

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE C. MANAGED CARE

CHAPTER 1275. BALANCE BILLING PROHIBITIONS AND OUT-OF-NETWORK

CLAIM DISPUTE RESOLUTION FOR CERTAIN PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1275.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual enrolled in a health benefit plan to which this chapter applies.

(2) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see S.B. [1409](#), 89th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1275.002. APPLICABILITY OF CHAPTER. This chapter applies only to:

(1) a health benefit plan offered by a nonprofit agricultural organization under Chapter [1682](#); and

(2) a health benefit plan:

(A) that is a self-insured or self-funded plan established by an employer for the benefit of the employer's employees in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and

(B) for which the plan sponsor has made an election, submitted to the commissioner in the form and manner prescribed by the commissioner, to apply this chapter to the plan for the relevant plan year.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 696 (H.B. [1592](#)), Sec. 1, eff. September 1, 2023.

Text of section effective until September 01, 2025

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE.

(a) The administrator of a health benefit plan to which this chapter applies 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 or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section [1275.051](#), [1275.052](#), [1275.053](#), or [1275.054](#), 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) 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 [1275.051](#), [1275.052](#), [1275.053](#), or [1275.054](#), as applicable.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 4(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 4(b), eff. September 1, 2025.

Text of section effective on September 01, 2025

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE.

(a) The administrator of a health benefit plan to which this chapter applies 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 [1275.051](#), [1275.052](#), or [1275.053](#), 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) 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 [1275.051](#), [1275.052](#), or [1275.053](#), as applicable.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 4(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 4(b), eff. September 1, 2025.

Sec. 1275.004. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION. Chapter [1467](#) applies to a health benefit plan to which this chapter applies, and the administrator of a health benefit plan to which this chapter applies is an administrator for purposes of that chapter.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

SUBCHAPTER B. PAYMENTS FOR CERTAIN SERVICES; BALANCE BILLING
PROHIBITIONS

Sec. 1275.051. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section [1301.155](#).

(b) The administrator of a health benefit plan to which this chapter applies shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network 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) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee 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 benefit 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](#).

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

Sec. 1275.052. OUT-OF-NETWORK FACILITY-BASED PROVIDER

PAYMENTS. (a) In this section, "facility-based provider" means a physician or health care provider who provides health care or medical services to patients of a health care facility.

(b) Except as provided by Subsection (d), the administrator of a health benefit plan to which this chapter applies 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 facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider. 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) Except as provided by Subsection (d), an out-of-network provider who is a facility-based 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 health benefit 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](#).

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in

advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

Sec. 1275.053. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section [1467.001](#).

(b) Except as provided by Subsection (d), the administrator of a health benefit plan to which this chapter applies 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 diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care or medical service performed by a participating provider. 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) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory 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 health benefit 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](#).

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2021, 87th Leg., R.S., Ch. 1034 (H.B. [3924](#)), Sec. 1, eff. September 1, 2021.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see S.B. [916](#), 89th Legislature, Regular Session, for amendments affecting the following section.

For expiration of this section, see Subsection (f).

Sec. 1275.054. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section [773.003](#),

Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a health benefit plan to which this chapter applies shall 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 the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

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

(2) if the political subdivision has not submitted the rate to the department, 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) The administrator shall 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) The administrator shall 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) 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 may not bill an enrollee receiving a health care or medical service or supply or transport 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 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) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. [2476](#)), Sec. 5, eff. September 1, 2023.