Rep. Frank J. Mautino

Filed: 10/26/2011

AMENDMENT TO SENATE BILL 1313

AMENDMENT NO. _____. Amend Senate Bill 1313 by replacing everything after the enacting clause with the following:

"Section 5. The State Employee Health Savings Account Law is amended by changing Sections 10-5 and 10-10 as follows:

(5 ILCS 377/10-5)

Sec. 10-5. Definitions. As used in this Law:

(a) "Deductible" means the total deductible of a high deductible health plan for an eligible individual and all the dependents of that eligible individual for a calendar year.

(b) "Dependent" means a dependent as defined in Section 3 of the State Employee Group Insurance Act of 1971, provided that any dependent age 26 or above, as defined under that Section, is eligible to be claimed by the eligible individual as a tax dependent under Section 152(a) of the Internal Revenue Code of 1986 ~~an eligible individual's spouse or child, as~~

~~defined in Section 152 of the Internal Revenue Code of 1986~~. "Dependent" also includes a party to or the child of a party to a civil union, as defined under Section 10 of the Illinois Religious Freedom Protection and Civil Union Act, provided that the party to, or the child of a party to, the civil union is eligible to be claimed by the eligible individual as a tax dependent under Section 152(a) of the Internal Revenue Code of 1986.

(c) "Eligible individual" means an employee, as defined in Section 3 of the State Employees Group Insurance Act of 1971, who contributes to health savings accounts on the employees' behalf, who:

(1) is covered by a high deductible health plan individually or with dependents; ~~and~~

(2) is not covered under any health plan that is not a high deductible health plan, except for:

(i) coverage for accidents;

(ii) workers' compensation insurance;

(iii) insurance for a specified disease or illness;

(iv) insurance paying a fixed amount per day per hospitalization; and

(v) tort liabilities; ~~and~~

(3) establishes a health savings account or on whose behalf the health savings account is established; ~~.~~

(4) is not entitled to Medicare; and

(5) cannot be claimed as a dependent on another person's tax return.

(d) "Employer" means a State agency, department, or other entity that employs an eligible individual.

(e) "Health savings account" or "account" means a trust or custodial account established under a State program exclusively to pay the qualified medical expenses of an eligible individual, or his or her dependents, that meets all of the following requirements:

(1) Except in the case of a rollover contribution, no contribution may be accepted:

(A) unless it is in cash; or

(B) to the extent that the contribution, when added to the previous contributions to the Account for the calendar year, exceeds the ~~lesser of (i) 100% of the eligible individual's deductible or (ii) the~~ contribution level set for that year by the Internal Revenue Service.

(2) The trustee or custodian is a bank, an insurance company, or another person approved by the Director of Insurance.

(3) No part of the trust assets shall be invested in life insurance contracts.

(4) The assets of the account shall not be commingled with other property except as allowed for under Individual Retirement Accounts.

(5) Eligible individual's interest in the account is nonforfeitable.

(f) "Health savings account program" or "program" means a program that includes all of the following:

(1) Participation ~~The purchase~~ by an eligible individual in an employer-sponsored ~~or by an employer of a~~ high deductible health plan.

(2) The contribution into a health savings account by an eligible individual or on behalf of an employee or by his or her employer. The total annual contribution may not exceed the amount ~~of the deductible or the amounts~~ listed in sub-item (B) of item (1) of subsection (e) ~~(f)~~ of this Section.

(g) "High deductible" means:

(1) In the case of self-only coverage, an annual deductible that is not less than the level set by the Internal Revenue Service and that, when added to the other annual out-of-pocket expenses required to be paid under the plan for covered benefits, does not exceed the maximum level set by the Internal Revenue Service ~~$5,000~~; and

(2) In the case of family coverage, an annual deductible of not less than the level set by the Internal Revenue Service and that, when added to the other annual out-of-pocket expenses required to be paid under the plan for covered benefits, does not exceed the maximum level set by the Internal Revenue Service ~~$10,000~~.

A plan shall not fail to be treated as a high deductible plan by reason of a failure to have a deductible for preventive care or, in the case of network plans, for having out-of-pocket expenses that exceed these limits on an annual deductible for services that are provided outside the network.

