HOUSE OF REPRESENTATIVES
TWENTY-FIFTH LEGISLATURE, 2010
STATE OF HAWAII

H.B. NO. 2089 H.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

PART I

SECTION 1. The legislature finds there is a vital need for employers and consumers to have a clear understanding of how health care premium dollars are allocated by health insurers in Hawaii, 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 more informed decisions and reward companies that minimize administrative waste.

According to the Kaiser Family Foundation, since 1999, average premiums for family coverage have increased one hundred nineteen per cent - from $5,791 in 1999 to $12,680 in 2008. Worker premium contributions have similarly increased from $1,543 to $3,354.

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 purpose of this Act is to maximize the value of health insurance premiums and control spiraling health care costs caused by the dramatic rise in administrative costs and insurer profits, by:

(1) Providing greater transparency with regard to how health insurance premiums are spent by insurers; and

(2) Requiring health insurers to spend a minimum percentage of insurance premiums on medical expenses.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new article to be appropriately designated and to read as follows:

"**ARTICLE**

HEALTH INSURANCE PREMIUM TRANSPARENCY

§431: -101 Definitions. As used in this chapter:

"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; provided that medical expenses incurred by the insurer, affiliates, and contractors under common management or control in servicing the insured for premiums received shall not be included as "administrative costs."

"Commissioner" means the insurance commissioner.

"Insurer" means an insurance company, health maintenance organization, mutual benefit society, or other entity providing a plan of health insurance, health benefits, or health care services, that is subject to the health insurance laws and regulations of this state.

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

"Medical expense" means the amount of money that an insurer spends on direct medical care services for its health plan enrollees during a calendar year, including physician services, non-physician health care professional services, hospital and other health facility services, drugs and medical devices, and other health care services, and shall include amounts paid to

health care providers for pay-for-performance or other quality or efficiency enhancing initiatives. "Medical expense" does not include amounts that are the financial responsibility of the enrollee, the insurer's administrative costs, or expenditures for which the insurer is reimbursed through other third-party liability.

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

"Multiple employer arrangement" means an arrangement by which health benefits are provided to the employees of two or more employers under a single health insurance plan. In a multiple employer arrangement, the employer assumes all or a substantial portion of the risk and shall include, but is not limited to a multiple employer welfare arrangement, multiple employer trust, or other form of benefit trust.

"Premiums" means the amount of money that the insurer, the insurer's affiliates and contractors under common management or control in servicing the insured earn in a calendar year from the or sale of health insurance, net of reinsurance, excluding dividends or credits applicable to prior years.

§431: -102 Annual premium transparency report. (a) Insurers shall report to the commissioner on how health care premiums are spent no later than March 1 of each year for the premiums earned for the immediately preceding calendar year.

(b) Insurers shall report how health insurance premiums were spent for each of the following categories of insurance provided by the insurer: preferred provider organization, health maintenance organization, point of service organization, and high deductible health plan. The report shall include the following itemized information for each category of insurance:

(1) Administrative costs, including the total expenditures for the following:

(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 insurance; and

(iv) Other insurance types;

(F) Any federal, state, or local taxes;

(G) Travel and entertainment costs;

(H) State and federal lobbying costs; and

(I) Other costs, 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;

(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 chapter and the rules adopted thereunder; and

(8) Such other information as the commissioner may request.

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

§431: -103 Medical expense threshold percentage requirements. (a) Insurers and their affiliates and contractors under common management or control in servicing the insured shall spend on medical expenses, a minimum of:

(1) Eighty per cent of the health insurance premiums collected in a calendar year from individual and small employer products; and

(2) Eighty-five per cent of the health insurance premiums collected in a calendar year from large employer products.

(b) The instructions and methodology for calculating and reporting medical expense threshold levels and issuing dividends or credits shall be specified by the commissioner.

§431: -104 Dividend or credit distribution. (a) In each case where the insurer fails to comply with the medical expense threshold requirements set forth in this chapter, the insurer shall issue a dividend or credit toward future premiums for the policyholder that is not less than an amount that would meet the applicable minimum medical expense threshold requirement.

(b) 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.

(c) The dividend or credit required to be distributed pursuant to this chapter shall be determined by the commissioner.

(d) The distribution of dividends or credits required under this chapter shall be made to each employer that was covered for any period in the preceding calendar year.

(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 such health insurance policies shall be paid or credited, as applicable, to the covered employers rather than 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 ratio threshold and an explanation of the insurer's plan to issue these dividends and credits in its annual premium transparency report submitted under section 431: -102.

§431: -105 Compliance audit. The commissioner may audit any insurer to determine compliance with this chapter.

§431: -106 Penalties for violating reporting requirements. Any insurer failing to comply with the reporting requirements of this chapter or of any rules adopted thereunder shall be subject to a fine of at least $1,000, and up to $10,000, for each day of violation.

§431: -107 Consumer and employer rights. Any consumer, employer, or their representatives, shall be entitled to seek an injunction to enforce any obligation established by this chapter or any rule adopted thereunder."

PART II

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding a new article to be appropriately designated and to read as follows:

"**ARTICLE**

HEALTH CARE SYSTEM TRANSPARENCY

§431: -201 Definitions. As used in this article:

"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;

(2) Creates 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

(3) Uses the information it collects to develop, disseminate and make electronically available, unified public reports annually on health care quality, safety, and efficiency.

"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 physician assistant licensed under chapter 453, a dentist licensed under chapter 448, a naturopathic physician licensed under chapter 455, a podiatrist licensed under chapter 463E, an advanced practice registered nurse practitioner licensed under chapter

457, a pharmacist licensed under chapter 461, a chiropractor licensed under 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 431:10A, or chapter 432 or 432D, regardless of form, offered or administered by a health care insurer, including 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.

§431: -202 Collection and dissemination of health care and related information. (a) To provide to health care providers, insurers, consumers, governmental agencies and others, information concerning health care in the state, and to provide information to assist in peer review for the purpose of quality assurance, subject to this article, 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) 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 laypersons, 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) 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.

§431: -203 Patient-level data utilization, charge, and quality report. (a) 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.

(b) The insurance commissioner shall, pursuant to chapter 91, promulgate rules and regulations necessary to administer this article."

PART III

SECTION 4. Section 432:1-102, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Article 2, article 2D, article 13, [~~and~~] article 14G, article , and article of chapter 431, and the powers there granted to the commissioner, shall apply to managed care plans, health maintenance organizations, or medical indemnity or hospital service associations, which are owned or controlled by mutual benefit societies, so long as the application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations."

SECTION 5. Section 432D-19, Hawaii Revised Statutes, is amended by amending subsection (d) to read as follows:

"(d) Article 2, article 13, [~~and~~] article 14G, article , and article of chapter 431, and the power

there granted to the commissioner, shall apply to health maintenance organizations, so long as the application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations."

SECTION 6. If any provision of this Act, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act, which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 7. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 8. This Act shall take effect on July 1, 2020.

Report Title:
Health Premium Transparency

Description:
Requires health insurers to report annually on how health insurance premiums are being spent; and spend a minimum amount of the premiums on medical expenses. Requires the Insurance Division of the Department of Commerce and Consumer Affairs to collect from health care providers, analyze, and disseminate health care information for use in a publication to assist the public in choosing health care providers. Effective July 1, 2020. (HB2089 HD1)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.