BILL ANALYSIS

S.B. 861
By: Hughes
Insurance
Committee Report (Unamended)

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. S.B. 861 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

S.B. 861 amends the Insurance Code to set out provisions regarding the coordination of vision and eye care benefits that apply 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, including certain types of plans specified by the bill. 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:

- the 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;
- before the plan coverage limit is reached, the issuer of a secondary health benefit plan or vision benefit plan, as determined under a coordination of benefits provision applicable to the plan, 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.

S.B. 861 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.

S.B. 861 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.

S.B. 861 exempts from its provisions a supplemental insurance policy that only pays benefits directly to the policyholder and includes the following definitions:

- "eye care expenses" means expenses related to vision or medical eye care services, procedures, or products;
- "health benefit plan" means a policy, agreement, contract, or evidence of coverage that provides comprehensive medical coverage; and
- "vision benefit plan" means a limited-scope policy, agreement, contract, or evidence of coverage that provides coverage for eye care expenses but does not provide comprehensive medical coverage.

S.B. 861 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.