By: Johnson H.B. No. 3943

A BILL TO BE ENTITLED

AN ACT

relating to prohibited conduct of a health benefit plan issuer in relation to affiliated and nonaffiliated providers.

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

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1462 to read as follows:

CHAPTER 1462. AFFILIATED PROVIDERS

Sec. 1462.001. DEFINITIONS. In this chapter:

(1) "Affiliated provider" means a health care provider that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a health benefit plan issuer.

(2) "Nonaffiliated provider" means a health care provider that does not directly, or indirectly through one or more intermediaries, control and is not controlled by or under common control with a health benefit plan issuer.

Sec. 1462.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843;

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(6) a stipulated premium company operating under Chapter 884;

(7) a fraternal benefit society operating under Chapter 885;

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

Sec. 1462.003. EXCEPTION TO APPLICABILITY OF CHAPTER. This chapter does not apply to an issuer, provider, or administrator of health benefits under:

(1) the state Medicaid program, including the Medicaid managed care program operated under Chapter 540, Government Code;

(2) the child health plan program under Chapter 62, Health and Safety Code;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601; or

(7) a workers' compensation insurance policy or other

form of providing medical benefits under Title 5, Labor Code.

Sec. 1462.004. REIMBURSEMENT OF AFFILIATED AND NONAFFILIATED PROVIDERS. (a) A health benefit plan issuer may not offer a higher reimbursement rate to a health care practitioner who is a member of a nonaffiliated provider based on a condition that the practitioner agrees to join an affiliated provider.

(b) A health benefit plan issuer may not pay an affiliated provider a reimbursement amount that is more than the amount the issuer pays a nonaffiliated provider for the same health care service.

(c) This section does not apply to value-based or capitation reimbursement arrangements.

Sec. 1462.005. PROHIBITION ON CERTAIN COMMUNICATIONS. (a) A health benefit plan issuer may not encourage or direct a patient to use the issuer's affiliated provider through any oral or written communication, including:

(1) online messaging regarding the provider; or

(2) patient- or prospective patient-specific advertising, marketing, or promotion of the provider.

(b) This section does not prohibit a health benefit plan issuer from encouraging or directing a patient to use an affiliated provider that:

(1) accepts a reimbursement rate that is lower than the rate a nonaffiliated provider would charge;

(2) is reimbursed by a health benefit plan issuer through a risk-sharing or capitation arrangement; or

(3) is tiered against other providers based on

value-based quality metrics.

Sec. 1462.006. PROHIBITION ON CERTAIN REFERRALS AND SOLICITATIONS. (a) A health benefit plan issuer may not require a patient to use the issuer's affiliated provider for the patient to receive the maximum benefit for the service under the patient's health benefit plan.

(b) A health benefit plan issuer may not offer or implement a health benefit plan that requires or induces a patient to use the issuer's affiliated provider, including by providing for reduced cost-sharing if the patient uses the affiliated provider.

(c) A health benefit plan issuer may not solicit a patient or prescriber to transfer a patient's prescription to the issuer's affiliated provider.

(d) This section does not prohibit a health benefit plan issuer from soliciting or inducing a patient to use an affiliated provider that:

(1) accepts a reimbursement rate that is lower than the rate a nonaffiliated provider would charge;

(2) is reimbursed by a health benefit plan issuer through a risk-sharing or capitation arrangement; or

(3) is tiered against other providers based on value-based quality metrics.

SECTION 2. Chapter 1462, Insurance Code, as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2026.

SECTION 3. This Act takes effect September 1, 2025.