

1-1 By: Zaffirini, Hancock S.B. No. 2476  
 1-2 (In the Senate - Filed March 10, 2023; March 23, 2023, read  
 1-3 first time and referred to Committee on Health & Human Services;  
 1-4 April 26, 2023, reported adversely, with favorable Committee  
 1-5 Substitute by the following vote: Yeas 6, Nays 0; April 26, 2023,  
 1-6 sent to printer.)

1-7 COMMITTEE VOTE

	Yea	Nay	Absent	PNV
1-8				
1-9	X			
1-10	X			
1-11	X			
1-12	X			
1-13	X			
1-14	X			
1-15			X	
1-16			X	
1-17			X	

1-18 COMMITTEE SUBSTITUTE FOR S.B. No. 2476 By: Perry

1-19 A BILL TO BE ENTITLED  
 1-20 AN ACT

1-21 relating to consumer protections against certain medical and health  
 1-22 care billing by emergency medical services providers.

1-23 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-24 SECTION 1. Subchapter A, Chapter 38, Insurance Code, is  
 1-25 amended by adding Section 38.006 to read as follows:

1-26 Sec. 38.006. EMERGENCY MEDICAL SERVICES PROVIDER BALANCE  
 1-27 BILLING RATE DATABASE. (a) A political subdivision may submit to  
 1-28 the department a rate set, controlled, or regulated by the  
 1-29 political subdivision for purposes of Section 1271.159, 1275.054,  
 1-30 1301.166, 1551.231, 1575.174, or 1579.112. The department shall  
 1-31 establish and maintain on the department's Internet website a  
 1-32 publicly accessible database for the rates.

1-33 (b) This section expires September 1, 2025.

1-34 SECTION 2. (a) Section 1271.008, Insurance Code, is  
 1-35 amended to read as follows:

1-36 Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A  
 1-37 health maintenance organization shall provide written notice in  
 1-38 accordance with this section in an explanation of benefits provided  
 1-39 to the enrollee and the physician or provider in connection with a  
 1-40 health care service or supply or transport provided by a  
 1-41 non-network physician or provider. The notice must include:

1-42 (1) a statement of the billing prohibition under  
 1-43 Section 1271.155, 1271.157, ~~or~~ 1271.158, or 1271.159, as  
 1-44 applicable;

1-45 (2) the total amount the physician or provider may  
 1-46 bill the enrollee under the enrollee's health benefit plan and an  
 1-47 itemization of copayments, coinsurance, deductibles, and other  
 1-48 amounts included in that total; and

1-49 (3) for an explanation of benefits provided to the  
 1-50 physician or provider, information required by commissioner rule  
 1-51 advising the physician or provider of the availability of mediation  
 1-52 or arbitration, as applicable, under Chapter 1467.

1-53 (b) A health maintenance organization shall provide the  
 1-54 explanation of benefits with the notice required by this section to  
 1-55 a physician or health care provider not later than the date the  
 1-56 health maintenance organization makes a payment under Section  
 1-57 1271.155, 1271.157, ~~or~~ 1271.158, or 1271.159, as applicable.

1-58 (b) Effective September 1, 2025, Section 1271.008,  
 1-59 Insurance Code, is amended to read as follows:

1-60 Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A

2-1 health maintenance organization shall provide written notice in  
2-2 accordance with this section in an explanation of benefits provided  
2-3 to the enrollee and the physician or provider in connection with a  
2-4 health care service or supply provided by a non-network physician  
2-5 or provider. The notice must include:

2-6 (1) a statement of the billing prohibition under  
2-7 Section 1271.155, 1271.157, or 1271.158, as applicable;

2-8 (2) the total amount the physician or provider may  
2-9 bill the enrollee under the enrollee's health benefit plan and an  
2-10 itemization of copayments, coinsurance, deductibles, and other  
2-11 amounts included in that total; and

2-12 (3) for an explanation of benefits provided to the  
2-13 physician or provider, information required by commissioner rule  
2-14 advising the physician or provider of the availability of mediation  
2-15 or arbitration, as applicable, under Chapter 1467.

2-16 (b) A health maintenance organization shall provide the  
2-17 explanation of benefits with the notice required by this section to  
2-18 a physician or health care provider not later than the date the  
2-19 health maintenance organization makes a payment under Section  
2-20 1271.155, 1271.157, or 1271.158, as applicable.

