug, or
19 supply is necessary and appropriate for the diagnosis or
20 treatment of an illness or injury in accord with generally
21 accepted standards of medical practice at the time the
22 service, drug, or supply is provided. When specifically
23 applied to a confinement it further means that the diagnosis
24 or treatment of the covered person's medical symptoms or
25 condition cannot be safely provided to that person as an
26 outpatient. A service, drug, or supply shall not be medically
27 necessary if it: (i) is investigational, experimental, or for
28 research purposes; or (ii) is provided solely for the
29 convenience of the patient, the patient's family, physician,
30 hospital, or any other provider; or (iii) exceeds in scope,
31 duration, or intensity that level of care that is needed to
32 provide safe, adequate, and appropriate diagnosis or
33 treatment; or (iv) could have been omitted without adversely
34 affecting the covered person's condition or the quality of

1 medical care; or (v) involves the use of a medical device,
2 drug, or substance not formally approved by the United States
3 Food and Drug Administration.
4 "Medical care" means the ordinary and usual professional
5 services rendered by a physician or other specified provider
6 during a professional visit for treatment of an illness or
7 injury.
8 "Medicare" means coverage under both Part A and Part B of
9 Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395,
10 et seq.
11 "Minimum premium plan" means an arrangement whereby a
12 specified amount of health care claims is self-funded, but
13 the insurance company assumes the risk that claims will
14 exceed that amount.
15 "Participating transplant center" means a hospital
16 designated by the Board as a preferred or exclusive provider
17 of services for one or more specified human organ or tissue
18 transplants for which the hospital has signed an agreement
19 with the Board to accept a transplant payment allowance for
20 all expenses related to the transplant during a transplant
21 benefit period.
22 "Physician" means a person licensed to practice medicine
23 pursuant to the Medical Practice Act of 1987.
24 "Plan" means the Comprehensive Health Insurance Plan
25 established by this Act.
26 "Plan of operation" means the plan of operation of the
27 Plan, including articles, bylaws and operating rules, adopted
28 by the board pursuant to this Act.
29 "Provider" means any hospital, skilled nursing facility,
30 hospice, home health agency, physician, registered pharmacist
31 acting within the scope of that registration, or any other
32 person or entity licensed in Illinois to furnish medical
33 care.
34 "Qualified high risk pool" has the same meaning given

1 that term in the federal Health Insurance Portability and
2 Accountability Act of 1996.
3 "Resident" means a person who is and continues to be
4 legally domiciled and physically residing on a permanent and
5 full-time basis in a place of permanent habitation in this
6 State that remains that person's principal residence and from
7 which that person is absent only for temporary or transitory
8 purpose.
9 "Skilled nursing facility" means a facility or that
10 portion of a facility that is licensed by the Illinois
11 Department of Public Health under the Nursing Home Care Act
12 or a comparable licensing authority in another state to
13 provide skilled nursing care.
14 "Stop-loss coverage" means an arrangement whereby an
15 insurer insures against the risk that any one claim will
16 exceed a specific dollar amount or that the entire loss of a
17 self-insurance plan will exceed a specific amount.
18 "Third party administrator" means an administrator as
19 defined in Section 511.101 of the Illinois Insurance Code who
20 is licensed under Article XXXI 1/4 of that Code.
21 (Source: P.A. 91-357, eff. 7-29-99; 91-735, eff. 6-2-00;
22 92-153, eff. 7-25-01.)

23 (215 ILCS 105/4) (from Ch. 73, par. 1304)
24 Sec. 4. Powers and authority of the board. The board
25 shall have the general powers and authority granted under the
26 laws of this State to insurance companies licensed to
27 transact health and accident insurance and in addition
28 thereto, the specific authority to:
29 a. Enter into contracts as are necessary or proper to
30 carry out the provisions and purposes of this Act, including
31 the authority, with the approval of the Director, to enter
32 into contracts with similar plans of other states for the
33 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

1 legal investments for insurers and may be carried as admitted
2 assets.
3 h. Establish rules, conditions and procedures for
4 reinsuring risks under this Act.
5 i. Employ and fix the compensation of employees. Such
6 employees may be paid on a warrant issued by the State
7 Treasurer pursuant to a payroll voucher certified by the
8 Board and drawn by the Comptroller against appropriations or
9 trust funds held by the State Treasurer.
10 j. Enter into intergovernmental cooperation agreements
11 with other agencies or entities of State government for the
12 purpose of sharing the cost of providing health care services
13 that are otherwise authorized by this Act for children who
14 are both plan participants and eligible for financial
15 assistance from the Division of Specialized Care for Children
16 of the University of Illinois.
17 k. Establish conditions and procedures under which the
18 plan may, if funds permit, discount or subsidize premium
19 rates that are paid directly by senior citizens, as defined
20 by the Board, and other plan participants, who are retired or
21 unemployed and meet other qualifications.
22 l. Establish and maintain the Plan Fund authorized in
23 Section 3 of this Act, which shall be divided into separate
24 accounts, as follows:
25 (1) accounts to fund the administrative, claim, and
26 other expenses of the Plan associated with eligible
27 persons who qualify for Plan coverage under Section 7 of
28 this Act, which shall consist of:
29 (A) premiums paid on behalf of covered
30 persons;
31 (B) appropriated funds and other revenues
32 collected or received by the Board;
33 (C) reserves for future losses maintained by
34 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 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 Adjustment 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. 90-30, eff. 7-1-97; 91-357, eff. 7-29-99.)

