**Sen. David Koehler**

# Filed: 3/7/2013



AMENDMENT TO SENATE BILL 34

AMENDMENT NO. _____. Amend Senate Bill 34 by replacing everything after the enacting clause with the following:

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

(20 ILCS 415/4c) (from Ch. 127, par. 63b104c)

Sec. 4c. General exemptions. The following positions in State service shall be exempt from jurisdictions A, B, and C, unless the jurisdictions shall be extended as provided in this Act:

(1) All officers elected by the people.

(2) All positions under the Lieutenant Governor, Secretary of State, State Treasurer, State Comptroller, State Board of Education, Clerk of the Supreme Court, Attorney General, and State Board of Elections.

(3) Judges, and officers and employees of the courts,

and notaries public.

(4) All officers and employees of the Illinois General Assembly, all employees of legislative commissions, all officers and employees of the Illinois Legislative Reference Bureau, the Legislative Research Unit, and the Legislative Printing Unit.

(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 universities under the jurisdiction of the Board of Governors of State Colleges and Universities, Illinois Community College Board, Southern Illinois University, Illinois Board of Higher Education, Board of Governors of State Colleges and Universities, the Board of Regents, University of Illinois, State Universities Civil Service System, University Retirement System of Illinois, so long as these are subject to the provisions of the State Universities Civil Service Act.

(10) The State Police so long as they are subject to the merit provisions of the State Police Act.

(11) (Blank).

(12) The technical and engineering staffs of the Department of Transportation, the Department of Nuclear Safety, the Pollution Control Board, and the Illinois Commerce Commission, and the technical and engineering staff providing architectural and engineering services in the Department of Central Management Services.

(13) All employees of the Illinois State Toll Highway

Authority.

(14) The Secretary of the Illinois Workers' Compensation Commission.

(15) All persons who are appointed or employed by the Director of Insurance under authority of Section 202 of the Illinois Insurance Code to assist the Director of Insurance in discharging his responsibilities relating to the rehabilitation, liquidation, conservation, and dissolution of companies that are subject to the jurisdiction of the Illinois Insurance Code.

(16) All employees of the St. Louis Metropolitan Area Airport Authority.

(17) All investment officers employed by the Illinois State Board of Investment.

(18) Employees of the Illinois Young Adult Conservation Corps program, administered by the Illinois Department of Natural Resources, authorized grantee under Title VIII of the Comprehensive Employment and Training Act of 1973, 29 USC 993.

(19) Seasonal employees of the Department of Agriculture for the operation of the Illinois State Fair and the DuQuoin State Fair, no one person receiving more than 29 days of such employment in any calendar year.

(20) All "temporary" employees hired under the Department of Natural Resources' Illinois Conservation Service, a youth employment program that hires young people

to work in State parks for a period of one year or less.

(21) All hearing officers of the Human Rights Commission.

(22) All employees of the Illinois Mathematics and Science Academy.

(23) All employees of the Kankakee River Valley Area Airport Authority.

(24) The commissioners and employees of the Executive Ethics Commission.

(25) The Executive Inspectors General, including special Executive Inspectors General, and employees of each Office of an Executive Inspector General.

(26) The commissioners and employees of the Legislative Ethics Commission.

(27) The Legislative Inspector General, including special Legislative Inspectors General, and employees of the Office of the Legislative Inspector General.

(28) The Auditor General's Inspector General and employees of the Office of the Auditor General's Inspector General.

(29) All employees of the Illinois Power Agency.

(30) Employees having demonstrable, defined advanced skills in accounting, financial reporting, or technical expertise who are employed within executive branch agencies and whose duties are directly related to the submission to the Office of the Comptroller of financial

information for the publication of the Comprehensive Annual Financial Report (CAFR).

(31) The employees of the Illinois Health Benefits Exchange.

(Source: P.A. 97-618, eff. 10-26-11; 97-1055, eff. 8-23-12.)

