



Senate

General Assembly

File No. 289

January Session, 2015

Substitute Senate Bill No. 9

Senate, March 30, 2015

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING THE RATE APPROVAL PROCESS FOR CERTAIN HEALTH INSURANCE POLICIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsections (a) to (c), inclusive, of section 38a-481 of the
2 general statutes are repealed and the following is substituted in lieu
3 thereof (*Effective January 1, 2016*):

4 (a) No individual health insurance policy shall be delivered or
5 issued for delivery to any person in this state, nor shall any
6 application, rider or endorsement be used in connection with such
7 policy, until a copy of the form thereof and of the classification of risks
8 and the premium rates have been filed with the commissioner. Rate
9 filings shall include an actuarial memorandum that includes, but is not
10 limited to, pricing assumptions and claims experience, premium rates
11 and loss ratios from the inception of the policy. The commissioner shall
12 adopt regulations, in accordance with chapter 54, to establish a
13 procedure for reviewing such policies. The commissioner shall
14 disapprove the use of such form at any time if it does not comply with

15 the requirements of law, or if it contains a provision or provisions
16 [which] that are unfair or deceptive or [which] that encourage
17 misrepresentation of the policy. The commissioner shall notify, in
18 writing, the insurer [which] that has filed any such form of the
19 commissioner's disapproval, specifying the reasons for disapproval,
20 and ordering that no such insurer shall deliver or issue for delivery to
21 any person in this state a policy on or containing such form. The
22 provisions of section 38a-19 shall apply to such orders.

23 (b) (1) No rate filed under the provisions of subsection (a) of this
24 section shall be effective until it has been [filed and] approved by the
25 commissioner in accordance with regulations adopted pursuant to this
26 subsection or as provided under subdivision (2) of this subsection. The
27 commissioner shall adopt regulations, in accordance with the
28 provisions of chapter 54, to prescribe standards to ensure that such
29 rates shall not be excessive, inadequate or unfairly discriminatory, as
30 described in section 6 of this act. [The commissioner may disapprove
31 such rate within thirty days after it has been filed if it fails to comply
32 with such standards, except that no rate filed under the provisions of
33 subsection (a) of this section for any Medicare supplement policy shall
34 be effective unless approved in accordance with section 38a-474.]

35 (2) Any rate filed under the provisions of subsection (a) of this
36 section for health insurance that provides coverage of the type
37 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
38 shall be approved in accordance with section 6 of this act.

39 (c) (1) No rate filed under the provisions of subsection (a) of this
40 section for any Medicare supplement policy shall be effective unless
41 approved in accordance with section 38a-474.

42 [(c)] (2) No insurance company, fraternal benefit society, hospital
43 service corporation, medical service corporation, health care center or
44 other entity [which] that delivers or issues for delivery in this state any
45 Medicare supplement policies or certificates shall incorporate in its
46 rates or determinations to grant coverage for Medicare supplement
47 insurance policies or certificates any factors or values based on the age,

48 gender, previous claims history or the medical condition of any person
49 covered by such policy or certificate.

50 Sec. 2. Section 38a-513 of the general statutes is repealed and the
51 following is substituted in lieu thereof (*Effective January 1, 2016*):

52 (a) No group health insurance policy, as defined by the
53 commissioner, or certificate shall be [issued or] delivered or issued for
54 delivery in this state unless a copy of the form for such policy or
55 certificate has been submitted to and approved by the commissioner
56 [under the regulations adopted pursuant to this section] and the
57 classification of risks and the premium rates have been filed with the
58 commissioner. The commissioner shall adopt regulations, in
59 accordance with the provisions of chapter 54, concerning the
60 provisions, submission and approval, other than as provided under
61 subdivision (2) of subsection (b) of this section, of such policies and
62 certificates and establishing a procedure for reviewing such policies
63 and certificates. If the commissioner issues an order disapproving the
64 use of such form, the provisions of section 38a-19 shall apply to such
65 order.

66 (b) (1) No rate filed under the provisions of subsection (a) of this
67 section shall be effective until it has been approved by the
68 commissioner in accordance with regulations adopted pursuant to this
69 subsection or as provided under subdivision (2) of this subsection. The
70 commissioner shall adopt regulations, in accordance with the
71 provisions of chapter 54, to prescribe standards to ensure that such
72 rates shall not be excessive, inadequate or unfairly discriminatory, as
73 described in section 6 of this act.

