ENROLLED ORIGINAL

AN ACT

Codification District of Columbia Official Code

2001 Edition

2011 Summer Supp.

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To establish ratemaking principles and standards as additional guidance in reviewing and approving health insurance rate filings, to set minimum medical loss ratio standards, to require that companies pay a rebate if the annual medical loss ratio is below the minimum standards, to require that all accident and sickness rate filings be made available for public inspection, to amend the Insurance Trade and Economic Development Amendment Act to protect victims of domestic violence from discrimination in the provision of insurance, to prohibit rate variation in health insurance rate-setting based on the gender or sex of an individual, to ban discontinuance of entire classes of health insurance policies as a pretext for dropping an individual policyholder, to require insurers to prove that they are not dropping a class of policies as a pretext for dropping an individual policyholder, to empower consumers by creating a private right of action against insurers that violate the new law, and to ensure that discontinued policyholders with severe illnesses and disabilities have at least 18 months of coverage if their coverage is legitimately discontinued, to amend the Fire and Casualty Act of 1940, the Hospital and Medical Services Corporation Regulatory Act of 1996, the Health Maintenance Organizations Act of 1996, and the Life Insurance Act of 1934 to make conforming amendments.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010".

TITLE I. RATEMAKING REFORM

Sec. 101. This title may be cited as the "Reasonable Health Insurance Ratemaking Reform Act of 2010".

Sec. 102. 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.

Sec. 103. 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 act 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 the Insurance Trade and Economic Development Amendment Act of 2000, effective April 3, 2001 (D.C. Law 13-265; D.C. Official Code § 31-2231.01 *et seq*.).

(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.

Sec. 104. Loss ratio disclosure.

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

Sec. 105. Annual rate filing requirement.

All insurers subject to this title 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 title. If the data submitted does not confirm that the insurer has satisfied the requirements of this title, 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 title. 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 title. 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.

Sec. 106. Commissioner's authority to rescind approved rates.

(a) The Commissioner may, at any time, require any insurer subject to this title to demonstrate that its rates and method for setting rates are in compliance with this title, notwithstanding that the filings then in effect had previously been approved. Any rates previously approved by the Commissioner, but subsequently disapproved under this title, 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 act, the Commissioner shall issue an order to the insurer specifying why the filing fails to meet the requirements of this title, 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 title, the Commissioner may order any relief which is appropriate, including disapproving a rate and awarding interest.

Sec. 107. 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.

(b) 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.

Sec. 108. 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 title, available for public inspection either at the Department of Insurance, Securities, and Banking or on its website.

Sec. 109. 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.

Sec. 110. Rules.

The Mayor, pursuant to Title 1 of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), shall issue rules to implement the provisions of this title.

Sec. 111. Application.

This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children Act of 2006, effective March 2, 2007 (D.C. Law 16-198; D.C. Official Code § 31-3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans.

TITLE II. HEALTHCARE JUSTICE FOR VICTIMS OF DOMESTIC VIOLENCE

Sec. 201. Short title.

This title may be cited as the "Healthcare Justice for Victims of Domestic Violence Amendment Act of 2010".

Sec. 202. The Insurance Trade and Economic Development Amendment Act of 2000, effective April 3, 2001 (D.C. Law 13-265; D.C. Official Code § 31-2231.01 *et seq.*), is amended as follows:

(a) Section 111 (D.C. Official Code § 31-2231.11) is amended as follows: **Amend § 31-2231.11**

(1) Subsection (b) is amended as follows:

(A) Strike the phrase "health insurance policy" and insert the phrase "health insurance" in its place.

(B) Strike the phrase "contract or policy" and insert the phrase "policy or contract of accident or health insurance" in its place.

(C) Strike the phrase "policy or contract" and inserting the phrase "policy or contract of health insurance" in its place.

(2) A new subsection (b-1) is added to read as follows:

"(b-1) For the purposes of subsections (a) and (b) of this section, no person shall inquire, directly or indirectly, as to whether an insured or applicant is, or has been, the victim of an intrafamily offense, sexual assault, dating violence, or stalking, or make use of information as to an insured or applicant's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking; provided, that this subsection shall not prohibit a person from asking about a medical condition or from using medical information to underwrite or to carry out its duties under a policy, even if the medical information is related to a medical condition that the person knows or has reason to know is related to an intrafamily offense, sexual assault, dating violence, or stalking, to the extent otherwise permitted under this act or applicable law. For purposes of this subsection, the term "intrafamily offense" shall have the same meaning as

provided in D.C. Official Code § 16-1001(8)."

(3) Subsection (c) is amended by striking the phrase "or political affiliation." and inserting the phrase "political affiliation, or an individual's status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking." in its place,

(b) Section 124 (D.C. Official Code § 31-2231.24) is amended by striking the phrase "issued, appeal" and inserting the phrase "issued, or later in connection with section 111(a), (b), or (b-1) upon a showing of good cause by a victim of an intrafamily offense, sexual assault, dating violence, or stalking, appeal" in its place.

