TAHP TRACKED BILLS - ALL BILLS 4-14-23

04-14-2023 - 10:26:35

A - *Action in the date range* R - *Link to Related Information* ( ) - Priority

TAHP

A HB 1 | Bonnen, Greg | General Appropriations Bill

Bill History: 04-12-23 S Reported from committee as substituted Senate Finance
04-13-23 S First placement on Senate Intent Calendar for
04-17-23 S Placed on the Senate Calendar for

A HB 4 | Capriglione, Gi | Personal Data Collection

Companions: HB 1844 Capriglione, Giovanni (Identical)
3- 7-23 H Introduced and referred to committee on House Business and Industry

Remarks: SUMMARY: This bill would create consumer rights over the collection and use of their personal data. The bill does not apply to "covered entities" regulated by HIPAA, such as MCOs and insurance companies.

DATE UPDATED: 9/1/23

3/13/23 hearing- Neutral

Bill History: 04-05-23 H Laid out for consideration in the House at 11:32am
04-05-23 H Passed (Vote: Y:146/N: 0)
04-05-23 S Received in the Senate

A HB 12 | Rose, Toni | 12 months postpartum Medicaid coverage

Remarks: SUMMARY: Extends continuous eligibility for Medicaid coverage for pregnant and postpartum women to not less than 12 months from 60 days. Retains current statute that allows for continuous eligibility for postpartum women for 6 months after the date the

women delivers or experiences an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

TAHP POSITION STATEMENT: How we administer Medicaid pregnancy coverage dramatically affects the overall wellbeing of Texas mothers and infants. Unfortunately, we rank 15th nationally for maternal mortality with even more significant disparities in minority communities. The postpartum period is critical, and longer coverage allows for continued access to essential health services and preventative care, reducing maternal health complications that arise after the 60-day limit. Texas should join the majority of states and extend Medicaid postpartum coverage to a full year.

DATE UPDATED: 2/26 by JL

3/16/23 hearing- Support, card

Bill History:
03-16-23 H Committee action pending House Select on Health Care Reform
03-21-23 H Voted favorably from committee on House Select on Health Care Reform
03-27-23 H Reported favorably from committee on House Select on Health Care Reform

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A HB 15 Thompson, Senfr The Mental Health Brain Research Institute

Companions: HJR 135 Thompson, Senfronia (Enabling)
4-11-23 S Received in the Senate

Remarks: SUMMARY: Establishes the Mental Health and Brain Research Institute of Texas to enhance the potential for medical and scientific breakthroughs in mental health and brain-related sciences and bio-medical research; award grants to universities, colleges, and other entities; and develop a research plan to foster collaboration between universities and colleges and other partners. Requires yearly reporting by the institute that outlines activities and awards, as well as strategic research plans and the impact of brain disease to the state. Requires a constitutional amendment to appropriate $3B.

TAHP POSITION: Support

DATE EFFECTIVE: Jan. 1, 2024

DATE UPDATED: 3/9 by JL

3/20/23 hearing- Support, card

Bill History: 04-11-23 H Laid out for consideration in the House at 11:14am
04-11-23 H Passed (Vote: Y:116/N: 29)
04-11-23 S Received in the Senate

A HB 25 Talarico, James Wholesale prescription drug importation

Remarks: SUMMARY: This bill would create a "wholesale prescription drug importation program," allowing contracts with wholesalers to seek importation of prescription drugs from Canadian suppliers. The bill would place guardrails on the program to ensure safety, and it would require annual reporting on participation, savings, and implementation. The program may be extended to other countries allowed by federal law to import drugs to the US.