Section 10. The Illinois Insurance Code is amended by changing Section 500-100 as follows:

(215 ILCS 5/500-100)

(Section scheduled to be repealed on January 1, 2017)

Sec. 500-100. Limited lines producer license.

(a) An individual who is at least 18 years of age and whom the Director considers to be competent, trustworthy, and of good business reputation may obtain a limited lines producer license for one or more of the following classes:

(1) insurance on baggage or limited travel health, accident, or trip cancellation insurance sold in connection with transportation provided by a common carrier;

(2) industrial life insurance, as defined in Section 228 of this Code;

(3) industrial accident and health insurance, as defined in Section 368 of this Code;

(4) insurance issued by a company organized under the Farm Mutual Insurance Company Act of 1986;

(5) legal expense insurance;

(6) enrollment of recipients of public aid or medicare in a health maintenance organization;

(7) a limited health care plan issued by an organization having a certificate of authority under the Limited Health Service Organization Act.

(a-5) An insurance navigator shall obtain a limited lines producer license for the purpose of advising qualified individuals under the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, and any amendments thereto, about health plans offered through the Illinois Health Benefits Exchange and other State and federal health programs as may be available. Insurance navigators must complete a training program in basic instruction about the Illinois Health Benefits Exchange, accident and health insurance business, and State and federal programs with which they will be assisting individuals.

Insurance navigators may not receive any direct compensation or personal economic benefit for assisting individuals with respect to any particular health benefits plan.

(b) The application for a limited lines producer license must be submitted on a form prescribed by the Director by a designee of the insurance company, health maintenance organization, or limited health service organization

appointing the limited insurance representative. The insurance company, health maintenance organization, or limited health service organization must pay the fee required by Section 500-135.

(c) A limited lines producer may represent more than one insurance company, health maintenance organization, or limited health service organization.

(d) An applicant who has met the requirements of this Section shall be issued a perpetual limited lines producer license.

(e) A limited lines producer license shall remain in effect as long as the appointing insurance company pays the respective fee required by Section 500-135 prior to January 1 of each year, unless the license is revoked or suspended pursuant to Section 500-70. Failure of the insurance company to pay the license fee or to submit the required documents shall cause immediate termination of the limited line insurance producer license with respect to which the failure occurs.

(f) A limited lines producer license may be terminated by the insurance company or the licensee.

(g) A person whom the Director considers to be competent, trustworthy, and of good business reputation may be issued a car rental limited line license. A car rental limited line license for a rental company shall remain in effect as long as the car rental limited line licensee pays the respective fee required by Section 500-135 prior to the next fee date unless

the car rental license is revoked or suspended pursuant to Section 500-70. Failure of the car rental limited line licensee to pay the license fee or to submit the required documents shall cause immediate suspension of the car rental limited line license. A car rental limited line license for rental companies may be voluntarily terminated by the car rental limited line licensee. The license fee shall not be refunded upon termination of the car rental limited line license by the car rental limited line licensee.

(h) A limited lines producer issued a license pursuant to this Section is not subject to the requirements of Section 500-30.

(i) A limited lines producer license must contain the name, address and personal identification number of the licensee, the date the license was issued, general conditions relative to the license's expiration or termination, and any other information the Director considers proper. A limited line producer license, if applicable, must also contain the name and address of the appointing insurance company.

(Source: P.A. 92-386, eff. 1-1-02.)

Section 15. The Comprehensive Health Insurance Plan Act is amended by adding Sections 16 and 17 as follows:

(215 ILCS 105/16 new)

Sec. 16. Cessation of operations. Notwithstanding any

other provision of this Act, the insurance operations of the Plan authorized by this Act shall cease on January 1, 2014 in accordance with Section 5-30 of the Illinois Health Benefits Exchange Law. Plan coverage does not apply to service provided on or after January 1, 2014 in accordance with Section 5-30 of the Illinois Health Benefits Exchange Law.

(215 ILCS 105/17 new)

Sec. 17. Repealer. This Act is repealed on January 1, 2015.

