1-1 By: Hughes S.B. No. 861

1-2 (In the Senate - Filed February 13, 2023; March 1, 2023,
1-3 read first time and referred to Committee on Health & Human
1-4 Services; April 17, 2023, reported adversely, with favorable
1-5 Committee Substitute by the following vote: Yeas 9, Nays 0;
1-6 April 17, 2023, sent to printer.)

1-7 COMMITTEE VOTE

1-8		Yea	Nay	Absent	PNV
1-9	Kolkhorst	X			
1-10	Perry	X			
1-11	Blanco	X			
1-12	Hall	X			
1-13	Hancock	X			
1-14	Hughes	X			
1-15	LaMantia	X			
1-16	Miles	X			
1-17	Sparks	X			

1-18 COMMITTEE SUBSTITUTE FOR S.B. No. 861 By: Hancock

1-19 A BILL TO BE ENTITLED
1-20 AN ACT

1-21 relating to coordination of vision and eye care benefits under
1-22 certain health benefit plans and vision benefit plans.
1-23 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-24 SECTION 1. Chapter 1203, Insurance Code, is amended by
1-25 adding Subchapter C to read as follows:
1-26 SUBCHAPTER C. VISION AND EYE CARE BENEFITS
1-27 Sec. 1203.101. DEFINITIONS. In this subchapter:
1-28 (1) "Eye care expenses" means expenses related to
1-29 vision or medical eye care services, procedures, or products.
1-30 (2) "Health benefit plan" means a policy, agreement,
1-31 contract, or evidence of coverage that provides comprehensive
1-32 medical coverage.
1-33 (3) "Vision benefit plan" means a limited-scope
1-34 policy, agreement, contract, or evidence of coverage that provides
1-35 coverage for eye care expenses but does not provide comprehensive
1-36 medical coverage.
1-37 Sec. 1203.102. APPLICABILITY OF SUBCHAPTER. This
1-38 subchapter applies only to a health benefit plan or vision benefit
1-39 plan that provides or arranges for benefits for vision or medical
1-40 eye care services, procedures, or products, including an
1-41 individual, group, blanket, or franchise insurance policy or
1-42 insurance agreement, a group hospital service contract, an evidence
1-43 of coverage, or a vision benefit plan offered by:
1-44 (1) an insurance company;
1-45 (2) a group hospital service corporation operating
1-46 under Chapter 842;
1-47 (3) a health maintenance organization operating under
1-48 Chapter 843;
1-49 (4) a stipulated premium company operating under
1-50 Chapter 884;
1-51 (5) a fraternal benefit society operating under
1-52 Chapter 885;
1-53 (6) a Lloyd's plan operating under Chapter 941;
1-54 (7) an exchange operating under Chapter 942; or
1-55 (8) a person or entity that provides a vision benefit
1-56 plan.
1-57 Sec. 1203.103. EXCEPTION. This subchapter does not apply
1-58 to a supplemental insurance policy that only pays benefits directly
1-59 to the policyholder.
1-60 Sec. 1203.104. COORDINATION OF BENEFITS BETWEEN PRIMARY AND

2-1 SECONDARY PLAN ISSUERS. (a) This section applies if:
2-2 (1) an enrollee is covered by at least two different
2-3 health benefit plans or vision benefit plans; and
2-4 (2) each plan provides the enrollee coverage for the
2-5 same vision or medical eye care services, procedures, or products.
2-6 (b) The issuer of the primary health benefit plan or vision
2-7 benefit plan, as determined under a coordination of benefits
2-8 provision applicable to the plan, is responsible for eye care
2-9 expenses covered under the plan up to the full amount of any plan
2-10 coverage limit applicable to the covered eye care expenses.
2-11 (c) Before the plan coverage limit described by Subsection
2-12 (b) is reached, the issuer of a secondary health benefit plan or
2-13 vision benefit plan, as determined under a coordination of benefits
2-14 provision applicable to the plan, is responsible only for eye care
2-15 expenses covered under the plan that are not covered under the
2-16 health benefit plan or vision benefit plan issued by the primary
2-17 plan issuer.
2-18 (d) After the plan coverage limit described by Subsection
2-19 (b) has been reached, the secondary plan issuer, in addition to the
2-20 responsibilities described by Subsection (c), is responsible for
2-21 any eye care expenses covered by both plans that exceed the plan
2-22 coverage limit described by Subsection (b) up to the coverage limit
2-23 of the secondary plan.
2-24 (e) When an enrollee is covered by more than one health
2-25 benefit plan or vision benefit plan that provides benefits for eye
2-26 care expenses, the enrollee may use each plan on the same date of
2-27 service up to the coverage limit of each plan.
2-28 (f) A vision benefit plan issuer shall coordinate benefits
2-29 with a health benefit plan issuer if both provide benefits for eye
2-30 care expenses.
2-31 (g) A vision benefit plan issuer may not require a claim
2-32 denial before adjudicating a claim up to the coverage limit of the
2-33 plan.
2-34 (h) Nothing in this section prevents a secondary plan issuer
2-35 from requiring proof that a related claim has been submitted to a
2-36 primary plan issuer for purposes of determining the remaining
2-37 balance up to the secondary plan's coverage limits.
2-38 (i) If a secondary plan issuer requires proof that a related
2-39 claim has been submitted to a primary plan issuer as described by
2-40 Subsection (h), the mechanism of providing proof must be through an
2-41 online submission.
2-42 Sec. 1203.105. CERTAIN COORDINATION OF BENEFITS PROVISIONS
2-43 PROHIBITED. (a) A health benefit plan or vision benefit plan
2-44 subject to this subchapter may not be delivered, issued for
2-45 delivery, or renewed in this state if:
2-46 (1) a provision of the plan excludes or reduces the
2-47 payment of benefits for eye care expenses to or on behalf of an
2-48 enrollee;
2-49 (2) the reason for the exclusion or reduction is that
2-50 eye care benefits are payable or have been paid to or on behalf of
2-51 the enrollee under another plan; and
2-52 (3) the exclusion or reduction would apply before the
2-53 full amount of the eye care expenses incurred by the enrollee and
2-54 covered by both plans have been paid or reimbursed or the full
2-55 amount of the applicable coverage limit of the plan containing the
2-56 exclusion or reduction is reached.
2-57 (b) Nothing in this section requires a secondary plan issuer
2-58 to pay an amount that, when added to a payment amount made by a
2-59 primary plan issuer, would exceed the usual and customary billed
2-60 charges of the health care provider.
2-61 Sec. 1203.106. CERTAIN COORDINATION OF BENEFITS PROVISIONS
2-62 VOID. A provision of a health benefit plan or vision benefit plan
2-63 that violates this subchapter is void.
2-64 Sec. 1203.107. RULES. The commissioner may adopt rules
2-65 necessary to implement this subchapter.
2-66 SECTION 2. The change in law made by this Act applies only
2-67 to a health benefit plan or vision benefit plan that is delivered,
2-68 issued for delivery, or renewed on or after January 1, 2024. A plan
2-69 delivered, issued for delivery, or renewed before January 1, 2024,

3-1 is governed by the law as it existed immediately before the
3-2 effective date of this Act, and that law is continued in effect for
3-3 that purpose.
3-4 SECTION 3. This Act takes effect September 1, 2023.

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