MONTANA REINSURANCE ASSOCIATON

PLAN OF OPERATIONS

AS ADOPTED BY THE BOARD OF DIRECTORS ON
August 11, 2026

Approved On: 10/8/26
By:

James Brown
Montana State Auditor,
Commissioner of Securities & Insurance

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SECTION 1. MONTANA REINSURANCE ASSOCIATION ACT

1.1 The Montana Reinsurance Association Act {Senate Bill 125) was signed into law on April 30, 2019, and codified in Title 33, chapter 22, part 13, of the Montana Code Annotated.

SECTION 2. PURPOSE

2.1 Senate Bill 125 authorized the creation of a Montana reinsurance program ("Program") through a 1332 State Innovation Waiver ("Waiver") to stabilize Montana's individual health insurance market through state-based innovation.

2.2 On June 19, 2019, the state of Montana applied for a Waiver under Section 1332 seeking to implement a reinsurance program for plan years 2020 through 2024. On August 16, 2019, the Department of Health & Human Services and the Department of the Treasury approved Montana's Waiver. The approval was effective from January 1, 2020 through December 31, 2024, subject to grant-specific terms and conditions.

2.3 On May 17, 2024, the state of Montana applied for a Section 1332 waiver extension. The Department of Health and Human Services and the Department of the Treasury approved Montana's waiver extension application of September 17, 2024. The approval is effective for a waiver period of January 1, 2025 through December 31, 2029. Updated grant-specific terms and conditions apply to the extension period.

SECTION 3. DEFINITIONS

3.1 "Association" means the Montana Reinsurance Association.

3.2 "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.

3.3 "Benefit Year" means the calendar year for which an Eligible Health Insurer provides coverage through an individual health insurance policy.

3.4 "Board" means the Association's board of directors.

3.5 "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.

3.6 "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 MCA 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.

3.7 "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.

3.8 "Payment Parameters" means the Attachment Point, Reinsurance Cap, and Coinsurance Rate for the Program.

3.9 "Program" means the Montana reinsurance program operated by the Association.

3.10 "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.

3.11 "Reinsurance Payments" means an amount paid by the Association to an Eligible Health Insurer under the Program.

SECTION 4. ASSOCIATION

4.1 The Association is established as a nonprofit legal entity, and shall operate pursuant to its enabling legislation, articles, bylaws, any administrative rules, and this plan of operation.

4.2 The Association shall comply with all applicable state and federal laws including, without limit, the Cash Management Improvement Act, as applicable.

4.3 Assist the Commissioner with all required Federal Reporting, per the grant- specific terms and conditions, including, but not limited to:

(a) Quarterly reports regarding the operation of the Reinsurance Program. Quarterly reports are due to CMS no later than 60 days following the end of the first 3 calendar quarters.

(b) Draft Annual Report regarding the Reinsurance Program. The Draft Annual Report must be submitted to CMS within 90 days of the end of the year. The Draft Annual Report must also be posted on the reinsurance website within 30 days of submission to CMS.

(c) Final Annual Report regarding the Reinsurance Program. The Final Annual Report must be submitted to CMS within 60 days of receipt of comments from CMS on the Draft Annual Report. The Final Annual Report must be posted on the reinsurance website within 30 days from CMS' approval of the report.

4.4 Assist the Commissioner with the Post-Award Public Forum that must be held within 60 days of receipt of the final award notice each year and notice of which must be published on the Montana Reinsurance Association's website at least 30 days prior to the Forum.

4.5 Assist the Commissioner with annual reporting of pass-through funding information by September 15 of each year in accordance with Section 15 of the grant Specific Terms and Conditions.

4.6 Assist the Commissioner with notification to CMS of any changes in state laws or regulations that could impact the waiver program. Notification of technical changes must be given at least 30 calendar days prior to the intended implementation date of the change in accordance with Section 2 of the grant Specific Terms and Conditions. Changes that are not considered technical changes require submission of a request for amendment to the waiver plan at least 15 months prior to the proposed implementation date in accordance with Section 9 of the grant Specific Terms and Conditions.

SECTION 5. MEMBERSHIP

5.1 Mandatory Membership. As a condition of doing business, an insurer that has issued or renewed disability insurance, as defined in MCA 33-1-207, regardless of license type, in Montana in the past 12 months, must be a member of the Association.

