SLS 12RS-573 **REENGROSSED**

Regular Session, 2012

SENATE BILL NO. 207

BY SENATOR MORRISH

HEALTH/ACC INSURANCE. Provides for review of health coverage premium rates. (8/1/12)

AN ACT

To enact R.S. 22:1098, relative to review of health coverage premium rates; to provide for definitions; to enact requirements that meet the provisions of effective rate review as defined by the U.S. Department of Health and Human Services; to provide for information to be filed by health insurance issuers; to provide for review of filed information by the commissioner of insurance; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1098 is hereby enacted to read as follows:

§1098. Review of health insurance premium rates

A. Definitions. As used in this Section, the following terms shall have the following meanings unless another meaning is clearly required by context:

(1) "Commissioner" means the commissioner of insurance.

(2) "Department of Health and Human Services" or "DHHS" means the U.S. Department of Health and Human Services or its sub-agencies, the Centers for Medicare and Medicaid Services, and the Center for Consumer Information and Insurance Oversight, or a successor organization of any of these agencies.

(3) "Excepted benefits" means benefits under one or more of the

following:

(a) Benefits not subject to requirements:

(i) Coverage only for accident or disability income insurance, or any combination.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations issued by the commissioner under the Administrative Procedure Act, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) Benefits not subject to requirements if offered separately:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as specified in reasonable regulations issued by the commissioner.

(c) Benefits not subject to requirements if offered as independent, non-coordinated benefits:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(d) Benefits not subject to requirements if offered as a separate insurance policy:

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.

(ii) Insurance coverage supplemental to military health benefits.

(iii) Similar supplemental coverage provided under a group health benefit plan.

(4) "Excessive" in relation to premiums means the premium charged for the health insurance coverage is considered to be unreasonably high in relation to the benefits provided under the product. In determining whether the premium rate is unreasonably high in relation to the benefits provided, the department shall consider:

(a) Whether the premium rate results in a projected medical loss ratio below the federal medical loss ratio standard in the applicable market to which the premium rate applies, after accounting for any adjustments allowable under federal law.

(b) Whether one or more of the assumptions on which the premium rate is based is not supported by substantial evidence.

(c) Whether the choice of assumptions or combination of assumptions on which the premium rate is based is unreasonable.

(5) "Grandfathered health plan" has the same meaning as that in 45 C.F.R. 147.140.

(6) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance or subscriber agreement subject to state law that regulates the business of insurance. "Health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title.

(7) "Individual health insurance coverage" or "individual policy" means health insurance coverage offered to individuals in the individual market, or through an association.

(8) "Product" means a package of benefits with a discrete set of rating and pricing methodologies including health care services paid for under any plan, policy, subscriber agreement, or certificate of insurance offered in the

state. Products, for the purposes of this Section, shall not include excepted benefits plans, high deductible health plans, or grandfathered plans.

(9) "Rate increase" means an increase of the rates for a product, including a premium volume-weighted average increase for all insureds for the aggregate rate changes during the twelve-month period preceding the proposed rate increase effective date.

(10) "Reasonable rate increase" means a rate increase subject to review that, following review, meets specified criteria.

(11) "Small group market" means the market in which small group coverage is issued as currently defined in R.S. 22:1061. "Small group" or "small employer" means any person, firm, corporation, partnership, trust, or association actively engaged in business which has employed an average of at least one but not more than fifty employees, and beginning on January 1, 2014, at least one but not more than one hundred employees, on business days during the preceding calendar year or plan year and that employs at least one employee on the first day of the plan year. "Small group" or "small employer" shall include coverage sold to small groups or small employers through associations or through a blanket policy. An employer group of one shall be considered individual insurance under this Section.

(12) "Unfairly discriminatory" means premium rates that result in premium differences between insureds within similar risk categories that do not reasonably correspond to differences in expected costs. When applied to premium rates charged, "unfairly discriminatory" shall refer to any premium rate charged by a small group or individual health insurance issuer in violation of R.S. 22:1095.

(13) "Unjustified" means a premium rate for which a health insurance issuer has provided data or documentation to the department in connection with premium rates for a product that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of a premium rate may be

determined or is otherwise inadequate insofar as the premium rate charged is clearly insufficient to sustain projected losses and expenses.

(14) "Unreasonable rate increase" means a rate increase subject to review that, following review, fails to meet specified criteria. "Unreasonable" means any rate increase that contains a provision or provisions that:

(a) Are excessive.

(b) Are unfairly discriminatory.

(c) Are unjustified.

(d) Do not comply with R.S. 22:1095 or federal law.

