DISTRICT OF COLUMBIA

OFFICIAL CODE

TITLE 31.

INSURANCE AND SECURITIES.

CHAPTER 33A.

HEALTH INSURANCE RATEMAKING.

2001 Edition

DISTRICT OF COLUMBIA OFFICIAL CODE

CHAPTER 33A. HEALTH INSURANCE RATEMAKING.

TABLE OF CONTENTS

CHAPTER 33A. HEALTH INSURANCE RATEMAKING.

§ 31-3311.01. RATEMAKING PRINCIPLES AND STANDARDS.

(a) All insurance premium rates and fees shall be made in accordance with the principles and standards set forth in this section. Uniformity among insurers in matters within the scope of this section shall not be required or prohibited.

(b) Due consideration shall be given to:

(1) Past and prospective loss experience within and, if necessary for actuarial credibility, outside the District;

(2) Conflagration and catastrophe hazards, if any;

(3) Past and prospective expenses, both within and, if necessary for actuarial credibility, outside the District;

(4) Underwriting profits;

(5) Contingencies;

(6) Investment income and reserve for losses as reported by the insurer in the insurer's financial statements;

(7) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to policyholders as reported by the insurer in the insurer's financial statements; and

(8) All other relevant factors within and, if necessary for actuarial credibility, outside the District.

(c) Rates or fees shall not be excessive, inadequate, or unfairly discriminatory. In determining whether rates are excessive or unfairly discriminatory, the Commissioner may consider:

(1) Historical and projected loss ratios, as described herein;

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

(3) Changes to cover benefits or health benefit plan design; and

(4) Changes in the insurer's health care cost and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan.

(d) The systems of expense provisions included in the rates or fees for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to a kind of insurance or with respect to a subdivision or combination of kinds of insurance for which separate expense provisions are applicable.

(e) Except as provided for in subsection (f) of this section, for any rate filing, the carrier shall demonstrate that the product for which the rate is filed has a target medical loss ratio of 70 % or greater for individual and small group policies and 75 % or greater for large group policies.

(f) The Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner"), in his or her discretion, may approve an exemption to the target medical loss ratio set forth in subsection (e) of this section, upon receipt of justification supporting the requested exemption and after a 30-day period of public notice. Justification for a medical loss ratio of less than 70 % for individual and small group policies or less than 75 % for large group policies shall be based upon the following factors:

(1) Product design or cost sharing attributes;

(2) Expected enrollment size;

(3) Length of time in the market;

(4) Claims pool credibility; and

(5) Any other relevant matter.

(Apr. 8, 2011, D.C. Law 18-360, § 102, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

Law 18-360, the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", was introduced in Council and assigned Bill No. 18-792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18-710 and transmitted to both Houses of Congress for its review. D.C. Law 18-360 became effective on April 8, 2011.

§ 31-3311.02. AGGREGATE MEDICAL LOSS RATIOS; DIVIDEND; AND RATING BANDS.

(a) For each calendar year, an insurer shall maintain an aggregate minimum medical loss ratio, as defined by rule, of 80% for individual policies, as defined by rule, 80% for small group policies, as defined by rule, and 85% for large group policies, as defined by rule. The medical loss ratio shall be defined by the Commissioner and shall be determined by rule in a manner and generally consistent with the same standards as the medical loss ratio defined in section 2718(b) of the Public Health Service Act, approved March 23, 2010 (124 Stat. 136; 42 U.S.C. § 300gg-18(b)). No later than May 31st of each year, insurers shall file an annual report with the Commissioner, in a manner and on a form prescribed by Commissioner, indicating the medical loss ratio calculated for all policies and contracts written for the previous calendar year.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this chapter when combined with actual experience to date.

(c) In each case where the insurer fails to substantially comply with the medical loss ratio requirements set forth in subsection (a) of this section, the insurer shall issue a rebate for all policyholders in an amount determined in accordance with section 2718(b)(1)(B) of the Public Health Service Act, approved March 23, 2010 (124 Stat. 136; 42 U.S.C. § 300gg-18(b)(1)(B). The annual report required by this section shall include the insurer's calculation of the rebates and an explanation of the insurer's plan to issue rebates. The instructions and format for calculating and reporting medical loss ratios and issuing rebates shall be prescribed by the Commissioner by rule. The Commissioner shall establish, by rule, procedures for the distribution of a rebate in the event of cancellation or termination by a policyholder.

(d) A plan of individual or small group health insurance rates shall not include a standard rate for any age that is more than 300% of the standard rate for the age with the lowest rate in the same plan and the standard rate for any age shall not be more than 104% of the standard rate for the previous age.

(e) An insurer's failure to comply with the rebate requirements in subsection (c) of this section or rating band requirements set forth in subsection (d) of this section shall constitute an unfair or deceptive act or practice and shall be subject to the penalties in Chapter 22A of this title.

(f) The Commissioner may audit any insurer to assure compliance with this section. Insurers shall retain at their principal place of business information necessary for the Commissioner to perform compliance audits.

(Apr. 8, 2011, D.C. Law 18-360, § 103, 58 DCR 896; Sept. 26, 2012, D.C. Law 19-171, § 85(a), 59 DCR 6190.)

HISTORICAL AND STATUTORY NOTES

Effect of Amendments

D.C. Law 19-171, in subsec. (b), substituted "this chapter" for "this act".

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

For history of Law 19-171, see notes under § 31-305.

§ 31-3311.03. LOSS RATIO DISCLOSURE.

Policies, certificates, and marketing materials shall prominently display medical loss ratio disclosure, as defined by rule.

