2026 LEGISLATIVE UPDATE:

2026 Healthcare legislative updates applicable to Plastic Surgeons practicing in Texas after the 89th Texas Legislature

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During the 140-day regular session of the 89th Texas Legislature, lawmakers passed a number of bills that are poised to further transform the healthcare landscape in our state. In this 2025 Healthcare legislative update, I had the help of Norton Rose Fulbright to highlight the most recent laws that are driving change and shaping the future of healthcare across Texas.

HB 216 Patient right to facility itemized bill for healthcare services and supplies Amends the Health and Safety Code to require healthcare providers who seek to balance bill patients for amounts owed beyond what is paid by a third-party payer to submit a written, itemized bill to patients for each service and supply provided, no later than 30 days after receiving final payment from the payer. Providers may deliver these bills electronically, by mail or in person, but must ensure that patients without active online profiles receive a physical or emailed copy according to their stated preference. Patients have the right to request and receive itemized bills through their preferred method for as long as the physician is required to retain the records. Licensing authorities are directed to take disciplinary action against providers who fail to comply with these requirements, except when a mailed bill is undeliverable or sent to an outdated address in good faith. These changes apply only to itemized bills issued on or after September 1, 2025.

Practical effect: The changes in HB 216 must be layered on top of existing No Surprises Act requirements and should be carefully reviewed to determine how they may change operations in managing the coordination of benefits and avoiding patient complaints. Disciplinary action is also contemplated by the state licensing agency for failure to comply with the new law.

HB 1314 Price estimates and billing requirements for healthcare facilities

Amends the consumer pricing provisions of the Health and Safety Code to update billing requirements for hospitals, ambulatory surgical centers, birthing centers and freestanding emergency medical care facilities. The legislation requires these facilities to provide a written estimate of charges for elective inpatient admissions, non-emergency outpatient surgical procedures or other services upon request and before scheduling. An “estimate” is defined as a written statement detailing the total expected billed charges for a nonemergency elective service or procedure. Facilities must deliver the estimate by e-mail within five business days of receiving a request, shortening the previous ten-day deadline. The estimate must also include information on how consumers can dispute final charges that exceed the estimate by US$400 or more. Facilities that violate these requirements are prohibited from initiating or facilitating third-party collection actions, reporting consumers to credit bureaus or pursuing legal action against consumers regarding disputed charges. These new requirements apply prospectively to estimate requests made on or after September 1, 2025; requests made before that date remain subject to the prior law.

Practical effect: HB 1314 defines the term “estimate” and establishes specific requirements for how healthcare charges must be communicated to consumers.

HB 4224 Consumer access to medical records

Amends current law relating to information regarding consumer access to healthcare records by requiring providers to prominently post clear instructions on how to request records and file complaints, both online and at their facilities.

Practical effect: HB 4224 addresses confusion and inconsistency in current processes regarding patient rights to request medical records and file complaints, as well as the procedures for exercising these rights.

HB 4454 Solicitation of patients and other prohibited marketing practices

HB 4454 amends the laws regarding patient solicitation and establishes a task force to study and recommend strategies for preventing patient exploitation and deceptive marketing practices. Establishes a Task Force on Patient Solicitation within HHSC to study, report on and recommend ways to prevent and enforce against improper patient solicitation and marketing practices by treatment facilities. The legislation empowers the Task Force, comprised of eight experts in healthcare or advertising, to access confidential information and requires the Task Force to submit biennial reports to the Legislature. It also updates and clarifies rules for mental health and chemical dependency facilities, strengthening prohibitions against fraudulent or misleading marketing, restricting certain referral and marketing arrangements, increasing civil penalties for violations and directs that advertising be clearly distinguished from clinical functions. HB 4454 prohibits the misuse of confidential patient information for solicitation without consent and makes conforming changes to related statutes for consistency.

