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# A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE RATE REGULATION.

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

1           SECTION 1. The legislature finds that Act 74, Session Laws  
2 of Hawaii 2002 (Act 74), established a health insurance rate  
3 regulation law.

4           Act 74 assisted the state economy by stabilizing health  
5 insurance, a significant fixed cost borne by Hawaii employers  
6 and employees to help mitigate the economic effects of the  
7 terrorist acts of September 11, 2001. Act 74 regulated health  
8 insurance rates to protect the public interest and to help  
9 ensure that health insurance rates are not excessive,  
10 inadequate, or unfairly discriminatory in a manner similar to  
11 the way that motor vehicle, workers' compensation, homeowners',  
12 and other property and casualty insurance lines are presently  
13 regulated. In addition, Act 74 ensured that rates would not be  
14 confiscatory or predatory.

15           The 2002 legislature found that rate regulation of other  
16 lines of insurance, such as motor vehicle, homeowners', and  
17 workers' compensation, had resulted in premium decreases from



1 1997 to 2002, while unregulated health insurance rates rose over  
2 the same period. The 2002 legislature found, and this  
3 legislature agrees, that rate regulation ensures that rates are  
4 not excessive, thereby protecting employers and employees from  
5 unduly burdensome and unwarranted premium increases. Rate  
6 regulation also ensures that rates are adequate to promote the  
7 long-term viability of health care plans and are actuarially  
8 prudent, while preventing predatory pricing.

9 Unfortunately, Act 74 was repealed on June 30, 2006, under  
10 its own terms.

11 The purpose of this Act is to re-establish a health  
12 insurance rate regulation.

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

16 "ARTICLE

17 HEALTH INSURANCE RATE REGULATION

18 §431: -101 **Scope and purpose.** (a) This article shall  
19 apply to all types of health insurance offered by managed care  
20 plans.

21 (b) The purpose of this article is to promote the public  
22 welfare by regulating health insurance rates to the end that



1 they shall not be excessive, inadequate, or unfairly  
2 discriminatory. Nothing in this article is intended to:

- 3 (1) Prohibit or discourage reasonable competition; or
- 4 (2) Prohibit or encourage, except to the extent necessary  
5 to accomplish the aforementioned purposes, uniformity  
6 in insurance rates, rating systems, rating plans, or  
7 practices.

8 This article shall be liberally interpreted to carry into effect  
9 this section.

10 **§431: -102 Definitions.** As used in this article:

11 "Commissioner" means the insurance commissioner.

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

15 "Managed care plan" or "plan" means a health plan as  
16 defined in chapter 431:10A, 432, or 432D, regardless of form,  
17 offered or administered by a health care insurer, including, but  
18 not limited to, a mutual benefit society or a health maintenance  
19 organization, mutual benefit societies of employee  
20 organizations, or voluntary employee beneficiary associations,  
21 but shall not include disability insurers licensed under chapter  
22 431.



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

5 "Supplementary rating information" includes any manual or  
6 plan of rates, classification, rating schedule, minimum premium,  
7 policy fee, rating rule, underwriting rule, statistical plan,  
8 and any other similar information needed to determine the  
9 applicable rates in effect or to be in effect.

10 "Supporting information" means:

- 11 (1) The experience and judgment of the filer and the  
12 experience or data of other organizations relied on by  
13 the filer;
- 14 (2) The interpretation of any other data relied upon by  
15 the filer; and
- 16 (3) Descriptions of methods used in making the rates and  
17 any other information required by the commissioner to  
18 be filed.

19 **§431: -103 Making of rates.** (a) Rates shall not be  
20 excessive, inadequate, or unfairly discriminatory and shall be  
21 reasonable in relation to benefits provided.



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

5 **§431: -104 Rate adjustment mandates.** (a) Except as  
6 otherwise provided by law, the commissioner may mandate filings  
7 for health insurance under section 431: -105 when the  
8 commissioner has actuarially sound information that current  
9 rates may be excessive, inadequate, or unfairly discriminatory.

