HOUSE BILL NO. 124

INTRODUCED BY C. HUNTER

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING A MONTANA HEALTH INSURANCE EXCHANGE AUTHORITY; ESTABLISHING AN OVERSIGHT BOARD; PROVIDING A PURPOSE, POWERS, AND DUTIES OF THE EXCHANGE AUTHORITY AND THE BOARD; DESCRIBING DUTIES OF THE COMMISSIONER OF INSURANCE RELATED TO THE EXCHANGE AUTHORITY AND THE BOARD; PROVIDING THE COMMISSIONER WITH RULEMAKING AUTHORITY RELATED TO THE EXCHANGE AUTHORITY AND BOARD; DESCRIBING CRITERIA USED BY AN EXCHANGE AUTHORITY TO CERTIFY A HEALTH PLAN; PROVIDING FOR AN ADVISORY COMMITTEE; DESCRIBING FUNDING OPTIONS; REQUIRING CERTAIN REPORTS AND RESEARCH; DESCRIBING EMPLOYER PARTICIPATION AND CONTRIBUTION OPTIONS WITHIN THE EXCHANGE; OUTLINING REQUIREMENTS FOR PARTICIPATION BY HEALTH INSURANCE ISSUERS INSIDE AND OUTSIDE THE EXCHANGE; AND PROVIDING AN EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Establishment of Montana health insurance exchange authority -- purpose -- operations.** (1) There is established a quasi-governmental entity known as the Montana health insurance exchange authority, which is subject to the supervision of the commissioner. The exchange authority shall incorporate as a nonprofit corporation as provided in Title 35, chapter 2.

(2) The purpose of the exchange authority is:

(a) to create and administer a state-based exchange, as provided under the federal act;

(b) to facilitate the purchase and the sale of qualified health plans;

(c) to establish a SHOP exchange intended to assist qualified small employers in enrolling their employees in qualified health plans;

(d) to facilitate the availability, choice, and adoption of private health insurance plans to eligible individuals and groups as described in [sections 1 through 14] and in the applicable sections of the federal act;

(e) to make qualified health plans available to qualified individuals and qualified small employers; and

(f) to implement the requirements of [sections 1 through 14], any rules adopted pursuant to [section 5],

and any applicable federal statutes or regulations specified by the commissioner by rule.

(3) The exchange authority is governed by a board appointed as provided in [section 3]. The board shall implement and direct the activities of the exchange authority as provided in [sections 1 through 14].

(4) The exchange authority and the board are subject to Article II, section 9, of the Montana constitution, and to the open meeting laws, provided for in Title 2, chapter 3.

(5) The department of public health and human services, provided for in 2-15-2201, shall cooperate with the exchange authority to coordinate eligibility systems in order to create a single point of entry for exchange applicants eligible for medicaid, the healthy Montana kids plan provided for in Title 53, chapter 4, part 11, and other available public programs.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 14], the following definitions apply:

(1) "Board" means the board of directors of the Montana health insurance exchange authority established in [section 1].

(2) "Exchange" or "exchange authority" means the Montana health insurance exchange authority established in [section 1].

(3) "Federal act" means the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, along with federal regulations or guidance issued for those acts.

(4) "Public small employer" means a city, town, county, or school district or an educational cooperative formed under a contract in accordance with 20-7-451.

(5) "Qualified employer" means a public small employer or a private small employer that offers health insurance or makes health insurance available pursuant to a collective bargaining agreement to its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange or at the employer's option to some or all of its part-time employees. To provide coverage through the SHOP exchange, one of the following conditions must apply:

(a) the qualified employer has its principal place of business in this state and provides health insurance coverage to all of its eligible employees, wherever the employees perform their work; or

(b) the qualified employer makes health insurance coverage available to all its eligible employees principally employed in this state.

(6) "Qualified health plan" means a health plan that has been certified as provided in [section 8].

(7) "Qualified individual" means an individual, including a minor, who:

(a) is seeking to enroll in a qualified health plan offered to individuals through the exchange authority;

(b) is a resident of this state;

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

(d) is or is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or a national of the United States, as defined in 8 U.S.C. 1101, or an alien lawfully present in the United States.

