An Act To Establish a Health Care Bill of Rights

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §205-A is enacted to read:

§ 205-A. Rate hearings

1. Hearing officer. In any proceeding regarding an individual or small group rate filing, the bureau shall contract for the services of an independent hearing officer to oversee the proceeding and may not utilize the services of existing bureau staff. An independent hearing officer must be an attorney in good standing licensed to practice law in this State. The insurer, nonprofit hospital and medical service organization, nonprofit health care service organization or health maintenance organization making the rate filing shall pay the cost of the hearing officer.

The hearing officer shall make a recommended decision to the superintendent after the hearing. The superintendent shall issue a final decision in the matter but may not substitute the judgment of the superintendent for the judgment of the hearing officer on matters of fact-finding. The superintendent may:

A. Affirm the decision of the hearing officer;

B. Remand the matter for further proceedings, findings of fact or conclusions of law; or

C. Reverse or modify the decision of the hearing officer, but only if the conclusions of law in the decision are arbitrary, capricious or not supported by substantial evidence on the record.

2. Advocacy panel. In any proceeding regarding an individual or small group rate filing, the bureau shall impanel an advocacy panel to represent the interests of consumers and the public. The bureau may contract for the services of an advocacy panel if existing staff resources are not adequate to represent the interests of consumers and the public. The insurer, nonprofit hospital and medical service organization, nonprofit health care service organization or health maintenance organization making the rate filing shall pay the cost of participation of the advocacy panel.

3. Rules. The bureau, after notice and hearing, may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. 24-A MRSA §2735-A, sub-§1, as enacted by PL 2001, c. 432, §4, is amended to read:

1. Notice of rate filing or rate increase on existing policies. An insurer offering individual health plans as defined in section 2736-C must provide written notice by first class mail of a rate filing to all affected policyholders at least ~~60~~90 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks or modification of any

formula or classification of risks. The notice must also inform policyholders of their right to request a hearing pursuant to section 229 or a special rate hearing pursuant to section 2736, subsection 4 or Title 24, section 2321, subsection 5. The notice must show the proposed rate and state that the rate is subject to regulatory approval. The superintendent may not take final action on a rate filing until ~~40~~70 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until ~~60~~90 days after the notice is provided or until the effective date under section 2736, whichever is later.

Sec. 3. 24-A MRSA §2735-A, sub-§2, as enacted by PL 2001, c. 432, §4, is amended to read:

2. Notice of rate increase on new business. When an insurer offering individual health plans as defined in section 2736-C quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following ~~90~~120 days. If the quote is in writing, the disclosure must also be in writing. If the increase is pending approval at the time of notice, the disclosure must include the proposed rate and state that it is subject to regulatory approval. If disclosure required by this subsection is not provided, an increase may not be implemented until at least ~~90~~120 days after the date the quote is provided or the effective date under section 2736, whichever is later.

Sec. 4. 24-A MRSA §2736, sub-§1, as amended by PL 2003, c. 428, Pt. F, §2, is further amended to read:

1. Filing of rate information. Every insurer shall file with the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. Every such filing must state the effective date of the filing. Every such filing must be made not less than ~~60~~90 days in advance of the stated effective date, unless the ~~60-day~~90-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 3, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests.

Sec. 5. 24-A MRSA §2736, sub-§2, as amended by PL 1997, c. 344, §8, is further amended to read:

2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates be reasonable and necessary and not ~~be excessive,~~ inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. A filing and supporting information, including all accompanying rates, rating formulas, rating classifications, trend documentation and actuarial information used to support the filing, are public records within the meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to section 2736-A.

Sec. 6. 24-A MRSA §2736, sub-§2-A is enacted to read:

2-A. Approval of filing. A rate filing may not be approved by the superintendent unless the superintendent makes an affirmative finding that the standards contained in this section are met and supported by documented evidence in the record or filing.

Sec. 7. 24-A MRSA §2736, sub-§3, as amended by PL 2003, c. 469, Pt. E, §9, is further amended to read:

3. Criteria for special rate hearings. Any filing of rates, rating formulas and modifications for Medicare supplement contracts as defined in chapter 67 and for individual health plans as defined in section 2736-C, subsection 1, paragraph C that satisfies any one of the criteria set forth in this subsection is subject to the provisions of subsection 4.