74 (2) Any rate filed under the provisions of subsection (a) of this
75 section for a small employer group health insurance policy that
76 provides coverage of the type specified in subdivisions (1), (2), (4), (11)
77 and (12) of section 38a-469 shall be approved in accordance with
78 section 6 of this act.

79 [(b)] (c) No insurance company, fraternal benefit society, hospital

80 service corporation, medical service corporation, health care center or
81 other entity [which] that delivers or issues for delivery in this state any
82 Medicare supplement policies or certificates shall incorporate in its
83 rates or determinations to grant coverage for Medicare supplement
84 insurance policies or certificates any factors or values based on the age,
85 gender, previous claims history or the medical condition of any person
86 covered by such policy or certificate.

87 [(c)] (d) Nothing in this chapter shall preclude the issuance of a
88 group health insurance policy that includes an optional life insurance
89 rider, provided the optional life insurance rider shall be filed with and
90 approved by the Insurance Commissioner pursuant to section 38a-430.
91 Any company offering such policies for sale in this state shall be
92 licensed to sell life insurance in this state pursuant to the provisions of
93 section 38a-41.

94 [(d)] (e) Not later than January 1, 2009, the commissioner shall adopt
95 regulations, in accordance with chapter 54, to establish minimum
96 standards for benefits in group specified disease policies, certificates,
97 riders, endorsements and benefits.

98 Sec. 3. Subsection (a) of section 38a-183 of the general statutes is
99 repealed and the following is substituted in lieu thereof (*Effective*
100 *January 1, 2016*):

101 (a) A health care center governed by sections 38a-175 to 38a-192,
102 inclusive, shall not enter into any agreement with subscribers unless
103 and until it has filed with the commissioner a full schedule of the
104 amounts to be paid by the subscribers and has obtained the
105 commissioner's approval [thereof] in accordance with section 6 of this
106 act. The commissioner [may refuse such approval if he finds such
107 amounts to] shall adopt regulations, in accordance with the provisions
108 of chapter 54, to prescribe standards to ensure that such amounts shall
109 not be excessive, inadequate or discriminatory, as described in section
110 6 of this act. Each such health care center shall not enter into any
111 agreement with subscribers unless and until it has filed with the
112 commissioner a copy of such agreement or agreements, including all

113 riders and endorsements thereon, and until the commissioner's
114 approval thereof has been obtained. The commissioner shall, within a
115 reasonable time after the filing of any request for an approval of [the
116 amounts to be paid,] any agreement or any form, notify the health care
117 center of [either his] the commissioner's approval or disapproval
118 thereof.

119 Sec. 4. Section 38a-208 of the general statutes is repealed and the
120 following is substituted in lieu thereof (*Effective January 1, 2016*):

121 No such corporation shall enter into any contract with subscribers
122 unless and until it has filed with the Insurance Commissioner a full
123 schedule of the rates to be paid by the subscribers and has obtained
124 said commissioner's approval [thereof] in accordance with section 6 of
125 this act. The commissioner [may refuse such approval if he finds such
126 rates to] shall adopt regulations, in accordance with the provisions of
127 chapter 54, to prescribe standards to ensure that such amounts shall
128 not be excessive, inadequate or discriminatory, as described in section
129 6 of this act. No hospital service corporation shall enter into any
130 contract with subscribers unless and until it has filed with the
131 Insurance Commissioner a copy of such contract, including all riders
132 and endorsements thereof, and until said commissioner's approval
133 thereof has been obtained. The Insurance Commissioner shall, within a
134 reasonable time after the filing of any such form, notify such
135 corporation [either of his] of the commissioner's approval or
136 disapproval thereof.

137 Sec. 5. Section 38a-218 of the general statutes is repealed and the
138 following is substituted in lieu thereof (*Effective January 1, 2016*):

139 No such medical service corporation shall enter into any contract
140 with subscribers unless and until it has filed with the Insurance
141 Commissioner a full schedule of the rates to be paid by the subscriber
142 and has obtained said commissioner's approval [thereof] in accordance
143 with section 6 of this act. The commissioner [may refuse such approval
144 if he finds such rates are] shall adopt regulations, in accordance with
145 the provisions of chapter 54, to prescribe standards to ensure that such

146 amounts shall not be excessive, inadequate or discriminatory, as
147 described in section 6 of this act. No such medical service corporation
148 shall enter into any contract with subscribers unless and until it has
149 filed with the Insurance Commissioner a copy of such contract,
150 including all riders and endorsements thereof, and until said
151 commissioner's approval thereof has been obtained. The Insurance
152 Commissioner shall, within a reasonable time after the filing of any
153 such form, notify such corporation [either of his] of the commissioner's
154 approval or disapproval thereof.