Section 20. The Illinois Health Benefits Exchange Law is amended by changing Sections 5-3, 5-5, and 5-15 and by adding Sections 5-4, 5-6, 5-16, 5-17, 5-18, 5-21, 5-23, and 5-30 as follows:

(215 ILCS 122/5-3)

Sec. 5-3. Legislative intent. The General Assembly finds the health benefits exchanges authorized by the federal Patient Protection and Affordable Care Act represent one of a number of ways in which the State can address coverage gaps and provide individual consumers and small employers access to greater coverage options. The General Assembly also finds that the State is best positioned to implement an exchange that is sensitive to the coverage gaps and market landscape unique to this State.

The purpose of this Law is to provide for the establishment

of an Illinois Health Benefits Exchange (the Exchange) to facilitate the purchase and sale of qualified health plans and qualified dental plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans and qualified dental plans offered in the small group market. The intent of the Exchange is to supplement the existing health insurance market to simplify shopping for individual and small employers by increasing access to benefit options, encouraging a competitive market both inside and outside the Exchange, reducing the number of uninsured, and providing a transparent marketplace and effective consumer education and programmatic assistance tools. ~~The purpose of this Law is to ensure that the State is making sufficient progress towards establishing an exchange within the guidelines outlined by the federal law and to protect Illinoisans from undue federal regulation. Although the federal law imposes a number of core requirements on state-level exchanges, the State has significant flexibility in the design and operation of a State exchange that make it prudent for the State to carefully analyze, plan, and prepare for the exchange. The General Assembly finds that in order for the State to craft a tenable exchange that meets the fundamental goals outlined by the Patient Protection and Affordable Care Act of expanding access to affordable coverage~~

~~and improving the quality of care, the implementation process should (1) provide for broad stakeholder representation; (2) foster a robust and competitive marketplace, both inside and outside of the exchange; and (3) provide for a broad-based approach to the fiscal solvency of the exchange.~~

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

(215 ILCS 122/5-4 new)

Sec. 5-4. Definitions. In this Law:

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

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

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

"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:

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

(2) coverage issued as a supplement to liability insurance;

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

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

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

(8) other similar insurance coverage, specified in federal regulations issued pursuant to the federal Health Information Portability and Accountability Act of 1996, Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

"Health benefit plan" does not include the following benefits if they are provided under a separate policy,

certificate, or contract of insurance or are otherwise not an integral part of the plan:

(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) other similar, limited benefits specified in federal regulations issued pursuant to Public Law 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 federal 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 to coverage under a group health plan.

"Health benefit plan" does not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under Section 514 of the federal Employee Retirement Income Security Act of 1974.

"Health insurance 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, or any other entity providing a plan of health insurance, health benefits, or health services. "Health insurance carrier" does not include short term, accident only, disability income, hospital confinement or fixed indemnity, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance

under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or a Consumer Operated and Oriented Plan.

"Illinois Health Benefits Exchange Fund" means the fund created outside of the State treasury to be used exclusively to provide funding for the operation and administration of the Exchange in carrying out the purposes authorized by this Law.

"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 and any additional requirements provided for under this Law.

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

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

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

(2) resides in this State;

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

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

"Secretary" means the Secretary of the federal Department

of Health and Human Services.

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

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees before January 1, 2016 and no more than 100 employees on and after January 1, 2016 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; provided however, that in the event of a conflict between the federal law and regulations and the State law and regulations, the federal law and regulations shall prevail;

(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 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 the Exchange ~~State health benefits exchange~~.

(a) It is declared that this State, beginning on the effective date of this amendatory Act of the 98th General Assembly ~~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. These health plans shall be available to individuals and small employers for enrollment by October 1, 2014.

(b) There is hereby created a political subdivision, body politic and corporate, named the Illinois Health Benefits Exchange. The Exchange shall be a public entity, but shall not be considered a department, institution, or agency of the State.

