HB 891 -- REVIEW OF HEALTH INSURANCE PREMIUM RATES

SPONSOR: McNeil

Beginning September 1, 2015, every health carrier that issues a health benefit plan form must file its premium rates, classification of risks relevant to the form, and sufficient information to support the premium to be charged to an enrollee or policyholder with the Director of the Department of Insurance, Financial Institutions and Professional Registration no later than 60 days prior to the premium effective date. Any public information included in the plan forms, rate filings, and supporting information will be posted on the department's website. Each rate filing must include the product form number and the approval date of the form to which the form applies, an actuarial justification, and information sufficient to support the rate including explanations that can be validated by a qualified member of the American Academy of Actuaries (MAAA). A rate filing from a health carrier must be submitted by a MAAA-qualified actuary that certifies by a conclusive statement and supporting documentation that the rates are not excessive, inadequate, or unfairly discriminatory.

All health benefit plan premium rates must consider and be in accordance with past and prospective losses, current and projected loss ratios, past and prospective expenses, health services utilization trend projections, current and projected per enrollee per month premium allocations, three year rate increase history, and adequacy of contingency reserves. Any risk classification, premium rates, and all modifications cannot establish an excessive, inadequate, or unfairly discriminatory rate. An excessive rate is a rate that is unreasonably high for the insurance coverage provided, and an inadequate rate is a rate that is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses. A rate that is unfairly discriminatory is an unfair trade practice. The director must review the proposed health premium rates including the submitted information and determine if the rates are appropriate, excessive, inadequate, or unfairly discriminatory within 30 days from the date of the rate filing.

The director must set a date for a public hearing within 10 days of receipt of a significant rate increase filing. The hearing must be held within 50 days after the department receives the filing to discuss the rate increase and to allow public testimony from proponents and opponents of the rate increase. The health carrier must provide timely notice of the hearing to all affected enrollees and policyholders and the notice must inform the affected enrollees and policyholders that he or she may testify at the hearing. The

director must approve or disapprove the rate within 20 days of the hearing. If the rate increase is disapproved the health carrier may appeal the decision of the director as specified in the administrative rule process. When the director approves a rate increase the health carrier must notify all enrollees and policyholders in writing within 10 days of the director's approval.