SLS 12RS-573 **ORIGINAL**

Regular Session, 2012

SENATE BILL NO. 207

BY SENATOR MORRISH

HEALTH/ACC INSURANCE. Provides for review of health coverage premium rates. (see Act)

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) "Health insurance issuer" means any entity that offers health

insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. "Health insurance issuer" shall include a health maintenance organization, as defined in R.S. 22:242.

(4) "Individual market" means the market in which health insurance is issued directly to a natural person and not through a group.

(5) "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, or certificate of insurance offered in the state.

(6) "Rate increase" means an increase in the premium rates of a specific product in the individual or small group market.

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

(8) "Small group market" means the market in which small group coverage is issued as currently defined in R.S. 22:1061.

(9) "Unreasonable rate increase" means a rate increase subject to review that, following review, fails to meet specified criteria.

B. For each product in the individual market and the small group market, whenever a health insurance issuer is required to file a rate increase with the Department of Health and Human Services, 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 the standard format required by DHHS and 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 nonclaims 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 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) The most significant factors causing the increase and a brief description of the policies' overall experience.

(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 forty-five 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.

(j) Applicable taxes and licensing or regulatory fees.

(k) The medical loss ratio.

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

(5) The commissioner shall use the following criteria to determine whether a rate increase is excessive, unjustified, or unfairly discriminatory, and, therefore, an unreasonable rate increase:

(a) 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) 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) 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.

(6) As part of the review of the proposed rate increase, the commissioner shall provide for a reasonable means for receipt and consideration of public input on the proposed 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) of this Section that the issuer has indicated is confidential.

(8) A proposed rate increase shall be deemed to have been reasonable if notice is not received by the health insurance issuer from the commissioner within forty-five days of the date of filing to the commissioner.

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.

Section 2. The provisions of this Act shall be effective thirty days 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 affirms 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 and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl Horne.

DIGEST

Proposed law requires a health insurance issuer to file information related to any proposed increase in base premium to 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 three separate parts of the preliminary justification. Requires the commissioner to ensure that the information received from the health insurance issuer be made available to the public on a department of insurance website.

Proposed law requires the commissioner to evaluate the proposed rate increase within 45 days of receipt of a filing by a health insurance issuer. Further provides information that the commissioner's review of the proposed rate shall include as well as the criteria the commissioner shall use to determine whether a rate increase is excessive, unjustified, or unfairly discriminatory. Requires the commissioner to provide for reasonable means for receipt and consideration of public input on the proposed increase. Prohibits the commissioner from releasing information provided by the health insurance issuer that the issuer has indicated is confidential.

Proposed law requires a health insurance issuer to notify the commissioner whether it intends to utilize the proposed rate increase or to refile within 15 days of receipt of the determination by the commissioner.

Effective 30 days 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 affirms 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.

(Adds R.S. 22:1098)