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TO: All Life, Accident and Health Insurers Writing Supplemental Cancer and Other Specified Disease Policies

FROM: Scott H. Richardson, CPCU 
Director

SUBJECT: Compliance with S.C. Code Ann. § 38-71-242

DATE: August 28, 2008

I. Background

Section 38-71-242 of the South Carolina Code became effective on June 4, 2008. That section provides:

(A)(1) When used in any individual or group specified disease insurance policy in connection with the benefits payable for goods or services provided by any health care provider or other designated person or entity, the terms 'actual charge', 'actual charges', 'actual fee', or 'actual fees' shall mean the amount that the health care provider or other designated person or entity:

(a) agreed to accept, pursuant to a network or other agreement with a health insurer, third-party administrator, or other third-party payor, as payment in full for the goods or services provided to the insured;

(b) agreed or is obligated by operation of law to accept as payment in full for the goods or services provided to the insured pursuant to a provider, participation agreement, or supplier agreement under Medicare, Medicaid, or any other government administered health care program, where the insured is covered or reimbursed by such program; or

(c) if both subitems (a) and (b) of this subsection apply, the lowest amount determined under these two subitems; and

(2) must include any applicable deductibles, coinsurance requirements, or co-pay requirements applicable to the insured under any government administered health care program or any private primary health insurance coverage for the health care provider's goods or services provided to the insured.

(B) This section applies to any individual or group specified disease insurance policy issued to any resident of this State that contains the terms ‘actual charge’, ‘actual charges’, ‘actual fee’, or ‘actual fees’ and does not contain an express definition for the terms ‘actual charge’, ‘actual charges’, ‘actual fee’, or ‘actual fees’.

(C) Notwithstanding any other provision of law, after the effective date of this section, an insurer or issuer of any individual or group specified disease insurance policy shall not pay any claim or benefits based upon an actual charge, actual charges, actual fee, or actual fees under the applicable policy in an amount in excess of the ‘actual charge’, ‘actual charges’, ‘actual fee’, or ‘actual fees’ as defined in this section.”

This statute codifies the Department’s longstanding interpretation of the term “actual charges” or similar wording in supplemental cancer policies. For many years, spanning the terms of three directors of insurance, the Department has consistently interpreted those terms to require insurers to pay benefits on an expense-incurred basis, and not to pay benefits to insureds in amounts greater than a medical provider agreed to accept as payment in full for services rendered to the insured.

Section 38-71-242 is based upon the same legal and public policy considerations upon which the Department has continuously relied in interpreting the term “actual charges” in supplemental disease policies. The statute embodies the basic principle of insurance, codified at S.C. Code Ann. § 38-1-20(19), that insurance is a contract of indemnification, and that an insured must suffer an actual out-of-pocket loss to receive payment of benefits. This construction of the term “actual charges” ensures that a few insureds and beneficiaries do not receive windfalls in the form of payments of benefits greater than sums actually paid to health care providers, either by insureds or beneficiaries, or by a primary health insurer. Such windfalls inevitably would cause premiums to increase exponentially for all and would restrict the availability and affordability of supplemental disease policies, to the detriment of the citizens of this state. Finally, the statute comports with the Department’s consistent position that allowing payment of benefits in excess of amounts actually paid to health care providers creates opportunities for fraudulent conduct, such as deliberately inflating medical bills solely for the purpose of allowing an insured or beneficiary to collect greater benefits under a supplemental disease policy.

II. Compliance With S.C. Code Ann. § 38-71-242

Unless expressly required to do so by a final judgment issued before June 4, 2008 by a court of competent jurisdiction, insurers that have issued supplemental cancer policies or other specified disease policy in this state containing the term(s) “actual charge,” “actual charges,” “actual fee,” or “actual fees” and that do not contain an express definition of those terms may not pay any claim or any benefit in excess of the amount specified in S.C. Code Ann. § 38-71-242.

Every insurer licensed in this state that has issued a supplemental cancer policy or other specified disease policy subject to the provisions of S.C. Code Ann. § 38-71-242 shall transmit a notice, in a form approved by the Department, to the named insured or beneficiary of each such policy informing him or her of the content of S.C. Code Ann. § 38-71-242.

III. Questions

Questions should be directed to the attention of Carla Griffin @ cgriffin@doi.sc.gov or (803) 737-6230.¹

¹ Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.