Practical effect:

Gab's take: Because plastic surgeons are "licensed by a state health care regulatory agency," they are already subject to the existing anti-kickback provisions in Chapter 102. While HB 4454 focuses its enforcement and task force mandates on the behavioral health sector, the statutory amendments to the Occupations Code apply across the board to "the art of healing." Any plastic surgeon engaged in "patient brokering"—such as paying a commission to a spa or an influencer for a surgical referral—is already violating the core of Chapter 102, which this bill reinforces and elevates in terms of enforcement scrutiny.

If a plastic surgeon uses a "call center" or a "marketing provider" that uses deceptive practices, lead-generation schemes, or undisclosed financial affiliations to secure patients, they are increasingly vulnerable to the same regulatory philosophy present in HB 4454.

Though HB 4454 does not explicitly name plastic surgeons, its passage signals a legislative appetite for cracking down on what is perceived as the commodification of patients. In the current climate, where aesthetics have become a massive, profit-driven industry, the same regulatory agencies tasked with cleaning up the "rehab racket" may eventually turn their focus to the aesthetic surgery industry, particularly regarding:

- **Influencer/Affiliate Marketing:** Where surgeons pay "referral fees" to social media personalities.
- **Lead Aggregators:** Services that promise "patient leads" in exchange for contractual kickbacks.

SB 984 Access to investigational treatments for qualifying patients

Amends the Health and Safety Code to allow healthcare facilities with federal human subject protections to provide individualized investigational treatments to patients with life-threatening or severely debilitating illnesses who have exhausted FDA-approved options and given written informed consent. The legislation details consent requirements, physician responsibilities and financial obligations and permits but does not require manufacturers to provide such treatments. It protects providers and manufacturers from liability if acting in good faith, prevents

state interference with patient access, ensures that insurance coverage for routine care or clinical trials remains unchanged and provides that heirs are not liable for treatment-related debts if the patient dies.

Practical effect: SB 984 expands access to individualized investigational treatments for patients with life-threatening or severely debilitating illnesses who have no FDA-approved options, by allowing eligible healthcare facilities to provide such treatments under strict consent and liability protections, while clarifying financial responsibilities and preserving insurance coverage for routine care.

HB 1052 Coverage of telemedicine, teledentistry and telehealth appointments

Amends the Insurance Code to require health benefit plans to cover telemedicine, teledentistry and telehealth services provided from locations outside Texas on the same basis as those provided within the state, as long as the patient primarily resides in Texas and the provider is licensed or authorized to provide services in Texas and maintains a physical office in Texas. HB 1052 clarifies and expands definitions related to telemedicine, specifically defining "distant site" and "originating site" to effect the changes. The legislation applies to plans issued or renewed on or after January 1, 2026.

Practical effect: HB 1052 improves patient access to healthcare services by requiring plans to cover telemedicine, teledentistry and telehealth services provided by certain out-of-state providers.

HB 2516 Medicare supplement plan eligibility for individuals under 65

Requires insurers that offer Medicare supplemental benefit plans to individuals 65 and older to also provide the same coverage to individuals under 65 who qualify for Medicare due to disability, end stage renal disease or amyotrophic lateral sclerosis. The legislation requires these younger individuals to be offered the same benefits and protections as those 65 and older, with standardized Plan A, B or D available at the same premium rate, and other plans capped at twice the rate for those 65 and older. HB 2516 provides that eligible individuals under 65 can enroll in these plans during a six-month period starting when they enroll in Medicare Part B, and insurers cannot deny coverage, impose waiting periods or discriminate based on health status during this time. The legislation applies to plans delivered, issued or renewed on or after September 1, 2025, and provides a special enrollment window for those already eligible when the law takes effect.

Effective immediately. **Practical effect**: HB 2516 provides supplemental coverage options for individuals under 65 who qualify for Medicare.

