GOV. COMM. 18-144
(HOUSE)

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Eloy S. Inos
Governor

Jude U. Hofschneider
Lieutenant Governor

14 FEB 2014

Honorable Joseph P. Deleon Guerrero
Speaker, House of Representatives
Eighteenth Northern Marianas
Commonwealth Legislature
Saipan, MP 96950

OFFICE OF THE SPEAKER
RECEIVED
BY: Pedro Tenorio
DATE: 2/14/14
TIME: 4:25 pm
CNMI LEGISLATURE

Honorable Ralph DLG. Torres
Senate President, The Senate
Eighteenth Northern Marianas
Commonwealth Legislature
Saipan, MP 96950

Dear Mr. Speaker and Mr. President:

This is to inform you that I have signed into law House Bill No. 18-159, SD1, entitled, "To amend the Commonwealth Insurance Act of 1983 as codified by 4 CMC § 7101 *et. Seq.*, to add a new Chapter 6 to 4 CMC, Div. 7, to provide for a premium rate review process; and for other purposes," which was passed by the House of Representatives and the Senate of the Eighteenth Northern Marianas Commonwealth Legislature.

This bill becomes **Public Law No. 18-34**. Copies bearing my signature are forwarded for your reference.

Sincerely,

ELOY S. INOS

cc: Lt. Governor; Lt. Governor's Legal Counsel; Attorney General's Office; Press Secretary; Department of Commerce; Department of Finance; Special Assistant for Administration; Special Assistant for Programs and Legislative Review

HOUSE CLERK'S OFC
RECEIVED BY
DATE 2/18/14 TIME 9:30a

Caller Box 10007 Saipan, MP 96950 Telephone: (670) 664-2200/2300 Facsimile: (670) 664-2211/2311

Eighteenth Legislature
of the
Commonwealth of the Northern Mariana Islands

IN THE HOUSE OF REPRESENTATIVES

Third Regular Session

January 9, 2014

Representative Edmund S. Villagomez, of Saipan, Precinct 3 (*for himself,*) in an open and public meeting with an opportunity for the public to comment, introduced the following Bill:

H. B. No. 18-159, SD1

AN ACT

TO AMEND THE COMMONWEALTH INSURANCE ACT OF 1983 AS CODIFIED BY 4 CMC § 7101 ET. SEQ., TO ADD A NEW CHAPTER 6 TO 4 CMC, DIV. 7, TO PROVIDE FOR A PREMIUM RATE REVIEW PROCESS; AND FOR OTHER PURPOSES.

The Bill was not referred to a House Committee.

THE BILL WAS PASSED BY THE HOUSE OF REPRESENTATIVES ON FIRST AND FINAL READING, JANUARY 9, 2014;
without amendments and transmitted to the
THE SENATE.

The Bill was not referred to a Senate Committee.
THE BILL WAS PASSED BY THE SENATE ON FIRST AND FINAL READING, JANUARY 14, 2014;
with amendments in the form of H. B. 18-159, SD1 and returned to
THE HOUSE OF REPRESENTATIVES.

The House of Representatives accepted the Senate amendments and passed H. B. 1-159, SD1 during its Second Day, Third Regular Session on January 31, 2014.

THE BILL WAS FINALLY PASSED ON JANUARY 31, 2014.

Linda B. Muña, House Clerk

Eighteenth Legislature
of the
Commonwealth of the Northern Mariana Islands

IN THE HOUSE OF REPRESENTATIVES

Second Day, Third Regular Session

January 31, 2014

H. B. 18-159, SD1

AN ACT

TO AMEND THE COMMONWEALTH INSURANCE ACT OF 1983 AS CODIFIED BY 4 CMC § 7101 *ET. SEQ.*, TO ADD A NEW CHAPTER 6 TO 4 CMC, DIV. 7, TO PROVIDE FOR A PREMIUM RATE REVIEW PROCESS; AND FOR OTHER PURPOSES.

Be it enacted by the Eighteenth Northern Marianas Commonwealth Legislature:

Section 1. Findings and Purpose. The purpose and intent of this Act is to amend the authorization of the insurance commissioner and other related parts of the CNMI Insurance Act of 1983 and CNMI PL 3-107, so as to provide the insurance commissioner clear authorization to implement the CNMI Insurance Act of 1983 and CNMI PL 3-107. This legislation also serves to permit the promulgation of regulations of health insurance carriers or issuers related to the Affordable Care Act. Lastly, the legislation adds a new Chapter 6 to 4 CMC, Div. 7 to create an effective health insurance premium rate review process in the CNMI.