(h) "High deductible health plan" means ~~a~~ health coverage ~~policy, certificate, or contract~~ that provides for payments for covered benefits that exceed the high deductible.

(i) "Qualified medical expense" means an expense paid by the eligible individual for medical care described in Section 213(d) of the Internal Revenue Code of 1986.

(Source: P.A. 97-142, eff. 7-14-11.)

(5 ILCS 377/10-10)

Sec. 10-10. Application; authorized contributions.

(a) Beginning in calendar ~~taxable~~ year 2012 ~~2011~~, each employer shall make available to each eligible individual a health savings account program, if that individual chooses to enroll in the program except that, for an employer who provides coverage pursuant to any one or more of subsections (i) through (n) of Section 10 of the State Employee Group Insurance Act, that employer may make available a health savings account program. An employer who makes a health savings account program available shall annually deposit an amount equal to one-third of the annual deductible ~~$2,750 annually~~ into an eligible individual's health savings account. Unused funds in a health

savings account shall become the property of the account holder at the end of a taxable year.

(b) Beginning in calendar ~~taxable~~ year 2012 ~~2011~~, an eligible individual may deposit contributions into a health savings account in accordance with the restrictions set forth in subsection (e) of Section 10-5. ~~The amount of deposit may not exceed the amount of the deductible for the policy.~~

(Source: P.A. 97-142, eff. 7-14-11.)

Section 10. The Illinois Insurance Code is amended by adding Section 500-123 as follows:

(215 ILCS 5/500-123 new)

Sec. 500-123. Consulting. A producer shall be prohibited from selling, soliciting, or negotiating insurance or limited lines insurance after the producer or an employee or contractor of the producer has been hired by the purchaser or prospective purchaser within the previous 5 years as a consultant concerning the insurance or limited lines insurance being sold, solicited, or negotiated. For the purposes of this Section, "producer" means an insurance producer, limited line producer, or temporary insurance producer.

Section 15. The Illinois Health Benefits Exchange Law is amended by adding Sections 5-4, 5-8, 5-11, 5-12, 5-13, 5-14, and 5-18 and by changing Section 5-10 as follows:

(215 ILCS 122/5-4 new)

Sec. 5-4. Definitions. For purposes of this Law:

"Board" means the Illinois Health Benefits Exchange Board established pursuant to this Law.

"Director" means the Director of Insurance.

"Essential health benefits" has the meaning provided under Section 1302(b) of the Federal Act.

"Exchange" means the Illinois Health Benefits Exchange established by this Law and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

"Executive Director" means the Executive Director of the Illinois Health Benefits Exchange.

"Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto or regulations or guidance issued under those Acts.

"Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" does not include:

(a) coverage for accident only or disability income insurance or any combination thereof;

(b) coverage issued as a supplement to liability

insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics; or

(h) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a non-profit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

"Individual Exchange" means the exchange marketplace established by this Law through which qualified individuals may obtain coverage through an individual market qualified health plan.

"Qualified dental plan" means a limited scope dental plan that has been certified in accordance with this Law.

"Qualified employee" means an eligible individual employed by a qualified employer who has been offered health insurance coverage by that qualified employer through the SHOP on the Exchange.

"Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans or qualified dental plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed.

"Qualified health plan" or "QHP" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Federal Act.

"Qualified health plan issuer" or "QHP issuer" means a health insurance issuer that offers a health plan that the Exchange has certified as a qualified health plan.

"Qualified individual" means an individual, including a minor, who:

(1) is seeking to enroll in a qualified health plan or qualified dental plan offered to individuals through the Exchange;

(2) resides in this State;

(3) at the time of enrollment, is not incarcerated,

other than incarceration pending the disposition of charges; and

(4) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

"Secretary" means the Secretary of the federal Department of Health and Human Services.

"SHOP Exchange" means the Small Business Health Options Program established under this Law through which a qualified employer can provide small group qualified health plans to its qualified employees.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. Beginning January 1, 2016, the definition of a "small employer" shall mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

(215 ILCS 122/5-8 new)

Sec. 5-8. Exchange Board. There is created the Illinois Health Benefits Exchange Board. The purpose of the Board is to administer the State health benefits exchange created pursuant to this Law and to conduct such other business as may further the administration of the State health benefits exchange. The Exchange shall operate subject to the supervision and control of the Board. The Exchange is created as a quasigovernmental agency and as such is not a State agency.

