**Rep. Frank J. Mautino**

# Filed: 11/7/2011



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 Employees Group Insurance Act of 1971, provided that the dependent meets the definition of "dependent" under Section 152 of the Internal Revenue Code of 1986, determined without regard to subdivisions (b)(1), (b)(2), and (d)(1)(B) of that Section ~~an eligible individual's spouse or child, as~~

~~defined in Section 152 of the Internal Revenue Code of 1986. "Dependent" includes a party to a civil union, as defined under Section 10 of the Illinois Religious Freedom Protection and Civil Union Act~~.

(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. Insurance consulting.

(a) The relationship between an insurance consultant and the person or public entity that retains the insurance consultant is a fiduciary relationship. Pursuant to this relationship, the insurance consultant shall perform its duties solely in the interest of the person or public entity and for the exclusive purpose of providing benefits to the person or public entity.

(b) A producer shall be prohibited from selling, soliciting, or negotiating insurance or limited lines insurance if the producer, an employee or contractor of the producer, or the producer's employer has been an insurance consultant for the purchaser or prospective purchaser within the previous 5 years concerning the insurance or limited lines insurance being sold, solicited, or negotiated.

(c) The following provisions shall apply concerning violations of this Section:

(1) In the event of a violation of subsection (b) of this Section where the purchaser is a public entity, any contract for insurance or limited lines insurance entered into in violation of subsection (b) of this Section is void unless, within 30 days after discovery of the violation, the governing council or board of the public entity or, if none, then the head of the public entity certifies in writing that, notwithstanding the violation, it is in the public interest to continue the contract. Any such action taken by a governing council or board shall be by a three-fifths vote of the members elected or appointed and shall take place in a public hearing or meeting. The certification shall be posted on the public entity's Internet website and shall be transmitted, in the case of a statewide public entity, to the Secretary of State and, in all other cases, to the clerk of the county in which the public entity's principal place of operations is located.

(2) In the event of a violation of this Section where the purchaser or prospective purchaser is a public entity, any contract between the public entity and the insurance consultant that committed the violation is void.

(3) In the event of a violation of this Section where the purchaser or prospective purchaser is a person, the person may, notwithstanding the contract's terms, rescind any contract entered into for insurance or limited lines insurance in violation of subsection (b) of this Section

and any contract with the insurance consultant that committed the violation.

(4) In addition to any other cause of action that may accrue, any knowing violation of this Section constitutes a violation of the Consumer Fraud and Deceptive Business Practices Act.

(d) For the purposes of this Section:

"Insurance consultant" means any person who, for compensation, advises, counsels, consults, or otherwise provides information to any person or public entity concerning the purchase, retention, exchange, surrender, exercise of rights, or disposition of insurance or limited lines insurance contracts. "Insurance consultant" does not include attorneys licensed or otherwise authorized to practice in this State who are engaged in the practice of law.

"Producer" means an insurance producer, limited lines producer, or temporary insurance producer.

Section 15. The Illinois Health Benefits Exchange Law is amended by adding Sections 5-4, 5-5, 5-8, 5-11, 5-12, 5-13, 5-14, 5-17, 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.

"Educated health care consumer" means an individual who is knowledgeable about the health care system and has a background or experience in making informed decisions regarding health, medical, and scientific matters.

"Employee" has the meaning given that term in the Illinois Health Insurance Portability and Accountability Act.

"Essential community provider" means a health care provider that serves predominately low-income, medically-underserved individuals, such as health care providers as defined in Section 340B(a)(4) of the federal Public Health Service Act.

"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 the following excepted benefits as set forth in Section 2791(c) of the federal Public Health Service Act:

(1) benefits not subject to requirements:

(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;

(2) benefits not subject to requirements if offered separately:

(a) limited scope dental or vision benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care, or any

combination thereof; or

(c) such other similar, limited benefits as are specified in regulations;

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

(a) coverage only for a specified disease or illness; or

(b) hospital indemnity or other fixed indemnity insurance; or

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

"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.

"Principal place of business" means the location in a state where an employer has its headquarters or significant place of business and where the persons with direction and control authority over the business are employed.

