
A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that the health insurance
2 market in Hawaii is currently dominated by one company and lacks
3 the competition that would otherwise inhibit improper behavior.
4 Suitable oversight of this industry is imperative to prevent
5 harm to small businesses and encourage other insurers to enter
6 the market.

7 This Act provides for oversight of health insurance rates,
8 a significant fixed cost borne by Hawaii employers and
9 employees. This Act proposes to regulate health insurance rates
10 in a manner similar to the way that motor vehicle, workers'
11 compensation, homeowners', and other property and casualty
12 insurance lines are presently regulated to ensure that rates are
13 not excessive, inadequate, or unfairly discriminatory. This Act
14 also ensures that rates will not be confiscatory or predatory.

15 Rate regulation ensures that rates are adequate to promote
16 the long-term viability of health care plans and are actuarially
17 prudent, while preventing predatory pricing that discourages
18 competition.



1 SECTION 2. Chapter 431, Hawaii Revised Statutes, is
2 amended by adding a new article to be appropriately designated
3 and to read as follows:

4 "ARTICLE

5 HEALTH INSURANCE RATE REGULATION

6 §431: -101 Scope and purpose. (a) This article shall
7 apply to all types of health insurance offered by managed care
8 plans.

9 (b) The purpose of this article is to promote the public
10 welfare by regulating health insurance rates to the end that
11 they shall not be excessive, inadequate, or unfairly
12 discriminatory. Nothing in this article is intended to:

- 13 (1) Prohibit or discourage reasonable competition; or
- 14 (2) Prohibit or encourage, except to the extent necessary
- 15 to accomplish the aforementioned purposes, uniformity
- 16 in insurance rates, rating systems, rating plans, or
- 17 practices.

18 This article shall be liberally interpreted to carry into effect
19 this section.

20 §431: -102 Definitions. As used in this article:

21 "Commissioner" means the insurance commissioner.



1 "Enrollee" means a person who enters into a contractual
2 relationship or who is provided with health care services or
3 benefits through a managed care plan.

4 "Managed care plan" or "plan" means a health plan as
5 defined in section 431:10H-205, or chapter 432 or 432D,
6 regardless of form, offered or administered by a health care
7 insurer, including but not limited to a mutual benefit society
8 or health maintenance organization, or voluntary employee
9 beneficiary associations, but shall not include disability
10 insurers licensed under chapter 431.

11 "Rate" means every rate, charge, classification, schedule,
12 practice, or rule. The definition of "rate" shall exclude fees
13 and fee schedules paid by the insurer to providers of services
14 covered under this article.

15 "Supplementary rating information" includes any manual or
16 plan of rates, classification, rating schedule, minimum premium,
17 policy fee, rating rule, underwriting rule, statistical plan,
18 and any other similar information needed to determine the
19 applicable rates in effect or to be in effect.



1 "Supporting information" means:

2 (1) The experience and judgment of the filer and the
3 experience or data of other organizations relied on by
4 the filer;

5 (2) The interpretation of any other data relied upon by
6 the filer; and

7 (3) Descriptions of methods used in making the rates and
8 any other information required by the commissioner to
9 be filed.

10 **§431: -103 Making of rates.** (a) Rates shall not be
11 excessive, inadequate, or unfairly discriminatory and shall be
12 reasonable in relation to the cost of the benefits provided.

13 (b) Except to the extent necessary to meet the provisions
14 of subsection (a), uniformity among managed care plans in any
15 matters within the scope of this section shall be neither
16 required nor prohibited.

17 **§431: -104 Rate adjustment mandates.** (a) Except as
18 otherwise provided by law, the commissioner may mandate filings
19 for health insurance under section 431: -105 when the
20 commissioner has actuarially sound information that current
21 rates may be excessive, inadequate, or unfairly discriminatory.



1 (b) Managed care plans shall submit the rate filings
2 within one hundred twenty days of the commissioner's mandate.

3 (c) The rate filings shall be subject to the rate filing
4 requirements under section 431: -105.

5 **§431: -105 Rate filings.** (a) Every managed care plan
6 shall file in triplicate with the commissioner, every rate,
7 charge, classification, schedule, practice, and rule and every
8 modification of any of the foregoing which it proposes to use.
9 Every filing shall state its proposed effective date and shall
10 indicate the character and extent of the coverage contemplated.
11 The filing shall also include a report on investment income.

