

HEALTH INSURANCE EXCHANGE

SECTION 1. ESTABLISHING THE EXCHANGE AUTHORITY

- Establishes the exchange authority as a quasi-governmental entity under the supervision of the insurance commissioner. The exchange authority will be governed by an appointed board and will be incorporated as a nonprofit corporation. Open meeting laws and the public's right to know apply to this entity.

SECTION 3. BOARD OF DIRECTORS

- The board of directors consists of 7 directors appointed for 3-year, staggered terms plus 2 non-voting members and one legislative liaison. Three board members will be appointed by the commissioner and must have specialized knowledge regarding health care financing, including one person with an actuarial background and one member of the business community. Four board members will be appointed by the governor, including the director of the state employee health benefit plan, the Medicaid director, one consumer advocate and one union representative.
- Each appointment is subject to confirmation by the senate.
- No board member may be affiliated in any way with a health insurance issuer or insurance producer organization.
- Initial board appointments must be made by July 1, 2011.

SECTION 4. POWERS AND DUTIES OF THE EXCHANGE AUTHORITY BOARD

- The board is charged with 36 separate duties. These include certifying qualified plans, rating health insurers, establishing a web portal and toll-free phone number, and making initial eligibility determinations for assistance programs and federal tax credits. Other powers and duties include creating an administrative structure by drafting a plan of operation, assessing fees on participating insurers, adopting bylaws, creating reports, advertising the exchange, and interacting with state and federal agencies.
- In addition, the board is instructed to explore ways to ease enrollment for small employers, encourage plan designs that reduce health care costs and promote disease prevention, establish guidelines for the role of producers in the exchange, and encourage participation of additional health insurers.

HEALTH INSURANCE EXCHANGE

SECTION 5. EXCHANGE AUTHORITY STAFF

- The board will hire and set forth the duties of the executive director and any additional professional staff.
- The staff will not be state employees.

SECTION 6. POWERS AND DUTIES OF THE COMMISSIONER

- The commissioner will adopt rules necessary to implement the provisions of this part. The commissioner will also approve or disapprove the plan of operation proposed by the board and the assessment fees that board will impose on insurers; develop a uniform health insurance application; and conduct periodic financial and performance audits of the exchange authority.

SECTION 7. GENERAL REQUIREMENTS FOR THE EXCHANGE AUTHORITY

- The exchange shall facilitate the purchase and sale of qualified health plans, establish a SHOP exchange, and begin making plans available on January 1, 2014.

SECTION 8. HEALTH PLAN CERTIFICATION

- The exchange may certify a health plan if the plan provides the essential health benefits package and offers at least a bronze or catastrophic level of coverage.
- The health insurer offering coverage must be licensed and in good standing in Montana, must receive rate and form approval for the plan, must offer at least silver and gold levels of coverage, must offer the same premium inside and outside the exchange, and must comply with all state and federal laws.

SECTION 9. ADVISORY COMMITTEE

- The commissioner and the board shall create an advisory committee consisting of up to 15 members, including stakeholders from the insurance industry, health care providers, consumer advocates and other stakeholders. The advisory committee will provide input to the board and the commissioner on issues such as the plan of operation and proposed administrative rules.

HEALTH INSURANCE EXCHANGE

SECTION 10. FUNDING FOR THE EXCHANGE AUTHORITY

- Specifies the funding required to operate the exchange authority will come from fees on health insurers and federal and private grants. No state funding will be used.

SECTION 11. ANNUAL REPORTS— RESEARCH

- Beginning in April 2015, the board is required to produce a written report to the governor, the commissioner and legislature detailing the status of the operation of the exchange, including, health plans available, experience of the plans, plan rates, administrative costs, complaints against the exchange, utilization of the exchanges, and other information.
- In August 2012, the board and the commissioner will jointly produce reports that examine topics relevant to making the exchange successful including the feasibility of merging the individual and small group market in 2014, the possibility of a multi-state exchange, and strategies to avoid adverse selection inside the exchange and others.

SECTION 12. EMPLOYER HEALTH INSURANCE EXCHANGE- DEFINED CONTRIBUTION

- A plan similar to the Utah defined contribution plan is proposed as an option for employers as a way to encourage enrollment in the small employer group exchange. A defined contribution plan allows employers or multiple employers of a single individual to contribute a defined amount to a plan that is selected by the employer or employee.

SECTION 13. HEALTH PLAN DESIGN REQUIREMENTS INSIDE AND OUTSIDE THE EXCHANGE

- Limits the number of plan designs that an insurer can offer inside the exchange to 3 in each tier. And, requires that insurers that are required to offer a silver and a gold plan inside the exchange, must also offer a silver and a gold plan outside the exchange, unless the insurer does not operate outside the exchange. Also requires insurers that offer a bronze plan or catastrophic plan outside the exchange to also offer a bronze plan or catastrophic plan inside the exchange.