LRB093 20789 SAS 46704 b

93RD GENERAL ASSEMBLY

State of Illinois

2003 and 2004

HB4549

Introduced 02/03/04, by Frank J. Mautino

SYNOPSIS AS INTRODUCED:

215 ILCS 105/2	from Ch. 73, par. 1302
215 ILCS 105/12	from Ch. 73, par. 1312

Amends the Illinois Insurance Code. In provisions defining an insurer, adds any self-insurance arrangement covered by stop-loss insurance that provides health care benefits in this State. In provisions requiring any deficit incurred or expected to be incurred on behalf of federally eligible individuals who qualify for Plan coverage be recouped by an assessment of insurers, provides instruction for computing an assessment. Requires each insurer to pay its assessment as required by the Plan. Requires that if assessments exceed the amounts actually needed, the excess shall be held and invested and used by the Plan to offset future net losses or reduce pool premiums. Defines future net losses. Makes other changes.

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A BILL FOR

AN ACT concerning insurance.

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

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

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

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

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

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

"Board" means the Illinois Comprehensive Health Insurance Board.

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

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

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

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

the following:

(A) A group health plan.

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

(C) Medicare.

(D) Medical assistance.

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

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

(G) A state health benefits risk pool.

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

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

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

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

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

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

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

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is claimed as a dependent by the principal insured for purposes of filing a federal income tax return and resides in the principal insured's household, and is a resident unmarried child under the age of 19 years; or who is an unmarried child who also is a full-time student under the age of 23 years and who is financially dependent upon the principal insured; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

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

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

"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 eligible pursuant to the federal Trade Act of 2002, 3 or more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

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

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

to nonpayment of premiums or fraud;

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

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

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

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

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

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

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers'

compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization and a voluntary health services plan) that is authorized to transact health insurance business in this State. Such term does not include a group health plan.

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

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

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

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

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

"Insurer" means any insurance company authorized to transact health insurance business in this State and any corporation that provides medical services and is organized under the Voluntary Health Services Plans Act or the Health Maintenance Organization Act. <u>"Insurer" also includes any self-insurance arrangement covered by stop-loss insurance that provides health care benefits in this State.</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03; 93-34, eff. 6-23-03; 93-477, eff. 8-8-03; 93-622, eff. 12-18-03.)

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

Sec. 12. Deficit or surplus.

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

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

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

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

(1) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction,

the numerator of which equals the number of Illinois insureds and certificate holders insured, reinsured, or covered, either directly or indirectly, by each insurer, and the denominator of which equals the total of all Illinois insureds and certificate holders insured, reinsured, or covered, either directly or indirectly, by all insurers, all determined as of the end of the prior calendar year;

(2) The Plan shall ensure that each insured and certificate holder is counted only once with respect to any assessment. For that purpose, the Plan shall require each insurer that obtains reinsurance of its insureds and certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The Plan shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection;

(3) Each insurer shall pay its assessment as required by the Plan;

(4) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the Plan to offset future net losses or to reduce pool premiums. For purposes of this subsection, future net losses include reserves for incurred but not reported claims;

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

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

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

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

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

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

(1) Any insurer that wishes to appeal all or any part of an assessment made pursuant to this Section shall first pay the amount of the assessment as set forth in the invoice provided by the board within the time provided in subsection f. of this Section. The board shall hold such payments in a separate interest-bearing account. The

payments shall be accompanied by a statement in writing that the payment is made under appeal. The statement shall specify the grounds for the appeal. The insurer may be represented in its appeal by counsel or other representative of its choosing.

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

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

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

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

(6) The board's determination with respect to any appeal received pursuant to this subsection shall be a final administrative decision as defined in Section 3-101 of the Code of Civil Procedure. The provisions of the

Administrative Review Law shall apply to and govern all proceedings for the judicial review of final administrative decisions of the board.

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

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