SENATE BILL NO. 556

INTRODUCED BY J. ELLIOTT

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATED TO INSURANCE CAPITAL AND PREMIUM TAXES; REQUIRING A HEALTH SERVICE CORPORATION TO PAY A PREMIUM TAX WHEN TOTAL ADJUSTED CAPITAL EXCEEDS 400 PERCENT OF THE AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL; PROVIDING RULEMAKING AUTHORITY TO THE COMMISSIONER OF INSURANCE FOR CALCULATION OF THE EXCESS TOTAL ADJUSTED CAPITAL, AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL, AND PREMIUM TAX; AUTHORIZING THE COMMISSIONER TO REDISTRIBUTE THE REVENUE DERIVED FROM THE HEALTH SERVICE CORPORATION PREMIUM TAX TO SUBSIDIZE THE SMALL BUSINESS HEALTH INSURANCE PURCHASING POOL, TO THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, OR FOR PREMIUM ASSISTANCE TO THE COMPREHENSIVE HEALTH ASSOCIATION; REVISING PROVISIONS ON EXCESS CAPITAL; AMENDING SECTIONS 33-2-1902, 33-2-1903, 33-2-1910, 33-22-1512, 33-22-1513, 33-30-105, AND 33-30-203, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Health service corporation premium tax proceeds -- state special revenue account.** (1) The proceeds of the revenue derived from the health service corporation premium tax provided for in 33-30-203 must be deposited in a state special revenue account for the purposes of providing health insurance to the people of Montana as provided in this section.

(2) The revenue may be used for the following programs if the commissioner determines that a waiting list exists:

(a) the small business health insurance purchasing pool provided for in Title 33, chapter 22, part 20;

(b) the state children's health insurance program provided for in Title 53, chapter 4, part 10; or

(c) the association plan and association portability plan provided for in Title 33, chapter 22, part 15.

Section 2. Section 33-2-1902, MCA, is amended to read:

"33-2-1902. Definitions. As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in

accordance with 33-2-1903~~(5)~~(4).

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic insurer" means any insurance company domiciled in this state.

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state.

(5) "Life or disability insurer" means:

(a) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of disability insurance, as described in 33-1-207, or life insurance, as described in 33-1-208;

(b) a licensed property and casualty insurer writing only disability insurance; or

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts.

(6) "NAIC" means the national association of insurance commissioners.

(7) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

(8) (a) "Property and casualty insurer" means:

(i) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of property insurance, as described in 33-1-210, or casualty insurance, as described in 33-1-206;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(9) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC~~, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC~~ as of [the effective date of this act]. The commissioner may revise the instructions by rule as provided in 33-2-1910.

(10) "RBC level" means an insurer's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC, where:

(a) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "company action level RBC" means, with respect to any insurer, the product of 2 and its authorized

control level RBC;

(c) "mandatory control level RBC" means the product of 0.70 and the authorized control level RBC; and

(d) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in 33-2-1904(2). If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

(12) "RBC report" means the report required in 33-2-1903.

(13) "Total adjusted capital" means the sum of:

(a) an insurer's statutory capital and surplus; and

(b) other items, if any, as the RBC instructions may provide."

Section 3. Section 33-2-1903, MCA, is amended to read:

"33-2-1903. RBC reports. (1) Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula ~~shall~~ must take into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks that are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

~~(4) An excess of capital over the amount produced by the risk-based capital requirements contained in this part and the formulas, schedules, and instructions referenced in 33-2-1906 through 33-2-1913 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this part. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this part.~~

~~(5)~~(4) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report so adjusted is referred to as an adjusted RBC report."

Section 4. Section 33-2-1910, MCA, is amended to read:

"33-2-1910. Supplemental provisions -- rules -- exemption. (1) The provisions of this part are supplemental to any other provisions of the laws of this state and do not preclude or limit any other powers or duties of the commissioner under the law, including but not limited to Title 33, chapter 2, part 13.

(2) The commissioner may adopt reasonable rules necessary for the implementation of this part.

(3) The commissioner may adopt rules for calculating the excess total adjusted capital, the authorized control level RBC, and the premium tax provided for in 33-30-203. The commissioner may revise the RBC instructions by rule to reflect changes adopted by the NAIC in order to maintain uniformity in regulating insurers.

