

State of Illinois 92nd General Assembly Legislation

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[Introduced]

[Engrossed]

92_HB5606enr

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1 AN ACT concerning the comprehensive health insurance
2 plan.

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 Section 8 as follows:

7 (215 ILCS 105/8) (from Ch. 73, par. 1308)

8 Sec. 8. Minimum benefits.

9 a. Availability. The Plan shall offer in an annually
10 renewable policy major medical expense coverage to every
11 eligible person who is not eligible for Medicare. Major
12 medical expense coverage offered by the Plan shall pay an
13 eligible person's covered expenses, subject to limit on the
14 deductible and coinsurance payments authorized under
15 paragraph (4) of subsection d of this Section, up to a
16 lifetime benefit limit of \$1,000,000 per covered individual.
17 The maximum limit under this subsection shall not be altered
18 by the Board, and no actuarial equivalent benefit may be
19 substituted by the Board. Any person who otherwise would
20 qualify for coverage under the Plan, but is excluded because
21 he or she is eligible for Medicare, shall be eligible for any
22 separate Medicare supplement policy or policies which the
23 Board may offer.

24 b. Outline of benefits. Covered expenses shall be
25 limited to the usual and customary charge, including
26 negotiated fees, in the locality for the following services
27 and articles when prescribed by a physician and determined by
28 the Plan to be medically necessary for the following areas of
29 services, subject to such separate deductibles, co-payments,
30 exclusions, and other limitations on benefits as the Board
31 shall establish and approve, and the other provisions of this

1 Section:

2 (1) Hospital services, except that any services
3 provided by a hospital that is located more than 75 miles
4 outside the State of Illinois shall be covered only for a
5 maximum of 45 days in any calendar year. With respect to
6 covered expenses incurred during any calendar year ending
7 on or after December 31, 1999, inpatient hospitalization
8 of an eligible person for the treatment of mental illness
9 at a hospital located within the State of Illinois shall
10 be subject to the same terms and conditions as for any
11 other illness.

12 (2) Professional services for the diagnosis or
13 treatment of injuries, illnesses or conditions, other
14 than dental and mental and nervous disorders as described
15 in paragraph (17), which are rendered by a physician, or
16 by other licensed professionals at the physician's
17 direction. This includes reconstruction of the breast on
18 which a mastectomy was performed; surgery and
19 reconstruction of the other breast to produce a
20 symmetrical appearance; and prostheses and treatment of
21 physical complications at all stages of the mastectomy,
22 including lymphedemas.

23 (2.5) Professional services provided by a physician
24 to children under the age of 16 years for physical
25 examinations and age appropriate immunizations ordered by
26 a physician licensed to practice medicine in all its
27 branches.

28 (3) (Blank).

29 (4) Outpatient prescription drugs that by law
30 require a prescription written by a physician licensed to
31 practice medicine in all its branches subject to such
32 separate deductible, copayment, and other limitations or
33 restrictions as the Board shall approve, including the
34 use of a prescription drug card or any other program, or

1 both.

2 (5) Skilled nursing services of a licensed skilled
3 nursing facility for not more than 120 days during a
4 policy year.

5 (6) Services of a home health agency in accord with
6 a home health care plan, up to a maximum of 270 visits
7 per year.

8 (7) Services of a licensed hospice for not more
9 than 180 days during a policy year.

10 (8) Use of radium or other radioactive materials.

11 (9) Oxygen.

12 (10) Anesthetics.

13 (11) Orthoses and prostheses other than dental.

14 (12) Rental or purchase in accordance with Board
15 policies or procedures of durable medical equipment,
16 other than eyeglasses or hearing aids, for which there is
17 no personal use in the absence of the condition for which
18 it is prescribed.

19 (13) Diagnostic x-rays and laboratory tests.

20 (14) Oral surgery (i) for excision of partially or
21 completely unerupted impacted teeth when not performed in
22 connection with the routine extraction or repair of

23 teeth; (ii) for excision of tumors or cysts of the jaws,
24 cheeks, lips, tongue, and roof and floor of the mouth;
25 (iii) required for correction of cleft lip and palate and
26 other craniofacial and maxillofacial birth defects; or
27 (iv) for treatment of injuries to natural teeth or a
28 fractured jaw due to an accident.