(215 ILCS 122/5-10)

Sec. 5-10. Exchange functions. On or before January 1, 2014, in compliance with paragraph (4) of subdivision (d) of Section 1311 of the federal Patient Protection and Affordable Care Act, the Exchange shall, at a minimum, do all of the following to implement Section 1311 of the federal Patient Protection and Affordable Care Act:

(1) Make qualified health plans available to qualified individuals and qualified employers.

(2) Implement procedures for the certification, recertification, and decertification, consistent with guidelines established by the U.S. Secretary of Health and Human Services, of health plans as qualified health plans. The Board shall require health plans seeking certification as qualified health plans to do all of the following:

(A) Submit a justification for any premium increase prior to the implementation of the increase.

The plans shall prominently post that information on their Internet web sites. The Board shall take this information, and the information and the recommendations provided to the Board by the Department of Insurance or the Department of Managed Health Care under paragraph (1) of subdivision (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The Board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the Department of Insurance and the Department of Managed Health Care.

(B) Make available to the public and submit to the Board, the U.S. Secretary of Health and Human Services, and the Department of Insurance or the Department of Public Health, as applicable, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under Title I of the federal Patient Protection and Affordable Care Act.

(ix) Other information as determined appropriate by the U.S. Secretary of Health and Human Services.

The information required under this paragraph (b) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section 1311 of the federal Patient Protection and Affordable Care Act.

(C) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet web site and through other means for individuals without access to the Internet.

(3) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(4) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans.

(5) With respect to each qualified health plan offered through the Exchange, do both of the following:

(A) assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the U.S. Secretary of Health and Human Services; and

(B) determine each qualified health plan's level of coverage in accordance with regulations adopted by the Secretary under paragraph (A) of subdivision (2) of Section 1302(d) of the federal Patient Protection and Affordable Care Act and any additional regulations adopted by the Exchange under this Law.

(6) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(7) Inform individuals of eligibility requirements for the Medicaid program, the Covering ALL KIDS Health Insurance Program, or any applicable State or local public program and, if through screening of the application by the Exchange the Exchange determines that an individual is eligible for any such program, enroll that individual in

the program.

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost sharing reduction under Section 1402 of the federal Patient Protection and Affordable Care Act.

(9) Grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by that Section because of either of the following:

(A) There is no affordable qualified health plan available through the Exchange or the individual's employer covering the individual.

(B) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

(10) Transfer to the Secretary of the Treasury all of the following:

(A) a list of the individuals who are issued a certification, including the name and taxpayer identification number of each individual;

(B) the name and taxpayer identification number of each individual who was an employee of an employer but

who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because:

(i) the employer did not provide the minimum essential coverage or the employer provided the minimum essential coverage but it was determined under item (C) of paragraph (2) of subdivision (c) of Section 36B of the Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(ii) the name and taxpayer identification number of each individual who notifies the Exchange under paragraph (4) of subdivision (b) of Section 1411 of the federal Patient Protection and Affordable Care Act that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year, and the effective date of such cessation;

(11) Provide to each employer the name of each employee of the employer described in subdivision (i) of Section 1311 of the federal Patient Protection and Affordable Care Act who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(12) Perform duties required of, or delegated to, the

Exchange by the U.S. Secretary of Health and Human Services or the Secretary of the Treasury related to the following:

(A) Determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility exemptions.

(B) Establishing procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

(C) Arranging for collection of contributions from participating employers and individuals.

(D) Arranging for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

(E) Establishing criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

(F) Establishing criteria for exclusion of vendors.

(G) Developing and implementing a plan for promoting public awareness of and participation in the program.

(H) Evaluating options for employer participation which may conform with common insurance practices.

(I) Providing for initial, annual, and special enrollment periods, in accordance with guidelines adopted by the Secretary under paragraph (6) of subdivision (c) of Section 1311 of the federal Patient Protection and Affordable Care Act.

