HOUSE BILL NO. 620

INTRODUCED BY T. BERRY

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

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

NEW SECTION. **Section 1. Establishment of treasure state health gateway -- purpose -- operation.** (1) There is established a quasi-governmental entity known as the treasure state health gateway or health gateway. The health gateway shall incorporate as a nonprofit corporation as provided in Title 35, chapter 2.

(2) The purpose of the health gateway is to:

(a) create and administer a state-based health gateway, as provided for under the federal act;

(b) establish an individual health gateway to facilitate the availability, choice, and adoption of private health insurance plans to eligible individuals as described in [sections 1 through 13] and in the applicable sections of the federal act;

(c) establish a SHOP health gateway intended to assist qualified employers in facilitating the enrollment of their employees in qualified health plans and to facilitate the availability, choice, and adoption of private health insurance plans to eligible groups as described in [sections 1 through 13] and in the applicable sections of the federal act;

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

(e) implement the requirements of [sections 1 through 13], any rules adopted pursuant to [section 5], and any applicable federal statutes or regulations.

(3) The health gateway must be governed by a board appointed as provided in [section 3]. The board shall implement and direct the activities of the health gateway as provided in [sections 1 through 13].

(4) The health gateway 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 health gateway to coordinate eligibility systems in order to create a single point of entry for health gateway 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 13], the following definitions apply:

(1) "Board" means the board of directors of the treasure state health gateway.

(2) "Essential health benefits" means those benefits described in section 1302(b) of the federal act, and regulations adopted by the secretary pursuant to that section.

(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) "Health insurance issuer" means an insurer, a health service corporation, a consumer operated and oriented plan established under 42 U.S.C. 18042, or a health maintenance organization that is licensed in this state.

(5) "Navigator" has the same meaning as described in the federal act. Navigators who actively sell, solicit, facilitate, or negotiate enrollment in particular health plans are subject to all Montana licensing laws that pertain to insurance producers pursuant to Title 33, chapter 17.

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

(7) (a) "Qualified employer" means a private or a public small employer that offers health insurance or makes health insurance available pursuant to a collective bargaining agreement to its full-time employees, or at the employer's option to some or all of its part-time employees, eligible for one or more qualified health plans

offered through the SHOP health gateway.

(b) To provide coverage through the SHOP health gateway, one of the following conditions must apply:

(i) 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

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

(8) "Qualified health plan" means a health plan that has been certified as provided in [section 7].

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

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

(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, a national of the United States, as defined in 8 U.S.C. 1101, or an alien lawfully present in the United States.

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

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

(12) (a) (i) "Small employer" means an employer that employed an average of at least 2 but not more than 50 employees during the preceding calendar year, except as provided in subsection (12)(a)(ii). For the purposes of this subsection (12)(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 health gateway 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 13] as long as that employer continuously makes enrollment through the SHOP health gateway available to its employees.

NEW SECTION. **Section 3. Board of directors -- composition -- appointment -- compensation.** (1) There is a board of directors of the health gateway consisting of nine directors appointed for 3-year, staggered terms, plus three nonvoting members and two nonvoting legislative liaisons.

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

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

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

(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 health gateway; and

(d) one must be a consumer eligible to purchase coverage in the individual market health gateway with significant experience in health care financing or health care access.

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

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

(b) one must be a representative of a union eligible to participate in the SHOP health gateway who has significant experience in health insurance plans; and

(c) one must be a representative of the medical community with specialized knowledge regarding health care access.

(4) The president of the senate and the speaker of the house shall jointly appoint two voting directors, one of which must be a representative of a health insurance issuer.

(5) The administrator of plans for group benefits provided in Title 2, chapter 18, part 8, shall serve as an ex officio nonvoting member of the board.

(6) The state medicaid director overseeing the state programs under Title 53, chapter 6, part 1, shall serve as an ex officio nonvoting member of the board.

(7) Directors may be reappointed.

(8) The board may vote to remove a director if that director is not actively participating in the affairs of the board.

(9) A board vacancy must be filled in the same manner as the original appointment.

(10) While serving on the board, a director, other than a health insurer director and insurance producer 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.

(11) The commissioner shall appoint a nonvoting member to participate in all board meetings as a representative of the commissioner.

(12) The president of the senate shall appoint one member of the senate and the speaker of the house shall appoint one member of the house to be nonvoting liaisons to the board.

(13) (a) Except as provided in subsection (13)(c), the costs of conducting meetings of the health gateway board are costs of the health gateway 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 liaisons 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.

(14) Board appointments must be made no later than June 1, 2011.

(15) The board shall meet at least quarterly, beginning in June 2011.

NEW SECTION. **Section 4. Powers and duties of board.** (1) (a) The board shall hire an executive director to supervise the administrative affairs, general management, and operations of the health gateway. The executive director shall also serve as ex officio secretary of the health gateway. Any of the duties identified in subsections (2) and (3) may be delegated by the board to health gateway staff.