A. The rate increase for any policyholder ~~may not exceed~~exceeds the index of inflation multiplied by 1.5 excluding any approved rate differential based on age. For the purposes of this subsection, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes Maine for the most recent 12-month period immediately preceding the date of the filing for which data are available.

B. The insurer ~~must~~fails to demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for those products average no less than 80% for the previous 12-month period. For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.

D. The insurer's surplus level exceeds the authorized control level as defined in section 6451, subsection 8, paragraph C by a factor of 3.

E. The insurer's net underwriting gain expressed as a percentage of an after-tax basis for any line of insurance or for all lines of insurance combined in the previous year is at or above the Consumer Price Index multiplied by 2.

Sec. 8. 24-A MRSA §2736, sub-§4, as amended by PL 2003, c. 469, Pt. E, §10, is further amended to read:

4. Special rate hearing. A rate hearing conducted with respect to filings that meet any one of the criteria in subsection 3 is subject to this subsection.

A. Any person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing ~~notwithstanding the satisfaction of the criteria in subsection 3~~.

B. If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing ~~notwithstanding the satisfaction of the criteria in subsection 3~~.

C. In any hearing conducted under this subsection, the ~~Bureau of Insurance and any party asserting~~burden of proving that the rates are ~~excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are~~reasonable and necessary, adequate, not unfairly discriminatory and in compliance with the requirements of section 6913 remains with the insurer.

Sec. 9. 24-A MRSA §2736, sub-§5 is enacted to read:

5. Standard for approval. The following standards apply to the making and use of rates pursuant to this section.

A. Rates are determined not to be reasonable and necessary if the rates are likely to produce a profit from business in this State that is unreasonably high in relation to the benefits provided, the surplus requirements and the surplus available, or if expenses are unreasonably high in relation to the benefits provided.

B. Rates are determined not to be reasonable and necessary if the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums when replenishment is attributable to investment losses.

C. Rates are determined to be inadequate if the rates are clearly insufficient, together with investment income attributable to the rates, to sustain projected losses and expenses for the benefits provided.

D. Rates are determined to be unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses or the rates fail to clearly and equitably reflect consideration of the policyholder's participation in a wellness program or clinically accepted course of preventive care.

Sec. 10. 24-A MRSA §2736, sub-§6 is enacted to read:

6. Factors to be considered. In determining whether the standards in subsection 5 have been met, the factors considered by the superintendent may include but are not limited to:

A. The past and prospective net underwriting gains of the insurer from the line of insurance for which the insurer seeks rate approval and from all of its lines of insurance;

B. The past, current and reasonably expected surplus levels of the carrier anticipated in the filing;

C. Investment income reasonably expected by the carrier from premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves;

D. The degree of competition in the market for which the rate approval is sought and in the overall health insurance market;

E. The degree to which testimony offered by the carrier in support of the components of its requested rates is supported by written evidence such as analyses, reports or studies; and

F. The profit and risk charge included in the previous year's rate filing and the profit actually achieved.

Sec. 11. 24-A MRSA §2736-A, first ¶, as amended by PL 2003, c. 469, Pt. E, §11, is further amended to read:

If a filing proposes an increase in rates or at any time the superintendent has reason to believe that a filing does not meet the requirements that rates ~~not~~ be ~~excessive,~~reasonable and necessary, and not inadequate, unfairly discriminatory or not in compliance with section 6913 or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. In any hearing conducted under this section, the burden of proving that rates are reasonable and necessary, adequate, not unfairly discriminatory and in compliance with the requirements of section 6913 remains with the insurer.

Sec. 12. 24-A MRSA §2736-C, sub-§2, ¶F, as enacted by PL 2003, c. 469, Pt. E, §12, is amended to read:

F. A carrier that adjusts its rate shall account for the savings offset payment or any recovery in that offset payment in its experience consistent with this section and section 6913. With regard to accounting for any recovery of the savings offset payment, a carrier shall provide demonstrable proof and quantify the total amount negotiated and saved by the carrier.

