Rep. Robyn Gabel

Filed: 5/23/2014

AMENDMENT TO SENATE BILL 2799

AMENDMENT NO. _____. Amend Senate Bill 2799 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) All employees of the Illinois Sentencing Policy Advisory Council.

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

(Source: P.A. 97-618, eff. 10-26-11; 97-1055, eff. 8-23-12; 98-65, eff. 7-15-13.)

Section 10. The Department of Insurance Law of the Civil Administrative Code of Illinois is amended by adding Section 1405-40 as follows:

(20 ILCS 1405/1405-40 new)

Sec. 1405-40. Transfer of the Comprehensive Health Insurance Plan.

(a) On January 1, 2015, all powers, duties, rights, and responsibilities of the Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board shall be transferred to the Department of Insurance.

(b) The Department of Insurance shall act on behalf of the Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board and shall have the power and duty to receive and answer correspondence, pay claims due and owing to the Department of Central Management Services revolving fund from any unencumbered funds, refer unpaid

vendors to the court of claims, and arrange for the orderly termination of any affairs of the Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board that remain unresolved on or after January 1, 2015.

(c) All books, records, papers, documents, property (real and personal), contracts, causes of action, and pending business pertaining to the powers, duties, rights, and responsibilities transferred by this amendatory Act of the 98th General Assembly from the Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board to the Department of Insurance, including, but not limited to, material in electronic or magnetic format and necessary computer hardware and software, shall be transferred to the Department of Insurance. Records shall remain intact as regulated by the federal Health Insurance Portability and Accountability Act of 1996.

(d) The personnel of the Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board shall be transferred to the Department of Insurance. The status and rights of those employees under the Personnel Code shall not be affected by the transfer. The rights of the employees and the State of Illinois and its agencies under the Personnel Code and applicable collective bargaining agreements or under any pension, retirement, or annuity plan shall not be affected by this amendatory Act of the 98th General Assembly.

(e) All unexpended appropriations and balances and other

funds available for use by the Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board shall be transferred for use by the Department of Insurance. Unexpended balances so transferred shall be expended only for the purpose for which the appropriations were originally made.

(f) The powers, duties, rights, and responsibilities transferred from the Comprehensive Health Insurance Plan and the Illinois Comprehensive Health Insurance Board shall be vested in and shall be exercised by the Department of Insurance.

(g) Whenever reports or notices are now required to be made or given or papers or documents furnished or served by any person to or upon the Comprehensive Health Insurance Plan or the Illinois Comprehensive Health Insurance Board in connection with any of the powers, duties, rights, and responsibilities transferred by this amendatory Act of the 98th General Assembly, the same shall be made, given, furnished, or served in the same manner to or upon the Department of Insurance.

(h) This amendatory Act of the 98th General Assembly does not affect any act done, ratified, or canceled or any right occurring or established or any action or proceeding had or commenced in an administrative, civil, or criminal cause by the Comprehensive Health Insurance Plan or the Illinois Comprehensive Health Insurance Board prior to January 1, 2015; such actions or proceedings may be prosecuted and continued by

the Department of Insurance.

Section 15. The Illinois State Auditing Act is amended by changing Section 3-1 as follows:

(30 ILCS 5/3-1) (from Ch. 15, par. 303-1)

Sec. 3-1. Jurisdiction of Auditor General. The Auditor General has jurisdiction over all State agencies to make post audits and investigations authorized by or under this Act or the Constitution.

The Auditor General has jurisdiction over local government agencies and private agencies only:

(a) to make such post audits authorized by or under this Act as are necessary and incidental to a post audit of a State agency or of a program administered by a State agency involving public funds of the State, but this jurisdiction does not include any authority to review local governmental agencies in the obligation, receipt, expenditure or use of public funds of the State that are granted without limitation or condition imposed by law, other than the general limitation that such funds be used for public purposes;

(b) to make investigations authorized by or under this Act or the Constitution; and

(c) to make audits of the records of local government agencies to verify actual costs of state-mandated programs

when directed to do so by the Legislative Audit Commission at the request of the State Board of Appeals under the State Mandates Act.

In addition to the foregoing, the Auditor General may conduct an audit of the Metropolitan Pier and Exposition Authority, the Regional Transportation Authority, the Suburban Bus Division, the Commuter Rail Division and the Chicago Transit Authority and any other subsidized carrier when authorized by the Legislative Audit Commission. Such audit may be a financial, management or program audit, or any combination thereof.

The audit shall determine whether they are operating in accordance with all applicable laws and regulations. Subject to the limitations of this Act, the Legislative Audit Commission may by resolution specify additional determinations to be included in the scope of the audit.

In addition to the foregoing, the Auditor General must also conduct a financial audit of the Illinois Sports Facilities Authority's expenditures of public funds in connection with the reconstruction, renovation, remodeling, extension, or improvement of all or substantially all of any existing "facility", as that term is defined in the Illinois Sports Facilities Authority Act.

The Auditor General may also conduct an audit, when authorized by the Legislative Audit Commission, of any hospital which receives 10% or more of its gross revenues from payments

from the State of Illinois, Department of Healthcare and Family Services (formerly Department of Public Aid), Medical Assistance Program.

