H. B. 3091

(By Delegate Frazier)

[Introduced February 10, 2011; referred to the Committee on Banking and Insurance then the Judiciary.]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §33-16B-5, relating to review of health insurer rate changes; prior approval of rate changes; public disclosure of proposed rate change; required materials to be submitted in rate filings; standards for approving, modifying or disapproving rates; public comment period; notice of approved rate change; hearings; and consumer advocate.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new section, designated §33-16B-5, to read as follows:

ARTICLE 16B. ACCIDENT AND SICKNESS RATES.

§33-16B-5. Review of rate changes.

(a) *Prior approval of rate changes.--*

Any insurer desiring to change rates on any policy form, contract, or certificate must submit electronically a rate filing request for approval with the commissioner. No rate or change to a rate shall be used unless approved by the commissioner, and unless policyholders have received notice as required in subsection (g).

Within thirty days of the close of the sixty day public comment period required under subsection (c), the commissioner shall issue an written decision with findings on the considerations listed in subsection (e), and any other considerations taken into account, to approve, modify, or disapprove the proposed rates. If, however, a hearing on the proposed rate change is held under subsection (h), the commissioner may reasonably extend the time to issue a written decision with findings to approve, modify, or disapprove the proposed rate change to accommodate a hearing schedule. Upon issuing the decision, the commissioner shall post his or her decision on the Insurance Commission's website and provide written notice to the insurer of the decision.

Failure to submit all of the information required or requested by the commissioner under subsection (c) shall make the rate filing incomplete. Within ten days of receiving a rate filing for a proposed rate change, the commissioner shall determine whether the filing is complete. If the commissioner determines that a filing is incomplete, the commissioner shall notify the insurer in writing that the filing is deficient and give the insurer an opportunity to

provide the missing information.

Approved rates shall be guaranteed by the insurer, as to the policyholders affected by the rates, for a period of not less than twelve months, or as an alternative to the insurer giving the guarantee, the approved rates may be applicable to all policyholders at one time if the insurer chooses to apply for that relief with respect to those policies no more frequently than once in any twelve month period.

The term "insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a nonprofit hospital service corporation, a nonprofit medical service corporation, a domestic insurance company that offers or provides health insurance coverage in the state and a foreign insurance company that offers or provides health insurance coverage in the state.

(b) *Public disclosure of proposed rate change.--*

Upon receipt of a rate filing requesting a rate change, the commissioner shall, within three business days, post the rate filing including all information required under subsection (c) on the commission's website, along with the insurer's rate filing summary required under subsection (c).

The commissioner shall prominently post links on its homepage to a webpage on which rate filings and summaries can be found. Links to rate filings and summaries shall be clearly labeled by name of the insurer, type of policy, and the filing date of the proposed rate change. If the commissioner uses a searchable database to publicly post rate filings, the commissioner shall post search instructions and plain-language explanatory material sufficient to make it easy to find a rate filing in the database.

(c) *Required materials to be submitted in rate filings.-*

Every rate filing submitted under subsection (a) for a proposed rate change shall include sufficient information and data to allow the commissioner to consider the factors set forth in subsection (e), any factors established under federal regulations concerning "unreasonableness" of premiums, and any other factors required by the commissioner.

The information in the rate filing shall be presented in a standard format to be determined by regulation by the commissioner, with information clearly labeled under headings.

The commissioner shall issue propose rules for legislative approval in accordance with article three, chapter twenty-nine-a of this code to establish the specific data and information required to be included in the rate filing to allow the commissioner to consider the factors in subsection (e), any factors under federal or state law, and any other information that the commissioner determines should be submitted. The commissioner may adopt and

require use of the disclosure form used for justification of premium increases under Section 1003(a)(2) of the Patient Protection and Affordable Care Act, except that the commissioner shall require additional disclosures in a standard format to the extent that the PPACA disclosure form does not include the information required to consider the factors in subsection (e), the information required under this subsection, and any additional information that the commissioner determines should be submitted.

