SUBJECT: Controlling insurance fraud

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Burnam, G. Lewis, J. Moreno, Olivo, Seaman, Thompson, Wise

0 nays

1 absent — Eiland

WITNESSES: (*On original bill:*)
For — Will Davis, Texas Association of Life and Health Insurers; Richard Evans, Texas Association of Business and Chambers of Commerce

Against — Cynthia Leiferman, Advocacy, Inc.; Conway McDanald, Texas Medical Association

On — Lisa McGiffert, Consumers Union

BACKGROUND: The Texas Insurance Code, Art. 1.10D authorizes the Department of Insurance to operate an insurance fraud unit.

Art. 1.10D, Section 6 exempts a person acting without malice from liability for providing information about suspected insurance fraud to law enforcement or any authorized government agency.

DIGEST: CSHB 3603 would add a statement of public policy to the Insurance Code, Art. 1.10D that the Legislature recognizes the potential for insurance fraud and intends the article to permit the full use of the expertise of the commissioner of insurance and the insurance department to investigate and fight insurance fraud in cooperation with law enforcement agencies. The bill would require anti-fraud warnings to be placed on claim forms, adoption of antifraud plans by insurance companies, and suspension or revocation of licenses of health care providers for fraud convictions.

The department's insurance fraud unit would be required to investigate in a timely manner all anti-fraud reports submitted to it. The unit would forward

to the regulatory body of a health care provider any information concerning a complaint against the provider upon entry of a final civil judgment or criminal conviction involving fraud.

The bill states that persons acting without malice to provide information about suspected insurance fraud would not be subject to liability for reporting it to an insurer's special investigative unit, fraud investigation employees, and investigators working on a contract basis with the insurer. This information would not be subject to public disclosure and could only be used in anti-fraud efforts.

Insurers would be required to include statements on their claim forms warning that it is illegal for anyone to present a claim for payment to an insurer containing information known to be false or misleading and that "persons that commit insurance fraud may be subject to criminal penalties, including fine and imprisonment." The absence of such a warning could not be used as a defense to insurance fraud. The warnings would not be required for reinsurance contracts.

Every insurer would be required to adopt an antifraud plan and file it for approval with the insurance fraud unit beginning on or before July 1, 2001. The plan would include the insurer's plans for investigating and reporting fraud and confidentiality procedures.

A statement would be added to Title 1 of the Texas Health and Safety Code that it is state policy to confront the problem of health care fraud by facilitating detection and prevention of fraud.

CSHB 3603 provides that it would constitute unprofessional conduct for a health care provider to present a claim with the intent to defraud if the provider knew the claim contained false information material to the payment of the claim. The license of a provider convicted of fraud would be suspended for one year. Upon a second conviction, the license would be revoked.

The regulatory body of a health profession could probate the suspension of a provider's license upon an express determination that probation would be in the best interests of the public. The determination would have to include the reasons and conditions for the probation.

CSHB 3603 would take effect September 1, 1999.

SUPPORTERS SAY:

Insurance fraud costs insurers $1 billion nationally. It also costs consumers, who ultimately must pay for these costs through higher premiums. CSHB 3603 would help fight insurance fraud in several ways. While the Insurance Code already authorizes the insurance fraud unit, the law did not include a statement of public policy authorizing use of all available insurance department resources to fight insurance fraud in cooperation with law enforcement agencies.

CSHB 3603 would strongly encourage insurers to develop their own plans for detecting and investigating insurance fraud and to coordinate their own anti-fraud measures with the state. It would warn against filing fraudulent claims by individuals and crack down on health care providers who file false claims.

The committee substitute has been written with direct involvement by health care providers and consumer groups to address any possible concerns. The required warning on claim forms was changed to decrease the chances it might discourage honest consumers from filing claims. Probated sentences could be given by health profession regulatory bodies to accommodate rural areas where the loss of one physician might have a devastating effect.

OPPONENTS SAY:

No apparent opposition.

NOTES:

The committee substitute incorporated many of the provisions from HB 2096 by J. Davis on health insurance fraud. The original version of HB 3603 had different warning language, allowed more insurer to insurer communication, and would have imposed a civil penalty on providers who committed certain kinds of insurance fraud.

The companion bill, SB 1556 by Fraser, was referred to the Senate Economic Development Committee.