By: Hughes, LaMantia S.B. No. 861

A BILL TO BE ENTITLED

AN ACT

relating to coordination of vision and eye care benefits under certain health benefit plans and vision benefit plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1203, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. VISION AND EYE CARE BENEFITS

Sec. 1203.101. DEFINITIONS. In this subchapter:

(1) "Eye care expenses" means expenses related to vision or medical eye care services, procedures, or products.

(2) "Health benefit plan" means a policy, agreement, contract, or evidence of coverage that provides comprehensive medical coverage.

(3) "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.

Sec. 1203.102. APPLICABILITY OF SUBCHAPTER. 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:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

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

(4) a stipulated premium company operating under Chapter 884;

(5) a fraternal benefit society operating under Chapter 885;

(6) a Lloyd's plan operating under Chapter 941;

(7) an exchange operating under Chapter 942; or

(8) a person or entity that provides a vision benefit plan.

Sec. 1203.103. EXCEPTION. 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) 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) 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.

1 (c) Before the plan coverage limit described by Subsection
2 (b) is reached, the issuer of a secondary health benefit plan or
3 vision benefit plan, as determined under a coordination of benefits
4 provision applicable to the plan, is responsible only for eye care
5 expenses covered under the plan that are not covered under the
6 health benefit plan or vision benefit plan issued by the primary
7 plan issuer.
8 (d) After the plan coverage limit described by Subsection
9 (b) has been reached, the secondary plan issuer, in addition to the
10 responsibilities described by Subsection (c), is responsible for
11 any eye care expenses covered by both plans that exceed the plan
12 coverage limit described by Subsection (b) up to the coverage limit
13 of the secondary plan.
14 (e) When an enrollee is covered by more than one health
15 benefit plan or vision benefit plan that provides benefits for eye
16 care expenses, the enrollee may use each plan on the same date of
17 service up to the coverage limit of each plan.
18 (f) A vision benefit plan issuer shall coordinate benefits
19 with a health benefit plan issuer if both provide benefits for eye
20 care expenses.
21 (g) A vision benefit plan issuer may not require a claim
22 denial before adjudicating a claim up to the coverage limit of the
23 plan.
24 (h) Nothing in this section prevents a secondary plan issuer
25 from requiring proof that a related claim has been submitted to a
26 primary plan issuer for purposes of determining the remaining
27 balance up to the secondary plan's coverage limits.

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

Sec. 1203.105. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED. (a) A health benefit plan or vision benefit plan subject to this subchapter may not be 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) 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. A provision of a health benefit plan or vision benefit plan that violates this subchapter is void.

Sec. 1203.107. RULES. The commissioner may adopt rules

1 necessary to implement this subchapter.

2 SECTION 2. The change in law made by this Act applies only
3 to a health benefit plan or vision benefit plan that is delivered,
4 issued for delivery, or renewed on or after January 1, 2024. A plan
5 delivered, issued for delivery, or renewed before January 1, 2024,
6 is governed by the law as it existed immediately before the
7 effective date of this Act, and that law is continued in effect for
8 that purpose.

9 SECTION 3. This Act takes effect September 1, 2023.