2-21 SECTION 3. Subchapter D, Chapter 1271, Insurance Code, is  
2-22 amended by adding Section 1271.159 to read as follows:

2-23 Sec. 1271.159. NON-NETWORK EMERGENCY MEDICAL SERVICES  
2-24 PROVIDER. (a) In this section, "emergency medical services  
2-25 provider" has the meaning assigned by Section 773.003, Health and  
2-26 Safety Code, except that the term does not include an air ambulance.

2-27 (b) Except as provided by Subsection (c), a health  
2-28 maintenance organization shall pay for a covered health care  
2-29 service performed for, or a covered supply or covered transport  
2-30 related to that service provided to, an enrollee by a non-network  
2-31 emergency medical services provider at:

2-32 (1) if the political subdivision has submitted the  
2-33 rate to the department under Section 38.006, the rate set,  
2-34 controlled, or regulated by the political subdivision in which:

2-35 (A) the service originated; or  
2-36 (B) the transport originated if transport is  
2-37 provided; or

2-38 (2) if the political subdivision has not submitted the  
2-39 rate to the department or does not have set, controlled, or  
2-40 regulated rates, the lesser of:

2-41 (A) the provider's billed charge; or  
2-42 (B) 325 percent of the current Medicare rate,  
2-43 including any applicable extenders and modifiers.

2-44 (c) A health maintenance organization shall adjust a  
2-45 payment required by Subsection (b)(1) each plan year by increasing  
2-46 the payment by the lesser of the Medicare Inflation Index or 10  
2-47 percent of the provider's previous calendar year rates.

2-48 (d) The health maintenance organization shall make a  
2-49 payment required by this section directly to the provider not later  
2-50 than, as applicable:

2-51 (1) the 30th day after the date the health maintenance  
2-52 organization receives an electronic clean claim as defined by  
2-53 Section 843.336 for those services that includes all information  
2-54 necessary for the health maintenance organization to pay the claim;  
2-55 or

2-56 (2) the 45th day after the date the health maintenance  
2-57 organization receives a nonelectronic clean claim as defined by  
2-58 Section 843.336 for those services that includes all information  
2-59 necessary for the health maintenance organization to pay the claim.

2-60 (e) A non-network emergency medical services provider or a  
2-61 person asserting a claim as an agent or assignee of the provider may  
2-62 not bill an enrollee receiving a health care service or supply or  
2-63 transport described by Subsection (b) in, and the enrollee does not  
2-64 have financial responsibility for, an amount greater than an  
2-65 applicable copayment, coinsurance, and deductible under the  
2-66 enrollee's health care plan that is based on:

2-67 (1) the amount initially determined payable by the  
2-68 health maintenance organization; or

2-69 (2) if applicable, a modified amount as determined

3-1 under the health maintenance organization's internal appeal  
3-2 process.

3-3 (f) This section may not be construed to require the  
3-4 imposition of a penalty under Section 843.342.

3-5 (g) This section expires September 1, 2025.

3-6 SECTION 4. (a) Section 1275.003, Insurance Code, is  
3-7 amended to read as follows:

3-8 Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a)  
3-9 The administrator of a health benefit plan to which this chapter  
3-10 applies shall provide written notice in accordance with this  
3-11 section in an explanation of benefits provided to the enrollee and  
3-12 the physician or health care provider in connection with a health  
3-13 care or medical service or supply or transport provided by an  
3-14 out-of-network provider. The notice must include:

3-15 (1) a statement of the billing prohibition under  
3-16 Section 1275.051, 1275.052, [~~or~~] 1275.053, or 1275.054, as  
3-17 applicable;

3-18 (2) the total amount the physician or provider may  
3-19 bill the enrollee under the enrollee's health benefit plan and an  
3-20 itemization of copayments, coinsurance, deductibles, and other  
3-21 amounts included in that total; and

3-22 (3) for an explanation of benefits provided to the  
3-23 physician or provider, information required by commissioner rule  
3-24 advising the physician or provider of the availability of mediation  
3-25 or arbitration, as applicable, under Chapter 1467.

3-26 (b) The administrator shall provide the explanation of  
3-27 benefits with the notice required by this section to a physician or  
3-28 health care provider not later than the date the administrator  
3-29 makes a payment under Section 1275.051, 1275.052, [~~or~~] 1275.053, or  
3-30 1275.054, as applicable.