TAHP POSITION: Support

EFFECTIVE DATE: 9/1/23

DATE UPDATED: 2/3 JB 2/21 JL

3/23 hearing - BH testified in support

Bill History: 04-12-23 H Laid out for consideration in the House at 11:24am
04-12-23 H Passed (Vote: Y:144/N: 1)
04-12-23 S Received in the Senate

A HB 44 Swanson, Valore No immunization discrimination in Medicaid

Remarks: SUMMARY: Prohibits providers from refusing to provide services to Medicaid and CHIP recipients who are not vaccinated. Requires HHSC to disenroll providers who do not comply and prohibits provider reimbursement.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid, CHIP

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/29/23 by JL

3/20/23 hearing- Neutral

Bill History: 03-20-23 H Committee action pending House Public Health
04-03-23 H Voted favorably from committee as substituted House Public Health
04-05-23 H Reported from committee as substituted House Public Health

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HB 54 Thompson, Senfr Personal needs allowance

Remarks:

SUMMARY: Increases the personal needs allowance, which is the portion of a resident's social security check that they are permitted to retain, from $60 to $85 per month for residents of nursing, assisted living, ICF-IID, or similar facilities.

TAHP POSITION: Support

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: The minimum monthly personal needs allowance for these residents does not adequately account for the recent substantial inflation to the cost of living and goods.

DATE UPDATED: 3/7 by JL

3/07/23 hearing- Support, card

Bill History:

03-14-23 H Voted favorably from committee as substituted House Human Services
03-23-23 H Reported from committee as substituted House Human Services
04-17-23 H Set on the House Calendar

HB 56 Ortega, Lina 12 month postpartum Medicaid coverage

Remarks:

SUMMARY: Extends continuous eligibility for pregnant and postpartum women to not less than 12 months from 60 days. Repeals language passed last session in HB 133 that limits eligibility to pregnant women who deliver or experience an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

TAHP POSITION STATEMENT: How we administer Medicaid pregnancy coverage dramatically affects the overall wellbeing of Texas mothers and infants. Unfortunately, we rank 15th nationally for maternal mortality with even more significant disparities in minority communities. The postpartum period is critical, and longer coverage allows for continued access to essential health services and preventative care, reducing maternal health complications that arise after the 60-day limit. Texas should join the majority of states and extend Medicaid postpartum coverage to a full year.

DATE UPDATED: 1/10 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 58 | Talarico, James | Local Ambulance Balance Billing

Companions: HB 89 | Talarico, James | (Identical)
2-23-23 H Introduced and referred to committee on House County Affairs

Remarks: SUMMARY: This is a refile of a bill (SB 790) that passed in the 87th, and it was likely filed unintentionally.

TAHP POSITION: Neutral

DATE UPDATED: 2/13 KS

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House County Affairs

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HB 62 | Talarico, James | Establish Office of Early Childhood programs

Companions: HB 51 | Talarico, James | (Refiled from 87R Session)

Remarks: SUMMARY: This bill would establish an Office of Early Childhood to coordinate and integrate child care, early childhood, and early care and learning programs in Texas.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED: 2/13 KS

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Public Education

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HB 89 | Talarico, James | Local Ambulance Balance Billing

Companions: HB 58 | Talarico, James | (Identical)
2-23-23 H Introduced and referred to committee on House County Affairs

Remarks: SUMMARY: This is a refile of a bill (SB 790) that passed in the 87th, and it was likely filed unintentionally.

TAHP POSITION: Neutral

DATE UPDATED: 2/13 KS

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House County Affairs

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HB 98 | Moody, Joe | Medicaid mental health in schools - LMHA

Companions:

SB 96	Menendez, Jose	(Refiled from 87R Session)
SB 113	Menendez, Jose	(Identical)
	3-15-23 S Committee action pending Senate Education	

Remarks: SUMMARY: Allows school districts to contract with LMHAs to provide MH services on campus. Requires the LMHA, at parent or guardian request, to provide the student 's PCP the results of the assessment conducted and any results of services provided. Allows school districts to enroll as Medicaid providers in order to receive Medicaid reimbursement. This is currently allowable under SHARS.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

DATE UPDATED: 11/15 by JL

3/20/23 hearing- Neutral

Bill History: 03-20-23 H Committee action pending House Select on Youth Health & Safety
03-23-23 H Voted favorably from committee on House Select on Youth Health & Safety
03-29-23 H Reported favorably from committee on House Select on Youth Health & Safety

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HB 109 | Johnson, Julie | Hearing Aids in Excess of Allowed Amounts

Companions:

SB 51	Zaffirini, Judith	(Identical)
	4- 5-23 S Committee action pending Senate Health and Human Services	

Remarks: SUMMARY: This bill would prohibit commercial plans that provide coverage for hearing aids from denying a claim for hearing aids solely on the basis that the aid is more than the benefit available under the plan. However, it does not require a plan to pay a claim in an amount that is more than the benefit available under the plan.

