THE SENATE
TWENTY-FOURTH LEGISLATURE, 2007
STATE OF HAWAII

S.B. NO. 12 S.D. 2 H.D. 2 C.D. 1

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9 Unfortunately, Act 74 was repealed on June 30, 2006,
10 pursuant to a sunset provision.

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 section 431:10A, or chapter 432 or 432D, regardless
17 of form, offered or administered by a health care insurer,
18 including but not limited to a mutual benefit society or health
19 maintenance organization, or voluntary employee beneficiary
20 associations, but shall not include disability insurers licensed
21 under chapter 431.

"Rate" means every rate, charge, classification, schedule, practice, or rule. The definition of "rate" excludes 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.

1 (b) Except to the extent necessary to meet subsection (a),
2 uniformity among managed care plans in any matters within the
3 scope of this section shall be neither required nor prohibited.
4 **§431: -104 Rate adjustment mandates.** (a) Except as
5 otherwise provided by law, the commissioner may mandate filings
6 for health insurance under section 431: -105 when the
7 commissioner has actuarially sound information that current
8 rates may be excessive, inadequate, or unfairly discriminatory.
9 (b) Managed care plans shall submit the rate filings
10 within one hundred twenty days of the commissioner's mandate.
11 (c) The rate filings shall be subject to the rate filing
12 requirements under section 431: -105.
13 **§431: -105 Rate filings.** (a) Every managed care plan
14 shall file in triplicate with the commissioner, every rate,
15 charge, classification, schedule, practice, or rule and every
16 modification of any of the foregoing that it proposes to use.
17 Every filing shall state its proposed effective date and shall
18 indicate the character and extent of the coverage contemplated.
19 The filing also shall include a report on investment income.
20 (b) Each filing shall be accompanied by a $50 fee payable
21 to the commissioner and shall be deposited in the commissioner's
22 education and training fund.

1 (c) At the same time as the filing of the rate, every
2 managed care plan shall file all supplementary rating and
3 supporting information to be used in support of or in
4 conjunction with a rate. The managed care plan may satisfy its
5 obligation to file supplementary rating and supporting
6 information by reference to material that has been approved by
7 the commissioner. The information furnished in support of a
8 filing may include or consist of a reference to:
9 (1) Its interpretation of any statistical data upon which
10 it relies;
11 (2) The experience of other managed care plans; or
12 (3) Any other relevant factors.
13 (d) When a filing is not accompanied by supporting
14 information or the commissioner does not have sufficient
15 information to determine whether the filing meets the
16 requirements of this article, the commissioner shall require the
17 managed care plan to furnish additional information and, in that
18 event, the waiting period shall commence as of the date the
19 information is furnished. Until the requested information is
20 provided, the filing shall not be deemed complete or filed and
21 the filing shall not be used by the managed care plan. If the
22 requested information is not provided within a reasonable time

1 period, the filing may be returned to the managed care plan as
2 not filed and not available for use. Rates shall be open to
3 public inspection upon filing with the commissioner; provided
4 that the commissioner establishes rules to ensure that
5 confidential and proprietary information is protected and shall
6 not be subject to public inspection.
7 (e) Rates shall be established in accordance with
8 actuarial principles, based on reasonable assumptions, and
9 supported by adequate supporting and supplementary rating
10 information. After reviewing a managed care plan's filing, the
11 commissioner may require that the managed care plan's rates be
12 based upon the managed care plan's own loss and expense
13 information.
14 (f) The commissioner shall review filings promptly after
15 the filings have been made to determine whether the filings meet
16 the requirements of this article.
17 (g) Except as provided herein, each filing shall be on
18 file for a waiting period of sixty days before the filing
19 becomes effective. The period may be extended by the
20 commissioner for an additional period not to exceed fifteen days
21 if the commissioner gives written notice within the waiting
22 period to the managed care plan that made the filing, that the

