_____ BILL NO. _____

INTRODUCED BY _____
(Primary Sponsor)

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE MONTANA HEALTH INSURANCE EXCHANGE; AUTHORIZING THE EXCHANGE TO OPERATE AS A SINGLE MARKET FOR ALL KINDS OF HEALTH INSURANCE PLANS; PROVIDING GREATER ACCESS TO AND CHOICE AND PORTABILITY OF DISABILITY INSURANCE PRODUCTS; PROVIDING FOR THE PROCESSING OF EMPLOYER AND EMPLOYEE CONTRIBUTIONS OR INDEPENDENT PREMIUM PAYMENTS; PROVIDING FOR ADMINISTERING ENROLLMENT AND COVERAGE SELECTION THROUGH AN ANNUAL OPEN SEASON; PROVIDING REQUIREMENTS FOR CONTINUATION OF COVERAGE; PROVIDING FOR DISPUTE RESOLUTION; REQUIRING PERSONAL RESPONSIBILITY FOR HEALTH CARE COSTS; PROVIDING FOR THE ESTABLISHMENT OF INDIVIDUAL ESCROW ACCOUNTS FOR CERTAIN INDIVIDUALS; PROVIDING FOR THE USE OF FUNDS IN THE POSSESSION OF THE STATE FOR PURPOSES OF ESTABLISHING ESCROW ACCOUNTS; AND PROVIDING A DELAYED EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 15], unless the context requires otherwise, the following definitions apply:

(1) "Applicant" means an individual seeking to participate in [sections 1 through 15].

(2) "Carrier" means any person or organization subject to the authority of the commissioner that provides one or more health benefit plans or insurance in Montana. The term includes an insurer, a health service corporation, a hospital or medical services corporation, a fraternal benefit society, a health maintenance organization, or a multiple employer welfare arrangement.

(3) "Commissioner" means the commissioner of insurance.

(4) (a) "Creditable coverage" means continual coverage of the applicant under any of the following health plans, with no lapse in coverage of more than 63 days immediately prior to the date of application:

(i) a group health plan;

(ii) health insurance coverage;

(iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C.

1395j through 1395w-4;

(iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;

(v) Title 10, chapter 55, United States Code;

(vi) a medical care program of the Indian health service or of a tribal organization;

(vii) the Montana comprehensive health association provided for in 33-22-1503;

(viii) a health plan offered under Title 5, chapter 89, of the United States Code;

(ix) a public health plan;

(x) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

(xi) a high-risk pool in any state; or

(xii) any other qualifying coverage required by HIPAA.

(b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

(5) "Dependent" means a person who meets the definition of a dependent as provided for in 26 U.S.C. 152 and includes the spouse of the principal insured or an individual who is related to the principal insured by birth, marriage, or adoption.

(6) "Eligible individual" means an individual who is eligible to participate in the exchange provided for in [sections 1 through 15] by reason of meeting one or more of the following qualifications:

(a) the individual is a Montana resident, meaning that the individual is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in Montana that remains the person's principal residence and from which the person is absent only for temporary or transitory purposes. A person who is a full-time student attending school or an institution of higher education outside of Montana may maintain Montana residency.

(b) the individual is not a Montana resident but is employed for at least 20 hours a week on a regular basis at a Montana location by a bona fide employer, and the individual's employer does not offer a group health insurance plan or the individual is not eligible to participate in any group health insurance plan offered by the individual's employer;

(c) the individual, whether a resident or not, is enrolled in or is eligible to enroll in a participating employer plan;

(d) the individual is self-employed in Montana, and if a nonresident self-employed individual, the individual's principal place of business is in Montana;

(e) the individual is a full-time student attending an institution of higher education located in Montana; or

(f) the individual, whether a resident or not, is a dependent of another individual who is an eligible individual.

(7) "Employer" means any individual, partnership, association, corporation, business trust, person, or group of persons employing one or more persons and filing payroll tax information on the person or persons.