TAHP POSITION: Neutral as long as a mandate is not added to the bill.

COVERAGE TYPES: Individual and group plans, CC plans, ERS and TRS and universities. Does not apply to Medicaid.

EFFECTIVE DATES: September 1, 2023

TAHP POSITION STATEMENT: TAHP does not oppose because it is not creating a new mandate

DATE UPDATED: 2/3 KS

3/21/23 hearing- Neutral

Bill History:
03-28-23 H Voted favorably from committee as substituted House Insurance
04-04-23 H Reported from committee as substituted House Insurance
04-04-23 H Recommended for Local and Consent Calendar

A HB 113 Ortega, Lina Medicaid community health worker expenses

Companions: SB 74 Johnson, Nathan (Identical)
2-15-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:
SUMMARY: Allows MCOs to categorize community health workers as medical expenses instead of as an administrative expense.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

TAHP POSITION STATEMENT: Community health workers play a vital role in connecting Medicaid members to health care and community services--critical components of managed care. They help increase health knowledge and self-sufficiency through a range of activities such as outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research.

DATE UPDATED: 1/11 by JL

3/07/23 hearing- Support, card

Bill History:
04-13-23 H Set on the House Calendar
04-13-23 H Laid out for consideration in the House at 1:31pm
04-13-23 H Passed to third reading (Vote: Y:130/N: 18)

HB 118 | Cortez, Philip | No Cost Sharing PSA Test Mandate

Remarks:

SUMMARY: This bill expands the existing state-mandated benefit for prostate cancer to new types of coverage (small employer groups, MEWAs, ERS, TRS, Medicaid, and CHIP) and adds prohibition for any enrollee cost-sharing to the existing mandate.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, ERS, TRS, CC, Medicaid, and CHIP

EFFECTIVE DATES: Plans delivered, issued for delivery, or renewed after 1/1/24.

MANDATE: Benefit Design Mandate

TAHP POSITION STATEMENT: TAHP opposes benefit mandates that are not evidence-based or supported by the medical community. The Affordable Care Act already requires health plans to cover preventive screenings with no cost-sharing for tests or treatments that receive an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF), as these are evidence-based. However, the USPSTF gives PSA tests for prostate cancer a "C" rating for men aged 55-69 and a "D" rating for those 70 and older, meaning the test should only be considered after consultation with a doctor due to potential harm. The USPTF warns that "many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction". State lawmakers should not pass mandates that lack evidence-based support or go above the Affordable Care Acts prevention mandates recommended by the U.S. Preventive Services Task Force

DATE UPDATED: 2/3/23

REFILE: HB 3951 (87th)

4/4/23 hearing- Oppose

Bill History:

04-04-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
04-04-23 H Committee action pending House Insurance
04-13-23 H Vote failed in committee on House Insurance

HB 132 | Bucy, John | Medicaid expansion

Companions:

HJR 7	Bucy, John	(Enabling)
	2-28-23 H Introduced and referred to committee on House Select on Health	

	Care Reform	
SB 39	Zaffirini, Judith	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	
SB 71	Johnson, Nathan	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: Expands Medicaid to all individuals eligible under the ACA. Requires HHSC to produce a report on expanded eligibility. Requires a constitutional amendment.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Jan. 1, 2024

DATE UPDATED: 1/9 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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A HB 134 Bernal, Diego Cranial Helmet Mandate

Remarks: SUMMARY: Requires plans to cover the full cost of a "cranial remolding orthosis" for a child diagnosed with craniostenosis; or plagiocephaly or brachycephaly if the child is between 3-18 months, has failed to respond to conservative therapy for at least 2 months, and meets additional indications. The mandated coverage may not be less favorable than coverage for other orthotics under the plan and must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other orthotics under the plan. 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.

