SENATE BILL NO. 125

INTRODUCED BY S. FITZPATRICK

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING THE MONTANA REINSURANCE ASSOCIATION AND PROGRAM; REQUIRING MANDATORY MEMBERSHIP OF HEALTH AND DISABILITY INSURERS; PROVIDING FOR A BOARD OF DIRECTORS; ESTABLISHING DUTIES OF THE INSURANCE COMMISSIONER; PROVIDING DUTIES AND POWERS OF THE BOARD AND ADMINISTRATOR; ESTABLISHING ASSOCIATION MEMBER ASSESSMENTS; ESTABLISHING REINSURANCE PAYMENTS TO ELIGIBLE HEALTH INSURERS; PROVIDING FOR DATA CONFIDENTIALITY; PROVIDING RULEMAKING AUTHORITY; PROVIDING FOR A SPECIAL REVENUE ACCOUNT; PROVIDING FOR CONTINGENT VOIDNESS; 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. Short title -- purpose.** [Sections 1 through 15] may be cited as the "Montana Reinsurance Association Act". The purpose of this act is to establish a Montana-based public reinsurance program in order to stabilize the individual health insurance market, maintain competition, and reduce premiums.

NEW SECTION. **Section 2. Reinsurance association -- mandatory membership -- exceptions.** (1) The Montana reinsurance association is established as a nonprofit legal entity. As a condition of doing business, an insurer that has issued or renewed disability insurance, as defined in 33-1-207, or stop-loss insurance, regardless of license type, in this state in the past 12 months must be a member of the association.

(2) The following types of disability insurers are exempt from the requirement to be association members and are not subject to the assessment in [section 8]:

(a) self-funded multiple employer welfare arrangements licensed under chapter 35;

(b) disability insurance sold through a fraternal benefit society as described in chapter 7;

(c) medicare supplement insurance as described in chapter 22, part 9; and

(d) long-term care insurance as described in chapter 22, part 11.

NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 15] the following definitions apply:

(1) "Association" means the Montana reinsurance association provided for in [sections 1 through 15].

(2) "Attachment point" means the threshold amount for claims costs incurred by an eligible health insurer for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments.

(3) "Benefit year" means the calendar year for which an eligible health insurer provides coverage through an individual health insurance policy.

(4) "Board" means the association's board of directors provided for in [section 4].

(5) "Coinsurance rate" means the rate at which the association will reimburse an eligible health insurer for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

(6) "Eligible health insurer" means a health insurer, health service corporation, or health maintenance organization that:

(a) offers individual health insurance coverage in the individual market, as defined in 33-22-140;

(b) offers a qualified health plan as defined in 42 U.S.C. 18021(a) that does not discriminate on the basis of health status in rating or issuance, covers all essential health benefits, and does not impose lifetime or annual limits or exclude pre-existing conditions; and

(c) incurs claims costs for an individual enrollee's covered benefits in the applicable benefit year.

(7) "Major medical" health insurance includes individual market and employer group health insurance that:

(a) is guaranteed available;

(b) is guaranteed renewable;

(c) does not impose pre-existing condition exclusions;

(d) (i) offers essential health benefits as defined in 42 U.S.C. 18022; or

(ii) for large employer group coverage, meets the federal requirements for minimum value;

(e) pays medical claims, with no lifetime or annual limits; and

(f) complies with the federal limits for maximum out-of-pocket.

(8) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the

Montana reinsurance program.

(9) "Program" means the Montana reinsurance program operated by the Montana reinsurance association.

(10) "Reinsurance cap" means the maximum amount of each claim incurred by an eligible health insurer for an enrolled individual's covered benefits in a benefit year, after which the claims costs for benefits are no longer eligible for reinsurance payments.

(11) "Reinsurance payments" means an amount paid by the association to an eligible health insurer under the program.

NEW SECTION. **Section 4. Association board of directors.** (1) The association is governed by a board of directors consisting of up to seven directors who have experience in health care, health insurance, or finance as follows:

(a) one director from each of the eligible health insurers, up to a maximum of three directors from the three eligible health insurers with the largest enrollment in the individual market;

(b) two insurer directors appointed by the commissioner who are participating members of the association; and

(c) two directors appointed by the governor to represent the public interest.

(2) The board of directors may be reimbursed by the association for travel expenses, but may not otherwise be compensated for their services.

(3) Each director has one vote.

(4) Initial appointments must be finalized no later than May 1, 2019, and the board shall meet for the first time no later than May 8, 2019.

NEW SECTION. **Section 5. Duties of commissioner -- rulemaking.** (1) The commissioner shall:

(a) oversee the activities of the association and the board;

(b) approve the plan of operation and the reinsurance parameters set by the board each year, no later than July 15, 2019, and no later than June 1 of each following year;

(c) collect the assessment;

(d) designate staff to attend all meetings of the board and the association as an ex-officio member; and

(e) require all eligible health insurers to calculate the premium amount the eligible health insurer would

have charged for the benefit year if the Montana reinsurance program had not been established. The eligible health insurer must submit this information as part of its rate filing. The commissioner shall consider this information as part of the rate review.