Section 2. Amendment. A new Chapter 6 is added to 4 CMC, Div. 7 to read as follows:

Chapter 6 — Rates and Rating Organizations

GENERAL PROVISIONS

§ 7601 Definitions

§ 7602 Purpose, intent of chapter

§ 7603 Application of chapter

§ 7604 Remedies of Commissioner for violations of chapter

RATES AND RATE MAKING

§ 7605 Filing rates, plans with Commissioner; prior approval by Commissioner; public inspection of rate filings; Mandatory Rate and Forms Filing as prescribed by Regulation

§ 7606 Hearing on rate filings pursuant to 4 CMC § 7201 *et. seq.*; order; review

§ 7607 Effect of noncompliance with rating regulation

§ 7608 Records requirements; inspection; statistics

§ 7609 Data must include certain information

§ 7610 Examining rating systems of insurers; costs

§ 7611 Collusive ratings prohibited; liability for damages

§ 7612 Authority for cooperative ratings and systems

§ 7613 Unauthorized adherence to rates, rating systems

§ 7614 Preparation of rates, rating systems and other administrative matters by insurers under common ownership

§ 7615 Method of rate making; factors considered; rules

§ 7616 Agreements among insurers for assignment of risks; rate modifications

RATING ORGANIZATIONS

§ 7633 Examination of rating, advisory and other organizations; payment of costs; acceptance of report from another state

§ 7634 Interchange of data; rules; promoting uniformity of rating laws

§ 7635 Withholding or giving false information prohibited

§ 7636 Procedure for suspension of rating organization license

§ 7637 Rating organization membership

Extended Powers of the CNMI Insurance Commissioner

§ 7638- Extended Powers of the CNMI Insurance Commissioner

GENERAL PROVISIONS

Section 3. Amendment. 4 CMC §7103 is hereby amended to add the following definitions:

(u) *Commissioner*. Means the Insurance Commissioner established by 4 CMC § 7104.

(v) *Rating organization.* As used in this chapter, unless the context requires otherwise, "rating organization" means:

(1) Every person, including an insurer or health insurance carrier, whether located within or outside the Commonwealth, who has as one of the person's object or purpose the making of rates, rating plans or rating systems; or

(2) Two or more insurers which act in concert for the purpose of making rates, rating plans or rating systems.

(w) *Advisory organization.* As used in this chapter, unless the context requires otherwise, "advisory organization" means every group, association or other organization of insurers, whether located within or outside the Commonwealth, which

assists authorized insurers which make their own filings or licensed rating organizations in rate making, by the collection and furnishing of loss or expense statistics or by the submission of recommendations, but which does not make filings under this chapter.

(x) *Member; subscriber.* As used in this chapter, unless the context requires otherwise,

(1) "Member" means:

(A) An insurer that participates in or is entitled to participate in the management of a rating, advisory or other organization.

(2) "Subscriber" means an insurer that is furnished at its request:

(A) With rates and rating manuals by a rating organization of which it is not a member; or

(B) With advisory services by an advisory organization of which it is not a member.

(y) *Individual market.* The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(z) *Group market.* The term "group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer or group.

(aa) *Large and small group markets.* The terms "large group market" and "small group market" mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of

themselves (and their dependents) through a group health plan maintained by a large employer (as defined in 4 CMC § 7103(ab)) or by a small employer (as defined in 4 CMC § 7103(ac)), respectively.

(ab) *Large employer.* The term "large group" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. This definition will remain in effect until federal statute mandates an amendment.

(ac) *Small group.* The term "small group" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. This definition will remain in effect until federal statute mandates an amendment.

(ad) CMS-The Centers for Medicare and Medicaid Services.

(ae) Effective Rate Review Program-A program which has been deemed effective by the Centers for Medicare and Medicaid Services (CMS) pursuant to 45 C.F.R. §154.301.

(af) Federal Medical Loss Ratio (MLR) - This ratio measures the share of a health care premium dollar spent on medical benefits, as opposed to company expenses such as overhead or profits.

(ag) Health Insurance Issuer-Any entity licensed, or required to be licensed, by the Insurance Division of the Department of Commerce that offers health benefit plans or policies covering eligible individuals or groups pursuant to this act. For the

purposes of this act, health insurance issuer includes an insurance company, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(ah) Product- means a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State.

(ai) Rate Insurance Increase-means any increase of the rates for a specific Product offered in the Individual or Small Group market.

(aj) Rate Increase Subject to Review- A rate increase that is equal to or greater than 10%, or more than one rate revision within 12 months, or has accumulated to more than 27% over three consecutive years, in the non-grandfathered individual and small group market.

(ak) Unreasonable Rate Increase- A rate increase that is, excessive, inadequate or unfairly discriminatory for the purposes of this chapter and as defined below:

(1) Excessive rate increase-The rate increase is an excessive rate increase if the increase causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage.

(2) Unjustified rate increase-The rate increase is an unjustified rate increase if the health insurance issuer provides data or documentation to the Commissioner in connection with the increase that is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined

(3) Unfairly discriminatory- The rate increase is an unfairly discriminatory rate increase if the increase results in premium differences between insureds within similar risk categories that are not permissible under applicable state and federal statutes and regulations.

§ 7602. Purpose, intent of chapter.

(1) The purpose of this chapter is to promote the public welfare by regulating health insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory, to authorize cooperation between insurers in rate making and other related matters, and to provide greater accountability and transparency in the health insurance industry in the Commonwealth and the regulation thereof.

§ 7603. Application of chapter.

This chapter applies to all forms of insurance on risks or operations in the Commonwealth, including health insurance, except:

(1) Reinsurance, as defined in 4 CMC §7507, other than joint reinsurance to the extent stated in § 7626;

(2) Insurance against loss of, or damage to, aircraft, including accessories and equipment, or against liability arising out of ownership, maintenance or use of aircraft;

(3) Wet marine and transportation insurance;

(4) Life insurance; or

(5) Surplus lines insurance.

§ 7604. Remedies of Commissioner for violations of chapter.