SB 815 Use of automated systems and adverse determinations in health benefit claims Prohibits utilization review agents from using automated decision systems, whether wholly or partially, to make adverse determinations about patient care. However, such systems may still be used for administrative support or fraud detection purposes. The legislation defines "algorithm," "artificial intelligence system" and "automated decision system," clarifying their roles in the utilization review process. It grants the Commissioner of Insurance the authority to audit and inspect the use of automated decision systems by utilization review agents. SB 815 strengthens notice requirements for adverse determinations by mandating that both the description and source of the screening criteria and review procedures used be included in the notice. Applies to health benefit plans delivered, issued or renewed on or after January 1, 2026, with prior plans remaining under the previous law.

Practical effect: SB 815 will prevent health plans and other utilization review agents from using algorithms or AI to make adverse determination decisions.

SB 1257 Health benefit plan coverage for gender transition adverse effects/reversals Amends the Insurance Code to require that health benefit plans, except for self-funded plans under ERISA, that provide or have ever provided coverage for an enrollee's gender transition procedure or treatment provide coverage for all possible adverse consequences, testing and any procedure, treatment or therapy necessary to manage, reverse, reconstruct from or recover from the enrollee's gender transition procedure or treatment, regardless of when the enrollee joined the plan or when the procedure occurred. This includes coverage for short- and long-term side effects and annual mental and physical health monitoring. The legislation defines "gender transition" broadly to include medical, surgical, hormonal and therapeutic interventions aimed at assisting an individual in identifying as a gender different from their biological sex. Implementation may be delayed if a state agency determines that federal authorization is required. Applies only to plans delivered, issued or renewed on or after January 1, 2026**.** **Practical effect**: SB 1257 requires plans that have ever provided gender transition coverage to provide broad coverage for adverse consequences, management, reversal or follow up related to gender transition procedure or treatment.

SB 1330 Billing and reimbursement for certain DME provided to Medicare enrollees Amends the Insurance Code to prohibit nonparticipating suppliers from charging Medicare enrollees more than 115 percent of the Medicare-approved amount for DME, orthotic devices or supplies and prosthetic devices or supplies, unless the enrollee agrees in writing to pay the additional amount and either pays in full or enters into a rental payment plan before receiving the item. The legislation provides that enrollees must receive clear written notice stating that Medicare will only reimburse 80 percent of the Medicare-approved amount and that Medicare supplement benefit plans are not required to pay any amount above the 115 percent cap. Violations of SB 1330 by nonparticipating suppliers are classified as false, misleading or deceptive acts under the Deceptive Trade Practices-Consumer Protection Act. Intentional violations are misdemeanor criminal offenses, with fines ranging from US$500 to US$1,000. The legislation applies to DME prosthetic and orthotic devices and supplies sold on or after the Act's September 1, 2025, effective date. **Practical effect:** SB 1330 will make it more difficult for DME companies to charge seniors with Medicare supplemental/ Medigap policies exorbitant amounts for DME, orthotics and prosthetics.

HB 426 Coverage for childhood cranial remolding orthosis Amends the Health and Safety Code to require that both the child health plan and Medicaid fully cover the cost of cranial remolding orthoses for children diagnosed with craniosynostosis, plagiocephaly or brachycephaly, provided that certain criteria are met. The legislation defines "cranial remolding orthosis" as a custom-fitted or custom-fabricated medical device that is applied to the head to correct a deformity, improve function or relieve symptoms of a structural cranial disease. It amends the Human Resources Code to require that coverage must be at least as favorable as other orthotic devices under Medicaid. Effective September 1, 2025, however, the legislation provides that implementation could be delayed if federal approval is required.

Practical effect: HB 426 requires Medicaid and the child health plan to fully cover cranial remolding orthoses for children with certain cranial conditions, ensuring coverage is at least as favorable as for other orthotic devices.