12 (b) Each filing shall be accompanied by a \$50 fee payable
13 to the commissioner, which fee shall be deposited in the
14 commissioner's education and training fund.

15 (c) At the same time as the filing of the rate, every
16 managed care plan shall file all supplementary rating and
17 supporting information to be used in support of or in
18 conjunction with a rate. The managed care plan may satisfy its
19 obligation to file supplementary rating and supporting
20 information by reference to material which has been approved by
21 the commissioner. The information furnished in support of a
22 filing may include or consist of a reference to:



1 (1) Its interpretation of any statistical data upon which
2 it relies;

3 (2) The experience of other managed care plans; or

4 (3) Any other relevant factors.

5 (d) When a filing is not accompanied by supporting
6 information or the commissioner does not have sufficient
7 information to determine whether the filing meets the
8 requirements of this article, the commissioner shall require the
9 managed care plan to furnish additional information and, in that
10 event, the waiting period shall commence as of the date the
11 information is furnished. Until the requested information is
12 provided, the filing shall not be deemed complete or filed and
13 the filing shall not be used by the managed care plan. If the
14 requested information is not provided within a reasonable time
15 period, the filing may be returned to the managed care plan as
16 not filed and not available for use.

17 (e) Except for a rate filed in accordance with
18 subsection (i), or a filing in whole or in part that the
19 commissioner orders to be held confidential and exempt from
20 public disclosure, a filing and any supporting information shall
21 be open to public inspection upon filing with the commissioner.



1 (f) After reviewing a managed care plan's filing, the
2 commissioner may require that the managed care plan's rates be
3 based upon the managed care plan's own loss and expense
4 information.

5 (g) The commissioner shall review filings promptly after
6 they have been made to determine whether they meet the
7 requirements of this article. The commissioner shall calculate
8 the investment income and accuracy of loss reserves upon which
9 filings are based, and the managed care plan shall provide the
10 information necessary to make the calculation.

11 (h) Except as provided herein and in subsection (d), each
12 filing shall be on file for a waiting period of ninety days
13 before the filing becomes effective. The period may be extended
14 by the commissioner for an additional period not to exceed
15 fifteen days if the commissioner gives written notice, within
16 the waiting period to the managed care plan that made the
17 filing, that the commissioner needs the additional time for the
18 consideration of the filing. Upon written application by the
19 managed care plan, the commissioner may authorize a filing,
20 which the commissioner has reviewed, to become effective before
21 the expiration of the waiting period or any extension thereof.
22 A filing shall be deemed to meet the requirements of this



1 article unless disapproved by the commissioner within the
2 waiting period or any extension thereof. The rates shall be
3 deemed to meet the requirements of this article until the time
4 the commissioner reviews the filing and so long as the filing
5 remains in effect.

6 (i) The commissioner, by written order, may suspend or
7 modify the requirement of filing as to any class of health
8 insurance, subdivision, or combination thereof, or as to classes
9 of risks, the rates for which cannot practicably be filed before
10 they are used. The order shall be made known to the affected
11 managed care plan. The commissioner may make examinations that
12 the commissioner deems advisable to ascertain whether any rates
13 affected by the order meet the standards set forth in section
14 431: -103.

15 (j) No managed care plan shall make or issue a contract or
16 policy except in accordance with filings which are in effect for
17 the managed care plan as provided in this article.

18 (k) The commissioner may make any special filing with
19 respect to any class of health insurance, subdivision, or
20 combination thereof which is subject to individual risk premium
21 modification and has been agreed to under a formal or informal
22 bid process effective when filed.



1 (1) For managed care plans having annual premium revenues
2 of less than \$10,000,000, the commissioner may adopt rules and
3 procedures that will provide the commissioner with sufficient
4 facts necessary to determine the reasonableness of the proposed
5 rates without unduly burdening the managed care plan and its
6 enrollees.

7 (m) All managed care plans shall file initial rates within
8 thirty days of the effective date of this article. These rates
9 shall be in effect until approved by the commissioner. The time
10 limits set forth in this article for the commissioner's review
11 of rates shall not apply to the commissioner's review of initial
12 rates; provided that the commissioner shall review the initial
13 rates within a reasonable period.

