By: Hancock, Whitmire

S.B. No. 999

A BILL TO BE ENTITLED

1 AN ACT

- 2 relating to consumer protections against certain medical and health
- 3 care billing by out-of-network ground ambulance service providers.
- 4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
- 5 SECTION 1. Section 38.004(a), Insurance Code, is amended to
- 6 read as follows:
- 7 (a) The department shall, each biennium, conduct a study on
- 8 the impacts of S.B. No. 1264, Acts of the 86th Legislature, Regular $\,$
- 9 Session, 2019, and subsequently enacted laws prohibiting an
- 10 individual or entity from billing an insured, participant, or
- 11 enrollee in an amount greater than an applicable copayment,
- 12 coinsurance, or deductible under the insured's, participant's, or
- 13 enrollee's managed care plan or imposing a requirement related to
- 14 that prohibition, on Texas consumers and health coverage in this
- 15 state, including:
- 16 (1) trends in billed amounts for health care or
- 17 medical services or supplies, especially emergency services,
- 18 laboratory services, diagnostic imaging services, ground ambulance
- 19 <u>services</u>, and facility-based services;
- 20 (2) comparison of the total amount spent on
- 21 out-of-network emergency services, laboratory services, diagnostic
- 22 imaging services, ground ambulance services, and facility-based
- 23 services by calendar year and provider type or physician specialty;
- 24 (3) trends and changes in network participation by

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- 1 providers of emergency services, laboratory services, diagnostic
- 2 imaging services, ground ambulance services, and facility-based
- 3 services by provider type or physician specialty, including whether
- 4 any terminations were initiated by a health benefit plan issuer,
- 5 administrator, or provider;
- 6 (4) trends and changes in the amounts paid to
- 7 participating providers;
- 8 (5) the number of complaints, completed
- 9 investigations, and disciplinary sanctions for billing by
- 10 providers of emergency services, laboratory services, diagnostic
- 11 imaging services, ground ambulance services, or facility-based
- 12 services of enrollees for amounts greater than the enrollee's
- 13 responsibility under an applicable health benefit plan, including
- 14 applicable copayments, coinsurance, and deductibles;
- 15 (6) trends in amounts paid to out-of-network
- 16 providers;
- 17 (7) trends in the usual and customary rate for health
- 18 care or medical services or supplies, especially emergency
- 19 services, laboratory services, diagnostic imaging services, ground
- 20 ambulance services, and facility-based services; and
- 21 (8) the effectiveness of the claim dispute resolution
- 22 process under Chapter 1467.
- 23 SECTION 2. The heading to Section 1271.158, Insurance Code,
- 24 is amended to read as follows:
- 25 Sec. 1271.158. <u>CERTAIN</u> NON-NETWORK <u>ANCIL</u>LARY [DIAGNOSTIC
- 26 IMAGING PROVIDER OR LABORATORY] SERVICE PROVIDERS [PROVIDER].
- 27 SECTION 3. Sections 1271.158(a), (b), and (c), Insurance

- 1 Code, are amended to read as follows:
- 2 (a) In this section, "diagnostic imaging provider,"
- 3 [provider" and "laboratory service provider," and "ground
- 4 <u>ambulance service</u> provider" have the meanings assigned by Section
- 5 1467.001.
- 6 (b) Except as provided by Subsection (d), a health
- 7 maintenance organization shall pay for a covered health care
- 8 service performed by or a covered supply related to that service
- 9 provided to an enrollee by a non-network diagnostic imaging
- 10 provider, [or] laboratory service provider, or ground ambulance
- 11 <u>service provider</u> at the usual and customary rate or at an agreed
- 12 rate if the provider performed the service in connection with a
- 13 health care service performed by a network physician or provider.
- 14 The health maintenance organization shall make a payment required
- 15 by this subsection directly to the physician or provider not later
- 16 than, as applicable:
- 17 (1) the 30th day after the date the health maintenance
- 18 organization receives an electronic clean claim as defined by
- 19 Section 843.336 for those services that includes all information
- 20 necessary for the health maintenance organization to pay the claim;
- 21 or
- 22 (2) the 45th day after the date the health maintenance
- 23 organization receives a nonelectronic clean claim as defined by
- 24 Section 843.336 for those services that includes all information
- 25 necessary for the health maintenance organization to pay the claim.
- 26 (c) Except as provided by Subsection (d), a non-network
- 27 diagnostic imaging provider, [or] laboratory service provider, or

