BILL ANALYSIS

Senate Research Center
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C.S.S.B. 2476
By: Zaffirini
Health & Human Services
4/21/2023
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

In 2019, the Texas Legislature passed S.B. 1294, also known as the Surprise Billing Act, authored by Senator Kelly Hancock. Prior to this law, when a health insurer refused to pay the full amount charged by an out-of-network doctor for a medical procedure, the doctor could bill the patient for the balance of the cost, often resulting in unexpected bills for patients. S.B. 1294, however, did not cover ground-ambulance services provided by municipalities, which continue to engage in balance billing.

S.B. 2476 would prohibit ground-ambulance services provided by municipalities from engaging in balance billing. This change would ensure that patients are not charged exorbitant prices for urgent trips to the hospital.

(Original Author's/Sponsor's Statement of Intent)

C.S.S.B. 2476 amends current law relating to consumer protections against certain medical and health care billing by emergency medical services providers.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 38, Insurance Code, by adding Section 38.006, as follows:

> Sec. 38.006. EMERGENCY MEDICAL SERVICES PROVIDER BALANCE BILLING RATE DATABASE. (a) Authorizes a political subdivision to submit to the Texas Department of Insurance (TDI) 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. Requires TDI to establish and maintain on TDI's Internet website a publicly accessible database for the rates.
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> (b) Provides that this section expires September 1, 2025.

SECTION 2. (a) Amends Section 1271.008, Insurance Code, as follows:

> Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) Requires a health maintenance organization (HMO) to 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. Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, including Section 1271.159, as applicable.
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> (b) Requires an HMO to 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 certain statutes, including Section 1271.159, as applicable.

(b) Amends Section 1271.008, Insurance Code, effective September 1, 2025, as follows:

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) Requires a health maintenance organization (HMO) to 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. Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, not including Section 1271.159, as applicable.

(b) Requires an HMO to 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 certain statutes, not including Section 1271.159, as applicable.

SECTION 3. Amends Subchapter D, Chapter 1271, Insurance Code, by adding Section 1271.159, as follows:

Sec. 1271.159. NON-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER. (a) Defines "emergency medical services provider."

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

(1) if the political subdivision has submitted the rate to TDI under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which the service originated or the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to TDI or does not have set, controlled, or regulated rates, the lesser of:

(A) the provider's billed charge; or

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

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

(d) Requires an HMO to make a payment required by this section directly to the provider not later than, as applicable:

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

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

(e) Prohibits a non-network emergency medical services provider or a person asserting a claim as an agent or assignee of the provider from billing an enrollee receiving a health care service or supply or transport described by Subsection (b)

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

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

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

(f) Prohibits this section from being construed to require the imposition of a penalty under Section 843.342 (Violation of Certain Claims Payment Provisions; Penalties).

(g) Provides that this section expires September 1, 2025.

SECTION 4. (a) Amends Section 1275.003, Insurance Code, as follows:

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a) Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, including Section 1275.054, as applicable. Makes conforming and nonsubstantive changes.

(b) Makes conforming and nonsubstantive changes to this subsection.

(b) Amends Section 1275.003, Insurance Code, effective September 1, 2025, as follows:

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a) Requires the administrator of a health benefit plan to which this chapter applies to 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 service or supply provided by a non-network physician or provider. Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, not including Section 1275.054, as applicable.

(b) Requires the administrator to provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date administrator makes a payment under certain statutes, not including Section 1275.054, as applicable.

SECTION 5. Amends Subchapter B, Chapter 1275, Insurance Code, by adding Section 1275.054, as follows:

Sec. 1275.054. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) Defines "emergency medical services provider."

(b) Requires the administrator of a health benefit plan to which Chapter 1275 (Balance Billing Prohibitions and Out-of-Network Claim Dispute Resolution for Certain Plans) applies, except as provided by Subsection (c), to pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to TDI under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which the service originated or the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to TDI or does not have set, controlled, or regulated rates, the lesser of:

(A) the provider's billed charge; or

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

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

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

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

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

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

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

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

(f) Provides that this section expires September 1, 2025.

SECTION 6. (a) Amends Section 1301.0045(b), Insurance Code, to create an exception under Section 1301.166 and to make nonsubstantive changes.

(b) Amends Section 1301.0045(b), Insurance Code, effective September 1, 2025, to not create an exception under Section 1301.166.

SECTION 7. (a) Amends Section 1301.010, Insurance Code, as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, including Section 1301.166, as applicable. Makes conforming and nonsubstantive changes.

