HOUSE BILL NO. 144

INTRODUCED BY SIMON

BY REQUEST OF THE LEGISLATIVE AUDIT COMMITTEE

A BILL FOR AN ACT ENTITLED: "AN ACT REDUCING THE NUMBER OF MEMBERS THE STATE AUDITOR SHALL APPOINT TO THE BOARD OF DIRECTORS OF THE MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM; AMENDING THE BOARD'S MEMBERSHIP; ELIMINATING THE STATE AUDITOR'S AUTHORITY TO APPROVE THE MONTANA SMALL EMPLOYER HEALTH INSURANCE PROGRAM BOARD'S PLAN OF OPERATION; ELIMINATING THE STATE AUDITOR'S AUTHORITY TO INTRODUCE AND TO ADOPT A TEMPORARY PLAN OF OPERATION; AMENDING SECTIONS 33-22-1818 AND 33-22-1819, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Section 33-22-1818, MCA, is amended to read:

"33-22-1818. Small employer carrier reinsurance program -- board membership. (1) There is a nonprofit entity ~~to be~~ known as the Montana small employer health reinsurance program.

(2)~~(a)~~ The program must operate subject to the supervision and control of the board. The board consists of nine members ~~appointed by the commissioner~~ plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

~~(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six~~ Five of the members of the board must be representatives of each of the five small employer carriers~~, one from each of the four small employer carriers~~ with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year~~, one from the remaining small employer carriers, and one~~. Each of the five companies eligible to name a representative to the board shall notify the commissioner of who the representative will be for the coming term. One member of the board must be from a disability reinsurance carrier. One member of the board must be ~~a~~ a representative of an issuer of a health benefit plan with a restricted network provision. One member of the board must be a small employer who is not active in the health care or insurance fields. One

member of the board must be a representative of the general public who is employed by a small employer and who is not employed in the health care or insurance fields.

(a) The five board members representing the largest small employer carriers shall nominate and elect the board member representing a disability reinsurance carrier. The commissioner shall appoint the board members representing an issuer of health benefit plans with a restricted network, representing a small employer, and representing an employee of a small employer.

~~(ii)~~(b) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term continues until that member's successor is appointed.

~~(iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove a board member for cause.~~

(3) On or before March 1 of each year, each assessable carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year."

Section 2. Section 33-22-1819, MCA, is amended to read:

"**33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation.** (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner for review a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may~~, after notice and hearing, approve~~ review the plan of operation ~~if the commissioner determines~~ to determine if it ~~to be~~ is suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. ~~The plan of operation is effective upon written approval by the commissioner.~~ The commissioner may make recommendations to the board if the commissioner determines the plan of operation does not meet the criteria of this subsection.

~~(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan~~

~~of operation is submitted by the board and approved by the commissioner.~~

~~(3)~~(2) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

~~(4)~~(3) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection ~~(8)(c)~~ (7)(c), make annual assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

~~(5)~~(4) A reinsuring carrier may reinsure with the program as provided for in this subsection ~~(5)~~:

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient

funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

~~(6) (a)~~(5) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection ~~(6)(b)~~ (5)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection ~~(6)~~ (5).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection ~~(6)~~ (5).

(c) The board shall annually review the methodology established under subsection ~~(6)(a)~~ (5)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

~~(7)~~(6) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

~~(8) (a)~~(7) (a) ~~Prior to~~ Before March 1 of each year, the board shall determine and report to the

commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses, and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year.

(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820. The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed $10.

(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum

of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection ~~(8)(d)~~ (7)(d).

~~(9)~~(8) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

~~(10)~~(9) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

~~(11)~~(10) The program is exempt from taxation.

~~(12)~~(11) On or before ~~March~~ July 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation.

~~(13)~~(12) All premiums and other money paid to the small employer carrier reinsurance program and all property and securities acquired through the use of money and interest and dividends earned on money belonging to the small employer carrier reinsurance program are solely the property of the program and must be used exclusively for the operations and obligations of the program. Money collected by the program is not subject to legislative appropriation."

