

By: Zaffirini, et al.
(Oliverson)

S.B. No. 2476

Substitute the following for S.B. No. 2476:

By: Oliverson

C.S.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, in the form and manner prescribed by the commissioner, 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

1 Section 1271.155, 1271.157, [~~or~~] 1271.158, or 1271.159, as
2 applicable;

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

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

11 (b) A health maintenance organization shall provide the
12 explanation of benefits with the notice required by this section to
13 a physician or health care provider not later than the date the
14 health maintenance organization makes a payment under Section
15 1271.155, 1271.157, [~~or~~] 1271.158, or 1271.159, as applicable.

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

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

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

26 (2) the total amount the physician or provider may
27 bill the enrollee under the enrollee's health benefit plan and an

1 itemization of copayments, coinsurance, deductibles, and other
2 amounts included in that total; and

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

7 (b) A health maintenance organization shall provide the
8 explanation of benefits with the notice required by this section to
9 a physician or health care provider not later than the date the
10 health maintenance organization makes a payment under Section
11 1271.155, 1271.157, or 1271.158, as applicable.

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

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

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

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

26 (A) the service originated; or

27 (B) the transport originated if transport is

1 provided; or

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

4 (A) the provider's billed charge; or

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

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

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

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

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

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

1 applicable copayment, coinsurance, and deductible under the
2 enrollee's health care plan that is based on:

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

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

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

10 (g) This section expires September 1, 2025.

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

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

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

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

27 (3) for an explanation of benefits provided to the

1 physician or provider, information required by commissioner rule
2 advising the physician or provider of the availability of mediation
3 or arbitration, as applicable, under Chapter 1467.

4 (b) The administrator shall provide the explanation of
5 benefits with the notice required by this section to a physician or
6 health care provider not later than the date the administrator
7 makes a payment under Section 1275.051, 1275.052, [~~or~~] 1275.053, or
8 1275.054, as applicable.

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

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

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

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

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

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

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

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

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

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

22 (A) the service originated; or

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

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

27 (A) the provider's billed charge; or

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

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

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

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

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

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

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

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

27 (f) This section expires September 1, 2025.

1 SECTION 6. (a) Section 1301.0045(b), Insurance Code, is
2 amended to read as follows:

3 (b) Except as provided by Sections 1301.0052, 1301.0053,
4 1301.155, 1301.164, ~~and~~ 1301.165, and 1301.166, this chapter may
5 not be construed to require an exclusive provider benefit plan to
6 compensate a nonpreferred provider for services provided to an
7 insured.

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

10 (b) Except as provided by Sections 1301.0052, 1301.0053,
11 1301.155, 1301.164, and 1301.165, this chapter may not be construed
12 to require an exclusive provider benefit plan to compensate a
13 nonpreferred provider for services provided to an insured.

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

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

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

25 (2) the total amount the physician or provider may
26 bill the insured under the insured's preferred provider benefit
27 plan and an itemization of copayments, coinsurance, deductibles,

1 and other amounts included in that total; and

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

6 (b) An insurer shall provide the explanation of benefits
7 with the notice required by this section to a physician or health
8 care provider not later than the date the insurer makes a payment
9 under Section 1301.0053, 1301.155, 1301.164, [~~or~~] 1301.165, or
10 1301.166, as applicable.

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

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

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

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

25 (3) for an explanation of benefits provided to the
26 physician or provider, information required by commissioner rule
27 advising the physician or provider of the availability of mediation

1 or arbitration, as applicable, under Chapter 1467.

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

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

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

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

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

21 (A) the service originated; or

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

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

26 (A) the provider's billed charge; or

27 (B) 325 percent of the current Medicare rate,

1 including any applicable extenders and modifiers.

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

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

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

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

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

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

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

1 (f) This section may not be construed to require the
2 imposition of a penalty under Section 1301.137.

3 (g) This section expires September 1, 2025.

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

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

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

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

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

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

1 1551.231, as applicable.

2 (b) Effective September 1, 2025, Section [1551.015](#),
3 Insurance Code, is amended to read as follows:

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

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

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

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

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

26 SECTION 10. Subchapter [E](#), Chapter [1551](#), Insurance Code, is
27 amended by adding Section 1551.231 to read as follows:

1 Sec. 1551.231. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES
2 PROVIDER PAYMENTS. (a) In this section, "emergency medical
3 services provider" has the meaning assigned by Section 773.003,
4 Health and Safety Code, except that the term does not include an air
5 ambulance.

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

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

15 (A) the service originated; or

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

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

20 (A) the provider's billed charge; or

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

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

27 (d) The administrator shall make a payment required by this

1 section directly to the provider not later than, as applicable:

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

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

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

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

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

20 (f) This section expires September 1, 2025.

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

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

1 care or medical service or supply or transport provided by an
2 out-of-network provider. The notice must include:

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

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

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

14 (b) The administrator shall provide the explanation of
15 benefits with the notice required by this section to a physician or
16 health care provider not later than the date the administrator
17 makes a payment under Section 1575.171, 1575.172, [~~or~~] 1575.173, or
18 1575.174, as applicable.

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

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

1 (1) a statement of the billing prohibition under
2 Section 1575.171, 1575.172, or 1575.173, as applicable;

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

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

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

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

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

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

1 emergency medical services provider at:

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

5 (A) the service originated; or

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

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

10 (A) the provider's billed charge; or

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

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

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

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

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

25 (e) An out-of-network provider who is an emergency medical
26 services provider or a person asserting a claim as an agent or
27 assignee of the provider may not bill an enrollee receiving a health

1 care or medical service or supply or transport described by
2 Subsection (b) in, and the enrollee does not have financial
3 responsibility for, an amount greater than an applicable copayment,
4 coinsurance, and deductible under the enrollee's managed care plan
5 that is based on:

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

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

10 (f) This section expires September 1, 2025.

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

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

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

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

27 (3) for an explanation of benefits provided to the

1 physician or provider, information required by commissioner rule
2 advising the physician or provider of the availability of mediation
3 or arbitration, as applicable, under Chapter 1467.

4 (b) The administrator shall provide the explanation of
5 benefits with the notice required by this section to a physician or
6 health care provider not later than the date the administrator
7 makes a payment under Section 1579.109, 1579.110, ~~[or]~~ 1579.111, or
8 1579.112, as applicable.

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

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

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

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

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

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

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

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

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

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

22 (A) the service originated; or

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

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

27 (A) the provider's billed charge; or

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

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

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

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

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

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

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

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

27 (f) This section expires September 1, 2025.

1 SECTION 15. The changes in law made by this Act apply only
2 to emergency medical services provided on or after January 1, 2024.
3 Emergency medical services provided before January 1, 2024, are
4 governed by the law in effect immediately before the effective date
5 of this Act, and that law is continued in effect for that purpose.

6 SECTION 16. The Texas Department of Insurance is not
7 required to establish the database described by Section 38.006,
8 Insurance Code, as added by this Act, before January 1, 2024.

9 SECTION 17. Except as otherwise provided by this Act, this
10 Act takes effect September 1, 2023.