By: Hancock, et al. (Oliverson) S.B. No. 999

Substitute the following for S.B. No. 999:

By: Oliverson C.S.S.B. No. 999

A BILL TO BE ENTITLED

AN ACT

relating to consumer protections against and county and municipal authority regarding certain medical and health care billing by ambulance service providers.

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

ARTICLE 1. ELIMINATING SURPRISE BILLING FOR CERTAIN GROUND AMBULANCE SERVICES UNDER CERTAIN HEALTH BENEFIT PLANS

SECTION 1.01. 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, 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.

SECTION 1.02. Subchapter D, Chapter 1271, Insurance Code, is amended by adding Section 1271.159 to read as follows:

Sec. 1271.159. NON-NETWORK GROUND AMBULANCE SERVICE PROVIDER. (a) In this section, "ground ambulance service provider" has the meaning assigned by Section 1467.001.

(b) A health maintenance organization shall pay for a covered health care service performed by or a covered supply related to that service provided to an enrollee by a non-network ground ambulance service provider at the usual and customary rate or at an agreed rate. The health maintenance organization shall make a payment required by this subsection 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.

(c) A non-network ground ambulance service 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 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:

(1) is based on:

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

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

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

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

SECTION 1.03. 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.

SECTION 1.04. 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, 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.

SECTION 1.05. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Section 1301.166 to read as follows:

Sec. 1301.166. OUT-OF-NETWORK GROUND AMBULANCE SERVICE PROVIDER. (a) In this section, "ground ambulance service provider" has the meaning assigned by Section 1467.001.

(b) An insurer shall pay for a covered medical care or health care service performed for or a covered supply related to that service provided to an insured by an out-of-network provider who is a ground ambulance service provider at the usual and customary rate or at an agreed rate. The insurer shall make a payment required by this subsection 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.

(c) An out-of-network provider who is a ground ambulance service 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 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:

(1) is based on:

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

(B) if applicable, the modified amount as

determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

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

SECTION 1.06. 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, 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.

SECTION 1.07. Subchapter E, Chapter 1551, Insurance Code, is amended by adding Section 1551.231 to read as follows:

Sec. 1551.231. OUT-OF-NETWORK GROUND AMBULANCE SERVICE PROVIDER PAYMENTS. (a) In this section, "ground ambulance service provider" has the meaning assigned by Section 1467.001.

(b) 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 related to that service provided to a participant by an out-of-network provider who is a ground ambulance service provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection 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.

(c) An out-of-network provider who is a ground ambulance service 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 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:

(1) is based on:

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

(B) if applicable, the modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

SECTION 1.08. 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, 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.

SECTION 1.09. Subchapter D, Chapter 1575, Insurance Code, is amended by adding Section 1575.174 to read as follows:

Sec. 1575.174. OUT-OF-NETWORK GROUND AMBULANCE SERVICE PROVIDER PAYMENTS. (a) In this section, "ground ambulance service provider" has the meaning assigned by Section 1467.001.

(b) 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 related to that service provided to an enrollee by an out-of-network provider who is a ground ambulance service provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection 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.

(c) An out-of-network provider who is a ground ambulance

service 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 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:

(1) is based on:

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

(B) if applicable, the modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

SECTION 1.10. 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, 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.

SECTION 1.11. Subchapter C, Chapter 1579, Insurance Code, is amended by adding Section 1579.112 to read as follows:

Sec. 1579.112. OUT-OF-NETWORK GROUND AMBULANCE SERVICE PROVIDER PAYMENTS. (a) In this section, "ground ambulance service provider" has the meaning assigned by Section 1467.001.

(b) 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 related to that service provided to an enrollee by an out-of-network provider who is a ground ambulance service provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection 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.

(c) An out-of-network provider who is a ground ambulance service 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 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:

(1) is based on:

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

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

SECTION 2.01. Section 1467.001, Insurance Code, is amended by adding Subdivision (3-b) and amending Subdivisions (4) and (6-a) to read as follows:

(3-b) [~~(4)~~] "Facility-based provider" means a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility.