5.2 Exempted Membership. Disability insurers are exempt from the requirement to be Association members and are not subject to assessment if the insurers solely issue or administer one or more of the following coverage types under the Montana Insurance Code:

(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) Excepted benefits as defined in MCA 33-22-140;
(d) Long-term care insurance as described in chapter 22, part 11; or
(e) Disability income insurance as defined in MCA 33-1-235.

SECTION 6. BOARD OF DIRECTORS

6.1 The Association is governed by a Board consisting of five directors who have experience in health care, health insurance, or finance:

(a) Three directors, one each from the Eligible Health Insurers with the largest enrollment in the individual market. If there are fewer than three, the Board shall select another director from a health insurance issuer that markets primarily Major Medical insurance.

(b) Insurer director appointed by the Commissioner who is a participating member of the Association; and

(c) One director appointed by the Governor to represent the public interest.

6.2 Each director has one vote.

6.3 The Board may be reimbursed by the Association for travel expenses but may not otherwise be compensated for their services.

SECTION 7. DUTIES OF THE BOARD OF DIRECTORS

7.1 The Board shall:

(a) Adopt a plan of operation and the reinsurance parameters for 2020, no later than June 15, 2019, in accordance with the requirements of the Program, and update the plan of operation and reinsurance parameters, if needed, no later than May 1 of each succeeding year, and submit to the Commissioner for approval. The Commissioner shall approve the Plan of Operation by June 20 of each year, if needed.

(i) The Board shall design and adjust the Payment Parameters to ensure that the Payment Parameters will:

- stabilize or reduce premium rates in the individual market;
- increase or maintain participation in the individual market;
- mitigate the impact high-cost individuals have on premium rates in the individual market;
- consider any federal funding available for the plan; and
- consider the total amount available to fund the plan.

(ii) The Attachment Point must be set by the Board at $40,000 or more, but may not exceed the Reinsurance Cap.

(iii) The Coinsurance Rate must be set by the Board between 50% and 80%.

(iv) The Reinsurance Cap must be set by the Board at $1,000,000 or less.

(v) The Board may adjust the Payment Parameters annually to the extent necessary to secure federal approval of the Waiver.

(b) Establish administrative and accounting procedures for the Association and the Program. Until otherwise determined by the Board, the Association shall adopt the Generally Accepted Accounting Principles.

(c) Select an Association Administrator who will pay reinsurance claims in accordance with the plan of operation and ensure by December 31 of the year following the applicable Benefit Year that all applicable Reinsurance Payments are disbursed to an Eligible Health Insurer.

(d) Set the budget for the Program for each policy year, including the assessment levels as provided in this plan of operation for the various members of the Association.

(f) Prepare an annual report on operations and finance and send the report to the Economic Affairs Interim Committee as provided in MCA 5-11-210 and the Commissioner by June 30 of each year beginning in 2020.

7.2 The Board may:

(a) Appoint actuarial or other committees as necessary to provide technical assistance and any other functions within the authority of the Association. A written record of the proceedings of each committee shall be maintained.

(b) Enter into contracts necessary to carry out the purposes of the Association.

(c) Apply for funds or grants from public or private sources.

SECTION 8. ANNUAL REVIEW AND AUDIT

8.1 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 Interim Committee of the legislature provided for in MCA 5-5-223 as provided in MCA 5-11-210 for review by June 30 of each year, beginning in 2020.

8.2 The Board may be audited by the legislative auditor.

SECTION 9. DUTIES OF THE COMMISSIONER

9.1 The Commissioner shall:

(g) Oversee the activities of the Association and the Board;

(h) Examine the affairs of the Board and Program;

(c) Review the plan of operation by the Board as needed within 30 days of receiving the plan or amendments to the plan from the Board and approve plan when approved by the Board with any final changes;

(d) With the assistance of the Association, collect the assessment as outlined in Section 11 and the federal funding designated for this Program;

(e) Designate staff to attend meetings of the Board and the Association as an ex-officio member; and

(f) As outlined in Section 12, require all Eligible Health Insurers to calculate the premium amount the Eligible Health Insurer would have charged for the Benefit Year if the 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.

9.2 The Commissioner may adopt rules necessary to implement the Montana Reinsurance Association Act. 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.

SECTION 10. ASSOCIATION ADMINISTRATOR

10.1 The Administrator shall be an employee of the nonprofit Association or an independent contractor and shall administer the Program, pursuant to the parameters decided by the Board. The Administrator shall ideally have experience with corporate governance; finance, accounting and budgeting; audit administration; corporate and regulatory compliance; financial and regulatory reporting; and reinsurance. The Board will set the Administrator's compensation every year considering the Administrator's experience and performance.

