

JAN 19 2007

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE RATE REGULATION.

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

1 SECTION 1. The legislature finds that Act 74, Session Laws
2 of Hawaii 2002 (Act 74), established a health insurance rate
3 regulation law.

4 Act 74 assisted the state economy by stabilizing health
5 insurance, a significant fixed cost borne by Hawaii employers
6 and employees to help mitigate the economic effects of the
7 terrorist acts of September 11, 2001. Act 74 regulated health
8 insurance rates to protect the public interest and to help
9 ensure that health insurance rates are not excessive,
10 inadequate, or unfairly discriminatory in a manner similar to
11 the way that motor vehicle, workers' compensation, homeowners',
12 and other property and casualty insurance lines are presently
13 regulated. In addition, Act 74 ensured that rates would not be
14 confiscatory or predatory.

15 The 2002 legislature found that rate regulation of other
16 lines of insurance, such as motor vehicle, homeowners', and
17 workers' compensation, had resulted in premium decreases from



1 they shall not be excessive, inadequate, or unfairly
2 discriminatory. Nothing in this article is intended to:

- 3 (1) Prohibit or discourage reasonable competition; or
- 4 (2) Prohibit or encourage, except to the extent necessary
5 to accomplish the aforementioned purposes, uniformity
6 in insurance rates, rating systems, rating plans, or
7 practices.

8 This article shall be liberally interpreted to carry into effect
9 this section.

10 **§431: -102 Definitions.** As used in this article:

11 "Commissioner" means the insurance commissioner.

12 "Enrollee" means a person who enters into a contractual
13 relationship or who is provided with health care services or
14 benefits through a managed care plan.

15 "Managed care plan" or "plan" means a health plan as
16 defined in chapter 431:10A, 432, or 432D, regardless of form,
17 offered or administered by a health care insurer, including, but
18 not limited to, a mutual benefit society or a health maintenance
19 organization, mutual benefit societies of employee
20 organizations, or voluntary employee beneficiary associations,
21 but shall not include disability insurers licensed under chapter
22 431.



1 "Rate" means every rate, charge, classification, schedule,
2 practice, or rule. The definition of "rate" excludes fees and
3 fee schedules paid by the insurer to providers of services
4 covered under this article.

5 "Supplementary rating information" includes any manual or
6 plan of rates, classification, rating schedule, minimum premium,
7 policy fee, rating rule, underwriting rule, statistical plan,
8 and any other similar information needed to determine the
9 applicable rates in effect or to be in effect.

10 "Supporting information" means:

- 11 (1) The experience and judgment of the filer and the
12 experience or data of other organizations relied on by
13 the filer;
- 14 (2) The interpretation of any other data relied upon by
15 the filer; and
- 16 (3) Descriptions of methods used in making the rates and
17 any other information required by the commissioner to
18 be filed.

19 **§431: -103 Making of rates.** (a) Rates shall not be
20 excessive, inadequate, or unfairly discriminatory and shall be
21 reasonable in relation to benefits provided.



1 (b) Except to the extent necessary to meet subsection (a),
2 uniformity among managed care plans in any matters within the
3 scope of this section shall be neither required nor prohibited.

4 **§431: -104 Rate adjustment mandates.** (a) Except as
5 otherwise provided by law, the commissioner may mandate filings
6 for health insurance under section 431: -105 when the
7 commissioner has actuarially sound information that current
8 rates may be excessive, inadequate, or unfairly discriminatory.

9 (b) Managed care plans shall submit the rate filings
10 within one hundred twenty days of the commissioner's mandate.

11 (c) The rate filings shall be subject to the rate filing
12 requirements under section 431: -105.

13 **§431: -105 Rate filings.** (a) Every managed care plan
14 shall file in triplicate with the commissioner, every rate,
15 charge, classification, schedule, practice, or rule and every
16 modification of any of the foregoing that it proposes to use.
17 Every filing shall state its proposed effective date and shall
18 indicate the character and extent of the coverage contemplated.
19 The filing also shall include a report on investment income.