14 **§431: -106 Reserves.** (a) If a managed care plan's net
15 worth exceeds thirty per cent of its annual health care
16 expenditures and operating expenses as reported on the most
17 recent financial statement filed with the commissioner, the
18 managed care plan's reserve in excess of thirty per cent of its
19 annual health care expenditures and operating expenses, shall be
20 reimbursed to hospitals and participating health care providers
21 in proportion to services rendered; provided that the general
22 excise tax exemption of a managed care plan under section 432-1-



1 403 shall be revoked should the managed care plan fail to
2 provide reimbursements pursuant to this subsection.

3 (b) Excess moneys applied in accordance with subsection
4 (a) shall be reallocated among all lines of health insurance
5 business sold by the managed care plan. Reallocation of moneys
6 pursuant to this section may be delayed until the amount of
7 moneys available to be reallocated exceeds \$10,000,000. Nothing
8 in this section shall prohibit a managed care plan from
9 maintaining reserves above minimum requirements but below the
10 maximum limit or from returning moneys to, or reducing moneys
11 payable by, enrollees of the managed care plan prior to reaching
12 the maximum limit.

13 (c) Nothing in this section shall be construed to alter or
14 eliminate the minimum reserve requirements applicable to the
15 managed care plan. In the event of a conflict, the minimum
16 reserve requirements shall control.

17 (d) Eighty per cent of all investment income on the net
18 reserves of investment manager fees shall be applied to the rate
19 determination and filing of the managed care plan. This
20 requirement may be waived or adjusted by the commissioner if the
21 commissioner determines it would impair the minimum reserve
22 requirements or solvency of the managed care plan.



1 **§431: -107 Policy revisions that alter coverage.** All
2 plan revisions that alter coverage in any manner shall be filed
3 with the commissioner. After review by the commissioner, the
4 commissioner shall determine whether a rate filing for the plan
5 revision must be submitted in accordance with section
6 431: -105. Plan revisions that affect the rate shall not be
7 used unless the rate associated with those revisions is approved
8 by the commissioner.

9 **§431: -108 Disapproval of filings.** (a) If within the
10 waiting period or any extension of the waiting period as
11 provided in section 431: -105, the commissioner finds that a
12 filing does not meet the requirements of this article, the
13 commissioner shall send to the managed care plan which made the
14 filing, written notice of disapproval of the filing specifying
15 in what respects the filing fails to meet the requirements of
16 this article and stating that the filing shall not become
17 effective.

18 (b) Whenever a managed care plan has no legally effective
19 rates as a result of the commissioner's disapproval of rates or
20 other act, interim rates shall be established as follows:

21 (1) In the event a filing is disapproved, in whole or in
22 part, a petition and demand for a contested case



1 hearing may be filed in accordance with chapter 91.

2 The managed care plan shall have the burden of proving
3 that the disapproval is not justified. While the
4 action of the commissioner in disapproving the rate
5 filing is being challenged, the aggrieved managed care
6 plan shall charge the rates established or the filed
7 rates, whichever is lower;

8 (2) In the event a filing is approved, a contested case
9 hearing in accordance with chapter 91 may be convened
10 pursuant to subsection (c) to determine if the
11 approved rates comply with the requirements of this
12 article. If an appeal is taken from the
13 commissioner's approval, or if subsequent to the
14 approval the commissioner convenes a hearing pursuant
15 to subsection (c), the filing of the appeal or the
16 commissioner's notice of hearing shall not stay the
17 implementation of the rates approved by the
18 commissioner, or the rates currently in effect,
19 whichever is higher; or

20 (3) The commissioner may waive or modify the requirements
21 of paragraph (1) or (2) if the application of those
22 paragraphs will endanger the financial solvency of the



1 managed care plan or the welfare of its enrollees.
2 The commissioner may also order that a specified
3 portion of the premiums be placed in an escrow account
4 approved by the commissioner. When new rates become
5 legally effective, the commissioner may order the
6 escrowed funds or any change in interim rates to be
7 refunded or allow the managed care plan to exact a
8 surcharge on premiums, whichever applies.

