THE SENATE
TWENTY-FIFTH LEGISLATURE, 2010
STATE OF HAWAII

S.B. NO. 2271 S.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE PREMIUMS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that there is a vital need for employers and consumers to have a clear understanding of how health care premiums are allocated by health insurance companies in this State and particularly how much of their premium dollars are spent on health care services as opposed to administration, profit, or other purposes. Full transparency of how health care insurance premiums are spent will empower health insurance purchasers to make informed decisions and reward companies that minimize administrative waste.

According to the Kaiser Family Foundation, since 1999, health insurance premiums have increased one hundred and thirty one per cent - from $5,791 in 1999 to $13,375 in 2009 - as compared to a general inflation increase of only twenty-eight per cent and an average worker's earnings increase of thirty-eight per cent. Worker premium contributions have similarly increased from $1,619 to $3,354 between 2000 and 2008.

According to the Commonwealth Fund, the fastest rising component of health care spending is administrative overhead. Between 2000 and 2005, the net insurance administrative overhead, including both administrative expenses and insurance industry profits, increased by twelve per cent per year. This increase is 3.4 percentage points faster than the average health expenditure growth of 8.6 per cent.

The legislature further finds that a minimum medical expense threshold is necessary to maximize the value of health insurance premiums and is an important step toward controlling spiraling health care costs, which are due, in part, to the dramatic rise in administrative costs and insurer profits.

The purpose of this Act is to require insurers to annually report how health care premiums are spent with emphasis on administrative and medical expenses and to designate a minimum medical expense threshold.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

MEDICAL DATA CLEARINGHOUSE

§ **-1 Medical data clearinghouse.** There is established a data clearinghouse for the State of Hawaii administratively located within the insurance division of the department of commerce and consumer affairs.

For the purposes of this section:

"Ambulatory surgery center" has the meaning given under 42, Code of Federal Regulations, section 416.2.

"Data clearinghouse" means a public health authority administratively located in the insurance division within the department of commerce and consumer affairs which does all of the following:

(1) Represents health care consumers, insurers, administrators, and health care providers; and

(2) Is formed specifically to do all of the following:

(A) Create a centralized repository for the state with credible and useful data elements for the purposes of quality improvement, health care provider performance comparisons, ready understandability, and consumer decision making; and

(B) Use the information it collects to develop, disseminate, and make electronically available,

unified public reports at least annually on health care quality, safety, and efficiency to foster the cooperation of the separate industry forces and improve the appropriate usage of health care services.

"Data element" means an item of information from a uniform patient billing form.

"Division" means the insurance division within the department of commerce and consumer affairs.

"Health care provider" means a physician or osteopath licensed pursuant to chapter 453, a dentist licensed pursuant to chapter 448, a naturopathic physician licensed pursuant to chapter 455, a podiatrist licensed pursuant to chapter 463E, an advanced practice nurse practitioner licensed pursuant to chapter 457, a physician assistant licensed pursuant to chapter 453, a pharmacist licensed pursuant to chapter 461, a chiropractor licensed pursuant to chapter 442, and includes ambulatory surgery centers and hospitals.

"Hospital" means any institution with an organized medical staff which admits patients for inpatient care, diagnosis, observation, and treatment.

"Insurer" means a health plan as defined in article 10A of chapter 431, or chapter 432 or 432D, regardless of form, offered or administered by a health care insurer, including but not limited to a mutual benefit society or health maintenance organization, or voluntary employee beneficiary associations.

"Patient" means a person who receives health care services from a health care provider.

§ -2 Collection and dissemination of health care and related information. (a) In order to provide to health care providers, insurers, consumers, and governmental agencies information concerning health care in the state, and in order to provide information to assist in peer review for the purpose of quality assurance, the division shall collect from health care providers, analyze, and disseminate health care information, as adjusted for case mix and severity, in language that is understandable to laypersons.

(b) Subject to this section the division may request health care claims information from insurers and administrators. The division shall analyze and publicly report the health care claims information with respect to the cost, quality, and effectiveness of health care, in language that is understandable by lay persons, and shall develop and maintain a centralized

data repository. The division may request health care claims information, which may be voluntarily provided by insurers and administrators, and may perform or contract for the performance of the other duties specified under this paragraph.

(c) Subject to this section, the division shall collect from hospitals and ambulatory surgical centers:

(1) Hospital-specific performance on the measures of care developed for acute myocardial infarction, heart failure, and pneumonia;

(2) Hospital-specific-performance on the public reporting measures for-hospital-acquired infections as published by the National Quality Forum; and

(3) Charge information, including, but not limited to, the number of discharges, average length of stay, average charge, average charge per day, and median charge for each of the fifty most common inpatient diagnosis-related groups and their twenty five most common outpatient surgical procedures.