(2) The commissioner may adopt rules necessary to implement [sections 1 through 15]. Any proposed administrative rules must be submitted to the board for review and comment before the proposed rules are submitted to the secretary of state.

NEW SECTION. **Section 6. Board duties -- powers.** (1) The board shall:

(a) adopt a plan of operation, including the reinsurance parameters for the following year, no later than June 15, 2019, in accordance with the requirements of [sections 1 through 15], and update the plan of operation and reinsurance parameters no later than May 1 of each succeeding year. The board shall submit its plan of operation, articles of incorporation, and bylaws to the commissioner for approval.

(b) establish administrative and accounting procedures for the association and the program;

(c) select an association administrator in accordance with [section 7] who will pay reinsurance claims in accordance with the plan of operation; and

(d) set the budget for the reinsurance program for each policy year, including the assessment levels as provided in [section 8] for the various members of the association.

(2) The board may:

(a) enter into contracts as necessary to carry out the purposes of [sections 1 through 15];

(b) appoint appropriate actuarial or other committees as necessary to provide technical assistance and any other functions within the authority of the association;

(c) with the approval of the commissioner, borrow money to effect the purposes of the association; and

(d) apply for funds or grants from public or private sources.

(3) An annual review of the association and the program for solvency and compliance must be performed by an independent certified public accountant using generally accepted accounting principles and submitted to the commissioner and the economic affairs committee of the legislature provided for in 5-5-223 as provided in 5-11-210 for review by June 30 of each year, beginning in 2020.

(4) The board shall prepare an annual report on operations and finance and send that report to the economic affairs interim committee as provided in 5-11-210 and the commissioner by June 30 of each year, beginning in 2020.

NEW SECTION. **Section 7. Association administrator.** (1) The board shall select an administrator, who is either an employee of the nonprofit association or an independent contractor, to administer the reinsurance program pursuant to the parameters decided by the board of directors. The board shall establish qualifications and compensation in the plan of operation for the administrator and the length of the contract of an independent contractor.

(2) The administrator shall:

(a) perform all administrative functions relating to the association;

(b) submit regular reports to the board regarding the operation of the association. The frequency, content, and form of the reports must be set forth in the plan of operation.

(c) pay reinsurance claims as provided for in the plan of operation.

NEW SECTION. **Section 8. Association member assessments.** (1) (a) (i) For 2020, the commissioner shall assess each member insurer 1% of its total premium volume covering Montana residents from 2019 for major medical health insurers in the individual and employer group health insurance market and 2% of total premium volume for all other health and disability insurers, as defined in 33-1-207, including any insurer selling stop-loss insurance in this state, regardless of type of license.

(ii) For each year after 2020, the commissioner shall assess each member insurer an amount up to 1% of its total premium volume from the prior calendar year for major medical health insurers in the individual and employer group health insurance market and up to 2% of total premium volume for all other health and disability insurers, as defined in 33-1-207, including any insurer selling stop-loss insurance in this state, regardless of type of license.

(b) The board shall determine the timing of the assessment.

(c) The commissioner shall consider the board's recommendation when determining the assessment amounts.

(d) The commissioner shall verify the amount of each insurer's assessment based on annual financial statements and other reports determined to be necessary.

(2) No later than April 1 of each year, the association shall determine and report to the commissioner the association's reinsurance payments and other expenses for the previous calendar year, including administrative expenses and any incurred but not reported claims for the previous calendar year.

(a) The report must consider investment income and other appropriate gains.

(b) The report must include an estimate of the assessments needed to cover the expected reinsurance claims for the following calendar year.

(3) If assessments and other funds collected by the association exceed the actual losses and administrative expenses of the association, the board shall use the excess funds to offset future claims or to reduce future assessments.

(4) The commissioner may, after notice and hearing:

(a) suspend or revoke the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment;

(b) impose a penalty on any insurer that fails to pay an assessment when due; or

(c) use any power granted to the commissioner to collect any unpaid assessment.

(5) An eligible health insurer may not submit claims for reinsurance payments unless the insurer has a medical loss ratio of 80% or greater, as defined in 45 CFR 158.221.

NEW SECTION. **Section 9. Payment parameters.** (1) The board shall design and adjust the payment parameters to ensure that the payment parameters will:

(a) stabilize or reduce premium rates in the individual market;

(b) increase or maintain participation in the individual market;

(c) mitigate the impact high-cost individuals have on premium rates in the individual market;

(d) consider any federal funding available for the plan; and

(e) consider the total amount available to fund the plan.

(2) The attachment point must be set by the board at $40,000 or more, but may not exceed the reinsurance cap.

(3) The coinsurance rate must be set by the board between 50% and 80%.

(4) The reinsurance cap must be set by the board at $1,000,000 or less.