- 1 ground ambulance service provider or a person asserting a claim as
- 2 an agent or assignee of the provider may not bill an enrollee
- 3 receiving a health care service or supply described by Subsection
- 4 (b) in, and the enrollee does not have financial responsibility
- 5 for, an amount greater than an applicable copayment, coinsurance,
- 6 and deductible under the enrollee's health care plan that:
- 7 (1) is based on:
- 8 (A) the amount initially determined payable by
- 9 the health maintenance organization; or
- 10 (B) if applicable, a modified amount as
- 11 determined under the health maintenance organization's internal
- 12 appeal process; and
- 13 (2) is not based on any additional amount determined
- 14 to be owed to the provider under Chapter 1467.
- SECTION 4. The heading to Section 1301.165, Insurance Code,
- 16 is amended to read as follows:
- 17 Sec. 1301.165. CERTAIN OUT-OF-NETWORK ANCILLARY
- 18 [DIAGNOSTIC IMAGING PROVIDER OR LABORATORY] SERVICE PROVIDERS
- 19 [PROVIDER].
- 20 SECTION 5. Sections 1301.165(a), (b), and (c), Insurance
- 21 Code, are amended to read as follows:
- 22 (a) In this section, "diagnostic imaging provider,"
- 23 [provider" and] "laboratory service provider," and "ground
- 24 ambulance service provider" have the meanings assigned by Section
- 25 1467.001.
- 26 (b) Except as provided by Subsection (d), an insurer shall
- 27 pay for a covered medical care or health care service performed by

- 1 or a covered supply related to that service provided to an insured
- 2 by an out-of-network provider who is a diagnostic imaging provider,
- 3 [or] laboratory service provider, or ground ambulance service
- 4 provider at the usual and customary rate or at an agreed rate if the
- 5 provider performed the service in connection with a medical care or
- 6 health care service performed by a preferred provider. The insurer
- 7 shall make a payment required by this subsection directly to the
- 8 provider not later than, as applicable:
- 9 (1) the 30th day after the date the insurer receives an
- 10 electronic clean claim as defined by Section 1301.101 for those
- 11 services that includes all information necessary for the insurer to
- 12 pay the claim; or
- 13 (2) the 45th day after the date the insurer receives a
- 14 nonelectronic clean claim as defined by Section 1301.101 for those
- 15 services that includes all information necessary for the insurer to
- 16 pay the claim.
- 17 (c) Except as provided by Subsection (d), an out-of-network
- 18 provider who is a diagnostic imaging provider, [or] laboratory
- 19 service provider, or ground ambulance service provider or a person
- 20 asserting a claim as an agent or assignee of the provider may not
- 21 bill an insured receiving a medical care or health care service or
- 22 supply described by Subsection (b) in, and the insured does not have
- 23 financial responsibility for, an amount greater than an applicable
- 24 copayment, coinsurance, and deductible under the insured's
- 25 preferred provider benefit plan that:
- 26 (1) is based on:
- 27 (A) the amount initially determined payable by

- 1 the insurer; or
- 2 (B) if applicable, the modified amount as
- 3 determined under the insurer's internal appeal process; and
- 4 (2) is not based on any additional amount determined
- 5 to be owed to the provider under Chapter 1467.
- 6 SECTION 6. The heading to Section 1551.230, Insurance Code,
- 7 is amended to read as follows:
- 8 Sec. 1551.230. PAYMENTS TO CERTAIN OUT-OF-NETWORK
- 9 ANCILLARY [DIACNOSTIC IMAGING PROVIDER OR LABORATORY] SERVICE
- 10 PROVIDERS [PROVIDER PAYMENTS].
- 11 SECTION 7. Sections 1551.230(a), (b), and (c), Insurance
- 12 Code, are amended to read as follows:
- 13 (a) In this section, "diagnostic imaging provider,"
- 14 [provider" and "laboratory service provider," and "ground
- 15 <u>ambulance service</u> provider" have the meanings assigned by Section
- 16 1467.001.
- (b) Except as provided by Subsection (d), the administrator
- 18 of a managed care plan provided under the group benefits program
- 19 shall pay for a covered health care or medical service performed for
- 20 or a covered supply related to that service provided to a
- 21 participant by an out-of-network provider who is a diagnostic
- 22 imaging provider, [or] laboratory service provider, or ground
- 23 <u>ambulance service provider</u> at the usual and customary rate or at an
- 24 agreed rate if the provider performed the service in connection
- 25 with a health care or medical service performed by a participating
- 26 provider. The administrator shall make a payment required by this
- 27 subsection directly to the provider not later than, as applicable:

