SECOND REGULAR SESSION

# SENATE BILL NO. 688

**97TH GENERAL ASSEMBLY**

INTRODUCED BY SENATOR LeVOTA.

Read 1st time January 9, 2014, and ordered printed.

TERRY L. SPIELER, Secretary.

5149S.01I



## AN ACT

To amend chapter 376, RSMo, by adding thereto three new sections relating to health insurance premium rate reviews, with an emergency clause.

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

Section A. Chapter 376, RSMo, is amended by adding thereto three new sections, to be known as sections 376.465, 376.466, and 376.468, to read as follows:

**376.465. 1. As used in sections 376.465 to 376.468, the following terms mean:**

**(1) "Department", the department of insurance, financial institutions and professional registration;**

**(2) "Director", the director of the department of insurance, financial institutions and professional registration;**

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

**(4) "Health benefit plan", shall have the same meaning as such term is defined in section 376.1350;**

**(5) "Health carrier", shall have the same meaning as such term is defined in section 376.1350;**

**(6) "Significant increase", a rate increase exceeding the rate increases contemplated in 42 U.S.C. Section 300gg-94 and outlined in any regulations promulgated under the authority granted therein.**

**2. Beginning July 1, 2014, every health carrier issuing a health benefit plan form which is submitted for approval under section 354.085, 354.405, 376.405, or 376.777 shall file with the director its premium rates and classification of risks pertaining to such form together with sufficient information to support the premium to be**

**charged. Such premium rates, classification of risks, and all modifications thereof shall be filed with the director no later than sixty days prior to their effective date. Plan forms, rate filings, and supporting data included in the definition of public record under section 610.010 shall be posted and available to the public on the department's website.**

**3. Each rate filing shall include:**

**(1) The product form number or numbers and approval date of the product form or forms to which the rate applies;**

**(2) A statement of actuarial justification; and**

**(3) Information sufficient to support the rate, including but not limited to:**

**(a) All factors that could be considered in calculating the premium to be paid for a health benefit plan;**

**(b) An appropriate explanation for each factor; and**

**(c) Any other information which would be needed to enable any other actuary who is a specifically qualified member of the American Academy of Actuaries to validate the rates and associated factors.**

**4. A rate filing required under this section shall be submitted by a qualified actuary representing the health carrier. The qualified actuary shall be a specifically qualified member of the American Academy of Actuaries. The statement by the qualified actuary shall:**

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

**(2) State the basis for such conclusion; and**

**(3) Attach all documentary material considered in reaching such conclusion.**

**5. All premium rates for health benefit plans shall be made in accordance with the following provisions and due consideration shall be given to:**

**(1) Past and prospective loss experience;**

**(2) Current and projected loss ratio;**

**(3) Past and prospective expenses;**

**(4) Trend projections related to utilization, and service or unit costs;**

**(5) Per enrollee per month allocation of current and projected premium;**

**(6) Three year history of rate increases for products subject to the rate increase; and**

**(7) Adequacy of contingency reserves.**

**6. Any risk classification, premium rates, and all modifications thereof shall not establish an excessive, inadequate, or unfairly discriminatory rate. No rate shall be held to be excessive unless such rate is unreasonably high for the insurance coverage provided. No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses. Unfair discrimination shall have the same meaning ascribed to such term in section 375.936.**

**7. In accordance with the procedures set forth in section 376.466, the director shall review the proposed rates, the information submitted in support of the proposed rates, and any supplemental information requested by the director or otherwise submitted to the director regarding the proposed rates and make a determination as to whether the rates are excessive, inadequate, or unfairly discriminatory within thirty days from the date of the filing by the health carrier.**

**8. The director may promulgate rules to implement the provisions of this section. Such regulations may, among other things, clarify or explain 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 the effective date of this section shall be invalid and void.**

**376.466. 1. Concurrent with the filing of a significant rate increase for approval by the department, a health carrier shall notify in writing all affected enrollees and policyholders of the proposed significant rate increase. Such notice shall specify the rate increase proposed that is applicable to each enrollee or policyholder, and shall include the ranking and quantification of those factors that are**

**responsible for the amount of the rate increase proposed. The notice shall include information about how the enrollee or policyholder can contact the department for assistance.**

**2. Within ten days of the date the health carrier files for approval of a significant rate increase, the director shall set a date for a public hearing on the proposed significant rate increase. The hearing shall be held no later than thirty days after the department receives the filing from the health carrier. The director shall provide a copy of any information filed by the health carrier under subsection 2 of section 376.465 to any person making a written request for the information. At the hearing, the health carrier may provide additional information in support of its proposed significant rate increase and any member of the public may provide information in support of or in opposition to the proposed significant rate increase.**

**3. The director shall solicit public comments on each proposed significant rate increase and shall post without delay all comments received on the department's website prior to approval or disapproval of the proposed significant rate increase.**

**4. The director shall consider the public testimony and comments received for consideration in determining whether to approve or disapprove such significant rate increase proposals.**

**5. Within twenty days of the hearing described in subsection 2 of this section, the director shall review all of the information submitted to determine whether the proposed significant rate increase is justified. No rate shall be considered justified that is excessive, inadequate, or unfairly discriminatory. If the director determines that the rate is justified, the director shall issue an order authorizing the health carrier to use the premium rate as proposed. If the director determines that the rate is not justified, the director shall issue an order prohibiting the use of the premium rate as proposed. The health carrier, or an enrollee or policyholder under section 376.468, may appeal the director's decision under chapter 536.**

**6. Within ten days of the director's decision and notice to the health carrier of such decision, the health carrier shall notify in writing all affected enrollees and policyholders of the determination of the director regarding the premium rate increase.**

**7. The director shall adopt regulations to implement the**

**provisions of 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, section 376.465, 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 the effective date of this section shall be invalid and void.**

**376.468. Any enrollee or policyholder notified by a health carrier of a proposed rate increase and the director's decision under section 376.466 shall be entitled to judicial review as provided in chapter 536 if:**

**(1) The enrollee or policyholder pays all or a majority portion of the premium for the health insurance policy; and**

**(2) The enrollee or policyholder will be paying all or a majority portion of the increase of premium for the health insurance policy; and**

**(3) The premium rate increase is:**

**(a) Equal to or greater than an eight percent increase in premium for a health insurance policy providing the same coverage for the new policy period as was provided in the immediately preceding policy period; or**

**(b) Equal to or greater than a twenty percent increase in premium for a health insurance policy which provides additional coverage for the new policy period as compared to the coverage provided in the immediately preceding policy period; and**

**(4) The appeal is the only appeal made for a premium increase for or during the new policy period.**

Section B. Because immediate action is necessary to ensure the efficient operation of the rate review process and compliance with federal law, this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and this act shall be in full force and effect upon its passage and approval.

✓