SB 493 Banning pharmacy gag clauses

Amends the Insurance Code to prohibit a Pharmacy Benefits Manager from, by contract or otherwise, prohibiting or restricting a pharmacist or pharmacy from informing an enrollee of any difference between the enrollee's out-of-pocket cost for a prescription drug under the enrollee's prescription drug benefit and the out-of-pocket cost without submitting a claim under the enrollee's prescription drug benefit. Any contract terms that limit a

pharmacist's ability to provide this information or communicate with plan sponsors or administrators are void and unenforceable. Applies only to a contract or agreement entered, amended or renewed on or after the bill's September 1, 2025, effective date. **Practical effect**: SB 493 will implement a consumer protection to ensure that consumers are not paying more for prescription drugs under their health plan than if they were to pay the cash price.

SB 670 Access to investigational sun protection products Amends the Health and Safety Code to allow eligible patients access to investigational sun protection products, defined as products containing ingredients that have completed phase one clinical trials but are not yet approved by the FDA, if their physician determines (in consultation with the patient), after considering all FDA-approved alternatives, that such products are more effective for the patient. The physician must recommend or prescribe in writing the investigational sun protection product. A physician is required to obtain written informed consent from the patient or, if the patient is a minor or lacks capacity, from a parent or legal guardian, before recommending or prescribing these products. The TMB is permitted to adopt a form for informed consent of investigational sun products. The legislation also provides authority for a manufacturer of an investigational sun protection product to make the product available and does not require a manufacturer to make the product available to a patient. The manufacturer is permitted to provide the product without being compensated or to charge the patient the manufacturer's "costs of, or costs associated with, the manufacture of the product." SB 670 does not create a private or state cause of action against a manufacturer or "any other person or entity involved in the case of an eligible patient using the product for any harm to the eligible patient resulting from the product." The TMB is prohibited from taking a disciplinary action against physician's license based on the physician's recommendation to or prescription for an investigational sun protection product so long as the physician met the medical standard of care and requirements of the chapter. Effective immediately**. Practical effect**: SB 670 seeks to expedite access to experimental sun protection products prior to receiving FDA approval.

HB 541 Direct patient care

Amends the Occupations Code to expand an existing provision concerning physicians who furnish direct primary care. As amended, the provision clarifies that licensed healthcare practitioners who enter into agreements with a patient to provide healthcare services in exchange for a direct fee are not subject to regulation by the TDI as insurers or HMOs. The legislation adds new and revised definitions for "direct patient care," "direct patient care agreement," "healthcare practitioner" and "healthcare service."

Practical effect: HB 541 allows healthcare practitioners other than physicians to take advantage of an existing law that permits patients to pay an agreed upon fee to a physician without interference from insurance companies.

HB 879 Integrating military vets into the civilian healthcare workforce Amends the Occupation Code to require the TMB, the Texas Physician Assistant Board and the Texas Board of Nursing to issue licenses to applicants who (1) are licensed in good standing in another state, (2) are veterans of the US armed forces who left military service within the past year, (3) were serving on active duty and authorized to treat military personnel or veterans at the time of leaving service, (4) were honorably discharged and (5) have passed the relevant Texas jurisprudence examination. There are exceptions for those applicants (A) whose licenses are under investigation or subject to a disciplinary order or (B) who have been convicted of or are under investigation for the commission of a felony or certain misdemeanors.

Practical effect: HB 879 creates an additional pathway for veterans who obtained medical or nursing experience while serving in the military to obtain a license in Texas.

HB 1700 Telemedicine, teledentistry and telehealth services

Amends the Occupations Code to require that each agency with regulatory authority over health professionals providing telemedicine, teledentistry or telehealth services adopt rules necessary to standardize formats for and retention of records related to a patient's consent to treatment, data collection and data sharing.

Practical effect: HB 1700 requires the promulgation of new rules that will provide professionals with clarity as to what is needed to document required patient consents when providing services virtually.

