AN ACT concerning finance.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 10 as follows:

(5 ILCS 375/10) (from Ch. 127, par. 530)

Sec. 10. Payments by State; premiums.

(a) The State shall pay the cost of basic non-contributory group life insurance and, subject to member paid contributions set by the Department or required by this Section, the basic program of group health benefits on each eligible member, except a member, not otherwise covered by this Act, who has retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code, and part of each eligible member's and retired member's premiums for health insurance coverage for enrolled dependents as provided by Section 9. The State shall pay the cost of the basic program of group health benefits only after benefits are reduced by the amount of benefits covered by Medicare for all members and dependents who are eligible for benefits under Social Security or the Railroad Retirement system or who had sufficient Medicare-covered government employment, except that

such reduction in benefits shall apply only to those members and dependents who (1) first become eligible for such Medicare coverage on or after July 1, 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the program on or after July 1, 1992; or (3) remain eligible for, but no longer receive Medicare coverage which they had been receiving on or after July 1, 1992. The Department may determine the aggregate level of the State's contribution on the basis of actual cost of medical services adjusted for age, sex or geographic or other demographic characteristics which affect the costs of such programs.

The cost of participation in the basic program of group health benefits for the dependent or survivor of a living or deceased retired employee who was formerly employed by the University of Illinois in the Cooperative Extension Service and would be an annuitant but for the fact that he or she was made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the Illinois Pension Code shall not be greater than the cost of participation that would otherwise apply to that dependent or survivor if he or she were the dependent or survivor of an annuitant under the State Universities Retirement System.

(a-1) Beginning January 1, 1998, for each person who becomes a new SERS annuitant and participates in the basic program of group health benefits, the State shall contribute toward the cost of the annuitant's coverage under the basic

program of group health benefits an amount equal to 5% of that cost for each full year of creditable service upon which the annuitant's retirement annuity is based, up to a maximum of 100% for an annuitant with 20 or more years of creditable service. The remainder of the cost of a new SERS annuitant's coverage under the basic program of group health benefits shall be the responsibility of the annuitant. In the case of a new SERS annuitant who has elected to receive an alternative retirement cancellation payment under Section 14-108.5 of the Illinois Pension Code in lieu of an annuity, for the purposes of this subsection the annuitant shall be deemed to be receiving a retirement annuity based on the number of years of creditable service that the annuitant had established at the time of his or her termination of service under SERS.

(a-2) Beginning January 1, 1998, for each person who becomes a new SERS survivor and participates in the basic program of group health benefits, the State shall contribute toward the cost of the survivor's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of the deceased employee's or deceased annuitant's creditable service in the State Employees' Retirement System of Illinois on the date of death, up to a maximum of 100% for a survivor of an employee or annuitant with 20 or more years of creditable service. The remainder of the cost of the new SERS survivor's coverage under the basic program of group health benefits shall be the responsibility of

the survivor. In the case of a new SERS survivor who was the dependent of an annuitant who elected to receive an alternative retirement cancellation payment under Section 14-108.5 of the Illinois Pension Code in lieu of an annuity, for the purposes of this subsection the deceased annuitant's creditable service shall be determined as of the date of termination of service rather than the date of death.

(a-3) Beginning January 1, 1998, for each person who becomes a new SURS annuitant and participates in the basic program of group health benefits, the State shall contribute toward the cost of the annuitant's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of creditable service upon which the annuitant's retirement annuity is based, up to a maximum of 100% for an annuitant with 20 or more years of creditable service. The remainder of the cost of a new SURS annuitant's coverage under the basic program of group health benefits shall be the responsibility of the annuitant.

(a-4) (Blank).

(a-5) Beginning January 1, 1998, for each person who becomes a new SURS survivor and participates in the basic program of group health benefits, the State shall contribute toward the cost of the survivor's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of the deceased employee's or deceased annuitant's creditable service in the State Universities

Retirement System on the date of death, up to a maximum of 100% for a survivor of an employee or annuitant with 20 or more years of creditable service. The remainder of the cost of the new SURS survivor's coverage under the basic program of group health benefits shall be the responsibility of the survivor.