Sec. 13. 24-A MRSA §2736-C, sub-§5, as amended by PL 2003, c. 469, Pt. E, §13, is further amended to read:

5. Loss ratios. For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least ~~65%~~75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims. If incurred claims were less than 75% of aggregate earned premiums over a continuous 12-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. The excess premium is the amount of premium above that amount necessary to achieve a 75% loss ratio for all of the carrier's small group policies during the same 12-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large. The superintendent may adopt rules setting forth appropriate methodologies regarding refunds pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. For each successive full calendar year period after this subsection becomes effective, the loss ratio required in this subsection must increase by one full percentage point until the maximum loss ratio required is 80%.

Sec. 14. 24-A MRSA §2808-B, sub-§2-A, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

2-A. Rate filings. A carrier offering small group health plans shall file with the superintendent the community rates for each plan and every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use.

A. Every filing must state the effective date of the filing. Every filing must be made not less than ~~60~~90 days in advance of the stated effective date, unless the ~~60-day~~90-day requirement is waived by the superintendent. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 2-B, paragraph E, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the carrier satisfactorily responds to any reasonable discovery requests.

B. A filing and supporting information, including all accompanying rates, rating formulas, rating classifications, trend documentation and actuarial information used to support the filing, are public records ~~except as provided by~~within the meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to subsection 2-B, paragraphs B or F.

C. Rates for small group health plans must be filed in accordance with this section and ~~subsections~~subsection 2-B ~~and 2-C~~ for premium rates effective on or after July 1, 2004, except that the filing of rates for small group health plans are not required to account for any savings offset payment or any recovery of that offset payment pursuant to subsection 2-B, paragraph D and section 6913 for rates effective before July 1, 2005.

Sec. 15. 24-A MRSA §2808-B, sub-§2-B, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

2-B. Rate review and hearings. ~~Except as provided in subsection 2-C, rate~~Rate filings are subject to this subsection.

A. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims. A rate filing or rate increase may not be approved without an affirmative finding that the standards described in paragraphs G and H are met and are supported by documented evidence.

B. If a filing proposes an increase in rates or at any time the superintendent has reason to believe that a filing does not meet the requirements that rates be reasonable and necessary and not ~~be excessive,~~ inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not

to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates be reasonable and necessary and not ~~be excessive,~~ inadequate, unfairly discriminatory or not in compliance with section 6913, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

D. A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and section 6913. With regard to accounting for any recovery of the savings offset payment, a carrier shall provide demonstrable proof and quantify the total amount negotiated and saved by the carrier.

E. Any filing of rates, rating formulas and modifications that satisfies any one of the criteria set forth in this paragraph is subject to the provisions of paragraph F:

(1) The proposed rate for any group or subgroup ~~does not include a unit cost change that~~ exceeds the index of inflation multiplied by 1.5, excluding any approved rate differential based on age. For the purposes of this subparagraph, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes this State for the most recent 12-month period immediately preceding the date of the filing for which data are available; ~~and~~

(2) The carrier ~~demonstrates~~fails to demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratio of benefits incurred to premiums earned averages no less than ~~78%~~75% for the previous ~~36-month~~12-month period~~.~~;

(3) The carrier's surplus level exceeds the authorized control level as defined in section 6451, subsection 8, paragraph C by a factor of 3; and

(4) The carrier's net underwriting gain expressed as a percentage on an after-tax basis for any line of insurance or for all lines of insurance combined in the previous year is at or above the Consumer Price Index multiplied by 2.

F. Any rate hearing conducted with respect to filings that meet any one of the criteria in paragraph E is subject to this paragraph.

(1) A person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing~~, notwithstanding the satisfaction of the criteria in paragraph E~~.

(2) If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing~~, notwithstanding the satisfaction of the criteria in paragraph E~~.

(3) In any hearing conducted under this paragraph, the ~~bureau and any party asserting~~burden of proving that the rates are ~~excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are~~reasonable and necessary, adequate, not unfairly discriminatory and in compliance with the requirements of section 6913 remains with the carrier.

G. The following standards apply to the making and use of rates pursuant to this section.

(1) Rates are determined not to be reasonable and necessary if the rates are likely to produce a profit from business in this State that is unreasonably high in relation to the benefits provided, the surplus requirements and the surplus available, or if expenses are unreasonably high in relation to the benefits provided.

(2) Rates are determined not to be reasonable and necessary if the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums when replenishment is attributable to investment losses.

