AN ACT in relation to health.

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

Section 1. Short title. This Act may be cited as the Family Health Insurance Program Act.

Section 5. Legislative intent. The General Assembly finds that, for the economic and social benefit of all citizens of this State, it is important to enable low-income families with children to access health benefits coverage, especially for preventive and maintenance health care. This helps these families to maintain and succeed in their work efforts. Coverage of the entire family also promotes the goals of the Children's Health Insurance Program. The General Assembly recognizes that assistance to help families purchase health benefits must be provided in a fair and equitable fashion and must treat families at the same income level in a similar fashion. The State of Illinois should also help low-income families transition from a program in which the State helps the family to secure the family's health coverage to a program in which the family is covered by private or employer-based insurance without help from a State program.

Section 10. Definitions.

"Children's Health Insurance Program" means the program of health insurance provided under the Children's Health Insurance Program Act.

"Department" means the Department of Public Aid.

"Family", consistent with Department rules under the Medical Assistance and Children's Health Insurance programs, means a group of people who live together and who include

minor children and their adult caretaker relatives. This may include parents or other blood-related adults when they are the children's caretaker. "Family" also includes the spouses of those parents or caretaker relatives. "Family" also includes any other persons who are defined as covered family members under employer-provided or private health insurance for which a single "family coverage" premium is paid.

"Medical Assistance Program" is the health care benefit program provided under Article V of the Illinois Public Aid Code.

"Program" means the Family Health Insurance Program.

Section 15. Operation of the program. The Family Health Insurance Program is created. The program shall operate subject to appropriation and shall be administered by the Department. Except as otherwise provided in this Act, the program is subject to the same rules and requirements as the Children's Health Insurance Program. Families have the option for their children to participate only in the Children's Health Insurance Program, even if the parents are eligible for coverage under this Act.

Section 20. Eligibility.

(a) The Department shall be responsible for all determinations of eligibility for the program.

(b) To be eligible for health insurance coverage under the program, a family must include a child who meets the non-financial and financial eligibility requirements for health coverage under the Children's Health Insurance Program or non-spend-down coverage under the Medical Assistance Program.

(c) A family determined eligible for the program remains eligible for 12 months, as long as it meets the following criteria:

(1) The family is an Illinois resident as defined in rules.

(2) At least one child in the family remains under the age of 19.

(3) The family is not excluded under subsection (d).

The Department shall determine each family's eligibility at least once each year.

(d) A family is not eligible for coverage under the program if it meets any of the following criteria:

(1) A premium required under the program is not paid. The Department shall adopt rules governing periods of coverage in the event of loss of eligibility due to unpaid premiums, waiting periods and conditions for re-enrollment, grace periods, notices, and hearing procedures relevant to this subsection.

(2) There is no longer a child in the family eligible under the Children's Health Insurance Program or non-spend-down Medical Assistance.

(3) The family is eligible for health insurance under the State of Illinois health benefits plan on the basis of a family member's employment with a public agency.

Section 25. Health benefits for families.

(a) Subject to appropriation, the Department shall provide health benefits coverage to eligible families by doing either of the following or a combination if required for federal approval:

(1) Subsidizing the cost of a family's coverage, for families with a member who has access to employer-provided or private family health coverage.

(2) Providing the family with health benefits that, subject to appropriation and without regard to any applicable cost-sharing under Section 30, are identical

to the benefits provided under the State's approved plan under Title XIX of the Social Security Act or any waivers granted by the federal Health Care Financing Administration, for families that do not have access to employer-provided family health coverage or for whom subsidization of that coverage under paragraph (1) is not cost-effective for the State, as determined by the Department pursuant to rules. Providers of health benefits under this paragraph (2) must be approved by the Department to provide health care under the Illinois Public Aid Code and shall be reimbursed at the same rate as providers under the State's approved plan under Title XIX of the Social Security Act. Any copayments required under Section 30 may be paid to the Department or retained by the provider, as provided by rule.

(b) The Department may provide the subsidy pursuant to subdivision (a)(1) directly to an insurance company, as a rebate to the family for premiums paid through payroll deduction, or in any other manner the Department deems cost-effective and accurate and best suited to accomplish the purposes of the program. The Department may also take appropriate measures to ensure that employers do not take unfair advantage of the subsidies provided under subdivision (a)(1) by increasing the subsidized employees' share of the premium for health insurance by amounts out-of-proportion to any increase in the actual total cost of the insurance.

(c) The Department may deny subsidization of coverage if the coverage fails to meet minimum benchmark standards adopted by the Department in rules. To be eligible for inclusion in the program, the plan must contain at least comprehensive major medical coverage of physician and hospital inpatient services. The Department may deny subsidization of coverage for a family under subdivision (a)(1) if it is more cost-effective to provide coverage for

the family under subdivision (a)(2).

