BILL ANALYSIS

S.B. 926
By: Hancock
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

The bill sponsor has informed the committee that in order to have a well-functioning health care market, patients must be engaged in the process and should be rewarded for choosing lower-priced, higher-quality care. However, the bill sponsor has further informed the committee that current state law and Texas Department of Insurance regulations make it difficult for state-regulated plans to offer policies providing for such rewards, meaning patients with state-regulated health plans have little incentive to shop for higher-quality and lower-priced services, as they pay the same out-of-pocket amount regardless of which provider they choose. S.B. 926 would authorize health maintenance organizations and insurers offering preferred provider benefit plans to incentivize insureds or enrollees to use certain physicians or providers through modified deductibles, copayments, coinsurance, or other cost-sharing provisions. In addition, the bill makes changes to state law regulating physician rankings by health benefit plans.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 5 of this bill.

ANALYSIS

Incentives to Use Certain Physicians or Providers

S.B. 926 amends the Insurance Code to authorize a health maintenance organization (HMO) or an insurer offering a preferred provider benefit plan to provide incentives for enrollees or insureds, as applicable, to use certain physicians or providers through modified deductibles, copayments, coinsurance, or other cost-sharing provisions. The bill establishes that an HMO or insurer that encourages an enrollee or insured, as applicable, to obtain a health care service from a particular physician or provider, including offering incentives to encourage enrollees or insureds to use specific physicians or providers, or that introduces or modifies a tiered network plan or assigns physicians or providers into tiers, has a fiduciary duty to the enrollee, group contract holder, insured, or policyholder, as applicable, to engage in that conduct only for the primary benefit of the enrollee, group contract holder, insured, or policyholder. The bill establishes that an HMO or insurer violates the fiduciary duty by offering incentives to encourage enrollees or insureds, as applicable, to use a particular physician or health care provider solely because the physician or provider directly or indirectly through one or more

intermediaries controls, is controlled by, or is under common control with the HMO or insurer. The bill also establishes the following as conduct that violates the fiduciary duty:

- using a steering approach or a tiered network to provide a financial incentive as an inducement to limit medically necessary services, encourage receipt of lower quality medically necessary services, or violate state or federal law;
- failing to implement reasonable procedures to ensure that:
    - as applicable, participating providers or preferred providers that enrollees or insureds are encouraged to use within any steering approach or tiered network are not of materially lower quality than participating providers or preferred providers that enrollees or insureds are not encouraged to use; and
    - the HMO or insurer does not make materially false statements or representations about a physician's or health care provider's quality of care or costs; and
- failing to use objective, verifiable, and accurate information as the basis of any encouragement or incentive under these bill provisions.

The bill prohibits an encouragement or incentive from being based solely on cost or imposing a cost-sharing requirement for out-of-network emergency services that is greater than the cost-sharing requirement that would apply had the services been furnished by a participating provider or preferred provider, as applicable. The bill's provisions regarding incentives to use certain physicians or providers do not apply to a vision care plan, as defined by reference to statutory provisions relating to access to optometrists used under a managed care plan.

Physician Ranking by Health Benefit Plans

Physician Ranking Requirements

Current law sets out certain conditions that must be met for a health benefit plan issuer, including a subsidiary or affiliate, to be authorized to rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians. S.B. 926 removes the conditions set out in current law, replaces them with new conditions applicable to such ranking or classification of physicians, and removes the specification that the conditions apply to the publication of such physician-specific information. The conditions prescribed by the bill differ from the conditions prescribed in current law as follows:

- the bill requires that the standards used by the issuer to rank or classify be developed or prescribed by an organization designated by the commissioner of insurance through rules adopted by the commissioner under related provisions added by the bill and subsequently described, whereas under current law the standards used by the issuer must conform to nationally recognized standards and guidelines as required by rules adopted by the commissioner regarding physician ranking under current law and subsequently described;
- the bill requires the ranking or classification and any methodology used to rank or classify to be disclosed to each affected physician at least 45 days before the date the ranking or classification is released, published, or distributed by the issuer and to identify the products or networks offered by the issuer for which the ranking or classification will be used, whereas under current law the standards and measurements to be used by the issuer must be disclosed to each affected physician before any evaluation period used by the issuer; and
- the bill newly requires that each affected physician be given an easy-to-use process to identify:
    - before the release, publication, or distribution of the ranking or classification, any discrepancy between the standards and the ranking or classification proposed by the issuer; and
    - after the release, publication, or distribution of the ranking or classification, any objectively and verifiably false information contained in the ranking or classification.

Moreover, with respect to the aforementioned easy-to-use process for an affected physician to identify certain discrepancies or false information, the bill requires that if a physician submits information sufficient to establish a verifiable discrepancy or objectively and verifiably false information contained in the ranking or classification or a violation of applicable provisions relating to standards for physician rankings, the issuer must remedy the discrepancy, false information, or violation by the later of the release, publication, or distribution of the ranking or classification or the 30th day after the date the issuer receives the information. Current law, in contrast, requires each affected physician to be afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that, at a minimum, includes due process protections that conform to the following protections:

- the issuer provides at least 45 days' written notice to the physician of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the issuer in its rating, tiering, ranking, or comparison decision;
- in addition to any written fair reconsideration process, the issuer, upon a request for review that is made within 30 days of receiving that notice, provides a fair reconsideration proceeding, at the physician's option, by teleconference at an agreed upon time or in person, at an agreed upon time or between the hours of 8 a.m. and 5 p.m. Monday through Friday;
- the physician has the right to provide information at a requested fair reconsideration proceeding for determination by a decision-maker, have a representative participate in the fair reconsideration proceeding, and submit a written statement at the conclusion of the fair reconsideration proceeding; and
- the issuer provides a written communication of the outcome of a fair reconsideration proceeding prior to any publication or dissemination of the rating, ranking, tiering, or comparison, which communication must include the specific reasons for the final decision.

Commissioner Rules

Under current law the commissioner, in adopting rules regarding physician rankings by health benefit plans, must either consider the standards, guidelines, and measures prescribed by certain nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care or, if no such national organizations have established standards or guidelines regarding an issue, consider the standards, guidelines, and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship. S.B. 926 removes both of those considerations and provides instead that, in adopting rules for the designation of an organization whose standards for physician ranking or classification may be used by a health benefit plan issuer, the commissioner may only designate an organization that meets the following criteria:

- the organization is a national medical specialty society or is a bona fide organization that is unbiased toward or against any medical provider or health benefit plan issuer; and
- the standards developed or prescribed by the organization that are to be used in rankings or classifications meet the following criteria:
    - emphasize quality of care;
    - are nationally recognized, in widely circulated peer-reviewed medical literature, expert-based physician consensus quality standards, or leading objective clinical evidence-based scholarship;
    - have a publicly transparent methodology;
    - if based on clinical outcomes, are risk-adjusted; and
    - are compatible with an easy-to-use process in which a physician or person acting on behalf of the physician may report data, evidentiary, factual, or mathematical discrepancies, errors, omissions, or faulty assumptions for investigation and, if appropriate, correction.

The bill defines "national medical specialty society" as a national organization that has a majority of members who are physicians, that represents a specific physician medical specialty, and that is represented in the house of delegates of the American Medical Association.

Sanctions

S.B. 926 requires the commissioner to prohibit a health benefit plan issuer from using a physician ranking or classification system otherwise authorized under applicable state law for not less than 12 consecutive months if the commissioner determines that the issuer has engaged in a pattern of discrepancies, falsehoods, or violations regarding rankings or classifications, as established by information submitted by physicians under the bill's provisions.

EFFECTIVE DATE

September 1, 2025.