3-31 (b) Effective September 1, 2025, Section 1275.003,  
3-32 Insurance Code, is amended to read as follows:

3-33 Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a)  
3-34 The administrator of a health benefit plan to which this chapter  
3-35 applies shall provide written notice in accordance with this  
3-36 section in an explanation of benefits provided to the enrollee and  
3-37 the physician or health care provider in connection with a health  
3-38 care or medical service or supply provided by an out-of-network  
3-39 provider. The notice must include:

3-40 (1) a statement of the billing prohibition under  
3-41 Section 1275.051, 1275.052, or 1275.053, as applicable;

3-42 (2) the total amount the physician or provider may  
3-43 bill the enrollee under the enrollee's health benefit plan and an  
3-44 itemization of copayments, coinsurance, deductibles, and other  
3-45 amounts included in that total; and

3-46 (3) for an explanation of benefits provided to the  
3-47 physician or provider, information required by commissioner rule  
3-48 advising the physician or provider of the availability of mediation  
3-49 or arbitration, as applicable, under Chapter 1467.

3-50 (b) The administrator shall provide the explanation of  
3-51 benefits with the notice required by this section to a physician or  
3-52 health care provider not later than the date the administrator  
3-53 makes a payment under Section 1275.051, 1275.052, or 1275.053, as  
3-54 applicable.

3-55 SECTION 5. Subchapter B, Chapter 1275, Insurance Code, is  
3-56 amended by adding Section 1275.054 to read as follows:

3-57 Sec. 1275.054. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES  
3-58 PROVIDER PAYMENTS. (a) In this section, "emergency medical  
3-59 services provider" has the meaning assigned by Section 773.003,  
3-60 Health and Safety Code, except that the term does not include an air  
3-61 ambulance.

3-62 (b) Except as provided by Subsection (c), the administrator  
3-63 of a health benefit plan to which this chapter applies shall pay for  
3-64 a covered health care or medical service performed for, or a covered  
3-65 supply or covered transport related to that service provided to, an  
3-66 enrollee by an out-of-network provider who is an emergency medical  
3-67 services provider at:

3-68 (1) if the political subdivision has submitted the  
3-69 rate to the department under Section 38.006, the rate set,

4-1 controlled, or regulated by the political subdivision in which:  
4-2 (A) the service originated; or  
4-3 (B) the transport originated if transport is  
4-4 provided; or  
4-5 (2) if the political subdivision has not submitted the  
4-6 rate to the department or does not have set, controlled, or  
4-7 regulated rates, the lesser of:  
4-8 (A) the provider's billed charge; or  
4-9 (B) 325 percent of the current Medicare rate,  
4-10 including any applicable extenders and modifiers.  
4-11 (c) The administrator shall adjust a payment required by  
4-12 Subsection (b)(1) each plan year by increasing the payment by the  
4-13 lesser of the Medicare Inflation Index or 10 percent of the  
4-14 provider's previous calendar year rates.  
4-15 (d) The administrator shall make a payment required by this  
4-16 section directly to the provider not later than, as applicable:  
4-17 (1) the 30th day after the date the administrator  
4-18 receives an electronic claim for those services that includes all  
4-19 information necessary for the administrator to pay the claim; or  
4-20 (2) the 45th day after the date the administrator  
4-21 receives a nonelectronic claim for those services that includes all  
4-22 information necessary for the administrator to pay the claim.  
4-23 (e) An out-of-network provider who is an emergency medical  
4-24 services provider or a person asserting a claim as an agent or  
4-25 assignee of the provider may not bill an enrollee receiving a health  
4-26 care or medical service or supply or transport described by  
4-27 Subsection (b) in, and the enrollee does not have financial  
4-28 responsibility for, an amount greater than an applicable copayment,  
4-29 coinsurance, and deductible under the enrollee's health benefit  
4-30 plan that is based on:  
4-31 (1) the amount initially determined payable by the  
4-32 administrator; or  
4-33 (2) if applicable, the modified amount as determined  
4-34 under the administrator's internal appeal process.  
4-35 (f) This section expires September 1, 2025.  
4-36 SECTION 6. (a) Section 1301.0045(b), Insurance Code, is  
4-37 amended to read as follows:  
4-38 (b) Except as provided by Sections 1301.0052, 1301.0053,  
4-39 1301.155, 1301.164, ~~and~~ 1301.165, and 1301.166, this chapter may  
4-40 not be construed to require an exclusive provider benefit plan to  
4-41 compensate a nonpreferred provider for services provided to an  
4-42 insured.  
4-43 (b) Effective September 1, 2025, Section 1301.0045(b),  
4-44 Insurance Code, is amended to read as follows:  
4-45 (b) Except as provided by Sections 1301.0052, 1301.0053,  
4-46 1301.155, 1301.164, and 1301.165, this chapter may not be construed  
4-47 to require an exclusive provider benefit plan to compensate a  
4-48 nonpreferred provider for services provided to an insured.  
4-49 SECTION 7. (a) Section 1301.010, Insurance Code, is  
4-50 amended to read as follows:  
4-51 Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An  
4-52 insurer shall provide written notice in accordance with this  
4-53 section in an explanation of benefits provided to the insured and  
4-54 the physician or health care provider in connection with a medical  
4-55 care or health care service or supply or transport provided by an  
4-56 out-of-network provider. The notice must include:  
4-57 (1) a statement of the billing prohibition under  
4-58 Section 1301.0053, 1301.155, 1301.164, ~~or~~ 1301.165, or 1301.166,  
4-59 as applicable;  
4-60 (2) the total amount the physician or provider may  
4-61 bill the insured under the insured's preferred provider benefit  
4-62 plan and an itemization of copayments, coinsurance, deductibles,  
4-63 and other amounts included in that total; and  
4-64 (3) for an explanation of benefits provided to the  
4-65 physician or provider, information required by commissioner rule  
4-66 advising the physician or provider of the availability of mediation  
4-67 or arbitration, as applicable, under Chapter 1467.  
4-68 (b) An insurer shall provide the explanation of benefits  
4-69 with the notice required by this section to a physician or health