B. For each product in the individual market and the small group market, whenever a health insurance issuer proposes a rate increase that meets or exceeds ten percent of the rate implemented, the issuer shall file with the commissioner information related to any proposed increase in base premium. To determine the requirement to file, the issuer shall apply current criteria and methodology promulgated by DHHS.

C.(1) For each rate increase subject to review according to the provisions of Subsection B of this Section, a health insurance issuer shall file with the commissioner, no later than one hundred twenty days in advance of the anticipated effective date of the increase, a preliminary justification for each product affected by the increase.

(2) The preliminary justification shall consist of the following Parts:

(a) Part I shall be a rate increase summary, consisting of the following detailed information:

(i) Historical and projected claims experience.

(ii) Trend projections related to utilization and service or unit costs.

(iii) Any claims assumptions related to benefit changes.

(iv) Allocation of the overall rate increase to claims and non-claims costs.

(v) Per enrollee per month allocation of current and projected premium.

(vi) Current loss ratio and projected loss ratio.

(vii) Three-year history of rate increases for the product associated with the rate increase.

(viii) Employee and executive compensation data from the health insurance issuer's annual financial statements.

(b) Part II shall be a be a written description justifying the rate increase, including a simple, brief narrative describing the data and assumptions used to develop the rate increase, and consisting of the following information:

(i) The rating methodology.

(ii) An explanation of the most significant factors causing the increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary.

(iii) A brief description of the policies' overall experience, including historical and projected expenses, and loss ratios.

(c) Part III shall consist of the following information:

(i) A description of the type of policy, benefits, renewability, general marketing method, and age limits.

(ii) The scope and reason for the rate increase.

(iii) The average annual premium per policy, before and after the rate increase.

(iv) The past experience and any other alternative or additional data used.

(v) A description of how the rate increase was determined, including the general description and source of each assumption used.

(vi) The cumulative loss ratio and a description of how it was calculated.

(vii) The projected future loss ratio and a description of how it was calculated.

(viii) The projected lifetime loss ratio that combines cumulative and future experience and a description of how it was calculated, including historical data beginning with the effective date of this Section.

(ix) The federal medical loss ratio standard in the applicable market to which the rate increase applies, accounting for any adjustments allowable under federal law.

(x) If the projected future loss ratio is less than the applicable federal medical loss ratio, a justification for this outcome.

(3) In its filing of information described in this Section, a health insurance issuer may indicate to the commissioner that the issuer considers certain information required pursuant to Paragraph C(2) of this Section confidential according to Louisiana public records law.

D.(1) The commissioner shall ensure that the information received from a health insurance issuer in accordance with the provisions of Paragraphs C(1) and (2) of this Section are made available to the public on a Department of Insurance website.

(2) Within sixty days of receipt of a filing from a health insurance issuer, the commissioner shall evaluate the proposed rate increase, make a determination whether the rate increase is a reasonable rate increase or an unreasonable rate increase based on sound actuarial principles, and notify the health insurance issuer of the determination.

(3) The commissioner's review of a proposed rate increase shall include an examination of:

(a) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase, and the validity of the historical data underlying the assumptions.

(b) The health insurance issuer's data related to past projections and actual experience.

(4) In his evaluation of a proposed rate increase, the commissioner shall consider the following factors to the extent applicable:

(a) Medical trend changes by major service categories.

(b) Utilization changes by major service categories.

(c) Cost-sharing changes by major service categories.

(d) Benefit changes.

(e) Changes in enrollee risk profile.

(f) Impact of overestimate or underestimate of medical trend in previous years on the current rate.

(g) Reserve needs.

(h) Administrative costs related to programs that improve health care quality.

(i) Other administrative costs related to programs that improve health care quality.

(j) Applicable taxes and licensing or regulatory fees.

(k) The medical loss ratio.

(l) The health insurance issuer's risk-based capital status and surplus relative to national standards.

(5) The commissioner shall use the following criteria to determine whether a rate increase is an unreasonable rate increase or is otherwise unlawful:

(a) To determine whether a rate increase is excessive, he shall consider whether the increase would cause the premium to be unreasonably high in relation to benefits, including consideration of the following:

(i) Whether a rate increase would result in a projected medical loss ratio below the applicable federal standard.

(ii) Whether one or more of the assumptions used by the health insurance issuer is not supported by substantial evidence.

(iii) Whether the choice of assumptions or combination thereof is unreasonable.

(b) To determine whether a rate increase is an unjustified rate increase, he shall consider whether data or documentation provided by the health insurance issuer is incomplete, inadequate, or otherwise does not provide a basis

to determine whether the increase is a reasonable increase.

(c) To determine whether a rate increase is unfairly discriminatory, he shall consider whether the proposed increase would result in premium differences between enrollees with similar risks that are not permitted under state law or do not reasonably correspond to expected differences in costs.

