By: Hull H.B. No. 2254

A BILL TO BE ENTITLED

AN ACT

relating to certain health care services contract arrangements entered into by insurers and health care providers.

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

SECTION 1. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.0065 to read as follows:

Sec. 1301.0065. VALUE-BASED AND CAPITATED PAYMENT ARRANGEMENTS WITH PRIMARY CARE PHYSICIANS OR PRIMARY CARE PHYSICIAN GROUPS NOT PROHIBITED. (a) In this section:

(1) "Primary care physician" means a specialist in family medicine, general internal medicine, or general pediatrics who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care, which may include chronic, preventive, and acute care.

(2) "Primary care physician group" means an entity through which two or more primary care physicians deliver health care to the public through the practice of medicine on a regular basis and that is:

(A) owned and operated by two or more physicians; or

(B) a freestanding clinic, center, or office of a nonprofit health organization certified by the Texas Medical Board under Section 162.001(b), Occupations Code, that complies with the

requirements of Chapter 162, Occupations Code.

(b) A preferred provider benefit plan or an exclusive provider benefit plan may provide or arrange for health care services with a primary care physician or primary care physician group through a contract for compensation under:

(1) a fee-for-service arrangement;

(2) a risk-sharing arrangement;

(3) a capitation arrangement under which a fixed predetermined payment is made in exchange for the provision of, or for the arrangement to provide and the guaranty of the provision of, a contractually defined set of covered services to covered persons for a specified period without regard to the quantity of services actually provided; or

(4) any combination of arrangements described by Subdivisions (1) through (3).

(c) A primary care physician or primary care physician group that enters into a contract described by Subsection (b) is not considered to be engaging in the business of insurance.

(d) A primary care physician or primary care physician group is not required to enter into a payment arrangement under this section, and an insurer may not discriminate against a physician or physician group that elects not to participate in an arrangement under this section, including by:

(1) reducing the fee schedule of a physician or physician group because the physician or physician group does not participate in the insurer's value-based or capitated payment arrangement or other payment arrangement provided under this

section; or

(2) requiring a physician or physician group to participate in the insurer's value-based or capitated payment arrangement or other payment arrangement provided under this section as a condition of participation in the insurer's provider network.

(e) A primary care physician or primary care physician group may file a complaint with the department if the physician or physician group believes the physician or physician group has been discriminated against in violation of Subsection (d).

(f) A contract allowing for a value-based or capitated payment arrangement or other payment arrangement provided under this section:

(1) may not create a disincentive to the provision of medically necessary health care services and may not interfere with the physician's independent medical judgment on which services are medically appropriate or medically necessary;

(2) must specify:

(A) in writing if compensation is being paid based on satisfaction of performance measures and, if so, specifically provide:

(i) the performance measures;

(ii) the source of the measures;

(iii) the method and time period for calculating whether the performance measures have been satisfied;

(iv) access to financial and performance-based information used to determine whether the

physician met those measures; and

(v) the method by which the physician may request reconsideration;

(B) that the attribution process will assign a patient to:

(i) first the patient's established physician, as determined by a prior annual exam or other office visits; and

(ii) if no established physician relationship exists, then a physician chosen by the patient;

(C) if payment involves capitation, whether a bridge rate, such as a discounted fee for service, will remain in effect for a certain period until sufficient data has been generated regarding utilization to allow an insurer to make an informed decision regarding fully capitated rates;

(D) whether the capitated rate, if any, will provide for a stop-loss threshold or a guaranteed minimum level of payment per month, and whether the physician will obtain stop-loss coverage; and

(E) whether payment will take into account patients who are added to or eliminated from the attributed population during the course of a measurement period;

(3) if payment involves capitation, must provide for the opportunity to renegotiate in good faith a revised capitation rate, or reimburse on a fee-for-service basis under a contractual fee schedule until a revised capitation rate is agreed to if there is a material increase in the scope of services provided by the

physician or a material change by the payer in the benefit structure; and

(4) must state:

(A) whether catastrophic events are excluded from the final cost calculation for an attributed population when compared to the cost target for the measurement period, if applicable; and

(B) if payment involves shared savings, whether the entire savings is shared when the minimum savings rate is reached, or whether only the amount in excess of the minimum savings rate is shared.

(g) This section does not authorize a preferred provider benefit plan or an exclusive provider benefit plan to provide or arrange for health care services with a primary care physician or primary care physician group through a contract for compensation under a global capitation arrangement.

(h) The parties to a contract under Subsection (b) are the primary care physician or primary care physician group and the preferred provider benefit plan or exclusive provider benefit plan. A party to a contract under Subsection (b) may not subcontract.

SECTION 2. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2025.