BILL ANALYSIS

H.B. 3269
By: Smithee
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Out-of-network ambulatory surgery centers play a significant role in the health care sector in Texas. Interested parties observe that since out-of-network facilities do not operate under a contract with insurance companies, their reimbursements are covered under the preferred provider organization provisions of a patient's insurance policy. A potential advantage of a preferred provider organization is that it offers the policy holder the flexibility to go to any health care provider the holder chooses. However, concerned parties contend that many insurance companies do not reimburse out-of-network ambulatory surgical centers for services or, if they do, that payments are based on an arbitrary cost-based system that is either tied to a percentage of Medicare or an unpublished rate schedule. Concerns have been raised that in such instances, out-of-network facilities are unable to cover operating costs and policy holders are denied access to the quality health care they have paid for in their insurance policies. H.B. 3269 seeks to address these issues by regulating a managed care plan issuer's payment of out-of-network ambulatory surgical center charges.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

H.B. 3269 amends the Insurance Code to require an issuer of a managed care plan that provides benefits for services provided by out-of-network ambulatory surgical centers to use a charge-based methodology that complies with the bill's provisions for computing a payment for a service provided by an out-of-network ambulatory surgical center if the ambulatory surgical center submits a claim for payment that includes a certification of the maximum usual and customary charge for the service determined by a database provider or a certification by a database provider that there are not sufficient reported charges in the database provider's database to establish a maximum usual and customary charge for the service.

H.B. 3269 defines, among other provisions, "usual and customary charge" as a charge for a service that is not higher than the 99th percentile of the charges for that service reported to a database provider by ambulatory surgical centers in the same Medicare region or by the designated reimbursement information organization with respect to ambulatory surgical centers in the same Medicare region, computed after excluding charges discounted under a governmental or nongovernmental health benefit plan and the top and bottom 10 percent of reported charges for that service for the region that are not discounted under a health benefit plan.

H.B. 3269 requires a plan issuer, if an out-of-network ambulatory surgical center submits a claim for payment of a charge that includes a certification from a database provider indicating that the billed charge is a usual and customary charge, to pay the billed charge minus any portion of the charge that is the enrollee's responsibility under the managed care plan.

H.B. 3269 requires a plan issuer, if an out-of-network ambulatory surgical center submits a claim for payment of a charge that includes a certification from a database provider indicating that the billed charge is higher than the maximum usual and customary charge, to pay the billed charge minus any portion of the charge that is the enrollee's responsibility under the managed care plan if the billed charge is justifiable considering special circumstances under which the services are provided. The bill requires the plan issuer, if the charge is not justifiable considering those circumstances, to pay the maximum usual and customary charge minus any portion of the charge that is the enrollee's responsibility under the managed care plan.

H.B. 3269 requires a plan issuer, if an out-of-network ambulatory surgical center submits a claim for payment of a charge that includes a certification by a database provider that there are not sufficient reported charges in the database provider's database to establish a maximum usual and customary charge for the service with respect to a billed charge, to pay 85 percent of the billed charge or an amount equal to the 99th percentile of the charges for the service reported by the designated reimbursement information organization for ambulatory surgical centers in the same Medicare region, whichever is less, minus any portion of the charge that is the enrollee's responsibility under the managed care plan.

H.B. 3269 sets out provisions relating to the prompt payment of a claim for payment of a charge submitted by an out-of-network ambulatory surgical center to an issuer of a preferred provider benefit plan or health maintenance organization (HMO) plan that includes a certification indicating either that the charge is a usual and customary charge or that there is insufficient data to establish such a charge and which claim is otherwise made in accordance with statutory provisions governing the payment of claims by a preferred provider benefit plan or HMO. The bill requires such a claim to be paid in accordance with applicable provisions relating to payment of claims by preferred provider benefit plans or HMOs as if the ambulatory surgical center were a preferred or participating provider, as applicable. The bill provides that, if the plan issuer fails to pay the claim in accordance with that requirement, the ambulatory surgical center is entitled to any applicable remedy to which a preferred or participating provider, as applicable, would be entitled for the plan issuer's failure to pay the claim and the plan issuer is subject to any penalty or disciplinary action under the Insurance Code to which the plan issuer would be subject for the plan issuer's failure to pay the claim.

H.B. 3269 sets out requirements for the language used in a managed care plan policy, certificate, evidence of coverage, or contract to describe the benefit provided under the plan for services provided by an out-of-network ambulatory surgical center relating to the computation of certain claim payments and the definitions of certain terms.

H.B. 3269 requires a database provider that is used to determine usual and customary charges with respect to services provided by an out-of-network ambulatory surgical center to be certified by the Texas Department of Insurance (TDI). The bill requires TDI to determine that the database provider and the database used by the provider comply with the requirements set out by the bill's provisions before certifying the database provider. The bill sets out requirements for a database provider relating to the length of time that the provider has been operating and compiling charges, database content, Internet website maintenance, and the ability to maintain charge data and distinguish charges subject to certain conditions. The bill requires the database provider to compute usual and customary charges for services provided by ambulatory surgical centers in accordance with the bill's provisions.

