

1 HOUSE BILL NO. 105

2 INTRODUCED BY R. DRISCOLL

3 BY REQUEST OF THE STATE AUDITOR

4

5 A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THAT RATES FOR HEALTH INSURANCE COVERAGE
6 BE FILED WITH THE COMMISSIONER OF INSURANCE FOR REVIEW; PROVIDING FOR CERTAIN
7 REFUNDS RELATED TO A MINIMUM LOSS RATIO; PROVIDING TERMS FOR RATE APPROVAL,
8 DISAPPROVAL, AND WITHDRAWAL OF APPROVAL; PROVIDING FOR A MINIMUM LOSS RATIO AND A
9 MINIMUM LOSS RATIO GUARANTEE; AND PROVIDING AN EFFECTIVE DATE."

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

12

13 **NEW SECTION. Section 1. Health insurance rates -- filing required -- use.** (1) Each health insurance
14 issuer that issues, delivers, or renews any health plan in the individual, small employer group, or large employer
15 group market shall, at least 60 days before use, file with the commissioner its rates, fees, dues, and other charges
16 for that product form to be paid by insureds, members, enrollees, or subscribers. This filing may be made
17 simultaneously with a notice of rate increase to policyholders required by 33-22-107.

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

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

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

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

27 (b) a statement of actuarial justification; and

28 (c) data sufficient to support the rate.

29 (5) The commissioner shall prescribe the form and content of the information required under this section.

30 (6) A rate filing required under this section must be submitted by a qualified actuary representing the

1 health insurance issuer. The qualified actuary shall certify in a form prescribed by the commissioner that, to the
2 best of the actuary's knowledge and belief, the rates comply with the applicable provisions of Title 33, rules
3 adopted pursuant to Title 33, and federal law.

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

6 (8) An insurer may use a rate filing under this section 60 days after the date of filing with the
7 commissioner unless specifically disapproved by the commissioner as provided in [section 2].

8 (9) [Sections 1 through 9] do not apply to coverage consisting solely of excepted benefits.

9

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

11 (1) The commissioner may disapprove a rate filing during the first 60 days after the date of filing. If the
12 commissioner fails to approve or disapprove a rate filing within 60 days after the filing, the filing is deemed
13 approved.

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

16 (3) In determining whether to disapprove a filing under [section 1], the commissioner shall consider
17 whether:

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

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

21 (c) the proposed premium rate is excessive, inadequate, or unfairly discriminatory. For the purposes of
22 this section, rates may be considered excessive if they are likely to produce a profit or surplus that is
23 unreasonably high in relation to services rendered, rates may be considered inadequate if they are clearly
24 insufficient to sustain projected losses and expenses, and rates are unfairly discriminatory if they violate
25 33-18-206, 33-22-526, 49-2-309, or other applicable state or federal laws prohibiting discrimination in health
26 insurance.

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

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

29 (4) To determine whether the proposed premium rates for health insurance coverage are reasonable
30 and not excessive, inadequate, or unfairly discriminatory, in addition to the required minimum loss ratio described

1 in [section 5], the commissioner may consider:

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

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

6 (c) the historical and projected minimum loss ratio;

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

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

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

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

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

16
17 **NEW SECTION. Section 3. Withdrawal of approval -- hearing -- refunds.** (1) (a) The commissioner
18 may, at any time after 30 days advance notice and for cause shown, withdraw any approval, including a deemed
19 approval.

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

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

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

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

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

- 1 (i) the rates merit disapproval pursuant to [section 2]; or
- 2 (ii) the rates constitute an unreasonable rate increase as adopted by the commissioner by rule.
- 3 (3) The health insurance issuer may request a hearing, as provided for in 33-1-701, for unresolved
- 4 disputes regarding a disapproval or a withdrawal of approval of a rate filing.
- 5 (4) At the end of the 30-day notice period provided for in (1)(c), if no hearing has been requested
- 6 pursuant to subsection (3), the health insurance issuer may no longer use those rates for renewal or new
- 7 business. The health insurance issuer may file with the commissioner new rates, which may be used immediately
- 8 upon filing.
- 9 (5) The commissioner may order that premium refunds be made to consumers who paid premiums
- 10 pursuant to a premium rate filing that was subsequently disapproved or for which approval was withdrawn.

11

12 **NEW SECTION. Section 4. Trade secret disclosure exemption.** The commissioner, upon request

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

14 to [section 1] that the commissioner determines to contain trade secrets as defined in 30-14-402. The

15 commissioner may not disclose that part of a filing that is subject to a health insurance issuer's request until the

16 commissioner makes a determination under this section.