5-1 care provider not later than the date the insurer makes a payment  
5-2 under Section 1301.0053, 1301.155, 1301.164, [~~or~~] 1301.165, or  
5-3 1301.166, as applicable.

5-4 (b) Effective September 1, 2025, Section 1301.010,  
5-5 Insurance Code, is amended to read as follows:

5-6 Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An  
5-7 insurer shall provide written notice in accordance with this  
5-8 section in an explanation of benefits provided to the insured and  
5-9 the physician or health care provider in connection with a medical  
5-10 care or health care service or supply provided by an out-of-network  
5-11 provider. The notice must include:

5-12 (1) a statement of the billing prohibition under  
5-13 Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable;

5-14 (2) the total amount the physician or provider may  
5-15 bill the insured under the insured's preferred provider benefit  
5-16 plan and an itemization of copayments, coinsurance, deductibles,  
5-17 and other amounts included in that total; and

5-18 (3) for an explanation of benefits provided to the  
5-19 physician or provider, information required by commissioner rule  
5-20 advising the physician or provider of the availability of mediation  
5-21 or arbitration, as applicable, under Chapter 1467.

5-22 (b) An insurer shall provide the explanation of benefits  
5-23 with the notice required by this section to a physician or health  
5-24 care provider not later than the date the insurer makes a payment  
5-25 under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as  
5-26 applicable.

5-27 SECTION 8. Subchapter D, Chapter 1301, Insurance Code, is  
5-28 amended by adding Section 1301.166 to read as follows:

5-29 Sec. 1301.166. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES  
5-30 PROVIDER. (a) In this section, "emergency medical services  
5-31 provider" has the meaning assigned by Section 773.003, Health and  
5-32 Safety Code, except that the term does not include an air ambulance.

5-33 (b) Except as provided by Subsection (c), an insurer shall  
5-34 pay for a covered medical care or health care service performed for,  
5-35 or a covered supply or covered transport related to that service  
5-36 provided to, an insured by an out-of-network provider who is an  
5-37 emergency medical services provider at:

5-38 (1) if the political subdivision has submitted the  
5-39 rate to the department under Section 38.006, the rate set,  
5-40 controlled, or regulated by the political subdivision in which:

5-41 (A) the service originated; or

5-42 (B) the transport originated if transport is  
5-43 provided; or

5-44 (2) if the political subdivision has not submitted the  
5-45 rate to the department or does not have set, controlled, or  
5-46 regulated rates, the lesser of:

5-47 (A) the provider's billed charge; or

5-48 (B) 325 percent of the current Medicare rate,  
5-49 including any applicable extenders and modifiers.

5-50 (c) An insurer shall adjust a payment required by Subsection  
5-51 (b)(1) each plan year by increasing the payment by the lesser of the  
5-52 Medicare Inflation Index or 10 percent of the provider's previous  
5-53 calendar year rates.