10.2 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 the form of the reports to be documented in the plan of operation, once determined by the Board; and

(c) Pay reinsurance claims in the manner determined by and documented in the plan of operation.

SECTION 11. ASSOCIATION MEMBER ASSESSMENTS

11.1 For 2020 and each year thereafter, the Commissioner shall assess each member insurer 1.2% of its total premium volume covering Montana residents, from the prior calendar year, regardless of type of license. An insurer's total premium volume may not include premiums a member insurer collects on any coverage issued for excepted benefits as defined in 33-22- 140.

11.2 The Board shall determine the timing of the assessment.

11.3 The Commissioner shall consider the Board's recommendation when determining the assessment amounts.

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

11.5 By June 30 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.

11.6 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.

11.7 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.

11.8 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 158.232(f}. An Eligible Health Insurer can receive reimbursements up until the point where its MLR would drop below 80%.

SECTION 12. CALCULATION OF REINSURANCE PAYMENTS

12.1 On or before June 20 of each year, each Eligible Health Insurer will calculate the premium amount the Eligible Health Insurer would have charged for the Benefit Year if the Program had not been established. The Eligible Health Insurer must submit this information as part of its rate filing.

12.2 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 lesser of:

(a) The claims costs minus the Attachment Point; or

(b) The Reinsurance Cap minus the Attachment Point.

12.3 The maximum reinsurance reimbursement for each Eligible Health Insurer will be calculated based upon the incurred claims information submitted by the insurer for the applicable Benefit Year and the reinsurance parameters established by the Board for that Benefit Year. The 80% MLR restriction will be based on the same Benefit Year as the reinsured claims.

12.4 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. "Total amount paid" means the amount paid by the Eligible Health Insurer based on the allowed amount less any deductible, coinsurance, or co-payment.

SECTION 13. ADMINISTRATION OF REINSURANCE PAYMENTS

13.1 Runout Period. Eligible Health Insurers shall use the Federal Edge Server cutoff of the year following the applicable Benefit Year as the cutoff date for claims paid for the applicable Benefit Year ("Runout Period").

Beginning with Benefit Year 2024 claims, each eligible health insurer's final CMS EDGE server outbound report file "High-Cost Risk Pool Detail Enrollee" (HCRPDE) for the applicable benefit year will be submitted for purposes of reinsurance claims reimbursement. HCRPDE files must be submitted to the program administrator and/or MT CSI by August 15 of the year following the applicable Benefit Year. By November 30th of the year following the applicable benefit year, the Board shall notify eligible health insurers of reinsurance payments to be made for the applicable benefit year. By December 31 of the year following the applicable Benefit Year, the Board must disburse all applicable Reinsurance Payments payable to an Eligible Health Insurer for the Runout Period.

13.2 If funds accumulated in the 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.

13.3 If funds accumulated in the 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.

13.4 The MLR requirements in MCA 33-22-1313(5)) should be applied to each member's reinsurance calculation before any reduction in overall reimbursements due to a funding shortfall in the Program. See Final Reinsurance Reimbursement Calculation in Schedule B.

SECTION 14. ELIGIBLE HEALTH INSURER REQUESTS FOR REINSURANCE PAYMENTS

14.1 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 the Program 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 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.

14.2 Data collected from Eligible Health Insurers under this section is confidential and not subject to public inspection.

SECTION 15. LIABILITY OF ASSOCIATION MEMBERS

15.1 An Association member may not be held liable for the acts or omissions of the Board or the Association membership.

SECTION 16. STATE AND FEDERAL SPECIAL REVENUE ACCOUNTS

16.1 There is a 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 and may be used only to provide funding for the administration, operation, and claims expenses incurred by the Program.

There must be deposited in the account:
(a) All assessments collected under Section 11;
(b) Any interest and income earned on the account; and
(c) Any other money from any other source accepted for the benefit of the account.

16.2 There is an account in the federal special revenue fund to the credit of the Board and administered by the Commissioner for the benefit of the Program.

There must be deposited in the account:
(a) Federal funding allocated as a result of a Waiver application;
(b) Any federal or grant funding; and
(c) Any interest and income earned on the account.

