SB3021

LRB094 18923 LJB 54370 b

94TH GENERAL ASSEMBLY

State of Illinois

2005 and 2006

SB3021

Introduced 1/20/2006, by Sen. J. Bradley Burzynski - Dale A. Righter - Kirk W. Dillard - Dave Syverson - Wendell E. Jones, et al.

SYNOPSIS AS INTRODUCED:

215 ILCS 170/20
215 ILCS 170/30
215 ILCS 170/35
215 ILCS 170/37 new
215 ILCS 170/40
215 ILCS 170/42 new
215 ILCS 170/70 new
215 ILCS 170/75 new

Amends the Covering ALL KIDS Health Insurance Act. Provides that a person must be a citizen of the United States, have an annual household income of less than $80,001, and have household assets of less than $10,000 to be eligible for the Program. Provides that the Department of Financial and Professional Regulation shall not incur an annual outreach and marketing expense of greater than $1,000,000 and that products, publications, and advertisements shall not contain the name or title of any elected official. Specifies health benefits that may be included in benefit packages. Sets forth premium, co-payment, and out-of-pocket cost requirements. Establishes the Covering ALL KIDS Health Insurance Program Review Committee and sets forth duties of the Committee. Limits State funding for the Covering ALL KIDS Health Insurance Program. Effective July 1, 2006.

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FISCAL NOTE ACT
MAY APPLY

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 Covering ALL KIDS Health Insurance Act is amended by changing Sections 20, 30, 35, and 40 and by adding Sections 37, 42, 70, and 75 as follows:

(215 ILCS 170/20)

(Section scheduled to be repealed on July 1, 2011)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 20. Eligibility.

(a) To be eligible for the Program, a person must be a child:

(1) who is a citizen of the United States and a resident of the State of Illinois; and

(2) who is ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act; and

(3) either (i) who is verified by the Department to have ~~has~~ been without health insurance coverage for a period set forth by the Department in rules, but not less than 6 months during the first month of operation of the Program, 7 months during the second month of operation, 8 months during the third month of operation, 9 months during the fourth month of operation, 10 months during the fifth month of operation, 11 months during the sixth month of operation, and 12 months thereafter, (ii) whose parent has lost employment that made available affordable dependent health insurance coverage, until such time as affordable employer-sponsored dependent health insurance coverage is again available for the child as set forth by the Department in rules, (iii) who is a newborn whose

responsible relative does not have available affordable private or employer-sponsored health insurance, or (iv) who, within one year of applying for coverage under this Act, lost medical benefits under the Illinois Public Aid Code or the Children's Health Insurance Program Act; and.

(4) whose annual household income, as determined and verified by the Department, is less than $80,001; and

(5) whose household assets do not exceed $10,000, excluding (i) the value of the residence in which the child lives and (ii) the value of a vehicle used by the household for transportation purposes; for purposes of this subdivision (5), "vehicle" does not include a recreational vehicle as defined in the Campground Licensing and Recreational Area Act.

An entity that provides health insurance coverage (as defined in Section 2 of the Comprehensive Health Insurance Plan Act) to Illinois residents shall provide health insurance data match to the Department of Healthcare and Family Services for the purpose of determining eligibility for the Program under this Act.

The Department of Healthcare and Family Services, in collaboration with the Department of Financial and Professional Regulation, Division of Insurance, shall adopt rules governing the exchange of information under this Section. The rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records, including provisions under the Federal Health Insurance Portability and Accountability Act (HIPAA).

(b) The Department shall monitor the availability and retention of employer-sponsored dependent health insurance coverage and shall modify the period described in subdivision (a)(3) if necessary to promote retention of private or employer-sponsored health insurance and timely access to healthcare services, but at no time shall the period described in subdivision (a)(3) be less than 6 months.

(c) The Department, at its discretion, may take into

account the affordability of dependent health insurance when determining whether employer-sponsored dependent health insurance coverage is available upon reemployment of a child's parent as provided in subdivision (a)(3).

(d) A child who is determined to be eligible for the Program shall remain eligible for 12 months, provided that the child maintains his or her residence in this State, has not yet attained 19 years of age, and is not excluded under subsection (e).

(e) A child is not eligible for coverage under the Program if:

(1) the premium required under Section 40 has not been timely paid; if the required premiums are not paid, the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums have been paid; if the required monthly premium is not paid, the child is ineligible for re-enrollment for a minimum period of 3 months; re-enrollment shall be completed before the next covered medical visit, and the first month's required premium shall be paid in advance of the next covered medical visit; or

(2) the child is an inmate of a public institution or an institution for mental diseases.

