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# REPORT:

# FINDINGS OF THE ILLINOIS LEGISLATIVE HEALTH INSURANCE EXCHANGE COMMISSION

AS REQUIRED BY SB 1555

## Introduction

On March 23, 2010, President Obama signed the Affordable Care Act (ACA) into law. One of the major functions of this law is the development of an “American Health Benefit Exchange,” or healthcare insurance Exchanges for each state, including Illinois. Using a definition developed by the Illinois Department of Insurance, a healthcare insurance Exchange is defined as a “transparent, centralized competitive health care marketplace.” An Exchange as authorized by the ACA must provide access (primarily through an internet website) to both public and private health insurance coverage for individuals and businesses with fewer than 100 employees. One significant tool the Exchange must leverage is the creation of a stream-lined, state-of-the-art internet portal through which consumers may shop for, compare, and enroll in health plans that meet their needs. However, the ACA also requires individuals be able to shop for and enroll in coverage over the phone, in-person, or by mail. While states may choose to create separate Exchanges for individuals as opposed to a business-centric Exchange, it is envisioned by the federal government that either state-operated or federally-operated health insurance Exchanges for individuals and small businesses will be in operation in the states by 2014. The federal government has stated that it will provide opportunity for residents of a state to access a federally-run Exchange if their state chooses to not establish an Exchange.

### ***Premium Tax Credits/Small Business Tax Credit/Penalties***

For individuals and small businesses who apply for coverage through an Exchange, the IRS will allow a tax credit to help offset the costs of insurance. Starting in 2014, this credit will also be refundable and can be paid in advance to an insurance company to help offset individual premiums. In regards to business, the tax credit is targeted towards businesses with low to moderate income employees. As a guide, the tax credit will be available to small businesses who pay at least half the cost of single coverage for their employees.

The ACA grants the Internal Revenue Service (IRS) to assess penalties for uninsurance on the part of individuals who fail to enroll in minimum coverage (given that they have access to affordable coverage). It also assesses penalties on employers who fail to offer coverage or who offer coverage that is ruled unaffordable. On the individual basis, the cost of non-insurance ramps up from 2014 to 2016, eventually becoming up to \$600 for individuals who earn up to 200 percent of the Federal Poverty Level (FPL) and \$1200 for individuals who earn up to 400 percent of the Federal Poverty Level. On the business side, by 2014, large employers who do not provide health insurance will annually pay \$2,000 per full-time employee after the first 30 employees as long as the business has at least one employee who receives subsidized coverage in the health insurance Exchange. In the case of employers with 50 or more full-time employees who offer health insurance, the employer will pay \$3,000 a year for each full-time employee who is offered coverage but instead receives a premium credit to purchase insurance coverage in the Exchange. As noted in the legislation, the total amount that employers will be required to pay in the cases of employees offered premium credits in the Exchange is capped at the amount of \$2,000 multiplied by the total number of full-time employees in excess of 30 that the business employs.

### ***Legislative History and Exchange Report Contents***

In Illinois, Governor Quinn created the Health Care Reform Implementation Council on July 30, 2010 to provide recommendations to the governor regarding health reform. In addition, the Illinois Department of Insurance was awarded \$1 million in September 2010 and slightly over \$5 million in August 2011 through a Federal grant to develop and evaluate establishing an Exchange in Illinois. Currently, the

Department of Healthcare and Family Services and the Department of Insurance are coordinating their actions so that various functions of each will be incorporated in a health insurance Exchange.

In an effort to determine public interests and lay the foundation of future actions towards an Exchange, the General Assembly passed Senate Bill 1555, which was signed into law as Public Act 97-0142 by Governor Quinn on July 14, 2011. This legislation states the intent of Illinois to create a state-sponsored health benefit insurance Exchange according to the federal guidelines set forth in the ACA and creates a legislative study committee to study the issues around the implementation and establishment of a health benefits Exchange in Illinois. Furthermore, this committee is tasked to report all their findings regarding their studies by September 30, 2011, of which this report contains. Specifically, this report is required to contain findings concerning (1) the governance and structure of the Exchange, (2) financial sustainability of the Exchange, and (3) stakeholder engagement, “including an ongoing role for the Legislative Study Committee or other legislative oversight of the Exchange.”

This report contains a number of informative items. Firstly, a summary of findings from an analysis conducted by Deloitte Consulting of the state of Illinois’ insurance situation is presented. After that, an analysis is made of the recommendations and goals presented for an Illinois Exchange in a report developed for the state of Illinois by HMA/Wakely Consulting Group. Next, an examination is made of the study committee’s findings regarding the possible forms of governance and structure of an Illinois Exchange. Through testimony from a variety of individuals, organizations and governmental bodies, it is found that a variety of options exist for different governing and structural arrangements for an Exchange, all seeking to ensure a representation of views and perspectives on the health care and insurance industry. In addition to these findings, this report also provides options for the question of financing the operations of the Exchange itself. Further into this report, the issue of ensuring stakeholder engagement within the setup process and operation of the Exchange is analyzed. Due to the nature of health care and insurance, many people and organizations have a stake in the actions of the Exchange. Efforts to ensure their cooperation and contribution to the Exchange and its outreach are detailed within this report. This report also contains specific legislative recommendations for the General Assembly and a timeline for implementation of the Health Benefit Exchange.

## **Deloitte Analysis**

Recently, the Illinois Department of Insurance contracted with Deloitte Consulting LLP (“Deloitte”) to perform an analysis of the current state of Illinois health insurance coverage as well as initial projections for future enrollment. They have since responded with a large amount of information relevant to the tasks of the Study Committee. Primarily, their information is relevant to knowing more about the current situation of health insurance coverage and affordability in Illinois.

The Deloitte analysis shows an insurance market in the State of Illinois that is in flux. Currently, a slim majority, 52 percent, of the population is covered by either a small or large group employer-sponsored plan. 32 percent of Illinois’ population is insured through Medicaid (20 percent) Medicare or a different subset of public insurance (12 percent total). Only four percent of the population has coverage through an individual plan, while 12 percent live without insurance. This is a picture of the current state of health insurance in Illinois at the end of a trend that has seen the percentage of employer coverage decline from 64 percent to 54 percent (in a 10 year period ending in 2008-2009). In that same time, individuals on Medicaid has almost doubled, from eight percent of the total population to 15 percent, while individuals on Medicare (and other public programs) increased from 11 to 12 percent of the population. This may be in part due to the fluctuating economy on a national/Illinois basis.

