Rep. Barbara Flynn Currie

Filed: 4/5/2013

AMENDMENT TO SENATE BILL 1515

AMENDMENT NO. _____. Amend Senate Bill 1515 by replacing everything after the enacting clause with the following:

"Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Sections 5 and 8 as follows:

(5 ILCS 375/5) (from Ch. 127, par. 525)

Sec. 5. Employee benefits; declaration of State policy. The General Assembly declares that it is the policy of the State and in the best interest of the State to assure quality benefits to members and their dependents under this Act. The implementation of this policy depends upon, among other things, stability and continuity of coverage, care, and services under benefit programs for members and their dependents. Specifically, but without limitation, members should have continued access, on substantially similar terms and conditions, to trusted family health care providers with whom

they have developed long-term relationships through a benefit program under this Act. Therefore, the Director must administer this Act consistent with that State policy, but may consider affordability, cost of coverage and care, and competition among health insurers and providers. All contracts for provision of employee benefits, including those portions of any proposed collective bargaining agreement that would require implementation through contracts entered into under this Act, are subject to the following requirements:

(i) By April 1 of each year, the Director must report and provide information to the Commission concerning the status of the employee benefits program to be offered for the next fiscal year. Information includes, but is not limited to, documents, reports of negotiations, bid invitations, requests for proposals, specifications, copies of proposed and final contracts or agreements, and any other materials concerning contracts or agreements for the employee benefits program. By the first of each month thereafter, the Director must provide updated, and any new, information to the Commission until the employee benefits program for the next fiscal year is determined. In addition to these monthly reporting requirements, at any time the Commission makes a written request, the Director must promptly, but in no event later than 5 business days after receipt of the request, provide to the Commission any additional requested information in the possession of the

Director concerning employee benefits programs. The Commission may waive any of the reporting requirements of this item (i) upon the written request by the Director. Any waiver granted under this item (i) must be in writing. Nothing in this item is intended to abrogate any attorney-client privilege.

(ii) Within 30 days after notice of the awarding or letting of a contract has appeared in the Illinois Procurement Bulletin in accordance with subsection (b) of Section 15-25 of the Illinois Procurement Code, the Commission may request in writing from the Director and the Director shall promptly, but in no event later than 5 business days after receipt of the request, provide to the Commission information in the possession of the Director concerning the proposed contract. Nothing in this item is intended to waive or abrogate any privilege or right of confidentiality authorized by law.

(iii) No contract subject to this Section may be entered into until the 30-day period described in item (ii) has expired, unless the Director requests in writing that the Commission waive the period and the Commission grants the waiver in writing.

(iv) If the Director seeks to make any substantive modification to any provision of a proposed contract after it is submitted to the Commission in accordance with item (ii), the modified contract shall be subject to the

requirements of items (ii) and (iii) unless the Commission agrees, in writing, to a waiver of those requirements with respect to the modified contract.

(v) By the date of the beginning of the annual benefit choice period, the Director must transmit to the Commission a copy of each final contract or agreement for the employee benefits program to be offered for the next fiscal year. The annual benefit choice period for an employee benefits program must begin on May 1 of the fiscal year preceding the year for which the program is to be offered. If, however, in any such preceding fiscal year collective bargaining over employee benefit programs for the next fiscal year remains pending on April 15, the beginning date of the annual benefit choice period shall be not later than 15 days after ratification of the collective bargaining agreement.

(vi) The Director must provide the reports, information, and contracts required under items (i), (ii), (iv), and (v) by electronic or other means satisfactory to the Commission. Reports, information, and contracts in the possession of the Commission pursuant to items (i), (ii), (iv), and (v) are exempt from disclosure by the Commission and its members and employees under the Freedom of Information Act. Reports, information, and contracts received by the Commission pursuant to items (i), (ii), (iv), and (v) must be kept confidential by and may not be

disclosed or used by the Commission or its members or employees if such disclosure or use could compromise the fairness or integrity of the procurement, bidding, or contract process. Commission meetings, or portions of Commission meetings, in which reports, information, and contracts received by the Commission pursuant to items (i), (ii), (iv), and (v) are discussed must be closed if disclosure or use of the report or information could compromise the fairness or integrity of the procurement, bidding, or contract process.

All contracts entered into under this Section are subject to appropriation and shall comply with Section 20-60(b) of the Illinois Procurement Code (30 ILCS 500/20-60(b)).

The Director shall contract or otherwise make available group life insurance, health benefits and other employee benefits to eligible members and, where elected, their eligible dependents. Any contract or, if applicable, contracts or other arrangement for provision of benefits shall be on terms consistent with State policy and based on, but not limited to, such criteria as administrative cost, service capabilities of the carrier or other contractor and premiums, fees or charges as related to benefits.