155 Sec. 6. (NEW) (*Effective January 1, 2016*) (a) (1) With respect to a
156 health insurance policy, agreement or contract that provides coverage
157 of the type specified in subdivisions (1), (2), (4), (11) and (12) of section
158 38a-469 of the general statutes, any (A) rate filed for such policy
159 pursuant to section 38a-481 of the general statutes, as amended by this
160 act, (B) rate filed for such policy pursuant to section 38a-513 of the
161 general statutes, as amended by this act, (C) schedule of amounts filed
162 for such agreement pursuant to section 38a-183 of the general statutes,
163 as amended by this act, (D) schedule of rates filed for such contract
164 pursuant to section 38a-208 of the general statutes, as amended by this
165 act, or (E) schedule of rates filed for such contract pursuant to section
166 38a-218 of the general statutes, as amended by this act, on or after
167 January 1, 2016, shall be filed not later than one hundred twenty
168 calendar days prior to the proposed effective date of such rates or
169 amounts.

170 (2) Each filer making a rate or amount filing pursuant to this
171 subsection shall:

172 (A) On the date the filer submits such rate or amount filing to the
173 Insurance Commissioner, clearly and conspicuously disclose to its
174 insureds or subscribers, in writing and in such form as the
175 commissioner may prescribe: (i) The proposed general rate or amount
176 increase and the dollar amount by which an insured's or subscriber's
177 policy or agreement will increase, including any increase because of
178 the insured's or subscriber's age or change in age rating classification

179 and the percentage increase or decrease of the proposed rate or
180 amount from the current rate or amount; (ii) a statement that the
181 proposed rate or amount is subject to Insurance Department review
182 and approval; and (iii) detailed information on the insured's right to
183 submit public comment to the Insurance Department, including the
184 Internet web site, mailing address and phone number of said
185 department and instructions on how to submit comments to the
186 department; and

187 (B) Include with its rate or amount filing an actuarial memorandum,
188 certified by a qualified actuary, that to the best of such actuary's
189 knowledge, (i) such rate or amount filing is in compliance with law,
190 and (ii) the rate or amount filing is not excessive, as described in this
191 section. For the purposes of this subparagraph, "qualified actuary"
192 means a member in good standing of the American Academy of
193 Actuaries who is qualified in accordance with the standards of the
194 American Academy of Actuaries.

195 (3) (A) Notwithstanding the provisions of section 38a-69a of the
196 general statutes, the Insurance Department shall post on its Internet
197 web site all documents, materials and other information provided to or
198 requested by the department in relation to a rate or amount filing
199 made pursuant to this subsection, including, but not limited to,
200 financial reports, financial statements, actuarial reports and actuarial
201 memoranda. The rate or amount filing and the documents, materials
202 and other information shall be posted not later than three business
203 days after the department receives such filing, and such posting shall
204 be updated to include any correspondence between the department
205 and the filer.

206 (B) The department shall provide for a written public comment
207 period of thirty calendar days following the posting of such filing. The
208 department shall include in such posting the date the public comment
209 period closes and instructions on how to submit comments to the
210 department.

211 (b) Except where a hearing is required under subsection (d) of this

212 section, the commissioner shall issue a written decision approving,
213 disapproving or modifying a rate or amount filing not later than forty-
214 five days after such filing was made. Such decision shall specify all
215 factors used to reach such decision and shall be posted on the Internet
216 web site of the Insurance Department not later than two business days
217 after the commissioner issues such decision.

218 (c) The commissioner shall not approve a rate or amount filing
219 made under this section if it is excessive, inadequate or unfairly
220 discriminatory. The commissioner shall conduct an actuarial review to
221 determine if the methodology and assumptions used to develop the
222 rate or amount filing are actuarially sound and in compliance with the
223 Actuarial Standards of Practice issued by the Actuarial Standards
224 Board.

