By: Davis of Harris H.B. No. 2556

A BILL TO BE ENTITLED

AN ACT

relating to the control of health insurance fraud.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Texas Insurance Code, Part I, Chapter 3, Life, Accident and Health Insurance, is amended to add a new Article 3.101 of a new Subchapter L, Insurer Anti-fraud Programs, as follows:

Art. 3.101. STATEMENT OF PUBLIC POLICY. The Legislature finds and declares that the business of health insurance involves many transactions which have potential for abuse and illegal activities. There are numerous law enforcement agencies on the state and local levels charged with the responsibility for investigating and prosecuting fraudulent activity. This chapter is intended to permit the full utilization of the expertise of the commissioner and the department so that they may more effectively investigate and discover insurance frauds, halt fraudulent activities, and assist and receive assistance from federal, state, local, and administrative law enforcement agencies in prosecution of persons who are parties in insurance frauds.

SECTION 2. Texas Insurance Code, Part I, Chapter 3, Life, Accident and Health Insurance, is amended to add a new Article 3.101-1 of a new Subchapter L, Insurer Anti-fraud Programs, as follows:

Art. 3.101-1. NOTICE OF PENALTY FOR FALSE OR FRAUDULENT CLAIMS; DISPLAY ON FORMS. Any insurer who, in connection with any

insurance contract or provision of contract described in this subsection, prints, reproduces, or furnishes a form to any person upon which that person gives notice to the insurer or makes claim against it by reason of accident, injury, or other noticed or claimed loss, or on a rider attached thereto, shall cause to be printed or displayed in comparative prominence with other content the statement or a statement substantially similar to the following in terms of intent and language: "Any person who knowingly presents 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." This statement shall be preceded by the words: "For your protection, Texas law requires the following to appear on this form" or other explanatory words of similar meaning.

SECTION 3. Texas Insurance Code, Part I, Chapter 3, Life, Accident and Health Insurance, is amended to add a new Article 3.101-2 of a new Subchapter L, Insurer Anti-fraud Programs, as follows:

Art. 3.101-2. ADMINISTRATIVE ACTION FOR FRAUD. If the commissioner of insurance determines that an insurer has been defrauded by the action of a health care provider, including a hospital, physician, dentist, chiropractor, nurse, or other practitioner of the health care or healing arts, the commissioner may order that the insurer retain such amounts that otherwise would be owed to that health care provider.

SECTION 4. Texas Insurance Code, Part I, Chapter 3, Life, Accident and Health Insurance, is amended to add a new Article 3.101-3 of a new Subchapter L, Insurer Anti-fraud Programs, as

follows:

Art. 3.101-3. INSURER ANTI-FRAUD INVESTIGATIVE UNITS. (a) Every insurer admitted to do business in this state that at any time in the previous calendar year had $10 million or more in direct premiums written shall:

(1) Establish and maintain a division within the company to investigate possible fraudulent claims by insureds or by persons making claims against policies held by insureds; or

(2) Contract with others to investigate possible fraudulent claims against policies held by insureds.

(b) An insurer subject to this chapter shall file annually for approval with the insurance fraud unit of the department (Texas Insurance Code Article 1.10D) beginning on or before July 1, 2001, a detailed description of the division established pursuant to this statute and the results of its investigations.

(c) Every insurer admitted to do business in this state, that in the previous calendar year had less than $10 million in direct premiums written, must adopt annually an anti-fraud plan and file it for approval with the insurance fraud unit of the department beginning on or before July 1, 2001. After the insurer's satisfaction of its first filing requirement under this statute, the insurer shall thereafter comply with the filing dates as established by the commissioner.

(d) In discharge of its obligation to establish and maintain an anti-fraud division, an insurer may contract with others to investigate possible fraudulent claims against policies held by insureds.

(e) If an insurer establishes and maintains an anti-fraud division, then insurer's anti-fraud plan shall include:

(1) A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts;

(2) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Insurance fraud unit of the department;

(3) A description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel;

(4) The names, addresses, telephone numbers, and fax numbers of the persons assigned by the insurer to staff the insurer's anti-fraud division; and

(5) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.

(f) If an insurer elects to contract with others to investigate possible fraudulent claims against policies held by insureds, then the insurer shall file for approval with the insurance fraud unit of the department:

(1) A copy of the written contract between the insurer and the entity with which the insurer has entered into an agreement to investigate possible fraudulent insurance claims;

(2) The names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the insurer has entered into an agreement to investigate possible fraudulent claims; and

(3) The qualifications of the principals of the entity with which the insurer has entered into an agreement to investigate possible fraudulent claims.

(g) Any insurer who obtains a certificate of authority after January 1, 2000, shall have 18 months in which to comply with the requirements of this section. After the insurer's satisfaction of its first filing requirement under this statute, the insurer shall thereafter comply with the filing dates as established by the commissioner.

(h) For purposes of this section, the term "division" includes the assignment of fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims.

(i) If an insurer hires additional employees or contracts with another entity to fulfill the requirements of this section, the additional cost incurred must be included as an administrative expense for ratemaking purposes.

