BILL ANALYSIS

C.S.H.B. 1776
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Certain dental insurance carriers have implemented contract provisions that limit the amount contracting dentists can charge an insured patient for services not covered by the plan. Without such provisions, a contracting dentist who treats a patient for procedures that either are not covered by the plan contract or are no longer covered because the patient has exhausted the annual limit on coverage can bill the patient the usual and customary fee.

Other insurance companies have shown interest in trying to follow suit in a trend that, if allowed to continue, may result in the fees for all dental services provided to insured patients, whether covered under a plan or policy or not, being determined largely by those companies and not by the treating dentist.

C.S.H.B. 1776 addresses concerns expressed by interested parties that support legislative measures to prevent insurance companies from setting maximum fees on services not covered by an insurance plan.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 1776 amends the Insurance Code to prohibit a contract between a health maintenance organization and a dentist or between an insurer and a dentist from limiting the fee the dentist may charge for a service that is not a covered service. The bill defines "covered service" in relation to an enrollee's health care plan contract or to a patient's employee benefit plan or health insurance policy, as applicable, for purposes of the bill's provisions.

EFFECTIVE DATE

September 1, 2011.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 1776 contains provisions not included in the original defining "covered service" in relation to an enrollee's health care plan contract or to a patient's employee benefit plan or health insurance policy, as applicable, for purposes of the bill's provisions relating to a contract between a health maintenance organization (HMO) and a dentist and to a contract between an insurer and dentist, respectively.

C.S.H.B. 1776 differs from the original by prohibiting a contract between an HMO and a dentist and a contract between an insurer and a dentist from limiting the fee the dentist may charge for a service that is not a covered service, whereas the original prohibits such contracts from limiting

the fee the dentist may charge for a service for which an enrollee's health care plan or a patient's employee benefit plan or health insurance policy, as applicable, does not provide a benefit or reimbursement, including a service that exceeds the annual or lifetime maximum plan or policy limit or that is provided during a waiting period.