Sen. David Koehler

Filed: 3/17/2011

1 AMENDMENT TO SENATE BILL 1729

2 AMENDMENT NO. ______. Amend Senate Bill 1729 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be cited as the
5 Illinois Health Coverage Exchange Establishment Act of 2011.

6 Section 5. Purpose and intent; application.
7 (a) The General Assembly hereby declares as follows:
8 (1) The purpose of this Act is to provide for the
9 establishment of an Illinois Health Coverage Exchange to
10 facilitate the purchase and sale of qualified health plans
11 in the individual market in this State, to provide for the
12 establishment of the Small Business Health Options Program
13 to assist qualified small employers in this State in
14 facilitating the enrollment of employees and their family
15 members in qualified health plans, and to provide an
16 efficient, cost-effective process to test eligibility and

1 enroll eligible individuals in public health care coverage
2 such as Medicaid or the Children's Health Insurance
3 Program.

4 (2) The intent of the Exchange is to offer private
5 health plans that provide financial security and
6 appropriate access to health care for individuals,
7 families, and employers in this State and in a manner that
8 is in the best interest of such individuals, reduce the
9 number of uninsured, provide a transparent marketplace and
10 consumer education, assist eligible individuals with
11 enrollment in public health care programs such as Medicaid
12 or the Children's Health Insurance Program, premium
13 assistance tax credits, cost-sharing reductions, and to
14 promote an innovative delivery system and payment reforms
15 referring to lower cost and improve quality.

16 (3) The federal Patient Protection and Affordable Care
17 Act (ACA) requires states to establish an operational
18 Exchange on or before January 1, 2014. In the event a state
19 does not demonstrate significant progress in the
20 implementation of an Exchange by January 1, 2013, then the
21 federal government will establish an Exchange for the
22 non-compliant state. Pursuant to the ACA, an Exchange will
23 determine eligibility and facilitate enrollment in public
24 health programs, including Medicaid and the Children's
25 Health Insurance Program. The Exchange will also provide a
26 marketplace for individuals, families, and employers to

1 shop for and purchase private health plans. The State of
2 Illinois finds that it is in the State's best interest to
3 establish an Exchange rather than defer to the federal
4 government.
5 (b) This Act shall be null and void if Congress and the
6 President take action to repeal or replace, or both, Section
7 1311 of the Affordable Care Act.

8 Section 10. Definitions. As used in this Act:
9 "Board" means the Illinois Health Benefits Exchange Board
10 established pursuant to this Act.
11 "Director" means the Director of Insurance.
12 "Educated health care consumer" means an individual who is
13 knowledgeable about the health care system and has background
14 or experience in making informed decisions regarding health,
15 medical, and scientific matters.
16 "Employee" has the meaning given that term in the Illinois
17 Health Insurance Portability and Accountability Act.
18 "Exchange" means the Illinois Health Benefits Exchange
19 established pursuant to this Act.
20 "Federal Act" means the federal Patient Protection and
21 Affordable Care Act (Public Law 111-148), as amended by the
22 federal Health Care and Education Reconciliation Act of 2010
23 (Public Law 111-152), and any amendments thereto or regulations
24 or guidance issued under those Acts.
25 "Health benefit plan" means a policy, contract,

1 certificate, or agreement offered or issued by a health carrier
2 to provide, deliver, arrange for, pay for, or reimburse any of
3 the costs of health care services. "Health benefit plan" does
4 not include:
5 (1) coverage only for accident or disability income
6 insurance or any combination thereof;
7 (2) coverage issued as a supplement to liability
8 insurance;
9 (3) liability insurance, including general liability
10 insurance and automobile liability insurance;
11 (4) workers' compensation or similar insurance;
12 (5) automobile medical payment insurance;
13 (6) credit-only insurance;
14 (7) coverage for only on-site medical clinics; or
15 (8) other similar insurance coverage specified in
16 federal regulations issued pursuant to Pub. L. No. 104-191,
17 under which benefits for health care services are secondary
18 or incidental to other insurance benefits.
19 "Health benefit plan" does not include the following benefits
20 if they are provided under a separate policy, certificate, or
21 contract of insurance or are otherwise not an integral part of
22 the plan:
23 (a) limited scope dental or vision benefits;
24 (b) benefits for long-term care, nursing home care,
25 home health care, community-based care, or any combination
26 thereof; or

(c) other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

"Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(ii) hospital indemnity or other fixed indemnity insurance.

"Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(A) medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(B) coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(C) similar supplemental coverage provided as coverage under a group health plan.

"Health carrier" or "carrier" means an entity subject to

1 the insurance laws and regulations of this State, or subject to
2 the jurisdiction of the Director, that contracts or offers to
3 contract to provide, deliver, arrange for, pay for, or
4 reimburse any of the costs of health care services, including a
5 sickness and accident insurance company, a health maintenance
6 organization, or any other entity providing a plan of health
7 insurance, health benefits, or health services.
8 "Qualified dental plan" means a limited scope dental plan
9 that has been certified in accordance with this Act.
10 "Qualified employer" means a small employer that elects to
11 make its full-time employees eligible for one or more qualified
12 health plans offered through the SHOP Exchange, and at the
13 option of the employer, some or all of its part-time employees,
14 provided that the employer:
15 (1) has its principal place of business in this State
16 and elects to provide coverage through the SHOP Exchange to
17 all of its eligible employees, wherever employed; or
18 (2) elects to provide coverage through the SHOP
19 Exchange to all of its eligible employees who are
20 principally employed in this State.
21 "Qualified health plan" means a health benefit plan that
22 has in effect a certification that the plan meets the criteria
23 for certification described in Section 1311(c) of the Federal
24 Act and this Act.
25 "Qualified individual" means an individual, including a
26 minor, who:

(1) is seeking to enroll in a qualified health 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 Section 30 of this Act.