"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:

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

(ii) resides in this State;

(iii) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(iv) 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. For purposes of this definition:

(a) all persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the federal Internal Revenue Code of 1986 shall be treated as a single employer;

(b) an employer and any predecessor employer shall be treated as a single employer;

(c) employees shall be counted in accordance with federal law and regulations and State law and regulations;

(d) if an employer was not in existence throughout the preceding calendar year, then the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that the employer will employ on business days in the current calendar year; and

(e) an employer that makes enrollment in qualified health plans or qualified dental plans available to its employees through the SHOP Exchange and would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small

employer for purposes of this Law as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

(215 ILCS 122/5-5)

Sec. 5-5. Establishment of a State Health Benefits Exchange ~~State health benefits exchange~~.

(a) It is declared that this State, beginning October 1, 2013, in accordance with Section 1311 of the federal Patient Protection and Affordable Care Act, shall establish a State health benefits exchange to be known as the Illinois Health Benefits Exchange in order to help individuals and small employers with no more than 50 employees shop for, select, and enroll in qualified, affordable private health plans that fit their needs at competitive prices. The Exchange shall separate coverage pools for individuals and small employers and shall supplement and not supplant any existing private health insurance market for individuals and small employers.

(b) There is hereby created a political subdivision, body politic and corporate named the Illinois Health Benefits Exchange that is not a State agency.

(c) The Exchange shall be comprised of an individual and a small business health options (SHOP) exchange. Pursuant to Section 1311(b)(2) of the Federal Act, the Exchange shall provide individual exchange services to qualified individuals and SHOP exchange services to qualified employers under a

single governance and administrative structure.

(d) The Exchange shall not duplicate or replace the regulatory functions of the Department of Insurance, including, but not limited to, the Department of Insurance's rate review authority.

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

(215 ILCS 122/5-10)

Sec. 5-10. Exchange functions.

(a) 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. ~~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, until the Board has the ability to do so, at which time the Board 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 pursuant to Section 5-11 of this Law.

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

(215 ILCS 122/5-11 new)

Sec. 5-11. Board powers and authorities.

(a) In addition to powers set forth elsewhere in this Law, the Board is authorized do the following:

(1) Have perpetual successions as a political subdivision, body politic and corporate and adopt bylaws, rules, and regulations to carry out the provisions of this Law. The bylaws may permit the Board to meet by telecommunication or electronic communication.

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

(5) Apply for, accept, and spend as appropriate any

federal or State grant money made available through or pursuant to the Affordable Care Act or any other federal or State-related opportunity in order to assist the Board as it implements the provisions of this Law.

(6) Enter into contracts or intergovernmental cooperation agreements as are necessary or proper to carry out the provisions and purposes or perform any of the functions described in this Law.

(7) Enter into commercial, banking, and financial arrangements as needed to manage the day—to—day operations of the Exchange.

(8) Take or defend any legal actions necessary to effectuate the purposes of this Law.

(9) Charge assessments to generate funding necessary to support the operation of the Exchange (assessments or fees charged to carriers shall not include any amount based on coverage, or premiums associated with such coverage, that is defined as an "excepted benefit" under Section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg-91)).

(10) Create an administration fund under direction of the Board and management by the Executive Director to:

(A) fund administrative and any other expenses of the Exchange; and

(B) receive and deposit into the administration fund any money collected or received by the Board

pursuant to this Law.

(215 ILCS 122/5-12 new)

Sec. 5-12. Exchange governance.

(a) The governing and administrative powers of the Exchange shall be vested in a body known as the Illinois Health Benefits Exchange Board. The following provisions shall apply:

(1) The Board shall consist of 9 voting members, seven of whom shall be appointed by the Governor and 2 of whom shall be appointed by the Attorney General. Board Appointees shall be subject to the advice and consent of a two-thirds vote of the members elected to the Senate.