SECTION 5. Texas Insurance Code, Part I, Chapter 3, Life, Accident and Health Insurance, is amended to add a new Article 3.101-4 of a new Subchapter L, Insurer Anti-fraud Programs, as follows:

Art. 3.101-4. IMMUNITY FOR INSURER-TO INSURER INFORMATION SHARING. (a) In the course of investigating possible insurance fraud claims, an insurer or its contracting entity may share information with other insurers or entities that have contracted with insurers to provide anti-fraud investigative services.

(b) The sharing of this information between insurers and

their contracting entities under this statute will not subject the parties that are sharing the information to liability for defamation by the health care provider if the purpose of the provision of information is for the purpose of reporting, detecting, or preventing the commission of fraudulent insurance acts and is made without malice, fraudulent intent, or bad faith.

(c) This section does not affect or modify any common law or statutory privilege or immunity.

SECTION 6. Texas Health & Safety Code, Title 1, is amended by adding Section 2.001, as part of a new chapter 2, Health Care Fraud Programs as follows:

Sec. 2.001. PUBLIC POLICY. It shall be the policy of this state to confront aggressively the problem of health care fraud in Texas by facilitating the detection and prevention of fraud at its source.

SECTION 7. Texas Health & Safety Code, Title 1, is amended by adding Section 2.002. as part of a new chapter 2, Health Care Fraud Programs as follows:

Sec. 2.002. DEFINITIONS. (a) "Insurer" means

(1) any life, health, & accident insurer; health & accident insurer; or health insurer; health maintenance organization; or any other company operating pursuant to Chapter 3, 10, 20, 20A, 22, or 26 of the Code and that is authorized to issue, deliver, or issue for delivery in this state policies, certificates, or contracts;

(2) any approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article

4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner of insurance under Article 21.52F, Insurance Code;

(3) any entity that direct contracts with employers, employees, labor unions, trade associations, or other groups to provide health benefit coverage; or

(4) any insurer authorized by the Texas Department of Insurance to write workers' compensation insurance in this state.

(b) "Health maintenance organization" means an organization as defined in Article 20A.02 of the Code.

(c) "Health care provider" means any person or entity that holds a license, certificate, or other form of authorization issued by an agency, board, commission, or other governmental unit of this state by which the holder is authorized to deliver, render, or otherwise provide health care or medical services to the public; this definition shall include but not be limited to all such persons who hold such licenses, certificates, or other authorizations issued pursuant to the provisions of Title 71 of the Texas Revised Civil Statutes and Title 4 of the Texas Health & Safety Code.

SECTION 8. Texas Health & Safety Code, Title 1, is amended by adding Section 2.003. as part of a new chapter 2, Health Care Fraud Programs as follows:

Sec. 2.003. UNPROFESSIONAL CONDUCT. (a) It shall constitute unprofessional conduct and grounds for disciplinary action for a provider to do any of the following in connection with his or her professional activities:

(1) Knowingly present or cause to be presented any

false or fraudulent claim for the payment of a loss under a contract of insurance

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim

(3) Commit an offense that is a violation of Chapter 35 of the Texas Penal Code or is a violation of any similar statute under the laws of other jurisdictions.

(b) In addition to such other provisions of civil or criminal law, a violation of this provision shall constitute cause for the suspension of the provider's license for one year upon a first conviction for fraud in any jurisdiction and revocation of a provider's license for a second conviction in any jurisdiction. The first and second convictions need not occur in the same jurisdiction for the revocation to be imposed.

SECTION 9. Texas Health & Safety Code, Title 1, is amended by adding Section 2.004 as part of a new chapter 2, Health Care Fraud Programs, as follows:

Sec. 2.004. NON-APPLICATION TO ERISA PLANS. No portion of this chapter shall be construed to apply to those self-funded health care plans that may be governed by the provisions of Employee Retirement Income Security Act of 1974, as amended.

SECTION 10. Texas Insurance Code, Article 1.10D, is amended by adding a new Section 3A, as follows:

Sec. 3A. INSURER ANTI-FRAUD INVESTIGATIVE REPORTS. (a) The insurance fraud unit shall receive, review, and investigate in a timely manner all insurer anti-fraud reports submitted pursuant

to the provisions of Texas Insurance Code, Article 3.101.

(b) The insurance fraud unit shall report in writing annually to the commissioner the number of cases completed and recommendations for new regulatory and statutory responses to the types of fraudulent activities being encountered by the insurance fraud unit.

SECTION 11. Texas Insurance Code, Article 1.10D, is amended by adding a new Subsection 2(h), as follows:

(h) The insurance fraud unit shall be funded by an anti-fraud assessment levied against insurers calculated as a percentage of the total premium written during the previous calendar year. The percentage and dates of payment shall be set by the commissioner upon notice and hearing. The anti-fraud assessment may not exceed 0.50 percent of gross premiums written by the insurer. The insurer may take as a credit against any premium tax obligations under the provisions of Article 4.11 of this code the amount paid on the anti-fraud assessment. The anti-fraud assessment shall be paid to the office of the comptroller of public accounts.

SECTION 12. This Act takes effect January 1, 2004.