

# HB0029



## 96TH GENERAL ASSEMBLY

### State of Illinois

2009 and 2010

HB0029

Introduced 1/14/2009, by Rep. Mary E. Flowers

#### SYNOPSIS AS INTRODUCED:

New Act

Creates the Premium and Loss Data Reporting Act. Provides that all insurers subject to the Act shall report to the Director of the Division of Insurance accurate and complete information for each accident and health coverage type requested. Sets forth the specific types of accident and health coverage requested for reporting. Imposes conditions on any rulemaking authority.

LRB096 03243 RPM 13260 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning insurance.

2 **Be it enacted by the People of the State of Illinois,**  
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the  
5 Premium and Loss Data Reporting Act.

6 Section 5. Application. This Act shall apply to: (i) all  
7 insurers authorized to transact the class of business set forth  
8 in subsection (b) of Class 1 and subsection (a) of Class 2 of  
9 Section 4 of the Illinois Insurance Code; and (ii) all health  
10 plans authorized under the Health Maintenance Organization  
11 Act.

12 Section 10. Definitions. In this Act:

13 "Accident only" means an insurance contract that provides  
14 coverage, alone or in combination, for death, dismemberment,  
15 disability, or hospital and medical care caused by or  
16 necessitated as a result of accident or specified kinds of  
17 accidents.

18 "Accidental death and dismemberment" means an insurance  
19 contract that pays a stated benefit in the event of death or  
20 dismemberment caused by accident or specified kinds of  
21 accidents.

22 "Administrative services only" means a contractual

1 arrangement utilized by a self-funded employer, whereby a  
2 separate company processes claims and provides other  
3 administrative services pertinent to the employer's health  
4 care plans. The fees associated with these services are  
5 included in this Act.

6 "Annual statement" means that statement required by  
7 Section 136 of the Illinois Insurance Code to be filed annually  
8 by the company with the Director.

9 "Blanket accident/sickness" means a health insurance  
10 contract that covers all of a class of persons not individually  
11 identified in the contract.

12 "Champus/Tricare supplement" means Civilian Health and  
13 Medical Program of the Uniformed Services (Champus).

14 "Champus/Tricare supplement" also includes a private health  
15 plan that provides beneficiaries eligible for Champus with  
16 supplemental health care coverage.

17 "Code" means the Illinois Insurance Code.

18 "Covered dependents at end of reporting quarter" means the  
19 total number of individuals covered by the primary insured's  
20 plan who receive coverage due to his or her dependent  
21 relationship to the primary insured, as of the final day of the  
22 reporting quarter.

23 "Dental" means insurance that provides benefits for  
24 routine dental examinations, preventive dental work, and  
25 dental procedures needed to treat tooth decay and diseases of  
26 the teeth and jaw.

1 "Direct premiums earned for new and renewal business" means  
2 the insurers direct premium earned from the first through the  
3 final day of the reporting quarter, and includes only premium  
4 specific to covered Illinois residents.

5 "Director" means the Director of the Division of Insurance  
6 of the Illinois Department of Financial and Professional  
7 Regulation.

8 "Direct losses incurred" means direct losses incurred from  
9 the first through the final day of the reporting quarter and  
10 includes only premium specific to covered Illinois residents.

11 "Direct premiums earned for new business only" means the  
12 direct premium earned for new business only from the first  
13 through the final day of the reporting and includes only  
14 premium specific to covered Illinois residents.

15 "Disability income" means a policy designed to compensate  
16 insureds for a portion of the income they lose because of a  
17 disabling injury or illness. "Disability income" includes  
18 business overhead expense, short-term, long-term, and combined  
19 short-term and long-term coverage.

20 "Employers, if group coverage, at end of reporting quarter"  
21 means for all group categories, the number of employers who  
22 covered Illinois resident employees, as of the final day of the  
23 reporting quarter.

24 "Excess/stop loss" means the type of insurance may be  
25 extended to either a health plan or self-insured employer plan.  
26 Its purpose is to insure against the risk that any one claim

1 will exceed a specific dollar amount or that an entire plan's  
2 losses will exceed a specific amount. "Excess/stop loss"  
3 includes accident and sickness, managed care, provider, and  
4 self-funded health plan coverage.

5 "FEHBP" means health, vision, and dental coverage provided  
6 pursuant to the Federal Employees Health Benefits Program.

