

HOUSE BILL NO. 282

98TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE WHITE.

0728H.011

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to health insurance premium rate filings.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Chapter 376, RSMo, is amended by adding thereto one new section, to be known as section 376.458, to read as follows:

376.458. 1. As used in this section, the following terms shall mean:

(1) **“Director”, the director of the department of insurance, financial institutions and professional registration;**

(2) **“Enrollee”, a policyholder, subscriber, covered person, or other individual participating in a health benefit plan;**

(3) **“Health benefit plan”, a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; except that, “health benefit plan” shall not include any coverage pursuant to a liability insurance policy, workers’ compensation insurance policy, Medicare supplement insurance policy, long-term care insurance policy, or medical payments insurance issued as a supplement to a liability policy;**

(4) **“Health carrier”, an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing coverage under a health benefit plan as defined herein;**

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

18 **(5) “Premium”, “Premium rate”, or “Rate”, all moneys paid by an individual or**
19 **group as a condition of receiving coverage, including any fees or other contributions**
20 **associated with the health benefit plan;**

21 **(6) “Premium rate change threshold”, an increase of ten percent or more in**
22 **premium rates from the current premium rates in use for any health benefit plan written**
23 **inside the state of Missouri or written outside the state of Missouri but insuring Missouri**
24 **residents.**

25 **2. No health carrier shall deliver, issue for delivery, continue, or renew any health**
26 **benefit plan on or after July 1, 2016, if written inside the state of Missouri or written**
27 **outside the state of Missouri but insuring Missouri residents until the classification of risks**
28 **and premium rates pertaining thereto have been filed with the director.**

29 **3. No health carrier shall use premium rates until at least thirty days after the date**
30 **the classification of risks and the premium rates pertaining thereto have been filed with the**
31 **director.**

32 **4. Premium rates shall not be excessive, inadequate, unfairly discriminatory, or**
33 **unjustified.**

34 **(1) A premium rate is excessive if such premium rate is unreasonably high for the**
35 **coverage provided under the health benefit plan;**

36 **(2) A premium rate is inadequate if such premium rate is unreasonably low for the**
37 **coverage provided under the health benefit plan and is insufficient to sustain projected**
38 **losses and expenses;**

39 **(3) A premium rate is unfairly discriminatory when a health carrier makes or**
40 **permits differences in premium rates between individuals of the same class and of**
41 **essentially the same risk;**

42 **(4) A premium rate is unjustified if the health carrier provides data or**
43 **documentation in connection with the premium rate that is incomplete, inadequate, or**
44 **otherwise does not provide a basis upon which the reasonableness of a premium rate can**
45 **be determined.**

46 **5. For premium rates meeting the premium rate change threshold, the health**
47 **carrier shall file, along with the classification of risks and premium rates, information**
48 **sufficient to justify the premium rate. Such information shall include, but is not limited**
49 **to:**

50 **(1) Identification of all policy forms to which such premium rate will apply,**
51 **including the total number of in-force policies or certificates;**

52 **(2) Medical cost trend changes by major service categories;**

- 53 **(3) Changes in utilization of services, including, but not limited to, hospital care,**
54 **pharmaceuticals, and doctors' office visits by major service categories;**
- 55 **(4) The health insurance issuer's data related to past projections and actual**
56 **experience;**
- 57 **(5) Cost-sharing changes by major service categories;**
- 58 **(6) Changes in benefits;**
- 59 **(7) Changes in enrollee risk profiles;**
- 60 **(8) Impact of over- and under-estimation of medical trends in the previous three**
61 **years on the current premium rate;**
- 62 **(9) The health carrier's reserve needs;**
- 63 **(10) Administrative costs related to programs that improve health care quality;**
- 64 **(11) Other administrative costs;**
- 65 **(12) Applicable taxes and licensing or regulatory fees;**
- 66 **(13) Medical loss ratio;**
- 67 **(14) The health carrier's capital and surplus;**
- 68 **(15) The impacts of geographic factors and variations;**
- 69 **(16) The impact of changes within a single risk pool to all products or plans within**
70 **the risk pool;**
- 71 **(17) The impact of reinsurance and risk adjustment payments and charges;**
- 72 **(18) Product development and startup costs, drug and other benefit costs or**
73 **expenses, and product age and credibility;**
- 74 **(19) The three-year history of premium rates for the product or group of products**
75 **associated with the premium rate increase if the product is three years old or older, and**
76 **if less than three years old, any available premium rate history;**
- 77 **(20) A statement of actuarial justification submitted by a qualified actuary**
78 **representing the health carrier. The qualified actuary shall be a specifically qualified**
79 **member of the American Academy of Actuaries (MAAA). The statement by the qualified**
80 **actuary shall:**
- 81 **(a) Certify that to the best of the actuary's knowledge and belief, the rates are not**
82 **excessive, inadequate, unfairly discriminatory, or unjustified;**
- 83 **(b) State the basis for such conclusion; and**
- 84 **(c) Attach all documentary material considered in reaching such conclusion;**
- 85 **(21) The names of the top five executive officers of the health carrier as determined**
86 **by their level of compensation and the total amount of the compensation package for each**
87 **officer. Such information shall be considered a part of the premium rate filing and shall**
88 **be considered an open record and available for public review and inspection; and**

89 (22) All other information determined to be necessary or relevant by the director.

90 6. For premium rates meeting the premium rate change threshold, the director
91 shall issue a determination as to whether the premium rates filed are excessive, inadequate,
92 unfairly discriminatory, or unjustified.

93 (1) The determination shall be issued to the health carrier that filed the
94 classification of risks and the premium rates pertaining thereto; and

95 (2) The director shall post the determination on the department's website or other
96 publicly accessible media in a manner that is prominent and informative to the public.

97 7. The health carrier may appeal the director's determination under subsection 6
98 of this section to the department.

99 8. The premium rates, classification of risks, and supporting nonproprietary
100 information filed under this section shall, as soon as filed, be an open record. Information
101 which is a trade secret, of a proprietary nature, or both shall not be an open record.

102 9. The director shall make all portions of premium rate filings which are open
103 records as specified under subsection 8 of this section available on the department's
104 website within ten business days after the filing is submitted. The director shall provide
105 a means by which the public can submit written comments concerning the filed premium
106 rates for a period as determined by the director. In no event shall such comment period
107 be less than twenty days.

108 10. The director may require the health carrier to respond in writing within ten
109 days to questions based on public comments.

110 11. Any violation of this section shall constitute a level two violation under section
111 374.049. For the purposes of this section, each use of a premium rate which was not filed
112 as required under this section when the use of the premium rate does not result from a data
113 processing error, as specified under subsection 10 of section 374.049, shall constitute a
114 separate violation.

115 12. The director may promulgate rules to effectuate the provisions of this section
116 including, but not limited to, the form and content of the information required to be
117 submitted under this section. Any rule or portion of a rule, as that term is defined in
118 section 536.010, that is created under the authority delegated in this section shall become
119 effective only if it complies with and is subject to all of the provisions of chapter 536 and,
120 if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any
121 of the powers vested with the general assembly under chapter 536 to review, to delay the
122 effective date, or to disapprove and annul a rule are subsequently held unconstitutional,
123 then the grant of rulemaking authority and any rule proposed or adopted after August 28,
124 2015, shall be invalid and void.

✓