THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

S.B. NO. 2917 H.D. 3

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE RATE REGULATION.

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

SECTION 1. Section 431:14F-102, Hawaii Revised Statutes, is amended by amending the definitions of "enrollee", "rate", and "supplementary rate information" to read as follows:

""Enrollee" means a person who enters into a contractual relationship with, or who is provided with health care services or benefits through, a managed care plan.

"Rate" means [~~every~~] a rate, charge, classification, schedule, practice, or rule. The definition of "rate" shall exclude fees and fee schedules paid by the insurer to providers of services covered under the Act.

"Supplementary rating information" includes [~~any~~] a manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule, statistical plan, and any other similar information needed to determine the applicable rates in effect or to be in effect."

SECTION 2. Section 431:14F-103, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Rates shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable in relation to the costs of the benefits provided."

SECTION 3. Section 431:14F-105, Hawaii Revised Statutes, is amended to read as follows:

"[~~[~~]**§431:14F-105**[~~]~~] **Rate filings.** (a) Every managed care plan shall file in triplicate with the commissioner, every rate, charge, classification, schedule, practice, or rule and every modification of any of the foregoing which it proposes to use. Every filing shall state its proposed effective date and shall indicate the character and extent of the coverage contemplated. The filing also shall include a report on investment income.

(b) Each filing shall be accompanied by a $50 fee payable to the commissioner, which fee shall be deposited in the commissioner's education and training fund.

(c) At the same time as the filing of the rate, every managed care plan shall file all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The managed care plan may satisfy its obligation to file supplementary rating and supporting information by reference to material which has been approved by

the commissioner. The information furnished in support of a filing may include or consist of a reference to:

(1) Its interpretation of any statistical data upon which it relies;

(2) The experience of other managed care plans; or

(3) Any other relevant factors.

(d) When a filing is not accompanied by supporting information or the commissioner does not have sufficient information to determine whether the filing meets the requirements of this article, the commissioner shall require the managed care plan to furnish additional information and, in that event, the waiting period shall commence as of the date the information is furnished. Until the requested information is provided, the filing shall not be deemed complete or filed and the filing shall not be used by the managed care plan. If the requested information is not provided within a reasonable time period, the filing may be returned to the managed care plan as not filed and not available for use. Rates shall be open to public inspection upon filing with the commissioner; provided that supporting and supplementary rating information filed with the commissioner shall be treated as confidential, proprietary information and shall not be subject to public inspection.

~~(e) Except for a rate filed in accordance with subsection (i), or a filing in whole or in part that the commissioner orders to be held confidential and exempt from public disclosure, a filing and any supporting information shall be open to public inspection upon filing with the commissioner.~~]

[~~(f)~~] (e) Rates shall be established in accordance with actuarial principles, based on reasonable assumptions, and supported by adequate supporting and supplementary rating information. After reviewing a managed care plan's filing, the commissioner may require that the managed care plan's rates be based upon the managed care plan's own loss and expense information.

[~~(g)~~] (f) The commissioner shall review filings promptly after they have been made to determine whether they meet the requirements of this article. The commissioner shall calculate the investment income and accuracy of loss reserves upon which filings are based, and the managed care plan shall provide the information necessary to make the calculation.

[~~(h)~~] (g) Except as provided herein [~~and in subsection (d)~~], each filing shall be on file for a waiting period of [~~ninety~~] thirty days before the filing becomes effective. The period may be extended by the commissioner for an additional

period not to exceed [~~fifteen~~] thirty days if the commissioner gives written notice[~~,~~] within the waiting period to the managed care plan that made the filing, that the commissioner needs the additional time for the consideration of the filing. Upon written application by the managed care plan, the commissioner may authorize a filing[~~, which~~] that the commissioner has reviewed[~~,~~] to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner, as provided in section 431:14F-108, within the waiting period or any extension thereof. The rates shall be deemed to meet the requirements of this article until the time the commissioner reviews the filing and so long as the filing remains in effect.

(h) If the commissioner finds that a filing does not meet the requirements of this article, the commissioner, as provided in section 431:14F-108, shall send the managed care plan a notice of disapproval within the applicable thirty-day period or thirty-day extension provided by subsection (g).

(i) The commissioner, by written order, may suspend or modify the requirement of filing as to any class of health insurance, subdivision, or combination thereof, or as to classes

of risks, the rates for which cannot practicably be filed before they are used. The order shall be made known to the affected managed care plan. The commissioner may make examinations that the commissioner deems advisable to ascertain whether any rates affected by the order meet the standards set forth in section 431:14F-103.

