

_____ BILL NO. _____

1
2 INTRODUCED BY _____
3 (Primary Sponsor)

4 A BILL FOR AN ACT ENTITLED: "AN ACT REGULATING RATE INCREASE APPROVAL FOR INSURERS
5 OFFERING INDIVIDUAL DISABILITY POLICIES AND SMALL EMPLOYER HEALTH INSURANCE COVERAGE;
6 PROVIDING DEFINITIONS; PROVIDING RATE APPROVAL PROCEDURES; ALLOWING PUBLIC
7 PARTICIPATION AND INTERVENTION BY CERTAIN AFFECTED PARTIES IN RATE INCREASE
8 PROCEDURES; PROVIDING THE COMMISSIONER OF INSURANCE WITH RULEMAKING AUTHORITY;
9 ALLOWING THE COMMISSIONER TO REQUIRE AN INSURER TO REIMBURSE THE COSTS OF AN
10 INTERVENOR; CREATING REPORTING REQUIREMENTS; AND AMENDING SECTIONS 33-22-241,
11 33-22-1803, AND 33-22-1809, MCA."

12
13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

14
15 **Section 1.** Section 33-22-241, MCA, is amended to read:

16 **"33-22-241. Definitions.** As used in 33-22-242, ~~and 33-22-243,~~ and [sections 2 through 4], unless the
17 context indicates otherwise, the following definitions apply:

18 (1) "Applicant" means an individual carrier that files an application for a rate increase.

19 ~~(1)~~(2) "Block of business" means an individual disability insurance policy certificate or contract filed and
20 approved by the commissioner pursuant to 33-1-501 and written and sold by a health care insurer to a defined
21 set of individuals. All individuals covered by the policy or contract are considered to be within the block of
22 business.

23 (3) "Carrier" means any person who provides an individual health benefit plan in this state subject to
24 state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit
25 society, a health service corporation, and a health maintenance organization. Companies that are affiliated
26 companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the
27 following may be considered as separate carriers:

28 (a) an insurance company or health service corporation that is an affiliate of a health maintenance
29 organization located in this state;

30 (b) a health maintenance organization located in this state that is an affiliate of an insurance company



1 or health service corporation; or

2 (c) a health maintenance organization that operates only one health maintenance organization in an
3 established geographic service area of this state.

4 ~~(2)~~(4) "Health care insurer" means a disability insurer, a health service corporation, a health
5 maintenance organization, or a fraternal benefit society.

6 (5) "Individual carrier" means a carrier that offers individual health benefit plans covering eligible
7 individuals and their dependents.

8 ~~(3)~~(6) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate,
9 subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health
10 maintenance organization subscriber contract and issued for delivery to an individual.

11 (b) Individual health benefit plan does not include a self-funded group health plan; a self-funded
12 multiemployer group health plan; a group conversion plan; an insured group health plan; accident-only, specified
13 disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare
14 supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability
15 insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

16 (7) "Premium" means all money paid by an individual as a condition of receiving coverage from an
17 individual carrier, including any fees or other contributions associated with the health benefit plan.

18 ~~(4)~~(8) "Qualifying previous coverage" means benefits or coverage provided under:

19 (a) medicare or medicaid;

20 (b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits
21 provided under the plan being applied for; or

22 (c) an individual health benefit plan, including coverage issued by a health maintenance organization,
23 a prepaid hospital or medical care plan, or a fraternal benefit society, that provides benefits similar to or
24 exceeding the plan being applied for.

25 (9) "Rate" means the amount a carrier charges a subscriber and includes but is not limited to premiums,
26 copayments, coinsurance obligations, deductibles, and charges."

27
28 **NEW SECTION. Section 2. Rate increase approval.** (1) An individual carrier may not increase the
29 rates it charges a subscriber unless it submits an application to the commissioner and the application is
30 approved by the commissioner.

1 (2) The application must be signed by officers of the applicant who exercise the functions of chief
2 executive officer and chief financial officer. Each person signing the application shall certify under oath to the
3 veracity of the representations, information, and data contained in the application.

