

HOUSE BILL NO. 105  
INTRODUCED BY R. DRISCOLL  
BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THAT RATES FOR HEALTH INSURANCE COVERAGE BE FILED WITH THE COMMISSIONER OF INSURANCE FOR REVIEW; PROVIDING STANDARDS FOR REVIEW AND NOTICE OF DEFICIENCY CERTAIN REFUNDS RELATED TO A MINIMUM LOSS RATIO; PROVIDING TERMS FOR RATE APPROVAL, DISAPPROVAL, AND WITHDRAWAL OF APPROVAL; PROVIDING FOR RULEMAKING AUTHORITY A MINIMUM LOSS RATIO AND A MINIMUM LOSS RATIO GUARANTEE; PROVIDING FOR CONTINGENT VOIDNESS AND PROVIDING AN EFFECTIVE DATE."

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

**NEW SECTION. Section 1. Health insurance rates -- filing required -- use.** (1) Each health insurance issuer, which includes Consumer Operated and Oriented Plan (CO-OP) established under 42 U.S.C 18042, that issues, delivers, or renews any health plan individual or small employer group health insurance coverage in the individual, or small employer group, or large employer group market shall, at least 60 days before the effective date of the rate use, file with the commissioner its rates, fees, dues, and other charges for each product form intended for use in Montana, together with sufficient information to support the premium to be charged as described in [sections 1 through 5.] for that product form to be paid by insureds, members, enrollees, or subscribers. This filing may be made simultaneously with a notice of rate premium increase to policyholders and certificate holders required by 33-22-107.

(2) A health insurance issuer may submit a single combined justification for rate increases subject to review affecting multiple products, if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same across all products. Rate increases are determined by combining the total amount of increases taken on a single product form, or

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market segment if the rate increase is the same for all products, over a 12 month period. A market segment means the individual or small group market.

~~(2)(3)~~ (3) The commissioner may waive the 60-day filing requirement under subsection (1) if the rate increase is implemented pursuant to 33-22-107(1)(b). However, the rates and justifications for the rate increase must still be filed.

(34) The health insurance issuer shall submit a new filing to reflect any material change to the previously filed ~~and approved~~ rate filing. For all other changes, the insurer shall submit an amendment to a previously filed ~~and approved~~ rate filing. The insurer may file an actuarial trend to phase in rate increases over a 12-month period. The insurer may file amendments to that trend within the 12-month period.

(45) The filing of rates for health plans must include:

(a) the product form number or numbers and approval date of the product form(s) to which the rate applies;

(b) a statement of actuarial justification; and

(c) data information sufficient to support the rate, as described in section 2.

~~(56)~~ (6) The commissioner shall prescribe the form and content of the information required under this section.

(67) A rate filing required under this section must be submitted by a qualified actuary representing the health insurance issuer. The qualified actuary shall certify in a form prescribed by the commissioner that, to the best of the actuary's knowledge and belief, the rates are not excessive, inadequate, unjustified, or unfairly discriminatory, as defined in [section 2] and comply with the applicable provisions of Title 33, rules adopted pursuant to Title 33, and federal law.

(78) The rate filing must be delivered by the national association of insurance commissioners' electronic filing system known as the system for electronic rate and form filing.

(89) An insurer may use a rate filing under this section 60 days after the date of filing with the commissioner ~~unless specifically disapproved by the commissioner as provided in [section 2]~~ the health insurance issuer fails to provide the minimum documentation required in [Section 2].

(910) [Sections 1 through 9] do not apply to coverage consisting solely of excepted benefits as defined in 33-22-140.

**NEW SECTION. Section 2. Timing and grounds for disapproval — option for deemed approval**

**Standards for review—notice of deficiency.** (1) The commissioner may disapprove a rate filing issue a notice of deficiency during the first 60 days after the date of filing of premium rates. If the commissioner fails to approve or disapprove a rate filing within 60 days after the filing, the filing is deemed approved.

(2) A rate filing is also deemed approved if the filing is accompanied by a minimum loss ratio guarantee as described in [section 6].

(3) In determining whether to disapprove a filing under [section 1], When reviewing a premium rate filing, the commissioner shall consider whether:

(a) the rates comply with all applicable state and federal law, including the applicable minimum loss ratio described in [section 5];

(b) the benefits are actuarially supported in relation to the premium charged;

(c) the proposed premium rate is excessive, inadequate, unjustified or unfairly discriminatory.

