By: Uresti S.B. No. 1495

A BILL TO BE ENTITLED

AN ACT

relating to payment of out-of-network ambulatory surgery benefits by certain health benefit plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:

CHAPTER 1458. PAYMENT OF OUT-OF-NETWORK BENEFITS FOR AMBULATORY SURGERY AND PROCEDURES

Sec. 1458.001. DEFINITIONS. In this chapter:

(1) "Ambulatory surgery or procedure" means a surgery or procedure provided in accordance with the medical standard of care to an ambulatory patient in an ambulatory surgical center or hospital outpatient department in this state.

(2) "Ambulatory surgical center" means a facility licensed under Chapter 243, Health and Safety Code.

(3) "Fair market value" means the marketplace value within a geozip area for the facility services for an ambulatory surgery or procedure based on payment information, excluding payments discounted under a governmental or nongovernmental health benefit plan.

(4) "Geozip area" means an area that includes all zip codes with the identical first three digits.

(5) "Hospital" includes a public or private institution licensed under Chapter 241 or 577, Health and Safety

Code.

(6) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires or provides incentives for those enrollees to use health care providers participating in the plan and procedures covered by the plan. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer;

(C) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(D) any other entity that issues a health benefit plan, including:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(7) "Out-of-network provider," with respect to a managed care plan, means a provider who is not a preferred or participating provider of the plan.

(8) "Usual and customary charge" with respect to an ambulatory surgery or procedure facility fee means the fair market

value of the facility fee for the ambulatory surgery or procedure within the geozip area in which the surgery or procedure is performed.

Sec. 1458.002. PAYMENT OF USUAL AND CUSTOMARY CHARGE REQUIRED. A managed care plan that provides a benefit for an ambulatory surgery or procedure provided by an ambulatory surgical center or hospital that is an out-of-network provider with respect to the plan must pay a benefit for the facility fee for the surgery or procedure that is computed based on the usual and customary charge with respect to the facility fee.

SECTION 2. Chapter 1458, Insurance Code, as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2012, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2011.