(1) If the Commissioner has reason to believe that a rate, rating plan or rating system filed or used by a Health Insurance Issuer or filed by a Rating or Advisory

Organization on behalf of an insurer does not comply with the requirements and standards of this chapter, the Commissioner may issue an order directing the insurer or the rating or advisory organization to discontinue or desist from the noncompliance. An order issued under this subsection is subject to the provisions of 4 CMC § 7606.

(2) If the Commissioner holds a hearing on an order issued pursuant to subsection (1) of this section, and the Commissioner finds that the requirements under this Chapter or federal law have not been met, the insurer or rating or advisory organization filing or using the rate, rating plan or rating system shall pay to the Commissioner the just and legitimate costs of the hearing, including actual necessary expenses.

(3) If the Commissioner finds after a hearing pursuant to 4 CMC § 7606 that any rate, rating plan or rating system violates the provisions of this chapter, the Commissioner may issue an order specifying the violation and stating when, within a reasonable period of time, the further use of such rate, rating plan or rating system by an insurer or rating or advisory organization shall be prohibited.

(4) If the Commissioner finds after a hearing pursuant to 4 CMC § 7606 that an insurer or rating or advisory organization is in violation of any provision of this chapter other than the provisions dealing with rates, rating plans or rating systems, the Commissioner may issue an order specifying the violation and requiring compliance within a reasonable time.

(5) If the Commissioner finds after a hearing pursuant to 4 CMC § 7606 that the violation of any of the provisions of this chapter applicable to it by any insurer or rating organization that has been the subject of a hearing was willful, the

Commissioner may suspend or revoke the certificate of authority of such insurer or the license of such rating organization.

(6) If the Commissioner finds after a hearing that any rating organization has willfully engaged in any fraudulent or dishonest act or practices, the Commissioner may suspend or revoke the license of such organization.

RATES AND RATE MAKING

Section 4. Repeal and Re-enactment. 4 CMC § 7504 (a) shall be repealed and amended as follows:

Filing rates, plans with Commissioner; Prior Approval by Commissioner; Public inspection of Rate Filings.

(1) Every Insurer shall file with the Commissioner copies of the rates, rating plans and rating systems used by it. All premium rates for tariff lines of insurance including life insurance, motor vehicle insurance and worker's compensation and health insurance policies, plans or contracts must be approved by the Commissioner prior to those rates being implemented, advertized, publicized, or otherwise represented. All filings shall be submitted at least sixty (60) days before the effective date and policy holders shall be notified at least thirty (30) days prior to the effective date.

(2) An insurer may satisfy its obligation to make such filings by becoming a member of or a subscriber to a licensed rating organization which makes such filings, and by authorizing the Commissioner to accept such filings on its behalf. Such insurer may so adopt the filings of a rating organization on part of the classes of risks insured by it and may make its own filings as to other classes which shall be uniform throughout the insurer's territorial classification.

(3) If an insurer will not implement charge, advertise, publicize, or otherwise represent new rates for a health insurance market in a given year, the insurer must certify this fact with the commissioner at least five (5) business days before the first day of the open enrollment period.

(4) If an insurer elects to discontinue offering and non-renews all of its health benefit plans in an individual, small group, or large group market in the CNMI as defined in this statute:

(a) It must provide a notice of this decision to the Commissioner and all affected individuals at least 180 calendar days prior to the discontinuance and nonrenewal.

(b) The notice to the Commissioner must be provided at least 3 business days prior to the notice to the individuals.

(c) An affidavit signed by both resident and general agent must be submitted within 60 calendar days of withdrawal from the market segment, verifying that all existing claims arising out of insurance transacted in that market segment have been paid in full.

(5) Expedited approval is granted if the rate filing meets one of the following conditions:

(a) The rate only applies to large group plans;

(b) The rate increase is less than 10 percent; or

(c) There has been no rate revision within the past 12 months.

(6) Any proposed rate revision in either the individual and/or small group market that meets or exceed any one of the following thresholds shall comply with the process set out in subsection (7) of this section:

(a) The rate increase is equal to or greater than 10%; or

(b) A rate revision has been made within the past 12 months; or

(c) The rate increase has accumulated to more than 27% over three consecutive years.

(7) Insurers making premium rate filings that meet or exceed either of the applicable thresholds set out in subsection (4) of this section shall furnish the following data:

(a) A description of the plan, policy or contract form number affected by the rate filing;

(b) For all rate filings that represent a rate increase, a rate summary worksheet as prescribed by the Commissioner by rule, a written description justifying the rate increase as prescribed by the Commissioner by regulation, and any and all of the reporting requirements prescribed by the Commissioner by regulation;

(c) A statement of the approximate number of persons in the Commonwealth affected by the rate increase;

(d) An actuarial certification indicating that, in the belief of the actuary;

i. the proposed rate or rate revision does not discriminate unfairly between policyholders or contract holders;

ii. in the case of Health Insurance Plans, the Medical Loss Ratio as calculated under federal guidelines including the actual data elements used in the Medical Loss Ratio calculation; and

(e) An officer of the insurer shall certify the completeness and accuracy of the data furnished in the filing;

(8) In reviewing all rate filings under this section, the Commissioner shall review the following to the extent applicable to the filing under review:

(a) The impact of medical trend changes by major service categories;

(b) The impact of utilization changes by major service categories;

(c) The impact of cost-sharing changes by major service categories;

(d) The impact of benefit changes;

(e) The impact of changes in enrollee risk profile;

(f) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;

(g) The impact of changes in reserve needs;

(h) The impact of changes in administrative costs related to programs that improve health care quality;

(i) The impact of changes in other administrative costs;

(j) The impact of changes in application taxes, licensing, or regulatory fees; Medical Loss Ratio;

(k) The insurer's capital and surplus; and

(l) Consumer comments regarding rate filing.