HB 2038 The Decreasing Occupational Certification Timelines, Obstacles and Regulations (DOCTOR) Act

Aims to streamline the process for foreign medical license holders, recent medical graduates to practice medicine in Texas. It requires the TMB to issue provisional licenses to qualified foreign-trained physicians with job offers to practice in a facility based or group practice setting sponsoring accredited graduate medical education programs, provided they meet specific educational, licensing, examination, language and legal work requirements and are not from countries posing national security risks. These provisional licenses are valid for two years and may be renewed for those who meet additional criteria, with practice initially limited to certain settings and, upon renewal, to underserved or rural areas. HB 2038 also creates a limited license for "physician graduates," recent medical school graduates not enrolled in residency and meeting additional specified criteria, allowing them to practice under the supervision of a fully licensed, board-certified sponsoring physician, but only in counties with populations under 100,000 and within the sponsoring physician's specialty. The legislation requires a supervising practice agreement between the supervising physician and the physician graduate. Physician graduates must disclose their status to patients, and their sponsoring physicians retain legal responsibility for their care. HB 2038 further seeks to ensure that health insurance policies may cover services provided by physician graduates. The TMB is tasked with adopting necessary rules by January 1, 2026.

Practical effect: HB 2038 provides additional paths to licensure for foreign medical graduates and physician graduates not enrolled in a residency program, subject to certain practice restrictions and/or renewal limitations.

HB 3749 Regulation of elective intravenous therapy

Known as Jenifer's Law, HB 3729 amends the Occupations Code to establish new regulations for the delegation and administration of elective intravenous (IV) therapy. The legislation defines "elective intravenous therapy." It authorizes physicians to delegate the prescribing and ordering of elective IV therapy to physician assistants and advanced practice registered nurses and of the administration of elective IV therapy to physician assistants and advanced practice registered nurses, provided there is adequate physician supervision. HB 3749 specifies that prescriptive authority agreements for elective IV therapy count toward the maximum number of such agreements a physician may have and clarifies that certain exceptions for medically underserved populations do not apply to these agreements. Applies to all relevant medical acts performed under physician delegation on or after its September 1, 2025, effective date.

Practical effect: HB 3749 establishes elective IV therapy as a medical act with the purpose of regulating IV therapy in medical spas and wellness settings.

SB 269 Serious adverse event reports by physicians

Amends the Health and Safety Code to require physician reporting of any serious adverse event that occurs within one year of a patient receiving an experimental, investigational or FDA emergency-authorized vaccine or drug (excluding clinical trials) to the federal Vaccine Adverse Event Reporting System or FDA MedWatch. SB 269 defines

"serious adverse events" as those resulting in death, life-threatening conditions, hospitalization, significant incapacity, birth defects or other medically necessary interventions. It directs that physicians will face non-disciplinary corrective action by the TMB for a first violation, and that any subsequent violations will lead to disciplinary action. The legislation prohibits the TMB from considering violations that occurred more than three years ago when deciding on disciplinary measures but requires the TMB to maintain records of those violations. It directs the Executive Commissioner of HHSC to adopt rules necessary to implement these requirements as soon as practicable after September 1, 2025.

Practical effect: SB 269 is intended to address any underreporting of adverse events associated with emergency-use authorized vaccines and drugs, and to ensure that data used to assess long-term safety and efficacy of such vaccines and drugs is complete.

SB 842 Ringside physician civil immunity for combative sports event

Amends the Occupations Code to grant a ringside physician immunity from civil liability arising from acts within the scope of the physician's responsibilities at a combative sports event, unless the cause of action arises from an act or omission constituting gross negligence by the physician. The legislation applies only to an action commenced on or after the bill's effective date. Effective immediately.

Practical effect: SB 842 was introduced to address the shortage of ringside physicians at licensed combative sports events. The bill's author notes that many physicians are reluctant to participate due to concerns about civil liability. By granting immunity from civil liability except in cases of gross negligence, this legislation seeks to encourage more physicians to serve at these events.