Certain characteristics define individuals currently without insurance. 18-25 year olds are most likely to not have health insurance (24 percent uninsured), with insurance coverage becoming more common as age increases. As income increases, insurance coverage increases accordingly. In households with income under 138 percent of the Federal Poverty Level, 34 percent of people are uninsured, while only five percent of people in households with income over 400 percent of the Federal Poverty Level are uninsured. Geographically, uninsurance rates vary from 12 percent of the adult population (age 18 to age 64) in urban counties to 19 percent uninsured in rural counties. In regards to reasons for uninsurance, the cost of health insurance is most cited (47 percent) with “health insurance is not offered by an employer” reported at 22 percent. Finally, among insured Illinois residents, the 83 percent report that they are “adequately” insured, with 13 percent reporting being underinsured and four percent not knowing for sure either way.

Deloitte has also reported on the concentration (competitiveness) of health insurance markets in Illinois. Currently, among the ten largest states, Illinois ranks second in overall market concentration, with the Health Care Service Corporation taking 49 percent of the entire market share. Only Michigan is reported to have more concentration (51 percent market share taken by Blue Cross Blue Shield of Michigan). Interestingly, Deloitte reports that the level of regulation in Illinois does not appear to negatively influence market competition. Illinois’ regulatory landscape in the health insurance market is similar to other states, as it “does not currently appear to present any unusual barriers to competition or potential future market entry by new carriers.”

With regards to affordability of health insurance, the report also analyzes the financial weight of insurance premiums and out of pocket costs to Illinois consumers. The total average premium and out-of-pocket cost of healthcare and insurance accounts for between 19 to 36 percent of household income when income is at 200 percent of the Federal Poverty Level. In this case, 19 percent of income is paid (on average) in the individual insurance market (including out-of-pocket costs) by a single person while 36 percent of income is paid in the small group market by a four person family making \$44,100 on insurance and out-of-pocket expenses for healthcare. As noted by Deloitte, the differences between individual and small group insurance premium rates are due to differences in benefit design (small group plans cover a larger share of medical expenses) and underwriting (individual insurance more often results in denial of coverage for people in bad health, whereas this is not permitted in the group market).

In addition to the previously listed points of analysis, the Deloitte report also makes certain market projections for the state of health insurance in Illinois in 2020. Based on their models, they have predicted:

- Continued shrinkage of the total Illinois population market share of Small and Large Group Employer (including the Exchange) plans from 52 percent currently to 49 percent.
- Individual plans (including the Exchange) rising from four percent share to eight percent share
- Medicaid increasing due to the Affordable Care Act eligibility expansion, but offset in part by assumed future economic improvement. The total rise expected to be one percent, from 20 to 21 percent.
- Medicare increases from 12 percent share currently to 15 percent share.
- Uninsured decreases from 12 percent share currently to seven percent share.
- Exchange membership will rise greatly in the first three years, to plateau at approximately 1.4 million covered lives by 2020.

All these predictions are subject to real world changes as they happen. For example, if the assumed economic recovery is slower than expected in the report, the change in the share of Medicaid,

Small/Large Group Employer plans, and Individual plans in Illinois insurance coverage could be significantly different. As such, caution must be taken when analyzing these predictions.

## **HMA/Wakely Consulting Group Strategic/Operational Needs Assessment**

The Illinois Department of Insurance also contracted an outside analysis of the needs and possible components of an Illinois Health Insurance Exchange to a collaboration of consulting firms lead by Health Management Associates (“HMA”). Also included in the contract were the Wakely Consulting Group and, for issues related to the eligibility system, CSG Government Solutions. These consultants have since delivered an analysis that lists many goals for an Exchange, various possible components of an Exchange, important functions of an Exchange, financial issues regarding the Exchange, the impact on Medicaid, and the next steps for Illinois to proceed in line with federal expectations.

Within the report, HMA/Wakely outlines projections regarding individual and business enrollment in the Exchange. According to their numbers, 486,000 people total will enroll in the Exchange. Out of that number, 149,000 will enroll through the Small Business Health Options Program (SHOP) and 337,000 people will enroll through the individual segment of the Exchange. They estimate that 73 percent of the 337,000 will receive some variety of premium/cost-sharing credit. By 2016, HMA/Wakely estimates that the Exchange will serve at least 1 million people (through both the small business and individual markets).

Along with these figures, HMA/Wakely also describes the operational functions of an Illinois Exchange as anticipated by the Federal law. From their report, these functions are summarized as:

“eligibility determination, online shopping, enrollment/billing/collections, customer service, producer management, navigator management, communications and outreach, plan specification and qualified health plan management, financial management, risk adjustment, oversight/governance/program evaluation, mandate certification and eligibility appeals, consumer protections, and federal/state oversight reporting.”

Most of these functions are described in more detail further in this report. HMA/Wakely’s report can also be found on the Commission on Government Forecasting and Accountability webpage. Overall, though, Illinois has only a limited amount of infrastructure and functionality in place that can be utilized for the Exchange. HMA/Wakely notes that this is not “surprising or unique to Illinois.” However, despite these limitations, Illinois does incorporate some of the functions of the Exchange through the All Kids program and CHIP.

The HMA/Wakely report describes the financial implications and potential costs of the Exchange in the startup and ongoing years. The report also provides considerable detail on costs and revenue options. Though this is discussed further in this report, their example revenue-enhancement option for financing the exchange would raise an assessment on participating health carriers and their plans. This assessment would be between 2.24 percent and 3.39 percent of total premium cost, compared to the similar program in Massachusetts at 3 to 4 percent premium cost for their Exchange (“Health Connector”) operation.

Medicaid and the program within Illinois will both change with further implementation of the ACA. On the federal level, the ACA will expand Medicaid coverage to individuals (and families) below 133 percent of the federal poverty level. Individuals above that level will have access to subsidized coverage through the Exchange. In Illinois, this expansion translates into a number of changes. Programs and agencies

that manage and work with Medicaid will have additional people in their workload, requiring additional expenses and greater staffing needs. Also, many individuals will be newly qualified for Medicaid, requiring a smooth process to allow transfer from existing coverage into the program and back out again depending on income variation. HMA/Wakely estimates that the costs of these changes to cost \$224.5 million in 2014, but these costs would be offset by savings in eligibility elimination of \$115.1 million for a total cost to the state of \$109.4 million. No estimate is provided regarding potential additional administrative costs.

