

1 AN ACT to amend the Comprehensive Health Insurance Plan  
2 Act by changing Sections 2 and 15.

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

5 Section 5. The Comprehensive Health Insurance Plan Act  
6 is amended by changing Sections 2 and 15 as follows:

7 (215 ILCS 105/2) (from Ch. 73, par. 1302)

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

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

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

15 "Board" means the Illinois Comprehensive Health Insurance  
16 Board.

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

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

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

1 "Creditable coverage" means, with respect to a federally  
2 eligible individual, coverage of the individual under any of  
3 the following:

4 (A) A group health plan.

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

7 (C) Medicare.

8 (D) Medical assistance.

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

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

12 (G) A state health benefits risk pool.

13 (H) A health plan offered under Chapter 89 of title  
14 5, United States Code.

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

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

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

26 "Creditable coverage" does not include coverage  
27 consisting solely of coverage of excepted benefits, (as  
28 defined in Section 2791(c) of title XXVII of the Public  
29 Health Service Act (42 U.S.C. 300 gg-91)), nor does it include  
30 any period of coverage under any of items (A) through (K)  
31 that occurred before a break of more than 90 63 days during  
32 all of which the individual was not covered under any of  
33 items (A) through (K) above. Any period that an individual  
34 is in a waiting period for any coverage under a group health

1 plan (or for group health insurance coverage) or is in an  
 2 affiliation period under the terms of health insurance  
 3 coverage offered by a health maintenance organization shall  
 4 not be taken into account in determining if there has been a  
 5 break of more than 90 63 days in any creditable ~~credible~~  
 6 coverage.

7 "Department" means the Illinois Department of Insurance.

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

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

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

28 "Eligible person" means a resident of this State who  
 29 qualifies for Plan coverage under Section 7 of this Act.

30 "Employee" means a resident of this State who is employed  
 31 by an employer or has entered into the employment of or works  
 32 under contract or service of an employer including the  
 33 officers, managers and employees of subsidiary or affiliated  
 34 corporations and the individual proprietors, partners and

1 employees of affiliated individuals and firms when the  
2 business of the subsidiary or affiliated corporations, firms  
3 or individuals is controlled by a common employer through  
4 stock ownership, contract, or otherwise.

5 "Employer" means any individual, partnership,  
6 association, corporation, business trust, or any person or  
7 group of persons acting directly or indirectly in the  
8 interest of an employer in relation to an employee, for which  
9 one or more persons is gainfully employed.

10 "Family" coverage means the coverage provided by the Plan  
11 for the covered person and his or her eligible dependents who  
12 also are covered persons.

13 "Federally eligible individual" means an individual  
14 resident of this State:

15 (1)(A) for whom, as of the date on which the  
16 individual seeks Plan coverage under Section 15 of this  
17 Act, the aggregate of the periods of creditable coverage  
18 is 18 or more months, and (B) whose most recent prior  
19 creditable coverage was under group health insurance  
20 coverage offered by a health insurance issuer, a group  
21 health plan, a governmental plan, or a church plan (or  
22 health insurance coverage offered in connection with any  
23 such plans) or any other type of creditable coverage that  
24 may be required by the federal Health Insurance  
25 Portability and Accountability Act of 1996, as it may be  
26 amended, or the regulations under that Act;

27 (2) who is not eligible for coverage under (A) a  
28 group health plan, (B) part A or part B of Medicare due  
29 to age, or (C) medical assistance, and does not have  
30 other health insurance coverage;

31 (3) with respect to whom the most recent coverage  
32 within the coverage period described in paragraph (1)(A)  
33 of this definition was not terminated based upon a factor  
34 relating to nonpayment of premiums or fraud;

1           (4) if the individual had been offered the option  
 2 of continuation coverage under a COBRA continuation  
 3 provision or under a similar State program, who elected  
 4 such coverage; and

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

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

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

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

17           "Health insurance coverage" means benefits consisting of  
 18 medical care (provided directly, through insurance or  
 19 reimbursement, or otherwise and including items and services  
 20 paid for as medical care) under any hospital and medical  
 21 expense-incurred policy, certificate, or contract provided by  
 22 an insurer, non-profit health care service plan contract,  
 23 health maintenance organization or other subscriber contract,  
 24 or any other health care plan or arrangement that pays for or  
 25 furnishes medical or health care services whether by  
 26 insurance or otherwise. Health insurance coverage shall not  
 27 include short term, accident only, disability income,  
 28 hospital confinement or fixed indemnity, dental only, vision  
 29 only, limited benefit, or credit insurance, coverage issued  
 30 as a supplement to liability insurance, insurance arising out  
 31 of a workers' compensation or similar law, automobile  
 32 medical-payment insurance, or insurance under which benefits  
 33 are payable with or without regard to fault and which is  
 34 statutorily required to be contained in any liability

1 insurance policy or equivalent self-insurance.

