By: Van de Putte S.B. No. 1544

A BILL TO BE ENTITLED

AN ACT

relating to payment of and disclosures related to certain ambulatory surgical center charges.

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 AMBULATORY SURGICAL CENTER CHARGES

Sec. 1458.001. DEFINITIONS. In this chapter:

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

(2) "Database provider" means a database provider certified by the department under Section 1458.006.

(3) "Designated reimbursement information organization" means an organization designated by the commissioner under Section 1458.008.

(4) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(5) "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 fraternal benefit society operating under Chapter 885;

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

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

(6) "Maximum usual and customary charge," with respect to a service provided by an ambulatory surgical center, means the highest amount that the ambulatory surgical center could charge for the service that would be considered a usual and customary charge, as defined by this section.

(7) "Out-of-network ambulatory surgical center," with respect to a managed care plan, means an ambulatory surgical center that is not a participating provider of the plan.

(8) "Participating provider," with respect to a managed care plan, means a health care provider who has contracted with the managed care plan issuer to provide services to plan enrollees.

(9) "Purchaser" means an enrollee of a managed care

plan, regardless of whether the enrollee pays any part of the enrollee's premium, and a sponsor of the managed care plan, regardless of whether the sponsor pays any part of an enrollee's premium.

(10) "Usual and customary charge" means 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:

(A) charges discounted under a governmental or nongovernmental health benefit plan; and

(B) the top and bottom 10 percent of reported charges for that service for the region that are not discounted under a health benefit plan.

Sec. 1458.002. APPLICABILITY OF CHAPTER. This chapter applies only to an issuer of a managed care plan that provides benefits for services provided by out-of-network ambulatory surgical centers.

Sec. 1458.003. PAYMENT OF CERTAIN OUT-OF-NETWORK AMBULATORY SURGICAL CENTERS. (a) A managed care plan issuer must use a charge-based methodology that complies with this chapter 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:

(1) a certification of the maximum usual and customary

charge for the service determined by a database provider; or

(2) 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.

(b) 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, the plan issuer shall pay the billed charge minus any portion of the charge that is the enrollee's responsibility under the managed care plan.

(c) 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, the plan issuer shall 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. If the charge is not justifiable considering special circumstances under which the services are provided, the plan issuer shall pay the maximum usual and customary charge minus any portion of the charge that is the enrollee's responsibility under the managed care plan.

(d) If an out-of-network ambulatory surgical center submits a claim for payment of a charge that includes a certification described by Subsection (a)(2) with respect to a billed charge, the plan issuer shall 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, computed as described by Section 1458.001(10), whichever is less, minus any portion of the charge that is the enrollee's responsibility under the managed care plan.

Sec. 1458.004. PROMPT PAYMENT OF USUAL AND CUSTOMARY CHARGE. If an out-of-network ambulatory surgical center submits to an issuer of a preferred provider benefit plan or health maintenance organization plan a claim for payment of a charge that includes a certification from a database provider indicating that the charge is a usual and customary charge or a certification described by Section 1458.003(a)(2) with respect to the charge and the claim for payment is otherwise made in accordance with Subchapter C, Chapter 1301, or Subchapter J, Chapter 843:

(1) the claim must be paid in accordance with the applicable subchapter as if the ambulatory surgical center were a preferred or participating provider, as applicable; and

(2) if the plan issuer fails to pay the claim in accordance with this section:

(A) the ambulatory surgical center is entitled to any remedy under Chapter 843 or 1301 to which a preferred or participating provider, as applicable, would be entitled for the plan issuer's failure to pay the claim in accordance with the applicable subchapter; and

(B) the plan issuer is subject to any penalty or disciplinary action under this code to which the plan issuer would

be subject for the plan issuer's failure to pay the claim in accordance with the applicable subchapter.

Sec. 1458.005. REQUIRED CONTRACT TERMS. The language used in the 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:

(1) must:

(A) provide that, if a certification described by Section 1458.003(a)(2) with respect to the charge is submitted with the claim, payment to an out-of-network ambulatory surgical center will be computed based on 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, computed as described by Section 1458.001(10), whichever is less;

(B) define "usual and customary charge" as that term is defined by Section 1458.001; and

(C) incorporate into the definition of "usual and customary charge" the definition of "database provider" assigned by Section 1458.001; and

(2) may not add or subtract language from a definition required by this section.

Sec. 1458.006. CERTIFICATION AND QUALIFICATIONS OF DATABASE PROVIDER AND DATABASE. (a) A database provider that is used to determine usual and customary charges for the purposes of this chapter must be certified by the department. The department may certify a database provider under this chapter only if the

department determines that the database provider and the database used by the provider for the purposes of this chapter comply with this section.

(b) A database provider must be an entity that:

(1) has been operating and collecting ambulatory surgical center out-of-network Current Procedural Terminology code charge data from this state for at least 10 years;

(2) has compiled out-of-network charges for ambulatory surgical centers in this state covering a period of at least seven years;

(3) maintains a database with content that complies with this section;

(4) maintains an active Internet website accessible to all ambulatory surgical centers subscribing to the database and to the public; and

(5) demonstrates an ability to:

(A) maintain a compilation of charge data that is absent any data required to be excluded under Subsection (e)(1); and

(B) distinguish charges that are not related to one another and eliminate irrelevant or erroneous charges from reported charge information.

(c) The database provider must compute usual and customary charges for services provided by ambulatory surgical centers in accordance with this chapter.

(d) The data in the database must contain out-of-network charges for:

(1) at least 350,000 out-of-network billed charges from ambulatory surgical centers in this state; and

(2) ambulatory surgical centers in each Medicare region in this state.