4 (3) The application must include, in summary form, the following:

- 5 (a) the rate of return if the application is approved;
6 (b) the average premium increase per subscriber if the application is approved;
7 (c) the medical loss ratios, reserves, and surpluses if the application is approved; and
8 (d) a summary of each of the applicant's nonmedical expenses for its most recent fiscal year.

9 (4) An application may not be approved under this section if the proposed rate is excessive, inadequate,
10 or unfairly discriminatory, the applicant's benefits are unreasonable in comparison to the proposed rate increase,
11 or the proposed rate increase violates a provision of this part.

12 (5) An applicant shall provide the commissioner with any evidence or documentation requested by the
13 commissioner.

14 (6) A review of an application pursuant to this section is subject to the following provisions:

15 (a) The commissioner shall conduct the review in accordance with rules used in determining reasonable
16 rates of return, reserves, surpluses, and nonmedical expense accounts.

17 (b) (i) Materials submitted to support an application are a public record. Summaries required of the
18 applicant must be posted on the commissioner's internet website within 10 days of their receipt by the
19 commissioner.

20 (ii) The commissioner shall provide notice of the application in one or more newspapers of general
21 circulation and through any electronic mail news service operated by the state of Montana or the commissioner.
22 The notice must inform members of the public as to how they may request a hearing on the application.

23 (c) (i) Upon the request of a consumer or a group representing the interests of consumers, if the
24 consumer or group is not requesting to intervene pursuant to [section 3], the commissioner shall hold an informal
25 public hearing. The hearing must be requested within 45 days of commissioner's notice. Members of the public
26 are entitled to participate in the meeting under the public meeting provisions of Title 2, chapter 3.

27 (ii) The commissioner may deny a request for a hearing if the proposed rate increase does not exceed
28 any medical inflation projections that the commissioner is relying on in reviewing the rate increase proposal.

29 (iii) The commissioner may consolidate hearings requested pursuant to subsection (6)(c)(i).

30 (d) If the commissioner disapproves an application, the applicant may petition for a hearing pursuant

1 to the applicable provisions of the Montana Administrative Procedure Act.

2 (e) The applicant has the burden at the hearing of proving by a preponderance of the evidence that the
3 application for the rate increase meets the requirements of this section.

4 (7) The commissioner may charge an application fee that is commensurate with the costs of
5 administering the application proceedings.

6 (8) The commissioner may adopt rules to implement this section including rules governing the filing of
7 applications.

8

9 **NEW SECTION. Section 3. Intervention in rate increase application proceedings -- payment of**
10 **attorney fees and costs of intervening person or organization -- rulemaking.** (1) Any person or organization
11 may present to the commissioner its views on an application for a rate increase.

12 (2) If a person or organization represents individuals that have an interest in the outcome of a rate
13 increase application and the commissioner finds that the interests of the individuals will not be adequately
14 represented by any of the parties to the application proceeding, the commissioner may allow the person or
15 organization representing the individuals to intervene in the application proceeding.

16 (3) A person or organization allowed to intervene in an application proceeding may petition the
17 commissioner for reimbursement of legal fees and costs, including witness fees. If the commissioner determines
18 that the intervenor has made a substantial contribution to the outcome of the application proceeding and an
19 award of attorney fees and costs is warranted, the commissioner shall direct the applicant to pay the reasonable
20 fees and costs of the intervenor.

21 (4) The commissioner may adopt rules to implement this section.

22

23 **NEW SECTION. Section 4. Reporting policy summaries.** (1) Each year, at a date and in a format
24 established by the commissioner, individual carriers shall submit the following information for each of the policies
25 they market:

26 (a) the number of applicants approved for coverage and the number of applicants denied;

27 (b) the percentage of average premium increase upon renewal for the previous 4 years;

28 (c) the average period of time a policyholder retains coverage through the policy;

29 (d) the percentage of premium dollars used to pay medical claims;

30 (e) the overall administrative overhead costs of the individual carrier;

- 1 (f) the services covered and limitations on those services; (g) the premiums charged;
2 (h) costs to the policyholder or persons covered by the policy other than premium costs; and
3 (i) any other information the commissioner requires.