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

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

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

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

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

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

27 "Insurer" means any insurance company authorized to  
28 transact health insurance business in this State and any  
29 corporation that provides medical services and is organized  
30 under the Voluntary Health Services Plans Act or the Health  
31 Maintenance Organization Act.

32 "Medical assistance" means the State medical assistance  
33 or medical assistance no grant (MANG) programs provided under  
34 Title XIX of the Social Security Act and Articles V (Medical

1 Assistance) and VI (General Assistance) of the Illinois  
2 Public Aid Code (or any successor program) or under any  
3 similar program of health care benefits in a state other than  
4 Illinois.

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

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

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

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

1 exceed that amount.

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

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

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

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

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

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

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

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



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

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

8 (Source: P.A. 90-30, eff. 7-1-97; 91-357, eff. 7-29-99;  
 9 91-735, eff. 6-2-00.)

10 (215 ILCS 105/15)

11 Sec. 15. Alternative portable coverage for federally  
 12 eligible individuals.

13 (a) Notwithstanding the requirements of subsection a. of  
 14 Section 7, any federally eligible individual for whom a Plan  
 15 application, and such enclosures and supporting documentation  
 16 as the Board may require, is received by the Board within 90  
 17 63 days after the termination of prior creditable coverage  
 18 shall qualify to enroll in the Plan under the portability  
 19 provisions of this Section.

20 (b) Any federally eligible individual seeking Plan  
 21 coverage under this Section must submit with his or her  
 22 application evidence, including acceptable written  
 23 certification of previous creditable coverage, that will  
 24 establish to the Board's satisfaction, that he or she meets  
 25 all of the requirements to be a federally eligible individual  
 26 and is currently and permanently residing in this State (as  
 27 of the date his or her application was received by the  
 28 Board).

29 (c) A period of creditable coverage shall not be  
 30 counted, with respect to qualifying an applicant for Plan  
 31 coverage as a federally eligible individual under this  
 32 Section, if after such period and before the application for  
 33 Plan coverage was received by the Board, there was at least a

1     90 63 day period during all of which the individual was not  
2 covered under any creditable coverage.

3           (d) Any federally eligible individual who the Board  
4 determines qualifies for Plan coverage under this Section  
5 shall be offered his or her choice of enrolling in one of  
6 alternative portability health benefit plans which the Board  
7 is authorized under this Section to establish for these  
8 federally eligible individuals and their dependents.

9           (e) The Board shall offer a choice of health care  
10 coverages consistent with major medical coverage under the  
11 alternative health benefit plans authorized by this Section  
12 to every federally eligible individual. The coverages to be  
13 offered under the plans, the schedule of benefits,  
14 deductibles, co-payments, exclusions, and other limitations  
15 shall be approved by the Board. One optional form of  
16 coverage shall be comparable to comprehensive health  
17 insurance coverage offered in the individual market in this  
18 State or a standard option of coverage available under the  
19 group or individual health insurance laws of the State. The  
20 standard benefit plan that is authorized by Section 8 of this  
21 Act may be used for this purpose. The Board may also offer a  
22 preferred provider option and such other options as the Board  
23 determines may be appropriate for these federally eligible  
24 individuals who qualify for Plan coverage pursuant to this  
25 Section.

26           (f) Notwithstanding the requirements of subsection f. of  
27 Section 8, any plan coverage that is issued to federally  
28 eligible individuals who qualify for the Plan pursuant to the  
29 portability provisions of this Section shall not be subject  
30 to any preexisting conditions exclusion, waiting period, or  
31 other similar limitation on coverage.

32           (g) Federally eligible individuals who qualify and  
33 enroll in the Plan pursuant to this Section shall be required  
34 to pay such premium rates as the Board shall establish and

1 approve in accordance with the requirements of Section 7.1 of  
2 this Act.

3 (h) A federally eligible individual who qualifies and  
4 enrolls in the Plan pursuant to this Section must satisfy on  
5 an ongoing basis all of the other eligibility requirements of  
6 this Act to the extent not inconsistent with the federal  
7 Health Insurance Portability and Accountability Act of 1996  
8 in order to maintain continued eligibility for coverage under  
9 the Plan.

10 (Source: P.A. 90-30, eff. 7-1-97.)

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