(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. The Board shall produce an assessment by July 1, 2016 to determine the viability of merging the SHOP Exchange and Individual Exchange functions into a single exchange by January 1, 2017.

(d) The Exchange shall promote a competitive marketplace that allows consumer access to affordable health coverage options. The Department shall review and recommend that the Board certify health benefit plans on the individual and SHOP Exchange, as applicable, provided that any such health benefit plan meets the requirements set forth in Section 1311(c) of the Federal Act and any other requirements of the Illinois

Insurance Code. The Board shall certify health benefit plans that the Department recommends for certification. If the Board fails to certify a health benefit plan that has been recommended by the Department, then the issuing insurer may file a mandamus action in a court of proper jurisdiction in a county where the principle place of business of the Board is located.

(e) The Exchange shall not supersede the provisions of the Illinois Insurance Code.

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

(215 ILCS 122/5-6 new)

Sec. 5-6. Health benefit plan certification.

(a) To be certified as a qualified health plan, a health benefit plan shall, at a minimum:

(1) provide the essential health benefits package described in Section 1302(a) of the Federal Act; except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection (e) of this Section if:

(A) the Board, in cooperation with the Department, has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) the health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Board, that the plan does not provide the full

range of essential pediatric dental benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

(2) obtain prior approval of premium rates and contract language from the Department;

(3) provide at least the minimum level of coverage prescribed by the Federal Act;

(4) ensure that the cost-sharing requirements of the plan do not exceed the limits established under Section 1302(c)(l) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the Federal Act;

(5) be offered by a health carrier that:

(A) is authorized and in good standing to offer health insurance coverage;

(B) offers at least one qualified health plan at the silver level and at least one plan at the gold level, as described in the Federal Act, through each component of the Board in which the health carrier participates; for the purposes of this subparagraph (B), "component" means the SHOP Exchange and the exchange for individual coverage within the American Health Benefit Exchange;

(C) charges the same premium rate for each

qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;

(D) does not charge any cancellation fees or penalties; and

(E) complies with the regulations established by the Secretary under Section 1311 (d) of the Federal Act and any other requirements as the Board may establish;

(6) meet the requirements of certification pursuant to the Board and the requirements of the Illinois Insurance Code provided in this Law and the requirements issued by the Secretary under Section 1311(c) of the Federal Act and rules promulgated or adopted pursuant to this Law or the Federal Act, which shall include:

(A) minimum standards in the areas of marketing practices;

(B) network adequacy;

(C) essential community providers in underserved areas;

(D) accreditation;

(E) quality improvement;

(F) uniform enrollment forms and descriptions of coverage; and

(G) information on quality measures for health benefit plan performance;

(7) be determined by the Board that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers; and

(8) include all outpatient clinics in the health plan's region that are controlled by an entity that also controls a 340B eligible provider as defined by Section 340B(a)(4) of the federal Public Health Service Act such that the outpatient clinics are subject to the same mission, policies, and medical standards related to the provision of health care services as the 340B eligible provider.

(b) The Board shall not withhold certification from 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 Board; or

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

(c) The Board 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, and prominently post the information on its publicly accessible Internet website;

(2) make available to the public, in plain language as defined in Section 1311(e)(3)(B) of the Federal Act, and submit to the Board, the Secretary, and the Department accurate and timely disclosure of the following:

(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 Act; and

(ix) other information as determined appropriate by the Secretary;

(3) permit 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 and make this information available to the individual through an Internet website that is publicly accessible and through other means for

individuals without access to the Internet; and

(4) promptly notify affected individuals of price and benefit changes or other changes in circumstances that could materially impact enrollment or coverage.

(d) The Board shall not exempt any health carrier seeking certification as a qualified health plan, regardless of the type or size of the health carrier, from licensure or solvency requirements and shall apply the criteria of this Section in a manner that ensures a level playing field between or among health carriers participating in the Exchange.

