HOUSE OF REPRESENTATIVES
TWENTY-FOURTH LEGISLATURE, 2007
STATE OF HAWAII

H.B. NO. 228

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that the health insurance market in Hawaii is currently dominated by one company, which doesn't provide a competitive market to inhibit any improper behavior. Suitable oversight of this industry is imperative to prevent harm to small businesses and encourage other insurers to enter the market.

This Act stabilizes health insurance, a significant fixed cost borne by Hawaii employers and employees. This Act proposes to regulate health insurance rates to protect the public interest and to help ensure that health insurance rates are not excessive, inadequate, or unfairly discriminatory in a manner similar to the way that motor vehicle, workers' compensation, homeowners', and other property and casualty insurance lines are presently regulated. Also, this Act assures that rates will not be confiscatory or predatory.

Rate regulation ensures that rates are not excessive, thereby protecting employers and employees from unduly burdensome and unwarranted premium increases. Rate regulation

also ensures that rates are adequate to promote the long-term viability of health care plans and are actuarially prudent, while preventing predatory pricing.

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 to the end 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 encourage, 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 carry into effect this section.

§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 431:10H-205, 432, or 432D, regardless of form, offered or administered by a health care insurer, including but not limited to a mutual benefit society or a health maintenance organization, or voluntary employee beneficiary associations, but shall not include disability insurers licensed under chapter 431.

"Rate" means every 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 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 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 section shall be neither required nor prohibited.

§431: -104 Rate adjustment mandates. (a) Except as otherwise provided by law, the commissioner may mandate filings for health insurance under section 431: -105 when the commissioner has actuarially sound information that current rates may be excessive, inadequate, or unfairly discriminatory.

(b) Managed care plans shall submit the rate filings within one hundred twenty days of the commissioner's mandate.

(c) The rate filings shall be subject to the rate filing requirements under section 431: -105.

§431: -105 Rate filings. (a) Every managed care plan shall file in triplicate with the commissioner, every rate, charge, classification, schedule, practice, and 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 shall also 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.

(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 subsection (d), each filing shall be on file for a waiting period of ninety days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen 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. 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.

(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 which are in effect for the managed care plan as provided in this article.

(k) The commissioner may make 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 effective when filed.

(1) 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.

(m) All managed care plans shall file initial rates within thirty days of the effective date of this article. 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.

§431: -106 Reserves. (a) If a managed care plan's net worth exceeds fifty per cent of its annual health care expenditures and operating expenses as reported on the most recent financial statement filed with the commissioner, the excess moneys shall either:

(1) Be returned to enrollees of the managed care plan; or

(2) Be applied to stabilize or reduce rates, charges, assessments, subscriptions, receipts, contributions,

fees, or dues payable by the enrollees of the managed care plan.

(b) Excess moneys applied in accordance with subsection (a)(2) shall be reallocated among all lines of health insurance business sold by the managed care plan. Reallocation of moneys pursuant to this section may be delayed until the amount of moneys available to be reallocated exceeds $10,000,000. Nothing in this section shall prohibit a managed care plan from maintaining reserves above minimum requirements but below the maximum limit or from returning moneys to, or reducing moneys payable by, enrollees of the managed care plan prior to reaching the maximum limit.

(c) Nothing in this section shall be construed to alter or eliminate the minimum reserve requirements applicable to the managed care plan. In the event of a conflict, the minimum reserve requirements shall control.

(d) Eighty per cent of all investment income on the net reserves of investment manager fees shall be applied to the rate determination and filing of the managed care plan. This requirement may be waived or adjusted by the commissioner if the commissioner determines it would impair the minimum reserve requirements or solvency of the managed care plan.

§431: -107 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 must be submitted in accordance with section 431: -105.

§431: -108 Disapproval of filings. (a) If within the waiting period or any extension of the waiting period as provided in section 431: -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 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 or other act, interim rates shall be established as follows:

(1) 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;

(2) 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; or

(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: -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. 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 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 must 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 upon not less than ten days written notice to the aggrieved party 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 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.

(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: -109 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 with any other person to monopolize an insurance market; or

(2) Engage in a boycott, on a concerted basis, of an insurance market.

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

§431: -110 Information to be furnished enrollees; hearings and appeals of enrollees. Every managed care plan which 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.

§431: -111 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. Violation of this section shall subject the one guilty of the violation to the penalties provided in section 431: -112.

§431: -112 Penalties. (a) If the commissioner finds that any 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 willful, the commissioner may impose a penalty of not more than $5,000 for each violation. The

penalties 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 it shall remain in effect for the period fixed by the commissioner unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

(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 upon not less than ten days' written notice to the person or organization. The notice shall specify the alleged violation.

§431: -113 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 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. Within fifteen 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 reviewed in the circuit court of the first circuit and an appeal from the decision of the court shall lie to the supreme court.

The review shall be taken and had in the manner 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 medical indemnity or hospital service associations, which are owned or controlled by mutual benefit societies, so long as such 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 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 on January 1, 2007.

INTRODUCED BY: _____

JAN 18 2007

Report Title:
Health Insurance; Rate Regulation

Description:
Prohibits health insurance rates that are excessive, inadequate, or unfairly discriminatory. Requires health care insurers to submit rate filings for approval by the insurance commissioner. Establishes penalties and appeal procedures.