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial, Medicaid

EFFECTIVE DATES: D, I, or R on or after 1/1/24

TAHP POSITION STATEMENT: Texas health plans and Texas Medicaid already cover cranial molding orthosis when they are medically necessary. Cranial orthotic devices can be found medically necessary, on a case-by-case basis, for treating infants with severe plagiocephaly, following therapy and surgical corrections. TAHP opposes expanding coverage for these devices in the absence of clear medical

evidence that these devices actually provide a clinical benefit to patients and expanding these devices to non-medically necessary cases. In the majority of cases the shape of a baby's head improves naturally over time as their skull develops or through the use of positional therapy. In the first randomized trial of the helmets, published in the BMJ, the authors found "virtually no treatment effect." The improvements were not significantly different between the helmet-wearers and the infants not wearing helmets. After two years, a researcher evaluating skull shape did not know which babies had worn helmets and which had not. In 2016 the Congress of Neurological Surgeons had a finding of clinical uncertainty when it comes to cranial therapy and stated that "aside from the perceived cosmetic results, the college does not claim a verifiable medical or clinical result." Use of cranial molding orthoses for plagiocephaly conditions is also inconsistent with American Academy of Pediatrics (AAP) guidelines, which recommend that use of cranial molding orthoses be reserved for severe cases of deformity. A 2020 review of the evidence in the Hayes Directory Annual Review found that there appears to be no new evidence supporting the use of cranial molding orthosis. Hayes gives a C rating for the use of cranial orthotic devices in infants with moderate to severe positional cranial deformity, and a D rating for the use of helmets in patients with very severe positional plagiocephaly and in most other conditions. Per Hayes, the evidence for the use of cranial molding orthosis continues to be of poor quality, while the limited evidence against their use remains strong.

DATE UPDATED: 2/2 BH

4/11/23 hearing- Oppose, testified

Bill History:

02-23-23 H Introduced and referred to committee on House Insurance
04-11-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
04-11-23 H Committee action pending House Insurance

A HB 141 Howard, Donna CHIP birth control coverage

Companions:

SB 407	Eckhardt, Sarah	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	
SB 2436	Lamantia, Morgan (F)	(Identical)
	3-23-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: Requires CHIP to cover prescription contraceptive drugs, supplies, or devices for children under 18 with written content. Prohibits CHIP from covering abortifacients or any other drug or device that terminates a pregnancy.

TAHP POSITION: Neutral

COVERAGE TYPES: CHIP

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

DATE UPDATED: 1/9 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Public Health

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HB 144 Bernal, Diego Ad valorem tax exemptions unpaid caregivers

Companions:

HB 122	Bernal, Diego	(Refiled from 87R Session)
HB 147	Bernal, Diego	(Identical)
	2-23-23 H Introduced and referred to committee on House Ways and Means	
HJR 16	Bernal, Diego	(Enabling)
	2-28-23 H Introduced and referred to committee on House Ways and Means	

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Ways and Means

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HB 147 Bernal, Diego From ad valorem taxation total appraised

Companions:

HB 122	Bernal, Diego	(Refiled from 87R Session)
HB 144	Bernal, Diego	(Identical)
	2-23-23 H Introduced and referred to committee on House Ways and Means	
HJR 16	Bernal, Diego	(Enabling)
	2-28-23 H Introduced and referred to committee on House Ways and Means	

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Ways and Means

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HB 169 Reynolds, Ron Minimum wage

Companions:

HB 60	Reynolds, Ron	(Refiled from 87R Session)
HB 731	Gonzalez, Jessica	(Refiled from 87R Session)

HB 1917	Turner, Chris	(Refiled from 87R Session)
HB 4484	Walle, Armando	(Refiled from 87R Session)
HB 737	Walle, Armando	(Identical)
	2-28-23 H Introduced and referred to committee on House International Relations/Economic Dev	

Remarks: SUMMARY: Establishes the minimum wage in Texas to be the greater of $15/hour or federal minimum wage. Applies to wages in private employment via a repealer.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/14 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House International Relations/Economic Dev

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A HB 181 Johnson, Jarvis Sickle cell disease registry

Remarks: SUMMARY: This bill would establish a sickle cell registry at DSHS, which would include a record of cases that occur in the state. The Department would submit annual reports to the legislature on information obtained through the registry.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

