Amend **SB 23** (House Committee Printing) by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ____. Chapter 1301, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. ANNUAL PREFERRED PROVIDER BENEFIT PLAN REPORT CARDS

Sec. 1301.301. DEFINITIONS. In this subchapter:

(1) "Direct losses incurred" means the sum of direct losses paid, plus an estimate of losses to be paid in the future, for all claims arising from the current reporting period and all prior reporting periods, minus the corresponding estimate made at the close of business for the preceding reporting period. The term does not include home office and other overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(2) "Direct losses paid" means the sum of all payments made during the reporting period for claimants under a preferred provider benefit plan before reinsurance has been ceded or assumed. The term does not include home office and other overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(3) "Direct premiums earned" means the amount of premium attributable to the coverage already provided in a given reporting period before reinsurance has been ceded or assumed.

(4) "Premium to direct patient care score" means direct losses incurred divided by direct premiums earned.

(5) "Network adequacy score" means the total number of claims paid as out-of-network by a preferred provider benefit plan divided by the total number of claims paid by the preferred provider benefit plan.

(6) "Claims paid score" means the total dollar amount paid by the preferred provider benefit plan as out-of-network divided by the total dollar amount of claims paid by the preferred provider benefit plan.

(7) "Allowables cap score" means the aggregate

percentage margin between the amount submitted on claims by non-contracted physicians or providers and the preferred provider benefit plan's allowable amount or the usual and customary amounts the preferred provider benefit plan is willing to pay.

(8) "Expected profit score" means the percentage of the premium dollar that represents the actuarially set allowance for profit.

(9) "Justified complaint" means a complaint submitted to the department for which the department determines there exists:

(A) a violation of a policy provision, contract provision, rule, or statute; or

(B) a valid concern that a prudent layperson would regard as customary a practice or service that is below customary business practice.

Sec. 1301.302. REPORT CARD. The commissioner shall develop and issue an annual preferred provider benefit plan report card that publicizes the scores described by Section 1301.303. The report card must be in a format that permits direct comparison of preferred provider benefit plans offered by insurers.

Sec. 1301.303. SCORES. (a) The report card must include the following:

(1) a premium to direct patient care score;

(2) a network adequacy score;

(3) a claims paid score;

(4) an allowables cap score;

(5) an expected profit score;

(6) the number of persons covered for each preferred provider benefit plan;

(7) the total dollar amount of premiums earned by the preferred provider benefit plan; and

(8) the number of justified complaints.

(b) The report card must contain a plain-language explanation of the scores that is understandable to the average layperson.

Sec. 1301.304. RULEMAKING. The commissioner shall adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement this subchapter, including rules governing

the filing of any financial reports or other information necessary for the annual report cards.

Sec. 1301.305. PUBLICATION AND PUBLICITY. (a) The commissioner shall:

(1) ensure the annual preferred provider benefit plan report cards are accessible to the public on the department's Internet website;

(2) provide the annual preferred provider benefit plan report cards to each member of each committee of the house of representatives or the senate that has jurisdiction over issues concerning health or insurance;

(3) provide a copy of the annual preferred provider benefit plan report card to each member of the public who submits a written request; and

(4) provide copies of the annual preferred provider benefit plan report card to public libraries throughout this state that request copies.

(b) The commissioner shall issue a press release when the annual report cards are issued under this subchapter.

SECTION _____. Chapter 843, Insurance Code, is amended by adding Subchapter O to read as follows:

SUBCHAPTER O. ANNUAL HEALTH MAINTENANCE ORGANIZATION REPORT CARDS

Sec. 843.501. DEFINITIONS. In this subchapter:

(1) "Direct losses incurred" means the sum of direct losses paid, plus an estimate of losses to be paid in the future, for all claims arising from the current reporting period and all prior reporting periods, minus the corresponding estimate made at the close of business for the preceding reporting period. The term does not include home office and other overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(2) "Direct losses paid" means the sum of all payments made during the reporting period for claimants before reinsurance has been ceded or assumed. The term does not include home office and other overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs,

utilization review costs, or claims processing costs.

(3) "Direct premiums earned" means the amount of premium attributable to the coverage already provided in a given reporting period before reinsurance has been ceded or assumed.

(4) "Premium to direct patient care score" means direct losses incurred divided by direct premiums earned.

(5) "Network adequacy score" means the sum of the total number of claims paid as out-of-network by a health maintenance organization and paid under a point-of-service rider divided by the total number of claims paid by the health maintenance organization.

(6) "Claims paid score" means the sum of the total dollar amount paid by the health maintenance organization as out-of-network and the total dollar amount paid under a point-of-service rider divided by the total dollar amount of claims paid by the health maintenance organization, including amounts paid under a point-of-service rider.

(7) "Allowables cap score" means the aggregate percentage margin between the amount submitted on claims by non-contracted physicians or providers and the health maintenance organization's allowable amount or the usual and customary amounts the health maintenance organization is willing to pay.

(8) "Expected profit score" means the percentage of the premium dollar that represents the actuarially set allowance for profit.

(9) "Justified complaint" means a complaint submitted to the department for which the department determines there exists:

(A) a violation of an evidence of coverage provision, contract provision, rule, or statute; or

(B) a valid concern that a prudent layperson would regard as customary a practice or service that is below customary business practice.

Sec. 843.502. REPORT CARD. (a) The commissioner shall develop and issue an annual health maintenance organization report card that publicizes the scores described by Section 843.503. The report card must be in a format that permits direct comparison of health maintenance organizations.

(b) The department shall develop and issue the annual health maintenance organization report card required under this subchapter in consultation with the office of public insurance counsel and in addition to any report card issued under Subchapter F, Chapter 501.

(c) In addition to any other authority granted by this code, the office of public insurance counsel is entitled to obtain the information reported by health maintenance organizations to the department under this subchapter.

Sec. 843.503. SCORES. (a) The report card must include the following:

(1) a premium to direct patient care score;

(2) a network adequacy score;

(3) a claims paid score;

(4) an allowables cap score;

(5) an expected profit score;

(6) the number of enrollees;

(7) the total dollar amount of premiums earned; and

(8) the number of justified complaints.

(b) The report card must contain a plain-language explanation of the scores that is understandable to the average layperson.

Sec. 843.504. RULEMAKING. The commissioner shall adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement this subchapter, including rules governing the filing of any financial reports or other information necessary for the annual report cards.

Sec. 843.505. PUBLICATION AND PUBLICITY. (a) The commissioner shall:

(1) ensure the annual health maintenance organization report cards are accessible to the public on the department's Internet website;

(2) provide the annual health maintenance organization report cards to each member of each committee of the house of representatives or the senate that has jurisdiction over issues concerning health or insurance;

(3) provide a copy of the annual health maintenance

organization report cards to each member of the public who submits a written request; and

(4) provide copies of the annual health maintenance organization report cards to public libraries throughout this state that request copies.

(b) The commissioner shall issue a press release when the annual report cards are issued under this subchapter.