~~(3)~~(4) The commissioner may exempt from the application of this part any domestic property and casualty insurer that:

(a) writes direct business only in this state;

(b) writes direct annual premiums of $2 million or less; and

(c) does not assume reinsurance in excess of 5% of direct premium written."

Section 5. Section 33-22-1512, MCA, is amended to read:

"33-22-1512. Association plan and association portability plan premium. (1) The association shall establish the schedule of premiums to be charged to eligible persons for membership in the association plan. The schedule of association plan premiums for eligible persons may not exceed 200% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The schedule of association portability plan premiums for federally defined eligible individuals may not at any time exceed 150% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The premium rates of the five insurers or health service corporations used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually at the request of the commissioner. The association shall use generally acceptable actuarial principles and structurally compatible rates.

(2) (a) The association, with the approval of the commissioner, may adopt a reduced premium rate schedule that is equitably proportional to the income level for eligible persons who have an income less than or equal to 150% of the federal poverty level. The association may not adopt a reduced premium rate schedule unless it has secured federal, state, or private funding specifically for that purpose and the use of the reduced premium rate schedule is limited to the available federal, state, or private funding. The commissioner is authorized to provide funding for this purpose from the revenue generated from the proceeds of the premium tax in 33-30-203.

(b) The association, with the approval of the commissioner, may adopt as many income categories as it finds necessary.

(c) Any person who qualifies for coverage under this section may apply to the association for a reduced premium. However, eligible persons with coverage in the traditional association plan must receive first priority for reduced premiums. By agreement of the association and the commissioner, reduced premiums may be made available to persons eligible for the portability plan.

(d) The association may grant as many reduced premiums as funding sources allow but may not increase overall premium rates to subsidize the reduced premium rate schedule. The association may limit the number of people receiving reduced premiums when funds are not available and may establish a waiting list for reduced premiums, if necessary."

Section 6. Section 33-22-1513, MCA, is amended to read:

"33-22-1513. Operation of association plan and association portability plans. (1) Upon acceptance

by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Upon application by a federally defined eligible individual or a TAA-eligible individual to the lead carrier for an association portability plan, the association may not:

(a) decline to offer an association portability plan; or

(b) except as provided in subsection (3), impose a preexisting condition exclusion with respect to an individual's association portability plan coverage if application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage.

(3) The association may impose a preexisting condition exclusion as provided in 33-22-1516 with respect to a TAA-eligible individual's association portability plan coverage if that individual does not meet the requirements defining a qualified TAA-eligible individual.

(4) Not less than 88% of the association plan and the association portability plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

(5) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan and association portability plan premiums.

(6) (a) Each participating member of the association shall share the losses because of claims expenses of the association plan and the association portability plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs in the following manner:

(i) Each participating member of the association must be assessed by the association on an annual basis an amount not to exceed 1% of the association member's total disability insurance premium received from or on behalf of Montana residents as determined by the commissioner. Assessments made under this subsection (6)(a) or funds from any other source must be allocated to the association plan and the association portability plan in proportion to the needs of the two plans. If the needs of the association plan and the association portability plan exceed the funds generated by the 1% assessment, the association is then authorized to spend any funds appropriated by the legislature for the support of the plans. Any appropriation to the association may be expended for the operation of the association plan or the association portability plan.

(ii) (A) Payment of an assessment is due within 30 days of receipt by a member of a written notice of the

annual assessment. After 30 days, the association shall charge a member:

(I) a late payment penalty of 1.5% a month or fraction of a month on the unpaid assessment, not to exceed 18% of the assessment due;

(II) interest at the rate of 12% a year on the unpaid assessment, to be accrued at 1% a month or fraction of a month; or

(III) both of the charges in subsections (6)(a)(ii)(A)(I) and (6)(a)(ii)(A)(II).

(B) Failure by a contributing member to tender the association assessment within the 30-day period is grounds for termination of membership. A member terminated for failure to tender the association assessment is ineligible to write health care benefit policies or contracts in this state under 33-22-1503(2).

(iii) An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year in which the member ceased doing disability insurance business. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $50.