225 (1) A rate or amount is excessive if it is unreasonably high for the
226 insurance provided in relation to the underlying risks and costs after
227 due consideration to (A) the experience of the filer; (B) the past and
228 projected costs of the filer including amounts paid and to be paid for
229 commissions; (C) any transfers of funds to the holding or parent
230 company, subsidiary or affiliate of the filer; (D) the filer's rate of return
231 on assets or profitability, as compared to similar filers; (E) a reasonable
232 margin for profit and contingencies; (F) any public comments received
233 on such filing; and (G) other factors the commissioner deems relevant.

234 (2) A rate or amount is inadequate if it is unreasonably low for the
235 insurance provided in relation to the underlying risks and costs and
236 continued use of such rate or amount would endanger solvency of the
237 filer.

238 (3) A rate or amount is unfairly discriminatory if the premium
239 charged for any classification is not reasonably related to the
240 underlying risks and costs, such that different premiums result for
241 insureds with similar risks and costs.

242 (d) (1) With respect to a health insurance policy, agreement or
243 contract that provides coverage of the type specified in subdivisions

244 (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes, if (A)
245 a rate, schedule of amounts or schedule of rates filed pursuant to
246 subdivision (1) of subsection (a) of this section is for more than a ten
247 per cent increase in such rate or amount, or (B) the Healthcare
248 Advocate requests, not later than five business days after such rate or
249 amount filing has been posted on the Internet web site of the Insurance
250 Department, a hearing on such rate or amount filing, the commissioner
251 shall, not later than five business days after the receipt of such request,
252 set a hearing date. The commissioner shall not be required to hold
253 more than four hearings pursuant to this subdivision in a calendar
254 year.

255 (2) Such hearing shall be held not later than ninety calendar days
256 prior to the proposed effective date of such rate or amount, at a place
257 and time that is convenient to the public.

258 (3) Upon setting the date, place and time of the hearing on the
259 proposed rate or amount, the commissioner shall immediately notify
260 the filer of the date, place and time of the hearing.

261 (4) Notwithstanding section 4-177a of the general statutes:

262 (A) The Healthcare Advocate shall be deemed an intervenor in any
263 hearing held pursuant to this subsection, shall be allowed to present
264 evidence and information at such hearing and shall be allowed to
265 present a closing argument in support of his or her position; and

266 (B) The Insurance Commissioner shall assist the Healthcare
267 Advocate to obtain from the Insurance Department or the filer
268 documents or materials related to the subject matter of the filing that
269 are not readily available from the Insurance Department's Internet web
270 site, provided such documents or materials are not confidential or
271 prohibited to be disclosed by law.

272 (5) If the presiding officer has allowed, pursuant to section 4-177c of
273 the general statutes, persons not named as parties or intervenors to
274 present oral or written statements, the commissioner shall consider, in

275 making a decision to approve, disapprove or modify a rate or amount
276 filing for which a hearing was held, such oral or written statements
277 and any written public comments submitted pursuant to
278 subparagraph (B) of subdivision (3) of subsection (a) of this section.

279 (6) Not later than thirty calendar days after the hearing, the
280 commissioner shall issue a final decision, in writing, approving,
281 disapproving or modifying the rate or amount filing. Such decision
282 shall specify all factors used to reach such decision and shall be posted
283 on the Internet web site of the Insurance Department not later than
284 two business days after the commissioner issues such decision.

285 (e) (1) If the Insurance Commissioner issues a decision to approve or
286 modify a rate or amount filing made pursuant to subsection (a) of this
287 section, the filer shall provide written notice to each insured or
288 subscriber by first class mail that states (A) the approved rate or
289 amount for the insured's or subscriber's policy or agreement, (B) any
290 increase in the rate or amount due to the insured's or subscriber's age
291 or change in age rating classification, and (C) the percentage increase
292 or decrease of the approved rate from the current rate of the insured or
293 subscriber.

294 (2) No such rate or amount shall be effective until thirty calendar
295 days after the notice has been sent by the filer as set forth in
296 subdivision (1) of this subsection or the effective date proposed under
297 subdivision (1) of subsection (a) of this section, whichever is later.