20 (b) Each filing shall be accompanied by a \$50 fee payable
21 to the commissioner and shall be deposited in the commissioner's
22 education and training fund.



1 (c) At the same time as the filing of the rate, every
2 managed care plan shall file all supplementary rating and
3 supporting information to be used in support of or in
4 conjunction with a rate. The managed care plan may satisfy its
5 obligation to file supplementary rating and supporting
6 information by reference to material that has been approved by
7 the commissioner. The information furnished in support of a
8 filing may include or consist of a reference to:

- 9 (1) Its interpretation of any statistical data upon which
10 it relies;
- 11 (2) The experience of other managed care plans; or
- 12 (3) Any other relevant factors.

13 (d) When a filing is not accompanied by supporting
14 information or the commissioner does not have sufficient
15 information to determine whether the filing meets the
16 requirements of this article, the commissioner shall require the
17 managed care plan to furnish additional information and, in that
18 event, the waiting period shall commence as of the date the
19 information is furnished. Until the requested information is
20 provided, the filing shall not be deemed complete or filed and
21 the filing shall not be used by the managed care plan. If the
22 requested information is not provided within a reasonable time



1 period, the filing may be returned to the managed care plan as
2 not filed and not available for use.

3 (e) Except for a rate filed in accordance with
4 subsection (i), or a filing in whole or in part that the
5 commissioner orders to be held confidential and exempt from
6 public disclosure, a filing and any supporting information shall
7 be open to public inspection upon filing with the commissioner.

8 (f) After reviewing a managed care plan's filing, the
9 commissioner may require that the managed care plan's rates be
10 based upon the managed care plan's own loss and expense
11 information.

12 (g) The commissioner shall review filings promptly after
13 the filings have been made to determine whether the filings meet
14 the requirements of this article. The commissioner shall
15 calculate the investment income and accuracy of loss reserves
16 upon which filings are based, and the managed care plan shall
17 provide the information necessary to make the calculation.

18 (h) Except as provided herein and in subsection (d), each
19 filing shall be on file for a waiting period of ninety days
20 before the filing becomes effective. The period may be extended
21 by the commissioner for an additional period not to exceed
22 fifteen days if the commissioner gives written notice, within



1 the waiting period to the managed care plan that made the
2 filing, that the commissioner needs the additional time for the
3 consideration of the filing. Upon written application by the
4 managed care plan, the commissioner may authorize a filing,
5 which the commissioner has reviewed, to become effective before
6 the expiration of the waiting period or any extension thereof.
7 A filing shall be deemed to meet the requirements of this
8 article unless disapproved by the commissioner within the
9 waiting period or any extension thereof. The rates shall be
10 deemed to meet the requirements of this article until the time
11 the commissioner reviews the filing and so long as the filing
12 remains in effect.

13 (i) The commissioner, by written order, may suspend or
14 modify the requirement of filing as to any class of health
15 insurance, subdivision, or combination thereof, or as to classes
16 of risks, the rates for which cannot practicably be filed before
17 they are used. The order shall be made known to the affected
18 managed care plan. The commissioner may make examinations that
19 the commissioner deems advisable to ascertain whether any rates
20 affected by the order meet the standards set forth in section
21 431: -103.



1 (j) No managed care plan shall make or issue a contract or
2 policy except in accordance with filings that are in effect for
3 the managed care plan as provided in this article.

4 (k) The commissioner may make the following rate effective
5 when filed: any special filing with respect to any class of
6 health insurance, subdivision, or combination thereof that is
7 subject to individual risk premium modification and has been
8 agreed to under a formal or informal bid process.

9 (1) For managed care plans having annual premium revenues
10 of less than \$10,000,000, the commissioner may adopt rules and
11 procedures that will provide the commissioner with sufficient
12 facts necessary to determine the reasonableness of the proposed
13 rates without unduly burdening the managed care plan and its
14 enrollees.

