BILL ANALYSIS

C.S.H.B. 633
By: Frank
Health Care Reform, Select
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has become commonplace in the medical industry to charge select customers vastly higher prices for the same service. While some would rightfully argue that businesses should be able to charge whatever the market will bear, this is taking place in an industry that serves vulnerable customers and that has limited price transparency and limited competition. It is currently legal for a hospital to accept $1,000 from an insured patient for a procedure while charging $4,000 or more for the same procedure if a person is paying cash or does not have insurance. While most ethically run medical facilities limit this practice, others take advantage of it in a predatory fashion and simply turn their patients over to collection agencies when the customers cannot pay the inflated bills. If a restaurant charged one person $10 for a meal and charged another person $40 for the same order, it would be considered price gouging—and rightfully so. We do not accept this type of price discrimination in most industries, yet it is the written business plan for many in health care. This price discrimination is ethically wrong, hurts the most vulnerable in our health care system, and should not be allowed. C.S.H.B. 633 seeks to address this issue by requiring that patients paying a hospital directly without using insurance for a health care service provided in the hospital are not charged an amount that is higher than the lowest contracted rate for that service allowable that the hospital has agreed to accept as payment in full as a contracted, preferred, or participating provider of certain health benefit plans.

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. 633 amends the Insurance Code to require a public or private licensed hospital, other than a licensed ambulatory surgical center, to accept directly from a patient, including a patient who is enrolled in a health benefit plan or otherwise entitled to coverage under a health benefit plan, full payment for a health care service provided in the hospital at the patient's request. The bill defines "health care service" as a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to an individual by a physician or other health care provider. If such payment is made by an enrollee, the hospital must accept that payment in lieu of submitting a claim to the enrollee's health benefit plan. The bill requires a patient's direct payment request to be made not later than the 60th day after the date on which the health care service is provided.

C.S.H.B. 633 prohibits the amount of the payment for a health care service provided in a hospital and for which the hospital accepts direct payment from a patient from exceeding the lowest contracted rate for the health care service that the hospital has agreed to accept as payment in full as a contracted, preferred, or participating provider of a health benefit plan. For purposes of the bill, a "health benefit plan" means an individual, group, blanket, or franchise insurance policy, a group hospital service contract, or an individual or group subscriber contract or evidence of coverage issued by a health maintenance organization, that provides benefits for health care services, and the term does not include Medicaid or Medicaid managed care, CHIP, or Medicare benefits. In addition to the health benefit plans so defined, the bill also applies to the following:

- a basic coverage plan under the Texas Employees Group Benefits Act;
- a basic plan under the Texas Public School Retired Employees Group Benefits Act;
- a primary care coverage plan under the Texas School Employees Uniform Group Health Coverage Act; and
- a plan providing basic coverage under the State University Employees Uniform Insurance Benefits Act.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 633 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 both the introduced and the substitute provide for the direct payment by a patient for a health care service in lieu of a claim for insurance benefits, the bill versions differ in their approach as follows:

- the substitute does not include a provision that was included in the introduced establishing that a physician or health care provider, as defined in the introduced, may not be prohibited from accepting directly from an enrollee full payment for a health care service in lieu of submitting a claim to the enrollee's health benefit plan;
- the substitute instead includes provisions that were not in the introduced that, as follows:
    - require a hospital, as defined by the substitute, to accept directly from a patient, including a patient who is an enrollee, full payment for a health care service provided in the hospital at the patient's request;
    - require the request to be made not later than the 60th day after the date on which the health care service is provided;
    - if the payment is made by an enrollee, require the hospital to accept that payment in lieu of submitting a claim to the enrollee's health benefit plan; and
    - establish that the term "health benefit plan" does not include Medicaid or Medicaid managed care, CHIP, or Medicare benefits; and
- the substitute replaces a provision included in the introduced that prohibited the charge for a health care service for which a physician or health care provider accepts a payment directly from an enrollee from exceeding the lowest contract rate for the health care service allowable under any health benefit plan with respect to which the physician or health care provider is a contracted, preferred, or participating provider with a provision prohibiting the amount of the payment for a health care service that was provided in the hospital and for which the hospital accepts payment directly from a patient from exceeding the lowest contracted rate for the health care service that the hospital has agreed to accept as payment in full as a contracted, preferred, or participating provider of a health benefit plan.