5-54 (d) The insurer shall make a payment required by this  
5-55 section directly to the provider not later than, as applicable:

5-56 (1) the 30th day after the date the insurer receives an  
5-57 electronic clean claim as defined by Section 1301.101 for those  
5-58 services that includes all information necessary for the insurer to  
5-59 pay the claim; or

5-60 (2) the 45th day after the date the insurer receives a  
5-61 nonelectronic clean claim as defined by Section 1301.101 for those  
5-62 services that includes all information necessary for the insurer to  
5-63 pay the claim.

5-64 (e) An out-of-network provider who is an emergency medical  
5-65 services provider or a person asserting a claim as an agent or  
5-66 assignee of the provider may not bill an insured receiving a medical  
5-67 care or health care service or supply or transport described by  
5-68 Subsection (b) in, and the insured does not have financial  
5-69 responsibility for, an amount greater than an applicable copayment,

6-1 coinsurance, and deductible under the insured's preferred provider  
6-2 benefit plan that is based on:

6-3 (1) the amount initially determined payable by the  
6-4 insurer; or

6-5 (2) if applicable, the modified amount as determined  
6-6 under the insurer's internal appeal process.

6-7 (f) This section may not be construed to require the  
6-8 imposition of a penalty under Section 1301.137.

6-9 (g) This section expires September 1, 2025.

6-10 SECTION 9. (a) Section 1551.015, Insurance Code, is  
6-11 amended to read as follows:

6-12 Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a)  
6-13 The administrator of a managed care plan provided under the group  
6-14 benefits program shall provide written notice in accordance with  
6-15 this section in an explanation of benefits provided to the  
6-16 participant and the physician or health care provider in connection  
6-17 with a health care or medical service or supply or transport  
6-18 provided by an out-of-network provider. The notice must include:

6-19 (1) a statement of the billing prohibition under  
6-20 Section 1551.228, 1551.229, ~~or~~ 1551.230, or 1551.231, as  
6-21 applicable;

6-22 (2) the total amount the physician or provider may  
6-23 bill the participant under the participant's managed care plan and  
6-24 an itemization of copayments, coinsurance, deductibles, and other  
6-25 amounts included in that total; and

6-26 (3) for an explanation of benefits provided to the  
6-27 physician or provider, information required by commissioner rule  
6-28 advising the physician or provider of the availability of mediation  
6-29 or arbitration, as applicable, under Chapter 1467.

6-30 (b) The administrator shall provide the explanation of  
6-31 benefits with the notice required by this section to a physician or  
6-32 health care provider not later than the date the administrator  
6-33 makes a payment under Section 1551.228, 1551.229, ~~or~~ 1551.230, or  
6-34 1551.231, as applicable.

6-35 (b) Effective September 1, 2025, Section 1551.015,  
6-36 Insurance Code, is amended to read as follows:

6-37 Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a)  
6-38 The administrator of a managed care plan provided under the group  
6-39 benefits program shall provide written notice in accordance with  
6-40 this section in an explanation of benefits provided to the  
6-41 participant and the physician or health care provider in connection  
6-42 with a health care or medical service or supply provided by an  
6-43 out-of-network provider. The notice must include:

6-44 (1) a statement of the billing prohibition under  
6-45 Section 1551.228, 1551.229, or 1551.230, as applicable;

6-46 (2) the total amount the physician or provider may  
6-47 bill the participant under the participant's managed care plan and  
6-48 an itemization of copayments, coinsurance, deductibles, and other  
6-49 amounts included in that total; and

6-50 (3) for an explanation of benefits provided to the  
6-51 physician or provider, information required by commissioner rule  
6-52 advising the physician or provider of the availability of mediation  
6-53 or arbitration, as applicable, under Chapter 1467.

6-54 (b) The administrator shall provide the explanation of  
6-55 benefits with the notice required by this section to a physician or  
6-56 health care provider not later than the date the administrator  
6-57 makes a payment under Section 1551.228, 1551.229, or 1551.230, as  
6-58 applicable.

6-59 SECTION 10. Subchapter E, Chapter 1551, Insurance Code, is  
6-60 amended by adding Section 1551.231 to read as follows:

6-61 Sec. 1551.231. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES  
6-62 PROVIDER PAYMENTS. (a) In this section, "emergency medical  
6-63 services provider" has the meaning assigned by Section 773.003,  
6-64 Health and Safety Code, except that the term does not include an air  
6-65 ambulance.