- 1 (1) the 30th day after the date the administrator
- 2 receives an electronic claim for those services that includes all
- 3 information necessary for the administrator to pay the claim; or
- 4 (2) the 45th day after the date the administrator
- 5 receives a nonelectronic claim for those services that includes all
- 6 information necessary for the administrator to pay the claim.
- 7 (c) Except as provided by Subsection (d), an out-of-network
- 8 provider who is a diagnostic imaging provider $\underline{,}$ [or] laboratory
- 9 service provider, or ground ambulance service provider or a person
- 10 asserting a claim as an agent or assignee of the provider may not
- 11 bill a participant receiving a health care or medical service or
- 12 supply described by Subsection (b) in, and the participant does not
- 13 have financial responsibility for, an amount greater than an
- 14 applicable copayment, coinsurance, and deductible under the
- 15 participant's managed care plan that:
- 16 (1) is based on:
- 17 (A) the amount initially determined payable by
- 18 the administrator; or
- 19 (B) if applicable, the modified amount as
- 20 determined under the administrator's internal appeal process; and
- 21 (2) is not based on any additional amount determined
- 22 to be owed to the provider under Chapter 1467.
- SECTION 8. The heading to Section 1575.173, Insurance Code,
- 24 is amended to read as follows:
- Sec. 1575.173. PAYMENTS TO CERTAIN OUT-OF-NETWORK
- 26 ANCILLARY [DIACNOSTIC IMAGING PROVIDER OR LABORATORY] SERVICE
- 27 PROVIDERS [PROVIDER PAYMENTS].

- SECTION 9. Sections 1575.173(a), (b), and (c), Insurance
- 2 Code, are amended to read as follows:
- 3 (a) In this section, "diagnostic imaging provider,"
- 4 [provider" and] "laboratory service provider," and "ground
- 5 <u>ambulance service</u> provider" have the meanings assigned by Section
- 6 1467.001.
- 7 (b) Except as provided by Subsection (d), the administrator
- 8 of a managed care plan provided under the group program shall pay
- 9 for a covered health care or medical service performed for or a
- 10 covered supply related to that service provided to an enrollee by an
- 11 out-of-network provider who is a diagnostic imaging provider, [or]
- 12 laboratory service provider, or ground ambulance service provider
- 13 at the usual and customary rate or at an agreed rate if the provider
- 14 performed the service in connection with a health care or medical
- 15 service performed by a participating provider. The administrator
- 16 shall make a payment required by this subsection directly to the
- 17 provider not later than, as applicable:
- 18 (1) the 30th day after the date the administrator
- 19 receives an electronic claim for those services that includes all
- 20 information necessary for the administrator to pay the claim; or
- 21 (2) the 45th day after the date the administrator
- 22 receives a nonelectronic claim for those services that includes all
- 23 information necessary for the administrator to pay the claim.
- (c) Except as provided by Subsection (d), an out-of-network
- 25 provider who is a diagnostic imaging provider [or] laboratory
- 26 service provider, or ground ambulance service provider or a person
- 27 asserting a claim as an agent or assignee of the provider may not

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- 1 bill an enrollee receiving a health care or medical service or
- 2 supply described by Subsection (b) in, and the enrollee does not
- 3 have financial responsibility for, an amount greater than an
- 4 applicable copayment, coinsurance, and deductible under the
- 5 enrollee's managed care plan that:
- 6 (1) is based on:
- 7 (A) the amount initially determined payable by
- 8 the administrator; or
- 9 (B) if applicable, the modified amount as
- 10 determined under the administrator's internal appeal process; and
- 11 (2) is not based on any additional amount determined
- 12 to be owed to the provider under Chapter 1467.
- 13 SECTION 10. The heading to Section 1579.111, Insurance
- 14 Code, is amended to read as follows:
- 15 Sec. 1579.111. PAYMENTS TO CERTAIN OUT-OF-NETWORK
- 16 <u>ANCILLARY</u> [DIAGNOSTIC IMAGING PROVIDER OR LABORATORY] SERVICE
- 17 PROVIDERS [PROVIDER PAYMENTS].
- 18 SECTION 11. Sections 1579.111(a), (b), and (c), Insurance
- 19 Code, are amended to read as follows:
- 20 (a) In this section, "diagnostic imaging provider,"
- 21 [provider" and "laboratory service provider," and "ground
- 22 <u>ambulance service</u> provider" have the meanings assigned by Section
- 23 1467.001.
- (b) Except as provided by Subsection (d), the administrator
- 25 of a managed care plan provided under this chapter shall pay for a
- 26 covered health care or medical service performed for or a covered
- 27 supply related to that service provided to an enrollee by an