1 commissioner needs the additional time for the consideration of
2 the filing. Upon written application by the managed care plan,
3 the commissioner may authorize a filing that the commissioner
4 has reviewed, to become effective before the expiration of the
5 waiting period or any extension thereof. A filing shall be
6 deemed to meet the requirements of this article unless
7 disapproved by the commissioner, as provided in section
8 431: -107, within the waiting period or any extension thereof.
9 The rates shall be deemed to meet the requirements of this
10 article until the time the commissioner reviews the filing and
11 so long as the filing remains in effect.
12 (h) If the commissioner finds that a filing does not meet
13 the requirements of this article, the commissioner, as provided
14 in section 431: -107, shall send the managed care plan a notice
15 of disapproval within the applicable sixty-day period or
16 fifteen-day extension provided by subsection (g).
17 (i) The commissioner, by written order, may suspend or
18 modify the requirement of filing as to any class of health
19 insurance, subdivision, or combination thereof, or as to classes
20 of risks, the rates which cannot practicably be filed before
21 they are used. The order shall be made known to the affected
22 managed care plan. The commissioner may make examinations that

1 the commissioner deems advisable to ascertain whether any rates
2 affected by the order meet the standards set forth in section
3 431: -103.
4 (j) No managed care plan shall make or issue a contract or
5 policy except in accordance with filings that are in effect for
6 the managed care plan as provided in this article.
7 (k) The commissioner may make the following rate effective
8 when filed: any special filing with respect to any class of
9 health insurance, subdivision, or combination thereof that is
10 subject to individual risk premium modification and has been
11 agreed to under a formal or informal bid process.
12 (l) For managed care plans having annual premium revenues
13 of less than $10,000,000, the commissioner may adopt rules and
14 procedures that will provide the commissioner with sufficient
15 facts necessary to determine the reasonableness of the proposed
16 rates without unduly burdening the managed care plan and its
17 enrollees; provided that the rates meet the standards of section
18 431: -103.
19 (m) Subsections (a) through (l) shall not apply to third
20 party administrator services, prepaid dental insurance offered
21 by managed care plans, prepaid vision insurance offered by
22 managed care plans and disability insurers licensed under

1 chapter 431. For managed care plans with rates based totally or
2 in part on the individual group's claims experience, insurers
3 subject to this subsection shall submit to the commissioner for
4 approval descriptions of the methodology to be used in creating
5 rates and every modification thereof that it proposes to use.
6 The description of methodology shall contain specific
7 information allowing a determination of rates that meet the
8 standards of section 431: -103(a) and supporting information
9 and justification. Every filing shall state its proposed
10 effective date and shall indicate the character and extent of
11 the coverage contemplated. Complete supporting and
12 supplementary rating information for rates shall be maintained
13 and made available to the commissioner upon request.
14 **§431: -106 Policy revisions that alter coverage.** All
15 plan revisions that alter coverage in any manner shall be filed
16 with the commissioner. After review by the commissioner, the
17 commissioner shall determine whether a rate filing for the plan
18 revision must be submitted in accordance with section
19 431: -105.
20 **§431: -107 Disapproval of filings.** (a) If, within the
21 waiting period or any extension of the waiting period as
22 provided in section 431: -105, the commissioner finds that a

1 filing does not meet the requirements of this article, the
2 commissioner shall send to the managed care plan that made the
3 filing, written notice of disapproval of the filing specifying
4 in what respects the filing fails to meet the requirements of
5 this article, specifying the actuarial, statutory, and
6 regulatory basis for the disapproval, including an explanation
7 of the application thereof that resulted in disapproval, and
8 stating that the filing shall not become effective.
9 (b) Whenever a managed care plan has no legally effective
10 rates as a result of the commissioner's disapproval of rates, a
11 finding pursuant to subsection (c) that a filing is no longer
12 effective, or other act, interim rates shall be established
13 within ten days of disapproval, or other act, as follows:
14 (1) The commissioner shall specify interim rates
15 sufficient to protect the interests of the managed
16 care plan and its enrollees, ensure the solvency of
17 the managed care plan, maintain the plan's health care
18 delivery, and prevent any impairment of enrollees'
19 health care benefits. When a new rate becomes legally
20 effective and the new rate is higher than the interim
21 rate, the commissioner shall allow the managed care
22 plan to retroactively adjust the premiums to the time