6-66 (b) Except as provided by Subsection (c), the administrator  
6-67 of a managed care plan provided under the group benefits program  
6-68 shall pay for a covered health care or medical service performed  
6-69 for, or a covered supply or covered transport related to that

7-1 service provided to, a participant by an out-of-network provider  
7-2 who is an emergency medical services provider at:

7-3 (1) if the political subdivision has submitted the  
7-4 rate to the department under Section 38.006, the rate set,  
7-5 controlled, or regulated by the political subdivision in which:

7-6 (A) the service originated; or  
7-7 (B) the transport originated if transport is  
7-8 provided; or

7-9 (2) if the political subdivision has not submitted the  
7-10 rate to the department or does not have set, controlled, or  
7-11 regulated rates, the lesser of:

7-12 (A) the provider's billed charge; or  
7-13 (B) 325 percent of the current Medicare rate,  
7-14 including any applicable extenders and modifiers.

7-15 (c) The administrator shall adjust a payment required by  
7-16 Subsection (b)(1) each plan year by increasing the payment by the  
7-17 lesser of the Medicare Inflation Index or 10 percent of the  
7-18 provider's previous calendar year rates.

7-19 (d) The administrator shall make a payment required by this  
7-20 section directly to the provider not later than, as applicable:

7-21 (1) the 30th day after the date the administrator  
7-22 receives an electronic claim for those services that includes all  
7-23 information necessary for the administrator to pay the claim; or

7-24 (2) the 45th day after the date the administrator  
7-25 receives a nonelectronic claim for those services that includes all  
7-26 information necessary for the administrator to pay the claim.

7-27 (e) An out-of-network provider who is an emergency medical  
7-28 services provider or a person asserting a claim as an agent or  
7-29 assignee of the provider may not bill a participant receiving a  
7-30 health care or medical service or supply or transport described by  
7-31 Subsection (b) in, and the participant does not have financial  
7-32 responsibility for, an amount greater than an applicable copayment,  
7-33 coinsurance, and deductible under the participant's managed care  
7-34 plan that is based on:

7-35 (1) the amount initially determined payable by the  
7-36 administrator; or

7-37 (2) if applicable, the modified amount as determined  
7-38 under the administrator's internal appeal process.

7-39 (f) This section expires September 1, 2025.

7-40 SECTION 11. (a) Section 1575.009, Insurance Code, is  
7-41 amended to read as follows:

7-42 Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a)  
7-43 The administrator of a managed care plan provided under the group  
7-44 program shall provide written notice in accordance with this  
7-45 section in an explanation of benefits provided to the enrollee and  
7-46 the physician or health care provider in connection with a health  
7-47 care or medical service or supply or transport provided by an  
7-48 out-of-network provider. The notice must include:

7-49 (1) a statement of the billing prohibition under  
7-50 Section 1575.171, 1575.172, [~~or~~] 1575.173, or 1575.174, as  
7-51 applicable;

7-52 (2) the total amount the physician or provider may  
7-53 bill the enrollee under the enrollee's managed care plan and an  
7-54 itemization of copayments, coinsurance, deductibles, and other  
7-55 amounts included in that total; and

7-56 (3) for an explanation of benefits provided to the  
7-57 physician or provider, information required by commissioner rule  
7-58 advising the physician or provider of the availability of mediation  
7-59 or arbitration, as applicable, under Chapter 1467.

7-60 (b) The administrator shall provide the explanation of  
7-61 benefits with the notice required by this section to a physician or  
7-62 health care provider not later than the date the administrator  
7-63 makes a payment under Section 1575.171, 1575.172, [~~or~~] 1575.173, or  
7-64 1575.174, as applicable.

7-65 (b) Effective September 1, 2025, Section 1575.009,  
7-66 Insurance Code, is amended to read as follows:

7-67 Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a)  
7-68 The administrator of a managed care plan provided under the group  
7-69 program shall provide written notice in accordance with this

8-1 section in an explanation of benefits provided to the enrollee and  
8-2 the physician or health care provider in connection with a health  
8-3 care or medical service or supply provided by an out-of-network  
8-4 provider. The notice must include:

8-5 (1) a statement of the billing prohibition under  
8-6 Section 1575.171, 1575.172, or 1575.173, as applicable;

8-7 (2) the total amount the physician or provider may  
8-8 bill the enrollee under the enrollee's managed care plan and an  
8-9 itemization of copayments, coinsurance, deductibles, and other  
8-10 amounts included in that total; and

8-11 (3) for an explanation of benefits provided to the  
8-12 physician or provider, information required by commissioner rule  
8-13 advising the physician or provider of the availability of mediation  
8-14 or arbitration, as applicable, under Chapter 1467.

