

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

*** Bill No. ***

Introduced By *****

By Request of the State Auditor

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE
CREATION OF A MONTANA HEALTH INSURANCE EXCHANGE AUTHORITY;
PROVIDING FOR RULEMAKING AUTHORITY; PROVIDING AN EFFECTIVE
DATE."

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

NEW SECTION. **Section 1. Establishment of the Montana
Health Insurance Exchange Authority.** (1) There is
established an entity known as the Montana Health Insurance
Exchange Authority, which shall be a quasi-governmental
entity, subject to the supervision of the Montana State
Auditor, Commissioner of Insurance. The exchange authority
shall be governed by an appointed board. The exchange
authority board shall implement and direct the activities
of the Montana Health Insurance Exchange Authority, whose
purpose is to create and administer a state-based exchange,
as described in Section 1311 of the Public Health Service
Act and [this part]. The exchange authority will facilitate
the availability, choice and adoption of private health

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

insurance plans to eligible individuals and groups as described in this part and in the applicable federal law.

(2) The exchange authority shall make individual and small employer group coverage available to Montana residents no later than January 1, 2014.

(3) The Montana Health Insurance Exchange Authority shall be established as a nonprofit corporation.

(3) Open meeting laws and the public's right to know as guaranteed in the Montana constitution and in Title 2 shall apply to this entity.

NEW SECTION. **Section 2. Montana Health Insurance Exchange Authority-definitions.** As used in this part, the definitions in 33-22-140 and the following definitions apply:

(1) "Board" means the board of directors of the Montana Health Insurance Exchange Authority, as provided for in [section 3].

(2) "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

(3) "Exchange authority" or "exchange" means the Montana Health Insurance Exchange Authority.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

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

(5) "Qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered in the small group market through the exchange provided that the employer:

(a) Has its principal place of business in this state and elects to provide coverage through the exchange to all of its eligible employees, wherever employed; or

(b) Elects to provide coverage through the exchange to all of its eligible employees who are principally employed in this State.

(6) "Qualified health plan" means a health plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Public Health Service Act and [section 8 of this Act.]

(7) "Qualified individual" means an individual who:

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(a) Is seeking to enroll in a qualified health plan in the individual market offered through the exchange; and

(b) Resides in this state.

(c) "Qualified individual" does not include an individual:

(i) If, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges; or

(ii) If, the individual is not, or is not reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

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

(9) "SHOP Exchange" means the Small Business Health Options Program established under [section 6 of this Act].

(10) "Small employer" means an employer that employed an average of one to not more than 100 employees during the preceding calendar year.

(a) For purposes of this subsection:

(i) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

Internal Revenue Code of 1986 shall be treated as a single employer;

(ii) An employer and any predecessor employer shall be treated as a single employer;

(iii) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(iv) An employer that makes enrollment in qualified health plans offered in the small group market available to its employees through the exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of [this Act] as long as it continuously makes enrollment in qualified health plans available to its employees.

(11) "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

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 and two nonvoting members serving 3-year staggered terms and appointed in the following manner:

(a) four directors must be appointed by the commissioner, one of whom must have specialized knowledge regarding health insurance and health care financing issues, one of whom must be a certified actuary, one of whom must be a representative of the business community with significant experience in health plans, and one of whom must be a representative of a health-related consumer advocacy organization with significant experience in health care financing issues; and

(b) three directors must be appointed by the governor, one of whom must be the director or the assistant director of the state employee health benefit plans, one of whom must be the deputy director in charge of the Medicaid division; one of whom must be a representative of a health-related consumer advocacy organization with significant experience in health care financing issues.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(2) Each director is entitled to one vote on the board.

(3) No appointee may be an employee of, a consultant to, a member of a board of directors of, affiliated with, have an ownership interest in, or otherwise 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, while serving on the board or on the staff of the exchange.

(4) The commissioner and the governor shall each appoint a representative from their respective staffs who has experience in health insurance and health care issues to participate in all board meetings as nonvoting members.

(5) The directors must be compensated and receive travel expenses in the same manner as members of the quasi-judicial boards under 2-15-124(7). The costs of conducting the meetings of the exchange authority board must be borne by the exchange authority.

(6) A board director or member must be replaced in the same manner as the original appointment if that board member or director resigns or is not actively participating in the affairs of the board. An individual appointed to

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

fill a vacancy shall serve only for the unexpired term, unless reappointed.

(7) Initial board appointments must be made no later than July 1, 2011.

(8) The board shall meet at least ten times every year, beginning August 2011.

NEW SECTION. **Section 4. Exchange authority staff.** (1)

The board shall hire an executive director to supervise the administrative affairs, general management and operations of the exchange authority and also serve as secretary of the exchange authority, ex officio. The executive director shall receive a salary commensurate with the duties of the office.