1 when the interim rate was first imposed. If the new
2 rate is lower than the interim rate, the commissioner
3 may order that the difference be applied to stabilize
4 future rates or be refunded to current enrollees of
5 the managed care plan;
6 (2) If a filing is disapproved, in whole or in part, a
7 petition and demand for a contested case hearing may
8 be filed in accordance with chapter 91. The managed
9 care plan shall have the burden of proving that the
10 disapproval is not justified; or
11 (3) If a filing is approved, a contested case hearing in
12 accordance with chapter 91 may be convened pursuant to
13 subsection (c) to determine if the approved rates
14 comply with the requirements of this article. If an
15 appeal is taken from the commissioner's approval or if
16 subsequent to the approval the commissioner convenes a
17 hearing pursuant to subsection (c), the filing of the
18 appeal or the commissioner's notice of hearing shall
19 not stay the implementation of the rates approved by
20 the commissioner, or the rates currently in effect,
21 whichever is higher.

1 (c) If at any time subsequent to the applicable review
2 period provided for in section 431: -105, the commissioner
3 finds that a filing does not comply with the requirements of
4 this article, the commissioner shall order a hearing upon the
5 filing. The hearing shall be held upon not less than ten days'
6 written notice to every managed care plan that made such a
7 filing. The notice shall specify the matters to be considered
8 at the hearing and state the specific factual and legal grounds
9 to support the commissioner's finding of noncompliance. If,
10 after a hearing the commissioner finds that a filing does not
11 meet the requirements of this article, the commissioner within
12 thirty days of the hearing, shall issue an order specifying in
13 what respects the filing fails to meet the requirements, and
14 stating when, within a reasonable period thereafter, the filing
15 shall be deemed no longer effective. Copies of the order shall
16 be sent to each managed care plan whose rates are affected by
17 the order. The order shall not affect any contract or policy
18 made or issued prior to the expiration of the period set forth
19 in the order.
20 (d) (1) Any enrollee of a managed care plan or
21 organization that purchases health insurance from a
22 managed care plan aggrieved with respect to any filing

1 that is in effect may make a written demand to the
2 commissioner for a hearing thereon; provided that the
3 managed care plan that made the filing shall not be
4 authorized to proceed under this subsection;
5 (2) The demand shall specify the grounds to be relied upon
6 by the aggrieved enrollee or organization and the
7 demand shall show that the enrollee or organization
8 has a specific economic interest affected by the
9 filing;
10 (3) If the commissioner finds that:
11 (A) The demand is made in good faith;
12 (B) The applicant would be so aggrieved if the
13 enrollee's or organization's grounds are
14 established; and
15 (C) The grounds otherwise justify a hearing;
16 The commissioner, within thirty days after receipt of
17 the demand, shall hold a hearing. The hearing shall
18 be held upon not less than ten days' written notice to
19 the aggrieved party and to every managed care plan
20 that made the filing. The aggrieved party shall bear
21 the burden of proving that the filing fails to meet
22 the standards set forth in section 431: -103; and

1 (4) If, after the hearing, the commissioner finds that the
2 filing does not meet the requirements of this article,
3 the commissioner shall issue an order specifying in
4 what respects the filing fails to meet the
5 requirements of this article, and stating when, within
6 a reasonable period, the filing shall be deemed no
7 longer effective. Copies of the order shall be sent
8 to the applicant and to every affected managed care
9 plan. The order shall not affect any contract or
10 policy made or issued prior to the expiration of the
11 period set forth in the order.
12 (e) The notices, hearings, orders, and appeals referred to
13 in this section, in all applicable respects, shall be subject to
14 chapter 91, unless expressly provided otherwise.
15 **§431: -108 Managed care plans; prohibited activity.** (a)
16 Except as permitted in this article, no managed care plan shall:
17 (1) Attempt to monopolize, or combine or conspire with any
18 other person to monopolize an insurance market; or
19 (2) Engage in a boycott, on a concerted basis, of an
20 insurance market.
21 (b) Except as permitted in this article, no managed care
22 plan shall make any arrangement with any other person that has