(4) "Ground ambulance service provider" means a health care provider using a ground vehicle in transporting an ill or

injured individual from a facility to another facility. The term includes an emergency medical services provider and a provider using emergency medical services vehicles, as those terms are defined by Section 773.003, Health and Safety Code, except the terms do not include an air ambulance. The term does not include a ground ambulance service provided by a county or municipality.

(6-a) "Out-of-network provider" means a diagnostic imaging provider, emergency care provider, facility-based provider, [~~or~~] laboratory service provider, or ground ambulance service provider that is not a participating provider for a health benefit plan.

SECTION 2.02. The heading to Subchapter B, Chapter 1467, Insurance Code, is amended to read as follows:

SUBCHAPTER B. MANDATORY MEDIATION FOR OUT-OF-NETWORK FACILITIES AND GROUND AMBULANCE SERVICE PROVIDERS

SECTION 2.03. Section 1467.050(a), Insurance Code, is amended to read as follows:

(a) This subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider that is a facility or ground ambulance service provider.

SECTION 2.04. Section 1467.051(a), Insurance Code, is amended to read as follows:

(a) An out-of-network provider or a health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:

(1) there is an amount billed by the provider and

unpaid by the issuer or administrator after copayments, deductibles, and coinsurance for which an enrollee may not be billed; and

(2) the health benefit claim is for:

(A) emergency care;

(B) an out-of-network laboratory service; [~~or~~]

(C) an out-of-network diagnostic imaging service; or

(D) an out-of-network ground ambulance service.

SECTION 2.05. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Section 1467.0555 to read as follows:

Sec. 1467.0555. MEDIATION INVOLVING GROUND AMBULANCE SERVICE PROVIDER. (a) A ground ambulance service provider may elect to submit multiple claims to mediation in one proceeding if:

(1) the total amount in controversy for the claims does not exceed $5,000; and

(2) the claims are limited to the same administrator or health benefit plan issuer.

(b) A mediation of a settlement of a health benefit claim for an out-of-network ground ambulance service must be completed not later than the 90th day after the date of the request for mediation.

ARTICLE 3. BALANCE BILLING FOR COUNTY AMBULANCE SERVICES

SECTION 3.01. Chapter 140, Local Government Code, is amended by adding Section 140.013 to read as follows:

Sec. 140.013. BALANCE BILLING FOR COUNTY AND MUNICIPAL AMBULANCE SERVICES. (a) "Balance billing" means the practice of

charging an enrollee in a health benefit plan to recover from the enrollee the balance of a health care provider's fee for a service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

(b) A county or municipality may elect to consider a health benefit plan payment toward a claim for air or ground ambulance services provided by the county or municipality as payment in full for those services regardless of the amount the county or municipality charged for those services.

(c) A county or municipality may not practice balance billing for a claim for which the county or municipality makes an election under Subsection (b).

ARTICLE 4. STUDY

SECTION 4.01. (a) In this section, "department" means the Texas Department of Insurance.

(b) The department shall conduct a study on the balance billing practices of county and municipal ground ambulance service providers, the variations in prices for county and municipal ground ambulance services, the proportion of ground ambulances that are in-network, trends in network inclusion, and factors contributing to the network status of ground ambulances. The department may seek the assistance of the Department of State Health Services in conducting the study.

(c) Not later than December 1, 2022, the department shall provide a written report of the results of the study conducted under Subsection (b) of this section to the governor, lieutenant governor, speaker of the house of representatives, and members of

the standing committees of the legislature with primary jurisdiction over the department.

(d) This section expires September 1, 2023.

ARTICLE 5. TRANSITION AND EFFECTIVE DATE

SECTION 5.01. The changes in law made by Articles 1 and 2 of this Act apply only to a ground ambulance service provided on or after January 1, 2022. A ground ambulance service provided before January 1, 2022, 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 5.02. This Act takes effect September 1, 2021.