Within their report, HMA/Wakely notes that given the time needed for insurance companies to develop plans and general issues for the state to set up a program of this size and complexity, it is necessary for the state to adhere to a strict timeline for developing the Exchange. Given the implementation date of 2014, the state is recommended to take actions as soon as possible to develop and create through legislation “an Exchange with appropriate authority over and responsibility for providing direction to the state’s implementation efforts.”

## **Governance and Structure of the Exchange**

As noted by the Illinois Department of Insurance, Illinois currently has approximately 1.5 million people uninsured. Of that number, some of the currently uninsured will receive Medicaid coverage and one million are expected to enroll in coverage under an Exchange by 2017. One of the many inquiries the study committee sought to learn more about is the issue of the operating model of the Exchange. As seen across the states, there are a variety of models used, ranging from a more hands-off approach to an active participant within the health insurance market itself. In order to understand the options available to Illinois, it is necessary to understand what is desired by the federal government (the essentials needed for an Exchange) and the alternatives presented by other states.

On one end of the spectrum is the “market organizer” model of operations, which is utilized in the state of Utah. In this model, the Exchange is intended to operate as a clearinghouse for health insurance coverage, where “any willing plan” that meets minimum requirements would not be precluded from being offered as an option for consumers. However, the Exchange itself would make no effort to bargain with insurers and otherwise attempt to influence the market for insurance (to try and seek reduced premiums or expanded benefits, for example). In this case, such an Exchange would allow market forces to generate competition among the insurance plans offered, though the Exchange would be responsible for ensuring that federal/state requirements are met regarding network adequacy, minimum benefits, requirements, etc.

On the opposite end of the spectrum is the “market developer” model, utilized (and envisioned) in Massachusetts (and California, though the Exchange is still in development). This model for an Exchange would more actively pursue coverage in a competitive manner, with the goal of leveraging the Exchange buying power to get its members the best possible deal on the most valuable coverage. For example, an Exchange in this case might require health plans to submit bids to the Exchange board for participation, and only some that submitted to best bids would be accepted to sell coverage on the Exchange for that year. A benefit of analyzing this option is the availability of information and experience from Massachusetts, which has had a form of an Exchange since before the ACA mandated it in the other states. In the case of Massachusetts, their Exchange requires that providers must meet state law requirements, provide good consumer value and high quality in their product, among other requirements. In practice, while a more competitive model, Massachusetts has never denied a bid. California’s version of an Exchange focuses on specific goals within the authorizing legislation, including that the Exchange must develop criteria for plan selection that “are in the best interests of qualified

individuals and small employers” and that the Exchange must contract with insurers with the goal of providing coverage that optimally combines choice, value, quality and service. However, California has no clear experience to speak to on their own model at this time.

In both cases, whether “market organizer” or “market developer,” states are required to allow comparison shopping tools that allow choices by consumers based on price and quality. This comparison shopping option can be compared to services such as “name your own price” tools on popular websites. These tools allow consumers to search for a product based on price, quality, value and numerous other options. In Illinois, the appropriate operating model will have at least three factors: organizational structure/governing model/guiding principles, Exchange size, and market competition.

### ***Factors Influencing the Operating Model***

The suitable organizational structure for an Illinois Exchange must take into account the direction that is taken by Illinois within the organizer-developer spectrum. An Exchange that seeks to be more involved in plan selection and provider bargaining will likely need a more complex structure than an Exchange that seeks to allow market forces to determine products offered. In the same manner, the governance model for an Illinois Exchange would have to be adjusted for the complexity inherent with a market developer model, if it is determined that the Exchange must behave along those lines. A broader spectrum of political/professional culpability in governance would be needed for an Exchange that intends to be proactive within the variety of areas covered by a “developing” model. In addition to these options, the issue of guiding principles will vary depending on the direction taken by an Illinois Exchange. Principles regarding Exchange negotiation with insurance providers will by definition be significantly different than for an Exchange that does not seek to have as active of role within the insurance field.

Another point of interest for an operating model is the size of the Exchange, that is, the lives covered by the Exchange, whether in the individual or small business markets. It is expected that the larger the pool of individuals, the more easily risk can be shared. As such, premiums in such a pool should therefore be more stable. Also, a larger pool should be able to achieve greater efficiency in financing (the cost to members on a per-month basis).

In addition, though not necessarily a direct correlation, an Exchange would likely need to be larger (on an organizational level) if it was to accommodate more lives. In addition to this point is the issue of competition within the health insurance market. In regards to the organizational structure/model, a market that has a high level of competition may be better able to provide better rates for consumers using the Exchange. On the other hand, a market with little competition may be able to utilize an Exchange to negotiate better rates for consumers if it is designed in the “market developer” model. Given the breadth and complicated nature of these decisions, HMA/Wakely suggests that defining the States’ broader goals (or guiding principles) for an Illinois exchange may make it easier for the State to consider its direction towards specific policies. This would ensure that the State’s goals are driving policy, and not the other way around.

### ***Considerations and Potential Goals for an Exchange***

Since the ACA was passed by Congress, the Illinois Department of Insurance and HMA/Wakely have analyzed potential goals for an Exchange in the Illinois health insurance field. As a result of consultations and recommendations from these and many other groups who have testified before the

Study Committee, this report has designated a series of goals and recommendations for an Illinois Exchange that fall under the field of an organizational model. These goals are not requirements, but rather key points of interest that an Exchange should recognize and account for if possible.

**1. An Exchange should encourage competition among health insurers.**

By its nature, an Exchange will bring together competing insurance providers. However, an incentive exists in favor of competition among these providers. The field of competition for providers will include the various components to health insurance plans: premiums, co-payments, treatments covered, other benefits. Through competition, providers will ensure that more choices exist for individuals, families and small employers. As such, the Exchange should seek to foster competition along these aims.

**2. An Exchange should seek enhanced value of health insurance products.**

As part of its design, an Exchange should seek to ensure that health insurance plans offered through it have the maximum value to the consumer. As a clearinghouse for insurance options, an Exchange is in a powerful position to compare the value of any insurance plan offered through it to any other plan. With this in mind, given the rising costs of health care and insurance, an Exchange should ensure that all plans offered through it have the most “bang for the buck” value to the consumer.