(8) "Secretary" means the secretary of the department of health and human services.

(9) "SHOP exchange" means the small business health options program established under [section 4].

(10) (a) (i) "Small employer" means an employer that employed an average of at least 1 but not more than 100 employees during the preceding calendar year, except as provided in subsection (10)(a)(ii). For the purposes of this subsection (10)(a):

(A) all persons treated as a single employer under 26 U.S.C. 414(b), (c), or (m) or under the regulations adopted pursuant to 26 U.S.C. 414(o) must be treated as a single employer;

(B) an employer and any predecessor employer must be treated as a single employer; and

(C) all employees must be counted, including part-time employees and employees who are not eligible for health insurance coverage through the employer.

(ii) For an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer must be based on the average number of employees reasonably expected to be employed by the employer on business days in the current calendar year.

(b) An employer that makes enrollment in qualified health plans available to its employees through the SHOP exchange and that no longer meets the definition of a small employer because of an increase in the number of its employees must continue to be treated as a small employer for purposes of [sections 1 through 14] as long as that employer continuously makes enrollment through the SHOP exchange available to its employees.

NEW SECTION. **Section 3. Board of directors -- composition -- appointment -- compensation.** (1) There is a board of directors of the Montana health insurance exchange authority consisting of seven directors appointed for 3-year, staggered terms, plus two nonvoting members and one nonvoting legislative liaison.

(2) The commissioner shall appoint three voting directors with the following qualifications:

(a) one must have specialized knowledge regarding health insurance and health care financing or health care access;

(b) one must have an actuarial background; and

(c) one must be a representative of the business community, have significant experience in health insurance plans, and be eligible to purchase coverage through the SHOP exchange.

(3) The governor shall appoint four voting directors with the following qualifications:

(a) one must be the administrator of plans for group benefits provided for in Title 2, chapter 18, part 8;

(b) one must be the state medicaid director overseeing the state programs under Title 53, chapter 6, part 1;

(c) one must be a representative of a health-related consumer advocacy organization with significant experience in health care financing or health care access; and

(d) one must be a representative of a union eligible to participate in the SHOP exchange who has significant experience in health insurance plans.

(4) Each appointment is subject to confirmation by the senate. Directors may be reappointed.

(5) The board may vote to recommend removal of a director if that director is not actively participating in the affairs of the board. The appointing official shall make the final decision on the removal.

(6) A board vacancy must be filled in the same manner as the original appointment, and the replacement director shall serve pending confirmation by the senate at the next regular session of the legislature.

(7) While serving on the board, a director may not be an employee of, consultant to, member of the board of directors of, affiliated with, have an ownership interest in, or otherwise be a representative of any health insurance issuer, insurance producer agency, insurance consultant organization, trade association of insurers, or association offering health insurance coverage to its members.

(8) The commissioner and the governor shall each appoint a nonvoting member to participate in all board meetings as a representative of their respective staffs. Each of these appointments must be a person with experience in health insurance and health care issues.

(9) The senate president and the speaker of the house shall jointly appoint a member of the legislature to be a nonvoting liaison to the board.

(10) (a) Except as provided in subsection (10)(c), the costs of conducting meetings of the exchange authority board are costs of the exchange authority board.

(b) The directors and the nonvoting members must be compensated and receive travel expenses as

provided in 2-15-124(7).

(c) The legislative liaison must be compensated by the legislative council, as provided in 5-2-302, subject to terms set by the legislative council for out-of-town meetings.

(11) Board appointments must be made no later than August 1, 2011.

(12) The board shall meet at least 10 times every year, beginning in August 2011.

