

BILL ANALYSIS

C.S.H.B. 1322
By: Buckley
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Usually, a patient has medical insurance with a medical benefit plan and a vision care benefit from a separate vision benefit plan company. Some vision benefit plan issuers do not allow patients to have their benefits coordinated with the patient's medical plan. Currently there are statutes and regulations that define how benefits are coordinated between two medical plans and two dental plans, however, statute does not exist for the specific scenarios involving how vision benefit plans should coordinate benefits with medical insurance plans. C.S.H.B. 1322 seeks to help patients by making it easier for them to coordinate their sources of health coverage so that they may use all of their coverages up to their coverage limits at the time of service without having to make multiple visits to the eye doctor or paying multiple copays, deductibles, and coinsurance amounts.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 1322 amends the Insurance Code to set out provisions regarding the coordination of vision benefits under certain benefit plans offered by benefit plan issuers specified by the bill applicable to a vision benefit plan or a health benefit plan that provides or arranges for benefits for vision or medical eye care services, procedures, or products. The bill provides for the following if a benefit plan enrollee is covered by at least two different applicable health benefit plans or vision benefit plans and each plan provides the enrollee coverage for the same vision or medical eye care services, procedures, or products:

- an issuer of the primary health benefit plan or vision benefit plan, as determined under a coordination of benefits provision applicable to the plan, is responsible for eye care expenses covered under the plan up to the full amount of any plan coverage limit applicable to the covered eye care expenses;
- the issuer of a secondary health benefit plan or vision benefit plan, before the plan coverage limit is reached, is responsible only for eye care expenses covered under the plan that are not covered under the health or vision benefit plan issued by the primary plan issuer;
- the secondary plan issuer, after the primary plan coverage limit has been reached, is also responsible for any eye care expenses covered by both plans that exceed the primary plan coverage limit up to the coverage limit of the secondary plan;

- the enrollee may use each plan on the same date of service up to the coverage limit of each plan when an enrollee is covered by more than one health benefit plan or vision benefit plan that provides benefits for eye care expenses;
- a vision benefit plan issuer must coordinate benefits with a health benefit plan issuer if both provide benefits for eye care expenses;
- a mechanism of providing proof must be submitted online if the secondary plan issuer requires proof that a related claim has been submitted to a primary plan issuer; and
- a vision benefit plan issuer may not require a claim denial before adjudicating a claim up to the coverage limit of the plan.

The bill establishes that these provisions do not prevent a secondary plan issuer from requiring proof that a related claim has been submitted to a primary plan issuer for purposes of determining the remaining balance up to the secondary plan's coverage limits.

C.S.H.B. 1322 prohibits an applicable health benefit plan or vision benefit plan from being delivered, issued for delivery, or renewed in Texas under the following conditions:

- a provision of the plan excludes or reduces the payment of benefits for eye care expenses to or on behalf of an enrollee;
- the reason for the exclusion or reduction is that eye care benefits are payable or have been paid to or on behalf of the enrollee under another plan; and
- the exclusion or reduction would apply before the full amount of the eye care expenses incurred by the enrollee and covered by both plans has been paid or reimbursed or the full amount of the applicable coverage limit of the plan containing the exclusion or reduction is reached.

The bill establishes that this prohibition does not require a secondary plan issuer to pay an amount that, when added to a payment amount made by a primary plan issuer, would exceed the usual and customary billed charges of the health care provider.

C.S.H.B. 1322 establishes that a provision of a health or vision benefit plan that violates the bill's provisions is void. The bill authorizes the commissioner of insurance to adopt rules necessary to implement the bill's provisions. The bill specifies the types of plans to which its provisions apply and excepts a supplemental insurance policy that only pays benefits directly to the policyholder from that applicability.

C.S.H.B. 1322 applies only to a health benefit plan or vision benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 1322 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

Whereas the introduced applied if a benefit plan enrollee is covered by at least two different benefit plans that provide benefits for eye care expenses, the substitute applies if an enrollee is covered by at least two different health benefit plans or vision benefit plans and each provide coverage for the same vision or medical eye care services, procedures, or products.

While the introduced required a benefit plan provider to whom an initial claim for reimbursement is submitted to pay up to the full amount of any coverage limit applicable to the covered eye care expenses and required a provider to whom a subsequent claim for expenses that are not reimbursed by the initial provider to reimburse for all eye care expenses covered

under the plan that are not reimbursed by a benefit plan provider to whom a claim for reimbursement was previously submitted, the substitute establishes the following:

- the issuer of the primary plan is responsible for covered eye care expenses up to the full amount of the plan coverage limit;
- the issuer of the secondary plan is responsible for expenses not covered by the plan issued by the primary issuer before the primary plan limit is reached; and
- the secondary issuer is also responsible for any expenses covered by both plans that exceed the primary plan coverage limit after that limit is reached.

The substitute does not include a provision from the introduced requiring each plan provider to provide a summary of expenses accepted and denied under the plan.

The substitute includes the following provisions absent from the introduced:

- a requirement for a vision benefit plan issuer to coordinate benefits with a health benefit plan issuer if they both provide benefits for eye care expenses;
- a prohibition against a vision benefit plan issuer requiring a claim denial before adjudicating a claim up to the coverage limit of the plan;
- a requirement for a mechanism of providing proof to be through an online submission if a secondary plan issuer requires proof that a related claim has been submitted to the primary plan issuer;
- a provision establishing that the bill's provisions do not prevent a secondary plan issuer from requiring proof relating to a claim submitted to the primary plan issuer to determine the remaining balance up to the secondary plan's coverage limits;
- a provision establishing that the prohibitions against the delivery, issuance for delivery, and renewal of a plan under certain conditions do not require a secondary plan issuer to pay an amount that would exceed the usual and customary billing charges when added to a payment amount by a primary plan issuer;
- a provision excepting a supplemental insurance policy that only pays benefits directly to the policyholder from applicability of the bill's provisions; and
- an authorization for the commissioner of insurance to adopt rules necessary to implement the bill's provisions.