(d) The commissioner shall consider R.S. 22:1095 and any applicable federal rating restrictions to determine whether rating increases are compliant with state and federal law.

(6) Within fifteen days of submission of any proposed rate increase which meets or exceeds the federal review threshold, the department shall publish a summary consistent with Part I and Part II of the rate increase information provided by the health insurance issuer on the department's website. After publication, the public shall have thirty days to submit comments to the department regarding the proposed rate increase.

(7) The commissioner shall, in accordance with Louisiana public records law, refrain from releasing information provided by a health insurance issuer pursuant to the provisions of Paragraph C(2)(c) of this Section that the issuer has indicated is confidential.

(8) A proposed rate increase shall be deemed to have been reasonable after the sixtieth day following the date of filing with the commissioner if notice is not received by the health insurance issuer from the commissioner regarding a final determination with respect to the reasonableness of the filing.

E. Within fifteen days of receipt of the determination by the commissioner that a proposed rate increase is an unreasonable rate increase, a health insurance issuer shall notify the commissioner whether it intends to utilize the proposed rate increase or to refile. If the issuer's intent is to utilize the rate, the notice shall include the issuer's justification for such utilization of the rate.

F. Any premium rate reviewed by the department shall be implemented

within ninety days of the proposed effective date documented in the filing. Any premium rate implemented following this date shall be void, and any health insurance issuer seeking to implement the rate thereafter shall be required to file a new rate filing in compliance with this Section.

G. The requirements set forth in this Section shall not apply to excepted benefits, high deductible health plans, grandfathered plans, or to those benefits specifically excepted from review in R.S. 22:1091(A).

H. The commissioner may promulgate such rules and regulations as may be necessary or proper to carry out the provisions of this Section. Such rules and regulations shall be promulgated and adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Section 2. The provisions of this Act shall expire and be void after a final, non-appealable judgment by the United States Supreme Court that includes the merits of the provisions of Section 2794 of the Public Health Service Act and that rejects the validity of such provisions, together with any and all federal regulations promulgated in accordance therewith by any federal agency. The provisions of this Act shall become null and void immediately upon congressional repeal of Section 2794 of the Public Health Service Act.

The original instrument was prepared by Cheryl Horne. The following digest, which does not constitute a part of the legislative instrument, was prepared by Michelle Broussard-Johnson.

DIGEST

Morrish (SB 207)

Proposed law requires a health insurance issuer to file information related to any proposed increase in base premium with the commissioner. Further requires the issuer to file with the commissioner, no later than 120 days in advance of the anticipated effective date of the increase, a preliminary justification for each product affected by the increase. Provides for specific information to be included in the preliminary justification. Requires the commissioner to ensure that the information received from the health insurance issuer be made available to the public on the Department of Insurance website.

Proposed law requires the commissioner to evaluate the proposed rate increase within 60 days of receipt of a filing by a health insurance issuer. Further provides information that shall be included in the commissioner's review of the proposed rate, as well as the criteria the commissioner shall use to determine whether a rate increase is excessive, unjustified, or unfairly discriminatory. Specifies that if the issuer does not receive a final determination within 60 days, the proposed rate increase shall be deemed reasonable.

Proposed law requires a summary of the rate increase information submitted by the

insurance issuer to be published on the department's website within 15 days of the submission. Specifies that the public shall have 30 days after publication to submit comments. Prohibits the commissioner from releasing information provided by the health insurance issuer that the issuer has indicated is confidential.

Proposed law requires an approved rate increase to be implemented within 90 days of the effective date documented in the issuer's filing. Provides that if the rate is implemented more than 90 days after approval, the rate shall be void.

Proposed law provides that proposed law shall expire and become void after a final, nonappealable judgment by the US Supreme Court that includes the merits of the provisions of Section 2794 of the Public Health Service Act and that rejects the validity of such provisions, together with any and all federal regulations promulgated in accordance therewith by any federal agency. Additionally provides that proposed law shall become null and void immediately upon congressional repeal of Section 2794 of the Public Health Service Act.

Effective August 1, 2012.

(Adds R.S. 22:1098)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill.

1. Provides for additional definitions.

2. Increases the time allowed for the commissioner to evaluate the proposed rate increase from 45 days to 60 days.

3. Requires a summary of the rate increase information submitted by the insurance issuer to be published on the department's website within 15 days of the submission. Specifies that the public shall have 30 days after publication to submit comments.

4. Requires an approved rate increase to be implemented within 90 days of the effective date documented in the issuer's filing. Provide that if the rate is implemented more than 90 days after approval, the rate shall be void.

5. Revises the effective date language.

Senate Floor Amendments to engrossed bill

1. Technical changes made.