**3. An Exchange should encourage insurers to make their best products available.**

As opposed to a completely hands-off approach, the Exchange should work with insurers to the extent that they make their best products available. This does not imply that an Exchange must take the path chosen by Massachusetts and California, but at least some interaction and bargaining would need to occur for insurance providers to know that the Exchange would prefer that their best products are made available.

**4. An Exchange is more attractive to health insurers as it gains more volume.**

Health insurers looking to their finances want to market their products to the largest group of consumers possible. To that end, an Exchange will increase their desirability to insurance companies looking to do business as they gain more individuals and businesses. For an insurer, an Exchange with many users is easier to market towards than scattered individuals and businesses.

**5. Competition reduces demand for government intervention.**

This is not a direct link to the utility of an Exchange, but rather an important point within the context of the operation of an Exchange in the insurance market. An Exchange that encourages competition makes its’ (and any other regulators) job easier in that an open market of insurers will hold each one accountable. This is not a perfect system by any means, but by encouraging more competition, an Exchange will reduce the likelihood that it will need to intervene in a potential issue.

**6. A better health insurance environment makes Illinois more attractive to employers**

A prospective business must take a variety of factors into account when considering where to build or expand. In the case of Illinois, a more stable and encompassing health insurance market would be a strong selling point to potential employers.

**7. The authorizing legislation to create an Exchange in Illinois “should not require the Exchange to certify all plans meeting federal requirements.”**

This goal would allow Illinois the option of being a market developer if it is desired in the future. By this, the Exchange would make the choice of including a plan based on the early market share of the Exchange and external market conditions. In addition, this allows the option to transition from a market developer to a focus on being a market organizer, if such an action is needed or wanted in the future.

***Exchange Governance and Accountability Options***

On the federal level, three main options have been offered for states in regards to delegating and assigning the functions of the health insurance Exchange. Specifically, states can assign the functions of an Exchange to an existing state agency, a quasi-governmental entity, or an independent non-profit entity with experience in administering benefits. However, the federal Exchange guidelines are clear on the point that no health carriers or affiliates are allowed to contract to provide services of the Exchange. In addition, no matter what the form the Exchange may be, it must have public accountability, transparency, and “technically competent leadership.” Using information from the Department of Insurance and other sources, a number of points can be made regarding the merits of each available option for delegating benefit Exchange functions.

A state agency, such as the Department of Insurance, would have a number of benefits. Specifically, an agency would have a large degree of public accountability and transparency. This would likely allow state audits of agency functions and activities to be performed with less difficulty than with an outside group. In addition, a state agency would have less difficulty coordinating activities among other state agencies for various functions regarding their work with the Exchange as they would already have institutional knowledge and professional liaisons with other agencies. However, a state agency has the risk of being more easily politicized than alternative groups. Also, due to the ability to be politicized and affected by various issues with state government, an agency would have an element of instability that would not be seen in other groups. Finally, a state agency would lack the independence of action that could be found elsewhere in other groups that may contract for Exchange functions.

A quasi-governmental organization has a number of different benefits and challenges than a traditional state agency, making it worthy of comparison in regards to ability to handle Exchange functions. This type of organization is, by nature, more independent than a state agency. There is less direct control and influence to cause concern as opposed to a state agency. In addition, a quasi-governmental organization may be exempt from certain state procurement/personnel laws, which would allow more flexibility in managing Exchange functions. Another issue of concern is that this type of organization would have more issues and planning needed to effectively coordinate activities among state agencies.

The third option, a non-profit organization, expands on the benefits and drawbacks of a quasi-governmental organization. In a non-profit, the decision-making process would be more flexible and able to absorb changes. The issue of politicization would be minimized, as changes in state leadership and partisan power would have fewer effects on a non-profit organization than a state agency or quasi-governmental organization. However, the same benefits of more distance from government and political influence also work against a non-profit to the extent that isolation from other state agencies would be a concern. The lack of knowledge and contacts that affects quasi-governmental groups would be magnified in a non-profit organization. Also worth comparison is the lack of accountability and transparency in a non-profit that would be seen more in a state agency or even a quasi-governmental organization. In these cases, distance from government would have to be balanced against the issue of public accountability and the need to preserve open government transparency.

One final consideration for any of the above options is how to incorporate legislative oversight into the governance of an Exchange. The current Legislative Study Committee is well-suited to continue its operations in a legislative oversight role upon the creation of the Exchange and the commencement of operations in 2014. However, it may be more appropriate to create a legislative committee or commission that is focused and designed to directly oversee operations and policy decisions of the Exchange itself (or to assign these duties to an existing committee or commission. Such a committee or commission could have a clear mandate and legislative authority to act as a check on the new Exchange in cases where policies or practices may veer from the original intent of the legislation creating the Exchange.

One example of a possible board composition is as follows:

The board of directors for an Illinois health insurance Exchange would be composed of 19 members. These members would include four ex officio non-voting members: the Directors or designees of the Illinois Departments of Insurance, Healthcare and Family Services, Human Services, and Public Health. Two members would be appointed by the Attorney General, including a lawyer with experience in public and private health insurance programs and a lawyer with experience working with the Attorney General's Health Care Bureau. Six members would be appointed by the Governor, including (1) a consumer representative who has been insured in the individual health insurance market in Illinois in the last two years, (2) a small employer representative with Illinois small business operation experience, (3) an employee representative of a small Illinois employer, (4) a certified health actuary, and (5) a representative of Illinois organized labor. Two members apiece would be appointed by the Speaker and Minority Leader of the Illinois House of Representatives and the President and Minority Leader of the Illinois Senate.

Draft federal regulation suggests that board members, regardless of who they represent or who appoints them, should have minimum technical expertise. The following is an excerpt from the proposed regulations:

“Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health or health policy issues related to the small group and individual markets and the uninsured.” (Pg. 185, Section 155.110, CMS-9989-P)

An important issue with the board composition described above is the lack of representation of insurers, agents/brokers, HMOs, Prepaid Service Providers and other individuals with an interest in the Exchange. Due to potential conflicts of interest, these individuals could be members of an advisory committee within the Exchange or non-voting members of the board. They would be able to formulate ideas and suggestions for policies that would be forwarded to the board of directors, but they would have no authority to set specific policy. The formation of a committee of individuals and organizations with experience within the healthcare field but unavoidably conflicted in interest would allow useful information and ideas from all players within the health insurance market to have a voice within the Exchange.

