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.

(c) A health maintenance organization violates the fiduciary duty described by Subsection (b) by offering incentives to encourage enrollees to use a particular physician or 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 health maintenance organization.

(d) Conduct that violates the fiduciary duty described by Subsection (b) includes:

(1) 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;

(2) failing to implement reasonable procedures to ensure that:

(A) participating providers that enrollees are encouraged to use within any steering approach or tiered network are not of materially lower quality than participating providers that enrollees are not encouraged to use; and

(B) the health maintenance organization does not make materially false statements or representations about a physician's or provider's quality of care or costs; and

(3) failing to use objective, verifiable, and accurate information as the basis of any encouragement or incentive under this section.

(e) An encouragement or incentive authorized by this section may not:

(1) be based solely on cost; or

(2) impose 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.

(f) This section does not apply to a vision care plan, as defined by Section 1451.157.

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.

(c) An insurer violates the fiduciary duty described by Subsection (b) by offering incentives to encourage insureds 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 insurer.

(d) Conduct that violates the fiduciary duty described by Subsection (b) includes:

(1) 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;

(2) failing to implement reasonable procedures to ensure that:

(A) preferred providers that insureds are encouraged to use within any steering approach or tiered network are not of materially lower quality than preferred providers that insureds are not encouraged to use; and

(B) the insurer does not make materially false statements or representations about a physician's or health care provider's quality of care or costs; and

(3) failing to use objective, verifiable, and accurate information as the basis of any encouragement or incentive under this section.

(e) An encouragement or incentive authorized by this section may not:

(1) be based solely on cost; or

(2) impose 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 preferred provider.

(f) This section does not apply to a vision care plan, as defined by Section 1451.157.

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 developed or prescribed by an organization designated by the commissioner through rules adopted under Section 1460.005;

(2) the ranking or classification and any methodology used to rank or classify:

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

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

(3) each affected physician is given an easy-to-use

process to identify:

(A) before the release, publication, or distribution of the ranking or classification, any discrepancy between the standards and the ranking or classification proposed by the health benefit plan issuer; and

(B) after the release, publication, or distribution of the ranking or classification, any objectively and verifiably false information contained in the ranking or classification [~~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 under Subsection (a)(3) sufficient to establish a verifiable discrepancy or objectively and verifiably false information contained in the ranking or classification or a violation of this chapter, the health benefit plan issuer must remedy the discrepancy, false information, or violation by the later of:

(1) the release, publication, or distribution of the ranking or classification; or

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

SECTION 5. Section 1460.005, Insurance Code, is amended by amending Subsection (c) and adding Subsection (d) to read as follows:

(c) In adopting rules under this section for purposes of Section 1460.003(a)(1), the commissioner may only designate an organization that meets the following requirements:

(1) the organization is:

(A) a national medical specialty society; or

(B) a bona fide organization that is unbiased toward or against any medical provider or health benefit plan issuer; and

(2) the standards developed or prescribed by the organization that are to be used in rankings or classifications:

(A) emphasize quality of care and:

(i) are nationally recognized, in widely circulated peer-reviewed medical literature, expert-based physician consensus quality standards, or leading objective clinical evidence-based scholarship;

(ii) have a publicly transparent methodology; and

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

(B) 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 [~~shall consider the standards, guidelines, and measures prescribed by nationally recognized organizations that 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~~].

(d) In this section, "national medical specialty society" means a national organization:

(1) with a majority of members who are physicians;

(2) that represents a specific physician medical specialty; and

(3) that is represented in the house of delegates of the American Medical Association.

SECTION 6. Section 1460.007, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) The commissioner shall prohibit a health benefit plan

issuer from using a ranking or classification system otherwise authorized under this chapter for not less than 12 consecutive months if the commissioner determines that the health benefit plan issuer has engaged in a pattern of discrepancies, falsehoods, or violations described by Section 1460.003(a-1).

SECTION 7. This Act takes effect September 1, 2025.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 926 passed the Senate on April 16, 2025, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 926 passed the House on May 28, 2025, by the following vote: Yeas 138, Nays 0, one present not voting.

Chief Clerk of the House

Approved:

Date

Governor