(9) Any filing made pursuant to this Chapter is a Public Record as defined by 1 CMC §9902 (f), and shall be open to public inspection pursuant to the procedures set forth in the Commonwealth Open Government Act (1 CMC §9901 *et. seq*).

§ 7606. Hearing on rate filings pursuant to 4 CMC § 7605; Order; Review.

(1) The Commissioner may hold a hearing on a filing made pursuant to 4 CMC § 7605 if the Commissioner determines that such a hearing would aid the Commissioner in determining whether to approve or disapprove the filing. A hearing under this section may be held at a place designated by the Commissioner and upon not less than 10 business days' written notice to the insurer or rating organization that made the filing and to any other person the Commissioner decides should be notified. A filing that is the subject of a hearing under this section becomes effective, if approved, as provided in subsection (4) of this section.

(2) A hearing held pursuant to subsection (1) of this section must be conducted by an administrative hearing officer provided for under 1 CMC § 9101 *et seq.* The administrative hearing officer shall report findings, conclusions and recommendations to the Commissioner within 30 calendar days of the close of the hearing. The insurer or rating organization proposing the rate filing shall have the burden of proving that the rate proposal is justified and shall pay to the Commissioner the fair and reasonable costs of the hearing, including actual necessary expenses, within 30 days of the close of the hearing should the Commissioner determine that the rates were not compliant with the applicable laws and regulations.

(3) Within 10 business days of receiving a report from the administrative hearing officer, the Commissioner shall issue an order approving or disapproving the filing. In the event the Commissioner is unable to provide a decision within the said time frame, the Commissioner reserves the right to request additional time as needed. If no request is made and the Carrier not informed, then the recommendation of the administrative hearing officer shall be rendered the final decision as of the 11th business day after the Commissioner receives the report from the hearing officer.

(4) An order issued under subsection (3) of this section may be reviewed as provided in 1 CMC § 9101 *et seq.* for review of contested cases. A filing approved by the Commissioner under this section shall be effective 10 business days after the order issued under subsection (3) of this section and shall remain effective during any review of the order. A filing disapproved by the Commissioner under this section shall remain effective during any review of the order. Any appeals to the decision rendered by the Commissioner may be filed with the CNMI Superior Court pursuant to the Administrative Procedures Act.

(5) The hearing procedures set forth in this section are to be used solely for the review of rate fillings. Nothing in this section shall be construed to diminish the powers and procedures set forth in 1 CMC §7201 for violations of other provisions of this Division.

§ 7607. Effect of noncompliance with rating regulation.

If the Commissioner has reason to believe that noncompliance by an insurer with the requirements and standards of this chapter to be willful, or if within the period prescribed by the Commissioner in the notice required by 4 CMC § 7619, the insurer, rating or advisory organization does not make such changes as may be necessary to correct the noncompliance specified by the Commissioner or establish to the satisfaction of the Commissioner that such specified noncompliance does not exist, then the Commissioner may hold a hearing in connection therewith, provided that within a reasonable period of time which shall be not less than 10 business days before the date of such hearing, the Commissioner shall mail written notice to the insurer, rating or advisory organization involved specifying the matters to be considered at such hearing.

§ 7608. Records requirements; inspection; statistics.

(1) Each insurer, rating organization or advisory organization shall maintain reasonable records, of the type and kind reasonably adapted to its method of operation, of its experience or the experience of its members and of the data, statistics or information collected or used by it in connection with the rates, rating plans, rating systems, underwriting rules, policy or bond forms, surveys or inspections made or used by it.

(2) The maintenance of such records in the office of a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating plans, rating systems or underwriting rules of such organization.

(3) Such records shall be available to the Commissioner for examination and inspection at any time in order to determine whether the filings made pursuant to 4 CMC § 7605 comply with this chapter.

(4) Each insurer shall maintain statistics under statistical plans compatible with the rating plans used by the insurer. An insurer may report its statistics through a recognized agency or advisory organization.

§ 7609. Data must include certain information.

The data collected and maintained by each insurer, rating organization or advisory organization pursuant to 4 CMC § 7610 shall be in sufficient detail to demonstrate the statistical significance of differences or correlations relevant to the rating plan definitions and rate differentials.

Section 5. Repealer and Enactment. 4 CMC §7201 (c) is hereby repealed and **"§ 7610. Examining Rating Systems of Insurers; Costs."** is enacted as follows.

(1) The Commissioner may make or cause to be made an examination of every insurer transacting any class of insurance to which the provisions of this division are applicable to ascertain whether such insurer and every rate and rating system used by it for every such class of insurance complies with the requirements and standards of this division.

(2) The Insurance Commissioner may examine the affairs, transactions, accounts, records, documents, and assets of each authorized insurer as often as the commissioner deems prudent.