SB 912 Continuing education tracking system for healthcare practitioners

Amends the Occupations Code to require each licensing entity that issues a license to a healthcare practitioner to establish, by rule, a continuing education tracking system for use by and accessible to healthcare practitioners, licensing entity staff and applicable continuing education providers by September 1, 2026. SB 912 mandates that the tracking system may collect and use only information that directly relates to a healthcare practitioner's compliance with continuing education requirements. It requires a licensing entity to verify that the healthcare practitioner has complied with any continuing education requirements of the licensing entity prior to renewing a healthcare practitioner's license. **Practical effect:** SB 912 requires licensing entities to establish or update continuing education tracking systems for healthcare practitioners. Practitioners will be responsible for ensuring that their continuing education is accurately reported.

SB 922 Electronic disclosure of certain medical information by practitioners Amends the Occupations Code to restrict the electronic disclosure of "sensitive test results," defined as a pathology report or radiology report that has a reasonable likelihood of showing a finding of malignancy or a test result that may reveal a genetic marker, before the third day after the date the sensitive test results are finalized. SB 922 stipulates that the responsibility for implementing this restriction falls to the person who administers or controls the patient's electronic health record. It provides legal protection for individuals who fail to comply with these new provisions, ensuring they are not subject to civil, criminal, administrative or professional disciplinary action as a result. Requests made before the effective date remain subject to the previous law.

Practical effect: Under SB 922, effective September 1, 2025, individuals who administer or control a patient's electronic health record are responsible for ensuring that pathology or radiology reports with a reasonable

likelihood of indicating malignancy, or test results that may reveal a genetic marker, are not posted or disclosed electronically to the patient until at least three days after the results are finalized.

SB 1318 Limits on noncompete agreements for physicians and practitioners

Amends the Texas Business and Commerce Code regarding noncompete agreements for physicians and certain healthcare practitioners. Key changes for physicians include:

• Buyout cap. The amount of the buy out of the non-compete must not be greater than the physician's total annual salary and wages at the time of termination of the contract or employment.

• Time and geographic limits. The term of the covenant cannot exceed the one-year anniversary of the date the contract or employment was terminated. The geographic radius is limited to a maximum of five miles from the location where the physician primarily practiced before the contract or employment terminated.

• Involuntary discharges without good cause. The covenant cannot be enforced if the physician is involuntarily discharged from the contract or employment without good cause. "Good cause" is defined as a reasonable basis for discharge of a physician from a contract or employment that is directly related to the physician's conduct, including the physician's conduct on the job or otherwise, job performance and contract or employment record.

• Clarity of terms. All terms and conditions must be clearly and conspicuously stated in writing.

• Administrative role exclusion. Clarifies that the "practice of medicine" does not include managing or directing medical services in an administrative capacity, such that noncompete agreements for such positions are not subject to the restrictions in Subsection 15.50(b). 47 The 89th Texas Legislature: 2025 Healthcare legislative update A new Section 15.501 creates new requirements for noncompete agreements to apply to dentists, nurses (both professional and vocational) and physician assistants to be enforceable. Key changes for healthcare practitioners include:

• Buyout option. Noncompete agreements must provide for a buyout at no more than the practitioner's total annual salary and wages at the time of termination.

• Time and geographic limits. The agreement must expire within one year of termination and may not cover more than a five-mile radius from the practitioner's primary practice location.

• Clarity of terms. All terms and conditions must be clearly and conspicuously stated in writing. The amendments to Section 15.52 make clear that the enforceability criteria and procedures outlined in Sections 15.50, 15.501, and 15.51 are exclusive and preempt any other law, including common law, related to noncompete agreements for covered healthcare practitioners. The new requirements apply to noncompete agreements that are entered into or renewed on or after September 1, 2025, while agreements executed or renewed before that date remain subject to prior law.

Practical effect: SB 1318 significantly amends the Texas Business and Commerce Code regarding noncompete agreements for physicians and certain healthcare practitioners. Healthcare employers are encouraged to promptly review and update their noncompete agreements to ensure compliance with agreements entered into or which may renew, including automatic renewals, on or after September 1, 2025.