Amend § 31-2231.24

Sec. 203. Application.

This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children Act of 2006, effective March 2, 2007 (D.C. Law 16-198; D.C. Official Code § 31-3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans.

TITLE III. HEALTHCARE EQUALITY

Sec. 301. Short title.

This title may be cited as the "Health Care Equality Act of 2010".

Sec. 302. Prohibition on gender-based discrimination in rate making.

(a) For the purposes of this section, the term "health benefit plan" shall have the same meaning as provided in section 2(1) of the Diabetes Health Insurance Coverage Expansion Act of 2000, effective October 21, 2000 (D.C. Law 13-175; D.C. Official Code § 31-3001(1)).

(b) An individual health benefit plan offered, sold, issued, or renewed to a District resident shall not have a premium rate, or any other underwriting decision, determined through a method that is in any way based upon the gender or sex of a person covered under the health benefit plan.

(c) Each individual health benefit plan offered, sold, issued, or renewed in the District shall provide hospitalization benefits for childbirth to the same extent as benefits provided in the policy for any covered illness. In addition to the provisions of this subsection and subsection (c) of this section, if a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the individual health benefit plan shall pay the cost of additional hospitalization for the newborn for up to 4 days.

(d) Each individual health benefit plan offered, sold, issued, or renewed in the District shall provide coverage for the cost of inpatient hospitalization services for a mother and newborn child for a minimum of:

(1) Forty-eight hours of inpatient hospitalization care after an uncomplicated

vaginal delivery; and

(2) Ninety-six hours of inpatient hospitalization care after an uncomplicated cesarean section.

(e) A mother may request a shorter length of stay than that provided in subsection (c) of this section if the mother decides, in consultation with the mother's attending provider, that less time is needed for recovery.

(f)(1) For a mother and newborn child who have a shorter hospital stay than that provided under subsection (c) of this section, the individual health benefit plan shall provide coverage for:

(A) One home visit scheduled to occur within 24 hours after hospital discharge; and

(B) An additional home visit if prescribed by the mother's attending provider.

(2) For a mother and newborn child who remain in the hospital for at least the length of time provided under subsection (c) of this section, the individual health benefit plan shall provide coverage for a home visit if prescribed by the mother's attending provider.

(3) A home visit under paragraph (1) or (2) of this subsection shall:

(A) Be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;

(B) Be provided by a registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and

(C) Include any services required by the mother's attending provider.

Sec. 303. Rules.

The Mayor, pursuant to Title 1 of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq*.), shall issue rules to implement the provisions of this title.

Sec. 304. Application.

This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children Act of 2006, effective March 2, 2007 (D.C. Law 16-198; D.C. Official Code § 31-3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans.

TITLE IV. IAN'S LAW

Sec. 401. Short title.

This title may be cited as the "Ian's Law Act of 2010".

Sec 402. Conditions for discontinuance of class of health insurance policies.

(a)If an insurer decides to discontinue a particular class of group, or blanket policy of, hospital, surgical, or medical expense insurance offered in the small or large group market, the policy of the class may be discontinued by the insurer only if:

(1) The insurer requests in such form as designated by the Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner") that the Commissioner approve the discontinuance, and the insurer receives the approval; provided, that the Commissioner shall:

(A) No sooner than 60 days after receipt of the request, grant the approval only if he or she determines that the discontinuance of the coverage of this class by the insurer is not with the intent, or as a pretext, to discontinue the coverage of any policyholder or any insured due to the claims experience or any health status-related factor relating to any policyholder or insured covered by any such policy; and

(B) Make the determination only after examining and taking into consideration the claim histories and premium rates for each policy in the class, historical profits and losses for the class of policies, comments from policyholders or others submitted to the Commissioner within 30 days after receipt of any such request, and any other information or analysis the Commissioner demands or considers relevant;

(2) The insurer, no later than the date that the request to the Commissioner under paragraph (2) of this subsection is made, provides written notice to each policyholder of this class in such market (and to all participants and beneficiaries covered under the coverage) of:

(A) The request;

(B) The earliest possible date that the Commissioner might approve the request;

(C) The earliest possible date that the coverage could be discontinued; and

(D) A statement written in plain English of the obligations of the insurer and the rights of policyholders; and

(3) The insurer, upon approval by the Commissioner of any such request:

(A) Provides written notice to each policyholder provided coverage of the class in the market (and to all participants and beneficiaries covered under the coverage) of the discontinuance at least 90 days prior to the date of discontinuance of the coverage;

(B) Offers to each policyholder of this class in the market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical, and medical

expense coverage currently being offered by the insurer to a group in the market; and

(C) In exercising the option to discontinue coverage of the class and in offering the option of coverage under another class, acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any insureds covered, or new insureds who may become eligible, for the coverage.