29 (15) Physical, speech, and functional occupational
30 therapy as medically necessary and provided by
31 appropriate licensed professionals.

32 (16) Emergency and other medically necessary
33 transportation provided by a licensed ambulance service
34 to the nearest health care facility qualified to treat a

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1 covered illness, injury, or condition, subject to the
2 provisions of the Emergency Medical Systems (EMS) Act.

3 (17) Outpatient services for diagnosis and
4 treatment of mental and nervous disorders provided that a
5 covered person shall be required to make a copayment not
6 to exceed 50% and that the Plan's payment shall not
7 exceed such amounts as are established by the Board.

8 (18) Human organ or tissue transplants specified by
9 the Board that are performed at a hospital designated by
10 the Board as a participating transplant center for that
11 specific organ or tissue transplant.

12 (19) Naprapathic services, as appropriate, provided
13 by a licensed naprapathic practitioner.

14 c. Exclusions. Covered expenses of the Plan shall not
15 include the following:

16 (1) Any charge for treatment for cosmetic purposes
17 other than for reconstructive surgery when the service is
18 incidental to or follows surgery resulting from injury,
19 sickness or other diseases of the involved part or
20 surgery for the repair or treatment of a congenital
21 bodily defect to restore normal bodily functions.

22 (2) Any charge for care that is primarily for rest,
23 custodial, educational, or domiciliary purposes.

24 (3) Any charge for services in a private room to
25 the extent it is in excess of the institution's charge
26 for its most common semiprivate room, unless a private
27 room is prescribed as medically necessary by a physician.

28 (4) That part of any charge for room and board or
29 for services rendered or articles prescribed by a
30 physician, dentist, or other health care personnel that
31 exceeds the reasonable and customary charge in the
32 locality or for any services or supplies not medically
33 necessary for the diagnosed injury or illness.

34 (5) Any charge for services or articles the

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1 provision of which is not within the scope of licensure
2 of the institution or individual providing the services
3 or articles.

4 (6) Any expense incurred prior to the effective
5 date of coverage by the Plan for the person on whose
6 behalf the expense is incurred.

7 (7) Dental care, dental surgery, dental treatment,
8 any other dental procedure involving the teeth or
9 periodontium, or any dental appliances, including crowns,
10 bridges, implants, or partial or complete dentures,

11 except as specifically provided in paragraph (14) of
12 subsection b of this Section.

13 (8) Eyeglasses, contact lenses, hearing aids or
14 their fitting.

15 (9) Illness or injury due to acts of war.

16 (10) Services of blood donors and any fee for
17 failure to replace the first 3 pints of blood provided to
18 a covered person each policy year.

19 (11) Personal supplies or services provided by a
20 hospital or nursing home, or any other nonmedical or
21 nonprescribed supply or service.

22 (12) Routine maternity charges for a pregnancy,
23 except where added as optional coverage with payment of
24 an additional premium for pregnancy resulting from
25 conception occurring after the effective date of the
26 optional coverage.

27 (13) (Blank).

28 (14) Any expense or charge for services, drugs, or
29 supplies that are: (i) not provided in accord with
30 generally accepted standards of current medical practice;
31 (ii) for procedures, treatments, equipment, transplants,
32 or implants, any of which are investigational,
33 experimental, or for research purposes; (iii)
34 investigative and not proven safe and effective; or (iv)

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1 for, or resulting from, a gender transformation
2 operation.

3 (15) Any expense or charge for routine physical
4 examinations or tests except as provided in item (2.5) of
5 subsection b of this Section.

6 (16) Any expense for which a charge is not made in
7 the absence of insurance or for which there is no legal
8 obligation on the part of the patient to pay.

9 (17) Any expense incurred for benefits provided
10 under the laws of the United States and this State,
11 including Medicare, Medicaid, and other medical
12 assistance, maternal and child health services and any
13 other program that is administered or funded by the
14 Department of Human Services, Department of Public Aid,
15 or Department of Public Health, military
16 service-connected disability payments, medical services
17 provided for members of the armed forces and their
18 dependents or employees of the armed forces of the United
19 States, and medical services financed on behalf of all
20 citizens by the United States.