(a) For the purposes of this section, rates may be considered excessive if they are likely to produce a profit or surplus that is unreasonably high in relation to services rendered, rates may be considered inadequate if they are clearly insufficient to sustain projected losses and expenses, cause the premium charged for the health insurance coverage to be

unreasonably high in relation to the benefits provided under the coverage. In order to determine if the rate is unreasonably high, the commissioner shall consider whether:

(i) The rate increase falls within the allowable federal minimum loss ratio as determined under 45 CFR Part 158;

(ii) The assumptions on which the rate increase is based are reasonable; and

(iii) One or more of the assumptions is not supported by the evidence.

(b) Rates may be considered inadequate if the rate is unreasonably low for the coverage provided and the commissioner may consider if the rate would endanger the solvency of the insurer or disrupt the insurance market in Montana.

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(c) A rate increase may be considered "unjustified" if the health insurance issuer provides data or documentation in connection with the increase that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

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(d) Rates are may be considered unfairly discriminatory if they violate 33-18-206, 33-22-526, 49-2-309, or other applicable state or federal laws prohibiting discrimination in health insurance.

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(d) the proposed premium rate is based upon reasonable administrative expenses; and

(e) the actuarial reasons and data submitted justify the rate.

(43) To determine whether the proposed premium rates for health insurance coverage are reasonable and not excessive, inadequate, unjustified or unfairly discriminatory, in addition to the required minimum loss ratio described in [section 5], the commissioner may consider:

(a) the health insurance issuer's financial position, including but not limited to surplus, reserves, and investment savings;

(b) historical and projected administrative costs and medical and hospital expenses, including medical trends;

(c) the historical and projected medical loss ratio;

(d) any anticipated change in the number of enrollees if the proposed premium rate is approved;

(e) changes to covered benefits or health plan design, along with actuarial projections concerning cost savings or additional expenses related to those changes;

(f) changes in the health insurance issuer's health care cost containment and quality improvement efforts following the health insurance issuer's last rate filing for the same category of health plan;

(g) product development and startup costs, drug and other benefit costs or expenses, and product age and credibility; and

(h) whether the proposed change in the premium rate is necessary to maintain the health insurance issuer's solvency or to maintain rate stability and prevent excessive rate increases in the future;

(h) Historical and projected claims experience;

(i) Trend projections related to utilization, and service or unit cost;

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- (j) Allocation of the overall rate increase to claims and non-claims costs;
- (k) Per enrollee per month allocation of current and projected premium;
- (l) Three year history of rate increases for the product or group of products associated with the rate increase, if the product is three years old or older; otherwise any available rate history;
- (m) Employee and executive compensation data from the health insurance issuer's annual financial statements; and
- (n) Any other applicable information identified in administrative rules adopted pursuant to Title 33.

(4) The commissioner shall review rate filings and if applicable, shall provide a notice of deficiency containing detailed reasons describing why the commissioner finds that the proposed premium rate is excessive, inadequate, unjustified or unfairly discriminatory. The notice must be provided within 60 days of receipt of filing.

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(5) Within 30 days after receiving a notice of deficiency alleging that a proposed rate is excessive, inadequate, unjustified or unfairly discriminatory, the insurer may amend its rate filing, request reconsideration based upon additional information, or implement the proposed rate, unless the rate is "unfairly discriminatory," as defined in subsection (2)(d).

(6) At the end of the 30 day period described in subsection (5), if the insurer implements a rate that the commissioner has determined to be excessive, unjustified or unfairly discriminatory, and if the rate is above the federal threshold described in 45 CFR 154.200, the commissioner shall file a report with the Secretary of Health and Human Services, indicating the commissioner's determination.

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NEW SECTION. Section 3. Withdrawal of approval -- hearing -- refunds. (1) (a) The

commissioner may, at any time after 30 days advance notice and for cause shown, withdraw any approval, including a deemed approval.

—(b) A notice by the commissioner disapproving a rate filing or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the health insurance issuer of the specific rationale for and the legal authority supporting the disapproval or withdrawal of approval in whole or in part.

—(c) The disapproval or withdrawal of approval does not take effect unless the disapproval or withdrawal of approval is issued after the commissioner has reviewed the rates and provided 30 days' notice to the person who filed the rates pursuant to 33-1-314 and this section.

—(2) The action by the commissioner to withdraw approval of a rate filing that was previously approved or deemed approved may occur only under the following circumstances:

—(a) the rate filing contained misrepresentations or material omissions of relevant information or was based on fraudulent information; and

—(b) the newly discovered information results in a finding by the commissioner that:

—(i) the rates merit disapproval pursuant to [section 2]; or

—(ii) the rates constitute an unreasonable rate increase as adopted by the commissioner by rule.