(e) The provisions of this Law that are applicable to qualified health plans shall also apply, to the extent relevant, to qualified dental plans, except as modified in accordance with the provisions of paragraphs (1), (2), and (3) of this subsection (e) or by rules adopted by the Board.

(1) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(2) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential 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 Board or the Secretary may specify by rule.

(3) Health carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a health carrier through a qualified dental plan and the other benefits are provided by a health 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.

(215 ILCS 122/5-15)

Sec. 5-15. Illinois Health Benefits Exchange Legislative Oversight ~~Study~~ Committee.

(a) There is created an Illinois Health Benefits Exchange Legislative Oversight ~~Study~~ Committee within the Commission on Government Forecasting and Accountability to provide accountability for ~~conduct a study regarding State implementation and establishment of~~ the Illinois Health Benefits Exchange and to ensure 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 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 ~~Study~~ 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 ~~Study~~ Committee shall be appointed no later than June 1, 2013 ~~within 30 days after the effective date of this Law. The co-chairs shall convene the first meeting of the committee no later than 45 days after the effective date of this Law~~.

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

(215 ILCS 122/5-16 new)

Sec. 5-16. Exchange governance. 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 11 voting members appointed by the Governor with the advice and consent of a majority of the members elected to the Senate. In addition, the Director of Healthcare and Family Services, and the Executive Director of the Exchange shall serve as non-voting, ex-officio members of the Board. The Governor shall also appoint as non-voting, ex-officio members one economist with experience in the health care markets and one educated health care consumer advocate. All Board

members shall be appointed no later than January 1, 2014.

(2) The Governor shall make the appointments so as to reflect no less than proportional representation of the geographic, gender, cultural, racial, and ethnic composition of this State and in accordance with subparagraphs (A), (B), and (C) of this paragraph, as follows:

(A) No more than one voting member may be an individual who is employed by, a consultant to, or a member of a board of directors of an insurer, a third-party administrator, or an insurance producer. No more than one voting member may be an individual who is a member of a board of directors of a health care provider, health care facility, or health clinic.

(B) At least one board member must represent each of the following interest groups:

(1) a labor interest group;

(2) a women's interest group;

(3) a minorities' interest group;

(4) a disabled persons' interest group;

(5) a small business interest group; and

(6) a public health interest group.

(C) Each person appointed to the Board should have demonstrated experience in at least one of the following areas:

(1) individual health insurance coverage;

(2) small employer health insurance;

(3) health benefits administration;

(4) health care finance;

(5) administration of a public or private health care delivery system;

(6) the provision of health care services;

(7) the purchase of health insurance coverage;

(8) health care consumer navigation or assistance;

(9) health care economics or health care actuarial sciences;

(10) information technology; or

(11) starting a small business with 50 or fewer employees.

(3) 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 a majority of the Board.

(4) The Exchange shall be administered by an Executive Director, who shall be appointed, and may be removed, by a majority of the Board. The Board shall have the power to determine compensation for the Executive Director.

(5) The terms of the non-voting, ex-officio members of the Board shall run concurrent with their terms of appointment to office, or in the case of the Executive Director, his or her term of appointment to that position,

subject to the determination of the Board. The terms of the members, including those non-voting, ex-officio members appointed by the Governor, shall be 4 years. Each member of the General Assembly identified in paragraph (1) of this Section shall initially appoint one member to a 3-year term, and one member to a 4-year term. Upon conclusion of the initial term, the next term and every term subsequent to it shall run for 3 years. Voting members shall serve no more than 3 consecutive terms.

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 after 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 2 consecutive terms following their completion of the unexpired term of a member of the Board.

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

(6) The Board shall, 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 recommendations to the Board and the Exchange. There shall be at a minimum, 4 technical advisory groups, including the following:

(1) an insurer advisory group;

(2) a business advisory group;

(3) a consumer advisory group; and

(4) a provider advisory group.

