Sen. Deanna Demuzio

Filed: 3/5/2008

1 AMENDMENT TO SENATE BILL 2380

2 AMENDMENT NO. ______. Amend Senate Bill 2380 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Comprehensive Health Insurance Plan Act is
5 amended by changing Section 2 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

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.

"Effective date of medical assistance" means the date that eligibility for medical assistance for a person is approved by the Department of Human Services or the Department of

Healthcare and Family Services, except when the Department of Human Services or the Department of Healthcare and Family Services determines eligibility retroactively. In such circumstances, the effective date of the medical assistance is the date the Department of Human Services or the Department of Healthcare and Family Services determines the person to be eligible for medical assistance.

"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

1 has been certified as eligible pursuant to the federal
2 Trade Act of 2002) the most recent coverage within the
3 coverage period described in paragraph (1)(A) of this
4 definition was not terminated based upon a factor relating
5 to nonpayment of premiums or fraud;
6 (4) if the individual (other than an individual who has
7 been certified as eligible pursuant to the federal Trade
8 Act of 2002) had been offered the option of continuation
9 coverage under a COBRA continuation provision or under a
10 similar State program, who elected such coverage; and
11 (5) who, if the individual elected such continuation
12 coverage, has exhausted such continuation coverage under
13 such provision or program.
14 However, an individual who has been certified as eligible
15 pursuant to the federal Trade Act of 2002 shall not be required
16 to elect continuation coverage under a COBRA continuation
17 provision or under a similar state program.
18 "Group health insurance coverage" means, in connection
19 with a group health plan, health insurance coverage offered in
20 connection with that plan.
21 "Group health plan" has the same meaning given that term in
22 the federal Health Insurance Portability and Accountability
23 Act of 1996.
24 "Governmental plan" has the same meaning given that term in
25 the federal Health Insurance Portability and Accountability
26 Act of 1996.

1 "Health insurance coverage" means benefits consisting of
2 medical care (provided directly, through insurance or
3 reimbursement, or otherwise and including items and services
4 paid for as medical care) under any hospital and medical
5 expense-incurred policy, certificate, or contract provided by
6 an insurer, non-profit health care service plan contract,
7 health maintenance organization or other subscriber contract,
8 or any other health care plan or arrangement that pays for or
9 furnishes medical or health care services whether by insurance
10 or otherwise. Health insurance coverage shall not include short
11 term, accident only, disability income, hospital confinement
12 or fixed indemnity, dental only, vision only, limited benefit,
13 or credit insurance, coverage issued as a supplement to
14 liability insurance, insurance arising out of a workers'
15 compensation or similar law, automobile medical-payment
16 insurance, or insurance under which benefits are payable with
17 or without regard to fault and which is statutorily required to
18 be contained in any liability insurance policy or equivalent
19 self-insurance.

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

26 "Health Maintenance Organization" means an organization as

1 defined in the Health Maintenance Organization Act.
2 "Hospice" means a program as defined in and licensed under
3 the Hospice Program Licensing Act.
4 "Hospital" means a duly licensed institution as defined in
5 the Hospital Licensing Act, an institution that meets all
6 comparable conditions and requirements in effect in the state
7 in which it is located, or the University of Illinois Hospital
8 as defined in the University of Illinois Hospital Act.
9 "Individual health insurance coverage" means health
10 insurance coverage offered to individuals in the individual
11 market, but does not include short-term, limited-duration
12 insurance.
13 "Insured" means any individual resident of this State who
14 is eligible to receive benefits from any insurer (including
15 health insurance coverage offered in connection with a group
16 health plan) or health insurance issuer as defined in this
17 Section.
18 "Insurer" means any insurance company authorized to
19 transact health insurance business in this State and any
20 corporation that provides medical services and is organized
21 under the Voluntary Health Services Plans Act or the Health
22 Maintenance Organization Act.
23 "Medical assistance" means the State medical assistance or
24 medical assistance no grant (MANG) programs provided under
25 Title XIX of the Social Security Act and Articles V (Medical
26 Assistance) and VI (General Assistance) of the Illinois Public

1 Aid Code (or any successor program) or under any similar
2 program of health care benefits in a state other than Illinois.
3 "Medically necessary" means that a service, drug, or supply
4 is necessary and appropriate for the diagnosis or treatment of
5 an illness or injury in accord with generally accepted
6 standards of medical practice at the time the service, drug, or
7 supply is provided. When specifically applied to a confinement
8 it further means that the diagnosis or treatment of the covered
9 person's medical symptoms or condition cannot be safely
10 provided to that person as an outpatient. A service, drug, or
11 supply shall not be medically necessary if it: (i) is
12 investigational, experimental, or for research purposes; or
13 (ii) is provided solely for the convenience of the patient, the
14 patient's family, physician, hospital, or any other provider;
15 or (iii) exceeds in scope, duration, or intensity that level of
16 care that is needed to provide safe, adequate, and appropriate
17 diagnosis or treatment; or (iv) could have been omitted without
18 adversely affecting the covered person's condition or the
19 quality of medical care; or (v) involves the use of a medical
20 device, drug, or substance not formally approved by the United
21 States Food and Drug Administration.
22 "Medical care" means the ordinary and usual professional
23 services rendered by a physician or other specified provider
24 during a professional visit for treatment of an illness or
25 injury.
26 "Medicare" means coverage under both Part A and Part B of

1 Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395, et
2 seq.
3 "Minimum premium plan" means an arrangement whereby a
4 specified amount of health care claims is self-funded, but the
5 insurance company assumes the risk that claims will exceed that
6 amount.
7 "Participating transplant center" means a hospital
8 designated by the Board as a preferred or exclusive provider of
9 services for one or more specified human organ or tissue
10 transplants for which the hospital has signed an agreement with
11 the Board to accept a transplant payment allowance for all
12 expenses related to the transplant during a transplant benefit
13 period.
14 "Physician" means a person licensed to practice medicine
15 pursuant to the Medical Practice Act of 1987.
16 "Plan" means the Comprehensive Health Insurance Plan
17 established by this Act.
18 "Plan of operation" means the plan of operation of the
19 Plan, including articles, bylaws and operating rules, adopted
20 by the board pursuant to this Act.
21 "Provider" means any hospital, skilled nursing facility,
22 hospice, home health agency, physician, registered pharmacist
23 acting within the scope of that registration, or any other
24 person or entity licensed in Illinois to furnish medical care.
25 "Qualified high risk pool" has the same meaning given that
26 term in the federal Health Insurance Portability and

1 Accountability Act of 1996.
2 "Resident" means a person who is and continues to be
3 legally domiciled and physically residing on a permanent and
4 full-time basis in a place of permanent habitation in this
5 State that remains that person's principal residence and from
6 which that person is absent only for temporary or transitory
7 purpose.
8 "Skilled nursing facility" means a facility or that portion
9 of a facility that is licensed by the Illinois Department of
10 Public Health under the Nursing Home Care Act or a comparable
11 licensing authority in another state to provide skilled nursing
12 care.
13 "Stop-loss coverage" means an arrangement whereby an
14 insurer insures against the risk that any one claim will exceed
15 a specific dollar amount or that the entire loss of a
16 self-insurance plan will exceed a specific amount.
17 "Third party administrator" means an administrator as
18 defined in Section 511.101 of the Illinois Insurance Code who
19 is licensed under Article XXXI 1/4 of that Code.
20 (Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03; 93-34,
21 eff. 6-23-03; 93-477, eff. 8-8-03; 93-622, eff. 12-18-03.)

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