(b) An employee of the health gateway staff, including the executive director:

(i) may not simultaneously be an employee of, a consultant to, a member of a board of directors of, affiliated with, have an ownership interest in, or otherwise be a representative of:

(A) any health insurance issuer, insurance producer agency, insurance consultant organization, trade association of insurers, or association offering health insurance coverage to its members;

(B) a union eligible to participate in the SHOP health gateway; or

(C) a health-related consumer advocacy organization;

(ii) may not be otherwise involved in or associated with the health care industry; and

(iii) must be paid and receive benefits, as determined by the board of directors. Health gateway staff are not state employees.

(2) In accordance with the federal act, other applicable federal statutes and regulations, and other rules adopted under this title, the board shall:

(a) implement procedures for the certification of health plans as qualified health plans and their recertification or decertification consistent with 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 and maintain an office in this state at any place it may designate;

(c) provide for enrollment periods, as set out under 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 health gateway in accordance with 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 regulations issued by the secretary under 42 U.S.C. 18022;

(g) use a standardized format for presenting health benefit options in the health gateway, including the use of the uniform outline of coverage as established under 42 U.S.C. 300gg-15 and 33-22-244 and 33-22-521;

(h) inform individuals in accordance with 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 health gateway for eligibility for one of the public programs listed in subsection (2)(h) and facilitate enrollment of any individual who the Montana department of public health and human services determines to be eligible;

(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 not an affordable qualified health plan available through the health gateway or the individual's employer for covering the individual; or

(ii) the individual meets the requirements for another 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 (2)(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 health gateway 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 (2)(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 health gateway through which a qualified employer:

(i) may access coverage options for its eligible employees; and

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

(o) perform duties required of the health gateway by the secretary or the United States secretary of the treasury 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 and standards developed by the secretary; 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) 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

(D) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the health gateway;

(q) accept all appropriately licensed health insurance producers who apply to sell plans and facilitate enrollment within both the individual health gateway and the SHOP health gateway;

(r) compensate licensed health insurance producers for any plan or plans that they sell within the individual health gateway or the SHOP health gateway;

(s) review information regarding the rate of premium growth within the health gateway and outside the health gateway in consultation with the commissioner;

(t) 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;

(u) consult with the advisory committee described in [section 8];

(v) meet the following financial integrity requirements:

(i) keep an accurate accounting of all health gateway 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 are accurately reflected in the operation of the health gateway.

(ii) provide an independently audited financial statement to 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 to the secretary's authority under the federal act and allow the commissioner or the secretary, in coordination with the inspector general of the U.S. department of health and human services, to:

(A) investigate the affairs of the health gateway;

(B) examine the properties and records of the health gateway; and

(C) require periodic reports in relation to activities undertaken by the health gateway as provided in [section 10]; and

(iv) in carrying out its activities under [sections 1 through 13], prohibit the use of funds for a purpose other than administrative and operational expenses of the health gateway. 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.

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

(x) develop a plan of operation that includes procedures and criteria detailing the implementation of the activities and duties assigned to the health gateway under [sections 1 through 13] and the federal act;

(y) 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;

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

(aa) encourage the use of cafeteria plans, defined in 26 U.S.C. 125 and also known as "125 plans", by employers participating in the health gateway;

(bb) develop strategies to ensure the viability of the health gateway by minimizing adverse risk selection inside and outside the health gateway.

(3) The board may:

(a) borrow money;

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

(c) 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 health gateway, 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. Powers and duties of commissioner -- rules.** (1) The commissioner shall:

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

(b) conduct periodic financial and performance audits of the health gateway; and

(c) adopt rules necessary to implement the provisions of [sections 1 through 13].

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

NEW SECTION. **Section 6. General requirements for health gateway.** (1) The health gateway shall act to implement the purposes described in [section 1].

(2) (a) The health gateway may contract with an eligible entity for any of the functions assigned to the health gateway under [sections 1 through 13] and not otherwise delegated to the commissioner or the board.

(b) 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.

(3) (a) The health gateway shall make available to qualified individuals and qualified employers a qualified health plan that has an effective date on or after January 1, 2014.

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

(4) The health gateway shall allow a health insurance issuer to offer a plan that provides limited scope vision benefits or 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 health gateway nor a health insurance issuer offering health plans through the health

gateway may charge an individual a fee or a penalty for termination of coverage if the individual enrolls in another type of minimum essential health benefits 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 7. Health plan certification.** (1) The health gateway 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;

(b) provides at least a bronze level of coverage, as provided in [section 11], 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 health gateway, 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 approval from the commissioner for the health plan as required by this title and has submitted premium rates for review pursuant to state law;

(iii) offers through the health gateway at least one qualified health plan in the silver level and at least one plan in the gold level, as provided in [section 11], through each component of the health gateway in which the issuer participates. For the purposes of this subsection (1)(d)(iii), "component" refers to the SHOP health gateway and the health gateway 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 12], outside the health gateway unless the issuer does not offer any health plans outside the health gateway;

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

(vi) does not charge any cancellation or termination fee or penalty in violation of [section 6]; and

(vii) complies with the regulations developed by the secretary under 42 U.S.C. 18031, rules adopted by the commissioner pursuant to [section 5], and any other operational and procedural requirements that the health

gateway may establish.