4 (2) Based on the information provided by individual carriers pursuant to subsection (1), the
5 commissioner shall prepare and publish a comparative policy summary designed to inform insurance consumers
6 and potential insurance consumers about the policies offered by reporting individual carriers. The summary
7 must be formatted and drafted in a way designed to be easily understood by insurance consumers and potential
8 insurance consumers.

9 (3) The summary must be posted on the commissioner's website and made available to insurance
10 agents and consumers.

11

12 **Section 5.** Section 33-22-1803, MCA, is amended to read:

13 **"33-22-1803. Definitions.** As used in this part, the following definitions apply:

14 (1) "Actuarial certification" means a written statement by a member of the American academy of
15 actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with
16 the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate
17 records and of the actuarial assumptions and methods used by the small employer carrier in establishing
18 premium rates for applicable health benefit plans.

19 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more
20 intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

21 (3) "Applicant" means a small employer carrier that files an application for a rate increase.

22 ~~(3)~~(4) "Assessable carrier" means all carriers of disability insurance, including excess of loss and stop
23 loss disability insurance.

24 ~~(4)~~(5) "Base premium rate" means, for each class of business as to a rating period, the lowest premium
25 rate charged or that could have been charged under the rating system for that class of business by the small
26 employer carrier to small employers with similar case characteristics for health benefit plans with the same or
27 similar coverage.

28 ~~(5)~~(6) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan,
29 developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard
30 benefit plan and that provides the benefits required by 33-22-1827.

1 ~~(6)~~(7) "Benefit value" means a numerical value based on the expected dollar value of benefits payable
2 to an insured under a health benefit plan. The benefit value must be calculated by the small employer carrier
3 using an actuarially based method and must take into account all health care expenses covered by the health
4 benefit plan and all cost-sharing features of the health benefit plan, including deductibles, coinsurance,
5 copayments, and the insured individual's maximum out-of-pocket expenses. The benefit value must apply
6 equally to indemnity-type health benefit plans and to managed care health benefit plans, including health
7 maintenance organization-type plans.

8 ~~(7)~~(8) "Bona fide association" means an association that:

- 9 (a) has been actively in existence for at least 5 years;
10 (b) was formed and has been maintained in good faith for purposes other than obtaining insurance;
11 (c) does not condition membership in the association on a health status-related factor relating to an
12 individual, including an employee of an employer or a dependent of an employee;
13 (d) makes health insurance coverage offered through the association available to a member regardless
14 of a health status-related factor relating to the member or an individual eligible for coverage through a member;
15 and
16 (e) does not make health insurance coverage offered through the association available other than in
17 connection with a member of the association.

18 ~~(8)~~(9) "Carrier" means any person who provides a health benefit plan in this state subject to state
19 insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society,
20 a health service corporation, and a health maintenance organization. For purposes of this part, companies that
21 are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except
22 that the following may be considered as separate carriers:

- 23 (a) an insurance company or health service corporation that is an affiliate of a health maintenance
24 organization located in this state;
25 (b) a health maintenance organization located in this state that is an affiliate of an insurance company
26 or health service corporation; or
27 (c) a health maintenance organization that operates only one health maintenance organization in an
28 established geographic service area of this state.

29 ~~(9)~~(10) "Case characteristics" means demographic or other objective characteristics of a small employer
30 that are considered by the small employer carrier in the determination of premium rates for the small employer,

1 provided that gender, claims experience, health status, and duration of coverage are not case characteristics
2 for purposes of this part.

3 ~~(10)~~(11) "Class of business" means all or a separate grouping of small employers established pursuant
4 to 33-22-1808.

5 ~~(11)~~(12) "Dependent" means:

6 (a) a spouse or an unmarried child under 19 years of age;

7 (b) an unmarried child, under 23 years of age, who is a full-time student and who is financially
8 dependent on the insured;

9 (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and
10 33-30-1003; or

11 (d) any other individual defined as a dependent in the health benefit plan covering the employee.