298 (f) Each insurance company, health care center, hospital service
299 corporation or medical service corporation subject to the provisions of
300 this section shall disclose in writing to a prospective customer of a
301 policy or agreement that may be affected by a rate or amount filing
302 made pursuant to this section, (1) that the rate or amount of such
303 policy or agreement is under review by the Insurance Department, and
304 (2) the proposed increase or decrease in the rate or amount of such
305 policy or agreement.

306 (g) Each insurance company, health care center, hospital service

307 corporation or medical service corporation subject to the provisions of
308 this section shall retain records of all earned premiums and incurred
309 benefits per calendar year for each policy or agreement for which a
310 rate or amount filing is made pursuant to this section. Such records
311 shall be retained for not less than seven years after the date each such
312 filing is made and shall include records for any rider or endorsement
313 used in connection with such policy or agreement.

314 (h) The Insurance Department shall retain all records of any rate or
315 amount filing made pursuant to this section for not less than seven
316 years after such filing was approved, disapproved or modified.

317 Sec. 7. (NEW) (*Effective January 1, 2016*) Not later than January
318 thirty-first, annually, the Insurance Department shall submit a report
319 to the joint standing committee of the General Assembly having
320 cognizance of matters relating to insurance that lists all rates filed
321 pursuant to section 38a-481 or 38a-513 of the general statutes, as
322 amended by this act, schedule of amounts filed pursuant to section
323 38a-183 of the general statutes, as amended by this act, and schedule of
324 rates filed pursuant to section 38a-208 or 38a-218 of the general
325 statutes, as amended by this act, for health insurance policies,
326 agreements or contracts that provide coverage of the type specified in
327 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
328 statutes, in the calendar year immediately preceding. Such report shall
329 include the name of the filer, the per cent increase or decrease of such
330 rate of amount filing, the per cent increase or decrease approved by the
331 Insurance Department, the market segment and the product type.

332 Sec. 8. Subsection (b) of section 4-186 of the general statutes is
333 repealed and the following is substituted in lieu thereof (*Effective*
334 *January 1, 2016*):

335 (b) (1) In the case of conflict between the provisions of this chapter
336 and the provisions of chapter 567 and provisions of the general
337 statutes relating to limitations of periods of time, procedures for filing
338 appeals, or jurisdiction or venue of any court or tribunal governing
339 unemployment compensation, employment security or manpower

340 appeals, the provisions of the law governing unemployment
 341 compensation, employment security and manpower appeals shall
 342 prevail.

343 (2) In the case of conflict between the provisions of this chapter and
 344 the provisions of section 6 of this act relating to the conducting of a
 345 hearing under said section, including, but not limited to, the period of
 346 time for rendering a final decision on a rate or amount filing for which
 347 a hearing was held under said section, the provisions of section 6 of
 348 this act shall prevail.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2016	38a-481(a) to (c)
Sec. 2	January 1, 2016	38a-513
Sec. 3	January 1, 2016	38a-183(a)
Sec. 4	January 1, 2016	38a-208
Sec. 5	January 1, 2016	38a-218
Sec. 6	January 1, 2016	New section
Sec. 7	January 1, 2016	New section
Sec. 8	January 1, 2016	4-186(b)

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 \$	FY 17 \$
Insurance Department	IF - Cost	Potential	Potential

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill requires the Department of Insurance (DOI) to hold a hearing on a rate request when either the request exceeds a 10% increase or when requested by the Office of the Healthcare Advocate (OHA). The bill specifies that no more than four such hearings must be held per year.

Under a current agreement between the department and OHA, hearings are held when a request exceeds 15% and is requested by OHA. To the extent that the terms of the bill lead to more rate hearings than under the current agreement, DOI could incur additional costs. Each such hearing costs the department approximately \$25,000 in contracted expenses.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sSB 9*****AN ACT CONCERNING THE RATE APPROVAL PROCESS FOR CERTAIN HEALTH INSURANCE POLICIES.*****SUMMARY:**

This bill imposes new requirements on the Insurance Department and health insurers, HMOs, and similar entities with regard to health insurance rates. It requires health insurers to file rates for group health insurance policies with the insurance commissioner for her approval. By law, the commissioner already must review and approve rates for individual health insurance policies, HMO contracts, and hospital and medical service corporations.