(b) If an insurer discontinues a particular class of group, or blanket policy of, hospital, surgical, or medical expense insurance offered in the small or large group market, other than where the Commissioner authorizes the discontinuance, the insurer shall be liable to the former holder or beneficiary of such policy, or to his or her estate, for compensatory damages arising from the discontinuance, plus costs and reasonable attorneys' fees, in an action which shall be commenced no later than 3 years after the date of the discontinuance. In any such action, the court may grant such injunctive relief as the court may consider proper.

(c) If major medical insurance or insurance providing major medical type benefits is discontinued, the Commissioner shall order that an extended benefit shall be provided during total disability, with respect to the sickness, injury, or pregnancy which caused the disability, of at least 18 months subsequent to the discontinuance of the insurance unless similar coverage is afforded for the total disability under another group plan.

Sec. 403. Rules.

The Mayor, pursuant to Title 1 of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq*.), shall issue rules to implement the provisions of this title.

Sec. 404. Application.

This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children Act of 2006, effective March 2, 2007 (D.C. Law 16-198; D.C. Official Code § 31-3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans.

TITLE V. CONFORMING AMENDMENTS

Sec. 501. Section 28 of the Fire and Casualty Act of 1940, effective October 9, 1940 (54 Stat. 1076; D.C. Official Code § 31-2502.28), is amended as follows:

(a) The section designation is amended to read as follows:

"Sec. 28. Rate and form filing requirements for accident and health policies.".

(b) Strike the phrase "issued by," and insert the phrase "issued by, and the rate-making and filing obligations of," in its place.

Sec. 502. The Health Maintenance Organization Act of 1996, effective April 9, 1997 (D.C. Law 11-235; D.C. Official Code § 31-3401 *et seq*.), is amended as follows:

(a) Section 9a (D.C. Official Code § 31-3408.01) is amended as follows:

(1) Paragraph (4) is amended by striking the phrase "; and" at the end and inserting a semicolon in its place.

(2) Paragraph (5) is amended by striking the period at the end and inserting the phrase "; and" in its place.

(3) A new paragraph (6) is added to read as follows:

"(6) The Reasonable Health Insurance Ratemaking Reform Act of 2010, passed on 2nd reading on December 7, 2010 (Enrolled version of Bill 18-792).".

(b) Section 16(b) (D.C. Official Code § 31-3415(b)) is amended by adding a new 4th sentence to read as follows:

"A health maintenance organization filing a schedule of enrollment fees or methodology for determining enrollment fees pursuant to this section shall also comply with the Reasonable Health Insurance Ratemaking Reform Act of 2010, passed on 2nd reading on December 7, 2010 (Enrolled version of Bill 18-792).".

Sec. 503. The Hospital and Medical Services Corporation Regulatory Act of 1996, effective April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31-3501 *et seq.*), is amended as follows:

(a) Section 4 (D.C. Official Code § 31-3503) is amended to read as follows:

(1) Paragraph (26) is amended by striking the phrase "; and" at the end of the paragraph and inserting a semicolon in its place.

(2) Paragraph (27) is amended by striking the period at the end and inserting the phrase "; and" in its place.

(3) A new paragraph (28) is added to read as follows:

"(28) The Reasonable Health Insurance Ratemaking Reform Act of 2010, passed on 2nd reading on December 7, 2010 (Enrolled version of Bill 18-792).".

(b) Section 9(e) (D.C. Official Code § 31-3508(e)) is amended by adding a new paragraph (4) to read as follows:

"(4) A corporation filing a rate pursuant to this section shall also comply with the Reasonable Health Insurance Ratemaking Reform Act of 2010, passed on 2nd reading on December 7, 2010 (Enrolled version of Bill 18-792).".

Sec. 504. Section 12 of Chapter V of the Life Insurance Act of 1934, approved June 19, 1934 (48 Stat. 1166; D.C. Official Code § 31-4712), is amended as follows:

(a) The section designation is amended to read as follows:

"Sec. 12. Accident and sickness policies.".

(b) Subsection (a) is amended by striking the last sentence and inserting the sentence "Rates filed with respect to a policy or certificate subject to the Reasonable Health Insurance Ratemaking Reform Act of 2010, passed on 2nd reading on December 7, 2010 (Enrolled version of Bill 18-792), shall also comply with the provisions of such act." in its place.

(c) Subsection (h)(1) is repealed.

TITLE VI. FISCAL IMPACT STATEMENT; EFFECTIVE DATE.

Sec. 601. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 602. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), and a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Code § 1-206(c)(1)), and publication in the District of Columbia Register.

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Chairman
Council of the District of Columbia

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Mayor
District of Columbia