### ***Public and Governmental Direction in the Exchange – Other States***

With relatively open federal guidelines regarding the leadership of the Exchange, it is useful to note the options taken or considered by other states regarding this issue. As a standard of comparison, California and Utah are useful alternatives.

## **California**

California offers a useful example of how a larger state can create an Exchange. Legislation has already been created that outlines the Exchange and the governing board. In this case, the Exchange is established as a quasi-governmental state agency. The board of directors will have the authority to make rules and criteria for plans in the Exchange. This board will be composed of five members, with one, the Secretary of California Health and Human Services, servicing as a voting ex-officio member. The other four members are to be appointed by the Governor (two) and the Legislature (two). Each member must have expertise in two of six categories: individual/small employer coverage issues, plan administration, health care finance, delivery system administration, and purchasing. The enacting legislation also encourages diversity of experience, cultural, ethnic and geographical representation of members. In regards to potential conflicts of interest, board and staff members may not be affiliated with health carriers, facilities, associates, agents, etc. It is possible for health providers to be board members only if they receive no compensation as a provider and have no ownership in a practice.

The small-business (SHOP) Exchange in California is set to be separate from the regular activities of the individual Exchange. However, this separation will be analyzed and reported upon to the legislature by December 2018 so that a decision can be made as to the need to merge the individual and SHOP markets. The Exchange is designed to coordinate the various eligibility functions and enrollment processes with the other agencies and organizations in state government, including transferring cases to the Exchange from these groups. In addition, the Exchange will collaborate with existing departments to provide individuals with enrollment options despite any changes in tax credit eligibility or any other state program eligibility.

In regards to financing, California has set forth in legislation the ability for the Exchange to assess charges on qualified health plans (QHPs), with the stipulation that charges do not change requirements for carriers to maintain the same premiums for plans in the Exchange as plans outside of the Exchange. At this time, these fees appear to be the only major financing arrangement for ongoing Exchange operations.

To the question of navigators and general consumer assistance, California has set forth a number of requirements in legislation for the Exchange. The Exchange will choose and set performance standards and compensation for Navigators. In regards to consumers, various protections will be set in place. The Director of the Department of Managed Health Care and the Insurance Commissioner will jointly review the Internet portal for the Exchange. In addition, individual health care plan carriers must update a directory of contracting health care providers that can be searched by name by individuals and provide information if the provider is accepting new patients. Also, the Exchange will provide oral interpretation services and phone options for hearing/speech impaired.

## **Utah**

In Utah, a Health Insurance Exchange is already functioning, though it is significantly different from the system envisioned for California. The Utah Health Exchange was initiated in 2008 and 2009, via legislation that directed the Office of Consumer Health Services to create an internet website to allow individuals and businesses to search for and compare health insurance plans and rates. According to their own website, their Exchange “is designed to connect consumers to the information they need to make informed health care choices.” Under the federal Affordable Care Act, Utah’s current Exchange will have certain specific components.

As envisioned, the Utah Exchange will be governed through a state agency with an advisory board, unlike the quasi-governmental agency planned for California. The Exchange governing board will be composed of eight members selected by the Director of the Office of Economic Development with input from the Insurance and Department of Health organizations. Some interest groups will have a role on the board, with two individuals representing producers, two representing consumers and one each representing large and small insurers.

In the Utah Exchange, both employers and individuals access information through the same website, as opposed to an arrangement of separate operations between individuals and a SHOP Exchange. It is primarily a waypoint for businesses and individuals to compare rates from insurance companies that offer plans in the state, and as such, has limited action on the insurance market as a whole. Consumers can access a website for the Exchange and input their zip code, age, gender and whether they use tobacco (in the case of the Blue Cross Blue Shield affiliate in Utah) and find a quote for themselves and their families.

Utah's Exchange is funded primarily through General Revenue allocations from the state budget. Unlike California, fees on QHPs are not a primary funding vehicle. Similar to California, Utah has legislation in place that requires insurers to use the same underwriting in policies they offer through the Exchange as policies offered apart from the Exchange. One of the many important differences between the current Utah model and what is required by the ACA is that Utah has no mechanism at this time for undertaking the additional responsibilities of offering premium subsidies as afforded by the ACA. This is a major difference from California, as the need to provide a mechanism whereby individuals obtain the premium studies that make health insurance affordable is extremely important under the ACA. This also adds substantial complexity to the Utah Exchange (or any exchange).

### ***The Navigator Program***

The navigator program is a concept that seeks to incorporate various public and private entities into an advertising and enlisting campaign for the Exchange. As the Exchange is designed to be able to accommodate people throughout the state of Illinois, the role of navigators will be to educate and reach out to people. This can be done through a variety of methods and organizations. It will be necessary, according to testimony from HMA/Wakely Consulting Group, to balance outreach so that difficult-to-reach populations are targeted without diluting the broad appeal for the Exchange.

One way of reaching out and educating people is to develop a "boots on the ground" effort by community-level agencies and civic organizations, similar to the outreach done for Medicaid and the All Kids program. This approach ensures that a more comprehensive effort can be attempted to inform all Illinois residents, regardless of income/location, about the potential in the Exchange program. Though more people have access to computers and technology than ever before, an individual outreach effort will draw people who have limited Internet access and who would otherwise have few options to find information regarding the Exchange.

Another valuable tool in educating consumers about the Exchange is the use of mass marketing. The consultants from HMA/Wakely Consulting Group described outreach efforts in the state of Massachusetts that utilized the Boston Red Sox baseball team. In the field of sports alone, Illinois boasts a number of professional and collegiate teams, which could be utilized to market the Exchange to millions of individuals. In addition to sports, Illinois has a well-developed transportation infrastructure that could also be used to market the Exchange to toll way, train and bus users.

## Duties of the Exchange

The state-level Health Benefits Exchange has a number of duties set forth in federal guidelines, ranging from informative to regulatory (only to the extent that the Exchange sets a bar for entry into the market and ensures that involved parties are following all federal/state laws). As discussed previously, it is permissible for the Exchange to contract some of their duties and obligations out to various organizations, as long as federal guidelines are met. Some of the specific duties of the Exchange are listed below.

1. One of the most important duties of the Exchange will be to certify, decertify and re-certify health benefit plans and rate them for the purposes of comparison for the Exchange. The health benefit plans must be certified as “Qualified Health Plans” before they can be marketed through the Exchange.