(3) Rates are determined to be inadequate if the rates are clearly insufficient, together with investment income attributable to the rates, to sustain projected losses and expenses for the benefits provided.

(4) Rates are determined to be unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses or the rates fail to clearly and equitably reflect consideration of the policyholder's participation in a wellness program or clinically accepted course of preventive care.

H. In determining whether the standards in subsection 5 have been met, the factors considered by the superintendent may include but are not limited to:

(1) The past and prospective net underwriting gains of the insurer from the line of insurance for which the insurer seeks rate approval and from all of its lines of insurance;

(2) The past, current and reasonably expected surplus levels of the carrier anticipated in the filing;

(3) Investment income reasonably expected by the carrier from premiums anticipated in the filing plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves;

(4) The degree of competition in the market for which the rate approval is sought and in the overall health insurance market;

(5) The degree to which testimony offered by the carrier in support of the components of its requested rates is supported by written evidence such as analyses, reports or studies; and

(6) The profit and risk charge included in the previous year's rate filing and the profit actually achieved.

I. If incurred claims were less than 75% of aggregate earned premiums over a continuous 12-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. For the purposes of calculating this loss-ratio percentage, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve a 75% loss ratio for all of the carrier's small group policies during the same 12-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large. The superintendent may adopt rules setting forth appropriate methodologies regarding refunds pursuant to this subsection. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. For each successive full calendar year period after this subsection becomes effective, the loss ratio required by this subsection must increase by one full percentage point until the maximum loss ratio is 80%.

Sec. 16. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2005, c. 121, Pt. E, §§1 and 2, is repealed.

Sec. 17. 24-A MRSA §2839-A, sub-§1, as amended by PL 2005, c. 121, Pt. F, §1, is further amended to read:

1. Notice of rate increase on existing policies. An insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, must provide written notice by first class mail of a rate increase to all affected policyholders or others who are directly billed for group coverage at least ~~60~~90 days before the effective date of any increase in premium rates. An increase

in premium rates may not be implemented until ~~60~~90 days after the notice is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

Sec. 18. 24-A MRSA §2839-A, sub-§2, as amended by PL 2005, c. 121, Pt. F, §1, is further amended to read:

2. Notice of rate increase on new business. When an insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following ~~90~~120 days. If the quote is in writing, the disclosure must also be in writing. If such disclosure is not provided, an increase may not be implemented until at least ~~90~~120 days after the date the quote is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

Sec. 19. 24-A MRSA §4313, sub-§13, as enacted by PL 1999, c. 742, §19, is repealed.

Sec. 20. 24-A MRSA §4313, sub-§14, as enacted by PL 1999, c. 742, §19, is amended to read:

14. Wrongful death action. ~~Notwithstanding subsection 13, an~~An enrollee or an enrollee's authorized representative may bring a cause of action against a carrier for its health care treatment decisions to seek a remedy under either this section or under Title 18-A, section 2-804, but may not seek remedies under both this section and Title 18-A, section 2-804.

SUMMARY

This bill makes the following changes to the laws regulating individual and small group health plans.

1. It increases the time period for advance notice of rate increases and rate changes to policyholders.

2. It requires the Department of Professional and Financial Regulation, Bureau of Insurance to hold public hearings when a rate increase is proposed.

3. It requires the Department of Professional and Financial Regulation, Bureau of Insurance to contract with an independent hearing officer to conduct rate hearings and to appoint an advocacy panel in those proceedings to represent the interests of consumers and the public.

4. It clarifies that all rate filings and information and documentation used to support the filings are public records and may be disclosed to the public.

5. It changes the standard of review that rates not be excessive to the standard that rates be reasonable and necessary.

6. It requires that rates not be approved unless certain standards are met and supported by evidence in the record.

7. It requires that carriers provide demonstrable proof and quantify the amount of any recovery of the savings offset payment through negotiations with health care providers as part of rate filings.

8. It increases the minimum loss ratios for individual and small group health plans and requires carriers to refund to policyholders the difference between the required loss ratio and the achieved loss ratio in instances when the carrier does not meet the minimum standards.

9. It repeals the exclusivity provision regarding an enrollee's right to sue under the Maine Revised Statutes, Title 24-A, chapter 56-A.