BILL ANALYSIS

Senate Research Center

H.B. 1562
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Business & Commerce
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Engrossed

DIGEST AND PURPOSE

Health care fraud and abuse are costing the national health care system several billion dollars annually. H.B. 1562 sets forth requirements for the investigation of insurance fraud, adoption of fraud plans by insurers and coordinated enforcement efforts with the attorney general, Medicaid, and the Texas Department of Insurance.

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 Article 1.10D, Insurance Code, by adding Section 3A, as follows:

> Sec. 3A. INSURER ANTIFRAUD INVESTIGATIVE REPORTS. (a) Authorizes the insurance fraud unit to receive, review, and investigate in a timely manner insurer antifraud reports submitted under Chapter 3K, of this code.
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> (b) Requires the insurance fraud unit to report annually in writing to the commissioner the number of cases completed and any recommendations for new regulatory and statutory responses to the types of fraudulent activities encountered by the insurance fraud unit.

SECTION 2. Amends Section 6, Article 1.10D, Insurance Code, by amending Subsection (a) and adding Subsection (e), as follows:

> (a) Provides that a person acting without malice, fraudulent intent, or bad faith is not subject to liability based on filing reports or furnishing, orally or in writing, other information concerning suspected, anticipated, or completed fraudulent insurance acts if the reports or information are provided to a special investigative unit of an insurer, including a person contracting to provide special investigative unit services, or an employee of an insurer who is responsible for the investigation of suspected fraudulent insurance acts.
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> (e) Prohibits information provided herein by an insurer to the insurance fraud unit and/or an authorized governmental agency from being subject to public disclosure. Authorizes the information to be used by the insurance fraud unit and/or governmental agency only for the performance of its duties as described herein. Requires an insurer to exercise reasonable care concerning the accuracy of the information conveyed to the insurance fraud unit, an authorized governmental agency, other insurers, or other persons or entities.

SECTION 3. Amends Chapter 3, Insurance Code, by adding Subchapter K, as follows:

SUBCHAPTER K. INSURER ANTIFRAUD PROGRAMS

Art. 3.97-1. DEFINITIONS. Defines “health care provider” and “insurer.”

Art. 3.97-2. NOTICE OF PENALTY FOR FALSE OR FRAUDULENT CLAIMS; DISPLAY ON FORMS. (a) Requires an insurer, if an insurer provides a form for a person to use to make a claim against a policy issued by the insurer or to give notice of a person's intent to make a claim against a policy issued by the insurer, to provide on that form, in comparative prominence with the other content on the form, a statement as follows: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

(b) Provides that this section does not apply to a claim made against a policy issued by a reinsurer.

Art. 3.97-3. INSURER ANTIFRAUD PLANS. (a) Requires an insurer to adopt an antifraud plan under this article. Authorizes the insurer to annually file that plan with the insurance fraud unit. Requires the plan to include certain requirements.

(b) Requires that, if an insurer participating in the STAR or STAR + Plus Medicaid program, or the state child health plan under Chapter 62, Health and Safety Code, has in place a fraud and abuse plan approved by a health and human services agency, such plan is to be deemed to meet the requirements of this subchapter. Requires that if such insurer is required by law to report possible fraudulent insurance acts to a health and human services agency and/or the Office of Attorney General, such insurer is to not be required to also report such acts to the insurance fraud unit.

(c) Requires the health and human services agencies, the Office of Attorney General, and the insurance fraud unit to coordinate enforcement efforts relating to acts covered by this subchapter that occur in relation to the state Medicaid program or state child health plan program.

SECTION 4. Amends Title 3A, Occupations Code, by adding Chapter 105, as follows:

CHAPTER 105. UNPROFESSIONAL CONDUCT BY HEALTH CARE PROVIDER

Sec. 105.001. DEFINITION. Defines “health care provider.”

Sec. 105.002. UNPROFESSIONAL CONDUCT. (a) Provides that a health care provider commits unprofessional conduct if the health care provider, in connection with the provider's professional activities knowingly presents or causes to be presented a false or fraudulent claim for the payment of a loss under an insurance policy or knowingly prepares, makes, or subscribes to any writing, with intent to present or use the writing, or to allow it to be presented or used, in support of a false or fraudulent claim under an insurance policy.

(b) Provides that in addition to other provisions of civil or criminal law, commission of unprofessional conduct under Subsection (a) constitutes cause for the revocation or suspension of a provider's license, permit, registration, certificate, or other authority or other disciplinary action.

SECTION 5. (a) Effective date: September 1, 2001.

(b) Requires the insurance fraud unit to make the initial report to the commissioner of insurance required under Section 3A(b), Article 1.10D, Insurance Code, as added by this Act, not later than January 1, 2003.