BILL ANALYSIS

Senate Research Center

S.B. 1051
By: Hughes
Health & Human Services
6/14/2023
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The coordination of benefits is necessary so that dual plans that provide healthcare coverage for a patient may determine their respective payment responsibility. Creating one universal and standard form to be used by all plans doing business in Texas should be established and required. This will expedite the process that will greatly benefit the patient.

Further, this proposal would eliminate errors with the various forms of different carriers/plans from appropriately covering patients. Such errors have resulted in patients in Texas receiving a surprise bill. The legislation would require the Texas Department of Insurance to create and mandate one document to be used in the process of coordinating benefits of the patient under dual plans.

Currently, the five major health insurance carriers in Texas have unique questionnaires asking for the same or similar information. A uniform Coordination of Benefits Questionnaire, created and approved by the Texas Department of Insurance, would simplify the process of coordination of a patient's benefits which are in the best interest of all patients who present themselves to any healthcare provider in Texas.

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

S.B. 1051 amends current law relating to a uniform coordination of benefits questionnaire for health benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 1203.102, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

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

SUBCHAPTER C. COORDINATION OF BENEFITS QUESTIONNAIRE

Sec. 1203.101. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations);

(3) a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations);

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations);

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements);

(6) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

(7) a Lloyd's plan operating under Chapter 941 (Lloyd's Plan); or

(8) an exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges).

(b) Provides that this subchapter, notwithstanding any other law, applies to:

(1) a small employer health benefit plan subject to Chapter 1501 (Health Insurance Portability and Availability Act), including coverage provided through a health group cooperative under Subchapter B (Coalitions and Cooperatives) of that chapter;

(2) a standard health benefit plan issued under Chapter 1507 (Consumer Choice of Benefits Plans);

(3) a basic coverage plan under Chapter 1551 (Texas Employees Group Benefits Act);

(4) a basic plan under Chapter 1575 (Texas Public School Employees Group Benefits Program);

(5) a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage);

(6) a plan providing basic coverage under Chapter 1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and the Texas A&M University System);

(7) alternative health benefit coverage offered by a subsidiary of the Texas Mutual Insurance Company under Subchapter M (Subsidiaries Authorized to Provide Health Benefit Coverage), Chapter 2054;

(8) group health coverage made available by a school district in accordance with Section 22.004 (Group Health Benefits for School Employees), Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533 (Medicaid Managed Care Program), Government Code;

(10) the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104 (Health Care Services), Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91 (Professional Employer Organizations), Labor Code.

Sec. 1203.102. CREATION OF UNIFORM COORDINATION OF BENEFITS QUESTIONNAIRE. Requires the commissioner of insurance (commissioner), in collaboration with appropriate stakeholders, to adopt rules establishing a uniform coordination of benefits questionnaire to be used by all health benefit plan issuers in this state.

Sec. 1203.103. UNIFORM AND COORDINATION OF BENEFITS QUESTIONNAIRE REQUIRED. Requires each health benefit plan issuer that issues a health benefit plan that includes a coordination of benefits provision to use the uniform coordination of benefits questionnaire established under Section 1203.102 and make the questionnaire available to health care providers as appropriate.

SECTION 2. (a) Requires the commissioner to adopt rules, not later than January 1, 2024, establishing the uniform condition of benefit questionnaire under Section 1203.102, Insurance Code, as added by this Act.

(b) Makes application of this Act prospective to February 1, 2024.

SECTION 3. Effective date: September 1, 2023.