BILL ANALYSIS

Senate Research Center

S.B. 51
By: Nelson
State Affairs
7/6/2005
Enrolled

AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

Current law allows companies a 30-day grace period on payment of premiums for employees no longer enrolled in group health plans. Therefore, health insurance companies do not find out that a particular employee is no longer enrolled in the group health plan until after the 30-day grace period. During that 30 days, a health care provider may provide medical services in good faith to a disenrolled employee and receive payment from the insurance company. At the end of the 30-day period, when the insurance company determines that the employee was not, in fact, enrolled in the group health plan for the 30-day period, the insurance company can retroactively recoup the payment made to the provider. S.B. 51 requires employers to be responsible for a health insurance premium until the end of the month in which an employee is removed from coverage under a group health plan and the insurer is notified of such removal to prevent retroactive recovery of payments made for medical services provided in good faith prior to retroactive disenrollement of the employee.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 1301, Insurance Code, as effective April 1, 2005, by adding Section 1301.0061, as follows:

> Sec. 1301.0061. TERMS OF ENROLLEE ELIGIBILITY. Requires that a contract between an insurer and a group policyholder under a preferred provider benefit plan include provisions regarding certain policy details.

SECTION 2. Amends Subchapter F, Chapter 843, Insurance Code, by adding Section 843.210, as follows:

> Sec. 843.210. TERMS OF ENROLLEE ELIGIBILITY. Requires that a contract between a health maintenance organization and a group contract holder include provisions regarding certain policy details.

SECTION 3. Amends Section 843.347, Insurance Code, by adding Subsections (h) and (i), as follows:

> (h) Provides that a health maintenance organization providing routine vision services as a single health care service plan or providing dental health care services as a single health care service plan is not required to comply with Subsection (c) with respect to those services. Defines "routine vision services."
>
> (i) Requires a health maintenance organization described by Subsection (h) to adhere to certain requirements.

SECTION 4. Amends Section 843.348, Insurance Code, by adding Subsections (i) and (j), as follows:

(i) Provides that a health maintenance organization providing routine vision services as a single health care service plan or providing dental health care services as a single health care service plan is not required to comply with Subsection (f) with respect to those services. Defines "routine vision services."

(j) Requires a health maintenance organization described by Subsection (i) to adhere to certain requirements.

SECTION 5. Makes application of Sections 843.210 and 1301.0061, Insurance Code, as added by this Act, prospective to January 1, 2006.

SECTION 6. Makes application of Subsections (h) and (i), Section 843.347, Insurance Code, and Subsections (i) and (j), Section 843.348, Insurance Code, as added by this Act, prospective to the 60th day after the effective date of this Act.

SECTION 7. Effective date: September 1, 2005.