BILL ANALYSIS

C.S.S.B. 51
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Pensions & Investments
Committee Report (Substituted)

BACKGROUND AND PURPOSE

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. C.S.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. The bill also changes verification and preauthorization call center requirements for dental and vision HMO's.

RULEMAKING AUTHORITY

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

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 of the Insurance Code by adding subsections (h) and (i). Provides that a HMO providing routine vision services as a single health care service plan or providing dental services as a single health care service plan is not required to comply with subsection (c) with respect to these services. Defines "routine vision services". Requires a HMO described by subsection (h) to have appropriate personnel reasonably available at a toll-free telephone number to provide verification from 8 am to 5 pm central time on Monday through Friday, unless the day is a legal holiday. Requires an HMO described by subsection (h) to have a telephone system capable of accepting or recording incoming phone calls for verification after 5 p.m. Monday through Friday and all day on Saturday, Sunday and legal holidays. These calls must be recorded and responded to within the next business day after the call is received.

SECTION 4: Amends section 843.348 of the Insurance Code by adding subsections (i) and (j). Provides that a HMO providing routine vision services as a single health care service plan or

providing dental services as a single health care service plan is not required to comply with subsection (f) with respect to these services. Defines "routine vision services".
Requires a HMO described by subsection (h) to have appropriate personnel reasonably available at a toll-free telephone number to provide preauthorization from 8 am to 5 pm central time on Monday through Friday, unless the day is a legal holiday. Requires an HMO described by subsection (i) to have a telephone system capable of accepting or recording incoming phone calls accepting requests for preauthorization after 5 p.m. Monday through Friday and all day on Saturday, Sunday and legal holidays. These calls must be recorded and responded to within the next business day after the call is received.

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

SECTION 6: Prospective application of provisions in sections 3 and 4.

SECTION 7: Effective date.

EFFECTIVE DATE

September 1, 2005

COMPARISON OF ORIGINAL TO SUBSTITUTE

The substitute adds new sections 3, 4 and 6, makes changes to the original section 3 (substitute section 5) regarding prospective application, and renumbers the other sections accordingly. Section 3 and 4 of the substitute change the hours of the dental and vision HMO call centers for verification and preauthorization. The language specifies that dental and vision HMO call centers must operate at a toll-free telephone number and have personnel reasonably available to provide verification and preauthorization from 8 am to 5 pm central time on Monday through Friday, unless the day is a legal holiday. Any after-hour, weekend or holiday messages must be recorded and responded to within the next business day. Section 6 of the substitute provides for prospective application of the provisions in sections 3 and 4.