(d) Subject to this section, the division shall collect from health care providers information on professional charges to include the health care provider's charges for their twenty five most frequently performed:

(1) Clinical procedures;

(2) Outpatient procedures; and

(3) Inpatient procedures.

§ **-3 Health care data reports.** The division shall prepare and submit to the governor and the legislature standard reports concerning health care providers and insurers that the division prepares, and shall collect information necessary for preparation of those reports. The division shall widely publicize and distribute health care data reports electronically to consumers on the division's website.

§ **-4 Uncompensated health care services report.** (a) The division shall prepare and submit to the governor and the legislature an annual report setting forth the number of patients to whom uncompensated health care services were provided by each hospital and the total charges for the uncompensated health care services provided to the patients for the preceding year, together with the number of patients and the total charges that were projected by the hospital for that year in the plan filed under subsection (b). The division shall widely publicize and distribute the uncompensated health care services report electronically to consumers on the division's website.

(b) Every hospital shall file with division an annual plan setting forth the projected number of patients to whom uncompensated health care services will be provided by the hospital and the projected total charges for the uncompensated health care services to be provided to the patients for the ensuing year.

§ **-5 Consumer guide.** (a) The division shall prepare and submit to the governor and the legislature an annual guide to assist consumers in selecting health care providers and insurers. The guide shall be written in language that is understandable to laypersons. The division shall widely publicize and distribute the guide electronically to consumers on the division's website.

(b) The division shall prepare and submit to the governor and to the legislature an annual guide to assist consumers in selecting hospitals and ambulatory surgery centers. The guide shall be written in language that is understandable to laypersons and shall include data derived from the annual survey of hospitals conducted by the American Hospital Association and the annual hospital fiscal survey. The division shall widely publicize and distribute the guide to consumers.

§ **-6 Patient-level data utilization, charge, and quality report.** The division shall prepare and submit to the legislature an annual report that summarizes utilization, charges, and quality data on patients treated by hospitals and ambulatory surgery centers during the most recent calendar year. The division shall widely publicize and distribute the patient level data utilization, charges, and quality report electronically to consumers on the division's website.

The insurance commissioner, pursuant to chapter 91, shall adopt rules necessary to administer this section."

SECTION 3. Chapter 431:14G, Hawaii Revised Statutes, is amended by adding two new sections to be appropriately designated and to read as follows:

"**§431:14G- Medical expense threshold requirements.** (a) Insurers shall expend a minimum of sixty-five per cent of the health insurance premiums earned in a calendar year, whether collected from individual and small employer insureds for individual and small employer products or collected from large employer insureds for large employer products, on medical expenses. The instructions and methodology for calculating and reporting medical expense threshold levels and issuing dividends or credits shall be specified by the commissioner.

(b) In each case where the insurer fails to comply with the medical expense threshold requirements set forth in subsection (a), the insurer shall issue a dividend or credit toward future premiums for the policyholder that is not less than the amount that would meet the minimum threshold requirement.

(c) Prior to distributing any dividend or credit, an insurer shall provide the commissioner with its plan for the distribution of all required dividends and credits as part of the required annual medical expense threshold. No distributions of required dividends or credits may be made without prior approval from the commissioner.

(d) The dividend or credit required to be distributed pursuant to subsections (b) and (c) shall be determined by the commissioner.

(e) Insurers that issue health insurance policies through out-of-state trusts, purchasing alliances or other group purchasing organizations, associations, or other multiple employer arrangements shall specify in the plan for distribution of dividends or credits that the dividends or credits for the health insurance policies shall be paid or credited, as applicable, to the covered employers, not the trust,

association, purchasing alliance or other group purchasing organization, or other multiple employer arrangement.

(f) If an insurer is required to issue a dividend or credit, the insurer shall include the insurer's calculations of the dividend or credits to be issued due to failure to satisfy the minimum medical expense threshold and an explanation of the insurer's plan to issue these dividends and credits in its annual premium transparency report.

(g) Any consumer or employer, or their representatives, shall be entitled to seek an injunction to enforce any obligation established by this section or any rule adopted pursuant to this section.

(h) Notwithstanding any provisions in this article to the contrary, any insurer failing or refusing to comply with the reporting requirements of this section or of any rules adopted pursuant to this section, shall be liable for a fine of no less than $1,000, and no more than $10,000, for each day of violation.