The bill establishes a specific rate approval process that applies to certain rates filed by an HMO, hospital or medical service corporation, or individual or small employer group health insurer issuing health insurance agreements, contracts, or policies. It requires:

1. the commissioner to hold up to four hearings a year on certain rate filings (a) that propose a rate increase of more than 10% or (b) for which the healthcare advocate requests a hearing;
2. certain rate filing entities to notify insureds and subscribers of proposed and approved rate increases and retain information related to rate filings for at least seven years;
3. the Insurance Department to post certain rate filings on its website and provide a 30-day public comment period, retain rate filing records for at least seven years, and report rate filing information annually to the Insurance and Real Estate Committee; and
4. the commissioner to adopt regulations that set standards to

ensure rates are not excessive, inadequate, or unfairly discriminatory, as the bill defines these terms.

The bill also makes minor, technical, and conforming changes.

EFFECTIVE DATE: January 1, 2016

INSURANCE DEPARTMENT REQUIREMENTS

Individual Health Insurance Policies

By law, rates for individual health insurance policies are subject to Insurance Department review and approval. The bill eliminates the provision that allows rates to go into effect automatically 30 days after they are filed. It instead provides a new rate-approval process, which is described below.

By law, the commissioner must adopt regulations to ensure that the rates charged for such policies are not excessive, inadequate, or unfairly discriminatory. The bill requires the regulations to incorporate the bill's description of these terms.

Under the bill, a rate is "excessive" if it is unreasonably high for the insurance in relation to the underlying risks and costs after due consideration to:

1. the filer's experience;
2. the filer's past and projected costs, including amounts paid and to be paid for commissions;
3. any transfers of funds to the filer's holding or parent company, subsidiary, or affiliate;
4. the filer's rate of return on assets or profitability, as compared to similar filers;
5. a reasonable margin for profit and contingencies;
6. any public comments received related to the filing; and

7. other factors the commissioner deems relevant.

A rate is “inadequate” if it is unreasonably low in relation to the underlying risks and costs and continued use of the rate would endanger the filer's solvency. It is “unfairly discriminatory” if the premium charged for any classification is not reasonably related to the underlying risks and costs, such that different premiums result for insureds with similar risks and costs.

Group Health Insurance Policies

The bill requires health insurers to file premium rates and classifications of risks for group health insurance policies with the commissioner. The insurers cannot use the rates until the commissioner approves them.

The bill requires the commissioner to adopt regulations setting standards to ensure rates are not excessive, inadequate, or unfairly discriminatory, as previously described.

The bill provides a rate approval process (described below) for small employer group health insurance policies (those covering 50 or fewer employees) covering (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, and (4) hospital or medical services.

HMO Agreements and Hospital and Medical Service Corporation Contracts

By law, HMOs, hospital service corporations, and medical service corporations cannot enter into any agreements or contracts with subscribers until the commissioner approves the rates they will charge subscribers. Under current law, the commissioner has to approve or disapprove rates within a reasonable time period. The bill instead provides a new rate approval process, as described below.

Under current law, the commissioner may refuse to approve rates if they are excessive, inadequate, or unfairly discriminatory. The bill instead requires the commissioner to adopt regulations setting

standards to ensure rates are not excessive, inadequate, or unfairly discriminatory, as previously described.

RATE APPROVAL PROCESS FOR CERTAIN RATE FILINGS

Applicability

The bill establishes a rate-approval process that applies to any rate filed by an HMO, hospital or medical service corporation, or an individual or small employer group health insurer that issues agreements, contracts, or policies that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services.

Process and Timeline

Beginning January 1, 2016, the bill requires the above entities to file rates with the Insurance Department within 120 days before their proposed effective date. The department must post each filing and supporting documents (e.g., financial statements and actuarial reports) on its website within three business days after receiving it and update the posting to include any correspondence between the department and the entity that filed it.

The department must provide a 30-day public comment period once the filing is posted on the website. The posting must include (1) the date the public comment period ends and (2) how to submit written comments to the department.

The act requires the commissioner to issue a written decision approving, modifying, or disapproving a rate filing within 45 days after receiving it, unless a hearing is required on the filing (see below). The decision must specify all factors used to reach it and be posted on the department's website within two business days after being issued.