7 "Hospital indemnity" means an insurance contract that pays  
8 a fixed dollar amount without regard to the actual expense  
9 incurred for each day the covered person is confined to the  
10 hospital as a result of injury, sickness, or medical condition.

11 "Hospital surgical" means an insurance contract that  
12 provides coverage to or reimburses the covered person for  
13 hospital, surgical, or medical expense incurred as a result of  
14 injury, sickness, or medical condition.

15 "In-state" groups means Illinois groups with group master  
16 contracts issued to a trust situated in Illinois.

17 "Insurer" means an insurance company authorized to  
18 transact the class of business as set forth in subsection (b)  
19 of Class 1 and subsection (a) of Class 2 of Section 4 of the  
20 Insurance Code, as well as health care plans authorized under  
21 the Health Maintenance Organization Act.

22 "Limited benefit" means the plan: (1) pays benefits for the  
23 diagnosis and treatment of a specifically named disease or  
24 diseases. Benefits can be paid as expense incurred, per diem,  
25 or a principle sum; (2) provides a daily benefit for  
26 confinement in a qualified intensive care unit of a certified

1 hospital. Benefits are specific to services delivered by the  
2 staff of a hospital intensive care unit. Benefits are not to  
3 exceed a stated dollar amount per day; and (3) provides  
4 benefits for services incurred as a result of human or  
5 non-human organ transplant. Benefits are specific to the  
6 delivery of care associated with the covered organ or tissue  
7 transplant. Benefits are not to exceed a stated dollar amount  
8 per day. "Limited benefit" includes coverage for specified  
9 disease, critical illness, dread disease, dread disease-cancer  
10 only, HIV indemnity, intensive care, and organ and tissue  
11 transplant.

12 "Long-term care" means coverage that includes long-term  
13 care, nursing home, and home care contracts that provide  
14 reimbursement for these services.

15 "Loss-ratio" means the insurer's ratio of direct losses  
16 incurred to direct premiums earned for new and renewal business  
17 from the first through the final day of the reporting quarter  
18 and includes only premium specific to covered Illinois  
19 residents.

20 "Major medical" means a hospital, surgical, or medical  
21 expense contract that is designed to cover expenses of serious  
22 illness, chronic care, or hospitalization. "Major medical"  
23 does not include hospital indemnity, accidental death and  
24 dismemberment, workers' compensation, credit accident and  
25 health, short-term accident and health, accident only,  
26 long-term care, Medicare supplement, pre-paid products,

1 student blanket, stand-alone policies, dental-only,  
2 vision-only, prescription drug benefits, disability income,  
3 specified disease, or similar supplementary benefits; coverage  
4 issued as a supplement to liability insurance; workers'  
5 compensation or similar insurance; or automobile  
6 medical-payment insurance.

7 "Medicare supplement" means a group or individual policy of  
8 accident or health insurance or a subscriber contract of  
9 hospital and medical service associations, other than a policy  
10 issued pursuant to a contract under Section 1876 of the federal  
11 Social Security Act or a policy issued pursuant to a  
12 demonstration project specified in Section 1395ss(g)(1) of the  
13 federal Social Security Act, which is advertised, marketed, or  
14 designed primarily as a supplement to reimbursements under  
15 Medicare for the hospital, medical, or surgical expenses of  
16 persons eligible for Medicare.

17 "Member months at end of reporting quarter" means the total  
18 number of months that each member or policyholder is provided  
19 coverage from the first day through the final day of the  
20 reporting quarter.

21 "Out-of-state" groups means groups that have master  
22 contracts issued to a trust situated outside of Illinois.

23 "Primary insureds at end of reporting quarter" means the  
24 total number of resident individual policyholders or resident  
25 group employee or member certificate holders, as of the final  
26 day of the reporting quarter.

1 "Quarter" means the following quarter years:

2 (1) October 1 through December 31;

3 (2) January 1 through March 31;

4 (3) April 1 through June 30; and

5 (4) July 1 through September 30.

6 "Short-term care" means coverage that includes medical and  
7 other services to insureds who need constant care in their own  
8 home or in a nursing facility for periods of less than one  
9 year. "Short-term care" includes home health care, nursing  
10 home, and adult day care.

11 "Student" means a health insurance contract that covers a  
12 class of students not individually identified in the contract.

13 "Travel" means limited benefit expense policies and  
14 benefits for loss incurred while traveling generally outside a  
15 100-mile radius of the US borders, subject to State  
16 limitations.