(2) The members appointed by the Governor shall include: (A) one educated health care consumer; (B) one representative of small employers with 50 or fewer employees that has direct, long-term experience operating a business in Illinois; (C) one individual with demonstrated and acknowledged expertise in the business of health insurance or health benefits administration with a retired inactive status; (D) one health economist, certified health actuary, or expert in health care finance; (E) one individual with experience in bargaining collectively for the provision of health insurance coverage; (F) one individual with knowledge and expertise in purchasing and facilitating enrollment in health plan coverage, including demonstrated knowledge and expertise

of the role of licensed health insurance producers and third-party administrators in connecting employers and individual consumers to health plan coverage a retired inactive status; and (G) one individual with experience as an essential community provider serving primarily underserved individuals living under 200% of the federal poverty level.

(3) The members appointed by the Attorney General shall include: one attorney with experience with public programs such as Medicaid and one attorney with experience working with the Attorney General's Health Care Bureau.

(4) 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.

(5) The Governor and the Attorney General shall coordinate appointments so as to reflect no less than proportional representation of the geographic, gender, cultural, racial, and ethnic composition of this State.

(6) The Director of Insurance, the Director of the Healthcare and Family Services, Director of Human Services, Director of Public Health, a representative from the Office of the Governor, and the Executive Director of

the Exchange shall serve as ex-officio, non-voting members of the Board.

(7) Within 60 days after the effective date of this amendatory Act of the 97th General Assembly, the Governor shall appoint 3 voting members of the Board for initial terms expiring June 30, 2015; the Governor shall appoint 2 public members and the Attorney General shall appoint one voting member of the Board for initial terms expiring June 30, 2014; and the Governor shall appoint 2 voting members and the Attorney General shall appoint one voting member of the Board for initial terms expiring June 30, 2013. All successors shall hold office for a term of 3 years from the first day of July in the year of appointment and running through June 30 of the third year, except in case of an appointment to fill a vacancy. A Board member shall hold office until the expiration of that member's term and until that member's successor is appointed and qualified.

(8) A person appointed to fill a vacancy and complete the unexpired term of a member of the Board shall only be appointed to serve out the unexpired term by the individual who made the original appointment within 45 days of the initial vacancy. A person appointed to fill a vacancy and complete the unexpired term of a member of the Board may be re-appointed to the Board for another term, but shall not serve than more than 3 consecutive terms following their completion of the unexpired term of a member of the Board.

(9) The Board shall elect one voting member of the Board to serve as chairperson and one voting member to serve as vice-chairperson, upon approval of at least 5 voting members of the Board.

(10) If a voting Board member's qualifications change due to a change in employment during the term of their appointment, the Board member shall resign their position, subject to reappointment by the individual who made the original appointment.

(11) Five voting members present shall constitute a quorum and the affirmative vote of at least 5 voting members is necessary for any action of the Board.

(12) The Board shall meet no less than quarterly on a schedule established by the chairperson. Meetings shall be public and public records shall be maintained subject to the Open Meetings Act. The Board must afford an opportunity for public comment at each of its meetings. No vacancy shall impair the ability for the Board to act provided a quorum is reached. Members shall serve without pay, but they are entitled to be reimbursed for their actual and reasonable expenses incurred in the performance of their duties, including travel expenses.

(13) The chairperson of the Board shall file a written report regarding the activities of the Board and the Exchange to the Governor and General Assembly annually, and the Legislative Oversight Committee established in Section

5-35 of this Law quarterly, beginning on July 1, 2012 and until December 31, 2014.

(14) 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, with the exception of willful and wanton misconduct.

(15) The Board shall adopt conflict of interest rules and recusal procedures. Such rules and procedures shall (A) prohibit a member of the Board from performing an official act that may have a direct economic benefit on a business or other endeavor in which that member has a direct or substantial financial interest and (B) require a member of the Board to recuse himself or herself from an official matter, whether direct or indirect. All recusals must be in advance, in writing and specify the reason and date of the recusal. All recusals shall be maintained by the Executive Director and shall be disclosed to any person upon written request.

(16) 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, an insurer, or a trade association of insurers, insurance producers or brokers, health care providers, or health care facilities or health or medical clinics while serving on the Board or on the staff of the Exchange, with

the exception of (i) 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, (ii) health care providers who are retired or inactive, and (iii) essential community providers.

(17) No employee of the Exchange shall be a member of the Board.

(18) 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.

(19) The Exchange shall be administered by an Executive Director, who shall be appointed, and may be removed, by a vote of at least 5 voting members the Board. The Board shall have the power to determine compensation for the Executive Director. 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.

