

HB5030



96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB5030

Introduced 1/25/2010, 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 Department 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.

LRB096 16760 RPM 32055 b

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 Department of
6 Insurance.

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

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

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

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

23 "Excess/stop loss" means the type of insurance may be
24 extended to either a health plan or self-insured employer plan.
25 Its purpose is to insure against the risk that any one claim
26 will exceed a specific dollar amount or that an entire plan's

1 losses will exceed a specific amount. "Excess/stop loss"
2 includes accident and sickness, managed care, provider, and
3 self-funded health plan coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 "Quarter" means the following quarter years:

- 1 (1) October 1 through December 31;
- 2 (2) January 1 through March 31;
- 3 (3) April 1 through June 30; and
- 4 (4) July 1 through September 30.

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

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

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

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

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

1 qualify as a bona fide wellness program, the program must:

2 (1) offer a limited reward or discount;

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

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

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

11 Section 15. Reports.

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

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

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

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

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

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

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

1 (12) excess/stop loss (includes accident and sickness,
2 managed care, provider, and self-funded health plan);

3 (13) FEHBP coverage provided pursuant to the federal
4 employees health benefits program.

5 (14) limited benefit (includes specified disease,
6 critical illness, dread disease, dread disease-cancer
7 only, HIV indemnity, intensive care, and organ and tissue
8 transplant);

9 (15) short-term care (includes home health care,
10 nursing home, and adult day care) Medicare supplement;

11 (16) Champus/Tricare supplement;

12 (17) travel;

13 (18) vision; and

14 (19) other accident and health care coverage not
15 specifically described.

16 (c) The following information is requested for each
17 accident and coverage type requested:

18 (1) direct premiums earned for new and renewal
19 business;

20 (2) direct losses incurred;

21 (3) direct premiums earned for new business;

22 (4) loss-ratio;

23 (5) employers, if group coverage, at end of reporting
24 quarter;

25 (6) primary insureds at end of reporting quarter;

26 (7) covered dependents at end of reporting quarter;

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