The Auditor General is authorized to conduct financial and compliance audits of the Illinois Distance Learning Foundation and the Illinois Conservation Foundation.

As soon as practical after the effective date of this amendatory Act of 1995, the Auditor General shall conduct a compliance and management audit of the City of Chicago and any other entity with regard to the operation of Chicago O'Hare International Airport, Chicago Midway Airport and Merrill C. Meigs Field. The audit shall include, but not be limited to, an examination of revenues, expenses, and transfers of funds; purchasing and contracting policies and practices; staffing levels; and hiring practices and procedures. When completed, the audit required by this paragraph shall be distributed in accordance with Section 3-14.

The Auditor General shall conduct a financial and compliance and program audit of distributions from the Municipal Economic Development Fund during the immediately preceding calendar year pursuant to Section 8-403.1 of the Public Utilities Act at no cost to the city, village, or incorporated town that received the distributions.

The Auditor General must conduct an audit of the Health Facilities and Services Review Board pursuant to Section 19.5 of the Illinois Health Facilities Planning Act.

The Auditor General of the State of Illinois shall annually conduct or cause to be conducted a financial and compliance audit of the books and records of any county water commission organized pursuant to the Water Commission Act of 1985 and shall file a copy of the report of that audit with the Governor and the Legislative Audit Commission. The filed audit shall be open to the public for inspection. The cost of the audit shall be charged to the county water commission in accordance with Section 6z-27 of the State Finance Act. The county water commission shall make available to the Auditor General its books and records and any other documentation, whether in the possession of its trustees or other parties, necessary to conduct the audit required. These audit requirements apply only through July 1, 2007.

The Auditor General must conduct audits of the Rend Lake Conservancy District as provided in Section 25.5 of the River Conservancy Districts Act.

The Auditor General must conduct financial audits of the Southeastern Illinois Economic Development Authority as provided in Section 70 of the Southeastern Illinois Economic Development Authority Act.

The Auditor General shall conduct a compliance audit in accordance with subsections (d) and (f) of Section 30 of the Innovation Development and Economy Act.

The Auditor General shall have the authority to conduct an audit of the Illinois Health Benefits Exchange. The audit may

be a financial audit, a management audit, a program audit, or any combination thereof.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09; 96-939, eff. 6-24-10.)

Section 20. 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.

(a) Except as otherwise provided in this Section, the insurance operations of the Plan authorized by this Act shall cease on January 1, 2015.

(b) Coverage under the Plan does not apply to service provided on or after January 1, 2015.

(c) The Plan shall cease enrolling new participants on December 31, 2014.

(d) The Plan shall cease providing coverage for participants enrolled prior to January 1, 2015 at 11:59 p.m. on December 31, 2014. Except as otherwise provided in this subsection (d), the Board shall provide at least 90 days written notice to all Plan participants of the cessation of coverage under this Section. For participants enrolled less than 90 days before January 1, 2015, notice of the cessation of coverage under this Section shall be provided to all applicants and to all participants upon enrollment.

(e) Any claim for payment under the Plan must be submitted no later than 90 days after January 1, 2015, and any valid claim submitted on or after January 1, 2015 must be paid within 90 days after receipt.

(f) Any grievance shall be resolved by the Board not later than October 31, 2015.

(g) 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.

(h) The Board shall, not later than June 30, 2014, submit to the Director 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 at the time the Plan ceases.

(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.

(i) No legal action by or against the Plan may be filed on or after January 1, 2016.

(j) General Revenue Fund funds remaining in the Plan after satisfaction of all of the Plan's liabilities shall be transferred back into the General Revenue Fund.

(k) The Board shall cease charging insurer assessments on January 1, 2015; however, the Board may charge and collect

insurer assessments pursuant to Section 12 of this Act as necessary to satisfy any remaining liabilities of the Plan. Insurer assessments remaining in the Plan after satisfaction of all of the Plan's liabilities shall be returned to insurers based on subsection (e) of Section 12 of this Act.

(215 ILCS 105/17 new)

Sec. 17. Repealer. This Act is repealed on July 1, 2016.

Section 25. The Illinois Health Benefits Exchange Law is amended by changing Sections 5-3, 5-5, 5-10, and 5-15 and by adding Sections 5-4, 5-11, 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, or health benefits. "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.

"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 through various options available to the employer, including, but not limited to: (a) offering one qualified health plan to employees, (b) offering multiple qualified health plans to employees, or (c) offering an employee-directed choice of a qualified health plan within an employer-selected coverage tier.

"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, 2015.

(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, which must include a premium impact study, by July 1, 2017 to determine the viability of merging the SHOP Exchange and Individual Exchange functions into a single exchange by January 1, 2018. Any recommended merger of the SHOP Exchange and Individual Exchange functions shall be subject to legislative approval.

(d) The Exchange shall promote a competitive marketplace

for 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.

(e) The Exchange shall not supersede the provisions of the Illinois Insurance Code, nor the functions of the Department of Insurance, the Department of Healthcare and Family Services, or the Department of Public Health.