—(3) The health insurance issuer may request a hearing, as provided for in 33-1-701, for unresolved disputes regarding a disapproval or a withdrawal of approval of a rate filing.

—(4) At the end of the 30-day notice period provided for in (1)(c), if no hearing has been requested pursuant to subsection (3), the health insurance issuer may no longer use those rates for renewal or new business. The health insurance issuer may file with the commissioner new rates, which may be used immediately upon filing.

—(5) The commissioner may order that premium refunds be made to consumers who paid premiums pursuant to a premium rate filing that was subsequently disapproved or for which approval was withdrawn.

NEW SECTION. Section 43. Trade secret disclosure exemption. The commissioner, upon request

by the health insurance issuer, may exempt from disclosure any part of a premium rate filing submitted

pursuant to [section 1] that the commissioner determines to contain trade secrets as defined in 30-14-402. The commissioner may not disclose that part of a filing that is subject to a health insurance issuer's request until the commissioner makes a determination under this section. The commissioner shall provide the issuer with 30 days advance notice of the determination before releasing the information to the public.

~~NEW SECTION. Section 5. Minimum loss ratio -- refunds to policyholders -- independent audits -- rules. (1) A health insurance issuer offering group or individual health insurance coverage, including grandfathered health plans as defined in section 1251 of the Public Health Service Act, 42 U.S.C. 18011, shall with respect to each plan year or for individual coverage for each policy year provide an annual refund to each covered policyholder or primary certificate holder under the group or individual health insurance coverage on a pro rata basis if the ratio of the amount of premium revenue expended by the health insurance issuer on reimbursement for clinical services provided to enrollees and for activities that improve health care quality to the total amount of premium revenue for the plan year, as defined in federal law, or the policy year for individual health insurance coverage, if defined in the policy or if not defined for the calendar year, is less than:~~

~~(a) 85% for health insurance issuers offering coverage in the large group market; or~~

~~(b) 80% for health insurance issuers offering coverage in the small group market or the individual market.~~

~~(2) (a) The minimum loss ratio for the individual health insurance market may be a lower percentage than provided in subsection (1) between January 1, 2011, and December 31, 2013, if:~~

~~(i) the commissioner requests a lower percentage after determining that the application of 80% may destabilize the individual health insurance market; and~~

~~(ii) the secretary of health and human services approves the request.~~

~~(b) Beginning January 1, 2014, the determination of the ratio pursuant to subsection (1) for group or individual health insurance coverage must be based on the averages of the premiums expended on the costs described in subsection (1) and the total premium revenue for each of the previous 3 years for the plan or policy.~~

---(3) The following items are excluded from the total amount of premium revenue used in the calculation in subsection (1):

---(a) federal and state taxes;

---(b) licensing fees or regulatory fees; and

---(c) payments or receipts for risk adjustment, risk corridors, and reinsurance provided for under sections 1341, 1342, and 1343 of the Public Health Service Act, 42 U.S.C. 18061 through 42 U.S.C. 18063.

---(4) The definitions relating to the medical loss ratio and the calculation of the medical loss ratio must comply with applicable state and federal regulations.

---(5) The commissioner shall adopt rules that implement applicable federal regulations regarding the calculation, the definitions, and the refund provisions related to the minimum loss ratio as set forth in section 2718 of the Public Health Service Act, 42 U.S.C. 300gg-18 and 45 CFR part 158.

---(6) (a) The total amount of an annual refund required under this section must be an amount equal to the product of the amount by which the percentage exceeds the ratio described in subsection (1) multiplied by the total amount of premium revenue, excluding the deductions allowed in subsection (3) for the plan year or the policy year.

---(b) The policyholder or certificate holder must receive a premium refund that is relative to the premium paid by the policyholder or certificate holder.

---(c) Premium refund payments must be made not later than 180 days after the end of the plan year or the policy year. Refunds made after 180 days must include 10% annual interest calculated from the end of the plan year or policy year. A premium refund of less than \$50 for each insured may be credited to the policyholder's or certificate holder's account.

---(7) The minimum loss ratio results for each year at issue must be independently audited at the health insurance issuer's expense. The audit report must be filed with the commissioner not later than 180 days after the end of the year at issue.

---(8) Each health insurance issuer shall provide its loss ratio data to the commissioner after the independent audit required in subsection (7) has been completed.

