[215 Ill. Comp. Stat. §§ 106/1 through 106/30.]

§§ 106/1 through 106/30: Children's Health Insurance Program Act

§ 1. Short title.

This Act may be cited as the Children's Health Insurance Program Act.

§ 5. Legislative intent.

The General Assembly finds that, for the economic and social benefit of all citizens of the State, it is important to enable low-income children of this State, to the extent funding permits, to access health benefits coverage, especially preventive health care. The General Assembly recognizes that assistance to help families purchase health benefits for low-income children must be provided in a fair and equitable fashion and must treat all children at the same income level in a similar fashion. The State of Illinois should help low-income families transition from a health care system where government partners with families to provide health benefits to low-income children to a system where families with higher incomes eventually transition into private or employer based health plans. This Act is not intended to create an entitlement.

§ 7. Eligibility verification.

Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to the

recipient at least 60 days prior to the end of the period of eligibility that informs them of the requirements for continued eligibility. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-health care benefits, that is sufficient to make a determination of continued eligibility for medical assistance or for benefits provided under the Program may be reviewed and verified, and subsequent action taken including client notification of continued eligibility for medical assistance or for benefits provided under the Program. The date of client notification establishes the date for subsequent annual eligibility reviews. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

§ 8. COVID-19 public health emergency.

Notwithstanding any other provision of this Act, the Department may take necessary actions to address the COVID-19 public health emergency to the extent such actions are required, approved, or authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Such actions may continue throughout the public health emergency and for up to 12 months after the period ends, and may include, but are not limited to: accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available; eliminating resource tests for some eligibility determinations; suspending redeterminations; suspending changes that would adversely affect an applicant's or recipient's eligibility; phone or verbal approval by an applicant to submit an application in lieu of applicant signature; allowing adult presumptive eligibility; allowing presumptive eligibility for children, pregnant women, and adults as often as twice per calendar year; paying for additional services delivered by telehealth; and suspending premium and co-payment requirements.

The Department's authority under this Section shall only extend to encompass, incorporate, or effectuate the terms, items, conditions, and other provisions approved, authorized, or required by the United States

Department of Health and Human Services, Centers for Medicare and Medicaid Services, and shall not extend beyond the time of the COVID-19 public health emergency and up to 12 months after the period expires.

§ 10. Definitions.

As used in this Act:

"Benchmarking" means health benefits coverage as defined in Section 2103 of the Social Security Act.

"Child" means a person under the age of 19.

"Department" means the Department of Healthcare and Family Services.

"Medical assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.

"Medical visit" means a hospital, dental, physician, optical, or other health care visit where services are provided pursuant to this Act.

"Program" means the Children's Health Insurance Program, which includes subsidizing the cost of privately sponsored health insurance and purchasing or providing health care benefits for eligible children.

"Resident" means a person who meets the residency requirements as defined in Section 5-3 of the Illinois Public Aid Code.

§ 15. Operation of the Program.

There is hereby created a Children's Health Insurance Program. The Program shall operate subject to appropriation and shall be administered by the Department of Healthcare and Family Services. The Department shall have the powers and authority granted to the Department under the Illinois Public Aid Code, including, but not limited to, Section 11-5.1 of the Code. The Department may contract with a Third Party Administrator or other entities to administer and oversee any portion of this Program. Beginning October 1, 2013, the determination of eligibility under this Act shall comply with the requirements of 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal regulations. If changes made to this Section require federal approval, they shall not take effect until such approval has been received.

§ 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 200% of the federal poverty level;

(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 may 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). A child who has been determined to be eligible for assistance must reapply or otherwise establish eligibility at least annually. An eligible child shall be required, as determined by the Department by rule, to report promptly those changes in income and other circumstances that affect eligibility. The eligibility of a child may be redetermined based on the information reported or may be terminated based on the failure to report or failure to report accurately. A child's responsible relative or caretaker may also be held liable to the Department for any payments made by the Department on such child's behalf that were inappropriate. An applicant shall be provided with notice of these obligations.

(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. 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.

§ 21. Presumptive eligibility.

Beginning on the effective date of this amendatory Act of the 96th General Assembly and except where federal law requires presumptive eligibility, no adult may be presumed eligible for health care coverage under the Program, and the Department may not cover any service rendered to an adult unless the adult has completed an application for benefits, all required verifications have been received and the Department or its designee has found the adult eligible for the date on which that service was provided. Nothing in this Section shall apply to pregnant women.

§ 22. Enrollment in program.

The Department shall develop procedures to allow community providers, schools, youth service agencies, employers, labor unions, local chambers of commerce, and religious organizations to assist in enrolling children in the Program.

§ 23. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

(b) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically made either on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements.

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more

comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act of the 96th General Assembly.