(5) The board may adjust the payment parameters annually to extent necessary to secure federal approval of the state innovation waiver.

NEW SECTION. **Section 10. Calculation of reinsurance payments.** (1) Each reinsurance payment must be calculated with respect to an eligible health insurer's incurred claims costs for an individual enrollee's

covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment must be calculated as the product of the coinsurance rate and the less of:

(a) the claims costs minus the attachment point; or

(b) the reinsurance cap minus the attachment point.

(2) The board shall ensure that the reinsurance payments made to the eligible health insurer do not exceed the total amount paid by the eligible health insurer for any eligible claim.

(3) For purposes of this section "total amount paid" means the amount paid by the eligible health insurer based on the allowed amount less any deductible, coinsurance, or co-payment.

NEW SECTION. **Section 11. Administration of reinsurance payments.** (1) Claims that are incurred during a benefit year and are submitted for reimbursement in the following benefit year by the date established by the board in the plan of operation will be allocated to the benefit year in which they are incurred. Claims submitted after the date established by the board following the benefit year in which they were incurred will be allocated to the next benefit year in accordance with the board's operating rules, policies, and procedures.

(2) If funds accumulated in the reinsurance program account in the state special revenue fund with respect to a benefit year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that benefit year, all claims for reimbursement allocable to that benefit year must be reduced proportionately to the extent necessary to prevent a deficiency in the funds for that benefit year. Any reduction in claims for reimbursement with respect to a benefit year must apply to all claims that are allocated to that benefit year without regard to when those claims were submitted for reimbursement, and any reduction must be applied to each claim in the same proportion.

(3) If funds accumulated in the reinsurance program account in the state special revenue fund exceed the actual claims for reimbursement and program expenses of the association in a given benefit year, the board shall use such excess funds to pay reinsurance claims in successive benefit years and may recommend to the commissioner a reduction in the assessment amount for the following year.

(4) For each applicable benefit year, the board must notify eligible health insurers of reinsurance payments to be made for the applicable benefit year by the date established by the board in the plan of operation in the year following the applicable benefit year.

(5) By August 15 of the year following the applicable benefit year, the board must disburse all applicable

reinsurance payments payable to an eligible health insurer.

NEW SECTION. **Section 12. Eligible health insurer requests for reinsurance payments.** (1) An eligible health insurer shall:

(a) make requests for reinsurance payment in accordance with any requirements established by the board;

(b) provide the association with access to data according to the rules and timeline established by the board in the plan of operation or by the commissioner in the administrative rules. The data environment utilized must be compatible with the federal risk adjustment program.

(c) maintain documents and records sufficient to substantiate the requests for reinsurance payments made pursuant to [sections 1 through 15] for a period of at least 6 years;

(d) apply all managed care, utilization review, case management, preferred provider arrangements, claims processing, and other methods of operation, as appropriate to each claim without regard to whether such claim is eligible for or may be paid by reinsurance;

(e) make records available upon request from the commissioner or the board for purposes of verification, investigation, audit, or other review of reinsurance payment requests; and

(f) repay to the reinsurance program account in the state special revenue fund any reinsurance overpayments as determined by the commissioner as a result of an investigation, audit or other review.

(2) Data collected from eligible health insurers under this section is confidential and not subject to public inspection.

NEW SECTION. **Section 13. Liability of association members.** An association member may not be held liable for the acts or omissions of the association board or the association membership.

NEW SECTION. **Section 14. Special revenue account -- reinsurance program.** (1) There is a reinsurance program account in the state special revenue fund established by 17-2-102. The account must be administered by the commissioner for the benefit of the program.

(2) There must be deposited in the account:

(a) all assessments collected under [section 8];

(b) federal funding allocated as a result of a section 1332 waiver application;

(c) any additional federal or grant funding;

(d) any interest and income earned on the account; and

(e) any other money from any other source accepted for the benefit of the account.

(3) The account may be used only to provide funding for the administration, operation, and claims expenses incurred by the program created in [section 2].

NEW SECTION. **Section 15. State innovation waiver.** The commissioner, the governor, and the board shall jointly apply, no later than July 1, 2019, to the U.S. secretary of health and human services under 42 U.S.C. 18052, for a state innovation waiver and federal pass-through funding to implement [sections 1 through 15] for benefit years beginning January 1, 2020, and future years, to maximize federal funding.

NEW SECTION. **Section 16. Codification instruction.** [Sections 1 through 15] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 15].

NEW SECTION. **Section 17. Contingent voidness.** The implementation of [sections 1 through 15] is contingent upon the approval of the state innovation waiver under [section 15]. If the state innovation waiver is not approved, [this act] is void.

NEW SECTION. **Section 18. Effective date.** [This act] is effective on passage and approval.

NEW SECTION. **Section 19. Retroactive applicability.** [This act] applies retroactively, within the meaning of 1-2-109, to premiums collected from health insurers on or after January 1, 2019.

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