(3) The Commissioner shall examine fully each insurer applying for authority to do business in the Commonwealth.

(4) The officers, managers, agents and employees of any insurer, under examination, may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation, together with all data, statistics and information of every kind and character collected or considered by such insurer in the conduct of the operations to which such examination relates.

(5) The reasonable cost of any examination authorized by this section shall be paid by the organization or insurer to be examined including the costs of the examiner himself together will all incidentals to the examination including actual necessary transportation and traveling expenses.

§ 7611. Collusive ratings prohibited; liability for damages.

In the event any insurer shall in collusion with any other insurer conspire to fix, set or adhere to insurance rates except as expressly sanctioned by the Insurance Code, such insurer shall be liable to any person damaged thereby for an amount equal to three times the amount of such damage together with the damaged party's attorney fees.

§ 7612. Authority for cooperative ratings and systems.

Subject to and in compliance with the provisions of this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data or carrying on of research.

§ 7613. Unauthorized adherence to rates, rating systems.

(1) Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules or policy or bond forms of such organizations, either consistently or intermittently, but, except as provided in 4 CMC §§ 7615, 7611, 7616, 7625, 7626, shall not agree with each other or rating organizations or others to adhere thereto. The fact that two or more authorized insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization, or the underwriting rules or policy or bond forms prepared by a rating or advisory organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and may be used only for the purpose of

supplementing or explaining any competent evidence of the existence of any such agreement.

§ 7614. Preparation of rates, rating systems and other administrative matters by insurers under common ownership.

With respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research, two or more admitted insurers having a common ownership or operating in the Commonwealth under common management or control are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer, and to the extent that such matters relate to co-surety bonds, two or more admitted insurers executing such bonds are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer.

§ 7615. Method of rate making; factors considered; rules.

The following standards shall apply to the making and use of rates:

(1) Rates shall not be excessive, inadequate or unfairly discriminatory.

(2) As to all classes of insurance, other than workers' compensation and title insurance:

(a) No rate shall be held to be excessive unless:

(A) Such rate is unreasonably high for the insurance provided; and

(B) A reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

(b) No rate shall be held inadequate unless such rate is unreasonably low for the insurance provided and:

(A) Use or continued use of such rate endangers the solvency of the insurer; or

(B) The use of such rate by the insurer has, or if continued will have, the effect of destroying competition or creating a monopoly.

(3) Rates for each classification of coverage shall be based on the claims experience of insurers within the Commonwealth on that classification of coverage unless that experience provides an insufficient base for actuarially sound rates.

(4) Due consideration shall be given to past and prospective loss experience within the Commonwealth, to the hazards of conflagration and catastrophe, to a reasonable margin for profit and to contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses specially applicable to the Commonwealth, and to all other relevant factors, including judgment factors deemed relevant, within the Commonwealth.

(5) The systems of expense provisions included in the rates for use by any 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 any such insurer or group of insurers with respect to any class of insurance, or with respect to any

subdivision or combination thereof for which subdivision or combination separate expenses are applicable.

(6) The Commissioner shall adopt rules to carry out the provisions of this section and may by rule specify further procedures relating to rates and ratemaking not inconsistent with this chapter.

(7) A rate increase based solely upon an insured's attaining or exceeding 65 years of age shall be presumed to be unfairly discriminatory unless the increase is clearly based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(8) Notwithstanding any other provision of this chapter, health insurance premium rates in the non-grandfathered individual and small group market may vary only by coverage tier, number of dependents, geographic region, age, and tobacco use; preexisting conditions exclusions and rates based solely on health status shall be presumed to be unfairly discriminatory.

(9) Notwithstanding any other provision of this chapter, annual lifetime coverage limits shall not be allowed under any contract executed under individual and small group plans for the provision of health insurance in the Commonwealth with the exception of grandfathered individual policies and benefits which are not Essential Health Benefits as defined in 45 CFR §156.20.

(10) Notwithstanding any other provision of this chapter, every insurer shall report Medical Loss Ratios, and spend a minimum of 85 percent of health insurance premiums for large group coverage, and 80 percent for individual and small group coverage, on medical care, rather than other items such as administrative and overhead costs; An issuer who fails to comply with this subsection shall issue rebates.

§ 7616. Agreements among insurers for assignment of risks; rate modifications.

Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to such insurance but who are unable to procure such insurance through ordinary methods. Such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the Commissioner.

§ 7617. Suspension or modification of filing requirement; Rules; Excess rates for Specific Risks.

(1) Under such rules and regulations as the Commissioner, by written order, may suspend or modify the requirement of filing as to any class of insurance, or subdivision or combination thereof, or as to classes of risks, for which the rates cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The Commissioner may make such examination as the Commissioner deems advisable to ascertain whether any rates affected by such order meet the standards set forth in 4 CMC § 7605.

(2) Upon the written application of the insured, stating the reasons therefor, filed with the Commissioner and approved by the Commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

§ 7618. Contracts to comply with effective filings; exception.

(1) No insurer shall make or issue a policy except in accordance with the filings which are in effect for the insurer as provided in this chapter.

§ 7619. Disapproval of filings by Commissioner; Noncompliance with Chapter.

