By: Zaffirini, Hancock West S.B. No. 2476

A BILL TO BE ENTITLED

AN ACT

relating to consumer protections against certain medical and health care billing by emergency medical services providers.

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

SECTION 1. Subchapter A, Chapter 38, Insurance Code, is amended by adding Section 38.006 to read as follows:

Sec. 38.006. EMERGENCY MEDICAL SERVICES PROVIDER BALANCE BILLING RATE DATABASE. (a) A political subdivision may submit to the department a rate set, controlled, or regulated by the political subdivision for purposes of Section 1271.159, 1275.054, 1301.166, 1551.231, 1575.174, or 1579.112. The department shall establish and maintain on the department's Internet website a publicly accessible database for the rates.

(b) This section expires September 1, 2025.

SECTION 2. (a) Section 1271.008, Insurance Code, is amended to read as follows:

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A health maintenance organization shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply or transport provided by a non-network physician or provider. The notice must include:

(1) a statement of the billing prohibition under Section 1271.155, 1271.157, [~~or~~] 1271.158, or 1271.159, as

applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) A health maintenance organization shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the health maintenance organization makes a payment under Section 1271.155, 1271.157, [~~or~~] 1271.158, or 1271.159, as applicable.

(b) Effective September 1, 2025, Section 1271.008, Insurance Code, is amended to read as follows:

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A health maintenance organization shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply provided by a non-network physician or provider. The notice must include:

(1) a statement of the billing prohibition under Section 1271.155, 1271.157, or 1271.158, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other

amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) A health maintenance organization shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the health maintenance organization makes a payment under Section 1271.155, 1271.157, or 1271.158, as applicable.

SECTION 3. Subchapter D, Chapter 1271, Insurance Code, is amended by adding Section 1271.159 to read as follows:

Sec. 1271.159. NON-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), a health maintenance organization shall pay for a covered health care service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by a non-network emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) A health maintenance organization shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The health maintenance organization shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(e) A non-network emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the

enrollee's health care plan that is based on:

(1) the amount initially determined payable by the health maintenance organization; or

(2) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process.

(f) This section may not be construed to require the imposition of a penalty under Section 843.342.

(g) This section expires September 1, 2025.

SECTION 4. (a) Section 1275.003, Insurance Code, is amended to read as follows:

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a health benefit plan to which this chapter applies shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1275.051, 1275.052, [~~or~~] 1275.053, or 1275.054, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule

advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1275.051, 1275.052, [~~or~~] 1275.053, or 1275.054, as applicable.

(b) Effective September 1, 2025, Section 1275.003, Insurance Code, is amended to read as follows:

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a health benefit plan to which this chapter applies shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1275.051, 1275.052, or 1275.053, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of

benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1275.051, 1275.052, or 1275.053, as applicable.

SECTION 5. Subchapter B, Chapter 1275, Insurance Code, is amended by adding Section 1275.054 to read as follows:

Sec. 1275.054. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a health benefit plan to which this chapter applies shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate,

including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health benefit plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, the modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

SECTION 6. (a) Section 1301.0045(b), Insurance Code, is

amended to read as follows:

(b) Except as provided by Sections 1301.0052, 1301.0053, 1301.155, 1301.164, [~~and~~] 1301.165, and 1301.166, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

(b) Effective September 1, 2025, Section 1301.0045(b), Insurance Code, is amended to read as follows:

(b) Except as provided by Sections 1301.0052, 1301.0053, 1301.155, 1301.164, and 1301.165, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

SECTION 7. (a) Section 1301.010, Insurance Code, is amended to read as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, [~~or~~] 1301.165, or 1301.166, as applicable;

(2) the total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Section 1301.0053, 1301.155, 1301.164, [~~or~~] 1301.165, or 1301.166, as applicable.

(b) Effective September 1, 2025, Section 1301.010, Insurance Code, is amended to read as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable;

(2) the total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable.

SECTION 8. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Section 1301.166 to read as follows:

Sec. 1301.166. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), an insurer shall pay for a covered medical care or health care service performed for, or a covered supply or covered transport related to that service provided to, an insured by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) An insurer shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The insurer shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply or transport described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that is based on:

(1) the amount initially determined payable by the insurer; or

(2) if applicable, the modified amount as determined under the insurer's internal appeal process.

(f) This section may not be construed to require the

imposition of a penalty under Section 1301.137.

(g) This section expires September 1, 2025.

SECTION 9. (a) Section 1551.015, Insurance Code, is amended to read as follows:

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group benefits program shall provide written notice in accordance with this section in an explanation of benefits provided to the participant and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1551.228, 1551.229, [~~or~~] 1551.230, or 1551.231, as applicable;

(2) the total amount the physician or provider may bill the participant under the participant's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1551.228, 1551.229, [~~or~~] 1551.230, or 1551.231, as applicable.

(b) Effective September 1, 2025, Section 1551.015, Insurance Code, is amended to read as follows:

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group benefits program shall provide written notice in accordance with this section in an explanation of benefits provided to the participant and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1551.228, 1551.229, or 1551.230, as applicable;

(2) the total amount the physician or provider may bill the participant under the participant's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1551.228, 1551.229, or 1551.230, as applicable.

SECTION 10. Subchapter E, Chapter 1551, Insurance Code, is amended by adding Section 1551.231 to read as follows:

Sec. 1551.231. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES

PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a managed care plan provided under the group benefits program shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, a participant by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant receiving a health care or medical service or supply or transport described by Subsection (b) in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, the modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

SECTION 11. (a) Section 1575.009, Insurance Code, is amended to read as follows:

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group program shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an

out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1575.171, 1575.172, [~~or~~] 1575.173, or 1575.174, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1575.171, 1575.172, [~~or~~] 1575.173, or 1575.174, as applicable.

(b) Effective September 1, 2025, Section 1575.009, Insurance Code, is amended to read as follows:

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group program shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under

Section 1575.171, 1575.172, or 1575.173, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1575.171, 1575.172, or 1575.173, as applicable.

SECTION 12. Subchapter D, Chapter 1575, Insurance Code, is amended by adding Section 1575.174 to read as follows:

Sec. 1575.174. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a managed care plan provided under the group program shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply or transport described by

Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, the modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

SECTION 13. (a) Section 1579.009, Insurance Code, is amended to read as follows:

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1579.109, 1579.110, [~~or~~] 1579.111, or 1579.112, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule

advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1579.109, 1579.110, [~~or~~] 1579.111, or 1579.112, as applicable.

(b) Effective September 1, 2025, Section 1579.009, Insurance Code, is amended to read as follows:

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1579.109, 1579.110, or 1579.111, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of

benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1579.109, 1579.110, or 1579.111, as applicable.

SECTION 14. Subchapter C, Chapter 1579, Insurance Code, is amended by adding Section 1579.112 to read as follows:

Sec. 1579.112. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a managed care plan provided under this chapter shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate,

including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, a modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

SECTION 15. The changes in law made by this Act apply only

to a ground ambulance service provided on or after January 1, 2024. A ground ambulance service provided before January 1, 2024, 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 16. Except as otherwise provided by this Act, this Act takes effect September 1, 2023.