(f) The Department shall adopt eligibility rules, including, but not limited to: rules regarding annual renewals of eligibility for the Program; rules providing for re-enrollment, grace periods, notice requirements, and hearing procedures under subdivision (e)(1) of this Section; and rules regarding what constitutes availability and affordability of private or employer-sponsored health insurance, with consideration of such factors as the percentage of income needed to purchase children or family health insurance, the availability of employer subsidies, and other relevant factors.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/30)

(Section scheduled to be repealed on July 1, 2011)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 30. Program outreach and marketing.

(a) The Department may provide grants to application agents and other community-based organizations to educate the public about the availability of the Program. The Department shall adopt rules regarding performance standards and outcomes measures expected of organizations that are awarded grants under this Section, including penalties for nonperformance of contract standards.

(b) The Department shall not incur an annual outreach and marketing expense greater than $1,000,000 in any given fiscal year.

(c) Any product, publication, or advertisement used to market or provide outreach for the Program may contain the name and contact information of the Department but shall not contain the name or title of any elected official in the State of Illinois.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/35)

(Section scheduled to be repealed on July 1, 2011)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 35. Health care benefits for children.

(a) The Department shall purchase or provide at least 3 different health care benefit packages ~~benefits~~ for eligible children that may include all or any combination of the following: ~~are identical to the benefits provided for children under the Illinois Children's Health Insurance Program Act, except for non-emergency transportation.~~

(1) inpatient hospital care;

(2) outpatient hospital care;

(3) physician services;

(4) laboratory and x-ray services;

(5) immunizations and other early and periodic screening, diagnostic, and treatment services;

(6) Federally Qualified Health Center and rural health clinic services;

(7) prescription drugs;

(8) dental care; or

(9) vision care.

(b) As an alternative to the benefits set forth in subsection (a), and when cost-effective, the Department may offer families subsidies toward the cost of privately sponsored health insurance, including employer-sponsored health insurance.

(c) Notwithstanding clause (i) of subdivision (a)(3) of Section 20, the Department may consider offering, as an alternative to the benefits set forth in subsection (a), partial coverage to children who are enrolled in a high-deductible private health insurance plan.

(d) Notwithstanding clause (i) of subdivision (a)(3) of Section 20, the Department may consider offering, as an alternative to the benefits set forth in subsection (a), a limited package of benefits to children in families who have private or employer-sponsored health insurance that does not cover certain benefits such as dental or vision benefits.

(e) The content and availability of benefits described in subsections (b), (c), and (d), and the terms of eligibility for those benefits, shall be at the Department's discretion and the Department's determination of efficacy and cost-effectiveness as a means of promoting retention of private or employer-sponsored health insurance.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/37 new)

Sec. 37. Premiums.

(a) Children who are enrolled in the Program under subsection (a) of Section 35 and whose annual household income

is less than $60,000 shall be subject to monthly premiums not to exceed $40 per month per child for the most comprehensive benefit package offered by the Department in the fiscal year beginning July 1, 2006. The Department may reduce the monthly premium requirement for any lesser benefit package offered by the Department. Premiums will only be charged on a maximum of 2 children per family. All monthly premiums shall be adjusted annually on July 1 of each fiscal year based on the percentage increase in the Consumer Price Index for All Urban Consumers for medical care for the preceding 12-month calendar year, as published by the United States Department of Labor, Bureau of Labor Statistics.

(b) Children who are enrolled in the Program under subsection (a) of Section 35 and whose annual household income is between $60,000 and $80,001 shall be subject to monthly premiums not to exceed $70 per month per child for the most comprehensive benefit package offered by the Department in the fiscal year beginning July 1, 2006. The Department may reduce the monthly premium requirement for any lesser benefit package offered by the Department. Premiums will only be charged on a maximum of 2 children per family. All monthly premiums shall be adjusted annually on July 1 of each fiscal year based on the percentage increase in the Consumer Price Index for All Urban Consumers for medical care for the preceding 12-month calendar year, as published by the United States Department of Labor, Bureau of Labor Statistics.

(215 ILCS 170/40)

(Section scheduled to be repealed on July 1, 2011)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 40. Cost-sharing.

(a) Children enrolled in the Program under subsection (a) of Section 35 are subject to the following cost-sharing requirements:

(1) For children with household incomes less than

$60,000, children will be subject to a $10 co-payment for physician visits, a $30 co-payment for emergency room visits, a $100 co-payment for in-patient hospital services, a co-payment on prescription drugs that is equal to 5% of the amount paid by the Department for the prescription, and a co-payment for outpatient hospital services that is equal to 5% of the amount paid by the Department for those services. ~~The Department, by rule, shall set forth requirements concerning co-payments and coinsurance for health care services and monthly premiums. This cost-sharing shall be on a sliding scale based on family income.~~ The Department may periodically modify such cost-sharing.

