SUBJECT: Fees for non-covered optometric services in insurance contracts

COMMITTEE: Insurance — favorable, without amendment

VOTE: 6 ayes — Smithee, Eiland, G. Bonnen, Morrison, Muñoz, C. Turner

1 nay — Taylor

2 absent — Creighton, Sheets

SENATE VOTE: On final passage, April 10 — 30-1 (Campbell)

WITNESSES: (*On House companion bill, HB 1280:*)
For — Tommy Lucas, Texas Optometric Association; (*Registered, but did not testify:* B.J. Avery, David Frazee, Kevin Gee, Justin Henderson, Carl Isett, John McCormick, and Aaron Wolf, Texas Optometric Association; Steve Nguyen; Tyler Rudd, Texas Academy of Pediatric Dentistry)

Against — Kandice Sanaie, Texas Association of Business; (*Registered, but did not testify:* Lucinda Saxon, National Association of Specialty Health Organizations; A.R. Schwartz, Texas Retail Optical Companies)

On — Jennifer Cawley, Texas Association of Life and Health Insurers; Debra Diaz-Lara, Texas Department of Insurance; David Gonzales, Texas Association of Health Plans

BACKGROUND: SB 554 by Carona et. al, enacted by the 82nd Legislature, prohibits contracts between health plans and dentists from limiting the fee a dentist can charge for dental services that are not covered by the health plan.

DIGEST: SB 632 would prohibit a contract between an insurer and an optometrist or therapeutic optometrist from limiting or discounting the fee the optometrist or therapeutic optometrist could charge for product or service not covered by a health plan.

The bill would define a "covered product or service" as a vision care product or service that could be reimbursed under an insurance enrollee's managed-care plan contract or which could be reimbursed subject to a

contractual limitation, including a deductible, a copayment, coinsurance, a waiting period, an annual or lifetime maximum limit, a frequency limitation, or an alternative benefit payment.

The bill would take effect September 1, 2013, and would apply only to a contract entered into or renewed on or after January 1, 2014.

SUPPORTERS SAY:

SB 632 would stop health plans from requiring optometrists, as a condition of signing plan contracts, to also agree to discounted fees for non-covered services to the plan's enrollees. Current law makes it difficult for individual optometrists to negotiate with insurance companies over the size of a discount for optional, non-covered services, such as a third pair of glasses or treated lenses, if they want to accept patients with insurance. A government solution is needed because antitrust restrictions also prevent health-care providers from banding together. In areas of the state where a large employer dominates, an optometrist has no choice but to sign a contract to serve patients. Once small negotiated discounts ranging from 5 percent to 10 percent are now much higher, forcing optometrists to offer products and services almost at cost with very little profit.

The bill would not increase health-care costs. Optometrists already offer their own discounts on services and products not covered by insurance plans and for those without insurance. The bill could lower health-care costs overall by allowing optometrists to offer their own discounts and set lower fees for both insured and uninsured patients as needed, which also would increase patient choice between optometrists.

The trend in fee discounts on non-covered services unfairly requires optometrists to cut their rates so that insurers can offer a more comprehensive benefit at a low cost. If insurers or employers want to offer these non-covered services, they should do so within the plan's benefits as covered services. This practice not only is unfair to optometrists, but also to consumers because it often requires optometrists to cost-shift their lost revenue onto their other patients, many of whom do not have vision insurance.

The bill would not affect services and products covered by an insurance plan, only those specifically not covered by insurance.

OPPONENTS SAY:

SB 632 would negatively impact the quality of the health insurance that employers could offer their employees and would raise health-care costs.

Insurance plans negotiate discounts and lower fees for non-covered services as an added benefit for plan members. The bill could cause insurers to add non-preventive services to a plan, which would increase premiums.

Alternately, SB 632 would raise costs for consumers by requiring them to pay the provider's full billed charges for non-covered services and products rather than a negotiated discount rate. Removing the ability of an insurance company to negotiate discounts with providers for non-covered services would put insured consumers at a disadvantage with regard to consumers without insurance, who may be given a discount because they are uninsured.

OTHER OPPONENTS SAY:

The state should set a cap on the size of a discount an insurance company could negotiate with an optometrist or therapeutic optometrist, rather than prohibiting negotiation altogether.

NOTES:

The companion bill, HB 1280 by Lozano, was reported favorably as substituted by the House Insurance Committee on April 16.