(2) The health gateway 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 health gateway; or

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

(3) The health gateway 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 health gateway shall use this information, along with information and recommendations provided to the health gateway 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 health gateway.

(b) make the following disclosures available in the format described in subsection (5) to the public, the health gateway, 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 health gateway enrollment;

(iv) data on health gateway 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 secretary.

(4) The commissioner, upon request by the health insurance issuer, may exempt from disclosure any part of the information provided by a health insurance issuer that is submitted to the health gateway that the commissioner determines to contain trade secrets as defined in 30-14-402.

(5) The information required in subsection (3) 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 health gateway for individuals without access to the internet.

(6) The health gateway 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 health gateway.

(7) This section does not prohibit a health insurance issuer from offering health plans outside of the health gateway to qualified individuals or qualified employers.

(8) This section may not be construed as compelling an individual to enroll in a qualified health plan or participate in the health gateway.

NEW SECTION. **Section 8. 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, health insurance 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 health gateway, and any other topics relevant to the health gateway.

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

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

NEW SECTION. **Section 9. Funding for the health gateway -- disclosure.** (1) The board shall develop a funding proposal to ensure that the health gateway is self-sustaining by January 1, 2015. Funding must

be limited to the minimum amount necessary to pay for the administrative costs and expenses incurred in the operation of the health gateway. Charges may be assessed only after all federal grants and other funding available from private or government sources have been exhausted. Services performed by the health gateway on behalf of other state or federal programs may not be funded with assessment or user fees. Any unspent funding by the health gateway must be used for future state operation of the health gateway or returned. An assessments may not be made on health insurance issuers for the development and implementation of the health gateway prior to January 1, 2014.

(2) The health gateway may not receive any revenue from the state general fund.

(3) In addition to any assessments charged, each health insurance issuer doing business in the health gateway shall pay an annual user fee of $50 to the state auditor's office to be deposited into the state special revenue fund. The commissioner shall transfer those funds to the health gateway to assist with administrative costs incurred by the health gateway.

NEW SECTION. **Section 10. Annual reports -- research.** (1) The health gateway shall publish the following on an internet website to educate consumers on insurance costs and costs of the health gateway:

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

(b) the administrative costs of the health gateway; and

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

(2) In addition to the financial reports required under [section 4], the board shall examine the operations of the health gateway and the demographics of the persons enrolled in the health gateway and submit a written report to the governor, the commissioner, the president of the senate, the speaker of the house, and the secretary. The report must review:

(a) the operation and administration of the health gateway. This information must include administrative costs, claims statistics, health gateway complaints data, and goals defined and achieved by the board, as well as any adverse selection trends that the health gateway 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 health gateway and enrollees purchasing health plans outside the health gateway.

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

(3) 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.

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

(b) strategies to avoid adverse risk selection inside and outside the health gateway;

(c) the feasibility of establishing a defined contribution arrangement, as described in [section 11], as one option for qualified employers seeking to participate in the SHOP health gateway to obtain coverage; and

(d) other studies as may be required by federal law.

NEW SECTION. **Section 11. Employer health insurance health gateway -- defined contribution arrangement.** (1) If as a result of the outcome of the feasibility study under [section 10] the board chooses to establish a defined contribution arrangement as one option for qualified employers seeking to participate in the SHOP health gateway, then beginning January 1, 2014, an eligible small employer may choose to participate in a defined contribution arrangement made available through the SHOP health gateway.

(2) For the purposes of this section:

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

(b) "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 the plan of operation adopted by the health gateway. The contribution must be an equivalent amount for all similarly situated 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 health gateway. The options for the employer may include:

(i) the mechanism offered by the health gateway;

(ii) a health reimbursement arrangement, as defined by federal law;

(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 eligible employee of any health plan offered by the health gateway 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 health gateway 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 health gateway 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 health gateway may:

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

(2) All health insurance issuers that participate in the health gateway 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 health gateway may also offer those network-based plans inside the health gateway.

(3) Nothing in [sections 1 through 13] may be construed to limit the number of plans or plan designs that a health insurance issuer may offer in the health gateway.

NEW SECTION. **Section 13. Relation to other laws.** (1) An action taken by the health gateway pursuant to [sections 1 through 13] may not be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this state.

(2) All health insurance issuers offering qualified health plans in this state are subject to the requirements

of the federal act.

NEW SECTION. **Section 14. Codification instruction.** [Sections 1 through 13] 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 13].

NEW SECTION. **Section 15. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 16. Contingent voidness.** If the parts of the Patient Protection and Affordable Care Act that relate to the health gateway are repealed or found to be unconstitutional by a court with final jurisdiction, then [this act] is void.

NEW SECTION. **Section 17. Effective date.** [This act] is effective on passage and approval.

NEW SECTION. **Section 18. Applicability.** [This act] applies to coverage through the health gateway issued on or after January 1, 2014.

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