"Small employer" has the meaning given that term in the Illinois Health Insurance Portability and Accountability Act. An employer that makes enrollment in qualified health 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 Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 15. Creation of the Exchange.

(a) There is hereby created a political subdivision, body

1 politic, and corporate, that is not a State entity, named the
2 Illinois Health Benefits Exchange. The governing and
3 administrative powers of the Exchange shall be vested in a body
4 known as the Illinois Health Benefits Exchange Board. The Board
5 shall consist of 9 voting members, 7 of whom shall be appointed
6 by the Governor with the advice and consent of the Senate and 2
7 of whom shall be appointed by the Attorney General with the
8 advice and consent of the Senate. The members appointed by the
9 Governor shall include:

10 (1) one consumer representative who is or has in the
11 preceding 2 years been insured in the individual health
12 insurance market in this State;

13 (2) one small employer representative with experience
14 operating a small business in this State;

15 (3) one employee representative of a small employer in
16 this State;

17 (4) one Illinois-licensed insurance producer with
18 experience facilitating the purchase of health insurance
19 coverage in the individual or small group market in this
20 State;

21 (5) one certified health actuary; and

22 (6) one Illinois-licensed health care provider or
23 other qualified representative with experience serving
24 underserved populations, including but not limited to the
25 uninsured and those receiving coverage through public
26 health care programs such as Medicaid or the Children's

1 Health Insurance Program, in both the community-based
2 health care setting and a hospital-based setting in this
3 State; and
4 (7) one representative of the organized labor
5 community in this State.
6 The members appointed by the Attorney General shall include:
7 (i) one health lawyer with experience in public
8 programs, such as Medicaid or the Children's Health
9 Insurance Program, and private health insurance coverage;
10 and
11 (ii) One health lawyer with experience working in
12 collaboration with the Attorney General's Health Care
13 Bureau.
14 (b) The Director of Insurance, the Director of the
15 Healthcare and Family Services, the Director of Human Services,
16 and the Director of Public Health shall serve as ex officio,
17 non-voting members of the Board.
18 (c) Four members of the General Assembly, one each
19 appointed by the President of the Senate, the Minority Leader
20 of the Senate, the Speaker of the House of Representatives, and
21 the Minority Leader of the House of Representatives, shall
22 serve as ex officio, nonvoting members of the Board.
23 (d) In making appointments to the Board, the appointing
24 authorities shall take into consideration the cultural,
25 ethnic, and geographic diversity of the State so that the
26 Board's composition reflects the communities of this State.

1 (e) The Board shall appoint one of its members as
2 chairperson of the Board. Members of the Board shall receive no
3 compensation, but shall be reimbursed for reasonable expenses
4 incurred in the necessary performance of their duties,
5 including travel.
6 (f) The Exchange shall procure necessary services and terms
7 using a process with integrity and transparency and that is
8 free of conflicts of interest and serves the best interest of
9 individuals, families, and employers purchasing coverage
10 through the Exchange.
11 (g) The meetings of the Board shall be subject to the Open
12 Meetings Act, except that the Board may hold closed sessions
13 when considering matters related to litigation, personnel,
14 contracting, and rates.
15 (h) Notwithstanding subsections (8) and (12) of Section
16 10-15 of the State Officials and Employees Ethics Act, no
17 member of the Board or its employees shall accept food or
18 refreshments or any item or items from any prohibited source.
19 (i) Board members shall have the responsibility and duty to
20 meet the requirements of this Act and all applicable State and
21 federal laws and regulations, to serve the public interest of
22 the individuals and small businesses seeking health insurance
23 coverage through the Exchange, and to ensure the operational
24 well-being and fiscal solvency of the Exchange.
25 (j) No member of the Board nor employees of the Board may
26 be an employee of any licensed carrier authorized to do

business in this State.

(k) No member of the Board nor employees of the Board 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, employee, or holds any position of management.

(l) The Director, or any person he or she may appoint, may, in the same manner as authorized for examination of domestic, foreign, or alien insurance companies, investigate the affairs of the Exchange and examine the properties and records of the Exchange and shall, at least annually, require the Exchange to provide periodic reporting to the Governor and the General Assembly in relation to the activities undertaken by the Exchange under this Act.