The regulations establishing the specific data and information required in the filing shall ensure that each filing includes, but is not limited to:

(1) *A rate filing summary* -- This summary must explain the filing in a manner that allows consumers to understand the rate change. The summary shall be in accordance with a form established by the commission. The information contained in this summary must match the information provided elsewhere in the filing.

(2) *Actuarial memorandum* -- (A) The actuarial memorandum shall describe the benefit plan for each product and a description of any changes to the benefit plan.

(B) The actuarial memorandum shall report:

(i) Insurer's overall medical trend factor assumed, and also broken down by rate of price inflation and rate of utilization/mix of services changes.

(ii) Claims history, for at least five years.

(iii) Claims history, for at least five years, by rate of

price inflation and utilization/mix of services, and by category of type of medical reimbursement, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, including laboratory, and radiology;

(iv) Claims history, for at least five years, broken down by major geographic region of the state. For purposes of this subsection "major geographic region" shall correspond to any areas defined under any geographic rating factors used, or shall be defined by the commissioner.

(v) An insurer requesting a rate change shall also provide information on aggregate cost increases for specific hospitals and for specific medical groups within a plan network, if requested by the commissioner.

(C) The actuarial memorandum shall explain how the proposed rate change was calculated, including a description of all assumptions, factors, calculations, and any other information pertinent to the proposed rate. The insurer must clearly identify and quantify medical trend factors and all other factors used in developing the rates. For example, the insurer must show all tier factors used, if any, age bands and factors used, geographic factors used, and benefit-level factors used.

The insurer must provide detailed support for each assumption used to determine the proposed rate change. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design,

benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported.

(D) The actuarial memorandum shall include rate tables, presented as determined by the commissioner.

(E) The actuarial memorandum shall, for each plan subject to a proposed increase, show the average increase, as well as the maximum increase to be charged for any policyholder and the minimum increase to be charged for any policyholder.

(F) The actuarial memorandum shall include the signature of and date that a qualified actuary reviewed the rate filing.

(3) Description of cost containment and quality improvement efforts -- The insurer must explain any changes the insurer has made in its health care cost containment efforts and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan, including a description of any factors that relate to the commissioner's consideration of affordability under subsection (e).

(4) Disclosure of certain expenses -- The insurer shall include information sufficient to show expenses relating to:

(A) Salaries, wages, bonuses or other compensation benefits;

(B) Broker commissions;

(C) Rent or occupancy expenses;

(D) Marketing and advertising;

(E) Federal and state lobbying expenses;

(F) All political contributions;

(G) All dues paid to trade groups that engage in lobbying or make political contributions;

(H) General offices expenses, including but not limited to sundries, supplies, telephone, printing and postage;

(I) Third party administration expenses or fees or other group service expense or fees;

(J) Legal fees and expenses and other professional or consulting fees;

(K) Other taxes, licenses and fees;

(L) Travel expenses; and

(M) Charitable contributions.

When possible, the insurer should show how the expenses in this subsection were applied on a per member per month basis to the rates subject to the proposed rate change.

(5) Certification of compliance -- The rate application shall be signed by the officers of the insurer who exercise the functions of a chief executive and chief financial officer. Each officer shall certify that the representations, data, and information provided to the commissioner to support the application are true and that the filing complies with state statutes, rules, product standards and filing requirements.

(d) Notice of proposed rate change and public comment period.-

An insurer shall send written notice of a proposed rate change to each policyholder affected by the change on or before the date

the rate filing or application is submitted to the commissioner. The notice shall:

(1) State in size 16-point font in bold the actual dollar amount of the proposed rate change and the specific percentage by which the current premium would be increased for the policyholder;

(2) Describe in plain, understandable terms any changes in the plan design or any changes in benefits, and highlight this information by printing in 16-point font in bold;

(3) Prominently include mailing and website addresses and telephone numbers for the insurer through which a person may request additional information;

(4) Provide information about public programs, including but not limited to Medicaid, High Risk Pools, and CHIP; and

(5) Shall state that the proposed rate change is subject to approval by the Insurance Commission, and inform policyholders of the sixty day public comment period available under this subection and provide the website address of the commission where the rate filing can be found.