(8) "Excepted benefits" means benefits under one or more of the following:

(a) coverage only for accident or disability income insurance, or both;

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

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

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for onsite medical clinics;

(h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, as approved by the commissioner;

(i) if offered separately, any of the following:

(i) limited-scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these types of care; or

(iii) other similar, limited benefits as approved by the commissioner;

(j) if offered as independent, noncoordinated benefits, any of the following:

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

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) medicare supplement coverage;

(ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United States Code; and

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

(9) "Exchange" means the entity established in [section 2].

(10) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, 45 CFR, parts 160 and 164.

(11) "Individual eligible for federal health coverage tax credits" means an individual who is eligible for benefits under section 201 of the Trade Act of 2002, 26 U.S.C. 35(c).

(12) "Participating employer plan" means a group health plan, as defined in federal law, 29 U.S.C. 1161 through 1169, 1181 through 1183, 1185 through 1185b, and 1191 through 1191c, that is sponsored by an employer and for which the plan sponsor has entered into an agreement with the exchange, in accordance with the provisions of [section 11], for the exchange to offer and administer health insurance benefits for enrollees in the plan.

(13) "Participating individual" means a person who has been determined by the exchange to be and who continues to remain an eligible individual for purposes of obtaining coverage under participating insurance plans offered through the exchange.

(14) "Participating insurance plan" means a health benefit plan offered through the exchange.

(15) "Plan year" means the period of time during which the insured is covered under a health benefit plan as stipulated in the contract governing the plan.

(16) "Preexisting condition provision" means a provision in a health benefit plan that limits, denies, or excludes benefits for a period of time for an enrollee for expenses or services related to a medical condition that was present before the date the coverage commenced, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. The time period for a preexisting condition provision begins when an application for insurance is made or when an applicant is in a waiting period for coverage under any plan. Genetic information may not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the information.

(17) "Producer" has the meaning provided in 33-2-1501.

(18) "Rate" means the premiums or fees charged by a health benefit plan for coverage under the plan.

NEW SECTION. **Section 2. Montana insurance exchange -- establishment -- purpose -- form.** (1) There is created a nonprofit unincorporated legal entity to be known as the Montana insurance exchange, which is created to effectuate the public purposes provided for in [sections 1 through 15], but with a legal existence separate from that of the state.

(2) The exchange is created for the limited purpose of providing the residents of Montana and other

individuals that may, from time to time, also be eligible to participate with greater access to and choice and portability of disability insurance products.

(3) The exchange shall operate in accordance with all requirements and restrictions set forth in [sections 1 through 15] and all other applicable laws of Montana and of the United States.

(4) Subject to the provisions of [sections 1 through 15], all eligible individuals must be permitted to obtain disability insurance benefits through the exchange.

NEW SECTION. **Section 3. Governance.** (1) The exchange must be governed by a board of directors, consisting of not less than seven or more than nine persons serving terms as established in the plan of operation. Two of the members must be appointed from the public at large by the commissioner. The other members of the board must be selected by member insurers subject to the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term in the same manner as initial appointments.

(2) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

(4) The board shall appoint an exchange director, who must be a full-time employee of the exchange. The exchange director shall administer all of the exchange's activities and contracts and supervise the staff of the exchange. The exchange director shall serve at the pleasure of the board.

NEW SECTION. **Section 4. Responsibilities.** The exchange shall:

(1) publicize the existence of the exchange and disseminate information on eligibility requirements and enrollment procedures for the exchange;

(2) establish and administer procedures for enrolling eligible individuals in the exchange, including:

(a) creating a standard application form to collect information necessary to determine the eligibility and previous coverage history of an applicant; and

(b) preparing and distributing certificate of eligibility forms and application forms to insurance producers and the general public;

(3) establish and administer procedures for the election of coverage by participating individuals, in accordance with [section 6], during open season periods and outside of open season periods upon the

occurrence of any qualifying event specified in [section 6(4)], including preparing and distributing to participating individuals:

(a) descriptions of the coverage, benefits, limitations, copayments, and premiums for all participating plans; and

(b) forms and instructions for electing coverage and arranging payment for coverage;

(4) collect and transmit to the applicable participating insurance plans all premium payments or contributions made by or on behalf of participating individuals, including developing mechanisms to:

(a) receive and process automatic payroll deductions for participating individuals enrolled in participating employer plans;

(b) enable participating individuals to pay, in whole or part, for coverage through the exchange by electing to assign to the exchange any federal earned income tax credit payments due the participating individual; and

(c) receive and process any federal or state tax credits or other premium support payments for health insurance as may be established by law;

(5) upon request, issue certificates of previous coverage in accordance with the provisions of HIPAA to all individuals who cease to be covered by a participating insurance plan;

(6) establish procedures to account for all funds received and disbursed by the exchange, including:

(a) maintaining a separate, segregated management account for the receipt and disbursement of money allocated to fund the administration of the exchange;

(b) maintaining a separate, segregated operations account for:

(i) the receipt of all premium payments or contributions made by or on behalf of participating individuals; and

(ii) the distribution of premium payments to participating plans and the distribution of commissions or payments to producers and other organizations that are permitted under [section 12] to receive payments for their services in enrolling eligible individuals or groups in the exchange; and

(7) submit to the commissioner, following the end of each plan year, the report of an independent audit of the exchange's accounts for the plan year.

NEW SECTION. **Section 5. Powers.** The exchange may:

(1) contract with vendors to perform one or more of the functions specified in [section 4];

(2) contract with private or public social service agencies to administer applications, eligibility verification, enrollment, and premium payments for specified groups or populations of eligible individuals or participating individuals;

(3) contract with employers to act as the plan administrator for participating employer plans, subject to the provisions of [section 11], and to undertake the obligations required by federal law of a plan administrator;

(4) set and collect fees from participating individuals, participating employer plans, and participating insurance plans in amounts sufficient to fund the cost of administering the exchange;

(5) seek and directly receive grant funding from the United States government, departments of state government, county or municipal governments, or private philanthropic organizations to defray the costs of operating the exchange;

(6) establish and administer rules and procedures governing the operations of the exchange;

(7) establish one or more service centers within Montana to facilitate enrollment;

(8) sue and be sued or otherwise take any necessary or proper legal action;

(9) establish bank accounts and borrow money.

NEW SECTION. **Section 6. Enrollment and coverage election.** (1) Any eligible individual may apply to participate in the exchange. An employer, a labor union, or an educational, professional, civic, trade, church, or social organization that has eligible individuals as employees or members may apply on behalf of those eligible persons. Upon determination by the exchange that an individual is eligible in accordance with the provisions of [sections 1 through 15] to participate in the exchange, the individual may enroll or, when applicable, be enrolled by the individual's parent or legal guardian in a participating insurance plan offered through the exchange during the next open season period or, when applicable, at other times as are specified in subsection (4).

(2) From November 1 to November 30 of each year, the exchange shall administer an open season during which any eligible individual may enroll in any health benefit plan offered through the exchange, subject to the provisions of [section 8], without a waiting period and may not be declined coverage.

(3) The first 90 days after the exchange begins to accept applications must be considered the initial open season.

(4) An eligible individual may enroll in a health benefit plan offered through the exchange, subject to the provisions of [section 9], without a waiting period at a time other than the annual open season for any of the following reasons and may not be denied coverage if the individual enrolls within 63 days of the triggering event:

(a) the individual loses coverage in an existing health insurance plan due to the death of a spouse, parent, or legal guardian;

(b) the individual or a covered dependent loses coverage in an existing health insurance plan due to a change in the individual's employment status;

(c) the individual or a covered dependent loses coverage in an existing health insurance plan because of a divorce, separation, or other change in familial status;

(d) the individual loses coverage in an existing health insurance plan because the individual achieves an age at which coverage lapses under that plan;

(e) the individual or a covered dependent becomes newly eligible by becoming a resident of Montana or because the individual's place of employment has been changed to Montana;

(f) the individual becomes newly eligible by becoming the spouse or dependent, by reason of birth, adoption, court order, or a change in custody arrangement, of an eligible individual;

(g) the individual becomes subject to a court order requiring the individual to provide health insurance coverage to certain dependents or enters into a new arrangement for the custody of dependents that requires the provision of health insurance for those dependents; or

(h) the individual loses coverage in a plan offered through the exchange by reason of the plan terminating participation in the exchange prior to the end of the plan year.