---(9) The loss ratio data must be listed according to line or business or type of market, including individual, small employer group, and large employer group.

---(10) The commissioner shall issue an annual public report that lists, by health insurance issuer, the actual loss ratios experienced in this state in the major medical health insurance market. The report must

include each health insurance issuer's loss ratio for the previous 5 years, beginning with the year 2010. The report must be released no later than June 1 for loss ratios experienced during the preceding calendar year.

~~NEW SECTION. Section 6. Minimum loss ratio guarantee. (1) Premium rates may be deemed approved as provided in [section 2] and may be used 60 days after they are filed with the department if the filing is accompanied by a minimum loss ratio guarantee. All other provisions of [sections 1 through 9] apply to health insurance issuers who choose the minimum loss ratio guarantee option provided in this section.~~

~~(2) The minimum loss ratio guarantee must:~~

~~(a) be in writing;~~

~~(b) be accompanied by the supporting data required in [section 4] and a certification from a qualified actuary; and~~

~~(c) contain at least the following information:~~

~~(i) an actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in [section 5];~~

~~(ii) a statement certifying that all rates, fees, dues, and other charges are not excessive, inadequate, or unfairly discriminatory;~~

~~(iii) detailed experience information concerning each policy form that covers 1,000 lives or more;~~

~~(iv) a step-by-step description of the process used to develop the minimum loss ratio required by federal law and [section 5]; and~~

~~(v) a guarantee that the minimum loss ratio required in [section 5], as applicable to each line of business or market segment for the calendar year in which the new rates take effect and for each subsequent year until new rates are filed, will meet or exceed the minimum loss ratio standards in [section 5].~~

~~(3) The actual loss ratio results for each year at issue must be independently audited at the health insurance issuer's expense, and the audit report must be filed with the commissioner not later than 180 days after the end of the year at issue.~~

~~(4) The health insurance issuer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum loss ratio for each line of business or market segment, as required by federal law, [section 5], and rules adopted by the department pursuant to [sections 1 through 9].~~

~~—(5) Premium rates and all data supporting those rates required in [sections 1 through 3] and this section must be filed with the commissioner at least 60 days before use if the minimum loss ratio guarantee is used. Approval by the commissioner is not required if the minimum loss ratio guarantee is used and those filings are deemed approved 60 days after filing.~~

~~—(6) The commissioner may request additional information or make further inquiries if the data described in this section appears to be inadequate, if questions arise, or if possible errors are noted.~~

~~—(7) The provisions of [sections 3 and 4] regarding withdrawal of approval and trade secret protection apply.~~

~~—(8) The filing of a policy, certificate, or membership contract form by a health insurance issuer using the minimum loss ratio guarantee rate filing procedure must provide to the insured an explanation of the minimum loss ratio guarantee, how it relates to the actual loss ratio, how it is calculated, and how applicable premium refunds are to be calculated and paid.~~

**NEW SECTION. Section 74. Collection of rating information -- distribution of information. (1)**

Health insurance issuers shall transmit to the commissioner rating information and trends in premium increases that are required by the secretary of health and human services, under 42 U.S.C. 300gg-94. The commissioner shall transmit this information to the secretary of health and human services.

(2) The commissioner shall post the public report referred to in [section 5] and the information described in subsection (1) of this section on the commissioner's website, except for the trade secret information that may be exempted under [section 43].

~~**NEW SECTION. Section 8. Public comment on proposed rate increases.** When a health insurance issuer files a schedule or table of premium rates for health insurance coverage under [section 4], the commissioner shall post on the commissioner's website the proposed rate increase and the insurer's prepared statement of justification for that rate increase and shall request that comments from consumers about the rate increase be sent to the commissioner's office. The commissioner may transmit comments received to the health insurance issuer requesting the increase and may request a response from the health insurance issuer concerning particular comments.~~

**NEW SECTION. Section 95. Rules.** The commissioner may adopt rules necessary to implement the provisions of [sections 1 through 94].

NEW SECTION. Section 6. {standard} Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 7. Contingent voidness. If the parts of the Patient Protection and Affordable Care Act that relate to health insurance rates are repealed or found to be unconstitutional by a court with final jurisdiction, then [this act] is void.

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NEW SECTION. Section 108. Codification instruction. [Sections 1 through 9] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 9].

NEW SECTION. Section 149. Effective date. [This act] is effective July 1, 2011, and applies to rate filings that affect health insurance coverage in the individual or small employer group market issued on or after January 1, 2012.

- END -

⑫ Applicability