21 (18) Any expense or charge for in vitro
22 fertilization, artificial insemination, or any other
23 artificial means used to cause pregnancy.

24 (19) Any expense or charge for oral contraceptives
25 used for birth control or any other temporary birth
26 control measures.

27 (20) Any expense or charge for sterilization or
28 sterilization reversals.

29 (21) Any expense or charge for weight loss
30 programs, exercise equipment, or treatment of obesity,
31 except when certified by a physician as morbid obesity
32 (at least 2 times normal body weight).

33 (22) Any expense or charge for acupuncture
34 treatment unless used as an anesthetic agent for a

1 covered surgery.

2 (23) Any expense or charge for or related to organ
3 or tissue transplants other than those performed at a
4 hospital with a Board approved organ transplant program
5 that has been designated by the Board as a preferred or
6 exclusive provider organization for that specific organ
7 or tissue transplant.

8 (24) Any expense or charge for procedures,
9 treatments, equipment, or services that are provided in
10 special settings for research purposes or in a controlled
11 environment, are being studied for safety, efficiency,
12 and effectiveness, and are awaiting endorsement by the
13 appropriate national medical speciality college for
14 general use within the medical community.

15 d. Deductibles and coinsurance.

16 The Plan coverage defined in Section 6 shall provide for
17 a choice of deductibles per individual as authorized by the
18 Board. If 2 individual members of the same family household,
19 who are both covered persons under the Plan, satisfy the same
20 applicable deductibles, no other member of that family who is
21 also a covered person under the Plan shall be required to
22 meet any deductibles for the balance of that calendar year.
23 The deductibles must be applied first to the authorized
24 amount of covered expenses incurred by the covered person. A
25 mandatory coinsurance requirement shall be imposed at the
26 rate authorized by the Board in excess of the mandatory
27 deductible, the coinsurance in the aggregate not to exceed
28 such amounts as are authorized by the Board per annum. At
29 its discretion the Board may, however, offer catastrophic
30 coverages or other policies that provide for larger
31 deductibles with or without coinsurance requirements. The
32 deductibles and coinsurance factors may be adjusted annually
33 according to the Medical Component of the Consumer Price
34 Index.

1 e. Scope of coverage.

2 (1) In approving any of the benefit plans to be
3 offered by the Plan, the Board shall establish such
4 benefit levels, deductibles, coinsurance factors,
5 exclusions, and limitations as it may deem appropriate
6 and that it believes to be generally reflective of and
7 commensurate with health insurance coverage that is
8 provided in the individual market in this State.

9 (2) The benefit plans approved by the Board may
10 also provide for and employ various cost containment
11 measures and other requirements including, but not
12 limited to, preadmission certification, prior approval,
13 second surgical opinions, concurrent utilization review
14 programs, individual case management, preferred provider
15 organizations, health maintenance organizations, and
16 other cost effective arrangements for paying for covered
17 expenses.

18 f. Preexisting conditions.

19 (1) Except for federally eligible individuals
20 qualifying for Plan coverage under Section 15 of this Act
21 or eligible persons who qualify for the waiver authorized
22 in paragraph (3) of this subsection, plan coverage shall

23 exclude charges or expenses incurred during the first 6
24 months following the effective date of coverage as to any
25 condition for which medical advice, care or treatment was
26 recommended or received during the 6 month period
27 immediately preceding the effective date of coverage.

28 (2) (Blank).

29 (3) Waiver: The preexisting condition exclusions as
30 set forth in paragraph (1) of this subsection shall be
31 waived to the extent to which the eligible person (a) has
32 satisfied similar exclusions under any prior individual
33 health insurance policy that was involuntarily terminated
34 because of the insolvency of the issuer of the policy and

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1 (b) has applied for Plan coverage within 90 ~~63~~ days
2 following the involuntary termination of that individual
3 health insurance coverage.

4 g. Other sources primary; nonduplication of benefits.