(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;

(c) Report to the board on all operations under his or her control and supervision;

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(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 this part.

NEW SECTION. **Section 5. Powers and duties of the commissioner--rules.** (1) The commissioner shall:

(a) Adopt rules necessary to implement the provisions of [this Act];

(b) Approve or disapprove the plan of operation that the board proposes;

(c) Develop a uniform health insurance application form and require its use, both inside and outside the exchange;

(d) Approve or disapprove the assessment fees that board proposes to impose for the purpose of paying for the ongoing administration of the exchange; and

(e) Conduct periodic audits of the financial transactions of the exchange authority.

NEW SECTION. **Section 6. General requirements for the exchange authority.** (1) The exchange shall:

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(a) Facilitate the purchase and sale of qualified health plans;

(b) Provide for the establishment of a SHOP Exchange that is designed to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market in this State; and

(2) The exchange shall meet the requirements of [this Act] and any administrative rules implemented under [this Act].

(3) The exchange may contract with an eligible entity for any of its functions described in [this Act], not otherwise delegated to the commissioner or the board. An eligible entity includes, but is not limited to, the Montana department of public health and human services or an entity that has experience in the individual and small group markets, but a health insurance issuer is not an eligible entity.

(4) The exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.

(5) The exchange shall not make available any health plan that is not a qualified health plan.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(6) The exchange shall allow a health insurance issuer to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(7) The exchange may make a qualified health plan available notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the federal act and applicable federal regulations.

NEW SECTION. Section 7. Powers and duties of the exchange authority board. (1) The board shall, according to the provisions of [this Act], applicable administrative rules and federal statute and regulations:

(a) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the federal act and applicable state law, of health plans as qualified health plans;

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

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

(c) Provide for enrollment periods, as determined by the Secretary under section 1311(c)(6) of the federal act and applicable state law;

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

(e) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under section 1311(c)(3) of the federal act and applicable state law;

(f) Utilize a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act and applicable state law;

(g) In accordance with section 1413 of the federal act and applicable state law, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

Security Act or any applicable state or local public program and if through screening of the application by the exchange, the exchange determines that any individual is eligible for any such program, enroll that individual in that program;

(h) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the federal act;

(i) Establish a SHOP Exchange through which individuals employed by qualified employers may enroll in any qualified health plan offered through the SHOP Exchange at the level of coverage specified by the employer;

(j) Subject to section 1411 of the federal act and applicable state law, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

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

(ii) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(k) Transfer to the federal secretary of the treasury the following:

(i) A list of the individuals who are issued a certification under subsection (1)(j), 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 tax credit under section 36B of the Internal Revenue Code of 1986 because:

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

(B) The employer provided the minimum essential health benefits coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(iii) The name and taxpayer identification number of:

(A) Each individual who notifies the exchange under section 1411(b)(4) of the federal act that he or she has changed employers; and

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

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

(m) Perform duties required of, or delegated to, the exchange by the secretary, the secretary of the treasury or the commissioner related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

(n) Select entities qualified to serve as navigators in accordance with section 1311(i) of the federal act and applicable state law and award grants to enable navigators to:

(i) Conduct public education activities to raise awareness of the availability of qualified health plans;

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(ii) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the federal act;

(iii) Facilitate enrollment in qualified health plans;

(iv) Provide referrals to the office of health insurance consumer assistance established under section 2793 of the Public Health Service Act and the office of the commissioner of insurance or any other appropriate state agency, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

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

(o) In consultation with the commissioner, review the rate of premium growth within the exchange and outside the exchange;

(p) 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 section 10108 of

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

the federal act, and collect the amount credited from the offering employer;

(q) Consult with stakeholders relevant to carrying out the activities required under [this Act], including:

(i) Educated health care consumers who are enrollees in qualified health plans;

(ii) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(iii) Representatives of small businesses and self-employed individuals;

(iv) The Montana department of health and human services;

(v) The insurance commissioner; and

(vi) Advocates for enrolling hard-to-reach populations.

(r) Seek and receive federal grants available pursuant to Section 1311 of the Public Health Service Act and other grant funding available from private or government sources;

(s) Pursuant to applicable state law, and in coordination with the commissioner, assess fees equitability among all health insurance issuers doing business in Montana;

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(i) limit assessment fees to the minimum amount necessary to pay for the administrative costs and expenses incurred in the operation of the exchange authority; and

(ii) annually report its administrative expenses to the commissioner, so that the assessment fees are accurately reflected in the applicable administrative rule.