The commissioner shall make available an e-mail alert system in which members of the public may sign up on the commission's website to receive notice of a proposed rate change for a selected insurer. The commissioner shall send such e-mail alerts within three business days after receiving a rate filing proposing a rate change.

Beginning on the date that the commissioner posts on the

commission's website a proposed rate change pursuant to Section B, the commissioner shall open a sixty day public comment period on the rate change and rate filing. The commissioner shall allow members of the public to comment by mail and e-mail, and the commissioner may create a website where members of the public can publicly post comments. The commissioner, in his or her discretion, may convene meetings around the state for consumers to comment and ask questions. The commissioner shall prominently post on the commission website information describing the public comment period that applies to proposed rate changes and informing members of the public how to submit a comment.

If a rate filing is found to be incomplete under subsection (c), the commissioner shall start a new sixty day public comment period after the commissioner determines that the filing is complete and posts the insurer's complete filing on the commission's website.

Within thirty days of the close of the sixty day public comment period required under this section, the commissioner shall issue an written decision with findings on the considerations listed in subsection (e), and any other considerations taken into account, to approve, modify, or disapprove the proposed rates. If, however, a hearing on the proposed rate change is held under subsection (h), the commissioner may reasonably extend the time to issue a written decision with findings to approve, modify, or disapprove the proposed rate change to accommodate a hearing

schedule. Upon issuing the decision, the commissioner shall post his or her decision on the commission's website and provide written notice to the insurer of the decision.

(e) *Standards for approving, modifying or disapproving rates.*-

When making any determination under this section, the commissioner shall act to guard the solvency of health insurers, protect the interests of consumers of health insurance and shall encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate affordability of coverage and access. Rates shall be: (1) Actuarially sound; (2) reasonable, and not excessive, inadequate, or unfairly discriminatory; and (3) based on reasonable administrative expenses. Rates may not be deceptive or constitute an unfair trade practice. An insurer shall have the burden to show by clear and convincing evidence that its rates comply with the terms of this subsection.

The commissioner shall disapprove a proposed rate change if the proposed rates are: (1) Not actuarially sound; (2) unreasonable; (3) excessive; (4) inadequate; (5) unfairly discriminatory; (6) based on unreasonable administrative expenses; (7) not in the public interest; or (8) if the rate filing is incomplete. In making the determination, the commissioner shall consider and issue findings on the following factors:

(A) Reasonableness and soundness of actuarial assumptions, calculations, projections, and factors used by the insurer to

arrive at the proposed rate change.

(B) The insurer's historical trends for medical claims. The commissioner may consider, for comparison, medical trends reported by other insurers in the state, or of medical trends for the state, a region, or the country as a whole. The commission may also consider inflation indices, such as the Consumer Price Index and the medical care component of the Consumer Price Index.

(C) Reasonableness of historical and projected administrative expenses.

(D) Compliance with medical loss ratio standards in effect under federal or state law. The commissioner may review and consider the insurer's medical loss ratio disclosures submitted pursuant to the Patient Protection and Affordable Care Act.

(E) Whether the rate change applies to an open or closed block of business. If it applies to a closed block of business, whether the applicant has pooled the experience of the closed block of business with all appropriate blocks of business that are not closed pursuant to Section F.

(F) Whether the insurer has complied with all federal and state requirements for pooling risk and requirements for participation in risk adjustment programs in effect under federal and state law.

(G) The financial condition of the insurance company for at least the past five years, including but not limited to, profitability, surplus, reserves, investment income, reinsurance,

dividends, and transfers of funds to affiliates and/or parent companies.

(H) Whether the proposed rate change and any contribution to surplus or profit margin included in the proposed rate change is reasonable in light of the entire company's surplus level and additional factors in the previous subsection.