(7) 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. A majority of the Board shall constitute a quorum and the affirmative vote of a majority is necessary for any action of the Board. No vacancy shall impair the ability of the Board to act provided a quorum is reached. Members shall serve without pay, but shall be reimbursed for their actual and reasonable expenses incurred in the performance of their duties. 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 5-15 quarterly, beginning on September 1, 2013 through December 31, 2014.

(8) The Board shall adopt conflict of interest rules and recusal procedures. Such rules and procedures shall (i) 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 (ii) require a member of the Board to recuse himself or herself from an official matter, whether direct or indirect. All recusals must be 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.

(9) The Board shall develop a budget for the implementation and operation of the Exchange for operating expenses, including, but not limited to:

(A) proposed compensation levels for the Executive Director and shall identify personnel and staffing needs for the implementation and operation of the Exchange;

(B) disclosure of funds received or expected to be received from the federal government for the infrastructure and systems of the Exchange and those funds received or expected to be received for program administration and operations; and

(C) delineation of those functions of the Exchange that are to be paid by State and federal programs that are allocable to the State's General Revenue Fund.

(10) The purpose of the Board shall be to implement the Exchange in accordance with this Section and shall be authorized to establish procedures for the operation of the Exchange, subject to legislative approval.

(215 ILCS 122/5-17 new)

Sec. 5-17. Insurer's assessment. Every carrier licensed to issue, and that issues for delivery, policies of accident and health insurance in this State shall be assessed. The Board shall within 90 days after the effective date of this amendatory Act of the 98th General Assembly and within the first quarter of each fiscal year thereafter, assess all insurers for the anticipated deficit in accordance with the provisions of this Section. The Board may also make additional assessments no more than 4 times a year to fund unanticipated deficits, implementation expenses, and cash flow needs. An insurer's assessment shall be determined by multiplying the total assessment, as determined in this Section, by a fraction, the numerator of which equals that insurer's direct Illinois premiums during the preceding calendar year and the denominator of which equals the total of all insurers' direct Illinois premiums. The Board may exempt those insurers whose share as determined under this Section would be so minimal as to not exceed the estimated cost of levying the assessment. The Board shall charge and collect from each insurer the amounts determined to be due under this Section. The assessment shall

be billed by Board invoice based upon the insurer's direct Illinois premium income as shown in its annual statement for the preceding calendar year as filed with the Director. The invoice shall be due upon receipt and must be paid no later than 30 days after receipt by the insurer.

When a carrier fails to pay the full amount of any assessment of $100 or more due under this Section there shall be added to the amount due as a penalty the greater of $50 or an amount equal to 5% of the deficiency for each month or part of a month that the deficiency remains unpaid. All moneys collected by the Board shall be placed in the Illinois Health Benefits Exchange Fund.

(215 ILCS 122/5-18 new)

Sec. 5-18. Illinois Health Benefits Exchange Fund. There is hereby created as a fund outside of the State treasury the Illinois Health Benefits 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.

(215 ILCS 122/5-21 new)

Sec. 5-21. 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 Internet website a producer locator section, featured prominently, through which individuals and small employers can find exchange-certified producers.

(215 ILCS 122/5-23 new)

Sec. 5-23. Examination or investigation of the Exchange; hearing.

(a) In addition to any powers conferred upon him or her by this or any other law, including Article XXIV of the Illinois Insurance Code, the Director or any person designated by him or her has the power to:

(1) at the expense of the Exchange, examine or investigate any and all aspects regarding the operation and finances of the Exchange and the Illinois Health Benefits Exchange Fund through free access to all books, records, files, papers, and documents relating to their operation and finances and may summon, subpoena, qualify, and examine as witnesses all persons having knowledge of such operation, including directors, officers, agents, or employees thereof; and

(2) require such reports as the Director may deem necessary.

(b) The examiners designated by the Director pursuant to this Section may make reports to the Director. Any report alleging substantive violations of this Law, any applicable provisions of the Illinois Insurance Code, any applicable Part of Title 50 of the Illinois Administrative Code, or federal law shall be in writing and be based upon facts obtained by the examiners. The report shall be verified by the examiners.