While the Exchange has latitude over which plans it chooses to designate as “qualified” for the purposes of being offered on the Exchange, certain minimums are determined by federal guidelines. A qualified health plan is one that (according to federal guidelines) provides “essential health benefits” and is offered by an insurer that is licensed and in good standing with the state. Also, the insurer must agree to offer at least one “silver” and one “gold” level plan out of the four listed in the Affordable Care Act. These plans, Bronze, Silver, Gold and Platinum, offer benefits that are actuarially equivalent to 60, 70, 80 or 90 percent of the full benefits provided under the plan. That is, the plans must agree to limit the expected out of pocket costs to 40, 30, 20 or 10 percent, respectively. This provision allows consumers to express a relative preference for higher premiums as opposed to the risk of higher copays and deductibles. In the case of “essential health benefits,” this includes minimum essential coverage and: ambulatory/emergency services, hospitalization, maternity/newborn care, mental health/substance use services, prescription drugs, rehab services and devices, lab services, preventative/wellness services (and chronic disease management), and pediatric services. In addition to this coverage, a plan must meet federal requirements regarding marketing, network adequacy, and quality improvement practices (these requirements have not been finalized at this time).

An insurer must also charge the same premium outside the Exchange as it charges to Exchange participants and comply with U.S. Health and Human Services and Department of Health requirements (in addition to any requirements established by the Exchange). Along with this, an insurer must be certified with the Exchange before any plan they have can be offered through the Exchange.

2. The Exchange is responsible for setting up enrollment periods. An enrollment period will be needed for the initial entry of individuals and businesses into the Exchange, but additional periods will be needed in the future. Depending on consumer need and input, the enrollment periods could be yearly or multiple times each year. However, Exchange administrators will have to balance the desire of consumers to have flexibility in their insurance arrangements with the desire for stability on the part of insurers who want to know how many people will be on their offered plan in a given year.
3. As part of the outreach efforts of the Exchange, it is required to set up and maintain a website and toll-free telephone hotline to work with consumers and inform them about qualified health

plans. In addition to this, the Exchange must create a calculator to determine the actual cost of insurance coverage after tax credits, cost-sharing incentives and other reductions.

4. With regards to the information requirements of the Exchange, it is required to inform consumers of their eligibility for Medicaid, CHIP or any other relevant state/federal health benefit program and enroll them in the program if they qualify. Also, the Exchange must inform participating employers of any employees who cease coverage during the health plan year.
5. For small businesses and their employees, the Exchange has some functions that are specific to their circumstances. As a policy duty, the Exchange is required to review the growth rates in insurance premiums inside and outside the Exchange and recommend to what extent to limit the “qualified employer status.” The federal guidelines currently limit it to small employers, but the option is left open for inclusion of larger employers. The Exchange is also required to credit a “free choice voucher” to the premiums of qualified employees and collect that amount from their employer.
6. As a natural part of their obligations under the ACA, Exchanges are required to consult with stakeholders of the Exchange and ACA activities. This encompasses a broad array of entities such as the legislature and state regulatory organizations, (including the Department of Insurance, for information on growth rates for premium costs). This also includes other external stakeholders, such as consumers, businesses, producers, providers, insurance companies and others (some of which are stipulated in proposed federal guidance). In addition, an Exchange is required to meet certain financial integrity requirements in the ACA. These include determining a sustainable funding source and not depending on federal financial support for ongoing Exchange operations.

## **Financing the Exchange**

A central component of the Exchange itself is the requirement in the ACA that a state-level Exchange must be self-sustaining by January 1, 2015. According to HMA/Wakely Consulting Group analysis, there are two main areas of costs that Illinois can expect within the next three to four years: start-up costs and ongoing costs once the Exchange is in operation. HMA/Wakely has stated that they estimate start-up costs for Illinois (in the 2011-2013 period) to be approximately \$92.3 million. However, they anticipate that these costs will be provided for through grants from the Federal government for Exchange establishment.

The \$92.3 million is composed primarily of two areas, Systems Development/Support and Program Operations. Systems Development/Support is expected to be \$75 million, with \$45.4 million for eligibility determination and enrollment, \$15.8 million for a website, \$9.6 million for a customer service call center, and \$4.1 million for a premium-billing system. For Program Operations, the total is \$18.9 million, with most of the costs accumulated in Facility costs (\$809,959), Salary and Benefits (\$8.4 million) and Consulting/Professional Support (\$7.0 million).

After the initial start-up costs, the overall operation cost of the Exchange will depend on a variety of factors, most notably, enrollment. Depending on whether enrollment is lower or higher than expected, the operating costs of the Exchange will be significantly larger. Enrollment in this circumstance is

whether people are able to quickly and easily join and use the Exchange for their health insurance purchases. Low and high enrollment are defined as the stratification by which fewer or more than anticipated people make use of the Exchange. Under low/high enrollment, 2015 expenses (for example) are expected to be between \$57.3 and \$88.6 million. The total enrollment will depend on many factors, but the most important will be the attractiveness of available plans (including cost) and the relative ease of using the Exchange.

Based on the costs involved, many options exist for financing the operations of the Exchange. However, there are potential pitfalls with each option, varying from sustainability of revenue source to political feasibility. The Department of Insurance and the Study Committee have collected a variety of possibilities.

HMA/Wakely Consulting Group has recently delivered a final report to the Illinois Department of Insurance that lays out various options for financing the Exchange. The most prominent option that they suggest is financing the Exchange through an assessment on participating Qualified Health Plans (QHPs). According to their calculations, they estimate that the assessment needed to finance Exchange operation costs would be between 2.24 percent and 3.39 percent of plan premiums. They note that the state of Massachusetts currently utilizes this approach in their "Health Connector" Exchange and has seen assessments between three and four percent on plan premiums. On an individual basis, HMA/Wakely has estimated that the cost of the Exchange per-member per-month to be between \$10.47 and \$16.83 in 2014 and between \$8.92 and \$13.47 in 2015. This pricing range and drop is anticipated to be as a result of increasing enrollment, indicating that 2016 and years following should see lower per-member per-month costs than previous years.

An additional option to finance the Exchange is to levy an assessment fee on insurers. This option provides significant income, but the question exists as to which insurers the assessment fee could be used on. A decision would have to be made between applying this fee to all health insurers in the state or to insurers who sell products through the Exchange. During at least two of the hearings of the Study Commission, stakeholders mentioned the viability of a claims transaction fee, such as the one levied in the State of Michigan to fund its Medicaid program. This fee would assess all plans that conduct claims transactions in the State, which includes both fully-insured and self-insured plans.