(20) 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.

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

(22) No member of the Board nor employee of the Exchange may be licensed, registered, or authorized to do business in this State by the Director. Nor may any member of the Board or employee of the Exchange receive compensation from any person or entity licensed, registered, or authorized to do business in this State by the Director.

(23) The Board may, as necessary, create and appoint qualified persons with requisite expertise to Exchange technical advisory groups. These Exchange technical advisory groups shall meet in a manner and frequency determined by the Board to discuss Exchange-related issues and to provide Exchange-related guidance, advice, and recommendation to the Board and the Exchange.

(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 122/5-17 new)

Sec. 5-17. Enrollment through brokers and agents; producer compensation.

(a) In accordance with Section 1312(e) of the Federal Act, the Exchange shall allow licensed insurance producers to (1) enroll qualified individuals in any qualified health plan, for which the individual is eligible, in the individual exchange, (2) assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the individual exchange, and (3) enroll qualified employers in any qualified health plan, for which the employer is eligible, offered through the SHOP exchange. Nothing in this subsection (a) shall be construed as to require a qualified individual or qualified employer to utilize a licensed insurance producer for any of the purposes outlined in this subsection (a).

(b) In order to enroll individuals and small employers in qualified health plans on the Exchange, licensed producers must complete a certification program. The Department of Insurance may develop and implement a certification program for licensed insurance producers who enroll individuals and employers in the

Exchange. The Department of Insurance may charge a reasonable fee, by regulation, to producers for the certification program. The Department of Insurance may approve certification programs developed and instructed by others, charging a reasonable fee, by regulation, for approval.

(c) The Exchange shall include on its website a producer locator section, featured prominently, through which individuals and small employers can find Exchange-certified producers.

(d) All licensed producers certified by the Department to enroll individuals and employers in qualified health plans shall be compensated by qualified health plan issuers in the same manner as qualified health plan issuers compensate producers for comparable health plans sold outside of 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) assessment collected by the Exchange (assessments or fees charged to carriers shall not include any amount

based on coverage, or premiums associated with such coverage, that is defined as an "excepted benefit" under Section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg-91));

(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 20. The Consumer Fraud and Deceptive Business Practices Act is amended by changing Section 2Z as follows:

(815 ILCS 505/2Z) (from Ch. 121 1/2, par. 262Z)

Sec. 2Z. Violations of other Acts. Any person who knowingly violates the Automotive Repair Act, the Automotive Collision

Repair Act, the Home Repair and Remodeling Act, the Dance Studio Act, the Physical Fitness Services Act, the Hearing Instrument Consumer Protection Act, the Illinois Union Label Act, the Job Referral and Job Listing Services Consumer Protection Act, the Travel Promotion Consumer Protection Act, the Credit Services Organizations Act, the Automatic Telephone Dialers Act, the Pay-Per-Call Services Consumer Protection Act, the Telephone Solicitations Act, the Illinois Funeral or Burial Funds Act, the Cemetery Oversight Act, the Cemetery Care Act, the Safe and Hygienic Bed Act, the Pre-Need Cemetery Sales Act, the High Risk Home Loan Act, the Payday Loan Reform Act, the Mortgage Rescue Fraud Act, subsection (a) or (b) of Section 3-10 of the Cigarette Tax Act, subsection (a) or (b) of Section 3-10 of the Cigarette Use Tax Act, the Electronic Mail Act, the Internet Caller Identification Act, paragraph (6) of subsection (k) of Section 6-305 of the Illinois Vehicle Code, Section 11-1431, 18d-115, 18d-120, 18d-125, 18d-135, 18d-150, or 18d-153 of the Illinois Vehicle Code, Section 500-123 of the Illinois Insurance Code, Article 3 of the Residential Real Property Disclosure Act, the Automatic Contract Renewal Act, or the Personal Information Protection Act commits an unlawful practice within the meaning of this Act.

(Source: P.A. 96-863, eff. 1-19-10; 96-1369, eff. 1-1-11; 96-1376, eff. 7-29-10; 97-333, eff. 8-12-11.)

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.".