(b) Makes conforming and nonsubstantive changes to this subsection.

(b) Amends Section 1301.010, Insurance Code, effective September 1, 2025, as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) Requires the insurer to 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 a non-network physician or provider. Requires that the notice include certain

information, including a statement of the billing prohibition under certain statutes, not including Section 1301.166, as applicable.

(b) Requires an insurer to 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 certain statutes, not including Section 1301.166, as applicable.

SECTION 8. Amends Subchapter D, Chapter 1301, Insurance Code, by adding Section 1301.166, as follows:

Sec. 1301.166. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER. (a) Defines "emergency medical services provider."

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

(1) if the political subdivision has submitted the rate to TDI under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which the service originated or the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to TDI or does not have set, controlled, or regulated rates, the lesser of:

(A) the provider's billed charge; or

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

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

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

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

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

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

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

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

(f) Prohibits this section from being construed to require the imposition of a penalty under Section 1301.137 (Violation of Claims Payment Requirements; Penalty).

(g) Provides that this section expires September 1, 2025.

SECTION 9. (a) Amends Section 1551.015, Insurance Code, as follows:

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, including Section 1551.231, as applicable. Makes conforming and nonsubstantive changes.

(b) Makes conforming and nonsubstantive changes to this subsection.

(b) Amends Section 1551.015, Insurance Code, effective September 1, 2025, as follows:

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) Requires the administrator of a managed care plan provided under the group benefits program to 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 physician or provider. Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, not including Section 1551.231, as applicable.

(b) Requires the administrator to 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 certain statutes, not including Section 1551.231, as applicable.

SECTION 10. Amends Subchapter E, Chapter 1551, Insurance Code, by adding Section 1551.231, as follows:

Sec. 1551.231. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) Defines "emergency medical services provider."

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

(1) if the political subdivision has submitted the rate to TDI under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which the service originated or the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to TDI or does not have set, controlled, or regulated rates, the lesser of:

(A) the provider's billed charge; or

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

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

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

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

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

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

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

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

(f) Provides that this section expires September 1, 2025.

SECTION 11. (a) Amends Section 1575.009, Insurance Code, as follows:

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) Requires that the written notice include certain information, including a statement of the billing prohibition under certain statutes, including Section 1575.174, as applicable. Makes conforming and nonsubstantive changes.

(b) Makes conforming and nonsubstantive changes to this subsection.

(b) Amends Section 1575.009, Insurance Code, effective September 1, 2025, as follows:

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) Requires the administrator of a managed care plan provided under the group program to 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. Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, not including Section 1575.174, as applicable.

(b) Requires the administrator to 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 certain statutes, not including Section 1575.174, as applicable.

SECTION 12. Amends Subchapter D, Chapter 1575, Insurance Code, by adding Section 1575.174, as follows:

Sec. 1575.174. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) Defines "emergency medical services provider."

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

(1) if the political subdivision has submitted the rate to TDI under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which the service originated or the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to TDI or does not have set, controlled, or regulated rates, the lesser of:

(A) the provider's billed charge; or

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

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

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

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

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

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

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

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

(f) Provides that this section expires September 1, 2025.

SECTION 13. (a) Amends Section 1579.009, Insurance Code, as follows:

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, including Section 1579.112, as applicable. Makes conforming and nonsubstantive changes.

(b) Makes conforming and nonsubstantive changes to this subsection.

(b) Amends Section 1579.009, Insurance Code, effective September 1, 2025, as follows:

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) Requires the administrator of a managed care plan provided under this chapter to 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. Requires that the notice include certain information, including a statement of the billing prohibition under certain statutes, not including Section 1579.112, as applicable.

(b) Requires the administrator to 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 certain statutes, not including Section 1579.112, as applicable.

SECTION 14. Amends Subchapter C, Chapter 1579, Insurance Code, by adding Section 1579.112, as follows:

Sec. 1579.112. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) Defines "emergency medical services provider."

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

(1) if the political subdivision has submitted the rate to TDI under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which the service originated or the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to TDI or does not have set, controlled, or regulated rates, the lesser of:

(A) the provider's billed charge; or

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

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

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

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

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

(e) Prohibits an out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider from billing an enrollee receiving a health care or medical service or supply or transport described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment,

coinsurance, and deductible under the enrollee's managed care plan that is based on:

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

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

(f) Provides that this section expires September 1, 2025.

SECTION 15. Makes application of this Act prospective to January 1, 2024.

SECTION 16. Effective date, except as otherwise provided by this Act: September 1, 2023.