H.B. NO. 1321

A BILL FOR AN ACT

RELATING TO PRESCRIPTION DRUG PLANS.

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

SECTION 1. The legislature finds that certain prescription drug plans are selling drugs in Hawaii pursuant to the Medicare Modernization Act, which established the drug benefit of medicare part D. Some companies selling drugs as prescription drug plans have a certificate of authority as a mutual benefit society, a health maintenance organization, or a for-profit insurer. However, other companies are operating solely as stand alone prescription drug plans under a limited authorization from the federal government. These plans have a window of three years to become authorized under state law and must be licensed by December 31, 2009, unless the State chooses not to have a licensing process for prescription drug plans. In order to provide this process for authorization and to bring these entities under regulatory oversight, enabling legislation is required. This legislation must impose requirements for licensing and oversight of financial solvency by the insurance commissioner.

The purpose of this Act is to impose regulatory oversight over prescription drug plans that are authorized to sell prescription drug benefits by the Centers for Medicare and Medicaid Services pursuant to medicare part D.

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

"**ARTICLE**

PRESCRIPTION DRUG PLANS

§431: -101 Scope; exemptions. The provisions of this article shall apply to prescription drug plans that:

(1) Are authorized by the Centers for Medicare and Medicaid Services to write medicare part D plans; and

(2) Do not have a certificate of authority under other provisions of Hawaii law.

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

"Commissioner" means the insurance commissioner of the State of Hawaii.

"Enrollee" means an individual who receives benefits from a prescription drug plan, including the individual's dependents and beneficiaries.

"Healthcare expenditures" means claims incurred.

"Net worth" means the excess of total admitted assets over total liabilities, provided that the liabilities shall not include fully subordinated debt.

"Operating expenses" means claims adjustment, administrative, soliciting, and reinsurance allowances.

"Prescription drug plan" means a plan authorized to sell prescription drug benefits by the Centers for Medicare and Medicaid Services pursuant to medicare part D.

§431: -103 Relationship to other laws. Except as expressly provided otherwise in this article, prescription drug plans shall be subject to the provisions of the insurance code.

§431: -104 Certificate of authority required. It is unlawful to establish or operate a prescription drug plan in this State unless the prescription drug plan has a valid certificate of authority issued by the commissioner under this article or other provisions of Hawaii law. No prescription drug plan shall operate in this State without a valid certificate of authority. The certificate of authority established by this section shall authorize the prescription drug plan to write prescription drug plan business. If the prescription drug plan writes another line of business it must do so under a

certificate of authority granted under the applicable provisions of Hawaii law.

§431: -105 Application for certificate of authority. (a) Any person may apply to the commissioner for a certificate of authority to establish and operate a domestic prescription drug plan to write prescription drug plan business in the State in compliance with this article.

(b) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, in a form prescribed by the commissioner, and include the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the internal conduct of the applicant;

(3) A list of the names, addresses, official positions, and biographical information, on forms acceptable to the commissioner, of the persons who are to be

responsible for the day-to-day operations of the applicant, including:

(A) The principal officers and all members of the board of directors, board of trustees, executive committee, or other governing board or committee; or

(B) The partners or members in the case of a partnership;

(4) A copy of any contract form used or to be used between any class of pharmacists and the prescription drug plan and a copy of any contract used or to be used between third party administrators or marketing consultants and the prescription drug plan;

(5) A copy of the form describing the coverage to be issued to the enrollees;

(6) A copy of the form of group contract used or to be used by the prescription drug plan;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, and both a copy of the applicant's most recent audited financial statement and the current financial statement;

(8) A financial feasibility plan that includes:

(A) Detailed enrollment projections;

(B) The methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person;

(C) A three year projection of balance sheets;

(D) A three year cash flow statements;

(E) Income and expense statements anticipated from the start of operations until the organization has had net income for at least one year; provided that a minimum of three years of statements shall be submitted; and

(F) A statement as to the sources of working capital as well as any other sources of funding;

(9) A power of attorney duly executed by the applicant, if not domiciled in this State, appointing the commissioner and duly authorized deputy commissioners, as the true and lawful attorneys of the applicant in and for this State upon whom all lawful process may be served in any legal action or proceeding against the

prescription drug plan on a cause of action arising in this State;

(10) A statement or map reasonably describing the geographic area or areas to be served in the State;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection against insolvency requirements in section 431: -106;

(14) A list of the names, addresses, and license numbers of all pharmacists or groups of pharmacists with which the prescription drug plan has agreements; and

(15) Such other information as the commissioner deems appropriate.

(c) If the commissioner finds that the applicant has met the requirements of this article and the applicable insurance laws, the commissioner shall issue a certificate of authority to the applicant. A certificate of authority may be denied in accordance with section 431: -108.

§431: -106 Protection against insolvency. (a) Net worth requirements shall be as follows:

(1) Before issuing any certificate of authority, the commissioner shall require the prescription drug plan to have an initial net worth of $2,000,000 and to maintain the minimum net worth required under paragraph (2) thereafter; and

(2) Every prescription drug plan shall maintain a minimum net worth equal to the greater of:

(A) $2,000,000;

(B) Two per cent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first $150,000,000 of premium revenues and one per cent of annual premium revenues on the premium revenues in excess of $150,000,000; or

(C) An amount equal to the sum of eight per cent of annual healthcare expenditures and operating expenses as reported on the most recent financial statement filed with the commissioner.

