Amend **CSSB 485** by striking all below the enacting clause and substituting the following:

SECTION 1. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1223 to read as follows:

CHAPTER 1223. MEDICAL LOSS RATIO

Sec. 1223.001. DEFINITIONS. In this chapter:

(1) "Enrollee" has the meaning assigned by Section 1457.001.

(2) "Evidence of coverage" has the meaning assigned by Section 843.002.

(3) "Market segment" means, as applicable, one of the following categories of health benefit plans issued by a health benefit plan issuer:

(A) individual evidences of coverage issued by a health maintenance organization;

(B) individual preferred provider benefit plans;

(C) evidences of coverage issued by a health maintenance organization to small employers as defined by Section 1501.002;

(D) preferred provider benefit plans issued to small employers as defined by Section 1501.002;

(E) evidences of coverage issued by a health maintenance organization to large employers as defined by Section 1501.002; and

(F) preferred provider benefit plans issued to large employers as defined by Section 1501.002.

(4) "Medical loss ratio" means direct losses incurred and direct losses paid for all preferred provider benefit plans issued by an insurer, divided by direct premiums earned for all preferred provider benefit plans issued by that insurer. This amount may not include home office and overhead costs, advertising costs, network development costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

Sec. 1223.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to a health benefit plan issuer that provides benefits for medical or surgical expenses incurred as a result of a health

condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) an exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843; or

(7) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) Notwithstanding any other law, this chapter applies to a health benefit plan issuer with respect to a standard health benefit plan provided under Chapter 1507.

(c) Notwithstanding Section 1501.251 or any other law, this chapter applies to a health benefit plan issuer with respect to coverage under a small employer health benefit plan subject to Chapter 1501.

Sec. 1223.003. EXCEPTIONS. This chapter does not apply with respect to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a Medicaid managed care program operated under Chapter 533, Government Code;

(4) Medicaid programs operated under Chapter 32, Human Resources Code;

(5) the state child health plan operated under Chapter 62 or 63, Health and Safety Code;

(6) a workers' compensation insurance policy; or

(7) medical payment insurance coverage provided under a motor vehicle insurance policy.

Sec. 1223.004. NOTIFICATION OF MEDICAL LOSS RATIO, MEDICAL COST MANAGEMENT, AND HEALTH EDUCATION COST. (a) A health benefit plan issuer shall report its medical loss ratio for each market segment, as applicable, with the annual report required under Section 843.155 or 1301.009. Beginning in the fourth year during which a health benefit plan issuer is required to make a report under this section, the issuer may report the medical loss ratio as a three-year rolling average.

(b) Each health benefit plan issuer shall include in the report described by Subsection (a), for each market segment, a separate report of costs attributed to medical cost management and health education. The commissioner by rule shall prescribe the reporting requirements for the costs, which may include:

(1) case management activities;

(2) utilization review;

(3) detection and prevention of payment of fraudulent requests for reimbursement;

(4) network access fees to preferred provider organizations and other network-based health benefit plans, including prescription drug networks, and allocated internal salaries and related costs associated with network development or provider contracting;

(5) consumer education solely relating to health improvement and relying on the direct involvement of health personnel, including smoking cessation and disease management programs and other programs that involve medical education;

(6) telephone hotlines, including nurse hotlines, that provide enrollees health information and advice regarding medical care; and

(7) expenses for internal and external appeals processes.

(c) The department shall post on the department's Internet website or another website maintained by the department for the benefit of consumers or enrollees:

(1) the information received under Subsections (a) and (b);

(2) an explanation of the meaning of the term "medical loss ratio," how the medical loss ratio is calculated, and how the ratio may affect consumers or enrollees; and

(3) an explanation of the types of activities and services classified as medical cost management and health education, how the costs for these activities and services are calculated, what those costs, when aggregated with a medical loss ratio, mean, and how the costs might affect consumers or enrollees.

(d) A health benefit plan issuer shall provide each enrollee or the plan sponsor, as applicable, with the Internet website address at which the enrollee or plan sponsor may access the information described by Subsection (c). A health benefit plan issuer must provide the information required under this subsection:

(1) to an enrollee, at the time of the initial enrollment of the enrollee in a health benefit plan issued by the health benefit plan issuer; and

(2) at the time of renewal of a health benefit plan to:

(A) each enrollee, if the health benefit plan is

an individual health benefit plan; or

(B) the plan sponsor, if the health benefit plan is a group health benefit plan.

(e) The commissioner shall adopt rules necessary to implement this section.

SECTION 2. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2011. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2011, is covered by the law in effect at the time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2009.