SB1717

LRB09809530RPM39673b

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

SB1717

Introduced 2/15/2013, by Sen. William R. Haine

SYNOPSIS AS INTRODUCED:

See Index

Amends the Comprehensive Health Insurance Plan Act. Provides that the insurance operations of the Comprehensive Health Insurance Plan authorized by the Act shall cease on January 1, 2014 and that Plan coverage does not apply to service provided on or after January 1, 2014. Provides for the repeal of the Comprehensive Health Insurance Plan Act on January 1, 2015. Amends the Illinois Health Benefits Exchange Law. Makes changes concerning the legislative intent of the Law. Sets forth definitions. Establishes the Illinois Health Benefits Exchange as a political subdivision, body politic and corporate. Provides that the Exchange shall be a public entity, but shall not be considered a department, institution, or agency of the State. Sets forth a provision concerning the certification of health benefit plans. Deletes references to the Illinois Health Benefits Exchange Legislative Study Committee and establishes instead the Illinois Health Benefits Exchange Legislative Oversight Committee within the Commission on Government Forecasting and Accountability. Provides that the governing and administrative powers of the Exchange shall be vested in a body known as the Illinois Health Benefits Exchange Board and sets forth provisions concerning appointments, terms, meetings, structure, recusal, budget, and purpose. Sets forth provisions concerning enrollment through brokers and agents and producer compensation. Effective immediately.

LRB098 09530 RPM 39673 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

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

Section 5. 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. Plan coverage does not apply to service provided on or after January 1, 2014.

(215 ILCS 105/17 new)

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 This Act is repealed on January 1, 2015.

Section 10. 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, and 5-21 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 robust and 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.

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

"Individual Exchange" means the exchange marketplace

established by this Law through which qualified individuals may obtain coverage through an individual market qualified health plan.

"Insurance producer" means a person required to be licensed under the laws of this State to sell, solicit, or negotiate insurance.

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

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

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

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

"Qualified health plan" or "QHP" means a health benefit plan that has in effect a certification that the plan meets the

criteria for certification described in Section 1311(c) of the Federal Act.

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

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

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

(2) resides in this State;

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

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

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

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

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an

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

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

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

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

(d) if an employer was not in existence throughout the preceding calendar year, then the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that 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 October 1, 2015 ~~2013~~, in accordance with Section 1311 of the federal Patient Protection and Affordable Care Act, shall establish a State health benefits exchange to be known as the Illinois Health Benefits Exchange in order to help individuals and small employers ~~with no more than 50 employees~~ shop for, select, and enroll in qualified, affordable private health plans that fit their needs at competitive prices. The Exchange shall separate coverage pools for individuals and small employers and shall supplement and not supplant any existing private health insurance market for individuals and small employers.

(b) There is hereby created a political subdivision, body politic and corporate, named the Illinois Health Benefits Exchange. 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 and robust marketplace that does not limit consumer access to affordable health coverage options. The Exchange shall certify health benefit plans on the individual and SHOP exchange, as applicable, provided that any such health benefit plan that meets the requirements set forth in Section 1311(c) of the Federal Act shall be offered on the individual and SHOP exchange.

(e) The Exchange shall not duplicate or replace the functions of the Department of Insurance, the Department of Healthcare and Family Services, or the Department of Public Health, including, but not limited to, the Department of Insurance's rate review authority.

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

(215 ILCS 122/5-6 new)

Sec. 5-6. Health benefit plan certification.

(a) The Exchange, in consultation with the Department of Insurance, shall certify a health benefit plan as a qualified health plan if the following provisions are met:

(1) the plan provides 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 Exchange 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 Exchange, 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) the premium rates and contract language have not been disapproved by the Director and the health carrier has fulfilled any statutorily required State rate filing requirements;

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

(4) the plan ensures that the cost-sharing

requirements of the plan do not exceed the limits established under Section 1302(c)(1) 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) the plan is 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 Illinois 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;

and

(6) the plan meets the requirements of certification pursuant to the Exchange provided in this Law and by the Secretary under Section 1311(c) of the Federal Act and rules adopted pursuant to this Law or the Federal Act.

(b) The Exchange 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 Exchange; 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 Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to do both of the following:

(1) Make available to the public, in plain language as defined in Section 1311(e)(3)(B) of the Federal Act, and submit to the Exchange, 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.

Where information is proprietary or confidential, it shall be exempted from being made available to the public.

(2) 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 in accordance with federal regulations.

(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) as follows:

(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 Insurance, 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 4 voting members may be

individuals who are 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 expertise in no less than 2 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;

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

(12) government-sponsored health care, such as Medicaid or CHIP.

(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. The Executive Director may not be a State employee or have been employed by or have had a contract with the State in the 3 years prior to his or her appointment. The Executive Director may not be nor have been an employee of an insurance company in the 3 years prior to his or her appointment.

(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 July 1, 2014 through December 31, 2016.

(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 advance, in writing, and specify the reason and date of the recusal. All recusals shall be maintained by the Executive Director and shall be disclosed to any person upon written request.

(9) The Board shall develop an initial budget for the implementation and operation of the Exchange for fiscal year 2015, fiscal year 2016, and fiscal year 2017 for review and approval by the Governor and the General Assembly. The initial budget shall include, but not be limited to, the following:

(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 Board shall recommend no later than March 1, 2014 a revenue-generating plan that shall be subject to the initial review and approval of the General Assembly

(11) 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. Illinois Health Benefits Exchange Fund. There is hereby created a fund outside of the State treasury to be known as 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.

(d) The Exchange shall have no role in developing or determining the manner or amount of compensation producers

receive from qualified health plans for individuals or employers enrolled in health plans through the Exchange.

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

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Statutes amended in order of appearance