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

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

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



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

4 (c) At the same time as the filing of the rate, every  
5 managed care plan shall file all supplementary rating and  
6 supporting information to be used in support of or in  
7 conjunction with a rate. The managed care plan may satisfy its  
8 obligation to file supplementary rating and supporting  
9 information by reference to material which has been approved by  
10 the commissioner. The information furnished in support of a  
11 filing may include or consist of a reference to:

- 12 (1) Its interpretation of any statistical data upon which  
13 it relies;
- 14 (2) The experience of other managed care plans; or
- 15 (3) Any other relevant factors.

16 (d) When a filing is not accompanied by supporting  
17 information or the commissioner does not have sufficient  
18 information to determine whether the filing meets the  
19 requirements of this article, the commissioner shall require the  
20 managed care plan to furnish additional information and, in that  
21 event, the waiting period shall commence as of the date the  
22 information is furnished. Until the requested information is



1 provided, the filing shall not be deemed complete or filed and  
2 the filing shall not be used by the managed care plan. If the  
3 requested information is not provided within a reasonable time  
4 period, the filing may be returned to the managed care plan as  
5 not filed and not available for use.

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

11 (f) After reviewing a managed care plan's filing, the  
12 commissioner may require that the managed care plan's rates be  
13 based upon the managed care plan's own loss and expense  
14 information.

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

21 (h) Except as provided herein and in subsection (d), each  
22 filing shall be on file for a waiting period of ninety days



1 before the filing becomes effective. The period may be extended  
2 by the commissioner for an additional period not to exceed  
3 fifteen days if the commissioner gives written notice, within  
4 the waiting period to the managed care plan that made the  
5 filing, that the commissioner needs the additional time for the  
6 consideration of the filing. Upon written application by the  
7 managed care plan, the commissioner may authorize a filing,  
8 which the commissioner has reviewed, to become effective before  
9 the expiration of the waiting period or any extension thereof.  
10 A filing shall be deemed to meet the requirements of this  
11 article unless disapproved by the commissioner within the  
12 waiting period or any extension thereof. The rates shall be  
13 deemed to meet the requirements of this article until the time  
14 the commissioner reviews the filing and so long as the filing  
15 remains in effect.

16 (i) The commissioner, by written order, may suspend or  
17 modify the requirement of filing as to any class of health  
18 insurance, subdivision, or combination thereof, or as to classes  
19 of risks, the rates for which cannot practicably be filed before  
20 they are used. The order shall be made known to the affected  
21 managed care plan. The commissioner may make examinations that  
22 the commissioner deems advisable to ascertain whether any rates





1 affected by the order meet the standards set forth in section  
2 431: -103.

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

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

11 (l) For managed care plans having annual premium revenues  
12 of less than \$10,000,000, the commissioner may adopt rules and  
13 procedures that will provide the commissioner with sufficient  
14 facts necessary to determine the reasonableness of the proposed  
15 rates without unduly burdening the managed care plan and its  
16 enrollees.

17 (m) All managed care plans shall file initial rates within  
18 thirty days of the effective date of this article. These rates  
19 shall be in effect until approved by the commissioner. The time  
20 limits set forth in this article for the commissioner's review  
21 of rates shall not apply to the commissioner's review of initial



1 rates; provided that the commissioner shall review the initial  
2 rates within a reasonable period.

3       **§431: -106 Reserves.** (a) If a managed care plan's net  
4 worth exceeds fifty per cent of its annual health care  
5 expenditures and operating expenses as reported on the most  
6 recent financial statement filed with the commissioner, the  
7 excess moneys shall either:

- 8       (1) Be returned to enrollees of the managed care plan; or
- 9       (2) Be applied to stabilize or reduce rates, charges,  
10       assessments, subscriptions, receipts, contributions,  
11       fees, or dues payable by the enrollees of the managed  
12       care plan.

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



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

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

11 **§431: -107 Policy revisions that alter coverage.** All  
12 plan revisions that alter coverage in any manner shall be filed  
13 with the commissioner. After review by the commissioner, the  
14 commissioner shall determine whether a rate filing for the plan  
15 revision must be submitted in accordance with section  
16 431: -105.

