By: Deuell S.B. No. 485

A BILL TO BE ENTITLED

AN ACT

relating to medical loss ratios of health benefit plan issuers.

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

SECTION 1. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1216 to read as follows:

CHAPTER 1216. MEDICAL LOSS RATIO AND HEALTH BENEFIT PLAN PREMIUMS

Sec. 1216.001. DEFINITIONS. In this chapter:

(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 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.

(2) "Direct losses paid" means the sum of all payments made during the period for claimants under a health benefit plan 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.

(3) "Direct premiums earned" means the amount of premium attributable to the coverage already provided in a given

1 period before reinsurance has been ceded or assumed.

2 (4) "Medical loss ratio" means direct losses incurred

3 divided by direct premiums earned.

4 Sec. 1216.002. APPLICABILITY OF CHAPTER. (a) This chapter

5 applies to the issuer of a health benefit plan that provides

6 benefits for medical or surgical expenses incurred as a result of a

7 health condition, accident, or sickness, including an individual,

8 group, blanket, or franchise insurance policy or insurance

9 agreement, a group hospital service contract, or an individual or

10 group evidence of coverage or similar coverage document that is

11 offered by:

12 (1) an insurance company;

13 (2) a group hospital service corporation operating

14 under Chapter 842;

15 (3) a fraternal benefit society operating under

16 Chapter 885;

17 (4) a stipulated premium company operating under

18 Chapter 884;

19 (5) an exchange operating under Chapter 942;

20 (6) a health maintenance organization operating under

21 Chapter 843;

22 (7) a multiple employer welfare arrangement that holds

23 a certificate of authority under Chapter 846; or

24 (8) an approved nonprofit health corporation that

25 holds a certificate of authority under Chapter 844.

26 (b) Notwithstanding any provision in Chapter 1551, 1575,

27 1579, or 1601 or any other law, this chapter applies to a health

1 benefit plan issuer with respect to:

2 (1) a basic coverage plan under Chapter 1551;

3 (2) a basic plan under Chapter 1575;

4 (3) a primary care coverage plan under Chapter 1579;

5 and

6 (4) basic coverage under Chapter 1601.

7 (c) Notwithstanding any other law, this chapter applies to a

8 health benefit plan issuer with respect to a standard health

9 benefit plan provided under Chapter 1507.

10 (d) Notwithstanding Section 1501.251 or any other law, this

11 chapter applies to a health benefit plan issuer with respect to

12 coverage under a small employer health benefit plan subject to

13 Chapter 1501.

14 Sec. 1216.003. EXCEPTION. This chapter does not apply with

15 respect to:

16 (1) a plan that provides coverage:

17 (A) for wages or payments in lieu of wages for a

18 period during which an employee is absent from work because of

19 sickness or injury;

20 (B) as a supplement to a liability insurance

21 policy;

22 (C) for credit insurance;

23 (D) only for dental or vision care;

24 (E) only for hospital expenses; or

25 (F) only for indemnity for hospital confinement;

26 (2) a Medicare supplemental policy as defined by

27 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

1 (3) a workers' compensation insurance policy; or
2 (4) medical payment insurance coverage provided under
3 a motor vehicle insurance policy.
4 Sec. 1216.004. MEDICAL LOSS RATIO REPORTING. The
5 commissioner by rule shall require each health benefit plan issuer
6 to report at least annually the health benefit plan issuer's
7 medical loss ratio for the preceding year for each health benefit
8 plan issued.
9 Sec. 1216.005. REVIEW OF PREMIUMS. (a) The commissioner by
10 rule shall establish a minimum medical loss ratio below which a
11 health benefit plan's premiums are excessive for the benefits
12 provided under the plan.
13 (b) If the commissioner determines that a health benefit
14 plan's medical loss ratio falls below the minimum established under
15 Subsection (a), the commissioner may order a health benefit plan
16 issuer to:
17 (1) implement a premium rate adjustment;
18 (2) issue any appropriate rebates to enrollees or plan
19 sponsors;
20 (3) file with the department an actuarial memorandum,
21 prepared by a qualified actuary, in accordance with rules adopted
22 to implement this section; or
23 (4) take any other remedial action the commissioner
24 determines is appropriate.
25 (c) The commissioner shall adopt rules as necessary to
26 implement this section, including rules regarding the frequency and
27 form of reporting medical loss ratios.

1 SECTION 2. This Act takes effect September 1, 2009.