Sen. Dan Kotowski

Filed: 4/2/2008

AMENDMENT TO SENATE BILL 871

AMENDMENT NO. _____. Amend Senate Bill 871 by replacing everything after the enacting clause with the following:

"ARTICLE 15. EXPANDING ACCESS TO HEALTH INSURANCE FOR YOUNG ILLINOISANS

Section 15-5. The Illinois Insurance Code is amended by adding Section 367.4 as follows:

(215 ILCS 5/367.4 new)

Sec. 367.4. Coverage of dependents until age 30.

(a) A group health insurance policy that provides coverage for an insured's dependents under which coverage of a dependent terminates at a specific age before the dependent's 30th birthday, and is delivered, issued, executed, or renewed in this State after June 1, 2009, shall, upon application of the dependent as set forth in subsection (c) of this Section,

provide health insurance coverage, excluding dental, life, and vision coverage, to the dependent after that specific age, until the dependent's 30th birthday. As used in this Section, "dependents" means any insured's children by blood or by law, including adopted children, stepchildren, and children for whom the insured is or was a court-appointed guardian, who:

(1) are less than 30 years of age;

(2) are unmarried;

(3) are residents of this State or are enrolled as full-time students at an accredited public or private institution of higher education; and

(4) are not actually provided coverage as named subscribers, insureds, enrollees, or covered persons under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Pub.L. 89-97 (42 U.S.C. 1395 et seq.).

(b) Nothing herein shall be construed to require that:

(1) coverage for services be provided to dependents before June 1, 2009; or

(2) an employer pay all or part of the cost of coverage for dependents as provided pursuant to this Section.

(c) Application for dependent coverage.

(1) A dependent covered by an insured's health insurance policy, which coverage under the policy terminates at a specific age before the dependent's 30th

birthday, may make a written election for coverage as a dependent pursuant to this Section, until the dependent's 30th birthday, at any of the following times:

(A) within 30 days prior to the termination of coverage at the specific age provided in the policy;

(B) within 30 days after meeting the requirements for dependent status as set forth in subsection (a) of this Section, when coverage for the dependent under the policy previously terminated; or

(C) during an open enrollment period, as provided pursuant to the policy, if the dependent meets the requirements for dependent status as set forth in subsection (a) of this Section during the open enrollment period.

(2) For 12 months after June 1, 2009, a dependent who qualifies for dependent status as set forth in subsection (a) of this Section, but whose coverage as a dependent under an insured's policy terminated under the terms of the policy prior to June 1, 2009, may make a written election to reinstate coverage under that policy as a dependent pursuant to this Section.

(3) Coverage for a dependent who makes a written election for health insurance coverage pursuant to this subsection shall consist of health insurance coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the

specific age provided in the policy. If health insurance coverage was modified under the policy for any similarly situated dependents prior to their termination of coverage at the specific age provided in the policy, the coverage shall also be modified in the same manner for the dependent seeking reinstatement.

(4) Coverage for a dependent who makes a written election for health insurance coverage pursuant to this subsection shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

(d) Premium adjustments and payments.

(1) A policy of insurance offered pursuant to this Section may require payment of a premium by the insured or dependent, as appropriate, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection (c). The premium shall not exceed 105% of the applicable portion of the premium previously paid for that dependent's coverage under the policy prior to the termination of coverage at the specific age provided in the policy.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the policy shall be based upon the difference between the policy's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the

Director which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payer, be made in monthly installments.

(e) Coverage for a dependent provided pursuant to this Section shall be provided until the earlier of the following:

(1) the dependent is disqualified for dependent status as set forth in subsection (a) of this Section;

(2) the date on which coverage ceases under the policy by reason of a failure to make a timely payment of any premium required under the policy by the insured or dependent for coverage provided pursuant to this Section; the payment of any premium shall be considered to be timely if made within 30 days after the due date or within a longer period as may be provided for by the policy; or

(3) the date upon which the employer under whose policy coverage is provided to a dependent ceases to provide coverage to the insured; nothing herein shall be construed to permit an insurer to refuse a written election for coverage by a dependent pursuant to subsection (c) of this Section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection.

(f) Notice regarding coverage for a dependent as provided pursuant to this Section shall be provided to an insured:

(1) in the certificate of coverage prepared for insureds by the insurer on or about the date of commencement of coverage; and

(2) by the insured's employer:

(A) on or before the coverage of an insured's dependent terminates at the specific age as provided in the policy;

(B) at the time coverage of the dependent is no longer provided pursuant to this Section because the dependent is disqualified for dependent status as set forth in subsection (a) of this Section, except that this employer notice shall not be required when a dependent no longer qualifies based upon paragraph (1) of subsection (a) of this Section;

(C) before any open enrollment period permitting a dependent to make a written election for coverage pursuant to subsection (c) of this Section; and

(D) immediately following June 1, 2009, with respect to information concerning a dependent's opportunity, for 12 months after June 1, 2009, to make a written election to reinstate coverage under a policy pursuant to paragraph (2) of subsection (c) of this Section.

Section 15-10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10 ~~356z.9~~, 364.01, 367.2, 367.2-5, 367.4, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization

pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an

acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or

other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium,

and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

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