1 the purpose or effect of restraining trade unreasonably or of
2 substantially lessening competition in the business of
3 insurance.
4 **§431: -109 Information to be furnished enrollees;**
5 **hearings and appeals of enrollees.** Every managed care plan that
6 makes its own rates, within a reasonable time after receiving
7 written request therefore and upon payment of reasonable charges
8 as it may make, shall furnish to any enrollee affected by a rate
9 made by it or to the authorized representative of the enrollee,
10 all pertinent information as to the rate; provided that the
11 managed care plan shall not be required to disclose supporting
12 information and supplementary rating information protected
13 pursuant to section 431: -105(d).
14 **§431: -110 False or misleading information.** No person or
15 organization shall wilfully withhold information from or
16 knowingly give false or misleading information to the
17 commissioner, any statistical agency designated by the
18 commissioner, or any managed care plan, which will affect the
19 rates or premiums chargeable under this article. Violation of
20 this section shall subject the one guilty of the violation to
21 the penalties provided in section 431: -111.

1 **§431: -111 Penalties.** (a) If the commissioner finds
2 that any person or organization has violated any provision of
3 this article, the commissioner may impose a penalty of not more
4 than $500 for each violation; provided that if the commissioner
5 finds the violation to be wilful, the commissioner may impose a
6 penalty of not more than $5,000 for each violation. The
7 penalties may be in addition to any other penalty provided by
8 law. For purposes of this section, any managed care plan using
9 a rate for which the managed care plan has failed to file the
10 rate, supplementary rating information, underwriting rules or
11 guides, or supporting information as required by this article,
12 shall have committed a separate violation for each day the
13 failure to file continues.
14 (b) The commissioner may suspend the license or operating
15 authority of any managed care plan that fails to comply with an
16 order of the commissioner within the time limited by the order,
17 or any extension thereof that the commissioner may grant. The
18 commissioner shall not suspend the license of any managed care
19 plan for failure to comply with an order until the time
20 prescribed for an appeal from the order has expired or, if an
21 appeal has been taken, until the order has been affirmed. The
22 commissioner may determine when a suspension of license or

1 operating authority shall become effective and it shall remain
2 in effect for the period fixed by the commissioner unless the
3 commissioner modifies or rescinds the suspension, or until the
4 order upon which the suspension is based is modified, rescinded,
5 or reversed.

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

12 **§431: -112 Hearing procedure and judicial review.** (a)
13 Any managed care plan aggrieved by any order or decision of the
14 commissioner made without a hearing, within thirty days after
15 notice of the order to the managed care plan, may make written
16 request to the commissioner for a hearing. The commissioner
17 shall hold a hearing within twenty days after receipt of the
18 request, and shall give not less than ten days' written notice
19 of the time and place of the hearing. The commissioner shall
20 promptly conduct and complete the hearing. Within fifteen days
21 after the hearing is completed, the commissioner shall affirm,
22 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~~] 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:

1 "(d) Article 2 [and], article 13, and article ___ of
2 chapter 431, and the power there granted to the commissioner,
3 shall apply to health maintenance organizations, so long as
4 [such] the application in any particular case is in compliance
5 with and is not preempted by applicable federal statutes and
6 regulations."
7 SECTION 5. Statutory material to be repealed is bracketed
8 and stricken. New statutory material is underscored.
9 SECTION 6. This Act shall take effect on January 1, 2008.

S.B. NO. 12
S.D. 2
H.D. 2
C.D. 1

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. (CD1)