NEW SECTION. **Section 7. Participation of plans in the exchange.** (1) A health benefit plan may not be offered through the exchange unless the commissioner has first certified to the exchange that:

(a) the carrier seeking to offer the plan is licensed to issue health insurance in Montana and is in good standing with the commissioner's office; and

(b) the plan meets the requirements of this section and the plan and the carrier are in compliance with all other applicable Montana health insurance laws.

(2) A plan may not be certified that excludes from coverage any individual otherwise determined by the exchange as meeting the eligibility requirements for participating individuals. The certification of plans to be offered through the exchange is not subject to any state law requiring competitive bidding.

(3) Each certification must be valid for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of either:

(a) withdrawal of certification by the commissioner; or

(b) discontinuation of participation in the exchange by the plan or carrier.

(4) Certification of a plan may be withdrawn only after notice to the carrier and opportunity for hearing. The commissioner may, however, decline to renew the certification of any carrier at the end of a certification term.

(5) Each plan certified by the commissioner as eligible to be offered through the exchange must contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits.

(6) Each plan certified by the commissioner as eligible to be offered through the exchange shall provide, subject to the plan's deductibles and coinsurance or copayment schedule, major medical coverage that includes the following:

(a) hospital benefits;

(b) surgical benefits;

(c) inhospital medical benefits;

(d) ambulatory patient benefits;

(e) prescription drug benefits;

(f) mental health benefits; and

(g) coverage required under Title 33, chapter 30, or this chapter.

(7) Carriers shall offer plans through the exchange at standard rates based on age, geography, and family composition and that are determined to be actuarially sound in the judgment of the commissioner. The provisions of Title 33, chapter 16, apply to plans offered through the exchange.

(8) The rates determined for the first plan year for which the plan is offered through the exchange may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits. However, any adjustments in rates must be made in advance of the plan year for which the rates will apply and on a basis that, in the judgment of the commissioner, is consistent with the general practice of carriers that issue health benefit plans to large employers.

(9) The exchange may not decline or refuse to offer or otherwise restrict the offering to any participating individual of any plan that has obtained certification by the commissioner in accordance with the provisions of this section in a timely fashion in advance of the annual open season.

(10) The exchange may not sponsor any insurance or benefit plan or contract with any carrier to offer any insurance or benefit plan as a participating plan that has not first been certified by the commissioner in accordance with the provisions of this section.

(11) The exchange may not impose on any participating plan or on any carrier or plan seeking to

participate in the exchange any terms or conditions, including any requirements or agreements with respect to rates or benefits, beyond or in addition to those terms and conditions established and imposed by the commissioner in certifying plans under the provisions of this section.

(12) The commissioner shall establish and administer regulations and procedures for certifying plans to participate in the exchange in accordance with the provisions of this section.

NEW SECTION. **Section 8. Underwriting rules.** The following rules govern the imposition by carriers of any preexisting condition provisions and rating surcharges with respect to a participating individual covered by a participating insurance plan:

(1) Except as otherwise specified in subsections (3) and (4), during any open season, a participating individual who elects to choose a different participating insurance plan or plan option for the next plan year may not be subject to any preexisting condition provisions and must be charged the standard rate of the new participating insurance plan or plan option for persons of the participating individual's age and geographic area. The provisions of this subsection apply to any election by a participating individual of coverage for any dependent who is also a participating individual.

(2) A new participating individual with 18 months or more of creditable coverage who enrolls in a participating insurance plan may not be subject to any preexisting condition provisions and must be charged the applicable standard rate, adjusted for age and geography, for the participating insurance plan.

(3) (a) A new participating individual with creditable coverage of between 2 and 17 months may enroll in a participating insurance plan, but the participating individual may be:

(i) subject to one or more preexisting condition provisions for a period not to exceed 12 months, with the number of months reduced by the number of months of creditable coverage;

(ii) charged a premium not to exceed 125% of the otherwise applicable standard rate, as adjusted for age and geography, for the participating insurance plan; or

(iii) subject to both subsections (3)(a)(i) and (3)(a)(ii).