12 ~~(12)~~(13) (a) "Eligible employee" means an employee who works on a full-time basis with a normal
13 workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an
14 employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this
15 eligibility criteria is applied uniformly among all of the employer's employees. The term includes a sole proprietor,
16 a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent
17 contractor is included as an employee under a health benefit plan of a small employer. The term also includes
18 those persons eligible for coverage under 2-18-704.

19 (b) The term does not include an employee who works on a part-time, temporary, or substitute basis.

20 ~~(13)~~(14) "Established geographic service area" means a geographic area, as approved by the
21 commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which
22 the carrier is authorized to provide coverage.

23 ~~(14)~~(15) "Health benefit plan" means any hospital or medical policy or certificate providing for physical
24 and mental health care issued by an insurance company, a fraternal benefit society, or a health service
25 corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does
26 not include coverage of excepted benefits if coverage is provided under a separate policy, certificate, or contract
27 of insurance.

28 ~~(15)~~(16) "Index rate" means, for each class of business for a rating period for small employers with
29 similar case characteristics, the average of the applicable base premium rate and the corresponding highest
30 premium rate.

1 ~~(16)~~(17) "New business premium rate" means, for each class of business for a rating period, the lowest
2 premium rate charged or offered or that could have been charged or offered by the small employer carrier to
3 small employers with similar case characteristics for newly issued health benefit plans with the same or similar
4 coverage.

5 ~~(17)~~(18) "Premium" means all money paid by a small employer and eligible employees as a condition
6 of receiving coverage from a small employer carrier, including any fees or other contributions associated with
7 the health benefit plan.

8 (19) "Rate" means the amount a carrier charges a subscriber and includes but is not limited to
9 premiums, copayments, coinsurance obligations, deductibles, and charges.

10 ~~(18)~~(20) "Rating period" means the calendar period for which premium rates established by a small
11 employer carrier are assumed to be in effect.

12 ~~(19)~~(21) "Restricted network provision" means a provision of a health benefit plan that conditions the
13 payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual
14 arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health
15 care services to covered individuals.

16 ~~(20)~~(22) "Small employer" means a person, firm, corporation, partnership, or bona fide association that
17 is actively engaged in business and that, with respect to a calendar year and a plan year, employed at least 2
18 but not more than 50 eligible employees during the preceding calendar year and employed at least two
19 employees on the first day of the plan year. In the case of an employer that was not in existence throughout the
20 preceding calendar year, the determination of whether the employer is a small or large employer must be based
21 on the average number of employees reasonably expected to be employed by the employer in the current
22 calendar year. In determining the number of eligible employees, companies are considered one employer if they:

- 23 (a) are affiliated companies;
24 (b) are eligible to file a combined tax return for purposes of state taxation; or
25 (c) are members of a bona fide association.

26 ~~(21)~~(23) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible
27 employees of one or more small employers in this state.

28 ~~(22)~~(24) "Standard health benefit plan" means a health benefit plan that is developed by a small
29 employer carrier and that contains the provisions required pursuant to 33-22-1828."
30

1 **Section 6.** Section 33-22-1809, MCA, is amended to read:

2 **"33-22-1809. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans under
3 this part are subject to the following provisions:

4 (a) The index rate for a rating period for any class of business may not exceed the index rate for any
5 other class of business by more than ~~20%~~ 5%.

6 (b) For each class of business, the premium rates charged during a rating period to small employers
7 with similar case characteristics for the same or similar coverage or the rates that could be charged to the
8 employer under the rating system for that class of business may not vary from the index rate by more than ~~25%~~
9 5% of the index rate.

10 (c) The percentage increase in the premium rate charged to a small employer for a new rating period
11 may not exceed the sum of the following:

12 (i) the percentage change in the new business premium rate measured from the first day of the prior
13 rating period to the first day of the new rating period; in the case of a health benefit plan into which the small
14 employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage
15 change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change
16 in the new business premium rate for the most similar health benefit plan into which the small employer carrier
17 is actively enrolling new small employers;

18 (ii) any adjustment, not to exceed ~~15%~~ 5% annually and adjusted pro rata for rating periods of less than
19 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents
20 of the small employer, as determined from the small employer carrier's rate manual for the class of business;
21 and

22 (iii) any adjustment because of a change in coverage or a change in the case characteristics of the
23 small employer, as determined from the small employer carrier's rate manual for the class of business.