(j) No managed care plan shall make or issue a contract or policy except in accordance with filings which are in effect for the managed care plan as provided in this article.

(k) The commissioner may make the following rate effective when filed: any special filing with respect to any class of health insurance, subdivision, or combination thereof which is subject to individual risk premium modification and has been agreed to under a formal or informal bid process.

(l) For managed care plans having annual premium revenues of less than $10,000,000, the commissioner may adopt rules and procedures that will provide the commissioner with sufficient facts necessary to determine the reasonableness of the proposed rates without unduly burdening the managed care plan and its enrollees[~~.~~]; provided that the rates meet the standards of section 431:14F-103.

[~~(m) All managed care plans shall file initial rates within thirty days of January 1, 2003. These rates shall be in effect until approved by the commissioner. The time limits set forth in this article for the commissioner's review of rates shall not apply to the commissioner's review of initial rates; provided that the commissioner shall review the initial rates within a reasonable period.~~]

(m) Subsections (a) through (l) shall not apply to third party administrator services, prepaid dental insurance offered by managed care plans, prepaid vision insurance offered by managed care plans and disability insurers licensed under chapter 431. For managed care plans with rates based totally or in part on the individual group's claims experience, insurers subject to this subsection shall submit to the commissioner for approval descriptions of the methodology to be used in creating rates and every modification thereof that it proposes to use. The description of methodology shall contain specific information allowing a determination of rates that meet the standards of section 431:14F-103(a). Every filing shall state its proposed effective date and shall indicate the character and extent of the coverage contemplated. Complete supporting and

supplementary rating information for rates shall be maintained and made available to the commissioner upon request."

SECTION 4. Section 431:14F-108, Hawaii Revised Statutes, is amended as follows:

1. By amending subsections (a) to (d) to read:

"(a) If within the waiting period or any extension of the waiting period [~~as~~] provided in section 431:14F-105, the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall send to the managed care plan [~~which~~] that made the filing, written notice of disapproval of the filing specifying in what respects the filing fails to meet the requirements of this article; specifying the actuarial, statutory, and regulatory basis for the disapproval, including a detailed explanation of the application thereof that resulted in disapproval; and stating that the filing shall not become effective.

(b) Whenever a managed care plan has no legally effective rates as a result of the commissioner's disapproval of rates, a finding pursuant to subsection (c) that a filing is no longer effective, or other act, interim rates shall be established within ten days of disapproval, or other act, as follows:

(1) The commissioner shall specify interim rates sufficient to protect the interests of the managed care plan and its enrollees, ensure the solvency of the managed care plan, maintain the plan's health care delivery, and prevent any impairment of enrollees' health care benefits. The interim rate shall be no less than the median between the existing rate and the disapproved rate. When a new rate becomes legally effective and the new rate is higher than the interim rate, the commissioner shall allow the managed care plan to exact a surcharge on premiums retroactive to the time when the interim rate was first imposed. If the new rate is lower than the interim rate, the commissioner may order that the difference be applied to stabilize future rates or be refunded to current enrollees of the managed care plan;

[~~(1)~~] (2) In the event a filing is disapproved, in whole or in part, a petition and demand for a contested case hearing may be filed in accordance with chapter 91. The managed care plan shall have the burden of proving that the disapproval is not justified[~~. While the action of the commissioner in disapproving the rate~~

~~filing is being challenged, the aggrieved managed care plan shall charge the rates established or the filed rates, whichever is lower~~]; or

[~~(2)~~] (3) In the event a filing is approved, a contested case hearing in accordance with chapter 91 may be convened pursuant to subsection (c) to determine if the approved rates comply with the requirements of this article. If an appeal is taken from the commissioner's approval or if subsequent to the approval the commissioner convenes a hearing pursuant to subsection (c), the filing of the appeal or the commissioner's notice of hearing shall not stay the implementation of the rates approved by the commissioner, or the rates currently in effect, whichever is higher[~~;~~

~~(3) The commissioner may waive or modify the requirements of paragraph (1) or (2) if the application of those paragraphs will endanger the financial solvency of the managed care plan or the welfare of its enrollees. The commissioner may also order that a specified portion of the premiums be placed in an escrow account approved by the commissioner. When new rates become~~

~~legally effective, the commissioner may order the escrowed funds or any change in interim rates to be refunded or allow the managed care plan to exact a surcharge on premiums, whichever applies~~].