(m) The Office of the Executive Inspector General shall have jurisdiction over the Exchange and all individuals supervising, directing, contracting, or working for the

1 Exchange.

2 Section 20. Terms of appointments. Within 60 days after the
3 effective date of this Act, the Governor shall appoint 3 voting
4 members of the Board for initial terms expiring June 30, 2015;
5 the Governor shall appoint 2 public members and the Attorney
6 General shall appoint one voting member of the Board for
7 initial terms expiring June 30, 2014; and the Governor shall
8 appoint 2 voting members and the Attorney General shall appoint
9 one voting member of the Board for initial terms expiring June
10 30, 2013. All successors shall hold office for a term of 3
11 years from the first day of July in the year of appointment and
12 running through June 30 of the third year, except in case of an
13 appointment to fill a vacancy. A Board member shall hold office
14 until the expiration of that member's term and until that
15 member's successor is appointed and qualified. Board members
16 may be appointed to subsequent terms. Vacancies shall be filled
17 in the same manner as original appointments for the balance of
18 the unexpired term. In case of vacancy when the Senate is not
19 in session, the Governor may make a temporary appointment until
20 the next meeting of the Senate, when the Governor or Attorney
21 General shall nominate such person to fill the open Board
22 position and any person so nominated who is confirmed by the
23 Senate shall hold his or her office during the remainder of the
24 term and until his or her successor is appointed and qualified.

Section 25. Executive Director. The Board shall appoint an Executive Director who shall be the chief executive officer of the Exchange. The Executive Director shall have at least 5 years of experience in health care policy, management, service, delivery, or coverage. In addition to any other duties set forth in this Act, the Executive Director shall:

(1) employ such staff as may be necessary to carry out the provisions of this Act;

(2) direct and supervise the administrative affairs and activities of the Exchange in accordance with its rules, regulations, and policies;

(3) attend meetings of the Board;

(4) keep minutes of all proceedings of the Board;

(5) approve all accounts for salaries, per diem payments, and allowable expenses of the Exchange and its employees and consultants and approve all expenses incidental to the operation of the Exchange; and

(6) perform any other duty that the Board requires for carrying out the provisions of this Act.

Section 30. Quorum; voting; meetings.

(a) Five members of the Board constitute a quorum for the purpose of conducting business.

(b) Actions of the Board must receive the affirmative vote of at least 5 members of the Board.

(c) The Board shall meet at least quarterly or more often

1 if necessary.

2 Section 35. Powers and authority of the Board.

3 (a) In addition to powers set forth elsewhere in this Act,
4 the Board may do the following:

5 (1) Adopt bylaws, rules, and regulations to carry out
6 the provisions of this Act.

7 (2) Authorize the Exchange to enter into contracts as
8 are necessary or proper to carry out the provisions and
9 purposes or perform any of the functions described in this
10 Act.

11 (3) Take or defend any legal actions necessary to
12 effectuate the purposes of this Act.

13 (4) Appoint appropriate legal, actuarial, and other
14 committees as necessary to provide technical assistance in
15 the operation of the Exchange, contract design, and any
16 other function described in this Act.

17 (5) Authorize commercial, banking, and financial
18 arrangements as needed to manage the day-to-day operations
19 of the Exchange.

20 (6) Appoint and fix the compensation of an Executive
21 Director.

22 (7) Enter into intergovernmental cooperation
23 agreements with governmental entities for the purpose of
24 sharing the cost of providing access to health care
25 coverage that are otherwise authorized by this Act or to

carry out other responsibilities under this Act provided such agreements adequately protect the confidentiality of information to be shared and comply with applicable State and federal laws and regulations.

(8) Establish conditions and procedures under which the exchange may, if charitable or other funds are provided, discount or subsidize premium rates and cost-sharing or prescription drug costs that are paid directly by other public or private entities, as defined by the Board.

(9) 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 Act.

(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 Act.

(b) The Board shall create an Exchange that shall:

(1) facilitate the purchase and sale of qualified health plans;

(2) assist qualified small employers in this State in

facilitating the enrollment of employees in qualified health plans;

(3) develop a process to certify plans eligible to participate in the Exchange; and

(4) facilitate enrollment in Medicaid or the Children's Health Insurance Program for eligible individuals;

(5) inform individuals of the potential for overpayments of advance premium tax credits and of procedures by which individuals can report a change of income that may affect the subsequent level of premium tax credits, including the availability of any safe harbor from recoupment of any overpayment, to the extent permissible under the Federal Act or any federal regulations promulgated thereunder; and

(6) meet the requirements of this Act and any regulations implemented under this Act.

(c) In addition to powers set forth elsewhere in this Act, the Board shall do all of the following:

(1) Make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

(2) Not make available any health benefit plan that is not a qualified health plan.

(3) Allow a health carrier to offer a plan that provides limited scope dental benefits meeting the

1 requirements of Section 9832(c)(2)(A) of the Internal
2 Revenue Code of 1986 through the Exchange, either
3 separately or in conjunction with a qualified health plan,
4 if the plan provides pediatric dental benefits meeting the
5 requirements of Section 1302(b)(1)(J) of the Federal Act.
6 (4) Not charge, or allow a health carrier offering
7 health benefit plans though the Exchange to charge, an
8 individual a fee or penalty for termination of coverage if
9 the individual enrolls in another type of minimum essential
10 coverage because the individual has become newly eligible
11 for that coverage or because the individual's
12 employer-sponsored coverage has become affordable under
13 the standards of Section 36B(c)(2)(C) of the Internal
14 Revenue Code of 1986.
15 (5) Implement procedures for the certification,
16 recertification, and decertification, consistent with
17 guidelines developed by the Secretary under Section
18 1311(c) of the Federal Act and Section 35 of this Act, of
19 health benefit plans as qualified health plans.
20 (6) Provide for the operation of a toll-free telephone
21 hotline to respond to requests for assistance.
22 (7) Provide for enrollment periods as provided under
23 Section 1311(c)(6) of the Federal Act.
24 (8) Maintain an Internet website through which
25 enrollees and prospective enrollees of qualified health
26 plans may obtain standardized comparative information on