(i) For purposes of this section:

"Health insurer" means any entity, including an insurance company authorized to issue health insurance, a health maintenance organization, or any other entity providing a plan

of health insurance, health benefits, or health care services, that is subject to the insurance laws and regulation of this State or subject to the jurisdiction of the commissioner.

"Medical expense" means the amount of money that the insurer spends on direct medical care services, hospital and other health facility services, drugs and medical devices, and other health care services that the health insurer incurs on behalf of its enrollees. It shall also include amounts paid to health care providers for pay-for-performance or other quality of efficiency enhancing initiatives. The term "medical expense" does not include amounts which are the financial responsibility of the enrollee, the insurer's administrative costs, or expenditures for which the insurer is reimbursed by an enrollee's other insurance coverage or other third party liability.

"Medical expense threshold" means the quotient, to the nearest one per cent, of the total medical expenses divided by the total premiums.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees, and their dependents, of two or more employers. In a multiple employer arrangement, the employer assumes all or a

substantial portion of the risk and shall include a multiple employer welfare arrangement, multiple employer trust, or other form of benefit trust.

"Premiums" means the amount of money that the insurer earns in a calendar year from the sale of health insurance, excluding dividends or credits applicable to prior years.

§431:14G- Annual premium transparency report. (a) Insurers shall submit an annual premium transparency report disclosing how health insurance premiums are spent annually. The premium transparency report shall include information for each of the following categories of insurance provided by the insurer: preferred provider organization, health maintenance organization, point of service, and high deductible health plan. This report shall include the following information for each category of insurance:

(1) A specific breakdown of administrative costs for the preceding calendar year 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 insurer; and

(iv) Other insurance types;

(F) Taxes, including:

(i) State and local insurance taxes;

(ii) State premium taxes;

(iii) Payroll taxes;

(iv) Federal and state income taxes;

(v) Real estate taxes; and

(vi) Other taxes;

(G) Travel and entertainment expenses;

(H) State and federal lobbying expenses;

(I) Other expenses, including non-executive salaries, wages and other benefits; rent and real estate expenses; certification, accreditation, board, bureau and association fees; auditing and actuarial fees; collection and bank service charges; occupancy, depreciation and

amortization; cost or depreciation of electronic data processing; claims and other services; regulatory authority licenses and fees; investment expenses; and aggregate write-ins for expenses; and

(J) Total expenses incurred in subparagraphs (A) to (I):

(2) The reporting insurer's name and address;

(3) The insurer's total earned premiums for the preceding calendar year, before dividends or credits applicable to prior years;

(4) The amount of interest earned on premiums for the preceding calendar year;

(5) The amount recovered from uninsured motorist insurance, accident insurance, workers' compensation insurance, and other third party liability during the preceding calendar year;

(6) The total medical expense incurred during the preceding calendar year;

(7) Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the insurer is in

compliance with this section and rules adopted pursuant to this section; and

(8) Other information as the commissioner may request.

(b) Insurers shall file the premium transparency report with the commissioner no later than March 1 of each year for the premiums earned for the immediately preceding calendar year.

(c) Notwithstanding any provisions in this article to the contrary, any insurer failing or refusing to comply with the reporting requirements of this section or any rules adopted pursuant to this section, shall be liable for a fine of not less than $1,000, and not more than $10,000, for each day of violation.

(d) All data or information required to be filed with the commissioner pursuant to this section shall be deemed a public record.

(e) Any consumer or employer, or their representatives, shall be entitled to seek an injunction to enforce any obligation established by this section or any rules adopted pursuant to this section.

(f) For purposes of this section:

"Administrative costs" means all expenditures associated with the administration of health benefit coverage, including

costs associated with claims processing, collection of premiums, marketing, operations, taxes, general overhead, salaries and benefits, quality assurance, utilization review and management, pharmacy and other benefit management, network contracting and management, and state and federal regulatory compliance.

"Interest" means the interest earned on the premiums by the insurer.

"Premiums" means the amount of money that the insurer earns in a calendar year from the sale of health insurance, excluding dividends or credits applicable to prior years."

SECTION 4. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 5. New statutory material is underscored.

SECTION 6. This Act shall take effect on July 1, 2050.

Report Title:
Health Insurance Premiums

Description:
Increases health insurance premium transparence, requires an annual premium transparency report, and creates a health information data clearinghouse; requires a minimum amount of premiums to be spent on medical expenses. Effective date 7/1/50. (SD1)

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