

By: Smith of Tarrant

H.B. No. 2329

Substitute the following for H.B. No. 2329:

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C.S.H.B. No. 2329

A BILL TO BE ENTITLED

AN ACT

relating to the creation of consumer report cards for the comparison of health care plans.

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

SECTION 1. 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.

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

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

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

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

14           (7) "Allowables cap score" means the aggregate  
15 percentage margin between the amount submitted on claims by  
16 non-contracted physicians or providers and the preferred provider  
17 benefit plan's allowable amount or the usual and customary amounts  
18 the preferred provider benefit plan is willing to pay.

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

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

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

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

1 customary business practice.

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

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

9 (1) a premium to direct patient care score;

10 (2) a network adequacy score;

11 (3) a claims paid score;

12 (4) an allowables cap score;

13 (5) an expected profit score;

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

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

18 (8) the number of justified complaints.

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

22 Sec. 1301.304. RULEMAKING. The commissioner shall adopt  
23 rules in the manner prescribed by Subchapter A, Chapter 36, as  
24 necessary to implement this subchapter, including rules governing  
25 the filing of any financial reports or other information necessary  
26 for the annual report cards.

27 Sec. 1301.305. PUBLICATION AND PUBLICITY. (a) The

1 commissioner shall:

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

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

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

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

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

17 SECTION 2. Chapter 843, Insurance Code, is amended by  
18 adding Subchapter O to read as follows:

19 SUBCHAPTER O. ANNUAL HEALTH MAINTENANCE ORGANIZATION REPORT CARDS

20 Sec. 843.501. DEFINITIONS. In this subchapter:

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

1 costs, administrative costs, utilization review costs, or claims  
2 processing costs.

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

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

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

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

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

25 (7) "Allowables cap score" means the aggregate  
26 percentage margin between the amount submitted on claims by  
27 non-contracted physicians or providers and the health maintenance

1 organization's allowable amount or the usual and customary amounts  
2 the health maintenance organization is willing to pay.

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

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

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

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

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

18 (b) The department shall develop and issue the annual health  
19 maintenance organization report card required under this  
20 subchapter in consultation with the Office of Public Insurance  
21 Counsel and in addition to any report card issued under Subchapter  
22 F, Chapter 501.

23 (c) In addition to any other authority granted by this code,  
24 the Office of Public Insurance Counsel is entitled to obtain the  
25 information reported by health maintenance organizations to the  
26 department under this subchapter.

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

1 following:

- 2 (1) a premium to direct patient care score;
- 3 (2) a network adequacy score;
- 4 (3) a claims paid score;
- 5 (4) an allowable cap score;
- 6 (5) an expected profit score;
- 7 (6) the number of enrollees;
- 8 (7) the total dollar amount of premiums earned; and
- 9 (8) the number of justified complaints.

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

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

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

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

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

27 (3) provide a copy of the annual health maintenance

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

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

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

8 SECTION 3. This Act takes effect immediately if it receives  
9 a vote of two-thirds of all the members elected to each house, as  
10 provided by Section 39, Article III, Texas Constitution. If this  
11 Act does not receive the vote necessary for immediate effect, this  
12 Act takes effect September 1, 2007.