SCHEDULE A

2020 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2020:

- Attachment Point: $40,000
- Reinsurance Cap: $101,750
- Coinsurance: 60%

2021 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2021:

- Attachment Point: $40,000
- Reinsurance Cap: $101,750
- Coinsurance: 60%

2022 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2022:

- Attachment Point: $40,000
- Reinsurance Cap: $106,100
- Coinsurance: 60%

2023 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2023:

- Attachment Point: $40,000
- Reinsurance Cap: $80,800
- Coinsurance: 60%

2024 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2024:

- Attachment Point: $40,000
- Reinsurance Cap: $90,000
- Coinsurance: 60%

SCHEDULE A (continued)

2025 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2025:

- Attachment Point: $40,000
- Reinsurance Cap: $91,000
- Coinsurance: 60%

2026 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2026:

- Attachment Point: $40,000
- Reinsurance Cap: $75,000
- Coinsurance: 60%

2027 Reinsurance Parameters

The Board hereby adopts the following Reinsurance Parameters for 2027:

- Attachment Point: $55,000
- Reinsurance Cap: $96,250
- Coinsurance: 60%

SCHEDULE B

Final Reinsurance Reimbursement Calculation

The following are the steps to be taken to calculate the final reinsurance reimbursement for each Eligible Health Insurer:

Step 1
The maximum reinsurance reimbursement for each Eligible Health Insurer will be calculated based upon the incurred claims information submitted by the insurer for the benefit year and payment parameters for the applicable year.

Step 2
The maximum reinsurance amounts for each Eligible Health Insurer from Step 1, along with the supplemental MLR information provided by each Eligible Health Insurer (i.e., the numerator and denominator data elements described by 45 CFR 158.221) will be used to calculate the MLR for the applicable year.

Step3
If the Step 2 calculated MLR for an Eligible Health Insurer is greater than 80%, the total reinsurance amount calculated in Step 1 will not be limited.

If the Step 2 calculated MLR for an Eligible Health Insurer is less than 80%, the total reinsurance amount calculated in Step 1 will be limited to the amount of reinsurance which can be paid to the Eligible Health Insurer and still produce an MLR for the applicable year of at least 80%, if possible.

To the extent an insurer's MLR will be less than 80%, even if the reinsurance reimbursement is reduced to $0, the insurer will not receive any reimbursement for the year.

Step4
If funds accumulated in the reinsurance program in the state special revenue fund are less than the total of the reinsurance amounts calculated in Step 3, the reimbursement amount for all claims will be reduced in the same proportion to eliminate the deficit (as described in 33-22-1316{2). This step will be equivalent to calculating an overall funded percentage for the program (equal to the funds accumulated in the special revenue fund divided by the total amount calculated in Step 3, with a maximum of 100%), then applying that percentage to each of the maximum reimbursement amounts calculated in Step 3 to arrive at the new reimbursement amount.

If the funds accumulated in the state special revenue fund are sufficient to cover the total maximum reinsurance reimbursements calculated in Step 3, no adjustment to the reimbursements will be made.

SCHEDULE B (continued)

Example:

Step 1: Maximum reinsurance reimbursement based on applicable payment parameters:

- Carrier A maximum reimbursement: $1SM
- Carrier B maximum reimbursement: $10M

Step 2: MLR calculated with maximum reinsurance reimbursement from Step 1

- Carrier A
  - MLR denominator= $100M
  - MLR numerator, prior to reinsurance recoveries= $98M
  - MLR, with Step 2 reinsurance amount= ($98M - $1SM) / $100M = 83%
- Carrier B:
  - MLR denominator= $100M
  - MLR numerator, prior to reinsurance recoveries= $8SM
  - MLR, with Step 2 reinsurance amount ($8SM - $10M) / $100M = 7S%

Step 3: Apply MLR cap to maximum reimbursement from Step 1

- Carrier A:
  - Step 2 yields 83% MLR
  - No further adjustments to Step 2 amount
- Carrier B:
  - Step 2 yields 7S% MLR
  - Reimbursement is capped at $SM, the amount yielding 80% MLR

Step 4: Total funding/ Total Step 3 reimbursement= $1SM / $20M = 7S% adjustment

- Carrier A prorated reimbursement: $1SM * 7S% = $11.2SM
- Carrier B prorated reimbursement: $SM * 7S% = $3.7SM

Summary of results:

	Carrier A	Carrier B	Market
Final Reinsurance Receivable	$11,2S0,000	$3,7S0,000	$1S,000,000
Final MLR	86.7S%	81.2S%	