BILL ANALYSIS

Senate Research Center

S.B. 1143
By: Carona
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Prior to the passage of S.B. 51, 79th Legislature, Regular Session, 2005, when a health insurer learned that an employee was no longer enrolled in an employer's group health insurance plan because the employee's employment had been terminated, the insurer could terminate the employee's coverage retroactively to the date of termination of employment. In the event that the employee had received health care services after termination from employment but before being removed from the insurance plan, the insurer could, and often did, recoup its payments from the health care providers providing services to the employee during that period. S.B. 51 shifted liability for these premiums from the health care provider to the employer through the end of the month during which the employee was removed from coverage. However, this was contingent on the insurer's receipt of notification that the employee was no longer participating in the group health plan.

As a result of S.B. 51, employers are now liable for premiums if the insurer does not receive notification of the employee's termination, even if no claims for health care services are made by the employee during the relevant time period. This most often happens to small businesses that do not have human resources or payroll departments to ensure timely notification to the insurer. Notably, in the correspondence relating to the adoption of rules in connection with the implementation of S.B. 51, the Texas Department of Insurance states that the intent of S.B. 51 was "to encourage prompt and timely notification of an individual's loss of group eligibility." However, no measures that would educate employers about their responsibilities under S.B. 51 were considered.

S.B. 1143 amends current law relating to requirements regarding employer liability for certain group health benefit plan premiums and to a health benefits study to be conducted by the Texas Department of Insurance.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 843.210, Insurance Code) and SECTION 2 (Section 1301.0061, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 843.210, Insurance Code, as follows:

> Sec. 843.210. TERMS OF ENROLLEE ELIGIBILITY. (a) Creates this subsection from existing text.
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> > (b) Requires that each health maintenance organization (HMO) that enters into a contract described by Subsection (a) (regarding the length of time a group contract holder is liable for an enrollee's premiums) notify the group contract holder periodically as provided by this section that the contract holder is liable for premiums on an enrollee who is no longer part of the group eligible for coverage under the contract until the HMO receives notification of termination of the enrollee's eligibility for that coverage.
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> > (c) Requires an HMO, if the HMO charges the group contract holder on a monthly basis for the coverage premiums, to include the notice required by

Subsection (b) in each monthly statement sent to the group contract holder. Requires an HMO, if the HMO charges the group contract holder on other than a monthly basis for the premiums, to notify the group contract holder periodically in the manner prescribed by the commissioner of insurance (commissioner) by rule.

(d) Requires that the notice required by Subsection (b) include a description of methods preferred by the HMO for notification by a group contract holder of an enrollee's termination from coverage eligibility.

SECTION 2. Amends Section 1301.0061, Insurance Code, as follows:

Sec. 1301.0061. TERMS OF ENROLLEE ELIGIBILITY. (a) Creates this subsection from existing text.

(b) Requires each insurer that enters into a contract described by Subsection (a) (regarding the length of time a group policyholder is liable for an enrollee's premiums) to notify the group policyholder periodically as provided by this section that the policyholder is liable for premiums on an individual who is no longer part of the group eligible for coverage until the insurer receives notification of termination of the individual's eligibility for coverage.

(c) Requires the insurer, if the insurer charges the group policyholder on a monthly basis for the premiums, to include the notice required by Subsection (b) in each monthly statement sent to the group policyholder. Requires the insurer, if the insurer charges the group policyholder on other than a monthly basis for the premiums, to notify the group policyholder periodically in the manner prescribed by the commissioner by rule.

(d) Requires that the notice required by Subsection (b) include a description of methods preferred by the insurer for notification by a group policyholder of an individual's termination from coverage eligibility.

SECTION 3. Amends Subchapter B, Chapter 32, Insurance Code, by adding Section 32.0221, as follows:

Sec. 32.0221. TEXAS HEALTH BENEFITS STUDY. (a) Requires the Texas Department of Insurance (TDI) to study the disparity in patient copayments between orally and intravenously administered chemotherapies, the reasons for the disparity, and the patient benefits in establishing copayment parity between oral and infused chemotherapy agents.

(b) Requires TDI, not later than August 1, 2010, to submit to the governor, the lieutenant governor, the speaker of the house of representatives, and the appropriate standing committees of the legislature a report regarding the results of the study conducted under Subsection (a), together with any recommendation for legislation.

SECTION 4. Makes application of the change in law made by Sections 1 and 2 of this Act prospective to January 1, 2010.

SECTION 5. Effective date: September 1, 2009.