NEW SECTION. **Section 4. Powers and duties of board.** (1) In accordance with the federal act, other applicable federal statutes and regulations specified by the commissioner by rule, other rules adopted under this title, and [sections 1 through 14], the board shall:

(a) implement procedures adopted by the commissioner by rule for the certification of health plans as qualified health plans and their recertification or decertification consistent with applicable state law and guidelines developed by the secretary under 42 U.S.C. 18031;

(b) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(c) provide for enrollment periods, as set out under applicable state law and 42 U.S.C. 18031;

(d) maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on qualified health plans;

(e) assign a rating to each qualified health plan offered through the exchange in accordance with applicable state law, rules adopted by the commissioner, and the criteria developed by the secretary under 42 U.S.C. 18031;

(f) determine each qualified health plan's level of coverage in accordance with applicable state law and regulations issued by the secretary under 42 U.S.C. 18022;

(g) use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage as established under 42 U.S.C. 300gg-15 and applicable under state law;

(h) inform individuals in accordance with applicable state law and 42 U.S.C. 18083 regarding eligibility requirements for the medicaid program under Title XIX of the Social Security Act, the children's health insurance program under Title XXI of the Social Security Act, and any applicable state or local public program;

(i) screen applications received by the exchange authority and facilitate enrollment of any individual who the exchange authority determines, through the screening, to be eligible for one of the programs listed in subsection (1)(h);

(j) establish and make available by electronic means a calculator to determine the actual cost of

coverage after application of any premium assistance tax credit under 26 U.S.C. 36B and any cost-sharing reduction under 42 U.S.C. 18071;

(k) grant a certification, subject to 42 U.S.C. 18081, that attests that an individual is exempt for the purposes of the individual responsibility penalty under 26 U.S.C. 5000A from the individual responsibility requirement or from the penalty imposed by 26 U.S.C. 5000A because:

(i) there is no affordable qualified health plan available through the exchange or the individual's employer for covering the individual; or

(ii) the individual meets the requirements for any other exemption from the individual responsibility requirement or penalty under 26 U.S.C. 5000A;

(l) transfer to the United States secretary of the treasury the following:

(i) a list of the individuals who are issued a certification under subsection (1)(k), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium assistance tax credit under 26 U.S.C. 36B because:

(A) the employer did not provide minimum essential health benefits coverage; or

(B) the employer provided minimum essential health benefits coverage but a determination under 26 U.S.C. 36B(c)(2)(C) found that either the coverage was unaffordable for the employee or did not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of:

(A) each individual who notifies the exchange authority under 42 U.S.C. 18081 that the individual has changed employers; and

(B) each individual who ceases coverage under a qualified health plan during the plan year and the effective date of that cessation;

(m) provide to each employer the name of each employee of the employer described in subsection (1)(l)(iii)(B) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(n) establish a SHOP exchange through which a qualified employer:

(i) may access coverage for its employees; and

(ii) is able to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage;

(o) perform duties required of the exchange authority by the secretary or the United States secretary of the treasury or the commissioner related to determining eligibility for premium assistance tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(p) (i) select entities qualified to serve as navigators in accordance with 42 U.S.C. 18031, applicable state law, the standards developed by the secretary, and adopted by the commissioner by rule; and

(ii) award grants to enable navigators to:

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance tax credits under 26 U.S.C. 36B and cost-sharing reductions under 42 U.S.C. 18071;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to the office of the commissioner for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan or coverage or a determination under that plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange authority;

(q) review the rate of premium growth within the exchange authority and outside the exchange authority in consultation with the commissioner;

(r) credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled in accordance with 42 U.S.C. 18101 and collect the amount credited from the offering employer;

(s) consult with the following stakeholders with regard to carrying out the activities required under [sections 1 through 14]:

(i) the advisory committee described in [section 9];

(ii) consumers who are enrollees in qualified health plans;

(iii) individuals and entities with experience in facilitating enrollment in qualified health plans;

(iv) representatives of small businesses and self-employed individuals;

(v) the department of public health and human services as provided for in 2-15-2201;

(vi) the commissioner; and

(vii) advocates for enrolling hard-to-reach populations;

(t) meet the following financial integrity requirements:

(i) keep an accurate accounting of all exchange authority activities, receipts, and expenditures and annually submit a report on these accountings to the secretary, the commissioner, the governor, and the legislature. The board shall also submit:

(A) a quarterly financial report to the commissioner;

(B) all reports required by the secretary; and

(C) an annual report on administrative expenses to the commissioner so that fees assessed pursuant to subsection (1)(v) are accurately reflected in the operation of the exchange authority.