(t) Adopt by-laws for the regulation of its affairs and the conduct of its business;

(u) Develop a plan of operation that includes procedures and criteria detailing the implementation of the activities and duties assigned to the exchange authority pursuant to [this Act] and applicable federal law.

(v) Maintain an office within the state of Montana at such place or places as it may designate;

(w) Require qualified plans to provide information and make disclosures required by state and federal law to their enrollees;

(x) Keep an accurate accounting of all expenditures and submit quarterly financial reports to the commissioner;

(y) Submit all reports required by the secretary;

(z) Require qualified health plans to implement activities to reduce health disparities, including the use

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

of language services, community outreach, and cultural competency training for their employees;

(aa) Assist in the implementation of reinsurance and risk adjustment mechanisms, as required by state and federal law;

(bb) Publicize the existence of the exchange, the exchanges 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 Section 125 cafeteria plans for use by employers participating in the exchange;

(ee) Establish a "defined contribution" program as described in [section 12], as one option for qualified small employers wishing to participate in the shop exchange;

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

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(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 healthcare and new innovations in healthcare delivery systems that promote efficiency, curb healthcare costs, provide value to healthcare consumers;

(ii) Develop strategies that encourage the participation of health insurance issuers in the exchange, including cooperatives and multi-state plans, 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 by participating carriers, employers, or organizations; and

(c) Enter into agreements with other 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 [this Act] provided

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

such 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 of aggregating all monies paid as tax credits, premium subsidies and premium payments made by, or on behalf of, individuals obtaining coverage through the exchange, including any premiums payments made by enrollees, employees, unions or other organizations and paying those monies to the health insurance issuer.

NEW SECTION. **Section 8. Health Plan Certification.**

(1) The exchange may certify a health plan as a qualified health plan if:

(a) The plan provides the essential health benefits package described in section 1302(a) of the federal act, 33-22-140, and applicable state and federal regulations;

(b) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(c) The health insurance issuer offering the plan:

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

(ii) Has received form and rate prior approval from the commissioner for that health plan as required by statute;

(iii) Offers at least one qualified health plan in the silver level and at least one plan in the gold level in the exchange;

(iv) Offers at least one qualified health plan in the silver level and at least one plan in the gold level 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; and

(vi) Complies with the regulations developed by the Secretary under section 1311(d) of the federal act, applicable state law and such other requirements as the exchange may establish.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(2) (a) The health plan meets the requirements of certification as promulgated by regulation by the secretary under section 1311(c)(1) of the federal act, applicable state law and by the exchange; and

(b) The exchange 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 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; or

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

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

(i) Submit a justification for any premium increase before implementation of that increase. The issuer shall prominently post the information on its Internet website.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

The exchange shall take this information, along with the information and the recommendations provided to the exchange by the commissioner under section 2794(b) of the Public Health Service Act and applicable state law, into consideration when determining whether to allow the issuer to make plans available through the exchange;

(ii) Make available to the public, in the format described in subsection (5), and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of the following:

- (A) Claims payment policies and practices;
- (B) Periodic financial disclosures;
- (C) Data on enrollment;
- (D) Data on disenrollment;
- (E) Data on the number of claims that are denied;
- (F) Data on rating practices;
- (G) Information on cost-sharing and payments with respect to any out-of-network coverage;
- (H) Information on enrollee and participant rights under Title I of the federal act and applicable state law; and
- (I) Other information as determined appropriate by the secretary, the exchange or the commissioner.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

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

(a) Be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the federal act and applicable state law; and

(b) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

NEW SECTION. **Section 9. Advisory committee.** (1) The commissioner, in consultation with the board, may 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. The advisory committee will meet when requested by the commissioner or the board.

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

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

(3) Public participation and comment, including written comments, must be encouraged by the committee.

NEW SECTION. **Section 10. Funding for the exchange authority--disclosure.** (1) The exchange shall charge an assessment fee, as allowed by rule and in coordination with the commissioner, to all health insurance issuers authorized to do business in this state, as necessary to support its operations provided under [this Act].

(2) Funding to operate the Montana Health Insurance Exchange Authority will come from federal and private grants and from assessment fees charged to health insurance issuers. No state funding will be allocated to the exchange authority.

(3) The exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the exchange, and the administrative costs of the exchange, on an Internet website to educate consumers on

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

such costs. This information shall include information on monies lost to waste, fraud and abuse.

NEW SECTION. **Section 11. Annual reports required-**

issues to be researched. (1) Every year, the board shall examine the operations of the exchange and the demographics of the persons enrolled in the exchange and submit a written "exchange report" to the governor, the commissioner, the president of the senate, the speaker of the house of representatives, and the secretary. The exchange report must review:

(a) The operation and administration of the exchange, including surveys and reports of health plans available to eligible individuals and the experience of the plans.

