FIRST REGULAR SESSION

SENATE BILL NO. 89

98TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR LeVOTA.

Pre-filed December 1, 2014, and ordered printed.

ADRIANE D. CROUSE, Secretary.

0444S.01I

AN ACT

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

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 sections 376.465, to read as follows:

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

(1) "Enrollee", a policyholder, subscriber, covered person, or other individual participating in a health benefit plan;

(2) "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 liability insurance policy, Medicare supplement insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(3) "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 in this section;

(4) "Premium rate", the cost of a health benefit plan per exposure base unit.

2. No health carrier shall deliver, issue for delivery, continue, or renew a health benefit plan written inside of the state of Missouri or

written outside of the state of Missouri but insuring Missouri residents on or after July 1, 2015, until the classification of risks and the premium rates pertaining thereto have been filed for approval with the director.

3. Premium rates are subject to disapproval if they are determined by the director to be excessive, inadequate, unjustified, or unfairly discriminatory.

4. When reviewing a premium rate filing, the director shall consider whether the proposed premium rate is excessive, inadequate, unjustified, or unfairly discriminatory. A premium rate is:

(1) Excessive if such premium rate is unreasonably high for the coverage provided under the health benefit plan;

(2) Inadequate if such premium rate is unreasonably low for the coverage provided under the health benefit plan and is insufficient to sustain projected losses and expenses;

(3) Unjustified if the health carrier provides data or documentation in connection with the premium rate that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of a premium rate may be determined;

(4) Unfairly discriminatory when a health carrier makes or permits differences in premium rates between individuals of the same class and of essentially the same hazard.

5. The health carrier shall provide, along with the classification of risks and premium rates, information sufficient to support the proposed premium rate. Such information shall include but is not limited to:

(1) Identification of all policy forms to which such premium rate will apply;

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

(3) Changes in utilization of services, including but not limited to, hospital care, pharmaceuticals, doctors' office visits by major service categories;

(4) Cost-sharing changes by major service categories;

(5) Changes in benefits;

(6) Changes in enrollee risk profile;

(7) Impact of over- or under-estimate of medical trend in the previous three years on the current premium rate;

(8) Health carrier's reserve needs;

(9) Administrative costs related to programs that improve health care quality;

(10) Other administrative costs;

(11) Applicable taxes and licensing or regulatory fees;

(12) Medical loss ratio;

(13) The health carrier's capital and surplus;

(14) The impacts of geographic factors and variations;

(15) The impact of changes within a single risk pool to all products or plans within the risk pool;

(16) The impact of reinsurance and risk adjustment payments and charges;

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

(18) The three-year history of premium rate increases for the product or group of products associated with the premium rate increase if the product is three years old or older and otherwise any available premium rate history;

(19) A statement of actuarial justification submitted by a qualified actuary representing the health carrier. The qualified actuary shall be specifically a qualified member of the American Academy of Actuaries. The statement by the qualified actuary shall:

(a) Certify that to the best of the actuary's knowledge and belief the rates are not excessive, inadequate, or unfairly discriminatory;

(b) State the basis for such conclusion; and

(c) Attach all documentary material considered in reaching such conclusion;

(20) The names of the top five executive officers of the health carrier as determined by their level of compensation and the total amount of the compensation package for each officer. Such information shall be considered a part of the premium rate filing and shall be considered an open record and available for public review and inspection; and

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

6. The health carrier proposing a premium rate has the burden of proving by clear and convincing evidence as set forth in subsection

5 of this section, that the proposed premium rate is not excessive, inadequate, unfairly discriminatory, or unjustified.

7. The director shall only approve such premium rates that are not excessive, inadequate, unfairly discriminatory, or unjustified. The director shall disapprove the premium rate if the director determines the premium rate is excessive, inadequate, unfairly discriminatory, or unjustified. The failure of the director to take action approving or disapproving a submitted premium rate within sixty days from the date of filing shall be deemed an approval thereof until such time as the director shall notify the submitting health carrier, in writing, of the disapproval thereof.

8. If the director disapproves the filing, the director shall notify the health carrier in writing of such disapproval. Such notice shall specify the reasons for disapproval and state the health carrier has thirty days after receiving such notice to submit a written request for a hearing before the director on the matter. A hearing under this subsection shall be conducted within ninety days of receipt of the written request. Upon request of the department or the health carrier, the director may issue a continuance.

9. Each premium rate filing and supporting nonproprietary information filed under this section shall, as soon as filed, be an open record. Notwithstanding the provisions of chapter 610, information which is a trade secret or of a proprietary nature, or both, shall not be an open record.

10. The director shall make all premium rate filings available on the department's website with ten business days after filing submission. The director shall provide a means by which the public can submit written comments concerning the proposed premium rate filing, for a period as determined by the director. In no event shall such comment period be less than twenty days.

11. The director may require the health carrier to respond in writing to comments received by the department.

12. Any violation of this section shall constitute a level two violation.

13. The director may promulgate rules to effectuate the provisions of this section, including, but not limited to, the form and content of the information required to be submitted under this

section. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2015, shall be invalid and void.

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