By: Frank H.B. No. 1959

A BILL TO BE ENTITLED

AN ACT

relating to certain practices of health benefit plan issuers to encourage the use of certain physicians and health care providers and rank physicians.

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

SECTION 1. Subchapter I, Chapter 843, Insurance Code, is amended by adding Section 843.322 to read as follows:

Sec. 843.322. INCENTIVES TO USE CERTAIN PHYSICIANS OR PROVIDERS. (a) A health maintenance organization may provide incentives for enrollees to use certain physicians or providers through modified deductibles, copayments, coinsurance, or other cost-sharing provisions.

(b) A health maintenance organization that encourages an enrollee to obtain a health care service from a particular physician or provider, including offering incentives to encourage enrollees 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 or group contract holder to engage in that conduct only for the primary benefit of the enrollee or group contract holder.

SECTION 2. Section 1301.0045(a), Insurance Code, is amended to read as follows:

(a) Except as provided by Sections [~~Section~~] 1301.0046 and 1301.0047, this chapter may not be construed to limit the level of

reimbursement or the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions, that are applicable to preferred providers or, for plans other than exclusive provider benefit plans, nonpreferred providers.

SECTION 3. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.0047 to read as follows:

Sec. 1301.0047. INCENTIVES TO USE CERTAIN PHYSICIANS OR HEALTH CARE PROVIDERS. (a) An insurer may provide incentives for insureds to use certain physicians or health care providers through modified deductibles, copayments, coinsurance, or other cost-sharing provisions.

(b) An insurer that encourages an insured to obtain a health care service from a particular physician or health care provider, including offering incentives to encourage 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 insured or policyholder to engage in that conduct only for the primary benefit of the insured or policyholder.

SECTION 4. Section 1460.003, Insurance Code, is amended by amending Subsection (a) and adding Subsection (a-1) to read as follows:

(a) A health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians or[~~,~~] 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,~~] unless:

(1) the standards used by the health benefit plan issuer to rank or classify are propagated or developed by an organization designated by the commissioner through rules adopted under Section 1460.005;

(2) the ranking, comparison, or evaluation:

(A) is disclosed to each affected physician at least 45 days before the date the ranking, comparison, or evaluation is released, published, or distributed to enrollees by the health benefit plan issuer; and

(B) identifies which products or networks offered by the health benefit plan issuer the ranking, comparison, or evaluation will be used for; and

(3) each affected physician is given an easy-to-use process to identify discrepancies between the standards and the ranking, comparison, or evaluation as propagated by the health benefit plan issuer [~~the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under Section 1460.005;~~

[~~(2) the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation period used by the health benefit plan issuer; and~~

[~~(3) each affected physician is 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:~~

[~~(A) the health benefit plan 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 health benefit plan issuer in its rating, tiering, ranking, or comparison decision;~~

[~~(B) in addition to any written fair reconsideration process, the health benefit plan issuer, upon a request for review that is made within 30 days of receiving the notice under Paragraph (A), provides a fair reconsideration proceeding, at the physician's option:~~

[~~(i) by teleconference, at an agreed upon time; or~~

[~~(ii) in person, at an agreed upon time or between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday;~~

[~~(C) 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~~

[~~(D) the health benefit plan 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. The written communication must include the specific reasons for the final decision~~].

(a-1) If a physician submits information to a health benefit plan issuer under Subsection (a)(3) sufficient to establish a discrepancy, the health benefit plan issuer must remedy the discrepancy by the later of:

(1) publication; or

(2) the 30th day after the date the health benefit plan issuer receives the information.

SECTION 5. Section 1460.005(c), Insurance Code, is amended to read as follows:

(c) In adopting rules under this section, the commissioner may only designate [~~shall consider the standards, guidelines, and measures prescribed by nationally recognized~~] organizations that meet the following requirements:

(1) the prescribing organization is bona fide and unbiased toward or against any medical provider;

(2) the standards to be used in rankings, comparisons, or evaluations:

(A) are nationally recognized, or based on expert-provider consensus or leading clinical evidence-based scholarship;

(B) have a publicly transparent methodology; and

(C) if based on clinical outcomes, are risk-adjusted; and

(3) the prescribing organization has an easy-to-use process by which a medical provider may report data, evidentiary, factual, or mathematical errors for prompt investigation and, if appropriate, correction [~~establish or promote guidelines and~~

~~performance measures emphasizing quality of health care, including the National Quality Forum and the AQA Alliance. If neither the National Quality Forum nor the AQA Alliance has established standards or guidelines regarding an issue, the commissioner shall consider the standards, guidelines, and measures prescribed by the National Committee on Quality Assurance and other similar national organizations. If neither the National Quality Forum, nor the AQA Alliance, nor other national organizations have established standards or guidelines regarding an issue, the commissioner shall consider 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~~].

SECTION 6. This Act takes effect September 1, 2025.