

BILL ANALYSIS

Senate Research Center

S.B. 861
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Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 861 will allow optometrists and ophthalmologists to coordinate the benefit plans of patients in instances where a patient has coverage with more than one benefit plan.

Commonly, a patient will have medical insurance with a medical benefit plan and a vision care benefit from a separate vision benefit plan company. But some vision benefit plan companies do not allow patients to have their benefits coordinated with a patient's medical plan.

Existing statutes and regulations define how benefits are coordinated between two medical and two dental plans. But statute does not exist for the specific scenarios involving how vision benefit plans should coordinate benefits with medical insurance plans.

S.B. 861 will help patients by making it easier for them to 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 co-pays, deductibles, and co-insurance amounts when coordination should be available to that patient.

S.B. 861 will improve the overall experience for patients by reducing plan coverage confusion and up-front costs and will also make doctors able to serve patients more efficiently.

(Original Author's/Sponsor's Statement of Intent)

S.B. 861 amends current law relating to coordination of vision and eye care benefits under certain health benefit plans and vision benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 1203.107, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1203, Insurance Code, by adding Subchapter C, as follows:

SUBCHAPTER C. VISION AND EYE CARE BENEFITS

Sec. 1203.101. DEFINITIONS. Defines "eye care expenses," "health benefit plan," and "vision benefit plan."

Sec. 1203.102. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter applies only to a health benefit plan or vision benefit plan that provides or arranges for benefits for vision or medical eye care services, procedures, or products, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an evidence of coverage, or a vision benefit plan offered by certain entities.

Sec. 1203.103. EXCEPTION. Provides that this subchapter does not apply to a supplemental insurance policy that only pays benefits directly to the policyholder.

Sec. 1203.104. COORDINATION OF BENEFITS BETWEEN PRIMARY AND SECONDARY PLAN ISSUERS. (a) Provides that this section applies if:

(1) an enrollee is covered by at least two different health benefit plans or vision benefit plans; and

(2) each plan provides the enrollee coverage for the same vision or medical eye care services, procedures, or products.

(b) Provides that the issuer of the primary health benefit plan or vision benefit plan, as determined under a coordination of benefits provisions 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.

(c) Provides that the issuer of a secondary health benefit plan or vision benefit plan, as determined under a coordination of benefits provisions applicable to the plan, before the plan coverage limit described by Subsection (b) is reached, is responsible only for the eye care expenses covered under the plan that are not covered under the health benefit plan or vision benefit plan issued by the primary plan issuer.

(d) Provides that the secondary plan issuer, after the coverage limit described by Subsection (b) has been reached, in addition to the responsibilities described by Subsection (c), is responsible for any eye care expenses covered by both plans that exceed the plan coverage limit described by Subsection (b) up to the coverage limit of the secondary plan.

(e) Authorizes an enrollee, when the enrollee is covered by more than one health benefit plan or vision benefit plan that provides benefits for eye care expenses, to use each plan on the same date of service up to the coverage limit of each plan.

(f) Requires a vision benefit plan issuer to coordinate benefits with a health benefit plan issuer if both provide benefits for eye care expenses.

(g) Prohibits a vision benefit plan issuer from requiring a claim denial before adjudicating a claim up to the coverage limit of the plan.

(h) Provides that nothing in this section prevents 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.

(i) Requires that the mechanism of providing proof, if a secondary plan issuer requires proof that a related claim has been submitted to a primary plan issuer as described by Subsection (h), be through an online submission.

Sec. 1203.105. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED. (a) Prohibits a health benefit plan or vision benefit plan subject to this subchapter from being delivered, issued for delivery, or renewed in this state if:

(1) a provision of the plan excludes or reduces the payment of benefits for eye care expenses to or on behalf of an enrollee;

(2) 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

(3) the exclusion or reduction would apply before the full amount of the eye care expenses incurred by the enrollee and covered by both plans have

been paid or reimbursed or the full amount of the applicable coverage limit of the plan containing the exclusion or reduction is reached.

(b) Provides that nothing in this section requires 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.

Sec. 1203.106. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID. Provides that a provision of a health benefit plan or vision benefit plan that violates this subchapter is void.

Sec. 1203.107. RULES. Authorizes the commissioner of insurance to adopt rules necessary to implement this subchapter.

SECTION 2. Makes application of this Act prospective to January 1, 2024.

SECTION 3. Effective date: September 1, 2023.