In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated.

Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(b) Deposit requirements shall be as follows:

(1) Unless otherwise provided below, each prescription drug plan shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other assets that are acceptable to the

commissioner and which shall have a value of not less than $300,000 at all times;

(2) Deposits shall be an admitted asset of the prescription drug plan in the determination of net worth;

(3) All income from deposits shall be an asset of the prescription drug plan. A prescription drug plan that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other assets of equal value. A security shall be approved by the commissioner before being deposited or substituted; and

(4) The deposit shall be used to protect the interests of the prescription drug plan's enrollees and to assure continuation of health care services to enrollees of a prescription drug plan.

(c) Every prescription drug plan, when determining liabilities, shall include an amount estimated in the aggregate to provide for:

(1) Any unearned premium and the payment of all claims for health care expenditures that have been incurred,

whether reported or unreported, which are unpaid and for which the organization is or may be liable; and

(2) The expense of adjustment or settlement of claims.

Liabilities shall be computed in accordance with the National Association of Insurance Commissioners' annual statement instructions, following the practices and procedures prescribed by the National Association of Insurance Commissioners' accounting practices and procedure manuals.

(d) Every contract between a prescription drug plan and a pharmacist shall be in writing and shall provide that in the event the prescription drug plan fails to pay for the pharmaceuticals as set forth in the contract, the subscriber or enrollee shall not be liable to the pharmacist for any sums owed by the prescription drug plan. In the event that a contract with a pharmacist has not been reduced to writing as required by this subsection or the contract fails to contain the required provisions, the pharmacist shall not collect or attempt to collect from the subscriber or enrollee sums owed by the prescription drug plan.

(e) Each prescription drug plan shall prepare a copy of its quarterly net solvency report, verified by at least two principal officers, for review by the commissioner on or before

the forty-fifth day of each calendar quarter. The commissioner may prescribe the forms on which the reports are to be prepared. Every prescription drug plan shall maintain a copy of its current net solvency report on the premises of its primary place of business. The commissioner may order an examination, subject to article 2, to determine whether a prescription drug plan is in compliance with this section. Any prescription drug plan that fails or refuses to prepare or produce the quarterly net solvency report for the commissioner's review as required by this subsection shall be liable for a fine in an amount not less than $100 and not more than $500 per day.

§431: -107 Annual and quarterly reports. (a) Every prescription drug plan shall file annually, on or before March 1, a report verified by at least two principal officers covering the preceding calendar year. Each prescription drug plan shall file quarterly with the commissioner, on or before the forty-fifth day after each calendar quarter, a copy of its quarterly report verified by at least two principal officers. These reports shall comply with sections 431:3-301 and 431:3-302. The commissioner may prescribe the forms on which the reports are to be filed, including but not limited to the content of the information and the guidelines for preparing the reports. In

addition, the prescription drug plan shall file the following annually with the commissioner by the dates specified herein:

(1) An audit of its financial statements, by an independent certified public accountant or an accounting firm designated by the prescription drug plan, reporting the financial condition and results of operations of the prescription drug plan on or before June 1 of each year, or a later date as the commissioner upon request or for cause may specify. The prescription drug plan, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner, in the commissioner's sole discretion, may disapprove the prescription drug plan's designation within fifteen days of receipt of the prescription drug plan's notice, whereupon the prescription drug plan shall be required to designate another independent certified public accountant or accounting firm. The audit required in this paragraph shall be prepared in accordance with the National Association of Insurance Commissioners' annual

statement instructions, following the practices and procedures prescribed by the National Association of Insurance Commissioners' accounting practices and procedures manuals; and

(2) A description of the available grievance procedures, the total number of grievances handled through those procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances on or before March 1 of each year.

(b) The commissioner may require additional reports as are deemed necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this chapter.

(c) The commissioner may waive the requirement to file financial statements if the prescription drug plan files the statements with the insurance regulator of the plan's domiciliary state.

(d) The commissioner may suspend or revoke the certificate of authority of any prescription drug plan that fails to file any of the documents required under subsection (a) or (b). In lieu of or in addition to the suspension or revocation of the certificate of authority of any prescription drug plan, the

commissioner may fine the prescription drug plan not less than $100 and not more than $500 for each day of delinquency.

§431: -108 Suspension, revocation, or denial of certificate of authority; imposition of administrative penalty. (a) Any certificate of authority issued under this article may be suspended or revoked, and any application for a certificate of authority may be denied, if the commissioner finds that any of the conditions listed below exist:

(1) The prescription drug plan is operating contrary to the information submitted to the commissioner in obtaining a certificate of authority, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The prescription drug plan is no longer financially solvent or may reasonably be expected to be unable to meet its current or future obligations to enrollees or prospective enrollees;

(3) The prescription drug plan has failed to correct, within the time prescribed by subsection (c), any deficiency occurring due to the prescription drug plan's prescribed minimum net worth being impaired;

(4) The prescription drug plan, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(5) The continued operation of the prescription drug plan would be hazardous to its enrollees;

(6) The prescription drug plan has otherwise failed to comply with this chapter; or

(7) The prescription drug plan fails to file documents required under sections 431: 107(a) or 431: 107(b).