(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 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

1 evidence is provided of:
2 (1) A notice of rejection or refusal to issue
3 substantially similar individual health insurance
4 coverage for health reasons by a health insurance issuer;
5 or
6 (2) A refusal by a health insurance issuer to issue
7 individual health insurance coverage except at a rate
8 exceeding the applicable Plan rate for which the person
9 is responsible.
10 A rejection or refusal by a group health plan or health
11 insurance issuer offering only stop-loss or excess of loss
12 insurance or contracts, agreements, or other arrangements for
13 reinsurance coverage with respect to the applicant shall not
14 be sufficient evidence under this subsection.
15 b. The board shall promulgate a list of medical or
16 health conditions for which a person who is either a citizen
17 of the United States or an alien lawfully admitted for
18 permanent residence and a resident of this State would be
19 eligible for Plan coverage without applying for health
20 insurance coverage pursuant to subsection a. of this Section.
21 Persons who can demonstrate the existence or history of any
22 medical or health conditions on the list promulgated by the
23 board shall not be required to provide the evidence specified
24 in subsection a. of this Section. The list shall be
25 effective on the first day of the operation of the Plan and
26 may be amended from time to time as appropriate.
27 c. Family members of the same household who each are
28 covered persons are eligible for optional family coverage
29 under the Plan.
30 d. For persons qualifying for coverage in accordance
31 with Section 7 of this Act, the board shall, if it determines
32 that such appropriations as are made pursuant to Section 12
33 of this Act are insufficient to allow the board to accept all
34 of the eligible persons which it projects will apply for

1 enrollment under the Plan, limit or close enrollment to
2 ensure that the Plan is not over-subscribed and that it has
3 sufficient resources to meet its obligations to existing
4 enrollees. The board shall not limit or close enrollment for
5 federally eligible individuals.
6 e. A person shall not be eligible for coverage under the
7 Plan if:
8 (1) He or she has or obtains other coverage under a
9 group health plan or health insurance coverage
10 substantially similar to or better than a Plan policy as
11 an insured or covered dependent or would be eligible to
12 have that coverage if he or she elected to obtain it.
13 Persons otherwise eligible for Plan coverage may,
14 however, solely for the purpose of having coverage for a
15 pre-existing condition, maintain other coverage only
16 while satisfying any pre-existing condition waiting
17 period under a Plan policy or a subsequent replacement
18 policy of a Plan policy.
19 (1.1) His or her prior coverage under a group
20 health plan or health insurance coverage, provided or
21 arranged by an employer of more than 10 employees was
22 discontinued for any reason without the entire group or
23 plan being discontinued and not replaced, provided he or
24 she remains an employee, or dependent thereof, of the
25 same employer.
26 (2) He or she is a recipient of or is approved to
27 receive medical assistance, except that a person may
28 continue to receive medical assistance through the
29 medical assistance no grant program, but only while
30 satisfying the requirements for a preexisting condition
31 under Section 8, subsection f. of this Act. Payment of
32 premiums pursuant to this Act shall be allocable to the
33 person's spenddown for purposes of the medical assistance
34 no grant program, but that person shall not be eligible

1 for any Plan benefits while that person remains eligible
2 for medical assistance. If the person continues to
3 receive or be approved to receive medical assistance
4 through the medical assistance no grant program at or
5 after the time that requirements for a preexisting
6 condition are satisfied, the person shall not be eligible
7 for coverage under the Plan. In that circumstance,
8 coverage under the plan shall terminate as of the
9 expiration of the preexisting condition limitation
10 period. Under all other circumstances, coverage under
11 the Plan shall automatically terminate as of the
12 effective date of any medical assistance.
13 (3) Except as provided in Section 15, the person
14 has previously participated in the Plan and voluntarily
15 terminated Plan coverage, unless 12 months have elapsed
16 since the person's latest voluntary termination of
17 coverage.
18 (4) The person fails to pay the required premium
19 under the covered person's terms of enrollment and
20 participation, in which event the liability of the Plan
21 shall be limited to benefits incurred under the Plan for
22 the time period for which premiums had been paid and the
23 covered person remained eligible for Plan coverage.
24 (5) The Plan has paid a total of $1,000,000 in
25 benefits on behalf of the covered person.
26 (6) The person is a resident of a public
27 institution.
28 (7) The person's premium is paid for or reimbursed
29 under any government sponsored program or by any
30 government agency or health care provider, except as an
31 otherwise qualifying full-time employee, or dependent of
32 such employee, of a government agency or health care
33 provider or, except when a person's premium is paid by
34 the U.S. Treasury Department pursuant to the federal