NEW SECTION. **Section 3. Effective date.** [This act] is effective on passage and approval.

-END-

APPROVED BY COM ON
HUMAN SERVICES & AGING

HOUSE BILL NO. 144

INTRODUCED BY SIMON

BY REQUEST OF THE LEGISLATIVE AUDIT COMMITTEE

A BILL FOR AN ACT ENTITLED: "AN ACT REDUCING THE NUMBER OF MEMBERS THE STATE AUDITOR SHALL APPOINT TO THE BOARD OF DIRECTORS OF THE MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM; AMENDING THE BOARD'S MEMBERSHIP; ELIMINATING THE STATE AUDITOR'S AUTHORITY TO APPROVE THE MONTANA SMALL EMPLOYER HEALTH INSURANCE PROGRAM BOARD'S PLAN OF OPERATION; ELIMINATING THE STATE AUDITOR'S AUTHORITY TO INTRODUCE AND TO ADOPT A TEMPORARY PLAN OF OPERATION; AMENDING SECTIONS 33-22-1818 AND 33-22-1819, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO INTRODUCED COPY (WHITE) FOR COMPLETE TEXT.

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Section 1. Section 33-22-1818, MCA, is amended to read:

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(2)~~(a)~~ The program must operate subject to the supervision and control of the board. The board consists of nine members ~~appointed by the commissioner~~ plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

~~(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six~~ Five of the members of the board must be representatives of each of the five small employer carriers~~, one from each of the four small employer carriers~~ with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year~~, one from the remaining small employer carriers, and one~~. Each of the five companies eligible to name a representative to the board shall notify the commissioner of who the representative will be for the coming term. One member of the board must be from a disability reinsurance carrier. One member of the board must be e a representative of an issuer of a health benefit plan with a restricted network provision. One member of the board must be a small employer who is not active in the health care or insurance fields. One

member of the board must be a representative of the general public who is employed by a small employer and who is not employed in the health care or insurance fields.

(a) The five board members representing the largest small employer carriers shall nominate and elect the board member representing a disability reinsurance carrier. The commissioner shall appoint the board members representing an issuer of health benefit plans with a restricted network, representing a small employer, and representing an employee of a small employer.

~~(iii)~~(b) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term continues until that member's successor is appointed.

~~(iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove a board member for cause.~~

(3) On or before March 1 of each year, each assessable carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year."

Section 2. Section 33-22-1819, MCA, is amended to read:

"**33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation.** (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner for review a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may~~, after notice and hearing, approve~~ review the plan of operation ~~if the commissioner determines~~ to determine if it ~~to be~~ is suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. ~~The plan of operation is effective upon written approval by the commissioner.~~ The commissioner may make recommendations to the board if the commissioner determines the plan of operation does not meet the criteria of this subsection.

~~(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan~~

~~of operation is submitted by the board and approved by the commissioner.~~

~~(3)~~(2) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

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~~(4)~~(3) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

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(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection ~~(8)(c)~~ (7)(c), make annual assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

~~(5)~~(4) A reinsuring carrier may reinsure with the program as provided for in this subsection ~~(5)~~:

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient

funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

~~(6) (a)~~(5) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection ~~(6)(b)~~ (5)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection ~~(6)~~ (5).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection ~~(6)~~ (5).

(c) The board shall annually review the methodology established under subsection ~~(6)(a)~~ (5)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

~~(7)~~(6) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

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(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820. The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed $10.

(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum

of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection ~~(8)(d)~~ (7)(d).

~~(9)~~(8) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

~~(10)~~(9) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

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~~(13)~~(12) All premiums and other money paid to the small employer carrier reinsurance program and all property and securities acquired through the use of money and interest and dividends earned on money belonging to the small employer carrier reinsurance program are solely the property of the program and must be used exclusively for the operations and obligations of the program. Money collected by the program is not subject to legislative appropriation."

NEW SECTION. **Section 3. Effective date.** [This act] is effective on passage and approval.

-END-