(b) Any rate surcharge may not be applied during the third year or subsequent years of the individual's enrollment in any participating insurance plan.

(4) (a) A new participating individual with 2 months or less of creditable coverage may enroll in a participating insurance plan, but the participating individual may be:

(i) subject to one or more preexisting condition provisions for a period not to exceed 12 months, with the

number of months to be reduced by the number of months of creditable coverage;

(ii) charged a premium not to exceed 150% of the otherwise applicable standard rate, adjusted for age and geography, for the participating insurance plan; or

(iii) subject to both subsections (4)(a)(i) and (4)(a)(ii).

(b) Any rate surcharge may not be applied during the third year or subsequent years of the individual's enrollment in any participating insurance plan.

(5) If an individual is enrolled in a plan offered through the exchange as a newly eligible dependent of a participating individual, by reason of birth, adoption, court order, or a change in custody arrangement, either during open season or outside of open season in accordance with [section 6(4)(f)], a carrier may not impose any preexisting condition provisions or any change in the rate charged to the participating individual, except for the difference, if any, in the participating insurance plan's standard rates that reflect the addition of a new dependent to the participating individual's coverage.

(6) Periods of creditable coverage with respect to an individual must be established through presentation of certifications or in another manner as may be specified in federal or state law.

(7) For new participating individuals without creditable coverage or with only limited creditable coverage as defined in subsections (3) and (4), a carrier may elect to waive the imposition of preexisting condition provisions and instead extend the applicable rate surcharge for an additional year beyond the time provided for in those subsections.

(8) For purposes of this section, any individual who is a participating individual by reason of enrollment in a participating employer plan must be considered to have 18 months of creditable coverage.

(9) For purposes of this section, any individual eligible for federal health coverage tax credits must be considered to have 18 months of creditable coverage.

NEW SECTION. **Section 9. Continuation of coverage.** (1) Any participating individual may continue to participate in any participating insurance plan as long as the individual remains an eligible individual, subject to the carrier's rules regarding cancellation for nonpayment of premiums or fraud, and participation may not be cancelled or nonrenewed because of any change in employer or employment status, marital status, health status, age, membership in any organization, or any other change that does not affect eligibility as described in [sections 1 through 15].

(2) A participating individual who is not a resident of Montana and who ceases to be an eligible individual

due to a qualifying event must be determined to remain an eligible individual and must be determined to remain a participating individual for a period not to exceed 36 months from the date of the qualifying event if:

(a) the qualifying event consists of a loss of eligible individual status due to:

(i) voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(ii) loss of qualified dependent status for any reason; and

(b) the participating individual elects to remain a participating individual and notifies the exchange of the election within 63 days of the qualifying event.

NEW SECTION. **Section 10. Dispute resolution.** (1) The commissioner shall establish procedures for resolving disputes arising from the operation of the exchange in accordance with the provisions of [sections 1 through 15], including disputes with respect to:

(a) the eligibility of an individual to participate in the exchange;

(b) the imposition of a coverage surcharge on a participating individual by a participating insurance plan; and

(c) the imposition of a preexisting condition provision on a participating individual by a participating insurance plan.

(2) In cases where a carrier, in accordance with the provisions of this section, imposes a preexisting condition exclusion or a premium surcharge in connection with enrollment of a participating individual in a participating insurance plan offered by the carrier and the participating individual disputes the imposition of the exclusion or surcharge, the participating individual may request that the commissioner issue a determination as to the validity or extent of the exclusion or surcharge under the provisions of [sections 1 through 15]. The commissioner or a designee shall issue a determination within 30 days of the request being filed with the department. If either the participating individual or the carrier disagrees with the outcome, the individual or carrier may submit a request for a hearing to the commissioner in accordance with Title 2, chapter 4.

NEW SECTION. **Section 11. Participating employer plans.** (1) Any employer may apply to the exchange to be the sponsor of a participating employer plan.

