HB0280

LRB09706640RPM46726b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB0280

Introduced 01/28/11, 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.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

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

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

Section 10. Definitions. In this Act:

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

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

"Administrative services only" means a contractual

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

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

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

"Champus/Tricare supplement" means Civilian Health and Medical Program of the Uniformed Services (Champus). "Champus/Tricare supplement" also includes a private health plan that provides beneficiaries eligible for Champus with supplemental health care coverage.

"Code" means the Illinois Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Quarter" means the following quarter years:

(1) October 1 through December 31;

(2) January 1 through March 31;

(3) April 1 through June 30; and

(4) July 1 through September 30.

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

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

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

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

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

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

(1) offer a limited reward or discount;

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

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

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

Section 15. Reports.

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

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

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

this State.

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

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

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

(1) major medical;

(2) hospital surgical;

(3) in-state groups;

(4) out-of-state groups;

(5) administrative services only;

(6) accident only;

(7) accidental death and dismemberment;

(8) blanket accident/sickness;

(9) dental;

(10) disability income (includes business overhead expense, short-term, and long-term);

(11) combined short-term and long-term;

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

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

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

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

(16) Champus/Tricare supplement;

(17) travel;

(18) vision; and

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

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

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

(2) direct losses incurred;

(3) direct premiums earned for new business;

(4) loss-ratio;

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

(6) primary insureds at end of reporting quarter;

(7) covered dependents at end of reporting quarter;

(8) member months at end of reporting quarter; and

(9) wellness program participation premium discounts.

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