By: Hopson H.B. No. 2954

A BILL TO BE ENTITLED

AN ACT

relating to reporting of medical loss ratios by certain managed care organizations under the Medicaid program.

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

SECTION 1. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0133 to read as follows:

Sec. 533.0133. MEDICAL LOSS RATIO. (a) In this section:

(1) "Capitated fees earned" means the total amount of capitated fees received by a managed care organization under this chapter that is attributable to coverage already provided to medical assistance recipients in a given period before reinsurance has been ceded or assumed.

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

(3) "Direct losses paid" means the sum of all payments made during the period for medical assistance recipients before

reinsurance has been ceded or assumed. This amount does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(4) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(5) "Medical loss ratio" means direct losses incurred divided by capitated fees earned.

(b) This section applies only to a managed care organization that contracts with the commission to provide a defined set of health care services to a medical assistance recipient through a managed care plan for a predetermined period in exchange for a capitated fee.

(c) A managed care organization shall report to the executive commissioner the organization's medical loss ratio with respect to medical assistance recipients enrolled in the managed care plan issued by the organization. The report must be sworn to by a member of the governing body of the managed care organization.

(d) The executive commissioner may:

(1) require a managed care organization to provide any information or documentation necessary to analyze and verify a report provided under Subsection (c); and

(2) issue a subpoena to compel the production of information, documentation, or testimony relating to the report.

(e) The executive commissioner, with the assistance of the state auditor, may audit a managed care organization that submits a report under Subsection (c) as necessary to analyze and verify the

information contained in the report.

(f) The executive commissioner shall analyze reports submitted under this section. Not later than January 15 of each year, the executive commissioner shall submit a report to the governor, the lieutenant governor, and the speaker of the house of representatives on the results of the analysis conducted with respect to reports submitted under Subsection (c) during the preceding year.

(g) A report submitted by a managed care organization under Subsection (c) and a report submitted by the executive commissioner under Subsection (f) are subject to Chapter 552.

(h) The executive commissioner shall adopt rules as necessary to implement this section, including rules regarding the frequency and form of reporting medical loss ratios and the period for which the medical loss ratios must be reported.

SECTION 2. Not later than September 1, 2007, the executive commissioner of the Health and Human Services Commission shall adopt rules required by Section 533.0133, Government Code, as added by this Act.

SECTION 3. The change in law made by this Act applies to a managed care organization that enters into or renews a contract with the Health and Human Services Commission under Chapter 533, Government Code, on or after September 1, 2007. A managed care organization that enters into a contract before September 1, 2007, is governed by the law in effect on the date the contract was entered into, and the former law is continued in effect for that purpose.

SECTION 4. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2007.