Another option, chosen by the state of Utah, is to fund the Exchange through the use of General Revenue. This has the benefit of being a sizable revenue stream, as numerous state operations derive significant amounts of income through General Revenue funding. However, this also places an Exchange in a competition among other programs for funding. Also, depending on political changes in leadership or legislative chambers, the General Revenue financing available for an Exchange could be quite variable.

One option mentioned by HMA/Wakely is leveraging the state Medicaid program. Other states are planning on utilizing the Exchange to determine Medicaid (and other public program) eligibility, which would allow the Exchange costs for this to be charged to the state Medicaid program. The program would be able to offset this by using federal match rates, which would lower overall Illinois costs, according to HMA/Wakely.

HMA/Wakely has also suggested utilizing the Exchange as a purchasing agent for other state programs, including the State Employee Group Insurance Program and other managed care plans. This would potentially provide an ongoing source of income for the Exchange and useful experience in the health insurance field. In addition, the possibility exists of consolidating various purchasing administrative costs for the state into fewer offices, thereby lowering some administrative costs.

A different option would be to levy an assessment fee on consumers. As no other state is pursuing this option, there is no data suggesting the financial viability of such a plan. However, any attempt to utilize this option would have to make allowances for income sensitivity and protections against multiple fee assessments on the same user. At the same time, such a fee would be unpopular among the consumers of the Exchange.

An additional possibility exists that would utilize a licensing fee on the “navigators” for the Exchange. Navigators are organizations who are utilized by the Exchange to help bring individuals and businesses to the Exchange, through advertising, social involvement, and a variety of other ways. A primary concern with this method of financial sustainability, however, is the concern that there will be only limited numbers of navigators. Certainly, in this scenario, there would be little money raised to fund Exchange operations unless extremely large fees were levied.

Levying an assessment on all health care stakeholders in the state is also available as an option for financing the Exchange. This option is not being pursued by other states, so there is limited information about the financial viability of such an option. However, such a plan could include hospitals, clinics, health benefit providers, carriers, pharmaceutical companies, medical supply companies, self-insured plans, etc. As such, this could have a broad base of entities to draw financial support from. However, this plan would likely encounter significant opposition from all the aforementioned groups and organizations. In addition, the questions exist as to the breadth of such a general levy and the possible impact on medical care and services.

There are other possible fees and options for financing the Exchange that have been suggested by HMA/Wakely, including additional insurance for dental, life and long-term care. Also, the option exists to sell advertising space on the Exchange website, which would bring in revenue and allow interested parties to market to their client base. A final option would be increasing taxes on politically viable options (“sin” taxes on tobacco, alcohol, etc.). All the listed options have various positive and negative factors which would have to be considered in order to finance the Exchange in the most effective way.

## **Addendum I**

### **Health Insurance Exchange Study Committee Presenters**

Illinois Department of Healthcare and Family Services – Mike Koetting  
Illinois Department of Insurance – Kate Gross  
Wakley Consulting Group – Jon Kingsdale  
Illinois Comprehensive Health Insurance Plan (CHIP) – Mindy Kolaz, Bob Wagner, Howard Bolnick  
Illinois Office of Health Information Technology – Laura Zaremba  
Illinois State Medical Society – Jim Tierney  
Illinois Hospital Association – Bill McAndrew  
Illinois State Dental Society – Dave Marsh  
Campaign for Better Health Care – Jim Duffett  
Champaign County Healthcare Consumers – Jen Tayabji  
Salud/Latino Health – Patricia Canessa  
United Food and Commercial Workers – Gene Mechanic  
AARP – Mary Patton  
American Cancer Society – Healthier Eagleton  
Citizen Action Illinois – DeLane Adams  
Sargent Shriver National Center on Poverty Law – Margaret Stapleton  
National Federation of Independent Business – Kimi Clarke-Maisch  
Illinois Chamber of Commerce – Jay Shattuck and Laura Minzer  
Aircraft Gear Company – Jim Knutson  
Illinois Academy of Family Physicians (Written testimony only)  
Illinois Maternal and Child Health Coalition (Written testimony only)  
SEIU Healthcare (Written testimony only)  
Illinois Primary Health Care Association (Written testimony only)  
Coalition of Insurance Agents and Brokers – Phil Lackman, Mike Wojcik, Greg Smith, Jeff Taylor  
Crossroads Coalition Community – Patrick Fox, Moriel McClerklin, Mike Wojcik  
Illinois Life Insurance Council – Larry Barry  
Aetna – Elena Butkus, Geoff Sandler  
Illinois Public Interest Research Group – Brian Imus  
Blue Cross/Blue Shield – Mike Brady  
Meridian Health Plan – Michael Murphy and Michael Stines  
Delta Dental (Written testimony only)  
Health Alliance (Written testimony only)  
Illinois Main Street Alliance – David Borris  
Black Women for Reproductive Justice – Toni Leonard  
Champaign County Black Chamber of Commerce – Reverend Zenial Bogan and Roger Abinader  
NAACP/Champaign County Branch – Patricia Avery  
League of Women Voters of Illinois – Janet Craft

**Addendum II**  
**Senate Bill 1555 / Public Act 97-0142**

**SB1555 Enrolled**            **LRB097 05655 RPM 45717 b**

AN ACT concerning insurance.

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

**ARTICLE 5.**  
**ILLINOIS HEALTH BENEFITS EXCHANGE**

Section 5-1. Short title. This Article may be cited as the Illinois Health Benefits Exchange Law.

Section 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 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.

Section 5-5. State health benefits exchange. It is declared that this State, beginning October 1, 2013, in accordance with Section 1311 of the federal Patient Protection and Affordable Care Act, shall establish a State health benefits exchange to be known as the Illinois Health Benefits Exchange in order to help individuals and small employers with no more than 50 employees shop for, select, and enroll in qualified, affordable private health plans that fit their needs at competitive prices. The Exchange shall separate coverage pools for individuals and small employers and shall supplement and not supplant any existing private health insurance market for individuals and small employers.

Section 5-10. Exchange functions.

(a) The Illinois Health Benefits Exchange shall meet the core functions identified by Section 1311 of the Patient Protection and Affordable Care Act and subsequent federal guidance and regulations.