17 "Vision" means limited benefit expense policies that  
18 provide benefits for eye care and eye care accessories and may  
19 include surgical benefits for injury or sickness associated  
20 with the eye.

21 "Wellness program participation premium discounts" means  
22 the dollar value of plan-administered premium discounts,  
23 rebates of premium or contribution, or waivers of all or part  
24 of a surcharge or cost-sharing mechanism, such as deductibles,  
25 co-pays, or coinsurance, provided to individual insureds for  
26 their participation in a bona fide wellness program, from the



1 first day through the final day of the reporting quarter. To  
2 qualify as a bona fide wellness program, the program must:

3 (1) offer a limited reward or discount;

4 (2) be reasonably designed to promote good health and  
5 disease prevention;

6 (3) allow policyholders to qualify for the program's  
7 reward at least once per year; and

8 (4) be available to all similarly situated employees,  
9 with reasonable alternative standards for those for which  
10 the general standard is unreasonably difficult or  
11 medically inadvisable.

12 Section 15. Reports.

13 (a) All insurers subject to this Act shall, beginning at  
14 the current quarter and year, and continuing through all  
15 subsequent quarters and years, report accurate and complete  
16 information for each accident and health coverage type  
17 requested to the Director. The following reports are requested:

18 (1) on the final day of each quarter, file a quarterly  
19 report for the prior quarter (not for the quarter on which  
20 the due date falls) regarding information on health benefit  
21 plans currently in force in this State; and

22 (2) on or before April 1 for the preceding year ending  
23 December 31, file an annual report for the prior year (not  
24 for the year on which the due date falls) regarding  
25 information on health benefit plans currently at force in

1           this State.

2           In addition, insurers with comprehensive major medical  
3           business currently in force in this State that covers more than  
4           500 unduplicated persons (primary insureds plus dependents)  
5           shall, on or before April 1 for the preceding year ending  
6           December 31, file a completed annual supplemental report with  
7           premium and loss data on health benefit plans currently in  
8           force in this State.

9           Information reported under this Section must be reported in  
10          an aggregate format. This Section does not allow for the  
11          collection of any information that allows for the  
12          identification of an individual provider.

13          (b) The following comprehensive major medical, major  
14          medical, and other hospital-surgical coverage types are  
15          requested in this Act:

- 16                 (1) major medical;
- 17                 (2) hospital surgical;
- 18                 (3) in-state groups;
- 19                 (4) out-of-state groups;
- 20                 (5) administrative services only;
- 21                 (6) accident only;
- 22                 (7) accidental death and dismemberment;
- 23                 (8) blanket accident/sickness;
- 24                 (9) dental;
- 25                 (10) disability income (includes business overhead  
26                 expense, short-term, and long-term);

- 1 (11) combined short-term and long-term;
  - 2 (12) excess/stop loss (includes accident and sickness,  
3 managed care, provider, and self-funded health plan);
  - 4 (13) FEHBP coverage provided pursuant to the federal  
5 employees health benefits program.
  - 6 (14) limited benefit (includes specified disease,  
7 critical illness, dread disease, dread disease-cancer  
8 only, HIV indemnity, intensive care, and organ and tissue  
9 transplant);
  - 10 (15) short-term care (includes home health care,  
11 nursing home, and adult day care) Medicare supplement;
  - 12 (16) Champus/Tricare supplement;
  - 13 (17) travel;
  - 14 (18) vision; and
  - 15 (19) other accident and health care coverage not  
16 specifically described.
- 17 (c) The following information is requested for each  
18 accident and coverage type requested:
- 19 (1) direct premiums earned for new and renewal  
20 business;
  - 21 (2) direct losses incurred;
  - 22 (3) direct premiums earned for new business;
  - 23 (4) loss-ratio;
  - 24 (5) employers, if group coverage, at end of reporting  
25 quarter;
  - 26 (6) primary insureds at end of reporting quarter;

- 1           (7) covered dependents at end of reporting quarter;  
2           (8) member months at end of reporting quarter; and  
3           (9) wellness program participation premium discounts.

4           Section 20. Rulemaking conditions. Rulemaking authority to  
5           implement this Act, if any, is conditioned on the rules being  
6           adopted in accordance with all provisions of the Illinois  
7           Administrative Procedure Act and all rules and procedures of  
8           the Joint Committee on Administrative Rules; any purported rule  
9           not so adopted, for whatever reason, is unauthorized.