(2) Any employer seeking to be the sponsor of a participating employer plan shall, as a condition of participation in the exchange, enter into a binding agreement with the exchange, which must include the following conditions:

(a) the sponsoring employer designates the exchange director to be the plan's administrator for the employer's group health plan and the exchange director agrees to undertake the obligations required of a plan administrator under federal law;

(b) only the coverage and benefits offered by participating insurance plans constitute the coverage and benefits of the participating employer plan;

(c) any individuals eligible to participate in the exchange by reason of their eligibility for coverage under the employer's participating employer plan, regardless of whether the individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan, may elect coverage under any participating insurance plan and neither the employer nor the exchange may limit the individual's choice of coverage from among all the participating insurance plans;

(d) the employer reserves the right to offer benefits supplemental to the benefits offered through the exchange, but any supplemental benefits offered by the employer must constitute a separate plan or plans under federal law, for which the exchange director may not be the plan administrator and for which neither the exchange director nor the exchange are responsible in any manner;

(e) the employer agrees that, for the term of the agreement, the employer will not offer to individuals eligible to participate in the exchange by reason of their eligibility for coverage under the employer's participating employer plan any separate or competing group health plan offering the same or substantially similar benefits as those provided by participating insurance plans through the exchange regardless of whether the individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan;

(f) the employer reserves the right to determine the criteria for eligibility, enrollment, and participation in the participating employer plan and the terms and amounts of the employer's contributions to that plan provided that during the term of the agreement with the exchange, the employer agrees not to alter or amend any criteria or contribution amounts at any time other than during an annual period designated by the exchange for participating employer plans to make changes in conjunction with the exchange's annual open season;

(g) the employer agrees to make available to the exchange any of the employer's documents, records, or information, including copies of the employer's federal and state tax and wage reports, that the commissioner reasonably determines are necessary for the exchange to verify:

(i) that the employer is in compliance with the terms of its agreement with the exchange governing the employer's sponsorship of a participating employer plan;

(ii) that the participating employer plan is in compliance with applicable laws relating to employee welfare

benefit plans, particularly those relating to nondiscrimination in coverage; and

(iii) the eligibility, under the terms of the employer's plan, of those individuals enrolled in the participating employer plan; and

(h) the employer agrees to also sponsor a cafeteria plan, as permitted under 26 U.S.C. 125, for all employees eligible for coverage under the employer's participating employer plan.

(3) The exchange may not enter into an agreement with an employer with respect to any employer participating plan if the agreement does not, at a minimum, incorporate the conditions specified in subsection (2).

(4) The exchange may not enter into any agreement with any employer with respect to any participating employer plan for the exchange to provide the participating employer plan with any additional or different services or benefits not otherwise provided or offered to all other participating employer plans.

(5) Beginning with the first plan year following the establishment of the exchange, the state, acting through the department of administration, shall enter into an agreement with the exchange to be the sponsor of a participating employer plan on behalf of all individuals eligible for health insurance benefits paid in whole or in part by the state by reason of current or past employment by the state or by reason of being a dependent of an eligible individual, except for any individuals who are eligible only for benefits consisting solely of coverage of excepted benefits.

NEW SECTION. **Section 12. Insurance producers.** (1) In cases when a producer enrolls an eligible individual or group in the exchange, the plan chosen by each individual shall pay the producer a commission voluntarily agreed to by the various carriers and producers.

(2) In cases when a membership organization enrolls its eligible members or the eligible members of its member entities in the exchange, the plan chosen by each individual shall pay the organization a fee equal to the commission specified in subsection (1). This section may not be considered to either require a membership organization that enrolls persons in the exchange to be licensed by the state as a producer or to permit an organization to provide any other services requiring licensure as a producer without first obtaining a license.

NEW SECTION. **Section 13. Statement of coverage form.** (1) Each employer in Montana shall annually file with the commissioner a form for each employee employed within Montana indicating the health insurance coverage status of the employee and the employee's dependents, including the source of coverage and the name of the insurer or plan sponsor and, if no coverage is indicated:

(a) the employee's election to, in lieu of insurance coverage, post a bond or establish an account in accordance with [section 15];

(b) the employee's election to apply or not apply for coverage through the exchange; and

(c) the employee's election to be considered or not to be considered for any publicly financed health insurance program or premium subsidy program administered by the state.