(ii) provide an independently audited financial statement to the board, the commissioner, the governor, and the legislature at least once every 12 months;

(iii) cooperate fully with any investigation conducted by the commissioner or the secretary pursuant to the secretary's authority under the federal act and allow the commissioner or the secretary, in coordination with the inspector general of the department of health and human services, to:

(A) investigate the affairs of the exchange authority;

(B) examine the properties and records of the exchange authority; and

(C) require periodic reports in relation to activities undertaken by the exchange authority as provided in [section 11]; and

(iv) in carrying out its activities under [sections 1 through 14], prohibit the use of funds for a purpose other than administrative and operational expenses of the exchange authority. Prohibited expenses include the use of funds for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

(u) seek and receive federal grants available pursuant to 42 U.S.C. 18031 and other grant funding available from private or government sources;

(v) pursuant to applicable state law and in coordination with the commissioner, assess fees in an equitable manner among all health insurance issuers doing business in Montana. The fees must be limited to the minimum amount necessary to pay for the administrative costs and expenses incurred in the operation of the exchange authority.

(w) adopt bylaws for the regulation of the board's affairs and the conduct of its business;

(x) develop a plan of operation that includes procedures and criteria detailing the implementation of the activities and duties assigned to the exchange authority under [sections 1 through 14] and the federal act;

(y) maintain an office in this state at any place it may designate;

(z) require qualified health plans to:

(i) provide information and make disclosures to their enrollees as required by state and federal law;

(ii) implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency training for their employees;

(aa) assist in the implementation of reinsurance and risk adjustment mechanisms for qualified health plans as required by state and federal law;

(bb) publicize the existence of the exchange, the exchange eligibility requirements and enrollment procedures, and the benefits and advantages of purchasing coverage through the exchange;

(cc) develop services that aid small employers in the administration of their group health plans;

(dd) facilitate the development of cafeteria plans, defined in 26 U.S.C. 125 and also known as "125 plans", for use by employers participating in the exchange;

(ee) establish a defined contribution arrangement, as described in [section 12], as one option for qualified employers seeking to participate in the SHOP exchange;

(ff) in consultation with stakeholders, establish guidelines regarding the role of insurance producers inside the exchange, including identifying ways for producers to assist consumers with enrollment in the exchange and setting limits on commission rates;

(gg) examine methods to limit plan design options to create adequate consumer choice and value while avoiding unnecessary, duplicative, and confusing plan designs;

(hh) encourage the development of plans that promote wellness, preventative health care, and new innovations in health care delivery systems that promote efficiency, curb health care costs, and provide value to health care consumers;

(ii) develop strategies that encourage the participation of health insurance issuers in the exchange, including cooperatives and multistate plans, and that offer good value to consumers and have high quality ratings; and

(jj) develop strategies to ensure the viability of the exchange by minimizing adverse risk selection.

(2) The board may:

(a) borrow money;

(b) approve the use of trademarks, brand names, seals, logos, and other similar instruments in communications regarding the exchange by participating health insurance issuers, employers, or organizations;

(c) enter into agreements with state and federal agencies;

(d) enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under [sections 1 through 14] provided that the agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations;

(e) establish lines of credit and cash and investment accounts; and

(f) establish and manage a system that aggregates all money received in the form of tax credits, premium subsidies, and premium payments made by or on behalf of individuals obtaining coverage through the exchange, including any premium payments made by enrollees, employees, unions, or other organizations, and pays the money received to the appropriate health insurance issuer.

NEW SECTION. **Section 5. Exchange authority staff.** (1) The board shall hire an executive director to supervise the administrative affairs, general management, and operations of the exchange authority. The executive director shall also serve as ex officio secretary of the exchange authority. The executive director shall receive a salary commensurate with the duties of the office as determined by the board.