15 (m) All managed care plans shall file initial rates within
16 thirty days of the effective date of this article. These rates
17 shall be in effect until approved by the commissioner. The time
18 limits set forth in this article for the commissioner's review
19 of rates shall not apply to the commissioner's review of initial
20 rates; provided that the commissioner shall review the initial
21 rates within a reasonable period.



1 **§431: -106 Reserves.** (a) If a managed care plan's net
2 worth exceeds fifty per cent of its annual health care
3 expenditures and operating expenses as reported on the most
4 recent financial statement filed with the commissioner, the
5 excess moneys shall either:

6 (1) Be returned to enrollees of the managed care plan; or

7 (2) Be applied to stabilize or reduce rates, charges,
8 assessments, subscriptions, receipts, contributions,
9 fees, or dues payable by the enrollees of the managed
10 care plan.

11 (b) Excess moneys applied in accordance with subsection
12 (a)(2) shall be reallocated among all lines of health insurance
13 business sold by the managed care plan. Reallocation of moneys
14 pursuant to this section may be delayed until the amount of
15 moneys available to be reallocated exceeds \$10,000,000. Nothing
16 in this section shall prohibit a managed care plan from
17 maintaining reserves above minimum requirements but below the
18 maximum limit or from returning moneys to, or reducing moneys
19 payable by, enrollees of the managed care plan prior to reaching
20 the maximum limit.

21 (c) Nothing in this section shall be construed to alter or
22 eliminate the minimum reserve requirements applicable to the



1 managed care plan. In the event of a conflict, the minimum
2 reserve requirements shall control.

3 (d) Eighty per cent of all investment income on the
4 reserves net of investment manager fees shall be applied to the
5 rate determination and filing of the managed care plan. This
6 requirement may be waived or adjusted by the commissioner if the
7 commissioner determines it would impair the minimum reserve
8 requirements or solvency of the managed care plan.

9 **§431: -107 Policy revisions that alter coverage.** All
10 plan revisions that alter coverage in any manner shall be filed
11 with the commissioner. After review by the commissioner, the
12 commissioner shall determine whether a rate filing for the plan
13 revision must be submitted in accordance with section
14 431: -105.

15 **§431: -108 Disapproval of filings.** (a) If, within the
16 waiting period or any extension of the waiting period as
17 provided in section 431: -105, the commissioner finds that a
18 filing does not meet the requirements of this article, the
19 commissioner shall send to the managed care plan that made the
20 filing, written notice of disapproval of the filing specifying
21 in what respects the filing fails to meet the requirements of



1 this article and stating that the filing shall not become
2 effective.

3 (b) Whenever a managed care plan has no legally effective
4 rates as a result of the commissioner's disapproval of rates or
5 other act, interim rates shall be established as follows:

6 (1) If a filing is disapproved, in whole or in part, a
7 petition and demand for a contested case hearing may
8 be filed in accordance with chapter 91. The managed
9 care plan shall have the burden of proving that the
10 disapproval is not justified. While the action of the
11 commissioner in disapproving the rate filing is being
12 challenged, the aggrieved managed care plan shall
13 charge the rates established or the filed rates,
14 whichever is lower; or

15 (2) If a filing is approved, a contested case hearing in
16 accordance with chapter 91 may be convened pursuant to
17 subsection (c) to determine if the approved rates
18 comply with the requirements of this article. If an
19 appeal is taken from the commissioner's approval or if
20 subsequent to the approval the commissioner convenes a
21 hearing pursuant to subsection (c), the filing of the
22 appeal or the commissioner's notice of hearing shall



1 not stay the implementation of the rates approved by
2 the commissioner, or the rates currently in effect,
3 whichever is higher;

- 4 (3) The commissioner may waive or modify the requirements
5 of paragraph (1) or (2) if the application of those
6 paragraphs will endanger the financial solvency of the
7 managed care plan or the welfare of its enrollees.