(1) If within the waiting period or the extension thereof, if any, as provided in 4 CMC § 7617(2), the Commissioner finds that a filing does not meet the requirements of this chapter, the Commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the Commissioner finds such filing fails to meet the requirements and stating that such filing shall not become effective.

(2) If the Commissioner has reason to believe that an insurer or rating or advisory organization is not complying with the requirements and standards of this chapter other than the requirements and standards dealing with rates, rating plans or rating systems, unless the Commissioner has reason to believe such noncompliance is willful, the Commissioner shall give notice in writing to such insurer or rating or advisory organization stating in what manner such noncompliance is alleged to exist and specifying a reasonable time, not less than 10 business days after the date of mailing, in which such noncompliance may be corrected.

§ 7620. Initiation of proceedings by aggrieved person to determine lawfulness of filings; hearing.

(1) Any person aggrieved with respect to any filing that is in effect, other than the insurer or rating organization that made the filing, may make written application to the Commissioner for a hearing on the filing. The application shall specify the grounds to be relied upon by the applicant.

(2) If the Commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds are established, and that such

grounds otherwise justify holding such a hearing, the Commissioner shall do one of the following:

(a) Conduct an examination for the limited purpose of adjudging the aggrieved person's complaint under 4 CMC § 7610 (1). The Commissioner shall not act under this paragraph if the filing concerns a rate, rating plan or rating system subject to 4 CMC § 7617 (1).

(b) Hold a hearing, within 30 calendar days after receipt of such application, at a place designated by the Commissioner and upon not less than 10 business days' written notice to the applicant and to the insurer or rating organization that made the filing.

§ 7621. Hearing and order procedure.

Conduct of the hearing, issuance of orders pursuant thereto and judicial review of orders shall be as provided in 1 CMC § 9101 *et seq.*

RATING ORGANIZATIONS

§ 7622. Application for license by rating organization.

No rating organization shall conduct its operations in the Commonwealth without first filing with the Commissioner a written application for a license as a rating organization for such classes of insurance, or subdivision or class of risk or a part or combination thereof as are specified in its application and shall file therewith:

(1) A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules and regulations governing the conduct of its business; and

(2) A list of its members and subscribers; and

(3) The name and address of a resident of the Commonwealth upon whom notices or orders of the Commissioner or process affecting such rating organization may be served; and

(4) A statement of its qualifications as a rating organization.

§ 7623. Licensing rating organizations generally; Rules; Revocation and Suspension; fees.

(1) If the Commissioner finds that the applicant represents a credible statistical base, is competent, trustworthy and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws, rules and regulations governing the conduct of its business conform to the requirements of law, the Commissioner shall issue a license specifying the classes of insurance, or subdivision or class of risk or a part or combination thereof for which the applicant is authorized to act as a rating organization. Each application shall be granted or denied in whole or in part by the Commissioner within 60 days of the date of its filing with the Commissioner.

(2) A license issued pursuant to this section shall remain in effect for three years unless suspended or revoked by the Commissioner. The license fee shall be as established by the Commissioner. A license issued pursuant to this section may be suspended or revoked by the Commissioner, after a hearing upon notice, in the event the rating organization ceases to meet the requirements of this section.

(3) Each rating organization shall notify the Commissioner promptly of every change regarding matters listed in 4 CMC § 7622(1), (2), and (3).

§ 7624. Rating organization to accept insurers as subscribers; Rules of Organization to be Reasonable; Review of applications for Subscribership and of Reasonableness of Rules.

(1) Subject to rules and regulations which have been approved by the Commissioner as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any class of insurance, subdivision or class of risk or a part or combination thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers.

(2) Each rating organization shall furnish its rating services without discrimination to its members and subscribers. Any rating organization may subscribe to or purchase actuarial, technical or other services, and such services shall be available to all members and subscribers without discrimination.

(3) The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, at the request of any subscriber or any such insurer, shall be reviewed by the Commissioner at a hearing held at a place designated by the Commissioner and upon at least 10 days' written notice to such rating organization and to such subscriber or insurer. If the Commissioner finds that such rule or regulation is unreasonable in its application to subscribers, the Commissioner shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within 30 days after it was made, the insurer may request a review by the Commissioner as if the application had been rejected. If the Commissioner finds that the insurer has been refused admittance

to the rating organization as a subscriber without justification, the Commissioner shall order the rating organization to admit the insurer as a subscriber. If the Commissioner finds that the action of the rating organization was justified, the Commissioner shall make an order affirming its action.

(4) No rating organization shall adopt any rule, the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

§ 7625. Cooperative activities among rating organizations and insurers.

(1) Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter hereby is authorized, provided the filings resulting from such cooperation are subject to and consistent with those sections which are applicable to filings generally.

(2) The Commissioner may review such cooperative activities and practices and if, after a hearing, the Commissioner finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, the Commissioner may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with those sections and requiring the discontinuance of such activity or practice.

§ 7626. Regulation of joint underwriting and joint reinsurance.

No group, association or other organization of insurers which engages in joint underwriting or joint reinsurance shall engage in any activity which is unfair, unreasonable or otherwise inconsistent with the provisions of this chapter.

§ 7627. Insured entitled to rate information; remedies of aggrieved persons.