(b) In order to meet the deadline of October 1, 2013 established by federal law to have operational a State exchange, the Department of Insurance and the Commission on Governmental Forecasting and Accountability is authorized to apply for, accept, receive, and use as appropriate for and on behalf of the State any grant money provided by the federal government and to share federal grant funding with, give

support to, and coordinate with other agencies of the State and federal government or third parties as determined by the Governor.

Section 5-15. Illinois Health Benefits Exchange Legislative Study Committee.

(a) There is created an Illinois Health Benefits Exchange Legislative Study Committee to conduct a study regarding State implementation and establishment of the Illinois Health Benefits Exchange.

(b) Members of the Legislative 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 Study Committee shall be appointed 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.

Section 5-20. Committee study. No later than September 30, 2011, the Committee shall report all findings concerning the implementation and establishment of the Illinois Health Benefits Exchange to the executive and legislative branches, including, but not limited to, (1) the governance and structure of the Exchange, (2) financial sustainability of the Exchange, and (3) stakeholder engagement, including an ongoing role for the Legislative Study Committee or other legislative oversight of the Exchange. The Committee shall report its findings with regard to (A) the operating model of the Exchange, (B) the size of the employers to be offered coverage through the Exchange, (C) coverage pools for individuals and businesses within the Exchange, and (D) the development of standards for the coverage of full-time and part-time employees and their dependents. The Committee study shall also include recommendations concerning prospective action on behalf of the General Assembly as it relates to the establishment of the Exchange in 2011, 2012, 2013, and 2014.

Section 5-25. Federal action. This Law shall be null and void if Congress and the President take action to repeal or replace, or both, Section 1311 of the Affordable Care Act.

## **ARTICLE 10. HEALTH SAVINGS ACCOUNT**

Section 10-1. Short title. This Article may be cited as the State Employee Health Savings Account Law.

Section 10-5. Definitions. As used in this Law:

(a) "Deductible" means the total deductible of a high deductible health plan for an eligible individual and all the dependents of that eligible individual for a calendar year.

(b) "Dependent" means an eligible individual's spouse or child, as defined in Section 152 of the Internal Revenue Code of 1986. "Dependent" includes a party to a civil union, as defined under Section 10 of the Illinois Religious Freedom Protection and Civil Union Act.

(c) "Eligible individual" means an employee, as defined in Section 3 of the State Employees Group Insurance Act of 1971, who contributes to health savings accounts on the employees' behalf, who:

- (1) is covered by a high deductible health plan individually or with dependents; and
- (2) is not covered under any health plan that is not a high deductible health plan, except for:
  - (i) coverage for accidents;
  - (ii) workers' compensation insurance;
  - (iii) insurance for a specified disease or illness;
  - (iv) insurance paying a fixed amount per day per hospitalization; and

(v) tort liabilities; and

(3) establishes a health savings account or on whose behalf the health savings account is established.

(d) "Employer" means a State agency, department, or other entity that employs an eligible individual.

(e) "Health savings account" or "account" means a trust or custodial account established under a State program exclusively to pay the qualified medical expenses of an eligible individual, or his or her dependents, that meets all of the following requirements:

(1) Except in the case of a rollover contribution, no contribution may be accepted:

(A) unless it is in cash; or

(B) to the extent that the contribution, when added to the previous contributions to the Account for the calendar year, exceeds the lesser of (i) 100% of the eligible individual's deductible or (ii) the contribution level set for that year by the Internal Revenue Service.

(2) The trustee or custodian is a bank, an insurance company, or another person approved by the Director of Insurance.

(3) No part of the trust assets shall be invested in life insurance contracts.

(4) The assets of the account shall not be commingle with other property except as allowed for under Individual Retirement Accounts.

(5) Eligible individual's interest in the account is nonforfeitable.

(f) "Health savings account program" or "program" means a program that includes all of the following:

(1) The purchase by an eligible individual or by an employer of a high deductible health plan.

(2) The contribution into a health savings account by an eligible individual or on behalf of an employee or by his or her employer. The total annual contribution may not exceed the amount of the deductible or the amounts listed in sub-item (B) of item (1) of subsection (f) of this Section.

(g) "High deductible" means:

(1) In the case of self-only coverage, an annual deductible that is not less than the level set by the Internal Revenue Service and that, when added to the other annual out-of-pocket expenses required to be paid under the plan for covered benefits, does not exceed \$5,000; and

(2) In the case of family coverage, an annual deductible of not less than the level set by the Internal Revenue Service and that, when added to the other annual out-of-pocket expenses required to be paid under the plan for covered benefits, does not exceed \$10,000. A plan shall not fail to be treated as a high deductible plan by reason of a failure to have a deductible for preventive care or, in the case of network plans, for having out-of-pocket expenses that exceed these limits on an annual deductible for services that are provided outside the network.

(h) "High deductible health plan" means a health coverage policy, certificate, or contract that provides for payments for covered benefits that exceed the high deductible.

(i) "Qualified medical expense" means an expense paid by the eligible individual for medical care described in Section 213(d) of the Internal Revenue Code of 1986.

#### Section 10-10. Application; authorized contributions.

(a) Beginning in taxable year 2011, each employer shall make available to each eligible individual a health savings account program, if that individual chooses to enroll in the program. An employer shall deposit \$2,750 annually into an eligible individual's health savings account. Unused funds in a health savings account shall become the property of the account holder at the end of a taxable year.

(b) Beginning in taxable year 2011, an eligible individual may deposit contributions into a health savings account. The amount of deposit may not exceed the amount of the deductible for the policy.

#### Section 10-15. Use of funds.

(a) The trustee or custodian must use the funds held in a health savings account solely (i) for the purpose of paying the qualified medical expenses of the eligible individual or his or her dependents, (ii)

to purchase a health coverage policy, certificate, or contract, or (iii) to pay for health insurance other than a Medicare supplemental policy for those who are Medicare eligible.

(b) Funds held in a health savings account may not be used to cover expenses of the eligible individual or his or her dependents that are otherwise covered, including, but not limited to, medical expense covered under an automobile insurance policy, worker's compensation insurance policy or self-insured plan, or another employer-funded health coverage policy, certificate, or contract.

**ARTICLE 90.  
AMENDATORY PROVISIONS**

(20 ILCS 4045/Act rep.)

Section 90-10. The Health Care Justice Act is repealed.

**ARTICLE 99.  
EFFECTIVE DATE**

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

**Effective Date: 7/14/2011**