(I) The financial performance for at least the past five years, or total years in existence if less, of the block of business subject to the proposed rate change, including, but not limited, to past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block.

(J) The financial performance for at least the past five years of insurer's statewide individual market business, and the insurer's overall statewide business.

(K) Any anticipated change in the number of enrollees if the proposed premium rate is approved.

(L) Changes to covered benefits or health benefit plan design.

(M) Whether the proposed change in rates is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future.

(N) The insurer's statement of purpose or mission in its corporate charter or mission statement.

(O) The hardship on members affected by the proposed rate change.

(P) Public comments received under subsection (d) pertaining

to the standards set forth in this subsection.

(Q) Affordability of the insurance product or products subject to the proposed rate change. This shall include consideration of the efforts of the insurer to maintain close control over its administrative costs, and changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same product; including:

(i) Implementation of strategies by the insurer to enhance the affordability of its products, including whether the insurer offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself that promote a focus on primary care, prevention and wellness, active management procedures for the chronically ill population; use of appropriate cost-efficient settings' and use of evidence based, quality care;

(ii) Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services;

(iii) Five-year rate change history for the population affected by the proposed rate change;

(iv) Constraints on affordability efforts including:

(a) State and federal requirements (e.g., state mandates, federal laws);

(b) Costs of medical services over which plans have limited control;

(c) Health plan solvency requirements; and

(d) The prevailing financing system in United States (i.e., the third-party payor system) and the resulting decrease in consumer price sensitivity.

Nothing in this subsection shall preclude the commissioner from considering any factor that, in the commissioner's discretion, is relevant to his or her determination. The commission shall have authority to issue rules, regulations and bulletins to facilitate consideration of the factors in this section.

Nothing in this section shall preclude the commissioner from requesting from an insurer information or data to support these factors or factors not on this list.

(e) *Closed blocks of business.--*

Until such time as Section 1312(c) ["Single Risk Pool"] of the Patient Protection and Affordable Care Act is fully in effect in the state, an insurer must pool the experience of a closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any policy within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool. A closed block of business is a policy or group of policies that are no longer being marketed or sold by the insurer, or that has less than five hundred in-force contracts in this state, or for which enrollment has dropped by more than twelve percent since the last rate filing.

(f) *Notice of approved rate change.--*

If the commissioner approves a rate change, the commissioner shall provide written notice to the insurer that rates have been approved. Upon receipt of a notice of approval, the insurer shall send written notice by first class mail to all policyholders affected by the rate change. The notice shall inform policyholders in size 16-point font in bold the actual dollar amount of the approved premium rate increase for the policyholder, the specific percentage by which the current premium will be increased for the policyholder, the effective date of the new rate, describe in plain, understandable terms any changes in plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions or conditions, and highlight this information by printing in 16-point font in bold. The notice shall also provide information about public programs, including but not limited to Medicaid, High Risk Pools, and CHIP.

No approved rate shall be effective less than sixty days from a policyholder's receipt of the notice required under this section.

(g) *Hearings.*--

At any time during the sixty day public comment period required under subsection (d), the commissioner shall issue an order scheduling a public hearing on the proposed rate change if:

(1) A consumer or his or her representative or a consumer advocacy group requests a hearing within forty-five days of the opening of the public comment period. Any person requesting a hearing under this subsection shall submit the request in writing.

Upon receiving a request, the commissioner shall decide within fifteen days whether to grant the hearing and if the commissioner decides not to grant the hearing, the commissioner shall issue written findings in support of that decision;

(2) The commissioner on his or her own motion determines to hold a hearing;

(3) The proposed rate change is "unreasonable" under the federal Patient Protection and Affordable Care Act;

(4) The Attorney General requests a hearing;

(5) The Consumer Advocate responsible for reviewing rate filings under subsection (i) requests a hearing; or

(6) If the rate request exceeds percent, or the proposed rate change would result in an annual increase exceeding percent.