(13) Establish the Navigator Program in accordance with subdivision (i) of Section 1311 of the federal Patient Protection and Affordable Care Act. The Exchange shall award grants to certain entities to do the following:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans.

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal Patient Protection and Affordable Care Act.

(C) Facilitate enrollment in qualified health plans.

(D) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the federal Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his

or her health plan, coverage, or a determination under that plan or coverage.

(E) Refer individuals with a grievance, complaint, or question regarding a plan, a plan's coverage, or a determination under a plan's coverage to a customer relations unit established by the Exchange.

(F) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(14) Establish the Small Business Health Options Program, separate from the activities of the Board related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market in a manner consistent with paragraph (2) of subdivision (a) of Section 1312 of the Federal Act. ~~(a) The Illinois Health Benefits Exchange shall meet the core functions identified by Section 1311 of the Patient Protection and Affordable Care Act and subsequent federal guidance and regulations.~~

~~(b) In order to meet the deadline of October 1, 2013 established by federal law to have operational a State exchange, the Department of Insurance and the Commission on Governmental Forecasting and Accountability is authorized to apply for, accept, receive, and use as appropriate for and on behalf of the State any grant money provided by the federal~~

~~government and to share federal grant funding with, give support to, and coordinate with other agencies of the State and federal government or third parties as determined by the Governor.~~

(Source: P.A. 97-142, eff. 7-14-11.)

(215 ILCS 122/5-11 new)

Sec. 5-11. Exchange powers. The Exchange shall have the power to do the following acts.

(1) Have perpetual successions as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business.

(2) Adopt an official seal and alter the same at pleasure.

(3) Maintain an office in the State at such place or places as it may designate.

(4) Employ such assistants, agents, managers, and other employees as may be necessary or desirable.

(5) Acquire, lease, purchase, own, manage, hold, and dispose of real and personal property.

(6) Receive and accept, from any source, aid or contributions, including money, property, labor, and other things of value.

(7) Charge assessments or user fees to generate funding necessary to support the operations of the Exchange.

(8) Exclude plans that fail to deliver robust consumer

protections, quality care, and reasonable costs, particularly if the plan has a history of unreasonable rate increases.

(9) Procure insurance against loss in connection with its property and other assets in such amounts and from such insurers as it deems desirable.

(10) Invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the U.S. of America or the State and in obligations that are legal investments for savings banks in the State.

(11) Issue bonds, bond anticipation notes, and other obligations of the Exchange for any of its corporate purposes, and to fund or refund the same and provide for the rights of the holders thereof, and to secure the same by pledge of revenues, notes, and mortgages of others.

(12) Borrow money for the purpose of obtaining working capital.

(13) Account for and audit funds of the Exchange and any recipients of funds from the Exchange.

(14) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers (copies of all contracts of the Exchange shall be maintained by the Exchange as public records, subject to the proprietary rights of any party to the contract).

(15) To the extent permitted under its contract with

other persons, consent to any termination, modification, forgiveness, or other change of agreement of any kind to which the Exchange is a party.

(16) Award grants to Navigators (applications for grants from the Exchange shall be made on a form prescribed by the Board).

(17) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the Exchange, provided individuals and employers have an adequate number and selection of choices.

(18) Sue and be sued, plead and be impleaded.

(19) Adopt regular procedures that are not in conflict with other provisions of the general statutes, for exercising the power of the Exchange.

(20) Apply for federal grants to cover the cost associated with setting up the Exchange.

(21) Do all acts and things necessary and convenient to carry out the purposes of the Exchange, provided such acts or things shall not conflict with the provisions of the federal Patient Protection and Affordable Care Act, regulations adopted there under, or federal guidance issued pursuant to the federal Patient Protection and Affordable Care Act.

(215 ILCS 122/5-12 new)

Sec. 5-12. Composition of the Board.

(a) The Exchange shall be governed by a Board of Directors comprised as follows:

(1) Four ex officio, non-voting members to include:

(A) the Director of Insurance or his or her designee with expertise in insurance regulation;

(B) the Director of Healthcare and Family Services or his or her designee;

(C) the Director of Human Services or his or her designee; and

(D) the Director of Public Health or his or her designee.