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

§ 25. Health benefits for children.

(a) The Department shall, subject to appropriation, provide health benefits coverage to eligible children by:

(1) Until December 31, 2013 and providing that no application for such coverage shall be accepted after September 30, 2013, subsidizing the cost of privately sponsored health insurance, including employer based health insurance, to assist families to take advantage of available privately sponsored health insurance for their eligible children; and

(2) Purchasing, until December 31, 2013, or providing health care benefits for eligible children. The health benefits provided under this subdivision (a)(2) shall, subject to appropriation and without regard to any applicable cost sharing under Section 30, be identical to the benefits provided for children under the State's approved plan under Title XIX of the Social Security Act. Providers under this subdivision (a)(2) shall be subject to approval 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. In addition, providers may retain co-payments when determined appropriate by the Department.

(b) The subsidization provided pursuant to subdivision (a)(1) shall be credited to the family of the eligible child.

(c) The Department is prohibited from denying coverage to a child who is enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) because the plan does not meet federal benchmarking standards or cost sharing and contribution requirements. To be eligible for inclusion in the Program, the plan shall contain comprehensive major medical coverage which shall consist of physician and hospital inpatient services. The Department is prohibited from denying coverage to a child who is enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) because the plan offers benefits in addition to physician and hospital inpatient services.

(d) The total dollar amount of subsidizing coverage per child per month pursuant to subdivision (a)(1) shall be equal to the average dollar payments, less premiums incurred, per child per month pursuant to subdivision (a)(2). The Department shall set this amount prospectively based upon the prior fiscal year's experience adjusted for incurred but not reported claims and estimated increases or decreases in the cost of medical care. Payments obligated before July 1, 1999, will be computed using State Fiscal Year 1996 payments for children eligible for Medical Assistance and income assistance under the Aid to Families with Dependent

Children Program, with appropriate adjustments for cost and utilization changes through January 1, 1999. The Department is prohibited from providing a subsidy pursuant to subdivision (a)(1) that is more than the individual's monthly portion of the premium.

(e) An eligible child may obtain immediate coverage under this Program only once during a medical visit. If coverage lapses, re-enrollment shall be completed in advance of the next covered medical visit and the first month's required premium shall be paid in advance of any covered medical visit.

(f) In order to accelerate and facilitate the development of networks to deliver services to children in areas outside counties with populations in excess of 3,000,000, in the event less than 25% of the eligible children in a county or contiguous counties has enrolled with a Health Maintenance Organization pursuant to Section 5-11 of the Illinois Public Aid Code, the Department may develop and implement demonstration projects to create alternative networks designed to enhance enrollment and participation in the program. The Department shall prescribe by rule the criteria, standards, and procedures for effecting demonstration projects under this Section.

(g) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Act or the Illinois Public Aid Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e of the Illinois Public Aid Code.

§ 26. Moratorium on eligibility expansions.

Beginning on the effective date of this amendatory Act of the 96th General Assembly, there shall be a 2-year moratorium on the expansion of eligibility through increasing financial eligibility standards, or through increasing income disregards, or through the creation of new programs that would add new categories of eligible individuals under the medical assistance program under the Illinois Public Aid Code in addition to those categories covered on January 1, 2011. This moratorium shall not apply to expansions required as a federal condition of State participation in the medical assistance program.

§ 30. Cost sharing.

(a) Children enrolled in a health benefits program pursuant to subdivision (a)(2) of Section 25 and persons enrolled in a health benefits waiver program pursuant to Section 40 shall be subject to the following cost sharing requirements:

(1) There shall be no co-payment required for well-baby or well-child care, including age-appropriate immunizations as required under federal law.

(2) Health insurance premiums for family members, either children or adults, in families whose household income is above 150% of the federal poverty level shall be payable monthly, subject to rules promulgated by the Department for grace periods and advance payments, and shall be as follows:

(A) $15 per month for one family member.

(B) $25 per month for 2 family members.

(C) $30 per month for 3 family members.

(D) $35 per month for 4 family members.

(E) $40 per month for 5 or more family members.

(3) Co-payments for children or adults in families whose income is at or below 150% of the federal poverty level, at a minimum and to the extent permitted under federal law, shall be $2 for all medical visits and prescriptions provided under this Act and up to $10 for emergency room use for a non-emergency situation as defined by the Department by rule and subject to federal approval.

(4) Co-payments for children or adults in families whose income is above 150% of the federal poverty level, at a minimum and to the extent permitted under federal law shall be as follows:

(A) $5 for medical visits.

(B) $3 for generic prescriptions and $5 for brand name prescriptions.

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

(5) (Blank).

(6) Co-payments shall be maximized to the extent permitted by federal law and are subject to federal approval.