1 Trade Adjustment Act of 2002.
2 (8) The person has or later receives other benefits
3 or funds from any settlement, judgement, or award
4 resulting from any accident or injury, regardless of the
5 date of the accident or injury, or any other
6 circumstances creating a legal liability for damages due
7 that person by a third party, whether the settlement,
8 judgment, or award is in the form of a contract,
9 agreement, or trust on behalf of a minor or otherwise and
10 whether the settlement, judgment, or award is payable to
11 the person, his or her dependent, estate, personal
12 representative, or guardian in a lump sum or over time,
13 so long as there continues to be benefits or assets
14 remaining from those sources in an amount in excess of
15 $100,000.
16 (9) Within the 5 years prior to the date a person's
17 Plan application is received by the Board, the person's
18 coverage under any health care benefit program as defined
19 in 18 U.S.C. 24, including any public or private plan or
20 contract under which any medical benefit, item, or
21 service is provided, was terminated as a result of any
22 act or practice that constitutes fraud under State or
23 federal law or as a result of an intentional
24 misrepresentation of material fact; or if that person
25 knowingly and willfully obtained or attempted to obtain,
26 or fraudulently aided or attempted to aid any other
27 person in obtaining, any coverage or benefits under the
28 Plan to which that person was not entitled.
29 f. The board or the administrator shall require
30 verification of residency and may require any additional
31 information or documentation, or statements under oath, when
32 necessary to determine residency upon initial application and
33 for the entire term of the policy.
34 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. 90-30, eff. 7-1-97; 91-639, eff. 8-20-99; 91-735, eff. 6-2-00.)

(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 an eligible person pursuant to the federal Trade Adjustment 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

1 application evidence, including acceptable written
2 certification of previous creditable coverage, that will
3 establish to the Board's satisfaction, that he or she meets
4 all of the requirements to be a federally eligible individual
5 and is currently and permanently residing in this State (as
6 of the date his or her application was received by the
7 Board).
8 (c) Except as otherwise provided in this Section, a
9 period of creditable coverage shall not be counted, with
10 respect to qualifying an applicant for Plan coverage as a
11 federally eligible individual under this Section, if after
12 such period and before the application for Plan coverage was
13 received by the Board, there was at least a 90 day period
14 during all of which the individual was not covered under any
15 creditable coverage. For a federally eligible person who has
16 been certified as an eligible person pursuant to the federal
17 Trade Adjustment Act of 2002, a period of creditable coverage
18 shall not be counted, with respect to qualifying an applicant
19 for Plan coverage as a federally eligible individual under
20 this Section, if after such period and before the application
21 for Plan coverage was received by the Board, there was at
22 least a 63 day period during all of which the individual was
23 not covered under any creditable coverage.
24 (d) Any federally eligible individual who the Board
25 determines qualifies for Plan coverage under this Section
26 shall be offered his or her choice of enrolling in one of
27 alternative portability health benefit plans which the Board
28 is authorized under this Section to establish for these
29 federally eligible individuals and their dependents.
30 (e) The Board shall offer a choice of health care
31 coverages consistent with major medical coverage under the
32 alternative health benefit plans authorized by this Section
33 to every federally eligible individual. The coverages to be
34 offered under the plans, the schedule of benefits,

1 deductibles, co-payments, exclusions, and other limitations
2 shall be approved by the Board. One optional form of
3 coverage shall be comparable to comprehensive health
4 insurance coverage offered in the individual market in this
5 State or a standard option of coverage available under the
6 group or individual health insurance laws of the State. The
7 standard benefit plan that is authorized by Section 8 of this
8 Act may be used for this purpose. The Board may also offer a
9 preferred provider option and such other options as the Board
10 determines may be appropriate for these federally eligible
11 individuals who qualify for Plan coverage pursuant to this
12 Section.
13 (f) Notwithstanding the requirements of subsection f. of
14 Section 8, any plan coverage that is issued to federally
15 eligible individuals who qualify for the Plan pursuant to the
16 portability provisions of this Section shall not be subject
17 to any preexisting conditions exclusion, waiting period, or
18 other similar limitation on coverage.
19 (g) Federally eligible individuals who qualify and
20 enroll in the Plan pursuant to this Section shall be required
21 to pay such premium rates as the Board shall establish and
22 approve in accordance with the requirements of Section 7.1 of
23 this Act.
24 (h) A federally eligible individual who qualifies and
25 enrolls in the Plan pursuant to this Section must satisfy on
26 an ongoing basis all of the other eligibility requirements of
27 this Act to the extent not inconsistent with the federal
28 Health Insurance Portability and Accountability Act of 1996
29 in order to maintain continued eligibility for coverage under
30 the Plan.
31 (Source: P.A. 92-153, eff. 7-25-01.)

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