Disclosures to Insureds or Subscribers and Prospective Customers

The bill requires each rate filing entity to disclose information to its insureds or subscribers on the date it submits a rate filing to the department, (1) clearly and conspicuously, (2) in writing, and (3) in a

form the commissioner prescribes. The disclosure must include:

1. the proposed general rate increase and the dollar amount by which a person's policy or agreement will increase, including any increase because of the person's age or change in age rating classification and the percentage increase or decrease in the proposed rate from the current rate;
2. a statement that the proposed rate or amount is subject to the Insurance Department's review and approval; and
3. detailed information on the person's right to submit public comment to the department, including the department's website, mailing address, phone number, and instructions on how to submit comments.

Each rate-filing entity must disclose in writing to a prospective customer the (1) fact that the department is reviewing the policy rates and (2) proposed rate increase or decrease.

If the commissioner approves or modifies a rate filing, the entity must provide written notice to each insured or subscriber by first class mail that states:

1. the approved rate for the person's policy, agreement, or contract;
2. any increase in the rate due to the person's age or change in age rating classification; and
3. the percentage increase or decrease in the approved rate from the person's current rate.

The bill prohibits a new rate from taking effect until (1) 30 days after the notice has been sent or (2) the effective date proposed in the rate filing, whichever is later.

Actuarial Memorandum

Under the bill, an entity's rate filing must include an actuarial

memorandum certified by a qualified actuary (i.e., a member in good standing with the American Academy of Actuaries). The actuary must certify that, to the best of his or her knowledge, the rate filing complies with law and is not excessive, as the bill describes that term (see above).

Rate Filing Review Requirements

The bill prohibits the commissioner from approving a rate that is excessive, inadequate, or unfairly discriminatory, as previously described. It requires her to conduct an actuarial review to determine if the methodology and assumptions used to develop the rate filing are actuarially sound and comply with the Actuarial Standards of Practice issued by the Actuarial Standards Board.

Hearing Required for Certain Rate Filings

The bill requires the commissioner to hold a hearing, in accordance with the Uniform Administrative Procedure Act (UAPA), on a rate filing when (1) an entity files a rate increase of more than 10% or (2) the healthcare advocate requests it within five business days after the department posts the filing on its website. The commissioner must, within five business days after receiving a request, set a hearing date. The bill requires the commissioner to hold the hearing within 90 days before the proposed effective date of the rate filing at a place and time convenient for the public. She must immediately notify the rate filer of the hearing date, place, and time.

The commissioner must, within 30 days after the hearing, issue a written decision approving, modifying, or disapproving the rate filing. The decision must specify all factors used to reach it and be posted on the department's website within two business days from being issued. In making her decision to approve, disapprove, or modify a rate filing, the commissioner must consider any (1) oral or written statements made at the hearing by anyone the presiding officer allows to present and (2) written comments submitted directly to the department.

Under the bill, the commissioner is not required to hold, in any

year, more than four hearings.

Healthcare Advocate

The bill deems the healthcare advocate to be an intervenor for purposes of any rate hearing the department holds under the bill's provisions, rather than requiring her to apply for intervenor status each time, as required by the UAPA. At a hearing, she may present evidence, information, and a closing argument.

The bill requires the commissioner to help the advocate obtain any of the department's rate-filing records that are not readily available from its website, provided they are not confidential or prohibited by law from disclosure.

Record Retention

The bill requires each rate-filing entity to retain records of earned premiums and incurred benefits by calendar year for each policy or agreement for which a rate filing was made under the bill. They must (1) keep the records for at least seven years after a filing was made and (2) include records for any rider or endorsement used in connection with the policy or agreement.

Under the bill, the Insurance Department must retain rate-filing records for at least seven years from the date it approved, modified, or disapproved the filing. This is already current practice.

ANNUAL REPORT TO INSURANCE COMMITTEE

The bill requires the Insurance Department to report annually by January 31 to the Insurance and Real Estate Committee all rates, amounts, and rate schedules filed in the immediately preceding calendar year by the above rate filing entities. The report must include the (1) filer's name, (2) percent rate increase or decrease filed and approved by the department, and (3) market segment and product type.

BACKGROUND

Related Bill

SB 1023, reported favorably by the Insurance and Real Estate Committee, requires health insurers to file small employer group health insurance rates with the insurance commissioner for approval. It also redefines “small employer” to mean an employer with between one and 100 employees, not including a sole proprietor.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 15 Nay 4 (03/12/2015)