3/13/23 hearing- Support, card

Bill History: 03-13-23 H Committee action pending House Public Health
03-20-23 H Voted favorably from committee on House Public Health
03-22-23 H Reported favorably from committee on House Public Health

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A HB 204 Bernal, Diego Medicaid Expansion

Companions:

HB 143	Bernal, Diego	(Refiled from 87R Session)

Remarks: SUMMARY: Requires HHSC to request an amendment to the 1115 waiver to expand Medicaid to counties that request it. Allows counties to expand Medicaid to all individuals eligible under the ACA. The waiver must also identify the sources of money to be used

to pay the state's share, but the bill is silent on which entity is required to pay the state's share.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

DATE UPDATED: 1/11 by JL

Bill History:
11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 226 Bernal, Diego Medicaid expansion

Companions:

SB 72	Johnson, Nathan	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	
SB 671	West, Royce	(Identical)
	2-17-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:
SUMMARY: Expands Medicaid to all individuals eligible under the ACA. Gives HHSC rulemaking authority. Requires HHSC to produce a report on expanded eligibility.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Jan. 1, 2024

DATE UPDATED: 3/7 by JL

Bill History:
11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 235 Howard, Donna Allow Pharmacists to Test/Treat

Companions:

HB 2049	Howard, Donna	(Refiled from 87R Session)

Remarks:
SUMMARY: This bill would allow pharmacists to furnish a prescription drug to a patient under a physician's written protocol. It would allow a pharmacist to perform rapid strep tests and rapid flu tests, and then furnish prescriptions to treat those acute conditions. The bill also provides that a pharmacist may not furnish a prescription drug under that section unless the pharmacist has completed a training program that is approved by

the board and is relevant to the condition treated by the drug.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

POSITION STATEMENT: TAHP supports reducing barriers to care. Numerous states have safely expanded authority to pharmacists to allow testing and treatment for a small number of illnesses. Because of provider shortages Texans often lack easy access to primary care providers. Expanding pharmacist authority will allow patients to access treatments quickly and affordably for certain illnesses.

DATE UPDATED: 2/1 KS

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Public Health

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HB 245 Gonzalez, Mary Community attendant wages

Remarks: SUMMARY: Increases community attendant wages to the greater of $15 an hour or federal minimum wage. Allows for community attendants to be a family member of the member, including the member's parent or spouse.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/3 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Human Services

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HB 290 Oliverson, Tom Multiple employer welfare arrangements

Companions: SB 1307 Hancock, Kelly (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would apply certain insurance mandates to MEWAs that provide comprehensive health plans. MEWAs would be subject to reserve requirements, asset protection requirements, the selection of providers chapter, and the utilization review chapter. A MEWA that provides a comprehensive health plan that is structured in the same way as a PPO/EPO would also be subject to

Chapter 1301 (PPO plan requirements) and Chapter 1467 (surprise billing prohibition). The bill would also modify the application and eligibility requirements for a certificate of authority.

TAHP POSITION: Neutral

COVERAGE TYPES: MEWAs

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/1 KS

3/07/23 hearing- Neutral

Bill History:

03-07-23 H Committee action pending House Insurance
03-14-23 H Voted favorably from committee on House Insurance
03-30-23 H Reported favorably from committee on House Insurance

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A HB 340 Thompson, Senfr Emotional Disturbance of a Child Mandate

Companions:

HB 240	Thompson, Senfronia	(Refiled from 87R Session)
SB 51	Zaffirini, Judith	(Refiled from 87R Session)

Remarks:

SUMMARY: The bill creates a new mandated benefit for "serious emotional disturbance of a child" for employer group plans, requiring coverage, based on medical necessity, for at least 45 days inpatient and 60 visits outpatient (which may not count a visit for medication management). Requires the same "amount limitations," deductibles, copayments, and coinsurance factors as for physical illness under the plan. Requires TDI study of the impact of coverage on premiums (due 8/1/22).