(1) Every rating organization and every insurer which makes its own rates, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, shall furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

(2) Every rating organization and every insurer which makes its own rates shall provide within the Commonwealth reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by the authorized representative, on written request by the person or authorized representative to review the manner in which such rating system has been applied in connection with the insurance afforded the person. If the rating organization or insurer fails to grant or reject such request within 30 days after it is made, the applicant may proceed in the same manner as if the application had been rejected.

(3) Any party affected by the action of such rating organization or such insurer on such request, within 30 days after written notice of such action, may appeal to the Commissioner, who, after a hearing held at a place designated by the Commissioner upon not less than 10 days' written notice to the appellant and to such rating organization or insurer, shall affirm or reverse such action.

§ 7628. Advisory organizations; registration; jurisdiction of Commissioner to restrict unfair practices.

(1) Every advisory organization shall file with the Commissioner:

(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation and of its bylaws, rules and regulations governing its activities; and

(b) A list of its members.

(c) The name and address of a resident of the Commonwealth upon whom notices may be served; and

(d) An agreement that the Commissioner may examine such advisory organization in accordance with 4 CMC § 7633; and

(2) Any insurer which makes its own filings or any rating organization may support its filings by statistics or adopt rate-making recommendations furnished to it by an advisory organization which has complied with this section. If, after a hearing, the Commissioner finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with this chapter, the Commissioner may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with this chapter. If the act or practice thus specified is not modified to comply with such order, the Commissioner may issue an order requiring any insurer which makes its own filings or any rating organization to discontinue the use of the statistics or rate-making recommendations furnished to it by such advisory organization.

§ 7629. Filing of health insurance premium rates; rules.

(1) Every insurer shall file with the Commissioner all schedules and tables of premium rates for health insurance to be used on risks in the Commonwealth, and shall file any amendments to or corrections of such schedules and tables. Premium

rates are subject to approval, disapproval or withdrawal of approval by the Commissioner as provided by 4 CMC § 7605.

(2) Except as provided in subsection (3) of this section, a rate filing by an insurer for any of the following health benefit plans shall be available for public inspection at any reasonable time after submission of the filing to the Commissioner:

(a) Health benefit plans for small employers.

(b) Portability health benefit plans.

(c) Individual health benefit plans.

(3) The Commissioner, after conducting an actuarial review of the rate filing, may approve a proposed premium rate for a health benefit plan for small employers or for an individual health benefit plan if, in the Commissioner's discretion, the proposed rates are:

(a) Actuarially sound;

(b) Reasonable and not excessive, inadequate or unfairly discriminatory; and

(c) Based upon reasonable administrative expenses, in accordance with 4 CMC § 7615 (10).

(4) In order to determine whether the proposed premium rates for a health benefit plan for small employers or for an individual health benefit plan are reasonable and not excessive, inadequate or unfairly discriminatory, the Commissioner may consider:

(a) The insurer's financial position, including but not limited to profitability, surplus, reserves and investment savings.

(b) Historical and projected administrative costs and medical and hospital expenses.

(c) Historical and projected loss ratio between the amounts spent on medical services and earned premiums.

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

(e) Changes to covered benefits or health benefit plan design.

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

(g) Whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future.

(h) Any public comments received under 4 CMC § 7630 pertaining to the standards set forth in subsection (4) of this section and this subsection.

(5) With the written consent of the insurer, the Commissioner may modify a schedule or table of premium rates filed in accordance with subsection (1) of this section.

(6) The requirements of this section do not supersede other provisions of law that require insurers, health care service contractors or multiple employer welfare arrangements providing health insurance to file schedules or tables of premium rates or proposed premium rates with the Commissioner or to seek the Commissioner's approval of rates or changes to rates.

(7) The Commissioner may by rule:

(a) Specify all information an insurer must submit as part of a rate filing under this section; and

(b) Identify the information submitted that will be exempt from disclosure under this section because the information constitutes a trade secret and would, if disclosed, harm competition.

§ 7630. Public comment on proposed rates for health insurance.

(1) When an insurer files a schedule or table of premium rates for individual, portability or small employer health insurance under 4 CMC § 7629, the Commissioner shall open a 30-day public comment period on the rate filing that begins on the date the insurer files the schedule or table of premium rates. The Commissioner shall post all comments to the website of the CNMI Department of Commerce without delay. The Commissioner may reduce the 30-day public comment period to a period of no less than 10 days if he deems it appropriate under the totality of the circumstances.

(2) The Commissioner shall give written notice to an insurer approving or disapproving a rate filing or, with the written consent of the insurer, modifying a rate filing submitted under 4 CMC § 7629 no later than 10 business days after the close of the public comment period. The notice shall comply with the requirements of 1 CMC § 9101 *et seq.*

§ 7631. Rate filing to include statement of administrative expenses; rules.

An insurer licensed by the Commissioner shall include in any rate filing under 4 CMC § 7629 with respect to individual and small group health insurance policies a statement of administrative expenses in the form and manner prescribed by the department by rule. The statement must include, but is not limited to:

(1) A statement of administrative expenses on a per member per month basis; and

(2) An explanation of the basis for any proposed premium rate increases or decreases.

§ 7632. Insurer examinations.

(1) The Commissioner shall examine every authorized insurer, including an audit of the financial affairs of such insurer, as often as the Commissioner determines an examination to be necessary but at least once each five years. An examination shall be conducted for the purpose of determining the financial condition of the insurer, its ability to fulfill its obligations and its manner of fulfillment, the nature of its operations and its compliance with the Insurance Code.

