H.B. NO. 1318

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE RATE REGULATION.

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

SECTION 1. The purpose of this Act is to protect the public welfare by stabilizing and, to the extent possible, reducing health insurance premiums. This measure benefits the public welfare because health insurance is a significant cost to the citizens of this State not only directly but also indirectly in the form of public funding of medical care for those unable to obtain medical insurance. This measure also benefits the state economy because health insurance, which most employers are required to offer to their employees, is a significant cost borne by Hawaii employers and employees.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new article to be appropriately designated and to read as follows:

"**ARTICLE**

HEALTH INSURANCE RATE REGULATION

§431: -101 Scope and purpose. (a) This article shall apply to all types of health insurance offered by managed care plans.

(b) The purpose of this article is to promote the public welfare by regulating health insurance rates so that they shall not be excessive, inadequate, or unfairly discriminatory. Nothing in this article is intended to:

(1) Prohibit or discourage reasonable competition; or

(2) Prohibit or discourage, except to the extent necessary to accomplish the aforementioned purposes, uniformity in insurance rates, rating systems, rating plans, or practices.

This article shall be liberally interpreted to effectuate its purposes.

§431: -102 Definitions. As used in this article:

"Commissioner" means the insurance commissioner.

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

"Managed care plan" or "plan" means a health plan as defined in chapter 431:10A, 432, or 432D, regardless of form, offered or administered by a health care insurer, including, but

not limited to, a mutual benefit society, a health maintenance organization, a mutual benefit society of an employee organization, or a voluntary employee beneficiary association, but shall not include disability insurers licensed under chapter 431.

"Rate" has the same meaning as set forth in section 431:14-101.5; provided that the definition of "rate" shall exclude fees and fee schedules paid by the insurer to providers of services covered under this article.

"Supplementary rating information" includes any 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.

"Supporting information" means:

(1) The experience and judgment of the filer and the experience or data of other organizations relied on by the filer;

(2) The interpretation of any other data relied upon by the filer; and

(3) Descriptions of methods used in making the rates and any other information required by the commissioner to be filed.

§431: -103 Making of rates. (a) Rates shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable in relation to the costs of the benefits provided.

(b) Except to the extent necessary to meet the provisions of subsection (a), uniformity among managed care plans in any matters within the scope of this article shall be neither required nor prohibited.

§431: -104 Rate filings. (a) Every managed care plan shall file in triplicate with the commissioner every rate and every modification of a rate that 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. A managed care plan shall not make a separate filing for each and every employer that it covers, but shall set forth the rate methodology applicable to the rates derived for each and every employer. The rate methodology provided by the managed care plan shall contain sufficient detail and supporting information to enable the commissioner to make the determination required by

section 431: -103(a). The commissioner may require that the managed care plan make sample filings that set forth the application of the rate methodology to specific employers designated by the commissioner.

All managed care plans shall file initial rates within thirty days of January 1, 2008. These rates shall be in effect until approved or disapproved 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, as the commissioner shall have a reasonable time to review the initial rates.

(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 that has been approved by the commissioner. The information furnished in support of a filing may include or consist of a reference to:

(1) The plan's interpretation of any statistical data upon which it relies;

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

(3) Any other relevant factors.

(d) When a filing is not accompanied by supplementary rating and 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 set forth in subsection (h) 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 disapproved.

(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) 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) 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) Except as provided herein and in subsections (d) and (i), each filing shall be on file for a waiting period of sixty days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed 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 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 within the waiting period or any extension thereof.

(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: -103.

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

(k) Any special filing with respect to any class of health insurance, subdivision, or combination thereof that is subject to individual risk premium modification and has been agreed to under a formal or informal bid process may be made effective upon filing in the sole discretion of the commissioner.

(l) For managed care plans having annual premium revenues of less than $10,000,000, the commissioner may adopt rules pursuant to chapter 91 that will require the managed care plan

to 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.

§431: -105 Policy revisions that alter coverage. All plan revisions that alter coverage in any manner shall be filed with the commissioner. After review by the commissioner, the commissioner shall determine whether a rate filing for the plan revision shall be submitted in accordance with section 431: -104. Plan revisions that affect the rate shall not be used unless the rate associated with those revisions is approved by the commissioner.

§431: -106 Disapproval of filings. (a) If within the waiting period or any extension of the waiting period as provided in section 431: -104(h), the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall send, to the managed care plan which made the filing, written notice of disapproval of the filing specifying in what respects the filing fails to meet the requirements of this article 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, interim rates shall be established as follows:

(1) In the event a filing is disapproved, in whole or in part, a request 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. Until the contested case proceeding or any appeal therefrom is terminated by a final order, the aggrieved managed care plan shall charge the rates established or the filed rates, whichever is lower; or

(2) The commissioner may allow the managed care plan to charge rates that are other than those established or filed if the application of the established or filed rate 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, as approved by the commissioner, be placed in an escrow account. When new rates become legally effective, the commissioner, in the commissioner's sole discretion, may order the

escrowed funds or any rate reduction to be refunded or allow the managed care plan to exact a surcharge on premiums.

(c) If at any time subsequent to the applicable review period provided for in section 431: -104, the commissioner finds that a filing does not comply with the requirements of this article, the commissioner shall order a hearing regarding the filing. The hearing shall be held not less than thirty days after written notice is given to the managed care plan that made the filing. The notice shall specify the matters to be considered at the hearing. If after a hearing the commissioner finds that a 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, 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 affected 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.

(d)(1) Any person or organization aggrieved with respect to any filing which is in effect may make written demand to the commissioner for a hearing thereon;

provided that the managed care plan which 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 or organization and the demand shall show that the person 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 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 not less than thirty days after written notice is given to the applicant and to every managed care plan which made the filing; 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 affected 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.

