BILL ANALYSIS

C.S.H.B. 2002
By: Oliverson
Health Care Reform, Select
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Many health insurance plans have deductibles, which is the amount of money a person must pay out of pocket before their health plan's full coverage applies. Additionally, some health plans have a maximum out-of-pocket limit, which is the most a person will have to pay for covered medical expenses in a given year. Once the out-of-pocket limit is reached, the health plan pays 100 percent of covered medical expenses for the remainder of the plan year. In some circumstances, the cash price that a doctor or medical facility offers for a treatment, test, or procedure is less costly than a health plan's negotiated rate. However, patients are not currently incentivized to seek out these deals because their cash payments do not count toward their deductible or maximum out-of-pocket expenses.

C.S.H.B. 2002 will allow any out-of-pocket cash payment made by an individual for medically necessary services and supplies to be credited toward their deductible and maximum out-of-pocket expenses. Allowing out-of-pocket payments to be credited in this manner provides several benefits, including encouraging cost-saving behavior, increasing health care affordability and access, and improving patient satisfaction.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 2002 amends the Insurance Code to require an insurer to credit toward an insured's deductible and annual maximum out-of-pocket expenses an amount the insured pays directly to any physician or health care provider for a medically necessary covered medical or health care service or supply under the following circumstances:

- a claim for the service or supply is not submitted to the insurer; and
- the amount paid by the insured to the physician or health care provider is less than the average discounted rate for the service or supply paid to an equivalently licensed or authorized preferred provider under the insured's preferred provider benefit plan.

C.S.H.B. 2002 requires an insurer to establish a procedure by which an insured may claim such a credit and to identify documentation necessary to support a claim for the credit. The bill requires information about the procedure and documentation to be readily accessible to an insured on the insurer's website.

C.S.H.B. 2002 applies only to a preferred provider benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 2002 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

While the introduced made the credit applicable to amounts paid for covered medical or health care services or supplies generally, the substitute limits application of the credit to amounts paid for covered medical or health care services or supplies that are medically necessary.