(b) For purposes of this subsection (6), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, life insurance, medicare risk or other similar medicare health maintenance organization payments, or medicaid health maintenance organization payments.

(c) Any income in excess of the incurred or estimated claims expenses of the association plan and the association portability plan and the operating and administrative expenses of the association must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan and association portability plan premiums.

(7) The proportion of the annual assessment allocated to the operation and expenses of the association plan, not to include any amount of late payment penalty or interest charged, may be offset by an association member against the premium tax payable by that association member pursuant to 33-2-705 or 33-30-203 for the year in which the annual assessment is levied. The commissioner shall report to the office of budget and program planning, as a part of the information required by 17-7-111, the total amount of premium tax offset claimed by association members during the preceding biennium. The proportion of the annual assessment allocated to the operation and expenses of the association portability plan and levied against an association member may not be offset against the premium tax payable by that association member.

(8) The association may also accept funding from the federal government, private foundations, and other

private funding sources."

Section 7. Section 33-30-105, MCA, is amended to read:

"33-30-105. Examination of ~~a~~ health service corporation. (1) If the commissioner believes that a health service corporation is unable or potentially unable to fulfill its contractual obligations to its members, the commissioner may conduct an examination of that corporation.

(2) In addition to the examination authorized in subsection (1), at least once every 4 years, the commissioner shall conduct an examination of each health service corporation to determine if the corporation is fulfilling its contractual obligations by prompt satisfaction of claims at the highest monetary level consistent with reasonable dues or fees~~,~~ and to determine that the corporation's management exercises appropriate fiscal controls, operations, and personnel policies to ~~assure~~ ensure that efficient and economic administration restrains overhead costs for the benefit of its members.

(3) The commissioner or the commissioner's examiners may examine and audit a health service corporation for compliance with 33-30-203.

~~(3)~~(4) Each health service corporation examined~~,~~ and its officers, employees, and insurance producers~~,~~ shall produce and make available to the commissioner or ~~his~~ the commissioner's examiners the accounts, records, documents, files, information, assets, and matters in ~~its~~ their possession or control relating to the subject of the examination.

~~(4)~~(5) The commissioner or ~~his~~ the commissioner's examiner shall make a verified report of the examination.

~~(5)~~(6) The report ~~shall~~ may comprise only facts appearing from the books, papers, records, or documents of the corporation examined or ascertained from the testimony, under oath, of individuals concerning its affairs and conclusions and recommendations as warranted by those facts.

~~(6)~~(7) The commissioner shall furnish a copy of the proposed report to the corporation examined not less than 20 days prior to its filing in ~~his~~ the commissioner's office. If the corporation requests a hearing, in writing, within the 20-day period, the commissioner shall grant one with respect to the report and ~~shall~~ may not file the report until after the hearing and after modifications, if any, that the commissioner ~~deems~~ considers proper.

~~(7)~~(8) The health service corporation shall pay for each examination conducted pursuant to subsections (1) ~~and (2)~~ through (3) in accordance with 33-1-413."

Section 8. Section 33-30-203, MCA, is amended to read:

"33-30-203. Premium tax -- exemption -- exception -- prohibition. (1) ~~A~~ Except as provided in subsection (2), a health service corporation is exempt from all premium taxes.

(2) A health service corporation shall pay to the commissioner a premium tax upon the total net premiums reported and computed at the rate of 2 3/4% if it has reported total adjusted capital that is in excess of 400% of the authorized control level RBC as those terms are defined in 33-2-1902.

(3) The report by the health service corporation for purposes of imposing the tax in subsection (2) must be submitted as provided in 33-30-107(3) and be reported on a form as prescribed by the commissioner.

(4) The provisions of this section are subject to the financial examination authority in 33-1-401.

(5) A health service corporation may not include the cost of any premium tax in its policy or contract rates of members or beneficiaries."

NEW SECTION. **Section 9. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 30, part 2, and the provisions of Title 33, chapter 30, part 2, apply to [section 1].

NEW SECTION. **Section 10. Effective date.** [This act] is effective on passage and approval.

NEW SECTION. **Section 11. Retroactive applicability.** [This act] applies retroactively, within the meaning of 1-2-109, to tax years beginning after December 31, 2006.

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