- 1 out-of-network provider who is a diagnostic imaging provider, [or]
- 2 laboratory service provider, or ground ambulance service provider
- 3 at the usual and customary rate or at an agreed rate if the provider
- 4 performed the service in connection with a health care or medical
- 5 service performed by a participating provider. The administrator
- 6 shall make a payment required by this subsection directly to the
- 7 provider not later than, as applicable:
- 8 (1) the 30th day after the date the administrator
- 9 receives an electronic claim for those services that includes all
- 10 information necessary for the administrator to pay the claim; or
- 11 (2) the 45th day after the date the administrator
- 12 receives a nonelectronic claim for those services that includes all
- 13 information necessary for the administrator to pay the claim.
- 14 (c) Except as provided by Subsection (d), an out-of-network
- 15 provider who is a diagnostic imaging provider [or] laboratory
- 16 service provider, or ground ambulance service provider or a person
- 17 asserting a claim as an agent or assignee of the provider may not
- 18 bill an enrollee receiving a health care or medical service or
- 19 supply described by Subsection (b) in, and the enrollee does not
- 20 have financial responsibility for, an amount greater than an
- 21 applicable copayment, coinsurance, and deductible under the
- 22 enrollee's managed care plan that:
- 23 (1) is based on:
- 24 (A) the amount initially determined payable by
- 25 the administrator; or
- 26 (B) if applicable, a modified amount as
- 27 determined under the administrator's internal appeal process; and

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- 1 (2) is not based on any additional amount determined
- 2 to be owed to the provider under Chapter 1467.
- 3 SECTION 12. Section 1467.001, Insurance Code, is amended by
- 4 adding Subdivision (3-b) and amending Subdivisions (4) and (6-a) to
- 5 read as follows:
- 6 (3-b) [(4)] "Facility-based provider" means a
- 7 physician, health care practitioner, or other health care provider
- 8 who provides health care or medical services to patients of a
- 9 facility.
- 10 (4) "Ground ambulance service provider" means a
- 11 private entity or municipality providing emergency and
- 12 <u>nonemergency ground ambulance services.</u> The term includes all
- 13 personnel employed by the private entity or municipality who bill
- 14 separately for ground ambulance services.
- 15 (6-a) "Out-of-network provider" means a diagnostic
- 16 imaging provider, emergency care provider, facility-based
- 17 provider, [er] laboratory service provider, or ground ambulance
- 18 service provider that is not a participating provider for a health
- 19 benefit plan.
- SECTION 13. Section 1467.050(a), Insurance Code, is amended
- 21 to read as follows:
- 22 (a) This subchapter applies only with respect to a health
- 23 benefit claim submitted by an out-of-network provider that is a
- 24 facility or ground ambulance service provider.
- 25 SECTION 14. Section 1467.051(a), Insurance Code, is amended
- 26 to read as follows:
- 27 (a) An out-of-network provider or a health benefit plan

- 1 issuer or administrator may request mediation of a settlement of an
- 2 out-of-network health benefit claim through a portal on the
- 3 department's Internet website if:
- 4 (1) there is an amount billed by the provider and
- 5 unpaid by the issuer or administrator after copayments,
- 6 deductibles, and coinsurance for which an enrollee may not be
- 7 billed; and
- 8 (2) the health benefit claim is for:
- 9 (A) emergency care;
- 10 (B) an out-of-network laboratory service; [or]
- 11 (C) an out-of-network diagnostic imaging
- 12 service; or
- 13 (D) an out-of-network ground ambulance service.
- 14 SECTION 15. Section 1467.081, Insurance Code, is amended to
- 15 read as follows:
- 16 Sec. 1467.081. APPLICABILITY OF SUBCHAPTER. This
- 17 subchapter applies only with respect to a health benefit claim
- 18 submitted by an out-of-network provider who is not a facility or
- 19 ground ambulance service provider.
- 20 SECTION 16. The changes in law made by this Act apply only
- 21 to a ground ambulance service provided on or after January 1, 2022.
- 22 A ground ambulance service provided before January 1, 2022, is
- 23 governed by the law in effect immediately before the effective date
- 24 of this Act, and that law is continued in effect for that purpose.
- 25 SECTION 17. This Act takes effect September 1, 2021.