(a-6) Beginning July 1, 1998, for each person who becomes a new TRS State annuitant and participates in the basic program of group health benefits, the State shall contribute toward the cost of the annuitant's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of creditable service as a teacher as defined in paragraph (2), (3), or (5) of Section 16-106 of the Illinois Pension Code upon which the annuitant's retirement annuity is based, up to a maximum of 100%; except that the State contribution shall be 12.5% per year (rather than 5%) for each full year of creditable service as a regional superintendent or assistant regional superintendent of schools. The remainder of the cost of a new TRS State annuitant's coverage under the basic program of group health benefits shall be the responsibility of the annuitant.

(a-7) Beginning July 1, 1998, for each person who becomes a new TRS State survivor and participates in the basic program of group health benefits, the State shall contribute toward the cost of the survivor's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of the deceased employee's or deceased

annuitant's creditable service as a teacher as defined in paragraph (2), (3), or (5) of Section 16-106 of the Illinois Pension Code on the date of death, up to a maximum of 100%; except that the State contribution shall be 12.5% per year (rather than 5%) for each full year of the deceased employee's or deceased annuitant's creditable service as a regional superintendent or assistant regional superintendent of schools. The remainder of the cost of the new TRS State survivor's coverage under the basic program of group health benefits shall be the responsibility of the survivor.

(a-8) A new SERS annuitant, new SERS survivor, new SURS annuitant, new SURS survivor, new TRS State annuitant, or new TRS State survivor may waive or terminate coverage in the program of group health benefits. Any such annuitant or survivor who has waived or terminated coverage may enroll or re-enroll in the program of group health benefits only during the annual benefit choice period, as determined by the Director; except that in the event of termination of coverage due to nonpayment of premiums, the annuitant or survivor may not re-enroll in the program.

(a-9) No later than May 1 of each calendar year, the Director of Central Management Services shall certify in writing to the Executive Secretary of the State Employees' Retirement System of Illinois the amounts of the Medicare supplement health care premiums and the amounts of the health care premiums for all other retirees who are not Medicare

eligible.

A separate calculation of the premiums based upon the actual cost of each health care plan shall be so certified.

The Director of Central Management Services shall provide to the Executive Secretary of the State Employees' Retirement System of Illinois such information, statistics, and other data as he or she may require to review the premium amounts certified by the Director of Central Management Services.

The Department of Healthcare and Family Services, or any successor agency designated to procure healthcare contracts pursuant to this Act, is authorized to establish funds, separate accounts provided by any bank or banks as defined by the Illinois Banking Act, or separate accounts provided by any savings and loan association or associations as defined by the Illinois Savings and Loan Act of 1985 to be held by the Director, outside the State treasury, for the purpose of receiving the transfer of moneys from the Local Government Health Insurance Reserve Fund. The Department may promulgate rules further defining the methodology for the transfers. Any interest earned by moneys in the funds or accounts shall inure to the Local Government Health Insurance Reserve Fund. The transferred moneys, and interest accrued thereon, shall be used exclusively for transfers to administrative service organizations or their financial institutions for payments of claims to claimants and providers under the self-insurance health plan. The transferred moneys, and interest accrued

thereon, shall not be used for any other purpose including, but not limited to, reimbursement of administration fees due the administrative service organization pursuant to its contract or contracts with the Department.

(b) State employees who become eligible for this program on or after January 1, 1980 in positions normally requiring actual performance of duty not less than 1/2 of a normal work period but not equal to that of a normal work period, shall be given the option of participating in the available program. If the employee elects coverage, the State shall contribute on behalf of such employee to the cost of the employee's benefit and any applicable dependent supplement, that sum which bears the same percentage as that percentage of time the employee regularly works when compared to normal work period.

(c) The basic non-contributory coverage from the basic program of group health benefits shall be continued for each employee not in pay status or on active service by reason of (1) leave of absence due to illness or injury, (2) authorized educational leave of absence or sabbatical leave, or (3) military leave with pay and benefits. This coverage shall continue until expiration of authorized leave and return to active service, but not to exceed 24 months for leaves under item (1) or (2). This 24-month limitation and the requirement of returning to active service shall not apply to persons receiving ordinary or accidental disability benefits or retirement benefits through the appropriate State retirement

system or benefits under the Workers' Compensation or Occupational Disease Act.