5 (1) The Plan shall be the last payor of benefits
6 whenever any other benefit or source of third party
7 payment is available. Subject to the provisions of
8 subsection e of Section 7, benefits otherwise payable
9 under Plan coverage shall be reduced by all amounts paid
10 or payable by Medicare or any other government program or
11 through any health insurance coverage or group health
12 plan, whether by insurance, reimbursement, or otherwise,
13 or through any third party liability, settlement,
14 judgment, or award, regardless of the date of the
15 settlement, judgment, or award, whether the settlement,
16 judgment, or award is in the form of a contract,
17 agreement, or trust on behalf of a minor or otherwise and
18 whether the settlement, judgment, or award is payable to
19 the covered person, his or her dependent, estate,
20 personal representative, or guardian in a lump sum or
21 over time, and by all hospital or medical expense
22 benefits paid or payable under any worker's compensation
23 coverage, automobile medical payment, or liability
24 insurance, whether provided on the basis of fault or
25 nonfault, and by any hospital or medical benefits paid or
26 payable under or provided pursuant to any State or
27 federal law or program.

28 (2) The Plan shall have a cause of action against
29 any covered person or any other person or entity for the
30 recovery of any amount paid to the extent the amount was
31 for treatment, services, or supplies not covered in this
32 Section or in excess of benefits as set forth in this
33 Section.

34 (3) Whenever benefits are due from the Plan because

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1 of sickness or an injury to a covered person resulting
2 from a third party's wrongful act or negligence and the
3 covered person has recovered or may recover damages from
4 a third party or its insurer, the Plan shall have the
5 right to reduce benefits or to refuse to pay benefits
6 that otherwise may be payable by the amount of damages
7 that the covered person has recovered or may recover
8 regardless of the date of the sickness or injury or the
9 date of any settlement, judgment, or award resulting from
10 that sickness or injury.

11 During the pendency of any action or claim that is
12 brought by or on behalf of a covered person against a
13 third party or its insurer, any benefits that would
14 otherwise be payable except for the provisions of this
15 paragraph (3) shall be paid if payment by or for the
16 third party has not yet been made and the covered person
17 or, if incapable, that person's legal representative
18 agrees in writing to pay back promptly the benefits paid
19 as a result of the sickness or injury to the extent of
20 any future payments made by or for the third party for
21 the sickness or injury. This agreement is to apply
22 whether or not liability for the payments is established
23 or admitted by the third party or whether those payments
24 are itemized.

25 Any amounts due the plan to repay benefits may be
26 deducted from other benefits payable by the Plan after
27 payments by or for the third party are made.

28 (4) Benefits due from the Plan may be reduced or
29 refused as an offset against any amount otherwise
30 recoverable under this Section.

31 h. Right of subrogation; recoveries.

32 (1) Whenever the Plan has paid benefits because of
33 sickness or an injury to any covered person resulting
34 from a third party's wrongful act or negligence, or for

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1 which an insurer is liable in accordance with the
2 provisions of any policy of insurance, and the covered
3 person has recovered or may recover damages from a third
4 party that is liable for the damages, the Plan shall have
5 the right to recover the benefits it paid from any
6 amounts that the covered person has received or may
7 receive regardless of the date of the sickness or injury
8 or the date of any settlement, judgment, or award
9 resulting from that sickness or injury. The Plan shall
10 be subrogated to any right of recovery the covered person
11 may have under the terms of any private or public health
12 care coverage or liability coverage, including coverage
13 under the Workers' Compensation Act or the Workers'
14 Occupational Diseases Act, without the necessity of
15 assignment of claim or other authorization to secure the
16 right of recovery. To enforce its subrogation right, the
17 Plan may (i) intervene or join in an action or proceeding
18 brought by the covered person or his personal
19 representative, including his guardian, conservator,
20 estate, dependents, or survivors, against any third party
21 or the third party's insurer that may be liable or (ii)
22 institute and prosecute legal proceedings against any
23 third party or the third party's insurer that may be
24 liable for the sickness or injury in an appropriate court
25 either in the name of the Plan or in the name of the
26 covered person or his personal representative, including
27 his guardian, conservator, estate, dependents, or
28 survivors.