24 (d) Adjustments in rates for claims experience, health status, and duration of coverage may not be
25 charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged
26 for all employees and dependents of the small employer.

27 (e) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the
28 rate factor associated with any industry classification may not vary from the average of the rate factors
29 associated with all industry classifications by more than 15% of that coverage.

30 (f) A small employer carrier shall:

1 (i) apply rating factors, including case characteristics, consistently with respect to all small employers
2 in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts
3 attributable to plan design and that do not reflect differences because of the nature of the groups. Differences
4 among base premium rates may not be based in any way on the actual or expected health status or claims
5 experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

6 (ii) treat all health benefit plans issued or renewed in the same calendar month as having the same
7 rating period.

8 (g) For the purposes of this subsection (1), a health benefit plan that includes a restricted network
9 provision may not be considered similar coverage to a health benefit plan that does not include a restricted
10 network provision.

11 (2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of
12 business. A small employer carrier may not offer to transfer a small employer into or out of a class of business
13 unless the offer is made to transfer all small employers in the class of business without regard to case
14 characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

15 (3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the
16 premium rates applicable to one or more small employers included within a class of business of a small
17 employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the
18 commissioner either that the suspension is reasonable in light of the financial condition of the small employer
19 carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance
20 market.

21 (4) In connection with the offering for sale of any health benefit plan to a small employer, a small
22 employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of
23 the following:

24 (a) the extent to which premium rates for a specified small employer are established or adjusted based
25 upon the actual or expected variation in claims costs or upon the actual or expected variation in health status
26 of the employees of small employers and the employees' dependents;

27 (b) the provisions of the health benefit plan concerning the small employer carrier's right to change
28 premium rates and the factors, other than claims experience, that affect changes in premium rates;

29 (c) the provisions relating to renewability of policies and contracts; and

30 (d) the provisions relating to any preexisting condition.

1 (5) (a) Each small employer carrier shall maintain at its principal place of business a complete and
2 detailed description of its rating practices and renewal underwriting practices, including information and
3 documentation that demonstrate that its rating methods and practices are based upon commonly accepted
4 actuarial assumptions and are in accordance with sound actuarial principles.

5 (b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an
6 actuarial certification certifying that the carrier is in compliance with this part and that the rating methods of the
7 small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must
8 contain information as specified by the commissioner. A copy of the actuarial certification must be retained by
9 the small employer carrier at its principal place of business.

10 (c) A small employer carrier shall make the information and documentation described in subsection
11 (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this part and
12 except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the
13 information must be considered proprietary and trade secret information and is not subject to disclosure by the
14 commissioner to persons outside of the department.

15 ~~(6) The commissioner may not require prior approval of the rating methods used by small employer~~
16 ~~carriers or the premium rates of the health benefit plans offered to small employers."~~

17
18 **NEW SECTION. Section 7. Rate increase approval.** (1) In addition to the provisions of 33-22-1809
19 governing rates, a small employer carrier may not increase the rates it charges a subscriber unless it submits
20 an application to the commissioner and the application is approved by the commissioner.

21 (2) The application must be signed by officers of the applicant who exercise the functions of chief
22 executive officer and chief financial officer. Each person signing the application shall certify under oath to the
23 veracity of the representations, information, and data contained in the application.

24 (3) The application must include, in summary form, the following:

25 (a) the rate of return if the application is approved;

26 (b) the average premium increase per subscriber if the application is approved;

27 (c) the medical loss ratios, reserves, and surpluses if the application is approved; and

28 (d) a summary of each of the applicant's nonmedical expenses for its most recent fiscal year.