(b) The experience of the plans shall include data on enrollees inside the exchange and enrollees purchasing health plans outside the exchange;

(c) The operation and administration of the exchange authority, including administrative costs, claims statistics, complaints data, and goals defined and achieved by the board; and

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(d) Any other significant observations regarding the utilization of the individual and the employer group health insurance exchange.

(2) The first exchange report will be due on April 15, 2015 and annually on that date thereafter.

(3) The board and the commissioner will jointly research, investigate and produce one or more reports on the following topics by August 2012:

(a) feasibility of merging the non-group and small group health insurance markets and risk pools, and the resulting impact on premium charged to individuals and small employer groups;

(b) feasibility of establishing a multi-state exchange and the effects of a multi-state exchange on health insurers and health care consumers in Montana;

(c) development of strategies to reduce health care costs, such as encouraging the use of accountable care organizations and the medical home model, and the effect of such changes on health care costs and health insurance premiums for exchange enrollees;

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

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(e) feasibility of a establishing a "basic plan" as described in the federal act for individuals whose income levels fall between 133% and 200% of the federal poverty level and the possible impact of such a plan on the exchange, the health insurance market and consumers of health care in Montana;

(f) feasibility of incorporating certain government sponsored health plans, such as the state employee plan and the school district plans, in the exchange and the possible impact on those plans, the exchange, and the health insurance market in Montana; and

(g) development of strategies to incorporate the Insure Montana program into the exchange.

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

(2) Defined contribution arrangement health benefit plans are employer group health plans individually selected by an employee of an employer, within the "actuarial tier"

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

of platinum, gold, silver or bronze (as defined in the federal act) selected by the employer.

(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) The employer determines the contribution amount, which must be a percentage of the premium. The range of allowed percentages will be established in rule. The percentage chosen must be the same for all eligible employees. The contribution percentage chosen may not be changed, except at the 12-month renewal date (or 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 mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the exchange authority, which may include:

- (i) the mechanism offered by the exchange authority;
- (ii) a health reimbursement arrangement, as defined in federal law;

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

(iii)a Section 125 cafeteria plan, as defined in federal law;

(iv) another plan or arrangement similar to (ii) or (iii), which is excluded or deducted from gross income under the Internal Revenue Code;

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

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

(i) That the employer has chosen the defined benefit contribution option;

(ii) The percentage of premium that the employer will contribute toward the purchase of health insurance for the employee and any dependents;

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

(iv) That each employee has a choice of any health benefit plan offered by the exchange authority, within the actuarial tier chosen by the employer.

(8) The employer must notify the employee that the employee and any dependents of the employee will be enrolled in the default plan selected by the employer and

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

payroll deductions will be initiated for premium payments, unless the employee, prior to 30 days before the end of the plan year (or the 12-month renewal date):

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

(b) Provides proof of coverage from another health benefit plan; or

(c) Specifically declines coverage in a health benefit plan.

(9) 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 the defined contribution plan;

(b) Impose a minimum employee participation percentage requirement on small employers choosing the defined benefit contribution option.

(10) A health insurance issuer that offers coverage to small employers through the exchange must:

(a) Issue coverage to small employer groups that choose the defined contribution option; and

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

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

NEW SECTION. **Section 13. Health plan design**

requirements inside the exchange—outside the exchange. (1)

Each health insurance issuer wishing to participate in the exchange may offer up to three different plan designs in each of the following benefit categories: platinum, gold, silver, and bronze (as defined in the federal act) in individual health insurance market and in the small employer group health insurance market.

(2) All issuers participating in the exchange must offer at least one gold plan and one silver plan, both inside and outside the exchange, unless the issuer does not operate outside the exchange.

(3) If the issuer offers a bronze plan or a plan with an actuarial value of 60% or less to individuals or small employer groups outside the exchange, it must also offer at least one substantially similar "qualified" bronze plan option inside the exchange.

(4) (a) All health insurance issuers that participate in the exchange and offer individual or small employer group preferred provider organization (PPO) health plans,

CD-ROM Draft Copy

Last printed 9/29/2010 4:05:00 PM
exchangebill(3)edited.docx

other plans with incentives for using particular networks of providers, or managed care plans outside the exchange, must also offer such network-based plans inside the exchange.

(b) Health insurer issuers must comply with the network adequacy rules promulgated under chapter 36, Part 2, or the network adequacy rules for PPOs that the commissioner shall adopt pursuant to 33-22-1707 for plans issued both inside and outside the exchange.

(c) Health insurance issuers must use the same network of providers for their health plans offered inside and outside the exchange.

NEW SECTION. **Section 14. {standard} Effective date.**

[This act] is effective July 1, 2011.

-END-