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 <u>or, if the individual has been certified as an eligible person pursuant to the federal Trade Adjustment Act of 2002, 3 or more months</u>, 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

1 offered in connection with any such plans) or any other
2 type of creditable coverage that may be required by the
3 federal Health Insurance Portability and Accountability
4 Act of 1996, as it may be amended, or the regulations
5 under that Act;
6 (2) who is not eligible for coverage under (A) a
7 group health plan, (B) part A or part B of Medicare due
8 to age, or (C) medical assistance, and does not have
9 other health insurance coverage;
10 (3) with respect to whom the most recent coverage
11 within the coverage period described in paragraph (1)(A)
12 of this definition was not terminated based upon a factor
13 relating to nonpayment of premiums or fraud;
14 (4) if the individual<u>, other than an individual who</u>
15 <u>has been certified as an eligible person pursuant to the</u>
16 <u>federal Trade Adjustment Act of 2002,</u> had been offered
17 the option of continuation coverage under a COBRA
18 continuation provision or under a similar State program,
19 who elected such coverage; and
20 (5) who, if the individual elected such
21 continuation coverage, has exhausted such continuation
22 coverage under such provision or program.
23 <u>An individual who has been certified as an eligible</u>
24 <u>person pursuant to the federal Trade Adjustment Act of 2002</u>
25 <u>shall not be required to elect continuation coverage under a</u>
26 <u>COBRA continuation provision or under a similar state</u>
27 <u>program.</u>
28 "Group health insurance coverage" means, in connection
29 with a group health plan, health insurance coverage offered
30 in connection with that plan.
31 "Group health plan" has the same meaning given that term
32 in the federal Health Insurance Portability and
33 Accountability Act of 1996.
34 "Governmental plan" has the same meaning given that term

1 in the federal Health Insurance Portability and
2 Accountability Act of 1996.
3 "Health insurance coverage" means benefits consisting of
4 medical care (provided directly, through insurance or
5 reimbursement, or otherwise and including items and services
6 paid for as medical care) under any hospital and medical
7 expense-incurred policy, certificate, or contract provided by
8 an insurer, non-profit health care service plan contract,
9 health maintenance organization or other subscriber contract,
10 or any other health care plan or arrangement that pays for or
11 furnishes medical or health care services whether by
12 insurance or otherwise. Health insurance coverage shall not
13 include short term, accident only, disability income,
14 hospital confinement or fixed indemnity, dental only, vision
15 only, limited benefit, or credit insurance, coverage issued
16 as a supplement to liability insurance, insurance arising out
17 of a workers' compensation or similar law, automobile
18 medical-payment insurance, or insurance under which benefits
19 are payable with or without regard to fault and which is
20 statutorily required to be contained in any liability
21 insurance policy or equivalent self-insurance.
22 "Health insurance issuer" means an insurance company,
23 insurance service, or insurance organization (including a
24 health maintenance organization and a voluntary health
25 services plan) that is authorized to transact health
26 insurance business in this State. Such term does not include
27 a group health plan.
28 "Health Maintenance Organization" means an organization
29 as defined in the Health Maintenance Organization Act.
30 "Hospice" means a program as defined in and licensed
31 under the Hospice Program Licensing Act.
32 "Hospital" means a duly licensed institution as defined
33 in the Hospital Licensing Act, an institution that meets all
34 comparable conditions and requirements in effect in the state

1 in which it is located, or the University of Illinois
2 Hospital as defined in the University of Illinois Hospital
3 Act.
4 "Individual health insurance coverage" means health
5 insurance coverage offered to individuals in the individual
6 market, but does not include short-term, limited-duration
7 insurance.
8 "Insured" means any individual resident of this State who
9 is eligible to receive benefits from any insurer (including
10 health insurance coverage offered in connection with a group
11 health plan) or health insurance issuer as defined in this
12 Section.
13 "Insurer" means any insurance company authorized to
14 transact health insurance business in this State and any
15 corporation that provides medical services and is organized
16 under the Voluntary Health Services Plans Act or the Health
17 Maintenance Organization Act.
18 "Medical assistance" means the State medical assistance
19 or medical assistance no grant (MANG) programs provided under
20 Title XIX of the Social Security Act and Articles V (Medical
21 Assistance) and VI (General Assistance) of the Illinois
22 Public Aid Code (or any successor program) or under any
23 similar program of health care benefits in a state other than
24 Illinois.
25 "Medically necessary" means that a service, drug, or
26 supply is necessary and appropriate for the diagnosis or
27 treatment of an illness or injury in accord with generally
28 accepted standards of medical practice at the time the
29 service, drug, or supply is provided. When specifically
30 applied to a confinement it further means that the diagnosis
31 or treatment of the covered person's medical symptoms or
32 condition cannot be safely provided to that person as an
33 outpatient. A service, drug, or supply shall not be medically
34 necessary if it: (i) is investigational, experimental, or for