29 (2) If any action or claim is brought by or on
30 behalf of a covered person against a third party or the
31 third party's insurer, the covered person or his personal
32 representative, including his guardian, conservator,
33 estate, dependents, or survivors, shall notify the Plan
34 by personal service or registered mail of the action or

1 claim and of the name of the court in which the action or
2 claim is brought, filing proof thereof in the action or
3 claim. The Plan may, at any time thereafter, join in the
4 action or claim upon its motion so that all orders of
5 court after hearing and judgment shall be made for its
6 protection. No release or settlement of a claim for
7 damages and no satisfaction of judgment in the action
8 shall be valid without the written consent of the Plan to
9 the extent of its interest in the settlement or judgment
10 and of the covered person or his personal representative.

11 (3) In the event that the covered person or his
12 personal representative fails to institute a proceeding
13 against any appropriate third party before the fifth
14 month before the action would be barred, the Plan may, in
15 its own name or in the name of the covered person or
16 personal representative, commence a proceeding against
17 any appropriate third party for the recovery of damages
18 on account of any sickness, injury, or death to the
19 covered person. The covered person shall cooperate in
20 doing what is reasonably necessary to assist the Plan in
21 any recovery and shall not take any action that would
22 prejudice the Plan's right to recovery. The Plan shall
23 pay to the covered person or his personal representative
24 all sums collected from any third party by judgment or
25 otherwise in excess of amounts paid in benefits under the
26 Plan and amounts paid or to be paid as costs, attorneys
27 fees, and reasonable expenses incurred by the Plan in
28 making the collection or enforcing the judgment.

29 (4) In the event that a covered person or his
30 personal representative, including his guardian,
31 conservator, estate, dependents, or survivors, recovers
32 damages from a third party for sickness or injury caused
33 to the covered person, the covered person or the personal
34 representative shall pay to the Plan from the damages

1 recovered the amount of benefits paid or to be paid on
2 behalf of the covered person.

3 (5) When the action or claim is brought by the
4 covered person alone and the covered person incurs a
5 personal liability to pay attorney's fees and costs of
6 litigation, the Plan's claim for reimbursement of the
7 benefits provided to the covered person shall be the full
8 amount of benefits paid to or on behalf of the covered
9 person under this Act less a pro rata share that
10 represents the Plan's reasonable share of attorney's fees
11 paid by the covered person and that portion of the cost
12 of litigation expenses determined by multiplying by the
13 ratio of the full amount of the expenditures to the full
14 amount of the judgement, award, or settlement.

15 (6) In the event of judgment or award in a suit or
16 claim against a third party or insurer, the court shall
17 first order paid from any judgement or award the
18 reasonable litigation expenses incurred in preparation
19 and prosecution of the action or claim, together with
20 reasonable attorney's fees. After payment of those
21 expenses and attorney's fees, the court shall apply out
22 of the balance of the judgment or award an amount

23 sufficient to reimburse the Plan the full amount of
24 benefits paid on behalf of the covered person under this
25 Act, provided the court may reduce and apportion the
26 Plan's portion of the judgement proportionate to the
27 recovery of the covered person. The burden of producing
28 evidence sufficient to support the exercise by the court
29 of its discretion to reduce the amount of a proven charge
30 sought to be enforced against the recovery shall rest
31 with the party seeking the reduction. The court may
32 consider the nature and extent of the injury, economic
33 and non-economic loss, settlement offers, comparative
34 negligence as it applies to the case at hand, hospital

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1 costs, physician costs, and all other appropriate costs.
2 The Plan shall pay its pro rata share of the attorney
3 fees based on the Plan's recovery as it compares to the
4 total judgment. Any reimbursement rights of the Plan
5 shall take priority over all other liens and charges
6 existing under the laws of this State with the exception
7 of any attorney liens filed under the Attorneys Lien Act.
8 (7) The Plan may compromise or settle and release
9 any claim for benefits provided under this Act or waive
10 any claims for benefits, in whole or in part, for the
11 convenience of the Plan or if the Plan determines that
12 collection would result in undue hardship upon the
13 covered person.
14 (Source: P.A. 91-639, eff. 8-20-99; 91-735, eff. 6-2-00;
15 92-2, eff. 5-1-01.)

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

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