(b) In addition to, or in lieu of, suspension or revocation of a certificate of authority pursuant to this section, the commissioner may levy an administrative fine upon the prescription drug plan in an amount not less than $500 and not more than $50,000 pursuant to section 431:3-221.

(c) The following shall pertain when a plan has an insufficient net worth:

(1) Whenever the commissioner finds that the net worth maintained by any prescription drug plan subject to this chapter is less than the minimum net worth required, the commissioner shall give written notice

to the prescription drug plan of the amount of the deficiency and require the prescription drug plan to:

(A) File with the commissioner a strategy for correction of the deficiency that is acceptable to the commissioner; and

(B) Correct the deficiency within a reasonable time, not to exceed sixty days, or within the extension of time granted by the commissioner. The deficiency shall be deemed an impairment and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the plan's certificate of authority or for placing the plan in conservation, rehabilitation, or liquidation; and

(2) Unless allowed by the commissioner, no prescription drug plan or person acting on its behalf, directly or indirectly, may renew, issue, or deliver any certificate, agreement, or contract of coverage in this State, for which a premium is charged or collected, when the prescription drug plan writing the coverage is impaired and the impairment is known to the prescription drug plan. However, the existence of

an impairment shall not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain new, renewed, or converted coverage.

(d) A certificate of authority may be suspended or revoked, an application for a certificate of authority may be denied, or an administrative penalty may be imposed, pursuant to the following procedures:

(1) Suspension or revocation of a certificate of authority, denial of an application, or imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the prescription drug plan or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct upon which suspension, revocation, denial, or administrative penalty is based. The prescription drug plan or applicant, in writing, may request a hearing pursuant to section 431:2-308; and

(2) If the prescription drug plan or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to

the prescription drug plan or applicant by certified or registered mail stating:

(A) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(B) A specific place for the hearing.

(e) When the certificate of authority of a prescription drug plan is suspended, the prescription drug plan shall not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

(f) When the certificate of authority of a prescription drug plan is revoked, the plan, immediately following the effective date of the order of revocation, shall proceed to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the plan. It shall engage in no further advertising or solicitation whatsoever. The commissioner, by written order, may permit further operation of the plan as the commissioner may find to be in the best interest of the enrollees, to the end that the

enrollees will be afforded the greatest practical opportunity to obtain continuing drug coverage.

§431: -109 Commissioner's authority. (a) In the event that a prescription drug plan fails to comply with this article, the commissioner may take appropriate action to enforce an order of the commissioner directing compliance. Applicable action includes any applicable action or penalty provided in the insurance code.

(b) Nothing contained in this section shall require the commissioner to disclose any information or records that demonstrate the existence or content of any investigation or activity of a criminal justice agency.

(c) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against health care providers.

(d) All remedies, penalties, and proceedings in chapter 431 are applicable to this article regarding prescription drug plans and shall be invoked and enforced solely and exclusively by the commissioner.

(e) Any order of the commissioner issued under this article shall be considered a final administrative action, may

be issued prior to hearing, shall be issued and served as provided in section 431:2-202, and may be appealed pursuant to chapter 91.

§431: -110 Rules. The commissioner may adopt rules pursuant to chapter 91 necessary for the purposes of this article."

SECTION 3. This Act shall take effect upon its approval.

INTRODUCED BY: Calvin K. Say

BY REQUEST

JAN 22 2007

H.B. NO. 1321

JUSTIFICATION SHEET

DEPARTMENT: Commerce and Consumer Affairs

TITLE: A BILL FOR AN ACT RELATING TO PRESCRIPTION DRUG PLANS.

PURPOSE: To establish licensing and solvency requirements for prescription drug plans that are offering a pharmacy benefit pursuant to Medicare Part D.

MEANS: Add a new article to chapter 431, Hawaii Revised Statutes.

JUSTIFICATION: The Centers for Medicare and Medicaid Services currently allow entities to offer a prescription drug plan in Hawaii. However, they also require that these entities become licensed prior to December 31, 2009. There is currently no enabling statutes for these entities, which are not otherwise established as a mutual benefit society, health maintenance organization, or for profit health insurer and which are selling only a pharmacy benefit. This bill will bring these entities under regulatory control and subject them to licensing, solvency and examination authority of the insurance commissioner for the protection of the public. Without this bill, some prescription drug plans may have to leave the market, thus depriving the public of maximum consumer choice.

Impact on the public: Improves the ability of the insurance commissioner to protect the public by regulating prescription drug plans.

Impact on the department and other agencies: None anticipated.

GENERAL FUND: None.

OTHER FUNDS: None.

PPBS PROGRAM DESIGNATION: CCA-106.

OTHER AFFECTED AGENCIES: None.

EFFECTIVE DATE: Upon approval.