BILL ANALYSIS

Senate Research Center
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S.B. 440
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DIGEST AND PURPOSE

Currently, insurance companies and health maintenance organizations (HMOs) often verify coverage or benefits for an insured to a preferred provider who requests such information prior to rendering covered services. Then, after the treatment has been provided, the insurer discovers an error and refuses payment to the provider. Also, some insurers and HMOs avoid the prompt payment requirements of state law by requiring preferred providers to agree to utilize a dispute resolution procedure which delays the payment process well beyond the 45-day time limit for the payment of "clean claims." As proposed, S.B. 440 requires insurance companies and HMOs to reimburse participating podiatrists for physical therapy services that are covered by the policy, and reimburse preferred providers who in good faith provide covered services after obtaining verification of coverage and benefits from the insurer and within the time period mandated by current law.

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 3, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, by amending Subsection (n) and add Subsection (o), as follows:

> (n) Authorizes a podiatrist to furnish physical therapy under a preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners.
>
> (o) Requires an insurer to verify coverage and benefits for an insured to a preferred provider who requests such information prior to rendering covered services. Prohibits the insurer from denying payment for the services rendered after coverage and benefits have been verified unless written notice of an error in verification is received by the preferred provider before treatment is performed.

SECTION 2. Amends Section 3A, Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, by adding Subsection (o), to prohibit an insurer from requiring the use of a dispute resolution procedure with a preferred provider that violates certain parts of this section.

SECTION 3. Amends Article 20A.18A, V.T.I.C., as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, by amending Subsection (j) and adding Subsection (k), as follows:

> (j) Makes a conforming change.
>
> (k) Requires a health maintenance organization to verify coverage and benefits for an enrollee to

a physician or provider who requests such information prior to rendering covered services. Prohibits the insurer from denying payment for the services rendered after coverage and benefits have been verified unless written notice of an error in verification is received by the physician or provider before treatment is performed.

SECTION 4. Amends Article 20A.18B, V.T.I.C., by adding Subsection (p), to prohibit a health maintenance organization from requiring the use of a dispute resolution procedure with a physician or provider that violates certain parts of this section

SECTION 5. Effective date: September 1, 2001.
Makes application of this Act prospective.