9 (c) If at any time subsequent to the applicable review
10 period provided for in section 431: -105, the commissioner
11 finds that a filing does not comply with the requirements of
12 this article, the commissioner shall order a hearing upon the
13 filing. The hearing shall be held upon not less than ten days'
14 written notice to every managed care plan that made such a
15 filing. The notice shall specify the matters to be considered
16 at the hearing. If after a hearing the commissioner finds that
17 a filing does not meet the requirements of this article, the
18 commissioner shall issue an order specifying in what respects
19 the filing fails to meet the requirements, and stating when,
20 within a reasonable period thereafter, the filing shall be
21 deemed no longer effective. Copies of the order shall be sent
22 to each managed care plan. The order shall not affect any



1 contract or policy made or issued prior to the expiration of the
2 period set forth in the order.

3 (1) Any person or organization aggrieved with respect to
4 any filing which is in effect may make written demand
5 to the commissioner for a hearing thereon; provided
6 that the managed care plan which made the filing shall
7 not be authorized to proceed under this subsection;

8 (2) The demand shall specify the grounds to be relied upon
9 by the aggrieved person or organization and the demand
10 must show that the person or organization has a
11 specific economic interest affected by the filing;

12 (3) If the commissioner finds that the demand is made in
13 good faith, that the applicant would be so aggrieved
14 if the person's or organization's grounds are
15 established, and that the grounds otherwise justify a
16 hearing, the commissioner, within thirty days after
17 receipt of the demand, shall hold a hearing. The
18 hearing shall be held upon not less than ten days
19 written notice to the aggrieved party and to every
20 managed care plan which made the filing; and

21 (4) If, after the hearing, the commissioner finds that the
22 filing does not meet the requirements of this article,



1 the commissioner shall issue an order specifying in
2 what respects the filing fails to meet the
3 requirements of this article, and stating when, within
4 a reasonable period, the filing shall be deemed no
5 longer effective. Copies of the order shall be sent
6 to the applicant and to every such managed care plan.
7 The order shall not affect any contract or policy made
8 or issued prior to the expiration of the period set
9 forth in the order.

10 (d) The notices, hearings, orders, and appeals referred to
11 in this section, in all applicable respects, shall be subject to
12 chapter 91, unless expressly provided otherwise.

13 **§431: -109 Managed care plans; prohibited activity.** (a)

14 Except as permitted in this article, no managed care plan shall:

- 15 (1) Attempt to monopolize, or combine or conspire with any
16 other person to monopolize an insurance market; or
17 (2) Engage in a boycott, on a concerted basis, of an
18 insurance market.

19 (b) Except as permitted in this article, no managed care
20 plan shall make any arrangement with any other person which has
21 the purpose or effect of restraining trade unreasonably or of



1 substantially lessening competition in the business of
2 insurance.

3 **§431: -110 Information to be furnished to enrollees;**
4 **hearings and appeals of enrollees.** Every managed care plan
5 which makes its own rates, within a reasonable time after
6 receiving written request therefor and upon payment of such
7 reasonable charges as it may make, shall furnish to any enrollee
8 affected by a rate made by it or to the authorized
9 representative of the enrollee, all pertinent information as to
10 the rate.

11 **§431: -111 False or misleading information.** No person
12 or organization shall wilfully withhold information from or
13 knowingly give false or misleading information to the
14 commissioner, any statistical agency designated by the
15 commissioner, or any managed care plan, which will affect the
16 rates or premiums chargeable under this article. Violation of
17 this section shall subject the one guilty of the violation to
18 the penalties provided in section 431: -112.

19 **§431: -112 Penalties.** (a) If the commissioner finds
20 that any person or organization has violated any provision of
21 this article, the commissioner may impose a penalty of not more
22 than \$500 for each violation; provided that if the commissioner



1 finds the violation to be wilful, the commissioner may impose a
2 penalty of not more than \$5,000 for each violation. The
3 penalties may be in addition to any other penalty provided by
4 law. For purposes of this section, any managed care plan using
5 a rate for which the managed care plan has failed to file the
6 rate, supplementary rating information, underwriting rules or
7 guides, or supporting information as required by this article,
8 shall have committed a separate violation for each day the
9 failure to file continues.

