BILL ANALYSIS

C.S.H.B. 1612
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Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The bill author has informed the committee that some hospitals charge their patients different prices for the same procedures, depending on the patients' insurance, or lack thereof. C.S.H.B. 1612 seeks to address this issue by limiting what hospitals are allowed to charge their uninsured patients.

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. 1612 amends the Health and Safety Code to require a licensed public or private hospital, not including a licensed ambulatory surgical center, to accept directly from a patient who is not enrolled in a health benefit plan or otherwise entitled to coverage under such a plan full payment for a health care service provided by the hospital at the patient's request. The bill requires such a request to be made not later than the 60th day after the date on which the patient receives a bill for or other final accounting of the health care service provided. The bill authorizes a hospital, in accepting payments under the bill's provisions for health care services provided by the hospital, to change patients' amounts that are either:

- not more than 25 percent greater than the amounts generally billed, as defined by federal law for a health care service; or
- not more than 50 percent greater than the lowest contracted rate for the service that the hospital has agreed to accept as payment in full as a contracted, preferred, or participating provider of a health benefit plan other than the following:
    - CHIP;
    - Medicare; or
    - the state Medicaid program, including the Medicaid managed care program.

C.S.H.B. 1612 defines the following terms for purposes of the bill's provisions:

- "enrollee" means an individual who is enrolled in a health benefit plan or otherwise entitled to coverage under a health benefit plan;
- "health benefit plan" means any individual or group arrangement with a public or private entity under which the entity will pay for, reimburse expenses for, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient, including an arrangement with:
    - an insurance company;

    - the sponsor or administrator of a self-insured health benefit plan;
    - a group hospital service corporation or a health maintenance organization operating under applicable state law;
    - the state Medicaid program, including the Medicaid managed care program;
    - a health benefit plan offered or administered by or on behalf of the state or a political subdivision of the state or an agency or instrumentality of the state or a political subdivision of the state, including a basic coverage plan under the Texas Employees Group Benefits Act, TRS-Care, TRS-ActiveCare, and a plan providing basic coverage under the State University Employees Uniform Insurance Benefits Act; or
    - any other entity providing a health insurance or health benefit plan subject to regulation by the Texas Department of Insurance; and
- "health care service" means 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.

EFFECTIVE DATE

September 1, 2025.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 1612 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 authorizes a hospital, in accepting payments directly from a patient for a health care service provided by the hospital, to change patients' amounts that are either not more than 25 percent greater than the amounts generally billed, as defined by federal law for a health care service, or not more than 50 percent greater than the lowest contracted rate for the service that the hospital has agreed to accept as payment in full as a contracted, preferred, or participating provider of a certain health benefit, whereas the introduced caps the amount of such payment for a service provided by the hospital at not more than 25 percent greater than 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 certain health benefit plan.