SENATE BILL No. 171

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-2-22.

Synopsis: Health plan use of premiums. Requires accident and sickness insurers and health maintenance organizations to annually report to the department of insurance concerning use of premiums. Provides for penalties for noncompliance.

Effective: July 1, 2010.

Becker

January 11, 2010, read first time and referred to Committee on Insurance and Financial Institutions.

Introduced

Second Regular Session 116th General Assembly (2010)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2009 Regular and Special Sessions of the General Assembly.

SENATE BILL No. 171

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-2-22 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]:

Chapter 22. Health Plan Use of Premiums

Sec. 1. As used in this chapter, "administrative expenses" includes health plan expenses associated with the following:

(1) Claims processing.

(2) Collection of premiums.

(3) Marketing.

(4) Operations.

(5) Taxes.

(6) General overhead.

(7) Salaries and benefits.

(8) Quality assurance.

(9) Utilization review and management.

(10) Benefit management.

(11) Network contracting and management.

(12) State and federal regulatory compliance.

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 3. As used in this chapter, "covered individual" means an individual entitled to coverage under a health plan policy or contract.

Sec. 4. As used in this chapter, "department" refers to the department of insurance created by IC 27-1-1-1.

Sec. 5. As used in this chapter, "health plan" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(2) A health maintenance organization (as defined in IC 27-13-1-19).

(3) A limited service health maintenance organization (as defined in IC 27-13-34-4).

Sec. 6. (a) As used in this chapter, "medical expense" means the financial obligation of a health plan to pay for direct health care services and products provided to covered individuals.

(b) The term includes health plan payments to health care providers for quality or efficiency enhancing initiatives.

(c) The term does not include:

(1) administrative expenses; or

(2) amounts that are the financial responsibility of a covered individual or a party other than the health plan.

Sec. 7. As used in this chapter, "medical loss ratio" means the quotient of:

(1) actual claim expenses; divided by

(2) earned premiums;

in a calendar year.

Sec. 8. (a) A health plan shall, before March 1 of each year, file with the department a report containing health plan information specific to each of the following categories for the immediately preceding calendar year:

(1) Health coverage provided by the health plan under each of the following:

(A) A policy of accident and sickness insurance using a preferred provider plan under IC 27-8-11.

(B) A policy of accident and sickness insurance not using a preferred provider plan under IC 27-8-11.

(2) Health coverage provided by the health plan under a health maintenance organization contract or limited service

health maintenance organization contract under IC 27-13.

(3) Health coverage provided by the health plan through a point of service product (as defined in IC 27-13-1-26).

(4) Health coverage provided by the health plan under a high deductible health plan (as defined in 26 U.S.C. 220(c)(2) or 26 U.S.C. 223(c)(2)).

(b) The report for each category specified in subsection (a) must include the following information:

(1) A specific breakdown of administrative expenses as follows:

(A) Chief executive officer and executive salaries and benefits.

(B) Commissions and other broker fees.

(C) Utilization and other benefit management expenses.

(D) Advertising and marketing expenses.

(E) Insurance, including the following categories of commercial insurance:

(i) Reinsurance.

(ii) General liability.

(iii) Professional liability.

(iv) Other.

(F) Taxes, including the following:

(i) State and local insurance.

(ii) State premium.

(iii) Payroll.

(iv) Federal and state income.

(v) Real estate.

(vi) Other.

(G) Travel and entertainment expenses.

(H) State and federal lobbying expenses.

(I) Other expenses, including the following:

(i) Nonexecutive salaries, wages, and benefits.

(ii) Rent and real estate expenses.

(iii) Certification, accreditation, board, bureau, and association fees.

(iv) Auditing and actuarial fees.

(v) Collection and bank service charges.

(vi) Occupancy, depreciation, and amortization.

(vii) Cost or depreciation of electronic data processing, claims, and other services.

(viii) Regulatory authority licenses and fees.

(ix) Investment expenses.

(x) Aggregate write-ins for expenses.

(J) Total expenses incurred.

(2) The health plan's name and address.

(3) The health plan's total premium.

(4) The amount of interest earned on premiums.

(5) The amount recovered from uninsured motorist insurance, accident insurance, workers compensation insurance, and other third party liability.

(6) The total medical expense incurred.

(7) The medical loss ratio.

(8) Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the health plan is in compliance with this chapter.

(9) Any other information requested by the commissioner.

Sec. 9. (a) The department shall:

(1) publish and maintain each report filed under section 8 of this chapter on the department's Internet web site; and

(2) make a hard copy of each report filed under section 8 of this chapter available to the public upon request.

(b) A report filed under section 8 of this chapter is a public record.

Sec. 10. The commissioner shall adopt rules under IC 4-22-2 to implement this chapter.

Sec. 11. (a) The commissioner may audit a health plan at any time to determine compliance with this chapter.

(b) If the commissioner, after notice and hearing under IC 4-21.5, determines that a health plan has violated this chapter, the commissioner may impose a civil penalty equal to:

(1) at least one thousand dollars ($1,000); and

(2) not more than ten thousand dollars ($10,000);

for each day of noncompliance.

(c) Civil penalties collected under this section must be deposited in the state general fund.