17

18 **NEW SECTION. Section 5. Minimum loss ratio -- refunds to policyholders -- independent audits**

19 **-- rules.** (1) A health insurance issuer offering group or individual health insurance coverage, including

20 grandfathered health plans as defined in section 1251 of the Public Health Service Act, 42 U.S.C. 18011, shall

21 with respect to each plan year or for individual coverage for each policy year provide an annual refund to each

22 covered policyholder or primary certificate holder under the group or individual health insurance coverage on a

23 pro rata basis if the ratio of the amount of premium revenue expended by the health insurance issuer on

24 reimbursement for clinical services provided to enrollees and for activities that improve health care quality to the

25 total amount of premium revenue for the plan year, as defined in federal law, or the policy year for individual

26 health insurance coverage, if defined in the policy or if not defined for the calendar year, is less than:

- 27 (a) 85% for health insurance issuers offering coverage in the large group market; or
- 28 (b) 80% for health insurance issuers offering coverage in the small group market or the individual market.
- 29 (2) (a) The minimum loss ratio for the individual health insurance market may be a lower percentage than
- 30 provided in subsection (1) between January 1, 2011, and December 31, 2013, if:

- 1 (i) the commissioner requests a lower percentage after determining that the application of 80% may
2 destabilize the individual health insurance market; and
- 3 (ii) the secretary of health and human services approves the request.
- 4 (b) Beginning January 1, 2014, the determination of the ratio pursuant to subsection (1) for group or
5 individual health insurance coverage must be based on the averages of the premiums expended on the costs
6 described in subsection (1) and the total premium revenue for each of the previous 3 years for the plan or policy.
- 7 (3) The following items are excluded from the total amount of premium revenue used in the calculation
8 in subsection (1):
- 9 (a) federal and state taxes;
- 10 (b) licensing fees or regulatory fees; and
- 11 (c) payments or receipts for risk adjustment, risk corridors, and reinsurance provided for under sections
12 1341, 1342, and 1343 of the Public Health Service Act, 42 U.S.C. 18061 through 42 U.S.C. 18063.
- 13 (4) The definitions relating to the medical loss ratio and the calculation of the medical loss ratio must
14 comply with applicable state and federal regulations.
- 15 (5) The commissioner shall adopt rules that implement applicable federal regulations regarding the
16 calculation, the definitions, and the refund provisions related to the minimum loss ratio as set forth in section 2718
17 of the Public Health Service Act, 42 U.S.C. 300gg-18 and 45 CFR part 158.
- 18 (6) (a) The total amount of an annual refund required under this section must be an amount equal to the
19 product of the amount by which the percentage exceeds the ratio described in subsection (1) multiplied by the
20 total amount of premium revenue, excluding the deductions allowed in subsection (3) for the plan year or the
21 policy year.
- 22 (b) The policyholder or certificate holder must receive a premium refund that is relative to the premium
23 paid by the policyholder or certificate holder.
- 24 (c) Premium refund payments must be made not later than 180 days after the end of the plan year or
25 the policy year. Refunds made after 180 days must include 10% annual interest calculated from the end of the
26 plan year or policy year. A premium refund of less than \$50 for each insured may be credited to the policyholder's
27 or certificate holder's account.
- 28 (7) The minimum loss ratio results for each year at issue must be independently audited at the health
29 insurance issuer's expense. The audit report must be filed with the commissioner not later than 180 days after
30 the end of the year at issue.

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

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

5 (10) The commissioner shall issue an annual public report that lists, by health insurance issuer, the actual
6 loss ratios experienced in this state in the major medical health insurance market. The report must include each
7 health insurance issuer's loss ratio for the previous 5 years, beginning with the year 2010. The report must be
8 released no later than June 1 for loss ratios experienced during the preceding calendar year.

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

14 (2) The minimum loss ratio guarantee must:

15 (a) be in writing;

16 (b) be accompanied by the supporting data required in [section 1] and a certification from a qualified
17 actuary; and

18 (c) contain at least the following information:

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

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

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

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

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

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

1 the end of the year at issue.

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

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

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

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

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

17
18 **NEW SECTION. Section 7. Collection of rating information -- distribution of information.** (1) Health
19 insurance issuers shall transmit to the commissioner rating information and trends in premium increases that are
20 required by the secretary of health and human services under 42 U.S.C. 300gg-94. The commissioner shall
21 transmit this information to the secretary of health and human services.

22 (2) The commissioner shall post the public report referred to in [section 5] and the information described
23 in subsection (1) of this section on the commissioner's website, except for the trade secret information that may
24 be exempted under [section 4].

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26 **NEW SECTION. Section 8. Public comment on proposed rate increases.** When a health insurance
27 issuer files a schedule or table of premium rates for health insurance coverage under [section 1], the
28 commissioner shall post on the commissioner's website the proposed rate increase and the insurer's prepared
29 statement of justification for that rate increase and shall request that comments from consumers about the rate
30 increase be sent to the commissioner's office. The commissioner may transmit comments received to the health

1 insurance issuer requesting the increase and may request a response from the health insurance issuer
2 concerning particular comments.

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4 NEW SECTION. Section 9. Rules. The commissioner may adopt rules necessary to implement the
5 provisions of [sections 1 through 9].

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7 NEW SECTION. Section 10. Codification instruction. [Sections 1 through 9] are intended to be
8 codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections
9 1 through 9].

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11 NEW SECTION. Section 11. Effective date. [This act] is effective July 1, 2011.

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