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HOUSE BILL NO. 87

INTRODUCED BY J. WELBORN

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; PROVIDING LIMITED RULEMAKING AUTHORITY; AMENDING SECTION 33-31-111, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY 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, ~~including a consumer-operated and consumer-oriented plan established under 42 U.S.C 18042,~~ that issues, delivers, or renews individual or small employer group health insurance coverage in the individual or small employer group market shall, at least 60 days before the rate goes into effect, 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]. This filing may be made simultaneously with a notice of 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 for all products. Rate increases are determined by combining the total amount of increases taken on a single product form or 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.

(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 still must be filed.

(4) The health insurance issuer shall submit a new filing to reflect any material change to the previous rate filing. For all other changes, the insurer shall submit an amendment to a previous

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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.

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

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

(b) a statement of actuarial justification; and

(c) information sufficient to support the rate as described in [section 2].

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

(7) 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 described in [section 2], and comply with the applicable provisions of Title 33, and rules adopted pursuant to Title 33, and federal law.

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

(9) An insurer may use a rate filing under this section 60 days after the date of filing with the commissioner unless the health insurance issuer fails to provide the minimum documentation required in [section 2].

(10) [Sections 1 through 5] do not apply to coverage consisting solely of excepted benefits as defined in 33-22-140.

NEW SECTION. Section 2. Standards for review -- notice of deficiency. (1) The commissioner may issue a notice of deficiency during the first 60 days after the date of filing of premium rates.

(2) (a) When reviewing a premium rate filing, the commissioner shall consider whether the proposed premium rate is excessive, inadequate, unjustified, or unfairly discriminatory. Rates may be considered excessive if they 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 excessive, the commissioner shall consider whether:

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~~(i) the rate increase falls within the allowable federal any applicable 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.

(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.

(d) Rates 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.

(3) In order to determine whether the proposed premium rates for health insurance coverage are not excessive, inadequate, unjustified, or unfairly discriminatory, 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) changes to covered benefits or health plan design, along with actuarial projections concerning cost savings or additional expenses related to those changes;

(e) 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;

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

(g) 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;

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- (h) historical and projected claims experience;
- (i) trend projections related to utilization and service or unit cost;
- (j) allocation of the overall rate increase to claims and nonclaims costs;
- (k) allocation of current and projected premium for each enrollee each month;
- (l) the 3-year history of rate increases for the product or group of products associated with the rate increase if the product is 3 years old or older and 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, except that the administrative rules may not include by reference any provisions of Public Law 111-148 and Public Law 111-152 and the regulations promulgated thereunder.

(4) The commissioner shall review rate filings and, if applicable, shall provide a notice of deficiencies 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.

(5) Within 30 days after receiving a notice of deficiencies 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, pursuant to 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, inadequate, unjustified, or unfairly discriminatory ~~and if the rate increase is above the threshold set as provided in 45 CFR 154.200, et seq., the commissioner shall file a report with the secretary of health and human services the commissioner shall publish the finding on the commissioner's website for the office of the commissioner of securities and insurance~~ indicating the commissioner's determination.

NEW SECTION. Section 3. 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

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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 4. Collection of rating information -- distribution of information. (1)~~

~~A health insurance issuer shall transmit to the commissioner rating information and trends in premium increases that are required by the United States secretary of health and human services. The commissioner shall transmit this information to the secretary of health and human services.~~

~~(2) The commissioner shall post the information described in subsection (1) on the commissioner's website, except for the trade secret information that may be exempted under [section 3].~~

NEW SECTION. Section 54. Rulemaking. The commissioner may adopt rules necessary to implement the provisions of [sections 1 through 5] except that the administrative rules may not include by reference any provisions of Public Law 111-148 and Public Law 111-152 and the regulations promulgated thereunder.

Section 6. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-

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701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-141, 33-22-142, 33-22-152, [sections 1 through 5], 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

NEW SECTION. Section 7. Codification instruction. [Sections 1 through 5] 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 5].

NEW SECTION. Section 8. 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 9. Contingent voidness. If parts of the federal Patient Protection and Affordable Care Act that relate to health insurance rates are repealed or found to be unconstitutional by a court of final jurisdiction, then [this act] is void.~~

NEW SECTION. Section 409. Effective date -- applicability. [This act] is effective July 1, 2013, and applies to rate filings that affect health insurance coverage in the individual or small group market issued on or after January 1, 2014.

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