The commissioner shall adopt regulations governing hearings. Those regulations shall, at a minimum, include timelines for scheduling and commencing hearings, and procedures to prevent delays in commencing or continuing hearings without good cause.

Hearings shall be conducted by a hearing examiner. The hearing examiner shall render a decision within thirty days of the closing of the record in the proceeding. The commissioner shall adopt, amend or reject a decision by the hearing examiner within ten days of the hearing examiner's decision.

Hearings shall be conducted pursuant to article five, chapter twenty-nine-a of this code; however, notwithstanding any provision of this code, the hearing examiner shall take judicial notice of

the public comments received during the hearing or the public comment period. This provision shall not be read to preclude any other judicial notice.

For purposes of judicial review, a decision to hold a hearing is not a final order or decision; however, a decision not to hold a hearing is final.

The commissioner shall provide notice of the hearing not less than fourteen days prior to the hearing. The notice shall be prominently published on the commission's website and in a newspaper or newspapers having aggregate general circulation throughout the state at least fourteen days prior to the hearing. The notice shall contain a description of the rates proposed to be charged and a copy of the notice shall be sent to the insurer. In addition, the insurer shall provide by first class mail, at least fourteen days prior to the public hearing, notice of the public hearing to all affected policyholders. The notice shall:

(1) Describe the proposed rate change. The public notice shall also provide information on opportunities for the public to provide comment on the proposal to the commissioner.

(2) Be published in all languages spoken by five percent or more of the policyholders, or one thousand people in the service area, whichever is less.

All documents, public comments, and correspondence with the commissioner submitted as part of the hearing are public records. The commissioner shall provide prompt and reasonable access to the

records concerning the proposed rate request to the public at no charge. The records shall be considered public records and be posted on the Insurance Commission's website.

The commissioner may contract with actuaries or subject matter experts to assist him or her in conducting the review or hearing required under this section. The actuary or other expert shall serve under the direction of the commissioner. The commissioner is exempt from the provisions of applicable state laws regarding public bidding procedures for purposes of entering into contracts pursuant to this subsection.

(h) *Consumer advocate.*--

There is created within the Office of the Insurance Commission a Consumer Advocate who shall represent and advocate on behalf of the interests of health insurance policyholders and members. The goal of the Consumer Advocate shall be to obtain the lowest possible rates for health insurance consistent with protection of insurer solvency.

Any rate increase request greater than ten percent, or resulting in an annual increase greater than ten percent, shall be reviewed by the Consumer Advocate. The Consumer Advocate may employ legal assistants, experts and actuaries necessary to carry out its function of advocating on behalf of policyholders and members. The commissioner shall ensure that such personnel and assistance are provided at a level sufficient to ensure that policyholder and member interests are effectively represented in

all proceedings under this section.

(i) *Intervenors.--*

The commissioner, on timely application shall allow any person with an interest in the outcome of a proposed rate change to intervene as a party to that proceeding. Policyholders, insured members, consumer advocates, and community representatives shall all be considered persons with an interest. Any person whose interest is determined to be affected may present evidence, examine and cross-examine witnesses, and offer oral and written arguments, and in connection therewith may conduct discovery proceedings in the same manner as is allowed in the court of this state. The specific intervention provisions of this subsection shall control in the event of a conflict with the requirements of general state administrative law.

This subsection does not limit the power of the commissioner to consolidate parties with similar interests for the purpose of intervention.

The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that: (1) The person represents the interests of consumers; and (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. A final action by the commission shall be subject to judicial review by the court in the county where services are rendered at the initiation of the insurer or any person that was a party to a

proceeding under this section.

(j) *Relationship with other law.-*

To the extent there is a conflict with any other provision of this article, the provisions of this section govern.

NOTE: The purpose of this bill it to provide review of health insurance rate changes, and includes requirements for public disclosure, a public comment period and prior approval.

This sections is new; therefore, it has been completely underscored.