8-15 (b) The administrator shall provide the explanation of  
8-16 benefits with the notice required by this section to a physician or  
8-17 health care provider not later than the date the administrator  
8-18 makes a payment under Section 1575.171, 1575.172, or 1575.173, as  
8-19 applicable.

8-20 SECTION 12. Subchapter D, Chapter 1575, Insurance Code, is  
8-21 amended by adding Section 1575.174 to read as follows:

8-22 Sec. 1575.174. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES  
8-23 PROVIDER PAYMENTS. (a) In this section, "emergency medical  
8-24 services provider" has the meaning assigned by Section 773.003,  
8-25 Health and Safety Code, except that the term does not include an air  
8-26 ambulance.

8-27 (b) Except as provided by Subsection (c), the administrator  
8-28 of a managed care plan provided under the group program shall pay  
8-29 for a covered health care or medical service performed for, or a  
8-30 covered supply or covered transport related to that service  
8-31 provided to, an enrollee by an out-of-network provider who is an  
8-32 emergency medical services provider at:

8-33 (1) if the political subdivision has submitted the  
8-34 rate to the department under Section 38.006, the rate set,  
8-35 controlled, or regulated by the political subdivision in which:

8-36 (A) the service originated; or  
8-37 (B) the transport originated if transport is  
8-38 provided; or

8-39 (2) if the political subdivision has not submitted the  
8-40 rate to the department or does not have set, controlled, or  
8-41 regulated rates, the lesser of:

8-42 (A) the provider's billed charge; or  
8-43 (B) 325 percent of the current Medicare rate,  
8-44 including any applicable extenders and modifiers.

8-45 (c) The administrator shall adjust a payment required by  
8-46 Subsection (b)(1) each plan year by increasing the payment by the  
8-47 lesser of the Medicare Inflation Index or 10 percent of the  
8-48 provider's previous calendar year rates.

8-49 (d) The administrator shall make a payment required by this  
8-50 section directly to the provider not later than, as applicable:

8-51 (1) the 30th day after the date the administrator  
8-52 receives an electronic claim for those services that includes all  
8-53 information necessary for the administrator to pay the claim; or

8-54 (2) the 45th day after the date the administrator  
8-55 receives a nonelectronic claim for those services that includes all  
8-56 information necessary for the administrator to pay the claim.

8-57 (e) An out-of-network provider who is an emergency medical  
8-58 services provider or a person asserting a claim as an agent or  
8-59 assignee of the provider may not bill an enrollee receiving a health  
8-60 care or medical service or supply or transport described by  
8-61 Subsection (b) in, and the enrollee does not have financial  
8-62 responsibility for, an amount greater than an applicable copayment,  
8-63 coinsurance, and deductible under the enrollee's managed care plan  
8-64 that is based on:

8-65 (1) the amount initially determined payable by the  
8-66 administrator; or

8-67 (2) if applicable, the modified amount as determined  
8-68 under the administrator's internal appeal process.

8-69 (f) This section expires September 1, 2025.

9-1 SECTION 13. (a) Section 1579.009, Insurance Code, is  
9-2 amended to read as follows:

9-3 Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a)  
9-4 The administrator of a managed care plan provided under this  
9-5 chapter shall provide written notice in accordance with this  
9-6 section in an explanation of benefits provided to the enrollee and  
9-7 the physician or health care provider in connection with a health  
9-8 care or medical service or supply or transport provided by an  
9-9 out-of-network provider. The notice must include:

9-10 (1) a statement of the billing prohibition under  
9-11 Section 1579.109, 1579.110, [~~or~~] 1579.111, or 1579.112, as  
9-12 applicable;

9-13 (2) the total amount the physician or provider may  
9-14 bill the enrollee under the enrollee's managed care plan and an  
9-15 itemization of copayments, coinsurance, deductibles, and other  
9-16 amounts included in that total; and

9-17 (3) for an explanation of benefits provided to the  
9-18 physician or provider, information required by commissioner rule  
9-19 advising the physician or provider of the availability of mediation  
9-20 or arbitration, as applicable, under Chapter 1467.

9-21 (b) The administrator shall provide the explanation of  
9-22 benefits with the notice required by this section to a physician or  
9-23 health care provider not later than the date the administrator  
9-24 makes a payment under Section 1579.109, 1579.110, [~~or~~] 1579.111, or  
9-25 1579.112, as applicable.