(2) For children with household incomes between $60,000 and $80,001, children will be subject to a $15 co-payment for physician visits, a $50 co-payment for emergency room visits, a $150 co-payment for in-patient hospital services, a co-payment on prescription drugs that is equal to 10% of the amount paid by the Department for the prescription, and a co-payment for outpatient hospital services that is equal to 10% of the amount paid by the Department for those services. The Department may periodically modify such cost sharing.

(3) ~~(2)~~ Notwithstanding paragraphs ~~paragraph~~ (1) and (2), there shall be no co-payment required for well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under State or federal law.

(b) Children enrolled in a privately sponsored health insurance plan under subsection (b) of Section 35 are subject to the cost-sharing provisions stated in the privately sponsored health insurance plan.

(c) Notwithstanding any other provision of law, rates paid by the Department shall not be used in any way to determine the usual and customary or reasonable charge, which is the charge for health care that is consistent with the average rate or

charge for similar services furnished by similar providers in a certain geographic area.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/42 new)

Sec. 42. Maximum out-of-pocket costs.

(a) Children who are enrolled in the Program under subsection (a) of Section 35 and whose annual household income is less than $60,000 shall be subject to a maximum out-of-pocket limitation of $500 per year.

(b) Children who are enrolled in the Program under subsection (a) of Section 35 and whose annual household income is between $60,000 and $80,001 shall be subject to a maximum out-of-pocket limitation of $750 per year.

(215 ILCS 170/70 new)

Sec. 70. Covering ALL KIDS Health Insurance Program Review Committee.

(a) The Covering ALL KIDS Health Insurance Program Review Committee is hereby created. The Committee shall consist of 15 members as follows:

(1) Twelve members appointed as follows: 2 members of the General Assembly and 1 member of the general public appointed by the President of the Senate; 2 members of the General Assembly and 1 member of the general public appointed by the Minority Leader of the Senate; 2 members of the General Assembly and 1 member of the general public appointed by the Speaker of the House of Representatives; and 2 members of the General Assembly and 1 member of the general public appointed by the Minority Leader of the House of Representatives. These members shall serve at the pleasure of the appointing authority.

(2) The Director of Healthcare and Family Services, or his or her designee.

(3) The Director of the Division of Insurance of the Department of Financial and Professional Regulation, or

his or her designee.

(4) The Secretary of Human Services, or his or her designee.

(b) Members appointed from the general public shall represent the following associations, organizations, and interests: statewide membership-based child advocacy organizations, insurance companies or statewide member-based organizations representing insurance companies, pharmacists or statewide member-based organizations representing pharmacists, physicians or statewide member-based organizations representing physicians, pediatricians or statewide member-based organizations representing pediatricians, hospitals or statewide member-based organizations representing hospitals, and providers of health care services to children. No single organization may have more than one representative appointed as a member from the general public.

(c) The President of the Senate and Speaker of the House of Representatives shall each designate one member of the Committee to serve as co-chairs.

(d) Committee members shall serve without compensation or reimbursement for expenses.

(e) The Committee shall meet at the call of the co-chairs, but at least quarterly.

(f) The Committee may conduct public hearings to gather testimony from interested parties regarding the Program.

(g) The Committee may advise appropriate State agencies regarding the establishment of proposed changes to the existing Program. The State agencies shall take into consideration any recommendations made by the Committee.

(h) The Department shall file an annual report with the Committee detailing Program participation and costs.

(215 ILCS 170/75 new)

Sec. 75. Funding limitation. The State shall not expend more than $72,600,000 for the Program in the fiscal year beginning July 1, 2006. The State shall not expend more than

$52,500,000 for the Program in the fiscal year beginning July 1, 2007. The State shall not expend more than $75,300,000 for the Program in the fiscal year beginning July 1, 2008. The State shall not expend more than $102,700,000 for the Program in the fiscal year beginning July 1, 2009. The State shall not expend more than $125,900,000 for the Program in the fiscal year beginning July 1, 2010. For the purposes of this Section, Program expenditures include, but are not limited to, the following:

(1) providing health care benefits to eligible children;

(2) expediting Medicaid payments to participating physicians;

(3) Program administration; and

(4) Program marketing and outreach.

Section 99. Effective date. This Act takes effect July 1, 2006.