(d) The Department may limit the monthly subsidy to an amount equal to the average monthly cost of providing coverage to comparable parents under subdivision (a)(2), or a larger amount established by the Department by rule. The Department, to the extent it imposes this limitation, must set this "average monthly cost" prospectively based on the prior fiscal year's experience adjusted for incurred-but-not-reported claims and estimated increases or decreases in the cost of medical care. The subsidy may not exceed the amount of the family's share of the premium for the health insurance.

Section 30. Cost-sharing.

(a) A family enrolled in a health benefits program under subdivision (a)(2) of Section 25 is subject to the following cost-sharing requirements to the extent permitted by federal requirements in waivers governing the funding of the program:

(1) A copayment may not be required for well-baby or well-child care, including age-appropriate immunizations as required under federal law.

(2) Health insurance premiums for a family whose household income is equal to or greater than 150% of the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2) must be payable monthly, subject to rules adopted by the Department for grace periods and advance payments, and must be as follows:

(A) $25 for a family composed of 2 covered persons.

(B) $30 for a family composed of 3 covered persons.

(C) $35 for a family composed of at least one

covered adult and 3 or more covered dependents.

(3) Copayments for a family whose income is at or below 150% of the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2), at a minimum and to the extent permitted under federal law, must be $2 for each medical visit and each prescription provided under this Act.

(4) Copayments for a family whose income is greater than 150% of the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2), at a minimum and to the extent permitted under federal law, must be as follows:

(A) $5 for each medical visit.

(B) $3 for each generic prescription and $5 for each brand-name prescription.

(C) $25 for each emergency room use for a non-emergency situation as defined by the Department by rule.

(5) The maximum allowable amount of out-of-pocket expenses for copayments is $100 per family per year.

(b) A family whose health benefits coverage is subsidized under subdivision (a)(1) of Section 25 is subject to (i) the cost-sharing provisions of the employer-provided or private family health coverage under which a family member is covered, (ii) the requirements imposed by the federal government under any waivers governing federal funding of the program, or (iii) both.

Section 35. Funding.

(a) The program is not an entitlement and shall not be construed to create an entitlement. Eligibility for the program is subject to appropriation of moneys by the State

and federal governments to fund the program.

(b) Any requirement imposed under this Act and any implementation of this Act by the Department shall cease in the event that moneys are not available for those purposes.

Section 40. Medical Assistance Plan amendments; federal waivers.

(a) The Department shall amend the State's Medical Assistance Plan and the State Children's Health Insurance Plan to the extent required to implement this Act and to the extent permitted by federal law in order to secure federal matching funds for the health coverages provided and administrative expenses incurred under this Act.

(b) Promptly after the effective date of this Act, the Department shall request any necessary waivers of federal requirements in order to allow receipt of federal funding for the health coverages subsidized or provided and administrative expenses incurred under this Act.

Section 45. Contracts with non-governmental bodies. All contracts with non-governmental bodies that are determined by the Department to be necessary for the implementation of this Act are deemed to be purchase of care as defined in the Illinois Procurement Code.

Section 50. Implementation date. The Department must begin implementing this Act on the effective date of this Act. Health benefits coverage may not be subsidized or provided under the program, and applications for enrollment in the program may not be taken, until January 1, 2002 at the earliest. Thereafter, the Department may delay implementation of any portions of the program as to which federal matching funds are not yet approved.

Section 55. Repealer. This Act is repealed on June 30, 2007.

Section 90. The Illinois Health Insurance Portability and Accountability Act is amended by changing Section 20 as follows:

(215 ILCS 97/20)

Sec. 20. Increased portability through limitation on preexisting condition exclusions.

(A) Limitation of preexisting condition exclusion period; crediting for periods of previous coverage. Subject to subsection (D), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) the exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) the exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (C)(1)) applicable to the participant or beneficiary as of the enrollment date.

(B) Preexisting condition exclusion. A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

Genetic information shall not be treated as a condition

described in subsection (A)(1) in the absence of a diagnosis of the condition related to such information.

(C) Rules relating to crediting previous coverage.

(1) Creditable coverage defined. For purposes of this Act, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan.

(b) Health insurance coverage.

(c) Part A or part B of title XVIII of the Social Security Act.

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928.

(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).

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

(k) Title XXI of the federal Social Security Act, State Children's Health Insurance Program.

(l) Coverage under the Family Health Insurance Program Act.

Such term does not include coverage consisting solely of coverage of excepted benefits.

(2) Excepted benefits. For purposes of this Act, the term "excepted benefits" means benefits under one or more of the following:

(a) Benefits not subject to requirements:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) Benefits not subject to requirements if offered separately:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as are specified in rules.

(c) Benefits not subject to requirements if offered, as independent, noncoordinated benefits:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(d) Benefits not subject to requirements if offered as separate insurance policy. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(3) Not counting periods before significant breaks in coverage.

(a) In general. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(b) Waiting period not treated as a break in coverage. For purposes of subparagraph (a) and subsection (D)(3), 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 (as defined in subsection (G)(2)) shall not be taken into account in determining the continuous period under subparagraph (a).

(4) Method of crediting coverage.