(d) The basic group life insurance coverage shall continue, with full State contribution, where such person is (1) absent from active service by reason of disability arising from any cause other than self-inflicted, (2) on authorized educational leave of absence or sabbatical leave, or (3) on military leave with pay and benefits.

(e) Where the person is in non-pay status for a period in excess of 30 days or on leave of absence, other than by reason of disability, educational or sabbatical leave, or military leave with pay and benefits, such person may continue coverage only by making personal payment equal to the amount normally contributed by the State on such person's behalf. Such payments and coverage may be continued: (1) until such time as the person returns to a status eligible for coverage at State expense, but not to exceed 24 months, (2) until such person's employment or annuitant status with the State is terminated, or (3) for a maximum period of 4 years for members on military leave with pay and benefits and military leave without pay and benefits (exclusive of any additional service imposed pursuant to law).

(f) The Department shall establish by rule the extent to which other employee benefits will continue for persons in non-pay status or who are not in active service.

(g) The State shall not pay the cost of the basic

non-contributory group life insurance, program of health benefits and other employee benefits for members who are survivors as defined by paragraphs (1) and (2) of subsection (q) of Section 3 of this Act. The costs of benefits for these survivors shall be paid by the survivors or by the University of Illinois Cooperative Extension Service, or any combination thereof. However, the State shall pay the amount of the reduction in the cost of participation, if any, resulting from the amendment to subsection (a) made by this amendatory Act of the 91st General Assembly.

(h) Those persons occupying positions with any department as a result of emergency appointments pursuant to Section 8b.8 of the Personnel Code who are not considered employees under this Act shall be given the option of participating in the programs of group life insurance, health benefits and other employee benefits. Such persons electing coverage may participate only by making payment equal to the amount normally contributed by the State for similarly situated employees. Such amounts shall be determined by the Director. Such payments and coverage may be continued until such time as the person becomes an employee pursuant to this Act or such person's appointment is terminated.

(i) Any unit of local government within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate,

a unit of local government must agree to enroll all of its employees, who may select coverage under either the State group health benefits plan or a health maintenance organization that has contracted with the State to be available as a health care provider for employees as defined in this Act. A unit of local government must remit the entire cost of providing coverage under the State group health benefits plan or, for coverage under a health maintenance organization, an amount determined by the Director based on an analysis of the sex, age, geographic location, or other relevant demographic variables for its employees, except that the unit of local government shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the unit of local government attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 50% of the employees are enrolled and the unit of local government remits the entire cost of providing coverage to those employees, except that a participating school district must have enrolled at least 50% of its full-time employees who have not waived coverage under the district's group health plan by participating in a component of the district's cafeteria plan. A participating school district is not required to enroll a full-time employee who has waived coverage under the district's health plan, provided that an appropriate official

from the participating school district attests that the full-time employee has waived coverage by participating in a component of the district's cafeteria plan. For the purposes of this subsection, "participating school district" includes a unit of local government whose primary purpose is education as defined by the Department's rules.

Employees of a participating unit of local government who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A participating unit of local government may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the unit of local government, its employees, or some combination of the two as determined by the unit of local government. The unit of local government shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine monthly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages, or contributed by the State for basic insurance coverages on behalf of its employees, adjusted for differences between State

employees and employees of the local government in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the unit of local government and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the unit of local government.

In the case of coverage of local government employees under a health maintenance organization, the Director shall annually determine for each participating unit of local government the maximum monthly amount the unit may contribute toward that coverage, based on an analysis of (i) the age, sex, geographic location, and other relevant demographic variables of the unit's employees and (ii) the cost to cover those employees under the State group health benefits plan. The Director may similarly determine the maximum monthly amount each unit of local government may contribute toward coverage of its employees' dependents under a health maintenance organization.

Monthly payments by the unit of local government or its employees for group health benefits plan or health maintenance organization coverage shall be deposited in the Local Government Health Insurance Reserve Fund.

