BILL ANALYSIS

Senate Research Center
86R33924 JES-F

C.S.H.B. 2486
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Business & Commerce
5/18/2019
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

C.S.H.B. 2486 amends current law relating to certain required disclosures and prohibited practices of certain employee benefit plans and health insurance policies that provide benefits for dental care services.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1451.205, Insurance Code, as follows:

Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. (a) Creates this subsection from existing text and makes no further changes.

(b) Requires a person or entity who provides or issues an employee benefit plan or health insurance policy or the employer or employee organization, if applicable, to establish an Internet website to provide resources and information to dentists, insureds, participants, employees, and members.

(c) Requires an employee benefit plan or health insurance policy provider or issuer to make accessible on the Internet website established under Subsection (b) information about the plan or policy sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy, the percentage of the allowed charges for a covered service that will be paid or reimbursed under the plan or policy, and, for a contracting provider dentist, an estimate of the amount of the payment or reimbursement available for the provider's services under the plan or policy. Requires access to the Internet website to be at no charge to patients under the plan or policy and dentists providing dental care services to the patients.

(d) Provides that an employee benefit plan or health insurance policy provider or issuer is not required to comply with Subsection (b) or (c) for a plan or policy that:

(1) provides for payment of the benefit for dental care services under the plan or policy:

(A) as an indemnity benefit based on a fixed schedule, regardless of the cost of the dental care service;

(B) on a cash-payment-only basis;

(C) directly to the beneficiary of the plan or policy or to the beneficiary’s assigns; and

(D) regardless of other coverage; and

(2) does not provide for a copayment, a deductible, a network, or contracting provider dentists.

SECTION 2. Amends Section 1451.206(a), Insurance Code, as follows:

(a) Redesignates existing Subdivisions (1)–(2) as Paragraphs (A)-(B) and creates Subdivision (1) from existing text. Requires the employee benefit plan or health insurance policy to:

(1) provide:

(A)-(B) makes nonsubstantive changes to these paragraphs; and

(C) one or more methods of payment or reimbursement that provide the dentist 100 percent of the contracted amount of the payment or reimbursement and that do not require the dentist to incur a fee to access the payment or reimbursement; and

(2) disclose on the Internet website required under Section 1451.205 (Disclosure of Benefit Terms) and on request of a dentist or a party to or beneficiary of the plan or policy the fees, if any, associated with the methods of payment or reimbursement available under the plan or policy.

SECTION 3. Amends Sections 1451.207(a) and (c), Insurance Code, as follows:

(a) Prohibits an employee benefit plan or health insurance policy from:

(1)–(2) makes no changes to these subdivisions;

(3)–(4) makes nonsubstantive changes to these subdivisions; or

(5) deducting the amount of an overpayment of a claim from a payment or reimbursement for a dental care service provided by a dentist who did not receive the overpayment.

(c) Defines "predetermination" for purposes of this subsection.

SECTION 4. Amends Subchapter E, Chapter 1451, Insurance Code, by adding Section 1451.208, as follows:

Sec. 1451.208. PRIOR AUTHORIZATION OF DENTAL CARE SERVICES. (a) Defines "prior authorization" for purposes of this section.

(b) Requires an employee benefit plan or health insurance policy provider or issuer, for services for which a prior authorization is required, on request of a patient or treating dentist, to provide to the dentist a written prior authorization of benefits for a dental care service for the patient. Requires the prior authorization to include a specific benefit payment or reimbursement amount. Prohibits the plan or policy provider or issuer, except as provided by Subsection (c), from paying or reimbursing the dentist in an amount that is less than the amount stated in the prior authorization.

(c) Authorizes an employee benefit plan or health insurance policy provider or issuer that preauthorizes a dental care service under Subsection (b) to deny a claim for the dental care service or reduce payment or reimbursement to the dentist for the service only if:

(1) the denial or reduction is in accordance with the patient's employee benefit plan or health insurance policy benefit limitations, including an annual maximum or frequency of treatment limitation, and the patient met the benefit limitation after the date the prior authorization was issued;

(2) the documentation for the claim fails to reasonably support the claim as preauthorized;

(3) the preauthorized dental care service was not medically necessary based on the prevailing standard of care on the date of the service, or is subject to denial under the conditions for coverage under the patient's plan or policy in effect at the time the service was preauthorized, because of a change in the patient's condition or because the patient received additional dental care services after the date the prior authorization was issued;

(4) a payor other than the employee benefit plan or health insurance policy provider or issuer is responsible for payment of the claim;

(5) the dentist received full payment for the preauthorized dental care service on which the claim is based;

(6) the claim is fraudulent;

(7) the prior authorization was based wholly or partly on a material error in information provided to the employee benefit plan or health insurance policy provider or issuer by any person not related to the provider or issuer; or

(8) the patient was otherwise ineligible for the dental care service under the patient's plan or policy, and the plan or policy provider or issuer did not know and could not reasonably have known that the patient was ineligible for the dental care service on the date the plan or policy provider or issuer preauthorized the dental care service.

SECTION 5. Provides that the changes in law made by this Act apply only to an employee benefit plan or health insurance policy that provides benefits for dental care services that is delivered, issued for delivery, renewed, or contracted for on or after the effective date of this Act. Provides that an employee benefit plan or health insurance policy that provides benefits for dental care services that is delivered, issued for delivery, renewed, or contracted for before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 6. Effective date: September 1, 2019.