9-26 (b) Effective September 1, 2025, Section 1579.009,  
9-27 Insurance Code, is amended to read as follows:

9-28 Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a)  
9-29 The administrator of a managed care plan provided under this  
9-30 chapter shall provide written notice in accordance with this  
9-31 section in an explanation of benefits provided to the enrollee and  
9-32 the physician or health care provider in connection with a health  
9-33 care or medical service or supply provided by an out-of-network  
9-34 provider. The notice must include:

9-35 (1) a statement of the billing prohibition under  
9-36 Section 1579.109, 1579.110, or 1579.111, as applicable;

9-37 (2) the total amount the physician or provider may  
9-38 bill the enrollee under the enrollee's managed care plan and an  
9-39 itemization of copayments, coinsurance, deductibles, and other  
9-40 amounts included in that total; and

9-41 (3) for an explanation of benefits provided to the  
9-42 physician or provider, information required by commissioner rule  
9-43 advising the physician or provider of the availability of mediation  
9-44 or arbitration, as applicable, under Chapter 1467.

9-45 (b) The administrator shall provide the explanation of  
9-46 benefits with the notice required by this section to a physician or  
9-47 health care provider not later than the date the administrator  
9-48 makes a payment under Section 1579.109, 1579.110, or 1579.111, as  
9-49 applicable.

9-50 SECTION 14. Subchapter C, Chapter 1579, Insurance Code, is  
9-51 amended by adding Section 1579.112 to read as follows:

9-52 Sec. 1579.112. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES  
9-53 PROVIDER PAYMENTS. (a) In this section, "emergency medical  
9-54 services provider" has the meaning assigned by Section 773.003,  
9-55 Health and Safety Code, except that the term does not include an air  
9-56 ambulance.

9-57 (b) Except as provided by Subsection (c), the administrator  
9-58 of a managed care plan provided under this chapter shall pay for a  
9-59 covered health care or medical service performed for, or a covered  
9-60 supply or covered transport related to that service provided to, an  
9-61 enrollee by an out-of-network provider who is an emergency medical  
9-62 services provider at:

9-63 (1) if the political subdivision has submitted the  
9-64 rate to the department under Section 38.006, the rate set,  
9-65 controlled, or regulated by the political subdivision in which:

9-66 (A) the service originated; or

9-67 (B) the transport originated if transport is  
9-68 provided; or

9-69 (2) if the political subdivision has not submitted the

10-1 rate to the department or does not have set, controlled, or  
10-2 regulated rates, the lesser of:

- 10-3 (A) the provider's billed charge; or
- 10-4 (B) 325 percent of the current Medicare rate,  
10-5 including any applicable extenders and modifiers.

10-6 (c) The administrator shall adjust a payment required by  
10-7 Subsection (b)(1) each plan year by increasing the payment by the  
10-8 lesser of the Medicare Inflation Index or 10 percent of the  
10-9 provider's previous calendar year rates.

10-10 (d) The administrator shall make a payment required by this  
10-11 section directly to the provider not later than, as applicable:

10-12 (1) the 30th day after the date the administrator  
10-13 receives an electronic claim for those services that includes all  
10-14 information necessary for the administrator to pay the claim; or

10-15 (2) the 45th day after the date the administrator  
10-16 receives a nonelectronic claim for those services that includes all  
10-17 information necessary for the administrator to pay the claim.

10-18 (e) An out-of-network provider who is an emergency medical  
10-19 services provider or a person asserting a claim as an agent or  
10-20 assignee of the provider may not bill an enrollee receiving a health  
10-21 care or medical service or supply or transport described by  
10-22 Subsection (b) in, and the enrollee does not have financial  
10-23 responsibility for, an amount greater than an applicable copayment,  
10-24 coinsurance, and deductible under the enrollee's managed care plan  
10-25 that is based on:

10-26 (1) the amount initially determined payable by the  
10-27 administrator; or

10-28 (2) if applicable, a modified amount as determined  
10-29 under the administrator's internal appeal process.

10-30 (f) This section expires September 1, 2025.

10-31 SECTION 15. The changes in law made by this Act apply only  
10-32 to a ground ambulance service provided on or after January 1, 2024.  
10-33 A ground ambulance service provided before January 1, 2024, is  
10-34 governed by the law in effect immediately before the effective date  
10-35 of this Act, and that law is continued in effect for that purpose.

10-36 SECTION 16. Except as otherwise provided by this Act, this  
10-37 Act takes effect September 1, 2023.

10-38 \* \* \* \* \*