(a) Standard method. Except as otherwise provided under subparagraph (b), for purposes of applying subsection (A)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(b) Election of alternative method. A group health plan, or a health insurance issuer offering group health insurance, may elect to apply subsection (A)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (a). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(c) Plan notice. In the case of an election with respect to a group health plan under subparagraph (b) (whether or not health insurance coverage is provided in connection with such plan), the plan shall:

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election; and

(ii) include in such statements a description of the effect of this election.

(d) Issuer notice. In the case of an election under subparagraph (b) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election; and

(ii) shall include in such statements a description of the effect of such election.

(5) Establishment of period. Periods of creditable coverage with respect to an individual shall be established through presentation or certifications described in subsection (E) or in such other manner as may be specified in regulations.

(D) Exceptions:

(1) Exclusion not applicable to certain newborns. Subject to paragraph (3), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. Subject to paragraph (3), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage.

The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Loss if break in coverage. Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(E) Certifications and disclosure of coverage.

(1) Requirement for Certification of Period of Creditable Coverage.

(a) A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (b):

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(b) The certification described in this subparagraph is a written certification of:

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision; and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(c) To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage

provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits. In the case of an election described in subsection (C)(4)(b) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1):

(a) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

(b) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Rules. The Department shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(4) Treatment of certain plans as group health plan for notice provision. A program under which creditable coverage described in subparagraph (c), (d), (e), or (f) of Section 20(C)(1) is provided shall be treated as a group health plan for purposes of this Section.

(F) Special enrollment periods.

(1) Individuals losing other coverage. A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible,

but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(c) The employee's or dependent's coverage described in subparagraph (a):

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

(d) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (c)(i) or termination of coverage or

employer contributions described in subparagraph (c)(ii).

(2) For dependent beneficiaries.

(a) In general. If:

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

then the group health plan shall provide for a dependent special enrollment period described in subparagraph (b) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(b) Dependent special enrollment period. A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (a)(iii).

(c) No waiting period. If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(G) Use of affiliation period by HMOs as alternative to preexisting condition exclusion.

(1) In general. A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any pre-existing condition exclusion allowed under subsection (A) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:

(a) such period is applied uniformly without regard to any health status-related factors; and

(b) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period.

(a) Defined. For purposes of this Act, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such

period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(b) Beginning. Such period shall begin on the enrollment date.

(c) Runs concurrently with waiting periods. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the Department.

(Source: P.A. 90-30, eff. 7-1-97; 90-736, eff. 8-12-98.)

Section 95. The Children's Health Insurance Program Act is amended by changing Section 20 as follows:

(215 ILCS 106/20)

(Section scheduled to be repealed on July 1, 2002)

Sec. 20. Eligibility.

(a) To be eligible for this Program, a person must be a person who has a child eligible under this Act and who is eligible under a waiver of federal requirements pursuant to an application made pursuant to subdivision (a)(1) of Section 40 of this Act or who is a child who:

(1) is a child who is not eligible for medical assistance;

(2) is a child whose annual household income, as determined by the Department, is above 133% of the federal poverty level and at or below 185% of the federal poverty level<u>; provided, that the Department may establish the upper limit of eligibility at 200% of the federal poverty level as part of acquiring federal</u>

waivers from the federal Health Care Financing Administration allowing Illinois to claim favorable levels of federal matching funds to provide health insurance to adult caretaker relatives of children under the Family Health Insurance Program Act;

(3) is a resident of the State of Illinois; and

(4) is a child who is either a United States citizen or included in one of the following categories of non-citizens:

(A) unmarried dependent children of either a United States Veteran honorably discharged or a person on active military duty;

(B) refugees under Section 207 of the Immigration and Nationality Act;

(C) asylees under Section 208 of the Immigration and Nationality Act;

(D) persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act;

(E) persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980;

(F) persons lawfully admitted for permanent residence under the Immigration and Nationality Act; and

(G) parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.

Those children who are in the categories set forth in subdivisions (4)(F) and (4)(G) of this subsection, who enter the United States on or after August 22, 1996, shall not be eligible for 5 years beginning on the date the child entered the United States.

(b) A child who is determined to be eligible for

assistance shall remain eligible for 12 months, provided the child maintains his or her residence in the State, has not yet attained 19 years of age, and is not excluded pursuant to subsection (c). Eligibility shall be re-determined by the Department at least annually.

(c) A child shall not be eligible for coverage under this Program if:

(1) the premium required pursuant to Section 30 of this Act has not been 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 had been paid. If the required monthly premium is not paid, the child shall be ineligible for re-enrollment for a minimum period of 3 months. Re-enrollment shall be completed prior to the next covered medical visit and the first month's required premium shall be paid in advance of the next covered medical visit. The Department shall promulgate rules regarding grace periods, notice requirements, and hearing procedures pursuant to this subsection;

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

(3) the child is a member of a family that is eligible for health benefits covered under the State of Illinois health benefits plan on the basis of a member's employment with a public agency.

(Source: P.A. 90-736, eff. 8-12-98.)