29 (4) An application may not be approved under this section if the proposed rate is excessive, inadequate,
30 or unfairly discriminatory, the applicant's benefits are unreasonable in comparison to the proposed rate increase,

1 or the proposed rate increase violates a provision of this part.

2 (5) An applicant shall provide the commissioner with any evidence or documentation requested by the
3 commissioner.

4 (6) A review of an application pursuant to this section is subject to the following provisions:

5 (a) The commissioner shall conduct the review in accordance with rules used in determining reasonable
6 rates of return, reserves, surpluses, and nonmedical expense accounts.

7 (b) (i) Materials submitted to support an application are a public record. Summaries required of the
8 applicant must be posted on the commissioner's internet website within 10 days of their receipt by the
9 commissioner.

10 (ii) The commissioner shall provide notice of the application in one or more newspapers of general
11 circulation and through any electronic mail news service operated by the state or the commissioner. The notice
12 must inform members of the public as to how they may request a hearing on the application.

13 (c) Upon the request of a consumer or a group representing the interests of consumers, the
14 commissioner shall hold a hearing, pursuant to the applicable provisions of the Montana Administrative
15 Procedure Act, on any application filed under this section. The hearing must be requested within 45 days of
16 commissioner's notice. Members of the public are entitled to participate in the hearing pursuant to Title 2,
17 chapter 3.

18 (d) If a hearing is not requested pursuant to subsection (6)(c) and the commissioner disapproves the
19 application, the applicant may petition for a hearing pursuant to the applicable provisions of the Montana
20 Administrative Procedure Act. Members of the public are entitled to participate in the hearing pursuant to Title
21 2, chapter 3.

22 (e) At least 45 days prior to the date of a hearing held under subsection (6)(d), the commissioner shall
23 notify the public of the hearing and the procedures for presenting views or for seeking intervenor status at the
24 hearing.

25 (f) The applicant has the burden at the hearing of proving by a preponderance of the evidence that the
26 application for the rate increase meets the requirements of this section.

27 (7) The commissioner may charge an application fee that is commensurate with the costs of
28 administering the application proceedings.

29

30 **NEW SECTION. Section 8. Intervention in rate increase application proceedings -- payment of**

1 **attorney fees and costs of intervening person or organization -- rulemaking.** (1) Any person or organization
2 may present to the commissioner its views on an application for a rate increase.

3 (2) If a person or organization represents individuals that have an interest in the outcome of a rate
4 increase application and the commissioner finds that the interests of the individuals will not be adequately
5 represented by any of the parties to the application proceeding, the commissioner may allow the person or
6 organization representing the individuals to intervene in the application proceeding.

7 (3) A person or organization allowed to intervene in an application proceeding may petition the
8 commissioner for reimbursement of legal fees and costs, including witness fees. If the commissioner determines
9 that the intervenor has made a substantial contribution to the outcome of the application proceeding and an
10 award of attorney fees and costs is warranted, the commissioner shall direct the applicant to pay the reasonable
11 fees and costs of the intervenor.

12 (4) The commissioner may adopt rules to implement this section.

13

14 **NEW SECTION. Section 9. Reporting policy summaries.** (1) Each year, at a date and in a format
15 established by the commissioner, small group carriers shall submit the following information for each of the
16 policies they market:

17 (a) the number of applicants approved for coverage and the number of applicants denied;

18 (b) the percentage of average premium increase upon renewal for the previous 4 years;

19 (c) the average period of time a policyholder retains coverage through the policy;

20 (d) the percentage of premium dollars used to pay medical claims;

21 (e) the overall administrative overhead costs of the small employer carrier;

22 (f) the services covered and limitations on those services;

23 (g) the average premium charged;

24 (h) costs to the policyholder or persons covered by the policy other than premium costs; and

25 (i) any other information the commissioner requires.

26 (2) Based on the information provided by small employer carriers pursuant to subsection (1), the
27 commissioner shall prepare and publish a comparative policy summary designed to inform insurance consumers
28 and potential insurance consumers about the policies offered by reporting small employer carriers. The
29 summary must be formatted and drafted in a way designed to be easily understood by insurance consumers
30 and potential insurance consumers.