17 **§431: -108 Disapproval of filings.** (a) If within the  
18 waiting period or any extension of the waiting period as  
19 provided in section 431: -105, the commissioner finds that a  
20 filing does not meet the requirements of this article, the  
21 commissioner shall send to the managed care plan which made the  
22 filing, written notice of disapproval of the filing specifying



1 in what respects the filing fails to meet the requirements of  
2 this article and stating that the filing shall not become  
3 effective.

4 (b) Whenever a managed care plan has no legally effective  
5 rates as a result of the commissioner's disapproval of rates or  
6 other act, interim rates shall be established as follows:

7 (1) In the event a filing is disapproved, in whole or in  
8 part, a petition and demand for a contested case  
9 hearing may be filed in accordance with chapter 91.

10 The managed care plan shall have the burden of proving  
11 that the disapproval is not justified. While the  
12 action of the commissioner in disapproving the rate  
13 filing is being challenged, the aggrieved managed care  
14 plan shall charge the rates established or the filed  
15 rates, whichever is lower; or

16 (2) In the event a filing is approved, a contested case  
17 hearing in accordance with chapter 91 may be convened  
18 pursuant to subsection (c) to determine if the  
19 approved rates comply with the requirements of this  
20 article. If an appeal is taken from the  
21 commissioner's approval or if subsequent to the  
22 approval the commissioner convenes a hearing pursuant



1 to subsection (c), the filing of the appeal or the  
2 commissioner's notice of hearing shall not stay the  
3 implementation of the rates approved by the  
4 commissioner, or the rates currently in effect,  
5 whichever is higher;

6 (3) The commissioner may waive or modify the requirements  
7 of paragraph (1) or (2) if the application of those  
8 paragraphs will endanger the financial solvency of the  
9 managed care plan or the welfare of its enrollees.

10 The commissioner may also order that a specified  
11 portion of the premiums be placed in an escrow account  
12 approved by the commissioner. When new rates become  
13 legally effective, the commissioner may order the  
14 escrowed funds or any change in interim rates to be  
15 refunded or allow the managed care plan to exact a  
16 surcharge on premiums, whichever applies.

17 (c) If at any time subsequent to the applicable review  
18 period provided for in section 431: -105, the commissioner  
19 finds that a filing does not comply with the requirements of  
20 this article, the commissioner shall order a hearing upon the  
21 filing. The hearing shall be held upon not less than ten days'  
22 written notice to every managed care plan that made such a



1 filing. The notice shall specify the matters to be considered  
2 at the hearing. If after a hearing the commissioner finds that  
3 a filing does not meet the requirements of this article, the  
4 commissioner shall issue an order specifying in what respects  
5 the filing fails to meet the requirements, and stating when,  
6 within a reasonable period thereafter, the filing shall be  
7 deemed no longer effective. Copies of the order shall be sent  
8 to each managed care plan. The order shall not affect any  
9 contract or policy made or issued prior to the expiration of the  
10 period set forth in the order.

11 (d) (1) Any person or organization aggrieved with respect  
12 to any filing which is in effect may make written  
13 demand to the commissioner for a hearing thereon;  
14 provided that the managed care plan which made the  
15 filing shall not be authorized to proceed under this  
16 subsection;

17 (2) The demand shall specify the grounds to be relied upon  
18 by the aggrieved person or organization and the demand  
19 must show that the person or organization has a  
20 specific economic interest affected by the filing;

21 (3) If the commissioner finds that the demand is made in  
22 good faith, that the applicant would be so aggrieved



1 if the person's or organization's grounds are  
2 established, and that the grounds otherwise justify a  
3 hearing, the commissioner, within thirty days after  
4 receipt of the demand, shall hold a hearing. The  
5 hearing shall be held upon not less than ten days'  
6 written notice to the aggrieved party and to every  
7 managed care plan which made the filing; and

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

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



1           **§431:    -109   Managed care plans; prohibited activity.**   (a)

2   Except as permitted in this article, no managed care plan shall:

3           (1)   Attempt to monopolize, or combine or conspire with any

4                   other person to monopolize an insurance market; or

5           (2)   Engage in a boycott, on a concerted basis, of an

6                   insurance market.