TAHP POSITION: Negotiating - Will be neutral if the bill is amended to adequately define "serious emotional disturbance of a child"

COVERAGE TYPES: ERS, TRS, Commercial

EFFECTIVE DATES: Plans issued for delivery, delivered, or renewed after 2024

TAHP POSITION STATEMENT:TAHP and its member health plans support mental health parity and access to mental health treatment, but we are opposed to the new, undefined, open-ended benefit mandate this bill creates that is vague and not adequately defined. The bill does not adequately define "serious emotional disturbance of a child" or identify the specif ic conditions to be covered. Because this is not a standard insurance benefit, unclear definitions and requirements create uncertainty regarding what a

plan is required to cover. This lack of certainty could be abused by providers to file claims for inappropriate care and increase costs for these services. The bill allows a benefit limitation of up to 45 days of inpatient care and 60 outpatient visits, but applying these limits is very likely to violate the mental health parity law. Because these limits are not allowed, the bill is essentially creating an unlimited benefit for "serious emotional disturbance of a child."

DATE UPDATED: 2/3 BH 2/21 by JL

Bill History:

11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Insurance
04-18-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance

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A HB 343 Goodwin, Vikki Prescriptive authority psychologists

Remarks:

SUMMARY: This bill would allow psychologists that receive a masters degree in psychopharmacology to prescribe mental health medications.

TAHP POSITION: Netural

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

Bill History:

11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Public Health

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A HB 351 Bell, Cecil Workers Comp Packaged Plan

Remarks:

SUMMARY: This bill would allow a workers' compensation carrier to contract with an accident and health insurance company to offer a packaged plan under which employees and their dependents are eligible for major medical expense coverage and employees are covered for medical benefits and other benefits required by Chapter 408, Labor Code. A packaged plan must provide that medical examinations required under Subchapter A, Chapter 408, Labor Code, are covered exclusively under the workers' comp policy in the packaged plan. The commissioner must adopt rules establishing solvency requirements under the chapter. This bill is not creating a new mandate.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/1 KS

3/07/23 hearing- Neutral

Bill History: 02-23-23 H Introduced and referred to committee on House Insurance
03-07-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-07-23 H Committee action pending House Insurance

HB 389 Collier, Nicole Fertility preservation mandate

Companions:

HB 1649	Button, Angie Chen	(Identical)
	4- 4-23 H Committee action pending House Insurance	
SB 447	Menendez, Jose	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: This bill mandates coverage for "fertility preservation services" to a covered person who will receive a medically necessary treatment that may impair fertility. The coverage mandate applies to any medically necessary treatment, including surgery, chemotherapy, and radiation, that the American Society of Clinical Oncology (ASCO) or the American Society for Reproductive Medicine (ASRM) has established may directly or indirectly cause impaired fertility. The fertility preservation services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the ASCO or the ASRM. These organizations consider sperm, oocyte, and embryo cryopreservation standard practices. If those procedures are not options for the patient, ovarian tissue cryopreservation and ovarian suppression with gonadotropin-releasing hormones have shown evidence of efficacy. The bill does not contemplate the long-term storage of embryos and related costs if an enrollee no longer has coverage from a state regulated health plan.

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial

EFFECTIVE DATES: D, I, or R after 1/1/24

MANDATE: Benefit

TAHP POSITION STATEMENT: The bill creates a new unfunded, mandated benefit, fertility preservation services, for a covered person who will receive a treatment that may impair fertility. In the 86th legislative session, this same mandated benefit (HB 2682) would have increased Medicaid costs by $5.2 million a year and TRS-active care costs by $4 million a year. The LBB found that this benefit

mandate would also increase health care costs to the TRS, UT systems, and ERS health plans that would result in increased premiums and contributions from the state, employers, or members.

Typical costs for fertility preservation services are in excess of $10,000, with hundreds more in added monthly storage charges. Mandating coverage for fertility preservation services could lead to increased costs for health insurance plans, ultimately resulting in higher premiums for customers. Additionally, mandating coverage could limit the ability of health insurers to negotiate prices with providers, which could lead to reduced innovation and competition in the healthcare industry.

Mandating coverage for fertility preservation services could also be complicated by the long-term storage benefit. While some patients may be able to afford the initial procedure, the ongoing cost of storing embryos or other reproductive material could be prohibitively expensive for many people. This could lead to a situation where patients are forced to choose between paying for expensive storage or risking the loss of their reproductive material if they lose health insurance or switch to other coverage in the market that does not have this mandate.