1 such plans.
2 (9) Assign a rating to each qualified health plan
3 offered through the Exchange in accordance with the
4 criteria developed by the Secretary under Section
5 1311(c)(3) of the Federal Act, and determine each qualified
6 health plan's level of coverage in accordance with
7 regulations issued by the Secretary under Section
8 1302(d)(2)(A) of the Federal Act. The Exchange shall make
9 this information public in a manner consistent with
10 subparagraph (B) of paragraph (18) of subsection (c) of
11 this Section and paragraph (3) of subsection (c) of Section
12 50 of this Act.
13 (10) Use a standardized format for presenting health
14 benefit options in the Exchange, including the use of the
15 uniform outline of coverage established under Section 2715
16 of the Public Health Service Act.
17 (11) In accordance with Section 1413 of the Federal
18 Act, inform individuals of eligibility requirements for
19 the Medicaid program under title XIX of the Social Security
20 Act, the Children's Health Insurance Program under title
21 XXI of the Social Security Act or any applicable State or
22 local public program and if through screening of the
23 application by the Exchange the Exchange determines that
24 any individual is eligible for any such program, then
25 enroll that individual in that program.
26 (12) Establish and make available by electronic means a

calculator to determine the actual cost of coverage after 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 Act.

(13) Establish a SHOP Exchange, separate from the activities related to the individual market, through which qualified employers may access coverage for their employees. The SHOP Exchange shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage.

(14) Subject to Section 1411 of the Federal Act, 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 responsibility requirement or from the penalty imposed by that Section because:

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

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

(15) Transfer to the federal Secretary of the Treasury the following:

1 (A) a list of the individuals who are issued a
2 certification under paragraph (14) of this subsection
3 (c), including the name and taxpayer identification
4 number of each individual;
5 (B) the name and taxpayer identification number of
6 each individual who was an employee of an employer but
7 who was determined to be eligible for the premium tax
8 credit under Section 36B of the Internal Revenue Code
9 of 1986 because:
10 (i) the employer did not provide minimum
11 essential coverage; or
12 (ii) the employer provided the minimum
13 essential coverage, but it was determined under
14 Section 36B(c)(2)(C) of the Internal Revenue Code
15 to either be unaffordable to the employee or not
16 provide the required minimum actuarial value; and
17 (C) the name and taxpayer identification number
18 of:
19 (i) each individual who notifies the Exchange
20 under Section 1411(b)(4) of the Federal Act that he
21 or she has changed employers; and
22 (ii) each individual who ceases coverage under
23 a qualified health plan during a plan year and the
24 effective date of that cessation.
25 (16) Provide to each employer the name of each employee
26 of the employer described in item (ii) of subparagraph (C)

of paragraph (15) of this subsection (c) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions.

(18) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(A) conduct public education activities to raise awareness of the availability of qualified health plans, premium assistance tax credits, cost sharing reductions, Medicaid and Children's Health Insurance Program eligibility, and related consumer protections;

(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 Act;

(C) facilitate enrollment in qualified health plans and public health care programs, such as Medicaid and the Children Health Insurance Program, where

1 permitted by State and federal law;
2 (D) provide referrals to the Office of Consumer
3 Health Insurance in the Department for any enrollee
4 with a grievance, complaint, or question regarding
5 their health benefit plan, coverage, or a
6 determination under that plan or coverage; and
7 (E) provide information in a manner that is
8 culturally and linguistically appropriate to the needs
9 of the population being served by the Exchange.
10 (19) Within 30 days after issuance of federal guidance
11 regarding the Navigator function in the Exchange, the
12 Board, in collaboration with the advisory committees,
13 shall establish an open process to explore the design and
14 operation of the Exchange's Navigator Program and any other
15 appropriate consumer assistance mechanisms. Within 6
16 months after the effective date of this Act or by February
17 1, 2012, whichever occurs first, the Board shall provide
18 recommendations related to the functions of the Exchange or
19 the role of navigators to the Governor and the General
20 Assembly for their consideration, including:
21 (A) the infrastructure of the existing private
22 sector health insurance distribution system in this
23 State to determine whether private sector resources
24 may be available and suitable for use by the Exchange;
25 (B) the effect the Exchange may have on private
26 sector employment in the health insurance distribution

system in this State;

(C) what functions, in addition to those required by the Patient Protection and Affordable Care Act, should be performed by Navigators;

(D) what training and expertise should be required of Navigators, and whether different markets and populations require Navigators with different qualifications;

(E) how Navigators should be retained and compensated, and how disparities between Navigator compensation and the compensation of insurance producers outside the Exchange can be minimized or avoided;

(F) how to ensure that Navigators provide information in a manner culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served by the Exchange, and that Navigators have the capacity to meet these needs; and

(G) what other means of consumer assistance may be appropriate and feasible, and how they should be designed and implemented.