(e) The data in the database may not:

(1) include:

(A) any data other than out-of-network billed charges of ambulatory surgical centers in this state;

(B) ambulatory surgical center charges that reflect payments discounted under governmental or nongovernmental health benefit plans; or

(C) information that is more than seven years old; or

(2) exclude charges accompanied by modifiers that indicate procedures with complications.

(f) An entity may not be certified as a database provider for the purposes of this chapter 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.

(g) The Internet website required by this section must allow an individual to determine the maximum usual and customary charge for a particular service provided by an ambulatory surgical center.

(h) The department shall ensure that:

(1) 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

(2) charge information that is more than seven years old is removed from the database.

(i) The department may charge a fee for certification under this section in an amount necessary to implement this section.

Sec. 1458.007. PROVISION OF USUAL AND CUSTOMARY CHARGE BY DATABASE PROVIDER. A database provider must 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 described by Section 1458.003(a)(2), 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 this chapter.

Sec. 1458.008. DESIGNATED REIMBURSEMENT INFORMATION ORGANIZATION. (a) The commissioner by rule shall designate an organization described by this section to report charges for services provided by ambulatory surgical centers under this chapter.

(b) The organization designated under this section must be an independent, not-for-profit organization created to:

(1) establish and maintain a database to help managed care plan issuers determine reimbursement rates for out-of-network charges; and

(2) provide patients with a clear, unbiased explanation of the reimbursement process.

Sec. 1458.009. DISCLOSURES REGARDING PAYMENT OF

OUT-OF-NETWORK AMBULATORY SURGICAL CENTER. (a) A managed care plan issuer that provides benefits under the plan for services provided by out-of-network ambulatory surgical centers must 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:

(1) the definition of "usual and customary charge" assigned by Section 1458.001 and a description of how payment to an out-of-network ambulatory surgical center will, if applicable, be based on 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, computed as described by Section 1458.001(10), whichever is less;

(2) the Internet website addresses of each database provider certified under this chapter at which a purchaser or prospective purchaser may access the database or a single website address at which an updated set of links to the website addresses of those database providers may be accessed; and

(3) a statement that if the payment due under the plan's out-of-network benefit provisions is not sufficient to cover the total billed charge, the 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.

(b) Disclosures under this section must:

(1) be made in language easily understood by

purchasers and prospective purchasers of managed care plans;

(2) be made in a uniform, clearly organized manner;

(3) be of sufficient detail and comprehensiveness as to provide for full and fair disclosure; and

(4) be updated as necessary to ensure that the disclosures are accurate.

Sec. 1458.010. ANNUAL ACTUARIAL CERTIFICATION. (a) A managed care plan issuer that offers a managed care plan that provides coverage for services provided by out-of-network ambulatory surgical centers must annually submit to the department a written certification stating:

(1) the difference in value for a purchaser between:

(A) the coverage without the out-of-network ambulatory surgical center benefits; and

(B) the coverage with the out-of-network ambulatory surgical center benefits; and

(2) that the difference between the amount a purchaser would be charged for the coverage without the out-of-network ambulatory surgical center benefits and the amount that a purchaser would be charged for the coverage with the out-of-network ambulatory surgical center benefits reflects the difference in value certified under Subdivision (1).

(b) The certification must be made in easily understood language, in a uniform, clearly organized manner, and be of sufficient detail and comprehensiveness as to provide for full and fair disclosure to an average consumer. The difference between the value of the coverage without the out-of-network ambulatory

surgical center benefits and the coverage with the out-of-network ambulatory surgical center benefits must be expressed in terms of a percentage, although use of a percentage alone is not sufficient to satisfy the requirements of this section.

(c) The certification must be made by an actuary who is certified by a nationally recognized actuarial certification organization recognized by the commissioner and who is not affiliated with the managed care plan issuer or any of the plan issuer's affiliates.

(d) A managed care plan issuer must make the certification required by this section readily available to the public.

Sec. 1458.011. PAYMENT IN FULL. 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.

Sec. 1458.012. REMEDIES. (a) A violation of this chapter by a managed care plan issuer is an unfair and deceptive act or practice under Chapter 541. If the department finds or it is otherwise determined that a managed care plan issuer violated this chapter, the department shall:

(1) take all appropriate corrective action and use any of the department's other enforcement powers to obtain the plan issuer's compliance; and

(2) if the violation results in an enrollee's use of an out-of-network ambulatory surgical center, order the plan issuer to

pay the out-of-network ambulatory surgical center's billed charge as indicated on the applicable claim form.

(b) The remedies provided by this section are in addition to remedies available under Section 1458.004 or any other provision of this code.

Sec. 1458.013. ACTION BY ATTORNEY GENERAL. The attorney general may, independent of the department, bring an action to enforce this chapter.

SECTION 2. Subchapter A, Chapter 243, Health and Safety Code, is amended by adding Section 243.0105 to read as follows:

Sec. 243.0105. FEE SCHEDULE. (a) An ambulatory surgical center must maintain a current schedule of retail fees for the services that the center typically provides.

(b) Before providing an elective service to an enrollee of a managed care plan, as defined by Section 1458.001, Insurance Code, an ambulatory surgical center that is not a participating provider under the plan must provide the enrollee with:

(1) 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

(2) if applicable, the Internet website address for the database provider the center uses for the purposes of certification of usual and customary charges under Chapter 1458, Insurance Code.

(c) An ambulatory surgical center must disclose to any patient or prospective patient a copy of the center's 100 most commonly provided services by procedure code. The center may make

the disclosure required by this subsection available by hard copy, electronically, or through an Internet website.

SECTION 3. Chapter 1458, Insurance Code, as added by this Act, applies only 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. Charges for services provided to an enrollee under a policy, certificate, or contract delivered, issued for delivery, or renewed before January 1, 2014, are 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 4. This Act takes effect September 1, 2013.