(2) The executive director shall, with the approval of the board:

(a) plan, direct, coordinate, and execute administrative functions in conformity with the policies and directives of the board;

(b) employ professional and clerical staff as necessary, subject to the provisions of subsection (3);

(c) report to the board on all operations of the exchange authority controlled or supervised by the executive director;

(d) prepare an annual budget and manage the administrative expenses of the exchange authority; and

(e) undertake any other activities necessary to implement the powers and duties of the board set forth in [sections 1 through 14].

(3) An employee of the exchange authority staff, including the executive director:

(a) may not simultaneously be an employee of, be a consultant to, be a member of a board of directors of, be affiliated with, have an ownership interest in, or otherwise be a representative of any health insurance issuer, insurance producer agency, insurance consultant organization, trade association of insurers, or association offering health insurance coverage to its members;

(b) must be paid and receive benefits, as determined by the board of directors, solely from grants or

assessments. Exchange authority staff are not state employees.

NEW SECTION. **Section 6. Powers and duties of commissioner -- rules.** (1) The commissioner shall:

(a) approve or disapprove the plan of operation that the board proposes;

(b) develop a uniform health insurance application form and require its use both inside and outside of the exchange authority;

(c) approve or disapprove the assessment fees that the board proposes to impose to pay for the ongoing administration of the exchange authority;

(d) conduct periodic financial and performance audits of the exchange authority; and

(e) adopt rules necessary to implement the provisions of [sections 1 through 14].

(2) The commissioner may investigate any complaints received from the public concerning the operation of the exchange authority.

NEW SECTION. **Section 7. General requirements for exchange authority.** (1) The exchange authority shall implement the purposes described in [section 1].

(2) (a) The exchange authority may contract with an eligible entity for any of the functions assigned to the exchange authority under [sections 1 through 14] and not otherwise delegated to the commissioner or the board.

(b) (i) For the purposes of subsection (2)(a), the term "eligible entity" includes the department of public health and human services, provided for in 2-15-2201, or an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities to be assumed by the entity.

(ii) The term does not include a health insurance issuer or an affiliate of a health insurance issuer.

(3) (a) The exchange authority shall make available to qualified individuals and qualified employers a qualified health plan that has an effective date after [the effective date of this act] but on or before January 1, 2014.

(b) The exchange authority may not make available any health plan that is not a qualified health plan, except as provided in subsection (4).

(4) The exchange authority shall allow a health insurance issuer to offer a plan that provides limited scope dental benefits that meet the requirements of 26 U.S.C. 9832(c)(2)(A), either separately or in conjunction with

a qualified health plan, if the plan provides pediatric dental benefits that meet the requirements of 42 U.S.C. 18022.

(5) Neither the exchange authority nor an issuer offering health plans through the exchange authority may charge an individual a fee or a penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of 26 U.S.C. 36B(c)(2)(C).

NEW SECTION. **Section 8. Health plan certification.** (1) The exchange authority may certify a health plan as a qualified health plan if the plan:

(a) provides the essential health benefits package described in 42 U.S.C. 18022 and applicable state and federal regulations;

(b) provides at least a bronze level of coverage, as provided in [section 13], unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act for catastrophic plans, and is offered only to individuals eligible for catastrophic coverage;

(c) has cost-sharing requirements that do not exceed the limits established under 42 U.S.C. 18022. For a plan that is offered through the SHOP exchange, the deductible may not exceed the limits established under 42 U.S.C. 18022;

(d) is offered by a health insurance issuer who:

(i) is licensed to offer health insurance coverage in this state and is in good standing;

(ii) has received form and rate approval from the commissioner for the health plan as required by this title;

(iii) offers through the exchange at least one qualified health plan in the silver level and at least one plan in the gold level, as provided in [section 13], through each component of the exchange in which the issuer participates. For the purposes of this section, "component" refers to the SHOP exchange and the exchange for individual coverage.