(20) Review the rate of premium growth within the Exchange and outside the Exchange and consider the information in developing recommendations to the Board about whether to continue limiting qualified employer status to small employers.

1 (21) Credit the amount of any free choice voucher to
2 the monthly premium of the plan in which a qualified
3 employee is enrolled, in accordance with Section 10108 of
4 the Federal Act, and collect the amount credited from the
5 offering employer.
6 (22) Consult with stakeholders relevant to carrying
7 out the activities required under this Act, including, but
8 not limited to:
9 (A) health care consumers who are enrollees in
10 qualified health plans;
11 (B) individuals and entities with experience in
12 facilitating enrollment in qualified health plans and
13 public health care programs, such as Medicaid or the
14 Children's Health Insurance Program;
15 (C) representatives of the employer community,
16 including small businesses, self-employed individuals,
17 and large self-insured plans;
18 (D) providers, including physicians, nurses,
19 behavioral health professionals, other allied health
20 professionals, and hospitals;
21 (E) representatives of union-administered health
22 benefit plans;
23 (F) entities or individuals with experience in
24 designing, managing, and purchasing health benefit
25 plans;
26 (G) the Department of Healthcare and Family

1 Services;
2 (H) the President of the Senate, the Minority
3 Leader of the Senate, the Speaker of the House of
4 Representatives, and the Minority Leader of the House
5 of Representatives;
6 (I) the Department of Human Services;
7 (J) the Department of Public Health; and
8 (K) advocates for enrolling hard to reach
9 populations.
10 (23) The Board, in collaboration with the advisory
11 committees, shall establish an open process to explore
12 several aspects of Exchange policy and provide
13 recommendations to the General Assembly about future
14 legislative action regarding:
15 (A) expanding the definition of small employer to
16 include employers with up to 100 employees, including
17 an analysis of the impact of such a policy on premiums
18 and access to health insurance coverage for
19 individuals and small businesses in this State;
20 (B) permitting employers with more than 100
21 employees to purchase coverage through the Exchange
22 beginning in 2017, including an analysis of the impact
23 of such a policy on premiums and access to health
24 insurance coverage for individuals and small
25 businesses in this State; and
26 (C) additional mechanisms to minimize the risk of

1 adverse selection in the Exchange.
2 In close cooperation with the Department of Healthcare
3 and Family Services and other impacted agencies and stake
4 holders, the Board shall make a recommendation as to
5 whether Illinois should adopt a Basic Health Plan as
6 allowed under Section 1331 of the ACA. Such a
7 recommendation should take into account, among other
8 things the potential impact on individuals who would be
9 covered under the Basic Health Plan, the potential cost to
10 the State, and the overall impact on the Exchange. Such a
11 recommendation must be made within 6 months after the final
12 rules for states by the Secretary regarding the
13 establishment of Basic Health Plans.
14 (25) Meet the following financial integrity
15 requirements:
16 (A) keep an accurate accounting of all activities,
17 receipts, and expenditures and annually submit to the
18 Secretary, the Governor, the Director, and the General
19 Assembly a report concerning such accountings;
20 (B) fully cooperate with any investigation
21 conducted by the Secretary pursuant to the Secretary's
22 authority under the Federal Act and allow the
23 Secretary, in coordination with the Inspector General
24 of the U.S. Department of Health and Human Services, to
25 do the following:
26 (i) investigate the affairs of the Exchange;

1 (ii) examine the properties and records of the
2 Exchange; and
3 (iii) require periodic reports in relation to
4 the activities undertaken by the Exchange; and
5 (C) in carrying out its activities under this Act,
6 not use any funds intended for the administrative and
7 operational expenses of the Exchange for staff
8 retreats, promotional giveaways, excessive executive
9 compensation, or promotion of federal or State
10 legislative and regulatory modifications.
11 (d) Unless authorized by law, the Board and any Exchange
12 employee or representative are not authorized to act in any
13 manner that implies or asserts that the Board or the Exchange
14 in and of itself can add to or impose any fiscal liability on
15 the State.
16 (e) The Board shall recognize waivers approved by the
17 Secretary pursuant to the Federal Act, recognizing that these
18 waivers may change over time and be of limited scope or
19 duration.

20 Section 40. Advisory committees.
21 (a) Within 60 days after the effective date of this Act,
22 the Board shall appoint a Technical Advisory Committee composed
23 of no more than 20 individuals responsible for developing the
24 standards and criteria for selecting qualified health plans to
25 be offered through the Exchange. Such standards and criteria

1 shall be developed based upon the tenets of value, quality, and
2 service and in a manner that serves the best interests of
3 qualified individuals and qualified small employers. The
4 Committee shall meet no less than once every 3 months and shall
5 provide recommendations to the Board regarding standards and
6 criteria for qualified health plans no later than 6 months
7 after its establishment. The Technical Advisory Committee
8 shall consult with the Stakeholder Advisory Committee
9 described in this Section regarding its draft recommendations
10 and provide time for substantive comment no less than once
11 prior to issuing any final recommendations for review by the
12 Board.
13 (b) Each person appointed to the Committee shall serve a
14 2-year term, and have demonstrated and acknowledged expertise
15 in at least 2 of the following areas:
16 (1) Individual health care coverage.
17 (2) Employer health care coverage.
18 (3) Health benefits plan administration, including
19 revenue cycle billing and collections.
20 (4) The health coverage needs of populations with
21 low-income limited health literacy and limited English
22 language proficiency.
23 (5) Health care finance.
24 (6) Administering a public or private health care
25 delivery system.
26 (7) Purchasing health plan coverage.