10 (b) The commissioner may suspend the license or operating
11 authority of any managed care plan that fails to comply with an
12 order of the commissioner within the time limited by the order,
13 or any extension thereof that the commissioner may grant. The
14 commissioner shall not suspend the license of any managed care
15 plan for failure to comply with an order until the time
16 prescribed for an appeal from the order has expired or, if an
17 appeal has been taken, until the order has been affirmed. The
18 commissioner may determine when a suspension of license or
19 operating authority shall become effective and it shall remain
20 in effect for the period fixed by the commissioner unless the
21 commissioner modifies or rescinds the suspension, or until the



1 order upon which the suspension is based is modified, rescinded,
2 or reversed.

3 (c) No penalty shall be imposed and no license or
4 operating authority shall be suspended or revoked except upon a
5 written order of the commissioner, stating the commissioner's
6 findings, made after a hearing held upon not less than ten days'
7 written notice to the person or organization. The notice shall
8 specify the alleged violation.

9 **§431: -113 Hearing procedure and judicial review.** (a)
10 Any managed care plan aggrieved by any order or decision of the
11 commissioner made without a hearing, within thirty days after
12 notice of the order to the managed care plan, may make written
13 request to the commissioner for a hearing. The commissioner
14 shall hold a hearing within twenty days after receipt of the
15 request, and shall give not less than ten days written notice of
16 the time and place of the hearing. Within fifteen days after
17 the hearing, the commissioner shall affirm, reverse, or modify
18 the commissioner's previous action, specifying the reasons for
19 the commissioner's decision. Pending the hearing and decision,
20 the commissioner may suspend or postpone the effective date of
21 the commissioner's previous action.



1 (b) Any final order or decision of the commissioner may be
2 reviewed in the circuit court of the first circuit and an appeal
3 from the decision of the court shall lie to the supreme court.
4 The review shall be taken and had in the manner provided in
5 chapter 91."

6 SECTION 3. Section 432:1-102, Hawaii Revised Statutes, is
7 amended by amending subsection (b) to read as follows:

8 "(b) Article 2 [~~and~~], article 13, and article of
9 chapter 431, and the powers there granted to the commissioner,
10 shall apply to managed care plans, health maintenance
11 organizations, or medical indemnity or hospital service
12 associations, which are owned or controlled by mutual benefit
13 societies, so long as such application in any particular case is
14 in compliance with and is not preempted by applicable federal
15 statutes and regulations."

16 SECTION 4. Section 432:1-403, Hawaii Revised Statutes, is
17 amended to read as follows:

18 "**§432:1-403 Nonprofit medical, hospital indemnity**
19 **associations; tax exemption.** Every association or society
20 organized and operating under this article solely as a nonprofit
21 medical indemnity or hospital service association or society or
22 both shall be, from the time of such organization, exempt from



1 every state, county and municipal tax, except unemployment
2 compensation tax[-]; provided that the general excise tax shall
3 apply to an association or society that fails to provide
4 reimbursements pursuant to subsection 431: -106(a). Nothing in
5 this section shall be deemed to exempt the association or
6 society from liability to withhold the taxes payable by its
7 employees and to pay the same to the proper collection officers,
8 and to keep such records, and make such returns and reports, as
9 may be required in the case of other corporations, associations
10 or societies similarly exempted from such taxes."

11 SECTION 5. Section 432D-19, Hawaii Revised Statutes, is
12 amended by amending subsection (d) to read as follows:

13 "(d) Article 2 [~~and~~], article 13, and article of
14 chapter 431, and the power there granted to the commissioner,
15 shall apply to health maintenance organizations, so long as such
16 application in any particular case is in compliance with and is
17 not preempted by applicable federal statutes and regulations."

18 SECTION 6. Statutory material to be repealed is bracketed
19 and stricken. New statutory material is underscored.

20 SECTION 7. This Act shall take effect on January 1, 2007.



Report Title:

Health Insurance; Rate Regulation

Description:

Prohibits health insurance rates that are excessive, inadequate, or unfairly discriminatory. Requires health care insurers to submit rate filings for approval by the insurance commissioner. Establishes penalties and appeal procedures.