8 The commissioner may also order that a specified
9 portion of the premiums be placed in an escrow account
10 approved by the commissioner. When new rates become
11 legally effective, the commissioner may order the
12 escrowed funds or any change in interim rates to be
13 refunded or allow the managed care plan to exact a
14 surcharge on premiums, whichever applies.

15 (c) If at any time subsequent to the applicable review
16 period provided for in section 431: -105, the commissioner
17 finds that a filing does not comply with the requirements of
18 this article, the commissioner shall order a hearing upon the
19 filing. The hearing shall be held upon not less than ten days'
20 written notice to every managed care plan that made such a
21 filing. The notice shall specify the matters to be considered
22 at the hearing. If, after a hearing the commissioner finds that



1 a filing does not meet the requirements of this article, the
2 commissioner shall issue an order specifying in what respects
3 the filing fails to meet the requirements, and stating when,
4 within a reasonable period thereafter, the filing shall be
5 deemed no longer effective. Copies of the order shall be sent
6 to each managed care plan. The order shall not affect any
7 contract or policy made or issued prior to the expiration of the
8 period set forth in the order.

9 (d) (1) Any person or organization aggrieved with respect
10 to any filing that is in effect may make a written
11 demand to the commissioner for a hearing thereon;
12 provided that the managed care plan that made the
13 filing shall not be authorized to proceed under this
14 subsection;

15 (2) The demand shall specify the grounds to be relied upon
16 by the aggrieved person or organization and the demand
17 shall show that the person or organization has a
18 specific economic interest affected by the filing;

19 (3) If the commissioner finds that:

20 (A) The demand is made in good faith;

21 (B) The applicant would be so aggrieved if the



1 person's or organization's grounds are
2 established; and
3 (C) The grounds otherwise justify a hearing;
4 The commissioner, within thirty days after receipt of
5 the demand, shall hold a hearing. The hearing shall
6 be held upon not less than ten days' written notice to
7 the aggrieved party and to every managed care plan
8 that made the filing; and

9 (4) If, after the hearing, the commissioner finds that the
10 filing does not meet the requirements of this article,
11 the commissioner shall issue an order specifying in
12 what respects the filing fails to meet the
13 requirements of this article, and stating when, within
14 a reasonable period, the filing shall be deemed no
15 longer effective. Copies of the order shall be sent
16 to the applicant and to every affected managed care
17 plan. The order shall not affect any contract or
18 policy made or issued prior to the expiration of the
19 period set forth in the order.

20 (e) The notices, hearings, orders, and appeals referred to
21 in this section, in all applicable respects, shall be subject to
22 chapter 91, unless expressly provided otherwise.



1 **§431: -109 Managed care plans; prohibited activity.** (a)

2 Except as permitted in this article, no managed care plan shall:

3 (1) Attempt to monopolize, or combine or conspire with any

4 other person to monopolize an insurance market; or

5 (2) Engage in a boycott, on a concerted basis, of an

6 insurance market.

7 (b) Except as permitted in this article, no managed care

8 plan shall make any arrangement with any other person that has

9 the purpose or effect of restraining trade unreasonably or of

10 substantially lessening competition in the business of

11 insurance.

12 **§431: -110 Information to be furnished enrollees;**

13 **hearings and appeals of enrollees.** Every managed care plan that

14 makes its own rates, within a reasonable time after receiving

15 written request therefore and upon payment of reasonable charges

16 as it may make, shall furnish to any enrollee affected by a rate

17 made by it or to the authorized representative of the enrollee,

18 all pertinent information as to the rate.

19 **§431: -111 False or misleading information.** No person or

20 organization shall wilfully withhold information from or

21 knowingly give false or misleading information to the

22 commissioner, any statistical agency designated by the



1 commissioner, or any managed care plan, which will affect the
2 rates or premiums chargeable under this article. Violation of
3 this section shall subject the one guilty of the violation to
4 the penalties provided in section 431: -112.

