BILL ANALYSIS

S.B. 1391
By: Uresti
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Business and insurance companies are beginning to consider outsourcing health care due the prospect of significant savings. Last year, 500,000 Americans traveled overseas for medical treatment. Hospitals in Thailand, India, and Singapore have been frequented by Americans seeking cosmetic surgery; however, many of these facilities are gaining reputations for heart surgery and knee and back procedures. United Group Programs sells self-insurance policies to small businesses and is offering a plan that requires patients to travel to the Bumrungrad International Hospital in Bangkok. This type of plan has the potential to save employers more than 50 percent on major medical costs.

S.B. 1391 prohibits certain health benefit plans from requiring enrollees to travel to a foreign country to receive health care services.

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

SECTION 1. Amends Subtitle A, Title 8, Insurance Code, by adding Chapter 1215, as follows:

CHAPTER 1215. OUT-OF-COUNTRY COVERAGE PROHIBITED

Sec. 1215.001. DEFINITIONS. Defines "enrollee," "foreign country," and "health care service."

Sec. 1215.002. APPLICABILITY OF CHAPTER. (a) Provides that this chapter applies only to certain health benefit plans.

(b) Provides that, for the purposes of Subsection (a), a health benefit plan includes a consumer choice of benefits plan issued under Chapter 1507 (Consumer Choice of Benefits Plans).

Sec. 1215.003. EXCEPTION. Sets forth health benefits plans to which this chapter does not apply.

Sec. 1215.004. OUT-OF-COUNTRY CARE PROHIBITED. Prohibits a health benefit plan issuer from issuing or offering for sale in this state a health benefit plan that requires an enrollee to travel to a foreign country to receive a particular health care service under the plan, or a discount on the amount an enrollee is required to pay to receive a particular health care service under the plan.

SECTION 2. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2008, is covered by the law in effect at the time the plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

SECTION 3. Effective date: September 1, 2007.

EFFECTIVE DATE

September 1, 2007.