(2) Two members appointed by the Attorney General to include:

(A) one attorney with experience with public programs such as Medicaid; and

(B) one attorney with experience working with the Attorney General's Health Care Bureau.

(3) Seven members appointed by the Governor with the advice and confirmation of the Senate pursuant to subsection (b) of this Section to include:

(A) one consumer representative;

(B) one small employer representative;

(C) one employee representative of a small employer in this State;

(D) one certified health actuary or health economist;

(E) one representative of the organized labor community in this State;

(F) one individual who qualifies for Medicaid under current or expanded Medicaid eligibility rules; and

(G) one community-based provider that mainly serves vulnerable individuals living under 200% of the federal poverty level.

The Governor shall make the appointments so as to reflect no less than proportional representation of the minority racial composition of the State.

(b) All appointments of members to the Board shall be subject to the advice and consent of the Senate pursuant to this Section. Appointments by the Governor pursuant to paragraph (3) of subsection (a) of this Section shall require the advice and consent of a 2/3 vote of the members elected to the Senate.

The Senate shall confirm or reject appointments within 30 session days or 60 calendar days after they are submitted by the Governor, whichever occurs first. Except in the case of appointments to fill vacancies, the confirmation time period specified in this Section shall not commence until all appointments required to be made in that year have been submitted by the Governor.

(215 ILCS 122/5-13 new)

Sec. 5-13. Terms of Board members.

(a) Initial members shall be appointed to the Board as follows: 4 members to serve one year, and until their successors are appointed and qualified; 4 members to serve 2 years, and until their successors are appointed and qualified; 6 members to serve 3 years, and until their successors are appointed and qualified; and 3 members to serve 4 years, and until their successors are appointed and qualified. As terms of initial members expire, their successors shall be appointed for terms to expire the first day in July 4 years thereafter, and until their successors are appointed and qualified. Any member is eligible for reappointment. A vacancy on the Board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(b) The Board shall elect a chairperson and a vice chairperson on an annual basis.

(c) Appointed Board members may not designate a representative to perform in their absence their respective duties. Meetings of the Board shall be held at such times as shall be specified in the bylaws adopted by the Board and at such other time or times as the chairperson deems necessary. All meetings of the Board shall be conducted in accordance with the Open Meetings Act. The Board must afford an opportunity for public comment at each of its meetings.

(d) Any Board member who fails to attend more than 50% of all meetings held during any calendar year shall be deemed to

have resigned from the Board.

(e) A majority of members appointed shall constitute a quorum for the transaction of any business or the exercise of any power of the Exchange.

(f) For the transaction of any business or the exercise of any power of the Exchange, the Exchange may act by a majority of the Board members present at any meeting at which a quorum is in attendance. No vacancy in the membership of the Board shall impair the right of the Board members to exercise all the rights and perform all the duties of the Board. Any action taken by the Board may be authorized by resolution approved by a majority of the Board members present at any regular or special meeting, which resolution shall take effect immediately unless otherwise provided in the resolution.

(g) Board members are entitled to receive, from funds of the Board, reimbursement for per diem and travel expenses. No other compensation is authorized.

(h) There is no liability on the part of, and no cause of action shall arise against, any member of the Board or its employees or agents for any action taken by them in the performance of their powers and duties under this Law.

(i) No Board member shall, for one year after the end of the member's service on the Board, accept employment with any health carrier that offers a qualified health benefit plan through the Exchange.

(j) The Board may exercise all powers granted to it

necessary to carry out the purposes of this Section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this Section.

(k) A member of the Board or of the staff of the Exchange shall not be employed by or be affiliated with a health care provider, a health care facility, a medical clinic, or an insurer, with the exception of health care providers not receiving compensation for rendering services as a provider who do not have an ownership interest in a professional health care practice.

(l) The Board shall hire an Executive Director to organize, administer, and manage the operations of the Exchange. The Executive Director shall be responsible for the selection of such other staff as may be authorized by the Board's operating budget as adopted by the Board. The Executive Director shall be exempt from civil service and shall serve at the pleasure of the Board.