H.B. 3269 requires the data in the database to contain out-of-network charges for at least 350,000 out-of-network billed charges from ambulatory surgical centers in Texas and for ambulatory surgical centers in each Medicare region in Texas. The bill prohibits the data in the database from excluding charges accompanied by modifiers that indicate procedures with complications or including any data other than out-of-network billed charges of ambulatory surgical centers in Texas, ambulatory surgical center charges that reflect payments discounted

under governmental or nongovernmental health benefit plans, or information that is more than seven years old.

H.B. 3269 prohibits an entity from being certified as a database provider if the entity owns or controls, or is owned or controlled by, or is an affiliate of, any entity with a pecuniary interest in the application of the database. The bill requires a database provider's Internet website to allow an individual to determine the maximum usual and customary charge for a particular service provided by an ambulatory surgical center. The bill requires TDI to ensure that the data in the database used to compute usual and customary charges of out-of-network ambulatory surgical centers is updated regularly to accurately reflect current ambulatory surgical center retail charges and that charge information that is more than seven years old is removed from the database. The bill authorizes TDI to charge a fee for database provider certification in an amount necessary to implement the bill's provisions relating to such certification.

H.B. 3269 requires a database provider to compute the maximum usual and customary charge for each service for which a billed charge is submitted to the provider by an ambulatory surgical center that subscribes to the database and provide the ambulatory surgical center with a certification of the maximum usual and customary charge or a certification that there are insufficient reported charges to establish a maximum usual and customary charge for the service, as applicable, that is sufficient to enable a managed care plan issuer to whom the ambulatory surgical center submits a claim for payment to comply with the bill's provisions.

H.B. 3269 requires the commissioner of insurance by rule to designate an organization to report charges for services provided by ambulatory surgical centers under the bill's provisions. The bill requires the designated organization to be an independent, not-for-profit organization created to establish and maintain a database to help managed care plan issuers determine reimbursement rates for out-of-network charges and to provide patients with a clear, unbiased explanation of the reimbursement process.

H.B. 3269 requires a managed care plan issuer that provides benefits under the plan for services provided by out-of-network ambulatory surgical centers to include in the summary plan description and on an Internet website maintained by the plan issuer and disclose to a prospective purchaser of the plan the following: the definition of "usual and customary charge," as defined by the bill, and a description of how payment to an out-of-network ambulatory surgical center will be based under certain circumstances; certain database provider Internet website addresses; and a statement specifying the amount that will be accepted as payment in full by the ambulatory surgical center if the payment due under the plan's out-of-network benefit provisions is not sufficient to cover the total billed charge. The bill sets out provisions relating to the content and form of such disclosures and requires the disclosures to be updated as necessary.

H.B. 3269 requires a managed care plan issuer that offers a managed care plan that provides coverage for services provided by out-of-network ambulatory surgical centers to submit to TDI each year a written actuarial certification stating the difference in value for a purchaser between coverage with and coverage without the out-of-network ambulatory surgical center benefits and also stating that the difference between the amounts a purchaser would be charged for the different coverages reflects the certified difference in value. The bill sets out criteria relating to the form and content of the certification and requires such a certification to be made by an actuary who is appropriately certified and is not affiliated with the managed care plan issuer or a plan issuer affiliate. The bill requires a managed care plan issuer to make the certification readily available to the public.

H.B. 3269 provides that, if the payment due under a managed care plan's out-of-network benefit provisions is not sufficient to cover the total billed charge, an ambulatory surgical center agrees to accept as payment in full the amount paid by the plan in accordance with those provisions plus any portion of the charge that is the enrollee's responsibility under the plan.

H.B. 3269 establishes that a violation of the bill's provisions by a managed care plan issuer is an unfair and deceptive act or practice. The bill requires TDI, if TDI finds or it is otherwise determined that a managed care plan issuer violated the bill's provisions, to take all appropriate corrective action and use any of TDI's other enforcement powers to obtain the plan issuer's compliance and, if the violation results in an enrollee's use of an out-of-network ambulatory surgical center, to order the plan issuer to pay the out-of-network ambulatory surgical center's billed charge as indicated on the applicable claim form. The bill specifies that such remedies are in addition to remedies available under the bill's provisions relating to prompt payment of usual and customary charges or any other Insurance Code provision. The bill authorizes the attorney general to bring an action independent of TDI to enforce the bill's provisions governing payment of out-of-network ambulatory surgical center charges.

H.B. 3269 applies its provisions relating to payment of out-of-network ambulatory surgical center charges to charges for services provided to an enrollee under a managed care plan policy, certificate, or contract delivered, issued for delivery, or renewed on or after January 1, 2014.

H.B. 3269 amends the Health and Safety Code to require an ambulatory surgical center to maintain a current schedule of retail fees for the services that the center typically provides. The bill requires an ambulatory surgical center that is not a participating provider under a managed care plan, before providing an elective service to an enrollee of the plan, to provide the enrollee with a copy of the center's most current fee schedule as it applies to the elective service the center expects to provide to the enrollee and, if applicable, the Internet website address for the database provider the center uses for the purposes of certification of usual and customary charges. The bill requires an ambulatory surgical center to disclose to any patient or prospective patient a copy of the center's 100 most commonly provided services by procedure code. The bill authorizes the ambulatory surgical center to make the required disclosure available by hard copy, electronically, or through an Internet website.

EFFECTIVE DATE

September 1, 2013.