(e) The notices, hearings, orders, and appeals referred to in this section, in all applicable respects, shall be subject to chapter 91, unless expressly provided otherwise.

§431: -107 Managed care plans; prohibited activity. (a) Except as permitted in this article, no managed care plan shall:

(1) Attempt to monopolize, or combine or conspire to monopolize, an insurance market; or

(2) Engage in a boycott of an insurance market.

(b) Except as permitted in this article, no managed care plan shall make any arrangement that has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance.

§431: -108 Information to be furnished enrollees; hearings and appeals of enrollees. Every managed care plan, within a reasonable time after receiving an enrollee's written request for rate information and upon the enrollee's payment of a reasonable charge, shall furnish to any enrollee affected by a

rate made by it or to the authorized representative of the enrollee, all pertinent information demonstrating how the rate was calculated.

§431: -109 False or misleading information. No person or organization shall wilfully withhold information from or knowingly give false or misleading information to the commissioner, any statistical agency designated by the commissioner, or any managed care plan, which will affect the rates or premiums chargeable under this article. A violator shall be subject to the penalties provided in section 431: -110.

§431: -110 Penalties. (a) If the commissioner finds that any plan, person, or organization has violated any provision of this article, the commissioner may impose a penalty of not more than $500 for each violation; provided that if the commissioner finds the violation to be wilful, the commissioner may impose a penalty of not more than $5,000 for each violation. The penalty may be in addition to any other penalty provided by law. For purposes of this section, any managed care plan using a rate for which the managed care plan has failed to file the rate, supplementary rating information, underwriting rules or guides, or supporting information as required by this article,

shall have committed a separate violation for each day the failure to file continues.

(b) The commissioner may suspend the license or operating authority of any managed care plan that fails to comply with an order of the commissioner within the time limited by the order, or any extension thereof that the commissioner may grant. The commissioner shall not suspend the license of any managed care plan for failure to comply with an order until the time prescribed for an appeal from the order has expired or, if an appeal has been taken, until the order has been affirmed. The commissioner may determine when a suspension of license or operating authority shall become effective and the suspension shall remain in effect for the period fixed by the commissioner, unless the commissioner modifies or rescinds the suspension.

(c) No penalty shall be imposed and no license or operating authority shall be suspended or revoked except upon a written order of the commissioner, stating the commissioner's findings, made after a hearing held not less than thirty days after written notice is given to the person or organization. The notice shall specify the alleged violation.

§431: -111 Hearing procedure and judicial review. (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 thirty days after receipt of the request, and shall give not less than ten days' written notice of the time and place of the hearing. Within thirty days after the hearing, 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.

(b) Any final order or decision of the commissioner may be appealed by the managed care plan to the circuit court of the first circuit and an appeal from the decision of that court shall lie to the appellate courts. The review shall be taken as provided in chapter 91."

SECTION 3. Section 432:1-102, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Article 2 [~~and~~], article 13, and article ___ of chapter 431, and the powers there granted to the commissioner, shall apply to managed care plans, health maintenance organizations, [~~or~~] and medical indemnity or hospital service

associations, [~~which~~] that are owned or controlled by mutual benefit societies, so long as [~~such~~] the application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations."

SECTION 4. Section 432D-19, Hawaii Revised Statutes, is amended by amending subsection (d) to read as follows:

"(d) Article 2 [~~and~~], article 13, and article ___ of chapter 431, and the power there granted to the commissioner, shall apply to health maintenance organizations, so long as [~~such~~] the application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations."

SECTION 5. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 6. This Act shall take effect upon its approval.

INTRODUCED BY: Calvin K.Y. Say

BY REQUEST

JAN 22 2006

H.B. NO. 1318

JUSTIFICATION SHEET

DEPARTMENT: Commerce and Consumer Affairs

TITLE: A BILL FOR AN ACT RELATING TO HEALTH INSURANCE RATE REGULATION.

PURPOSE: To provide for the oversight by the Insurance Commissioner of health insurance premium rates. The proposal would allow the Commissioner to disapprove rates if they are excessive, inadequate, or unfairly discriminatory.

MEANS: Add a new article to chapter 431, Hawaii Revised Statutes, and amend Hawaii Revised Statutes section 432:1-102 and 432D-19.

JUSTIFICATION: Hawaii's health insurance market is characterized by very limited competition. In this environment, rate oversight is needed to prevent excessive rates. It is also needed to create a level playing field by not allowing health insurers with large reserves to use those reserves to unfairly under-price smaller competitors or new entrants.

No other state besides Hawaii mandates employer group health insurance. When government mandates by law that citizens buy a product, it has some responsibility to review the product for fair pricing. Rate oversight allows the Insurance Commissioner to act to protect the public in evaluating rates. This is important because premium rates are impossible for the public to evaluate properly without the detailed information provided in rate filings. Additionally, rate oversight is a key mechanism by which the insurance commissioner can be proactive in preventing insurer insolvencies. Rate oversight is also needed because rates are expected to continue to rise and the public needs some

assurance that pricing is being done in a fair and reasonable way.

Impact on the public: There should be a positive impact on the public as they continue to be provided with a mechanism for screening out health premium rates that are excessive, inadequate, or unfairly discriminatory. The public will be better protected against insolvencies and may benefit from increased competition that can result from the level playing field provided by rate oversight.

Impact on the department and other agencies: The cost of health rate oversight is estimated at about $350,000 per year to be paid out of the Compliance Resolution Fund.

GENERAL FUND: None.

OTHER FUNDS: None.

PPBS PROGRAM DESIGNATION: CCA-106

OTHER AFFECTED AGENCIES: None.

EFFECTIVE DATE: Upon approval.