(c) If at any time subsequent to the applicable review period provided for in section 431:14F-105, the commissioner finds that a filing does not comply with the requirements of this article, the commissioner shall order a hearing upon the filing. The hearing shall be held upon not less than ten days' written notice to every managed care plan that made such a filing. The notice shall specify the matters to be considered at the hearing[~~.~~] and state the specific factual and legal grounds to support the commissioner's finding of noncompliance. If after a hearing the commissioner finds that a filing does not meet the requirements of this article, the commissioner [~~shall~~] within thirty days of the hearing, shall issue an order specifying in what respects the filing fails to meet the requirements, and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. Copies of the order shall be sent to each managed care plan[~~.~~] whose rates are affected by the order. The order shall not

affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(d)(1) Any [~~person or~~] enrollee of a managed care plan or organization that purchases health insurance from a managed care plan aggrieved with respect to any filing [~~which~~] that is in effect may make written demand to the commissioner for a hearing thereon; provided that the managed care plan [~~which~~] that made the filing shall not be authorized to proceed under this subsection;

(2) The demand shall specify the grounds to be relied upon by the aggrieved [~~person~~] enrollee or organization and the demand [~~must~~] shall show that the [~~person~~] enrollee or organization has a specific economic interest affected by the filing;

(3) If the commissioner finds that the demand is made in good faith, that the applicant would be so aggrieved if the [~~person's~~] enrollee's or organization's grounds are established, and that the grounds otherwise justify a hearing, the commissioner, within thirty days after receipt of the demand, shall hold a hearing. The hearing shall be held upon not less than

ten days' written notice to the aggrieved party and to every managed care plan [~~which~~] that made the filing[~~,~~]. The aggrieved party shall bear the burden of proving that the filing fails to meet the standards set forth in section 431:14F-103; and

(4) If, after the hearing, the commissioner finds that the filing does not meet the requirements of this article, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this article, and stating when, within a reasonable period, the filing shall be deemed no longer effective. Copies of the order shall be sent to the applicant and to every such managed care plan. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order."

SECTION 5. Section 431:14F-110, Hawaii Revised Statutes, is amended to read as follows:

"[~~,~~]**§431:14F-110**[~~,~~] **Information to be furnished enrollees; hearings and appeals of enrollees.** Every managed care plan [~~which~~] that makes its own rates, within a reasonable time after receiving written request therefor and upon payment of such

reasonable charges as it may make, shall furnish to any enrollee affected by a rate made by it or to the authorized representative of the enrollee, all pertinent information as to the rate[~~.~~]; provided that the managed care plan shall not be required to disclose supporting information and supplementary rating information protected pursuant to section 431:14F-105(d)."

SECTION 6. Section 431:14F-113, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Any managed care plan aggrieved by any order or decision of the commissioner made without a hearing, within thirty days after notice of the order to the managed care plan, may make written request to the commissioner for a hearing. The commissioner shall hold a hearing within twenty days after receipt of the request, and shall give not less than ten days' written notice of the time and place of the hearing. The commissioner shall promptly conduct and complete the hearing. Within fifteen days after the hearing[~~.~~] is completed, the commissioner shall affirm, reverse, or modify the commissioner's previous action, specifying the reasons for the commissioner's decision. Pending the hearing and decision, the commissioner

may suspend or postpone the effective date of the commissioner's previous action."

SECTION 7. Act 74, Session Laws of Hawaii 2002, section 6 as amended by Act 3, Session Laws of Hawaii 2003, section 22 is amended to read as follows:

"SECTION 6. This Act shall take effect on January 1, 2003; provided that this Act shall be repealed on June 30, [~~2006;~~] 2010; and provided further that sections 432:1-102(b) and 432D-19(d), Hawaii Revised Statutes, shall be reenacted in the form in which they read on the day before the effective date of this Act."

SECTION 8. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 9. This Act shall take effect on July 1, 2020.

S.B. NO. 2917

Report Title:
Health Insurance Rate Regulation

Description:
Increases parity between health insurance provider rate reporting requirements; accelerates rate approval process; protects confidentiality of providers' proprietary filings; requires Insurance Commissioner to disclose findings resulting in hearings or rate disapproval; provides that upon request, managed care plans will provide supporting information on rates for experience-rated and certain other groups. Takes effect on July 1, 2020. (SB2917 HD3)