

TEXT OF PROPOSED AMENDMENT TO REGULATION

Title 10. Investment

Chapter 5. Insurance Commissioner

Subchapter 2. Policy Forms and Other Documents

Article 1.9. Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable in Relation to the Premium Charged Pursuant to Subdivision (C) of Section 10293

Amend Title 10, Section 2222.12 to read:

§ 2222.12. Standards of Reasonability.

The authority of the commissioner under Insurance Code Section 10293 being to withdraw approval of policy forms the benefits of which are not reasonable in relation to the premium charged, whether the approval of any form of an insurer should be withdrawn pursuant to said section shall be determined by an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop. Some of such factors which will be considered by the commissioner are hereinafter in this article set forth, but their listing does not preclude an insurer from urging any other factors which it considers relevant to the issue involved.

(a) Benefits provided by a hospital, medical or surgical policy shall be deemed to be reasonable in relation to premiums ~~if either~~ if both of the criteria in subdivisions (1) and (2), below, are satisfied:

(1) ~~(A)~~ (A) the lifetime anticipated loss ratio is not less than 70%, and ~~(2) (B)~~ (B) in the case of a rate revision, the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage is also not less than 70%, or, if the insurer chooses to include disease management expenses in determining compliance with these standards, ~~(3) (C)~~ (C) the sum of the lifetime anticipated loss ratio and the lifetime anticipated disease management ratio is not less than 70%, and ~~(4) (D)~~ (D) in the case of a rate revision, the sum of the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage and the anticipated disease management ratio over the future period for which revised rates are computed to provide coverage is also not less than 70% ~~and~~ and;

(2) the insurer's projected medical loss ratios in the individual market, calculated using the method described in the interim final rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. §§ 158.220-158.232, 75 Fed. Reg. 74927-74928, (December 1, 2010)) and incorporated herein by reference, are not less than 80%.

(b) Benefits provided by a hospital, medical, or surgical policy delivered or issued for delivery to any person in this State prior to July 1, 2007 and not subject to any rate revision effective on or after July 1, 2007 shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(c) Benefits provided by supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(d) Benefits provided by a hospital, medical or surgical policy designed to supplement Medicare, as defined in subdivision (l) of Insurance Code section 10192.4, must meet the loss ratio standards established in Subdivision (a)(1)(A) of Section 10192.14 of the Insurance Code.

NOTE: Authority cited: Insurance Code section 10293.

Reference: Insurance Code section 10293(a).