

SENATE BILL NO. 125

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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;

- 1 (b) disability insurance sold through a fraternal benefit society as described in chapter 7;
- 2 (c) medicare supplement insurance as described in chapter 22, part 9; and
- 3 (d) long-term care insurance as described in chapter 22, part 11.

4

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

6 apply:

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

8 (2) "Attachment point" means the threshold amount for claims costs incurred by an eligible health insurer

9 for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are

10 eligible for reinsurance payments.

11 (3) "Benefit year" means the calendar year for which an eligible health insurer provides coverage through

12 an individual health insurance policy.

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

14 (5) "Coinsurance rate" means the rate at which the association will reimburse an eligible health insurer

15 for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and

16 below the reinsurance cap.

17 (6) "Eligible health insurer" means a health insurer, health service corporation, or health maintenance

18 organization that:

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

20 (b) offers a qualified health plan as defined in 42 U.S.C. 18021(a) that does not discriminate on the basis

21 of health status in rating or issuance, covers all essential health benefits, and does not impose lifetime or annual

22 limits or exclude pre-existing conditions; and

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

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

25 that:

26 (a) is guaranteed available;

27 (b) is guaranteed renewable;

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

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

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

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

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

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

4 Montana reinsurance program.

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

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

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

12

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

16 (a) ~~one director~~ THREE DIRECTORS, ONE EACH from ~~each of the eligible health insurers; up to a maximum~~
17 ~~of three directors from the three eligible health insurers with the largest enrollment in the individual market; IF~~
18 THERE ARE FEWER THAN THREE, THE BOARD SHALL SELECT ANOTHER DIRECTOR FROM A HEALTH INSURANCE ISSUER THAT
19 MARKETS PRIMARILY MAJOR MEDICAL INSURANCE.

20 (b) ~~two~~ ONE insurer ~~directors~~ DIRECTOR appointed by the commissioner who ~~are participating members~~
21 IS A PARTICIPATING MEMBER of the association; and

22 (c) ~~two directors~~ ONE DIRECTOR appointed by the governor to represent the public interest.

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

25 (3) Each director has one vote.

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

28

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

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

1 (b) approve the plan of operation and the reinsurance parameters set by the board each year, no later
 2 than July 15, 2019, and no later than June 1 of each following year AS NEEDED WITHIN 30 DAYS OF RECEIVING THE
 3 PLAN OR AMENDMENTS TO THE PLAN FROM THE BOARD;

4 (c) WITH THE ASSISTANCE OF THE ASSOCIATION, collect the assessment AND THE FEDERAL FUNDING
 5 DESIGNATED FOR THIS PROGRAM;

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

7 (e) require all eligible health insurers to calculate the premium amount the eligible health insurer would
 8 have charged for the benefit year if the Montana reinsurance program had not been established. The eligible
 9 health insurer must submit this information as part of its rate filing. The commissioner shall consider this
 10 information as part of the rate review.

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

14
 15 NEW SECTION. Section 6. Board duties -- powers. (1) The board shall:

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

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

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

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

25 (2) The board may:

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

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

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

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

1 (3) An annual review of the association and the program for solvency and compliance must be performed
 2 by an independent certified public accountant using generally accepted accounting principles and submitted to
 3 the commissioner and the economic affairs committee of the legislature provided for in 5-5-223 as provided in
 4 5-11-210 for review by June 30 of each year, beginning in 2020.

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

8
 9 **NEW SECTION. Section 7. Association administrator.** (1) The board shall select an administrator,
 10 who is either an employee of the nonprofit association or an independent contractor, to administer the reinsurance
 11 program pursuant to the parameters decided by the board of directors. The board shall establish qualifications
 12 and compensation in the plan of operation for the administrator and the length of the contract of an independent
 13 contractor.

14 (2) The administrator shall:

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

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

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

19
 20 **NEW SECTION. Section 8. Association member assessments.** (1) (a) (i) For 2020, the commissioner
 21 shall assess each member insurer 1% of its total premium volume covering Montana residents from 2019 for
 22 major medical health insurers in the individual and employer group health insurance market and 2% of total
 23 premium volume for all other health and disability insurers, as defined in 33-1-207, ~~including any insurer selling~~
 24 ~~stop-loss insurance in this state~~, regardless of type of license.

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

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

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

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

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

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

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

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

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

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

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

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

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

21
22 **NEW SECTION. Section 9. Payment parameters.** (1) The board shall design and adjust the payment
23 parameters to ensure that the payment parameters will:

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

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

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

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

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

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

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

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

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

5
6 **NEW SECTION. Section 10. Calculation of reinsurance payments.** (1) Each reinsurance payment
7 must be calculated with respect to an eligible health insurer's incurred claims costs for an individual enrollee's
8 covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the
9 reinsurance payment is \$0. If the claims costs exceed the attachment point, the reinsurance payment must be
10 calculated as the product of the coinsurance rate and the less of:

- 11 (a) the claims costs minus the attachment point; or
- 12 (b) the reinsurance cap minus the attachment point.

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

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

17
18 **NEW SECTION. Section 11. Administration of reinsurance payments.** (1) Claims that are incurred
19 during a benefit year and are submitted for reimbursement in the following benefit year by the date established
20 by the board in the plan of operation will be allocated to the benefit year in which they are incurred. Claims
21 submitted after the date established by the board following the benefit year in which they were incurred will be
22 allocated to the next benefit year in accordance with the board's operating rules, policies, and procedures.

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

30 (3) If funds accumulated in the reinsurance program account in the state special revenue fund exceed

1 the actual claims for reimbursement and program expenses of the association in a given benefit year, the board
2 shall use such excess funds to pay reinsurance claims in successive benefit years and may recommend to the
3 commissioner a reduction in the assessment amount for the following year.

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

7 (5) By August 15 of the year following the applicable benefit year, the board must disburse all applicable
8 reinsurance payments payable to an eligible health insurer.

9
10 **NEW SECTION. Section 12. Eligible health insurer requests for reinsurance payments.** (1) An

11 eligible health insurer shall:

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

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

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

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

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

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

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

28
29 **NEW SECTION. Section 13. Liability of association members.** An association member may not be

30 held liable for the acts or omissions of the association board or the association membership.