Notwithstanding any other provisions of this Act, by January 1, 2014, the Department of Central Management Services, in consultation with the Chief Procurement Officer, shall contract or make otherwise available a program of group health

benefits for Medicare-primary members and their Medicare-primary dependents. The Director may procure a single contract or multiple contracts that provide a program of group health benefits that is comparable in stability and continuity of coverage, care, and services to the program of health benefits offered to other members and their dependents under this Act. The initial procurement of a contract or contracts under this paragraph is not subject to the provisions of the Illinois Procurement Code, except for Sections 20-60, 20-65, 20-70, and 20-160 and Article 50 of that Code, provided that the Chief Procurement Officer may, in writing with justification, waive any certification required under Article 50. A contract entered into pursuant to this paragraph is not subject to review by the Commission, regardless of any other provision in this Section or Act.

The Director may prepare and issue specifications for group life insurance, health benefits, other employee benefits and administrative services for the purpose of receiving proposals from interested parties.

The Director is authorized to execute a contract, or contracts, for the programs of group life insurance, health benefits, other employee benefits and administrative services authorized by this Act (including, without limitation, prescription drug benefits). All of the benefits provided under this Act may be included in one or more contracts, or the benefits may be classified into different types with each type

included under one or more similar contracts with the same or different companies.

The term of any contract may not extend beyond 5 fiscal years. Upon recommendation of the Commission, the Director may exercise renewal options of the same contract for up to a period of 5 years. Any increases in premiums, fees or charges requested by a contractor whose contract may be renewed pursuant to a renewal option contained therein, must be justified on the basis of (1) audited experience data, (2) increases in the costs of health care services provided under the contract, (3) contractor performance, (4) increases in contractor responsibilities, or (5) any combination thereof.

Any contractor shall agree to abide by all requirements of this Act and Rules and Regulations promulgated and adopted thereto; to submit such information and data as may from time to time be deemed necessary by the Director for effective administration of the provisions of this Act and the programs established hereunder, and to fully cooperate in any audit.

(Source: P.A. 93-839, eff. 7-30-04.)

(5 ILCS 375/8) (from Ch. 127, par. 528)

Sec. 8. Eligibility.

(a) Each employee eligible under the provisions of this Act and any rules and regulations promulgated and adopted hereunder by the Director shall become immediately eligible and covered for all benefits available under the programs. Employees

electing coverage for eligible dependents shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and procedures specified by the Director, including the completion and submission of all documentation and forms required by the Director.

(1) Every member originally eligible to elect dependent coverage, but not electing it during the original eligibility period, may subsequently obtain dependent coverage only in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

(2) Members described above being transferred from previous coverage towards which the State has been contributing shall be transferred regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled.

(3) Eligible and covered members that are eligible for coverage as dependents except for the fact of being members shall be transferred to, and covered under, dependent status regardless of preexisting conditions, waiting periods, or other requirements that might jeopardize claim payments to which they would otherwise have been entitled upon cessation of member status and the election of

dependent coverage by a member eligible to elect that coverage.

(b) New employees shall be immediately insured for the basic group life insurance and covered by the program of health benefits on the first day of active State service. Optional life insurance coverage one to 4 times the basic amount, if elected during the relevant eligibility period, will become effective on the date of employment. Optional life insurance coverage exceeding 4 times the basic amount and all life insurance amounts applied for after the eligibility period will be effective, subject to satisfactory evidence of insurability when applicable, or other necessary qualifications, pursuant to the requirements of the applicable benefit program, unless there is a change in status that would confer new eligibility for change of enrollment under rules established supplementing this Act, in which event application must be made within the new eligibility period.

(c) As to the group health benefits program contracted to begin or continue after June 30, 1973, each annuitant, survivor, and retired employee shall become immediately eligible for all benefits available under that program. Each annuitant, survivor, and retired employee shall have coverage effective immediately, provided that the election is properly filed in accordance with the required filing dates and procedures specified by the Director, including the completion and submission of all documentation and forms required by the

Director. Annuitants, survivors, and retired employees may elect coverage for eligible dependents and shall have the coverage effective immediately, provided that the election is properly filed in accordance with required filing dates and procedures specified by the Director, except that, for a survivor, the dependent sought to be added on or after the effective date of this amendatory Act of the 97th General Assembly must have been eligible for coverage as a dependent under the deceased member upon whom the survivor's annuity is based in order to be eligible for coverage under the survivor.