The Local Government Health Insurance Reserve Fund is hereby created as a nonappropriated trust fund to be held

outside the State Treasury, with the State Treasurer as custodian. The Local Government Health Insurance Reserve Fund shall be a continuing fund not subject to fiscal year limitations. The Local Government Health Insurance Reserve Fund is not subject to administrative charges or charge-backs, including but not limited to those authorized under Section 8h of the State Finance Act. All revenues arising from the administration of the health benefits program established under this Section shall be deposited into the Local Government Health Insurance Reserve Fund. Any interest earned on moneys in the Local Government Health Insurance Reserve Fund shall be deposited into the Fund. All expenditures from this Fund shall be used for payments for health care benefits for local government and rehabilitation facility employees, annuitants, and dependents, and to reimburse the Department or its administrative service organization for all expenses incurred in the administration of benefits. No other State funds may be used for these purposes.

A local government employer's participation or desire to participate in a program created under this subsection shall not limit that employer's duty to bargain with the representative of any collective bargaining unit of its employees.

(j) Any rehabilitation facility within the State of Illinois may apply to the Director to have its employees, annuitants, and their eligible dependents provided group

health coverage under this Act on a non-insured basis. To participate, a rehabilitation facility must agree to enroll all of its employees and remit the entire cost of providing such coverage for its employees, except that the rehabilitation facility shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the rehabilitation facility attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 50% of the employees are enrolled and the rehabilitation facility remits the entire cost of providing coverage to those employees. Employees of a participating rehabilitation facility who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A participating rehabilitation facility may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the rehabilitation facility, its employees, or some combination of the 2 as determined by the rehabilitation facility. The rehabilitation facility shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine quarterly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the rehabilitation facility in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the rehabilitation facility and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the rehabilitation facility.

Monthly payments by the rehabilitation facility or its employees for group health benefits shall be deposited in the Local Government Health Insurance Reserve Fund.

(k) Any domestic violence shelter or service within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a domestic violence shelter or service must agree to enroll all of its employees and pay the entire cost of providing such coverage for its employees. The domestic violence shelter shall not be required to enroll those of its employees who are covered spouses or dependents under this plan

or another group policy or plan providing health benefits as long as (1) an appropriate official from the domestic violence shelter attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan and (2) at least 50% of the employees are enrolled and the domestic violence shelter remits the entire cost of providing coverage to those employees. Employees of a participating domestic violence shelter who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, or special circumstance as defined by the Director or during the annual Benefit Choice Period. A participating domestic violence shelter may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with employees, or some combination of the 2 as determined by the domestic violence shelter or service. The domestic violence shelter or service shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the domestic violence shelter or

service in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the domestic violence shelter or service and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the domestic violence shelter or service.

Monthly payments by the domestic violence shelter or service or its employees for group health insurance shall be deposited in the Local Government Health Insurance Reserve Fund.

(l) A public community college or entity organized pursuant to the Public Community College Act may apply to the Director initially to have only annuitants not covered prior to July 1, 1992 by the district's health plan provided health coverage under this Act on a non-insured basis. The community college must execute a 2-year contract to participate in the Local Government Health Plan. Any annuitant may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

The Director shall annually determine monthly rates of payment subject to the following constraints: for those community colleges with annuitants only enrolled, first year

rates shall be equal to the average cost to cover claims for a State member adjusted for demographics, Medicare participation, and other factors; and in the second year, a further adjustment of rates shall be made to reflect the actual first year's claims experience of the covered annuitants.

(l-5) The provisions of subsection (l) become inoperative on July 1, 1999.

(m) The Director shall adopt any rules deemed necessary for implementation of this amendatory Act of 1989 (Public Act 86-978).

(n) Any child advocacy center within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a child advocacy center must agree to enroll all of its employees and pay the entire cost of providing coverage for its employees. The child advocacy center shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the child advocacy center attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan and (2) at least 50% of the employees are enrolled and the child advocacy center remits the entire cost of providing coverage to those employees. Employees of a participating child advocacy center who are not enrolled due to coverage under

another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, or special circumstance as defined by the Director or during the annual Benefit Choice Period. A participating child advocacy center may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the child advocacy center, its employees, or some combination of the 2 as determined by the child advocacy center. The child advocacy center shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the child advocacy center in age, sex, geographic location, or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the child advocacy center and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the child advocacy center.

Monthly payments by the child advocacy center or its employees for group health insurance shall be deposited into the Local Government Health Insurance Reserve Fund.
(Source: P.A. 95-331, eff. 8-21-07; 95-632, eff. 9-25-07; 95-707, eff. 1-11-08; 96-756, eff. 1-1-10.)

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