(m) No employee of the Exchange shall be a member of the Board or an employee of a trade association of (i) insurers, (ii) insurance producers or brokers, (iii) health care providers, or (iv) health care facilities or health or medical clinics while serving on the Board or on the staff of the Exchange.

(n) No employee of the Exchange shall, for one year after terminating employment with the Exchange, accept employment with any health carrier that offers a qualified health benefit plan through the Exchange.

(o) Any employee of the Exchange who sells, solicits, or negotiates insurance or will sell, solicit, or negotiate insurance to individuals and small employers shall be licensed not later than one year after such employee begins employment with the Exchange.

(p) The Exchange has the authority to enter into an agreement with an eligible entity to carry out responsibilities of the Exchange.

(q) The Board may establish advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(r) No member of the Board nor employee of the Exchange shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has any reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her family or on either of the following:

(1) any source of income provided to, received by, or promised to a member within 12 months prior to the time

when a decision is made; or

(2) any business entity in which the member is a director, officer, partner, trustee, or employee or holds any position of management.

(s) The Board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the Board and carrying out the purposes of this Section. The bylaws shall do the following:

(1) specify procedures for selection of officers and qualifications for reappointment, provided that no Board member shall serve more than 9 consecutive years;

(2) require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program; and

(3) specify policies and procedures regarding conflicts of interest; the policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(215 ILCS 122/5-14 new)

Sec. 5-14. Illinois Health Benefits Exchange Legislative Oversight Committee.

(a) There is created an Illinois Health Benefits Exchange Legislative Oversight Committee within the Commission on Government Forecasting and Accountability to provide

accountability for the Illinois Health Benefits Exchange and to ensure that Exchange operations and functions align with the goals and duties outlined by this Law. The Committee shall also be responsible for providing policy recommendations to ensure that the Exchange aligns with the Federal Act, amendments to the Federal Act, and regulations promulgated pursuant to the Federal Act.

(b) Members of the Legislative Oversight Committee shall be appointed as follows: 3 members of the Senate shall be appointed by the President of the Senate; 3 members of the Senate shall be appointed by the Minority Leader of the Senate; 3 members of the House of Representatives shall be appointed by the Speaker of the House of Representatives; and 3 members of the House of Representatives shall be appointed by the Minority Leader of the House of Representatives. Each legislative leader shall select one member to serve as co-chair of the Committee.

(c) Members of the Legislative Oversight Committee shall be appointed within 30 days after the effective date of this amendatory Act of the 97th General Assembly. The co-chairs shall convene the first meeting of the Committee no later than 45 days after the effective date of this Law.

(d) The Executive Director of the Exchange must provide updates to the Legislative Oversight Committee in person about the Exchange's progress every quarter for the first 2 years beginning at the start of employment on the Exchange.

(215 ILCS 122/5-18 new)

Sec. 5-18. Illinois Health Benefit Exchange Fund. There is hereby created as a special fund outside of the State treasury the Illinois Health Benefit Exchange Fund to be used, subject to appropriation, exclusively by the Exchange to provide funding for the operation and administration of the Exchange in carrying out the purposes authorized in this Law. The Fund shall consist of the following:

(1) any user fees or other assessment collected by the Exchange;

(2) income from investments made on behalf of the Fund;

(3) interest on deposits or investments of money in the Fund;

(4) money collected by the Board as a result of legal or other action taken by the Board on behalf of the Exchange or the Fund;

(5) money donated to the Fund;

(6) money awarded to the Fund through grants; and

(7) any other money from any other source accepted for the benefit of the Fund.

Any investment earnings of the Fund shall be credited to the Fund. No part of the Fund may revert or be credited to the General Revenue Fund or any special fund in the State Treasury. A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

Section 90. The State Finance Act is amended by adding Section 5.809 as follows:

(30 ILCS 105/5.809 new)

Sec. 5.809. The Illinois Health Benefit Exchange Fund.

(215 ILCS 122/5-15 rep.)

(215 ILCS 122/5-20 rep.)

Section 95. The Illinois Health Benefits Exchange Law is amended by repealing Sections 5-15 and 5-20.

Section 97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

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