1 research purposes; or (ii) is provided solely for the
2 convenience of the patient, the patient's family, physician,
3 hospital, or any other provider; or (iii) exceeds in scope,
4 duration, or intensity that level of care that is needed to
5 provide safe, adequate, and appropriate diagnosis or
6 treatment; or (iv) could have been omitted without adversely
7 affecting the covered person's condition or the quality of
8 medical care; or (v) involves the use of a medical device,
9 drug, or substance not formally approved by the United States
10 Food and Drug Administration.

11 "Medical care" means the ordinary and usual professional
12 services rendered by a physician or other specified provider
13 during a professional visit for treatment of an illness or
14 injury.

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

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

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

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

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

33 "Plan of operation" means the plan of operation of the
34 Plan, including articles, bylaws and operating rules, adopted

by the board pursuant to this Act.

"Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, registered pharmacist acting within the scope of that registration, or any other person or entity licensed in Illinois to furnish medical care.

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

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

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

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

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

(Source: P.A. 91-357, eff. 7-29-99; 91-735, eff. 6-2-00; 92-153, eff. 7-25-01.)

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

Sec. 4. Powers and authority of the board. The board shall have the general powers and authority granted under the laws of this State to insurance companies licensed to

1 transact health and accident insurance and in addition
2 thereto, the specific authority to:
3 a. Enter into contracts as are necessary or proper to
4 carry out the provisions and purposes of this Act, including
5 the authority, with the approval of the Director, to enter
6 into contracts with similar plans of other states for the
7 joint performance of common administrative functions, or with
8 persons or other organizations for the performance of
9 administrative functions including, without limitation,
10 utilization review and quality assurance programs, or with
11 health maintenance organizations or preferred provider
12 organizations for the provision of health care services.
13 b. Sue or be sued, including taking any legal actions
14 necessary or proper.
15 c. Take such legal action as necessary to:
16 (1) avoid the payment of improper claims against
17 the plan or the coverage provided by or through the plan;
18 (2) to recover any amounts erroneously or
19 improperly paid by the plan;
20 (3) to recover any amounts paid by the plan as a
21 result of a mistake of fact or law; or
22 (4) to recover or collect any other amounts,
23 including assessments, that are due or owed the Plan or
24 have been billed on its or the Plan's behalf.
25 d. Establish appropriate rates, rate schedules, rate
26 adjustments, expense allowances, agents' referral fees, claim
27 reserves, and formulas and any other actuarial function
28 appropriate to the operation of the plan. Rates and rate
29 schedules may be adjusted for appropriate risk factors such
30 as age and area variation in claim costs and shall take into
31 consideration appropriate risk factors in accordance with
32 established actuarial and underwriting practices.
33 e. Issue policies of insurance in accordance with the
34 requirements of this Act.

1 f. Appoint appropriate legal, actuarial and other
2 committees as necessary to provide technical assistance in
3 the operation of the plan, policy and other contract design,
4 and any other function within the authority of the plan.
5 g. Borrow money to effect the purposes of the Illinois
6 Comprehensive Health Insurance Plan. Any notes or other
7 evidence of indebtedness of the plan not in default shall be
8 legal investments for insurers and may be carried as admitted
9 assets.
10 h. Establish rules, conditions and procedures for
11 reinsuring risks under this Act.
12 i. Employ and fix the compensation of employees. Such
13 employees may be paid on a warrant issued by the State
14 Treasurer pursuant to a payroll voucher certified by the
15 Board and drawn by the Comptroller against appropriations or
16 trust funds held by the State Treasurer.
17 j. Enter into intergovernmental cooperation agreements
18 with other agencies or entities of State government for the
19 purpose of sharing the cost of providing health care services
20 that are otherwise authorized by this Act for children who
21 are both plan participants and eligible for financial
22 assistance from the Division of Specialized Care for Children
23 of the University of Illinois.
24 k. Establish conditions and procedures under which the
25 plan may, if funds permit, discount or subsidize premium
26 rates that are paid directly by senior citizens, as defined
27 by the Board, and other plan participants, who are retired or
28 unemployed and meet other qualifications.
29 l. Establish and maintain the Plan Fund authorized in
30 Section 3 of this Act, which shall be divided into separate
31 accounts, as follows:
32 (1) accounts to fund the administrative, claim, and
33 other expenses of the Plan associated with eligible
34 persons who qualify for Plan coverage under Section 7 of