(2) Each form under subsection (1) must be signed by the individual to whom it pertains.

(3) Each self-employed individual in Montana shall annually file the form described in subsection (1) with the commissioner.

(4) The director of the department of public health and human services shall annually file the form described in subsection (1) with the commissioner on behalf of all individuals receiving benefits under the state's medicaid program and children's health insurance program, except for individuals who are also covered by Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 1395j through 1395w-4.

(5) For purposes of this section, health insurance coverage does not include any coverage consisting solely of one or more excepted benefits.

(6) The commissioner shall prepare and distribute the forms required under this section.

NEW SECTION. **Section 14. Insurance market consolidation.** (1) A carrier may not issue or renew an individual health benefit plan, other than through the exchange, after the first day of the plan year following the first regular open season conducted by the exchange in accordance with [section 6].

(2) A carrier may not issue or renew a group health benefit plan to a small employer with at least 10 or fewer employees, other than through the exchange, after the first day of the plan year following the first regular open season conducted by the exchange in accordance with [section 6].

(3) Subsections (1) and (2) do not apply to any health benefit plan that consists solely of one or more excepted benefits.

NEW SECTION. **Section 15. Personal responsibility.** (1) Effective January 1, 2009, the following individuals who are over 18 years of age and who have not yet attained 65 years of age shall offer proof of their ability to pay for medical care for themselves and their dependents:

(a) residents of Montana; or

(b) individuals who become residents of Montana, within 63 days of establishing residency.

(2) Individuals subject to the requirement in subsection (1) must be considered to be in compliance with subsection (1) if they either:

(a) indicated coverage under any health benefit plan in accordance with [section 13]; or

(b) demonstrate proof of financial security in accordance with subsection (3).

(3) Pursuant to subsection (2)(b), individuals electing to demonstrate proof of financial security to pay for medical expenditures shall present to the commissioner a bond in the amount of $10,000 or shall deposit with the commissioner $10,000 in an interest-bearing escrow account.

(4) If in any calendar year an individual subject to the requirement in subsection (1) fails to comply with subsection (1), the department of revenue shall establish an escrow account in the name of that individual and shall:

(a) retain and deposit in the account all funds that may be owed to the individual by the state, including but not limited to any overpayment by the individual of any taxes imposed by the state;

(b) obtain an order for the attachment of the wages of the individual to satisfy the requirements of this section; or

(c) satisfy the requirements of both subsections (4)(a) and (4)(b).

(5) With respect to any escrow account established in accordance with this section, either by reason of an individual making the election specified in subsection (3) or by reason of an individual being subject to subsection (4), the amount deposited, retained, or collected may not exceed $10,000 in aggregate for any individual.

(6) This section may not be construed to authorize the department of revenue to retain any amount for the purposes of this section that otherwise would be paid to a claimant agency or agencies of the state as debts described in 17-4-103.

(7) Money held in escrow in accordance with this section may be disbursed by the department of revenue only to pay for medical claims for health care services provided to the individual during the period when the individual was not in compliance with subsection (1).

(8) The department of revenue shall close the account and remit the remaining funds to the individual within 6 months of receiving notification that the individual:

(a) has elected to comply with the requirement in subsection (1) by submitting proof of insurance coverage in accordance with subsection (2)(a); or

(b) is no longer subject to subsection (1) by reason of no longer being a resident of Montana.

(9) If the department of revenue determines that an individual for whom an account has been established has not been a resident of Montana for a consecutive period of 36 months or more, the department shall close the account and remit the remaining funds to the individual or, if the department cannot locate the individual, shall dispose of the funds in accordance with the provisions of Title 70, chapter 9, part 8.

(10) Any judgment requiring payment by an individual to a hospital, physician, or other health care provider for charges incurred during a period when the individual failed to comply with subsection (1) must include an order permitting the attachment of the wages of the individual to satisfy the judgment.

NEW SECTION. **Section 16. Codification instruction.** [Sections 1 through 15] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 15].

NEW SECTION. **Section 17. Effective date.** [This act] is effective January 1, 2008.

- END -