BILL ANALYSIS

C.S.H.B. 2414
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

In order to have a well-functioning health care market, patients must be engaged. Patients should be rewarded for choosing lower-cost, higher-quality care. Currently, patients have no incentive to shop for lower-cost care because they often pay the same amount regardless of which provider they choose. The Texas Department of Insurance's interpretation of current law has made it illegal for insurance plans to reward enrollees who shop for low-cost, high-quality care. C.S.H.B. 2414 seeks to allow insurance plans to provide incentives to patients for choosing lower-cost providers.

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. 2414 amends the Insurance Code to authorize a health maintenance organization (HMO) or health care insurer to provide incentives for enrollees or insureds, as applicable, to use certain physicians or providers through modified deductibles, copayments, coinsurance, or other cost-sharing provisions. The bill establishes that an HMO or insurer that encourages an enrollee or insured to obtain a health care service from a particular physician or provider, including offering incentives to encourage enrollees or insureds to use specific physicians or providers, or that introduces or modifies a tiered network plan or assigns physicians or providers into tiers, has a fiduciary duty to the enrollee, group contract holder, insured, or policyholder, as applicable, to engage in that conduct only for the primary benefit of the enrollee, group contract holder, insured, or policyholder.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 2414 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.

The substitute omits the provision from the introduced excluding a self-funded employee welfare benefit plan accessing a value-based risk sharing contract arrangement entered into by an authorized health insurer or HMO and a health care provider or group of providers from the acts considered to be engaging in the business of insurance on the basis of contracting to provide indemnification or expense reimbursement for a medical expense by direct payment, reimbursement, or otherwise.

The substitute omits the provisions from the introduced authorizing a preferred provider benefit plan to provide or arrange for health care services with a physician or health care provider through a contract or subcontract for compensation under certain arrangements.

The substitute includes provisions that were not in the introduced relating to the fiduciary duty of an HMO or insurer that encourages an enrollee or insured to obtain a health care service from a particular physician or provider or that introduces or modifies a tiered network plan or assigns physicians or providers into tiers to the enrollee, group contract holder, insured, or policyholder.