5 **§431: -112 Penalties.** (a) If the commissioner finds
6 that any person or organization has violated any provision of
7 this article, the commissioner may impose a penalty of not more
8 than \$500 for each violation; provided that if the commissioner
9 finds the violation to be wilful, the commissioner may impose a
10 penalty of not more than \$5,000 for each violation. The
11 penalties may be in addition to any other penalty provided by
12 law. For purposes of this section, any managed care plan using
13 a rate for which the managed care plan has failed to file the
14 rate, supplementary rating information, underwriting rules or
15 guides, or supporting information as required by this article,
16 shall have committed a separate violation for each day the
17 failure to file continues.

18 (b) The commissioner may suspend the license or operating
19 authority of any managed care plan that fails to comply with an
20 order of the commissioner within the time limited by the order,
21 or any extension thereof that the commissioner may grant. The
22 commissioner shall not suspend the license of any managed care



1 plan for failure to comply with an order until the time
2 prescribed for an appeal from the order has expired or, if an
3 appeal has been taken, until the order has been affirmed. The
4 commissioner may determine when a suspension of license or
5 operating authority shall become effective and it shall remain
6 in effect for the period fixed by the commissioner unless the
7 commissioner modifies or rescinds the suspension, or until the
8 order upon which the suspension is based is modified, rescinded,
9 or reversed.

10 (c) No penalty shall be imposed and no license or
11 operating authority shall be suspended or revoked except upon a
12 written order of the commissioner, stating the commissioner's
13 findings, made after a hearing held upon not less than ten days'
14 written notice to the person or organization. The notice shall
15 specify the alleged violation.

16 **§431: -113 Hearing procedure and judicial review. (a)**
17 Any managed care plan aggrieved by any order or decision of the
18 commissioner made without a hearing, within thirty days after
19 notice of the order to the managed care plan, may make written
20 request to the commissioner for a hearing. The commissioner
21 shall hold a hearing within twenty days after receipt of the
22 request, and shall give not less than ten days' written notice



1 of the time and place of the hearing. Within fifteen days after
2 the hearing, the commissioner shall affirm, reverse, or modify
3 the commissioner's previous action, specifying the reasons for
4 the commissioner's decision. Pending the hearing and decision,
5 the commissioner may suspend or postpone the effective date of
6 the commissioner's previous action.

7 (b) Any final order or decision of the commissioner may be
8 reviewed in the circuit court of the first circuit and an appeal
9 from the decision of the court shall lie to the supreme court.
10 The review shall be taken and had in the manner provided in
11 chapter 91."

12 SECTION 3. Section 432:1-102, Hawaii Revised Statutes, is
13 amended by amending subsection (b) to read as follows:

14 "(b) Article 2 [~~and~~], article 13, and article of
15 chapter 431, and the powers there granted to the commissioner,
16 shall apply to managed care plans, health maintenance
17 organizations, or medical indemnity or hospital service
18 associations, which are owned or controlled by mutual benefit
19 societies, so long as [~~such~~] the application in any particular
20 case is in compliance with and is not preempted by applicable
21 federal statutes and regulations."



1 SECTION 4. Section 432D-19, Hawaii Revised Statutes, is
2 amended by amending subsection (d) to read as follows:

3 "(d) Article 2 [~~and~~], article 13, and article of
4 chapter 431, and the power there granted to the commissioner,
5 shall apply to health maintenance organizations, so long as
6 [~~such~~] the application in any particular case is in compliance
7 with and is not preempted by applicable federal statutes and
8 regulations."

9 SECTION 5. Statutory material to be repealed is bracketed
10 and stricken. New statutory material is underscored.

11 SECTION 6. This Act shall take effect on January 1, 2008.

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INTRODUCED BY:

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Report Title:

Health Insurance; Rate Regulation

Description:

Prohibits health insurance rates that are excessive, inadequate or unfairly discriminatory. Requires health care insurers to submit rate filings for approval by the insurance commissioner. Establishes penalties and appeal procedures.

