BILL ANALYSIS

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C.S.S.B. 207
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State Affairs
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Spiraling health care costs are driving health insurance carriers to implement cost-containment measures that might result in decreased claims payouts and increased numbers of policy rescissions. In fact, national claims data indicate that the amount insurance carriers are paying out for claims is lower than in the past, and consumers are paying more medical expenses out-of-pocket.

The increase of health insurance policy cancellations and rescissions have caused a number of states to subject major health insurers to regulatory inquiries and subsequent fines. For example, last year in California, both Anthem Blue Cross of California and Blue Shield of California agreed to reinstate insurance coverage to a total of 2,220 former members whose policies were revoked and pay up to $15 million in fines. The Managed Health Care Department of California has reached similar settlements with other insurers over policy rescissions.

This bill is intended to protect consumers from unscrupulous carriers that seek to maximize profit by prohibiting health insurance carriers from offering any monetary or material compensation to incentivize an employee to increase the number of rescinded or canceled health insurance policies, or to reduce the payout associated with a claim.

C.S.S.B. 207 amends current law relating to prohibition of certain business practices related to rescission of coverage under health benefit plans.

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 Subtitle C, Title 6, Insurance Code, by adding Chapter 848, as follows:

CHAPTER 848. PROHIBITED PRACTICES RELATED TO RESCISSION

Sec. 848.001. APPLICABILITY. Provides that this chapter applies to a health benefit plan that provides benefits in this state for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by an insurance company; a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations); a fraternal benefit society operating under Chapter 885 (Fraternal Benefit Societies); a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies); a reciprocal exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges); a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations); a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements); or an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations).

(b) Provides that this chapter does not apply to:

(1) a health benefit plan that provides coverage only for a specified disease or diseases or under an individual limited benefit policy, for accidental death or dismemberment, as a supplement to a liability insurance policy, or for dental or vision care;

(2) disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(3) credit insurance coverage;

(4) a hospital confinement indemnity policy;

(5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(6) a workers' compensation insurance policy;

(7) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner of insurance determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section.

Sec. 848.002. BAD FAITH RESCISSION. (a) Provides that it is an unfair method of competition or an unfair or deceptive act or practice for purposes of Chapter 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices) for a health benefit plan issuer to set rescission goals, quotas, or targets; pay compensation of any kind, including a bonus or award, that varies according to the number of rescissions; set, as a condition of employment, a number or volume of rescissions to be achieved; or set a performance standard, for employees or by contract with another entity, based on the number or volume of rescissions.

(b) Defines "rescission."

SECTION 2. Effective date: September 1, 2009.