(iv) offers at least one qualified health plan in the silver level and at least one plan in the gold level, as provided in [section 13], outside the exchange unless the issuer does not offer any health plans outside the exchange;

(v) charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange or outside the exchange;

(vi) does not charge any cancellation or termination fee or penalty in violation of [section 7]; and

(vii) complies with the regulations developed by the secretary under 42 U.S.C. 18031, applicable state law, and any other requirements that the exchange authority may establish.

(2) In addition to the requirements in subsection (1), a plan may be certified if the plan meets the requirements of certification set forth in the regulations promulgated by the secretary under 42 U.S.C. 18031, by rules adopted pursuant to [section 1 through 14], and by the exchange authority in its plan of operation and the exchange authority determines that making the health plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

(3) The exchange authority may not exclude a health plan:

(a) on the basis that the plan is a fee-for-service plan;

(b) through the imposition of premium price controls by the exchange authority; or

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

(4) The exchange authority shall require each health insurance issuer seeking certification of a plan as a qualified health plan to:

(a) submit a justification for any premium increase before implementation of that increase. The issuer shall prominently post the information justifying any premium increase on its internet website. The exchange authority shall use this information, along with information and recommendations provided to the exchange authority by the commissioner under 42 U.S.C. 300gg-94 and applicable state law, to help determine whether to allow the health insurance issuer to make plans available through the exchange.

(b) make the following disclosures available in the format described in subsection (5) to the public, the exchange authority, the secretary, and the commissioner in as accurate and as timely a manner as possible:

(i) claims payment policies and practices;

(ii) periodic financial disclosures;

(iii) data on enrollment;

(iv) data on disenrollment;

(v) data on the number of claims that are denied;

(vi) data on rating practices;

(vii) information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) information on enrollee and participant rights under Title I of the federal act and applicable state law; and

(ix) other information as determined appropriate by the exchange authority, the secretary, or the commissioner.

(5) The information required in subsection (4) must:

(a) be provided in plain language, as that term is defined in 42 U.S.C. 18031 and applicable state law; and

(b) include information for an individual to determine, in a timely manner upon the request of the individual, the cost to that individual of deductibles, copayments, coinsurance, and other cost-sharing required under an individual plan or coverage with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information must be made available to the individual through an internet website and through other means specified by the exchange authority for individuals without access to the internet.

(6) The exchange authority may not exempt any health insurance issuer seeking certification of a qualified health plan, regardless of the type or size of the issuer, from Montana licensure or solvency requirements and shall apply the criteria of this section in a manner that ensures equitable treatment for all health insurance issuers participating in the exchange.

NEW SECTION. **Section 9. Advisory committee.** (1) The commissioner, after consultation with the board, shall establish an advisory committee consisting of up to 15 representatives from the insurance industry, producer organizations, consumer advocacy groups, labor unions, employers, health care providers, and other interested parties.

(2) The advisory committee shall meet at least twice every calendar year and more often if requested by the commissioner or the board.

(3) The advisory committee may offer input regarding proposed rules, the plan of operation for the exchange authority, and any other topics relevant to the exchange.

(4) The advisory committee shall encourage public participation and comment, including written comments, which must be forwarded to the commissioner.

(5) The exchange authority may reimburse advisory committee members for their reasonable travel and per diem expenses.

NEW SECTION. **Section 10. Funding for exchange authority -- disclosure.** (1) The exchange authority shall charge assessment fees, as provided by rule, to all health insurance issuers authorized to do

business in this state as necessary to support its operations under [sections 1 through 14]. The assessment fees must be determined in consultation with the commissioner, and the amount of the assessment fees must be approved by the commissioner.

(2) Funding to operate the exchange authority must be obtained through federal and private grants and from assessment fees charged under subsection (1) to health insurance issuers. The exchange authority may not receive state funding.

(3) The exchange authority shall publish the following on an internet website to educate consumers on insurance costs and costs of the exchange authority:

(a) the average costs of licensing, regulatory fees, and any other payments required by the exchange authority;

(b) the administrative costs of the exchange authority; and

(c) information on money lost to waste, fraud, and abuse as related to health insurance and the operation of the exchange.