7           (b)   Except as permitted in this article, no managed care

8   plan shall make any arrangement with any other person which has

9   the purpose or effect of restraining trade unreasonably or of

10   substantially lessening competition in the business of

11   insurance.

12           **§431:    -110   Information to be furnished enrollees;**

13   **hearings and appeals of enrollees.**   Every managed care plan

14   which makes its own rates, within a reasonable time after

15   receiving written request therefor and upon payment of such

16   reasonable charges as it may make, shall furnish to any enrollee

17   affected by a rate made by it or to the authorized

18   representative of the enrollee, all pertinent information as to

19   the rate.

20           **§431:    -111   False or misleading information.**   No person

21   or organization shall wilfully withhold information from or

22   knowingly give false or misleading information to the





1 commissioner, any statistical agency designated by the  
2 commissioner, or any managed care plan, which will affect the  
3 rates or premiums chargeable under this article. Violation of  
4 this section shall subject the one guilty of the violation to  
5 the penalties provided in section 431: -112.

6 **§431: -112 Penalties.** (a) If the commissioner finds  
7 that any person or organization has violated any provision of  
8 this article, the commissioner may impose a penalty of not more  
9 than \$500 for each violation; provided that if the commissioner  
10 finds the violation to be wilful, the commissioner may impose a  
11 penalty of not more than \$5,000 for each violation. The  
12 penalties may be in addition to any other penalty provided by  
13 law. For purposes of this section, any managed care plan using  
14 a rate for which the managed care plan has failed to file the  
15 rate, supplementary rating information, underwriting rules or  
16 guides, or supporting information as required by this article,  
17 shall have committed a separate violation for each day the  
18 failure to file continues.

19 (b) The commissioner may suspend the license or operating  
20 authority of any managed care plan that fails to comply with an  
21 order of the commissioner within the time limited by the order,  
22 or any extension thereof that the commissioner may grant. The



1 commissioner shall not suspend the license of any managed care  
2 plan for failure to comply with an order until the time  
3 prescribed for an appeal from the order has expired or, if an  
4 appeal has been taken, until the order has been affirmed. The  
5 commissioner may determine when a suspension of license or  
6 operating authority shall become effective and it shall remain  
7 in effect for the period fixed by the commissioner unless the  
8 commissioner modifies or rescinds the suspension, or until the  
9 order upon which the suspension is based is modified, rescinded,  
10 or reversed.

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

17 **§431: -113 Hearing procedure and judicial review.** (a)  
18 Any managed care plan aggrieved by any order or decision of the  
19 commissioner made without a hearing, within thirty days after  
20 notice of the order to the managed care plan, may make written  
21 request to the commissioner for a hearing. The commissioner  
22 shall hold a hearing within twenty days after receipt of the



1 request, and shall give not less than ten days' written notice  
2 of the time and place of the hearing. Within fifteen days after  
3 the hearing, the commissioner shall affirm, reverse, or modify  
4 the commissioner's previous action, specifying the reasons for  
5 the commissioner's decision. Pending the hearing and decision,  
6 the commissioner may suspend or postpone the effective date of  
7 the commissioner's previous action.

8 (b) Any final order or decision of the commissioner may be  
9 reviewed in the circuit court of the first circuit and an appeal  
10 from the decision of the court shall lie to the supreme court.  
11 The review shall be taken and had in the manner provided in  
12 chapter 91."

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

15 "(b) Article 2 [~~and~~], article 13, and article of  
16 chapter 431, and the powers there granted to the commissioner,  
17 shall apply to managed care plans, health maintenance  
18 organizations, or medical indemnity or hospital service  
19 associations, which are owned or controlled by mutual benefit  
20 societies, so long as such application in any particular case is  
21 in compliance with and is not preempted by applicable federal  
22 statutes and regulations."



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

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

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

10 SECTION 6. This Act shall take effect on January 1, 2008.

11

INTRODUCED BY:

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**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.