(c) If a report is made, the Director shall deliver a

duplicate thereof to the Exchange or persons examined and afford the Exchange or such persons examined an opportunity to request a hearing to object to the report. The Exchange or such persons examined may request a hearing within 30 days after receipt of the duplicate of the examination report by giving the Director written notice of such request together with written objections to the report. Any hearing shall be conducted in accordance with Sections 402 and 403 of the Illinois Insurance Code. The right to hearing is waived if the delivery of the report is refused or the report is otherwise undeliverable or the Exchange or such persons examined do not timely request a hearing.

After the hearing or upon expiration of the time period during which the Exchange or such persons may request a hearing, if the examination reveals that the Exchange or such persons examined are operating in violation of any applicable provision of this Article, the Illinois Insurance Code, any applicable Part of Title 50 of the Illinois Administrative Code, prior order, or federal law, the Director, in the written order, may require the Exchange or such persons examined to take any action the Director considers necessary or appropriate in accordance with the report or examination hearing. If the Director issues an order, it shall be issued within 90 days after the report is filed, or if there is a hearing, within 90 days after the conclusion of the hearing. The order is subject to review under the Administrative Review Law.

(215 ILCS 122/5-30 new)

Sec. 5-30. Dissolution of Comprehensive Health Insurance Plan.

(a) Except as otherwise provided in this Section, the insurance operations of the Comprehensive Health Insurance Plan authorized by the Comprehensive Health Insurance Plan Act shall cease on January 1, 2014. As used in this Section, "Plan" means the Comprehensive Health Insurance plan.

(b) Coverage under the Plan does not apply to service provided on or after January 1, 2014.

(c) A claim for payment under the Plan must be submitted within 180 days after January 1, 2014 and paid within 60 days after receipt.

(d) Any grievance shall be resolved by the Plan Board not later than 360 days after January 1, 2014. In this Section, "Plan Board" means the Illinois Comprehensive Health Insurance Board.

(e) Balance billing under this Section by a health care provider that is not a member of the provider network arrangement used by the Plan is prohibited.

(f) The Plan Board shall, not later than June 30, 2013, submit to the Director of Insurance a plan of dissolution, which must provide for, but not be limited to, the following:

(1) Continuity of care for an individual who is covered under the Plan and is an inpatient on January 1, 2014.

(2) A final accounting of assessments.

(3) Resolution of any net asset deficiency.

(4) Cessation of all liability of the Plan.

(5) Final dissolution of the Plan.

(g) The plan of dissolution may provide that, with the approval of the Plan Board and the Director, a power or duty of the association may be delegated to a person that is to perform functions similar to the functions of the Plan.

(h) The Director shall, after notice and hearing, approve a plan of dissolution submitted under subsection (f) of this Section if the Director determines that the plan of dissolution is suitable to ensure the fair, reasonable, and equitable dissolution of the Plan and complies with subsection (f) of this Section. If the Director does not find that the plan of dissolution is suitable to ensure the fair, reasonable, and equitable dissolution of the Plan, he or she may by order require changes to the plan that cure the deficiencies identified in his or her findings.

(i) A plan of dissolution submitted under subsection (f) of this Section is effective upon the written approval of the Director.

(j) An action by or against the Plan must be filed not more than one year after January 1, 2014.

(k) General Revenue Fund funds remaining in the Plan on the date on which final dissolution of the Plan occurs must be transferred back into the General Revenue Fund.

(l) Insurer assessments remaining in the Plan on the date on which dissolution of the Plan occurs must be returned to insurers based on subsection e of Section 12 of the Comprehensive Health Insurance Plan Act.

(m) The Plan, or the person or entity to which the Plan delegates powers under subsection (g) of this Section, may implement this Section in accordance with the plan of dissolution approved by the Director under subsection (h) of this Section.

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