NEW SECTION. **Section 11. Annual reports -- research.** (1) In addition to the financial reports required under [section 4], the board shall examine the operations of the exchange authority and the demographics of the persons enrolled in the exchange and submit a written report to the governor, the commissioner, the president of the senate, the speaker of the house of representatives, and the secretary. The report must review:

(a) the operation and administration of the exchange authority. This information must include administrative costs, claims statistics, complaints data, and goals defined and achieved by the board, as well as any adverse selection trends that the exchange experienced during the preceding calendar year.

(b) surveys and reports regarding health plans available to eligible individuals. A report on experiences of health plans must include data on enrollees inside the exchange and enrollees purchasing health plans outside the exchange.

(c) any other significant observations regarding the market for employer group health insurance and individual health insurance on the exchange.

(2) The annual report required under this section must be filed on April 15 or the next business day if April 15 falls on a weekend. The first report is due on April 15, 2015.

(3) The board and the commissioner shall jointly research, investigate, and produce one or more reports

on the following topics by August 31, 2012:

(a) the feasibility of merging the nongroup and small group health insurance markets and risk pools, with an assessment of the resulting impact on premiums charged to individuals and small employer groups and recommendations on how to ease market disruption if that change is made;

(b) the feasibility of establishing a multistate exchange, along with an assessment of the effects of a multistate exchange on health insurers and health care consumers in Montana;

(c) strategies to reduce health care costs and an assessment of how implementation of those strategies would affect health care costs and health insurance premiums for exchange enrollees. The strategies must include but are not limited to encouraging the use of accountable care organizations and patient-centered medical homes.

(d) strategies to avoid adverse risk selection inside the exchange;

(e) the feasibility of establishing a basic health program as described in 42 U.S.C. 18051 for individuals whose income levels fall between 133% and 200% of the federal poverty level and the possible impact of establishing a basic health program on the exchange, the health insurance market, and consumers of health care in Montana;

(f) the feasibility of incorporating in the exchange certain government-sponsored health plans, such as the group benefit plans under Title 2, chapter 18, part 7 or 8 and the plans providing coverage for school district personnel, along with an assessment of the possible impact on the plans, the exchange, and the health insurance market in Montana;

(g) strategies to incorporate the role of insurance producers into the business of the exchange; and

(h) strategies to incorporate into the exchange the small business health insurance purchasing pool provided for in Title 33, chapter 22, part 20.

NEW SECTION. **Section 12. Employer health insurance exchange -- defined contribution arrangement.** (1) Beginning January 1, 2014, an eligible small employer may choose to participate in a defined contribution arrangement made available through the SHOP exchange.

(2) For the purposes of this section:

(a) "actuarial tier" means a level of coverage of platinum, gold, silver, or bronze, as defined in 42 U.S.C. 18022; and

(b) "defined contribution arrangement health benefit plan" or "defined contribution arrangement" means

an employer group health plan that is individually selected by an employee of a qualified employer and that is within the actuarial tier.

(3) An employer that chooses to participate in a defined contribution arrangement may not offer a major medical health benefit plan that is not a part of the defined contribution arrangement.

(4) In a defined contribution arrangement, the employer determines the employer contribution amount, which must comply with any applicable rules adopted by the commissioner and plan of operation adopted by the exchange authority. The contribution must be an equivalent amount for all eligible employees. Once chosen, the contribution amount may not be changed except at the 12-month renewal date or at the beginning of the next plan year for that group health plan.