Except as otherwise provided in this Act, where husband and wife are both eligible members, each shall be enrolled as a member and coverage on their eligible dependent children, if any, may be under the enrollment and election of either.

Regardless of other provisions herein regarding late enrollment or other qualifications, as appropriate, the Director may periodically authorize open enrollment periods for each of the benefit programs at which time each member may elect enrollment or change of enrollment without regard to age, sex, health, or other qualification under the conditions as may be prescribed in rules and regulations supplementing this Act. Special open enrollment periods may be declared by the Director for certain members only when special circumstances occur that affect only those members.

(d) Beginning with fiscal year 2003 and for all subsequent years, eligible members may elect not to participate in the

program of health benefits as defined in this Act. The election must be made during the annual benefit choice period, subject to the conditions in this subsection.

(1) Members must furnish proof of health benefit coverage, either comprehensive major medical coverage or comprehensive managed care plan, from a source other than the Department of Central Management Services in order to elect not to participate in the program.

(2) Members may re-enroll in the Department of Central Management Services program of health benefits upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions, provided that there was not a break in coverage of more than 63 days.

(3) Members may also re-enroll in the program of health benefits during any annual benefit choice period, without evidence of insurability.

(4) Members who elect not to participate in the program of health benefits shall be furnished a written explanation of the requirements and limitations for the election not to participate in the program and for re-enrolling in the program. The explanation shall also be included in the annual benefit choice options booklets furnished to members.

(d-5) Beginning July 1, 2005, the Director may establish a

program of financial incentives to encourage annuitants receiving a retirement annuity ~~from the State Employees Retirement System~~, but who are not eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97) to elect not to participate in the program of health benefits provided under this Act. The election by an annuitant not to participate under this program must be made in accordance with the requirements set forth under subsection (d). The financial incentives provided to these annuitants under the program may not exceed $150 per month for each annuitant electing not to participate in the program of health benefits provided under this Act.

(d-6) Beginning July 1, 2013, the Director may establish a program of financial incentives to encourage annuitants with 20 or more years of creditable service but who are not eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act, as added by Public Law 89-97) to elect not to participate in the program of health benefits provided under this Act. The election by an annuitant not to participate under this program must be made in accordance with the requirements set forth under subsection (d). The program established under this subsection (d-6) may include a prorated incentive for annuitants with fewer than 20 years of creditable service, as determined by the Director. The financial incentives provided to these annuitants under this

program may not exceed $500 per month for each annuitant electing not to participate in the program of health benefits provided under this Act.

(e) Notwithstanding any other provision of this Act or the rules adopted under this Act, if a person participating in the program of health benefits as the dependent spouse of an eligible member becomes an annuitant, the person may elect, at the time of becoming an annuitant or during any subsequent annual benefit choice period, to continue participation as a dependent rather than as an eligible member for as long as the person continues to be an eligible dependent. In order to be eligible to make such an election, the person must have been enrolled as a dependent under the program of health benefits for no less than one year prior to becoming an annuitant.

An eligible member who has elected to participate as a dependent may re-enroll in the program of health benefits as an eligible member (i) during any subsequent annual benefit choice period or (ii) upon showing a qualifying change in status, as defined in the U.S. Internal Revenue Code, without evidence of insurability and with no limitations on coverage for pre-existing conditions.

A person who elects to participate in the program of health benefits as a dependent rather than as an eligible member shall be furnished a written explanation of the consequences of electing to participate as a dependent and the conditions and procedures for re-enrolling as an eligible member. The

explanation shall also be included in the annual benefit choice options booklet furnished to members.

(Source: P.A. 97-668, eff. 1-13-12.)

Section 10. The Illinois Procurement Code is amended by adding Section 25-205 as follows:

(30 ILCS 500/25-205 new)

Sec. 25-205. Procurement of health benefits for Medicare-primary members and their dependents. The Department of Central Management Services, in consultation with the Chief Procurement Officer, shall contract or make otherwise available a program of group health benefits for Medicare-primary members and their Medicare-primary dependents. The Director may procure a single contract or multiple contracts that provide a program of group health benefits that is comparable in stability and continuity of coverage, care, and services to the program of health benefits offered to other members and their dependents under the State Employees Group Insurance Act of 1971. The Department of Central Management Services shall provide administrative support and provide consultation to assist with the procurement. The initial procurement is not subject to the provisions of this Code, except for Sections 20-60, 20-65, 20-70, and 20-160, and Article 50, provided that the Chief Procurement Officer may, in writing with justification, waive

any certification required under Article 50.

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