1 (8) Education and outreach.
2 The Board shall consider the expertise of the other members
3 of the Committee and attempt to make appointments so that the
4 Committee's composition reflects a diversity of expertise.
5 (c) Within 30 days after the Board's establishment, it
6 shall appoint a Stakeholder Advisory Committee composed of no
7 fewer than 5 Illinois health care consumers, 5 Illinois small
8 business owners, 5 Illinois-licensed health care providers
9 from a variety of provider types, including, but not limited
10 to, hospitals, private practice medical groups, community
11 health centers, and safety net providers that have experience
12 providing medical care to underserved populations, and 5 health
13 plans that rank among the 10 largest in this State for premium
14 volume. Committee members shall serve one-year terms.
15 (d) The Board may establish additional advisory committees
16 to assist in carrying out its duties under the Act.
17 (e) Members of committees shall receive no compensation,
18 but shall be reimbursed for reasonable expenses incurred in the
19 necessary performance of their duties, including travel.
20 (f) The meetings of all advisory committees shall be
21 subject to the Open Meetings Act.

22 Section 45. Annual report. The Board shall report in
23 writing to the Governor, the Clerk of the House of
24 Representatives, and the Clerk of the Senate by the 30th day of
25 June, annually, the details and results of its administration

1 of this Act. The Board's report shall include an audited
2 financial report, and may include any recommendation intended
3 to improve the value of health coverage sold through the
4 Exchange to patients, families, and employers. The Board shall
5 make such report publicly available on the Exchange website.

6 Section 50. Health benefit plan certification.
7 (a) The Exchange may certify a health benefit plan as a
8 qualified health plan if:
9 (1) the plan provides the essential health benefits
10 package described in Section 1302(a) of the Federal Act,
11 except that the plan is not required to provide essential
12 benefits that duplicate the minimum benefits of qualified
13 dental plans, as provided in subsection (e) of this
14 Section, if:
15 (A) the Exchange has determined that at least one
16 qualified dental plan is available to supplement the
17 plan's coverage; and
18 (B) the carrier makes prominent disclosure at the
19 time it offers the plan, in a form approved by the
20 Exchange, that the plan does not provide the full range
21 of essential pediatric benefits, and that qualified
22 dental plans providing those benefits and other dental
23 benefits not covered by the plan are offered through
24 the Exchange;
25 (2) the premium rates and contract language have been

1 approved by the Director;
2 (3) the plan provides at least a bronze level of
3 coverage, as determined pursuant to paragraph (9) of
4 subsection (c) of Section 35 of this Act, unless the plan
5 is certified as a qualified catastrophic plan, meets the
6 requirements of the Federal Act for catastrophic plans, and
7 will only be offered to individuals eligible for
8 catastrophic coverage;
9 (4) the plan's cost-sharing requirements do not exceed
10 the limits established under Section 1302(c)(1) of the
11 Federal Act and if the plan is offered through the SHOP
12 Exchange, then the plan's deductible does not exceed the
13 limits established under Section 1302(c)(2) of the Federal
14 Act;
15 (5) the health carrier offering the plan:
16 (A) is licensed and in good standing to offer
17 health insurance coverage in this State;
18 (B) offers at least one qualified health plan in
19 the silver level and at least one plan in the gold
20 level through each component of the Exchange in which
21 the carrier participates, where "component" refers to
22 the SHOP Exchange and the Exchange for individual
23 coverage;
24 (C) charges the same premium rate for each
25 qualified health plan without regard to whether the
26 plan is offered through the Exchange and without regard

to whether the plan is offered directly from the carrier or through an insurance producer;

(D) does not charge any cancellation fees or penalties in violation of paragraph (4) of subsection (c) of Section 35 of this Act; and

(E) complies with the regulations developed by the Secretary under Section 1311(d) of the Federal Act and such other requirements as the Exchange may establish.

Should the qualified health plan offer the benefits of qualified dental plans, the health and dental benefits shall be placed separately.