1 this Act, which shall consist of:
2 (A) premiums paid on behalf of covered
3 persons;
4 (B) appropriated funds and other revenues
5 collected or received by the Board;
6 (C) reserves for future losses maintained by
7 the Board; and
8 (D) interest earnings from investment of the
9 funds in the Plan Fund or any of its accounts other
10 than the funds in the account established under item
11 2 of this subsection;
12 (2) an account, to be denominated the federally
13 eligible individuals account, to fund the administrative,
14 claim, and other expenses of the Plan associated with
15 federally eligible individuals who qualify for Plan
16 coverage under Section 15 of this Act, which shall
17 consist of:
18 (A) premiums paid on behalf of covered
19 persons;
20 (B) assessments and other revenues collected
21 or received by the Board;
22 (C) reserves for future losses maintained by
23 the Board; ~~and~~
24 (D) interest earnings from investment of the
25 federally eligible individuals account funds; and
26 (E) grants provided pursuant to the federal
27 Trade Adjustment Act of 2002; and
28 (3) such other accounts as may be appropriate.
29 m. Charge and collect assessments paid by insurers
30 pursuant to Section 12 of this Act and recover any
31 assessments for, on behalf of, or against those insurers.
32 (Source: P.A. 90-30, eff. 7-1-97; 91-357, eff. 7-29-99.)

33 (215 ILCS 105/7) (from Ch. 73, par. 1307)

1 Sec. 7. Eligibility.
2 a. Except as provided in subsection (e) of this Section
3 or in Section 15 of this Act, any person who is either a
4 citizen of the United States or an alien lawfully admitted
5 for permanent residence and who has been for a period of at
6 least 180 days and continues to be a resident of this State
7 shall be eligible for Plan coverage under this Section if
8 evidence is provided of:
9 (1) A notice of rejection or refusal to issue
10 substantially similar individual health insurance
11 coverage for health reasons by a health insurance issuer;
12 or
13 (2) A refusal by a health insurance issuer to issue
14 individual health insurance coverage except at a rate
15 exceeding the applicable Plan rate for which the person
16 is responsible.
17 A rejection or refusal by a group health plan or health
18 insurance issuer offering only stop-loss or excess of loss
19 insurance or contracts, agreements, or other arrangements for
20 reinsurance coverage with respect to the applicant shall not
21 be sufficient evidence under this subsection.
22 b. The board shall promulgate a list of medical or
23 health conditions for which a person who is either a citizen
24 of the United States or an alien lawfully admitted for
25 permanent residence and a resident of this State would be
26 eligible for Plan coverage without applying for health
27 insurance coverage pursuant to subsection a. of this Section.
28 Persons who can demonstrate the existence or history of any
29 medical or health conditions on the list promulgated by the
30 board shall not be required to provide the evidence specified
31 in subsection a. of this Section. The list shall be
32 effective on the first day of the operation of the Plan and
33 may be amended from time to time as appropriate.
34 c. Family members of the same household who each are