Government mandates and overregulation hinder innovation and add costs to an already expensive system, which are borne by employers and families through increasingly unaffordable premiums. Texas already ranks third in the nation when it comes to regulations that go beyond the federal requirements of the ACA.

While we recognize the importance of fertility preservation services for patients undergoing medical treatments that could impact their fertility, we believe that the decision to purchase coverage of these services should be left up to employers and families rather than being mandated by the state. Many health insurers already offer coverage for these services in their plans, and customers can choose to purchase plans that include this coverage if it is important to them.

UPDATED: 2/3 BH

4/4/23 hearing- Oppose, card

Bill History:

02-23-23 H Introduced and referred to committee on House Insurance
04-04-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
04-04-23 H Committee action pending House Insurance

HB 465 | Thierry, Shawn | Doula Medicaid Coverage Pilot

Remarks: SUMMARY: Requires HHSC, in consultation with the Perinatal Advisory Council, to establish a pilot program to provide doula services within Medicaid in Harris County and the county with the most maternal and infant deaths by Sept. 1, 2024. The qualifications for an individual to be considered a doula and the doula services to be covered under the pilot program will be established by rule. HHSC is also responsible for establishing the qualifications for eligibility. The pilot must terminate by Sept. 1, 2029. Requires HHSC to publish an annual report on the cost of the pilot and the impact on birth outcomes. The final report must summarize the pilot program results, include feedback from participating doulas and members, and include a recommendation to continue/expand/terminate the program.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/9 by JL

3/07/23 hearing- Neutral

Bill History: 03-14-23 H Voted favorably from committee on House Human Services
03-23-23 H Reported favorably from committee on House Human Services
04-17-23 H Set on the House Calendar

HB 468 | Thierry, Shawn | Raises the Age of the Cochlear Implant Mandate

Remarks: SUMMARY: HB 468 amends the current mandated benefit (adopted in 2019 in HB 490) for a medically necessary hearing aid or cochlear implant and related services and supplies to apply to an enrollee who is age 25 or younger instead of the current age 18 or younger.

TAHP POSITION: Neutral as long as bill is not amended

COVERAGE TYPES: EPO, HMO, MEWA, CC, ERS/TRS/UT.

EFFECTIVE DATES:9/1/23

MANDATE: Benefit

TAHP POSITION STATEMENT: TAHP is neutral on HB 468, which expands the mandated benefit (adopted in 2019 in HB 490) for a hearing aid or cochlear implant to an enrollee who is age 25 or younger instead of the current age 18 or younger. TAHP does

not oppose this mandate, as it does not create a significant cost increase.

DATE UPDATED: 2/19 KS

3/28/23 hearing- Neutral

Bill History: 03-28-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-28-23 H Committee action pending House Insurance
04-04-23 H Voted favorably from committee on House Insurance

HB 487 Thompson, Senfr 12 month postpartum Medicaid coverage

Companions: HB 1824 Thierry, Shawn (Identical)
3- 7-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: Builds on HB 133 last session by extending postpartum coverage to 12 months from six months and removes language passed last session in HB 133 that limits eligibility to pregnant women who deliver or experience an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: How we administer Medicaid pregnancy coverage dramatically affects the overall wellbeing of Texas mothers and infants. Unfortunately, we rank 15th nationally for maternal mortality with even more significant disparities in minority communities. The postpartum period is critical, and longer coverage allows for continued access to essential health services and preventative care, reducing maternal health complications that arise after the 60-day limit. Texas should join the majority of states and extend Medicaid postpartum coverage to a full year.

DATE UPDATED: 11/15 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 496 Meza, Terry Prohibits Conversion Therapy Coverage

Companions: HB 2516 Meza, Terry (Refiled from 87R Session)

Remarks: SUMMARY: This bill prohibits health plan coverage of conversion therapy, which means a practice or treatment provided to a person by a health care provider or nonprofit organization that seeks to change the person's sexual orientation, including by attempting to change the person's behavior or gender identity or expression; or eliminate or reduce the person's sexual or romantic attractions or feelings toward individuals of the same sex.