(2) Instead of conducting an examination of an authorized foreign or alien insurer, the Commissioner may accept an examination report on the insurer that is prepared by the insurance department for the state of domicile or state of entry of the insurer if:

(a) At the time of the examination the insurance department of the state was accredited under the Financial Regulation Standards and Accreditation Program or successor program of the National Association of Insurance Commissioners; or

(b) The examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited insurance department and who, after a review of the examination work papers and report, state under

oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(3) Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the Commissioner.

(4) Any person examined under this section shall pay to the Commissioner the just and legitimate costs of the examination as determined by the Commissioner, including actual necessary transportation, traveling expenses and assessments. the Commissioner shall maintain the right and duty to issue an RFP for an Examiner, whose fees and cost will be paid for by the carrier being examined; upon procuring the services of an Examiner, each carrier to be examined, notwithstanding Public Law 17-28 and 4 CMC § 7508, shall first make deposit of a $5,000 Examiner Fee (non-refundable, payable to the Treasurer, and is to be deposited in Examiner Service Fee Fund to be expended to cover the fees and costs related to the carrier being examined) – separate from the normal fees and cost to be assessed by the Examiner for cost of Examiner's service.

§ 7633. Examination of rating, advisory and other organizations; payment of costs; acceptance of report from another state.

(1) The Commissioner may make or cause to be made an examination of each rating and advisory organization complying with and referred to in 4 CMC § 7622 or 4 CMC § 7628 and of each organization referred to in 4 CMC § 7626 as often as the Commissioner deems expedient.

(2) The reasonable costs of any such examination shall be paid by the organization examined, upon presentation to it of a detailed account of such costs.

The officers, manager, agents and employees of any such organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its methods of operation.

(3) All such examinations shall be conducted as provided in 4 CMC § 7632.

(4) In lieu of any such examination the Commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of such state.

§ 7634. Interchange of data; rules; promoting uniformity of rating laws.

(1) Reasonable rules and plans may be promulgated by the Commissioner for the interchange of data necessary for the application of rating plans.

(2) In order to further uniform administration of rate regulatory laws, the Commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult and cooperate with them with respect to rate making and the application of rating systems.

§ 7635. Withholding or giving false information prohibited.

No person shall willfully withhold information from or knowingly give false or misleading information to the Commissioner, to any statistical agency designated by the Commissioner, to any rating organization, or to any insurer, which will affect the rates or premiums chargeable under this chapter.

§ 7636. Procedure for suspension of rating organization license.

The Commissioner may suspend the license of any rating organization which fails to comply with an order of the Commissioner within the time limited by such order, or any extension thereof which the Commissioner may grant. The

Commissioner shall not suspend the license of any rating organization for failure to comply with an order until the time prescribed for an appeal therefrom has expired or, if an appeal has been taken, until such order has been affirmed. The Commissioner may determine when a suspension of license shall become effective, and it shall remain in effect for the period fixed by the Commissioner, unless the Commissioner modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded or reversed.

§7637. Rating organization membership.

(1) Nothing contained in this chapter shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

EXTENDED POWERS OF THE CNMI INSURANCE COMMISSIONER

§7638. Extended Powers of the CNMI Insurance Commissioner.

The CNMI Insurance Commissioner shall have the authority expressly conferred to the state by the Affordable Care Act [42 U.S.C. 300gg-22 (b)] any public law or federal legislation related to insurance as amended or supplemented from time to time, this division, and such other authority as may be reasonably implied from the provisions of the Affordable Care Act, unless expressly provided otherwise by law. The powers and duties of the commissioner include, but are not limited to:

(a) Administering and enforcing the provisions of this division;

(b) Promulgating such rules and regulations as may be necessary for effectuating any provision of this division and of the Patient Protection and Affordable Care Act and any other applicable public or federal legislation, as amended or supplemented from time to time.

(c) Conducting examinations and investigations to determine whether any person has violated any provision of this division or regulations promulgated pursuant to it and securing information useful in lawful administration of any such provisions or regulations;

(d) Issuing orders pursuant to 4 CMC 7106.

Section 6. Severability. If any provisions of this Act or the application of any such provision to any person or circumstance should be held invalid by a court of competent jurisdiction, the remainder of this Act or the application of its provisions to persons or circumstances other than those to which it is held invalid shall not be affected thereby.

Section 7. Savings Clause. This Act and any repealer contained herein shall not be construed as affecting any existing right acquired under contract or acquired under statutes repealed or under any rule, regulation, or order adopted under the statutes. Repealers contained in this Act shall not affect any proceeding instituted under or pursuant to prior law. The enactment of the Act shall not have the effect of terminating, or in any way modifying, any liability, civil or criminal, which shall already be in existence on the date this Act becomes effective.

Section 8. Effective Date. This Act shall take effect upon its approval by the Governor, or becoming law without such approval.

Attested to by: _____
Linda B. Muña, House Clerk

Certified by: _____
SPEAKER JOSEPH P. DELEON GUERRERO
House of Representatives
18th Northern Marianas Commonwealth Legislature

APPROVED this 14TH day of FEBRUARY, 2014

_____
ELOY S. INOS
Governor
Commonwealth of the Northern Mariana Islands