1 covered persons are eligible for optional family coverage
2 under the Plan.
3 d. For persons qualifying for coverage in accordance
4 with Section 7 of this Act, the board shall, if it determines
5 that such appropriations as are made pursuant to Section 12
6 of this Act are insufficient to allow the board to accept all
7 of the eligible persons which it projects will apply for
8 enrollment under the Plan, limit or close enrollment to
9 ensure that the Plan is not over-subscribed and that it has
10 sufficient resources to meet its obligations to existing
11 enrollees. The board shall not limit or close enrollment for
12 federally eligible individuals.
13 e. A person shall not be eligible for coverage under the
14 Plan if:
15 (1) He or she has or obtains other coverage under a
16 group health plan or health insurance coverage
17 substantially similar to or better than a Plan policy as
18 an insured or covered dependent or would be eligible to
19 have that coverage if he or she elected to obtain it.
20 Persons otherwise eligible for Plan coverage may,
21 however, solely for the purpose of having coverage for a
22 pre-existing condition, maintain other coverage only
23 while satisfying any pre-existing condition waiting
24 period under a Plan policy or a subsequent replacement
25 policy of a Plan policy.
26 (1.1) His or her prior coverage under a group
27 health plan or health insurance coverage, provided or
28 arranged by an employer of more than 10 employees was
29 discontinued for any reason without the entire group or
30 plan being discontinued and not replaced, provided he or
31 she remains an employee, or dependent thereof, of the
32 same employer.
33 (2) He or she is a recipient of or is approved to
34 receive medical assistance, except that a person may

1 continue to receive medical assistance through the
2 medical assistance no grant program, but only while
3 satisfying the requirements for a preexisting condition
4 under Section 8, subsection f. of this Act. Payment of
5 premiums pursuant to this Act shall be allocable to the
6 person's spenddown for purposes of the medical assistance
7 no grant program, but that person shall not be eligible
8 for any Plan benefits while that person remains eligible
9 for medical assistance. If the person continues to
10 receive or be approved to receive medical assistance
11 through the medical assistance no grant program at or
12 after the time that requirements for a preexisting
13 condition are satisfied, the person shall not be eligible
14 for coverage under the Plan. In that circumstance,
15 coverage under the plan shall terminate as of the
16 expiration of the preexisting condition limitation
17 period. Under all other circumstances, coverage under
18 the Plan shall automatically terminate as of the
19 effective date of any medical assistance.
20 (3) Except as provided in Section 15, the person
21 has previously participated in the Plan and voluntarily
22 terminated Plan coverage, unless 12 months have elapsed
23 since the person's latest voluntary termination of
24 coverage.
25 (4) The person fails to pay the required premium
26 under the covered person's terms of enrollment and
27 participation, in which event the liability of the Plan
28 shall be limited to benefits incurred under the Plan for
29 the time period for which premiums had been paid and the
30 covered person remained eligible for Plan coverage.
31 (5) The Plan has paid a total of $1,000,000 in
32 benefits on behalf of the covered person.
33 (6) The person is a resident of a public
34 institution.

(7) The person's premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of such employee, of a government agency or health care provider <u>or, except when a person's premium is paid by the U.S. Treasury Department pursuant to the federal Trade Adjustment Act of 2002</u>.

(8) The person has or later receives other benefits or funds from any settlement, judgement, or award resulting from any accident or injury, regardless of the date of the accident or injury, or any other circumstances creating a legal liability for damages due that person by a third party, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or assets remaining from those sources in an amount in excess of $100,000.

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

1 Plan to which that person 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
11 the policy, or (v) at the Plan's option, 30 days after the
12 Plan makes any inquiry concerning a person's eligibility or
13 place of residence to which the person does not reply.
14 h. Except under the conditions set forth in subsection g
15 of this Section, the coverage of any person who ceases to
16 meet the eligibility requirements of this Section shall be
17 terminated at the end of the current policy period for which
18 the necessary premiums have been paid.
19 (Source: P.A. 90-30, eff. 7-1-97; 91-639, eff. 8-20-99;
20 91-735, eff. 6-2-00.)

21 (215 ILCS 105/15)
22 Sec. 15. Alternative portable coverage for federally
23 eligible individuals.
24 (a) Notwithstanding the requirements of subsection a. of
25 Section 7 and except as otherwise provided in this Section,
26 any federally eligible individual for whom a Plan
27 application, and such enclosures and supporting documentation
28 as the Board may require, is received by the Board within 90
29 days after the termination of prior creditable coverage shall
30 qualify to enroll in the Plan under the portability
31 provisions of this Section. A federally eligible person who
32 has been certified as an eligible person pursuant to the
33 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 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 an eligible person pursuant to the federal Trade Adjustment 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

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

1 Health Insurance Portability and Accountability Act of 1996
2 in order to maintain continued eligibility for coverage under
3 the Plan.
4 (Source: P.A. 92-153, eff. 7-25-01.)

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