By: Kolkhorst S.B. No. 884

A BILL TO BE ENTITLED

AN ACT

relating to establishment of a shared savings program for certain managed care plans.

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

SECTION 1. Subtitle C, Title 8, Insurance Code, is amended by adding Chapter 1276 to read as follows:

CHAPTER 1276. SHARED SAVINGS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1276.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a health care practitioner or health care facility that provides health care services or supplies under a license, certificate, registration, or similar authorization issued by this state.

(2) "Managed care plan" means a health benefit plan under which health care services or supplies are provided to enrollees through contracts with health care providers and that requires enrollees to use contracting providers or that provides a different level of coverage for enrollees who use contracting providers.

(3) "Out-of-network provider" means a health care provider of any health care service or supply that does not have a contract under an enrollee's health benefit plan.

(4) "Program" means the shared savings program established under this chapter.

Sec. 1276.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to nonemergency health care services or supplies covered under a managed care plan.

(b) This chapter applies only to the following health benefit plans:

(1) a health benefit plan provided by a health maintenance organization operating under Chapter 843;

(2) a preferred provider benefit plan provided under Chapter 1301; or

(3) a basic coverage plan provided under Chapter 1551.

(c) Notwithstanding any other law, this chapter applies to an administrator of a health benefit plan described by this section.

Sec. 1276.003. RULES. The commissioner may adopt rules necessary to implement this chapter.

SUBCHAPTER B. PROGRAM REQUIREMENTS

Sec. 1276.051. PROGRAM REQUIRED. (a) A health benefit plan issuer or administrator to which this chapter applies shall establish a shared savings program in accordance with this chapter.

(b) A health benefit plan issuer or administrator shall provide written notice to its enrollees of the program.

Sec. 1276.052. AVERAGE CONTRACTED RATE DISCLOSURE. (a) As part of the program, a health benefit plan issuer or administrator shall establish and operate a toll-free telephone number and publicly accessible Internet website for a plan enrollee to request disclosure of the average contracted rate paid under the plan to a health care provider in the plan's provider network for a

particular health care service or supply in the preceding 12 months.

(b) A health benefit plan issuer or administrator shall disclose to the enrollee the rate the enrollee requested under Subsection (a).

Sec. 1276.053. HEALTH CARE PROVIDER ESTIMATE. An out-of-network provider shall, on an enrollee's request, provide the enrollee a written estimate of the final charge for a proposed health care service or supply eligible for the enrollee's program. The estimate must include all costs associated with the service or supply and reflect the enrollee's final out-of-pocket cost associated with the proposed service or supply.

Sec. 1276.054. SHARED SAVINGS PAYMENT. (a) Except as provided by Subsection (b), if an enrollee who requests a disclosure under Section 1276.052 elects and receives a health care service or supply with an actual cost equal to an amount less than the rate disclosed under Section 1276.052, the health benefit plan issuer or administrator shall pay to the enrollee 50 percent of the difference between the disclosed rate and the actual cost, minus any applicable deductible, copayment, or coinsurance.

(b) A health benefit plan issuer is not required to pay an enrollee under Subsection (a) if the difference described by that subsection is less than $50.

(c) A health benefit plan issuer or administrator shall pay an enrollee under Subsection (a) not later than the 30th day after the date on which the enrollee submits a program claim.

Sec. 1276.055. DEDUCTIBLES UNDER PROGRAM. (a) This section

applies only to a health care service or supply for which an enrollee received:

(1) a disclosure under Section 1276.052; and

(2) an estimate under Section 1276.053 equal to an amount at least $50 less than the rate provided under the disclosure.

(b) A health benefit plan issuer or administrator shall apply a deductible for a health care service or supply to which this section applies in an amount equivalent to the deductible applied to a network service or supply.

Sec. 1276.056. LIABILITY FOR UNFORESEEN CHARGE OVER ESTIMATE. If the final charge for the health care service or supply described by Section 1276.055(a) is an amount greater than the amount estimated under Section 1276.053 due to unforeseen circumstances, the enrollee's health benefit plan issuer or administrator shall pay 95 percent of the difference not to exceed the allowed amount for the service or supply and the enrollee is responsible for the remaining difference.

SECTION 2. Chapter 1276, 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.