(6) the plan meets the requirements of certification as set forth by the Board, in collaboration with the Technical Advisory Committee, and by the Secretary under Section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance; and

(7) the Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

(b) The Exchange shall not exclude a health benefit plan:

(1) on the basis that the plan is a fee-for-service plan;

(2) through the imposition of premium price controls by the Exchange; or

(3) on the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(c) The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) submit a justification for any premium increase before implementation of that increase; the carrier shall prominently post the information on its Internet website; the Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the Director under Section 2794(b) of the Public Health Service Act, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

(2) make available to the public, in the format described in paragraph (3) of subsection (c) of this Section, and submit to the Exchange, the Secretary, and the Director, accurate and timely disclosure of current data relating to the following:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment;

(D) data on disenrollment;

(E) data on the number of claims that are denied, including pre-certification denials and limitations on requested services;

(F) data on rating practices;

(G) information on cost-sharing and payments with respect to any out-of-network coverage;

(H) information on enrollee and participant rights under title I of the Federal Act;

(I) data on how the plan's quality scores, consumer satisfaction levels, and performance levels compare to national metrics and others in the Exchange; and

(J) other information as determined appropriate by the Secretary; and

(3) enable individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including 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 website and through other means for individuals without access to the Internet, and in a manner consistent with subparagraph (E) of paragraph (18) of subsection (c)

1 of Section 35 of this Act and this paragraph (3).
2 The information required in paragraph (2) of this
3 subsection (c) shall be provided in plain language, as that
4 term is defined in Section 1311(e)(3)(B) of the Federal Act.
5 (d) The Exchange shall not exempt any health carrier
6 seeking certification of a qualified health plan, regardless of
7 the type or size of the carrier, from State licensure or
8 solvency requirements and shall apply the criteria of this
9 Section in a manner that assures a level playing field between
10 or among health carriers participating in the Exchange.
11 (e) Application to dental plans shall comport with all of
12 the following provisions:
13 (1) The provisions of this Act that are applicable to
14 qualified health plans shall also apply to the extent
15 relevant to qualified dental plans except as modified in
16 accordance with the provisions of paragraphs (2), (3), and
17 (4) of this subsection (e) or by regulations adopted by the
18 Exchange.
19 (2) The carrier shall be licensed to offer dental
20 coverage, but need not be licensed to offer other health
21 benefits.
22 (3) The plan shall be limited to dental and oral health
23 benefits, without substantially duplicating the benefits
24 typically offered by health benefit plans without dental
25 coverage and shall include, at a minimum, the essential
26 pediatric dental benefits prescribed by the Secretary

pursuant to Section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may specify by regulation.

(4) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

Section 55. Funding; publication of costs.

(a) The Exchange shall be financed in a manner independent of general revenue funds, but that shall preclude any allocations of identifiable costs to State entities for specific services.

(b) The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on money lost to waste, fraud, and abuse.

Section 60. Relation to other laws. Nothing in this Act and no action taken by the Exchange pursuant to this Act shall be construed to preempt or supersede the authority of the Director

to regulate the business of insurance. Except as expressly provided to the contrary in this Act, all health carriers offering qualified health plans in this State shall comply fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the Director.

Section 65. Health insurance coverage survey. The Department of Insurance shall conduct an annual household and employer survey regarding health insurance coverage in this State, the cost of which shall be incorporated into the operation costs of the Exchange. This purpose of this report is to measure the current state of health insurance coverage in this State, and such information shall inform the Exchange in its pursuit to achieve the goals put forth in this Act. The Department of Revenue and other relevant State departments and agencies shall provide the Department with any and all relevant information for the purposes of successfully completing this survey. The Department shall deliver this report to the Board, the Governor, the Clerk of the House of Representatives, and the Clerk of the Senate by November 1, 2012, and the first day of July annually thereafter. The Department of Insurance shall make such report publicly available on its website. At a minimum, the report shall include:

(1) primary and secondary sources of health insurance coverage for individuals and families in this State;

(2) demographic characteristics of insured and

1 uninsured individuals in this State, including, but not
2 limited to:
3 (A) household income and size;
4 (B) age;
5 (C) gender;
6 (D) race;
7 (E) sexual orientation;
8 (F) geographic location;
9 (G) employment status; and
10 (H) disability status;
11 (3) barriers to health insurance coverage including,
12 but not limited to:
13 (A) financial;
14 (B) physical;
15 (C) religious or other personal restrictions;
16 (D) administrative barriers, including barriers
17 resulting from the operation of the Exchange; and
18 (E) language barriers; and
19 (4) survey of Employer-based coverage in this State,
20 including, but not limited to:
21 (A) health benefits offer rates;
22 (B) health benefits take-up rates among employees;
23 (C) scope of benefits provided (including, but not
24 limited to, comprehensive, scheduled, high-deductible,
25 catastrophic, or hospital-only coverage), including
26 the types of health plans;

1 (D) exclusions, restrictions, and waiting periods;
2 (E) worker and employer premium contributions in
3 accordance with the following provisions;
4 (i) employer size (under 20; 20-99; 100-499;
5 and over 500);
6 (ii) part-time, full-time, and seasonal
7 employee;
8 (iii) salaried, hourly employees, or exempt
9 and non-exempt employees; and
10 (iv) employee and dependent coverage available
11 and take-up rate;
12 (F) organizational characteristics of the
13 employer, including, but not limited to:
14 (i) employer size (under 20; 20-99; 100-499;
15 and over 500);
16 (ii) part-time, full-time, and seasonal
17 employee;
18 (iii) salaried, hourly employees, or exempt
19 and non-exempt employees; and
20 (iv) employee and dependent coverage available
21 and take-up rate; and
22 (G) for employers not offering coverage, reasons
23 for not offering.

24 Section 70. Illinois Administrative Procedures Act. The
25 provisions of the Illinois Administrative Procedures Act as now

1 or hereafter amended are hereby expressly adopted and
2 incorporated herein as though a part of this Act and shall
3 apply to all administrative rules and procedures of the
4 Exchange under this Act.

