



New Texas Mandated Benefits for 2026

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The Texas legislature wrapped up its 89th legislative session in June, having passed a number of bills related to health insurance. Below are the bills signed into law that relate to employer-sponsored plans. They apply to insured medical plans written out of Texas only and, where applicable, pharmacy benefit managers (“PBMs”) operating in Texas, and are effective for health plans delivered or renewed on or after January 1, 2026, unless otherwise noted below.

■ Summary

Senate Bill 896 – Extends the automatic enrollment period for newborns from 31 to 60 days following birth.

House Bill 388 – Requires the creation and use of a standardized coordination of benefits questionnaire to streamline the billing process, effective February 1, 2026.

House Bill 1052 – Requires 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.

House Bill 2254 – Permits preferred and exclusive provider benefit plans to contract with primary care physicians and physician groups on a risk basis, including capitation or other risk-sharing arrangements. Participation in these arrangements is voluntary, and insurers cannot discriminate against physicians or groups who opt out.

House Bill 3057 – Requires health benefit plans that provide coverage for chimeric antigen receptor T-cell therapy (CAR T) to cover medically necessary CAR T therapy when administered by qualified, FDA-certified providers within the plan's network.

House Bill 3233 – Prohibits PBMs from storing or processing patient data for a Texas resident in a location outside of the United States or its territories. Effective for contracts entered into on or after September 1, 2025.

House Bill 3812 – Extends the duration of preauthorization exemptions from six months to one-year, includes additional claims in preauthorization exemption evaluations, and prohibits the physician supervising utilization management at a health plan from holding an administrative license.

Senate Bill 493 – Prohibits PBMs from including gag clauses in contracts with pharmacies that would prohibit a pharmacist from informing an enrollee of any difference between the patient's out-of-pocket cost for a prescription drug using the PBM benefit and the out-of-pocket price when paying cash. Effective for contracts entered into on or after September 1, 2025.

Senate Bill 527 – Prohibits a health benefit plan covering general anesthesia from excluding medically necessary general anesthesia services relating to dental services for a covered individual, provided that: (1) the individual is younger than 13 years of age and unable to undergo the dental service without general anesthesia due to a documented physical, mental, or medical reason; and (2) a qualified provider of anesthesia services performs the anesthesia.

Senate Bill 815 – Restricts health plans from utilizing artificial intelligence or algorithms for claim denials. However, such systems may still be used for administrative support or fraud detection purposes.

Senate Bill 916 – Extends protections against surprise billing for ground ambulance services in Texas through September 1, 2027. Grants DSHS expanded authority to suspend or revoke the licenses of emergency medical service providers who either intentionally give false information or repeatedly break payment rules with respect to insurance coverage for out-of-network emergency care.

Senate Bill 926 – Permits HMOs and insurers to provide incentives, such as adjusted deductibles, copayments, coinsurance or other cost-sharing mechanisms or to use a tiered network to encourage enrollees or insureds to utilize specific physicians or providers. Prevents plans from using these incentives to limit medically necessary services or provide lower quality of care.

Senate Bill 1236 – Permits pharmacists an opportunity to refuse a proposed modification to a network contract and voids modifications that are not approved and signed by the pharmacist under most circumstances. With some exceptions, under this bill, a health benefit plan could only recoup the dispensing fee and not the cost of the drug or any other cost. Also requires pharmacy benefits to include on the health insurance card a unique identifier that indicates whether the plan is subject to regulation by TDI.

Senate Bill 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.

Senate Bill 1332 – Allows health plans to waive premiums when a health plan receives late notification of an employee's departure from a company if the employee did not receive covered services following their departure. It applies to fully insured PPO/EPO and HMO businesses.

Senate Bill 2544 – Out-of-network providers, health benefit plan issuers or administrators may request mandatory mediation for health benefit claims involving out-of-network facilities no later than 180 days after the provider receives an initial payment for the relevant service or supply. Effective June 20, 2025. Currently, there is no deadline.

Employer Action

For the most part, employers with insured medical plans written out of Texas should be aware of the above changes and no employer action is required. However, employers should amend their cafeteria plans for Senate Bill 896 before it goes into effect (by December 31, 2025, for a 2026 calendar year plan).