(5) An employer that chooses to establish a defined contribution arrangement for the purpose of providing a health plan for its employees shall:

(a) establish a procedure by which its employees may use pretax dollars to purchase a health plan from the exchange authority. The options may include:

(i) the mechanism offered by the exchange authority;

(ii) a health reimbursement arrangement, as defined by the commissioner by rule;

(iii) a cafeteria plan, as defined in 26 U.S.C. 125; or

(iv) another plan or arrangement similar to a health reimbursement arrangement or cafeteria plan that similarly allows a portion of premiums to be excluded or deducted from gross income under the Internal Revenue Code;

(b) choose a default plan for employees who do not exercise their right to choose a defined contribution arrangement; and

(c) inform each employee of the following at least 60 days before the end of the plan year or the 12-month renewal date of the group health insurance coverage:

(i) the employer's decision to offer the defined contribution arrangement;

(ii) the contribution to premiums that the employer will make toward the purchase of health insurance for the employee and any dependents;

(iii) the actuarial tier chosen by the employer; and

(iv) the choice available to each employee of any health plan offered by the exchange authority that is within the actuarial tier chosen by the employer.

(6) (a) The employer shall notify the employee that, unless the employee indicates otherwise as provided

in subsection (6)(b), the employer will enroll the employee and any dependents of the employee in the default plan selected by the employer and initiate payroll deductions for premium payments.

(b) An employee shall notify an employer prior to 30 days before the end of the plan year or the 12-month renewal date if:

(i) the employee has selected a different health plan offered through the exchange within the actuarial tier chosen by the employer;

(ii) the employee has coverage from another health plan, for which the employee shall provide proof of coverage to the employer; or

(c) the employee specifically declines coverage in a health plan.

(7) A health insurance issuer who offers health plans to small employers through the exchange may not:

(a) establish an employer minimum contribution level for an employer participating in a defined contribution arrangement; or

(b) impose a minimum employee participation percentage requirement on small employers choosing the defined contribution arrangement.

(8) A health insurance issuer that offers coverage to small employers through the SHOP exchange shall:

(a) issue coverage to small employer groups that choose the defined contribution arrangement; and

(b) accept premium payments for an enrollee from multiple sources, including multiple employers.

(9) For employer group health plans that are subject to a collective bargaining agreement, any obligation in the collective bargaining agreement must be maintained, including but not limited to the level of an employer's contribution toward premium payment, enrollment thresholds, composite-rate premium, and the provision of other group benefits.

NEW SECTION. **Section 13. Health plan design requirements -- benefit categories.** (1) All health insurance issuers participating in the exchange shall offer at least one gold plan and one silver plan, as described in 42 U.S.C. 18022, both inside and outside the exchange, unless the health insurance issuer does not operate outside the exchange.

(2) A health insurance issuer participating in the exchange may offer in the individual health insurance market and in the small employer group health insurance market up to three different plan designs in each of the benefit categories of platinum, gold, silver, bronze, and catastrophic, as described in 42 U.S.C. 18022.

(3) (a) Except as provided in subsection (3)(b), if a health insurance issuer offers a bronze plan, which

is a plan with an actuarial value of 60% or less, or a catastrophic plan to individuals or small employer groups outside the exchange, the health insurance issuer shall also offer at least one qualified health plan inside the exchange that is substantially similar.

(b) The provisions of subsection (3)(a) do not apply if the exchange authority refuses to certify any health plans that meet the requirements of [section 8] as qualified to be offered inside the exchange.

(4) (a) All health insurance issuers that participate in the exchange and offer individual or small employer group preferred provider organization health plans, other plans with incentives for using particular networks of providers, or managed care plans outside the exchange shall also offer those network-based plans inside the exchange.

(b) Health insurance issuers described in subsection (4)(a) shall comply with the network adequacy rules promulgated under Title 33, chapter 36, part 2, or any network adequacy rules for preferred providers adopted by the commissioner pursuant to 33-22-1707 for plans issued both inside and outside the exchange.

(c) Health insurance issuers shall use the same network of providers for health plans that they offer inside the exchange for the health plans offered outside the exchange.

NEW SECTION. **Section 14. Relation to other laws.** (1) An action taken by the exchange pursuant to [sections 1 through 14] may not be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this state.

(2) Unless expressly provided to the contrary in [sections 1 through 14], all health insurance issuers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

NEW SECTION. **Section 15. Codification instruction.** [Sections 1 through 14] 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 14].

NEW SECTION. **Section 16. Effective date.** [This act] is effective July 1, 2011.

- END -