5 Section 900. The Personnel Code is amended by changing
6 Section 4c as follows:

7 (20 ILCS 415/4c) (from Ch. 127, par. 63b104c)
8 Sec. 4c. General exemptions. The following positions in
9 State service shall be exempt from jurisdictions A, B, and C,
10 unless the jurisdictions shall be extended as provided in this
11 Act:
12 (1) All officers elected by the people.
13 (2) All positions under the Lieutenant Governor,
14 Secretary of State, State Treasurer, State Comptroller,
15 State Board of Education, Clerk of the Supreme Court,
16 Attorney General, and State Board of Elections.
17 (3) Judges, and officers and employees of the courts,
18 and notaries public.
19 (4) All officers and employees of the Illinois General
20 Assembly, all employees of legislative commissions, all
21 officers and employees of the Illinois Legislative
22 Reference Bureau, the Legislative Research Unit, and the
23 Legislative Printing Unit.
24 (5) All positions in the Illinois National Guard and

Illinois State Guard, paid from federal funds or positions in the State Military Service filled by enlistment and paid from State funds.

(6) All employees of the Governor at the executive mansion and on his immediate personal staff.

(7) Directors of Departments, the Adjutant General, the Assistant Adjutant General, the Director of the Illinois Emergency Management Agency, members of boards and commissions, and all other positions appointed by the Governor by and with the consent of the Senate.

(8) The presidents, other principal administrative officers, and teaching, research and extension faculties of Chicago State University, Eastern Illinois University, Governors State University, Illinois State University, Northeastern Illinois University, Northern Illinois University, Western Illinois University, the Illinois Community College Board, Southern Illinois University, Illinois Board of Higher Education, University of Illinois, State Universities Civil Service System, University Retirement System of Illinois, and the administrative officers and scientific and technical staff of the Illinois State Museum.

(9) All other employees except the presidents, other principal administrative officers, and teaching, research and extension faculties of the universities under the jurisdiction of the Board of Regents and the colleges and

1 universities under the jurisdiction of the Board of
2 Governors of State Colleges and Universities, Illinois
3 Community College Board, Southern Illinois University,
4 Illinois Board of Higher Education, Board of Governors of
5 State Colleges and Universities, the Board of Regents,
6 University of Illinois, State Universities Civil Service
7 System, University Retirement System of Illinois, so long
8 as these are subject to the provisions of the State
9 Universities Civil Service Act.
10 (10) The State Police so long as they are subject to
11 the merit provisions of the State Police Act.
12 (11) (Blank).
13 (12) The technical and engineering staffs of the
14 Department of Transportation, the Department of Nuclear
15 Safety, the Pollution Control Board, and the Illinois
16 Commerce Commission, and the technical and engineering
17 staff providing architectural and engineering services in
18 the Department of Central Management Services.
19 (13) All employees of the Illinois State Toll Highway
20 Authority.
21 (14) The Secretary of the Illinois Workers'
22 Compensation Commission.
23 (15) All persons who are appointed or employed by the
24 Director of Insurance under authority of Section 202 of the
25 Illinois Insurance Code to assist the Director of Insurance
26 in discharging his responsibilities relating to the

1 rehabilitation, liquidation, conservation, and dissolution
2 of companies that are subject to the jurisdiction of the
3 Illinois Insurance Code.
4 (16) All employees of the St. Louis Metropolitan Area
5 Airport Authority.
6 (17) All investment officers employed by the Illinois
7 State Board of Investment.
8 (18) Employees of the Illinois Young Adult
9 Conservation Corps program, administered by the Illinois
10 Department of Natural Resources, authorized grantee under
11 Title VIII of the Comprehensive Employment and Training Act
12 of 1973, 29 USC 993.
13 (19) Seasonal employees of the Department of
14 Agriculture for the operation of the Illinois State Fair
15 and the DuQuoin State Fair, no one person receiving more
16 than 29 days of such employment in any calendar year.
17 (20) All "temporary" employees hired under the
18 Department of Natural Resources' Illinois Conservation
19 Service, a youth employment program that hires young people
20 to work in State parks for a period of one year or less.
21 (21) All hearing officers of the Human Rights
22 Commission.
23 (22) All employees of the Illinois Mathematics and
24 Science Academy.
25 (23) All employees of the Kankakee River Valley Area
26 Airport Authority.

1 (24) The commissioners and employees of the Executive
2 Ethics Commission.
3 (25) The Executive Inspectors General, including
4 special Executive Inspectors General, and employees of
5 each Office of an Executive Inspector General.
6 (26) The commissioners and employees of the
7 Legislative Ethics Commission.
8 (27) The Legislative Inspector General, including
9 special Legislative Inspectors General, and employees of
10 the Office of the Legislative Inspector General.
11 (28) The Auditor General's Inspector General and
12 employees of the Office of the Auditor General's Inspector
13 General.
14 (29) The Board members and employees of the Illinois
15 Health Benefits Exchange.
16 (Source: P.A. 95-728, eff. 7-1-08 - See Sec. 999.)

17 Section 999. Effective date. This Act takes effect upon
18 becoming law.".