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

(215 ILCS 122/5-10)

Sec. 5-10. Exchange functions.

(a) On or before January 1, 2016, in compliance with paragraph (4) of subdivision (d) of Section 1311 of the federal Patient Protection and Affordable Care Act, the Exchange shall, at a minimum, do all of the following to implement Section 1311 of the federal Patient Protection and Affordable Care Act:

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

(2) Implement procedures for the certification, recertification, and decertification, consistent with Section 5-11 of this Act and the guidelines established by

the U.S. Secretary of Health and Human Services, of health plans as qualified health plans.

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

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

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

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

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

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

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

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

(9) Coordinate with other State and county agencies.

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

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

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

(11) Transfer to the Secretary of the Treasury of the United States all of the following:

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

(B) the name and taxpayer identification number of each individual who was an employee of an employer, but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because:

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

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

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

(13) Perform duties required of, or delegated to, the Exchange by the U.S. Secretary of Health and Human Services or the Secretary of the Treasury of the United States related to the following:

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

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

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

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

(E) Establishing criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to

maintain enrollment in selected products.

(F) Establishing criteria for exclusion of vendors.

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

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

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

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

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

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

(C) Facilitate enrollment in qualified health plans.

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

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

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

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

~~Section 1311 of the Patient Protection and Affordable Care Act and subsequent federal guidance and regulations.~~

(b) The ~~In order to meet the deadline of October 1, 2013 established by federal law to have operational a State exchange, the~~ Department of Insurance and the Commission on Government ~~Governmental~~ Forecasting and Accountability is authorized to apply for, accept, receive, and use as appropriate for and on behalf of the State any grant money provided by the federal government and to share federal grant funding with, give support to, and coordinate with other agencies of the State and federal government or third parties as determined by the Governor, until the Board has the ability to do so, at which time the Board is authorized to apply for, accept, receive, and use as appropriate for and on behalf of the State any grant money provided by the federal government and to share federal grant funding with, give support to, and coordinate with other agencies of the State and federal government or third parties pursuant to Section 5-11 of this Law.

(Source: P.A. 97-142, eff. 7-14-11; revised 9-11-13.)

(215 ILCS 122/5-11 new)

Sec. 5-11. 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) fulfill all premium rate and contract filing requirements and ensure that no contract language has been disapproved by the Director;

(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)(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) 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 of the Illinois Insurance Code and the Department;

(6) meet the requirements of certification pursuant to the requirements of the Department and 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) include 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; and

(8) submit a justification for any premium increase prior to the implementation of the increase; the plans shall prominently post that information on their Internet websites; the Board shall take this information, and the information and the recommendations provided to the Board by the Department of Insurance or the Department of Managed Health Care under paragraph (1) of subdivision (b) of

Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange; the Board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the Department of Insurance and the Department of Managed Health Care.

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

(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 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, including, but not

limited to, accredited clinical quality measures; and

(2) permit individuals to learn, in a timely manner upon the request of the individual, the comparative quality standards of the plans along established clinical data-based standards and 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.

(c) The Department 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.

(d) 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 (d) 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 September 1, 2014 ~~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 September 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 represent the following interests, of which no more than 2 may represent any one interest:

(1) the insurance industry;

(2) health care administrators; and

(3) licensed health care professionals.

(B) At least 7 voting members shall represent the following interest groups, with each interest group represented by at least one voting member:

(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. 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, 6 technical advisory groups, including the following:

(1) an insurer advisory group;

(2) a business advisory group;

(3) a consumer advisory group;

(4) a provider advisory group;

(5) an insurance producer advisory group; and

(6) a dentist 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 January 1, 2015 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 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, to be submitted to the General Assembly along with the Governor's annual budget proposal and approved by the General Assembly, 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;

(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; and

(D) beginning January 1, 2016, insurer assessments contingent upon the use of federal funds for the first year of operation of the Exchange and upon the review and recommendations of the Commission on Government Forecasting and Accountability.

(10) The Board shall, in consultation with the Health Benefits Exchange Legislative Oversight Committee, produce a cost-benefit analysis of the State's essential health benefits no later than August 1, 2015 for the purposes of informing the U.S. Department of Health and Human Services in their re-evaluation of the essential health benefits for plan years 2016 and beyond.

(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. 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. 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, excluding those premiums from limited lines policies and supplemental insurance policies, during the preceding calendar year and the denominator of which equals the total of all insurers' direct Illinois premiums, excluding those premiums from limited lines policies and supplemental insurance policies. 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, excluding premium income from limited lines policies and supplemental insurance policies, 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.

Insurers shall be assessed only an amount not exceeding the General Assembly's approved Board budget. No assessment shall be made on insurers while assessments are being made pursuant to Section 12 of the Comprehensive Health Insurance Plan Act. The assessment shall also take into consideration any unspent federal funds remaining and shall be reduced accordingly.

The Board shall prepare annually a complete and detailed written report accounting for all funds received and dispensed during the preceding fiscal year.

(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 122/5-23 new)

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

The Director shall have the ability to examine or investigate the Exchange pursuant to his or her authority under Article XXIV of the Illinois Insurance Code.

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