(Apr. 8, 2011, D.C. Law 18-360, § 104, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.04. ANNUAL RATE FILING REQUIREMENT.

All insurers subject to this chapter shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy form or certificate form, for approval by the Commissioner. The supporting documentation shall demonstrate, in accordance with actuarial principles and standards, using reasonable assumptions, that the appropriate medical loss ratio standards can be expected to be met over the entire period for which rates are computed and that insurer is in compliance with the ratemaking principles of this chapter. If the data submitted does not confirm that the insurer has satisfied the requirements of this chapter, the Commissioner shall notify the insurer in writing of the deficiency within 30 business days of the date that the data is submitted. The insurer shall have 30 days after the date of the Commissioner's notice to file amended rates that comply with this chapter. If the insurer fails to file amended rates within the 30-day period, the Commissioner shall order that the insurer's filed rates for the nonconforming policies and certificates be reduced to an amount that would bring the rates into compliance with this chapter. Upon request of the insurer and before any order or notice issued pursuant to this section becomes final, the Commissioner shall hold a hearing upon not less than 10 business days' written notice to the insurer specifying the matters to be considered at the hearing. The insurer's failure to file amended rates within the specified time or the issuance of the Commissioner's order amending the rates shall not preclude the insurer from filing an amendment of its rates at a later time.

(Apr. 8, 2011, D.C. Law 18-360, § 105, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.05. COMMISSIONER'S AUTHORITY TO RESCIND APPROVED RATES.

(a) The Commissioner may, at any time, require any insurer subject to this chapter to demonstrate that its rates and method for setting rates are in compliance with this chapter, notwithstanding that the filings then in effect had previously been approved. Any rates previously approved by the Commissioner, but subsequently disapproved under this chapter, shall be considered disapproved on a prospective basis only from the date of the notice of disapproval, unless the insurer made a material misrepresentation in its contract form or rate filings, in which case the rates shall be deemed disapproved on a retroactive basis.

(b) If, at any time subsequent to the approval of rates, the Commissioner finds that a filing does not meet the requirements of this chapter, the Commissioner shall issue an order to the insurer specifying why the filing fails to meet the requirements of this chapter, and, stating when, within a reasonable period thereafter, the filing shall be no longer effective. The order shall not affect any subscriber contract, group certificate, or other contract made or issued prior to the expiration of the period set forth in the order. The Commissioner may, prior to issuing the order and if requested by the insurer, hold a hearing upon not less than 10 business days' written notice to the insurer specifying the matters to be considered at the hearing.

(c) For violations of this chapter, the Commissioner may order any relief which is appropriate, including disapproving a rate and awarding interest.

(Apr. 8, 2011, D.C. Law 18-360, § 106, 58 DCR 896; Sept. 26, 2012, D.C. Law 19-171, § 85(b), 59 DCR 6190.)

HISTORICAL AND STATUTORY NOTES

Effect of Amendments

D.C. Law 19-171, in subsec. (b), substituted "this chapter" for "this act".

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

For history of Law 19-171, see notes under § 31-305.

§ 31-3311.06. POST-CLAIMS UNDERWRITING AND PRIOR APPROVAL FOR RESCISSION, CANCELLATION, OR LIMITATION.

(a) An insurer shall not rescind an enrollee's plan or coverage once the enrollee is covered under the plan or coverage involved; provided, that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. The plan or coverage shall not be cancelled without prior notice to the Commissioner as required by subsection (b) of this section and prior notice to the consumer and an opportunity to appeal as required by the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 109; scattered sections of the United States Code).

(b) A health carrier shall provide at least 30 days advance written notice to each plan enrollee, or for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) of this section regardless of, in the case of group or only to an individual within the group. The notice shall explain the reason for the rescission, procedures of appealing, and how to contact the Health Care Ombudsman and the Department of Insurance, Securities, and Banking for further information.

(c) Prior to rescinding the enrollee's plan or coverage, the insurer shall provide to the Commissioner documentation to support the rescission and the Commissioner shall have 5 business days following receipt of the proposed rescission and supporting documentation to review the documentation to determine if the insurer is complying with the requirements of subsection (a) of this section. The insurer may rescind the plan or coverage after the end of the 5-day period of review unless the Commissioner objects or disapproves the proposed rescission within the 5-day period.

(Apr. 8, 2011, D.C. Law 18-360, § 107, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.07. PUBLIC RECORDS.

The Commissioner shall, as soon as practicable, make all rate filings, including all supporting documentation, amended filings, and reports filed pursuant to this chapter, available for public inspection either at the Department of Insurance, Securities, and Banking or on its website.

(Apr. 8, 2011, D.C. Law 18-360, § 108, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.08. ANNUAL REPORT AND RECOMMENDATIONS.

On June 1, 2011, and every year thereafter, the Commissioner shall report to the Council any significant National Association of Insurance Commissioners adoptions related to health care reform, including medical loss ratios and loss ratio disclosure, and any recommendations if the District law differs.

(Apr. 8, 2011, D.C. Law 18-360, § 109, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.09. RULES.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, shall issue rules to implement the provisions of this chapter.

(Apr. 8, 2011, D.C. Law 18-360, § 110, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.10. APPLICATION.

This chapter shall apply to policies and certificates of insurance that are health benefit plans as defined under § 31-3271(4) that are issued 90 days after April 8, 2011. This chapter shall not apply to short-term limited duration health benefit plans.

(Apr. 8, 2011, D.C. Law 18-360, § 111, 58 DCR 896.)

HISTORICAL AND STATUTORY NOTES

Legislative History of Laws

For history of Law 18-360, see notes under § 31-3311.01.