TAHP POSITION: Neutral

COVERAGE TYPES: EPO/PPO, HMO, MEWA, CC, ERS/TRS/University, Medicaid/CHIP

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/3 BH

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Insurance

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HB 500 | Bonnen, Greg | Supplemental appropriations

Remarks: SUMMARY: Includes $2.9B in General Revenue and $5.5B in All Funds to address the Medicaid shortfall for fiscal year 2023.

TAHP POSITION: Neutral

DATE UPDATED: 3/6 by JL

Bill History: 03-07-23 H Filed
03-09-23 H Introduced and referred to committee on House Appropriations

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HB 512 | Bernal, Diego | Medicaid expansion

Companions:

HB 171	Bernal, Diego	(Refiled from 87R Session)
HB 389	Israel, Celia	(Refiled from 87R Session)
HB 398	Bucy, John	(Refiled from 87R Session)
HB 4406	Ramos, Ana-Maria	(Refiled from 87R Session)
SB 38	Zaffirini, Judith	(Refiled from 87R Session)
SB 118	Johnson, Nathan	(Refiled from 87R Session)

Remarks: SUMMARY: Expands Medicaid to all individuals eligible under the ACA. Requires HHSC to produce a report on expanded eligibility. Requires a

constitutional amendment.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Jan. 1, 2024

DATE UPDATED: 1/11 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 526 Wu, Gene HIV Testing Mandate

Remarks: SUMMARY: A health care provider who takes a sample of a person's blood as part of an annual medical screening may submit the sample for an HIV diagnostic test, regardless of whether it is part of a primary diagnosis, unless the person opts out of the HIV test. Before taking a sample of a person's blood as part of an annual medical screening, a health care provider must verbally inform the person that an HIV test will be performed unless the person opts out. The bill mandates coverage for HIV tests, regardless of whether the test or medical procedure is related to the primary diagnosis of the health condition, accident, or sickness for which the enrollee seeks medical or surgical treatment. It also requires HHSC to adopt rules requiring the commission to provide HIV tests.

TAHP POSITION: Neutral

COVERAGE TYPES: EPO/PPO, HMO, MEWA, ERS/TRS/University

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

TAHP POSITION STATEMENT: TAHP is neutral because insures are already required to cover these services.

MANDATE: Benefit

DATE UPDATED: 2/3 BH

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Insurance

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HB 580 Raymond, Richar Medicaid single claims portal

Companions: HB 1625 Raymond, Richard (Refiled from 87R Session)

SB 432	Hinojosa, Chuy	(Refiled from 87R Session)

Remarks:

SUMMARY: Requires HHSC to build a single portal, within existing resources, for providers to submit electronic claims, PA requests, claims appeals and reconsiderations, clinical data, and other documentation that MCOs request for PA and claims processing; and obtain electronic remittance advice, EOB statements, and other standardized reports.

TAHP POSITION: Oppose

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

TAHP POSITION STATEMENT: TAHP opposes a new consolidated claims portal because it is a waste of valuable state resources and disregards the existing technology and infrastructure already in place through Medicaid managed care organizations (MCOs). MCOs already operate efficient claims portals with real-time access to claims information, reduced administrative burden on providers, and improved patient experience. There is no need for the state to duplicate these portals. The construction of a new portal would require significant resources, including staff hiring, technology purchasing, and ongoing maintenance, which would be better spent improving other areas of the healthcare system. Previous experience with consolidated portals in Texas has not proven valuable, with low utilization rates. HHSC already operates a single portal for nursing homes to submit claims, but utilization is low, with only 2.3% of claims being submitted through the portal. Providers choose to use the MCO portals because they offer more functionality and ease of use. A fully functional portal similar to health plan portals would require significant investment, with estimated ongoing cost over $10 million per year.

DATE UPDATED: 2/4 by JD

Bill History:

11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Human Services

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A HB 592	Shaheen, Matt	Telehealth Across State Lines

Remarks:

SUMMARY: This bill allows health professionals that are licensed in a different state to provide telemedicine and telehealth services in Texas if they hold an unrestricted license, have not been subject to disciplinary proceedings, and register with the applicable licensing agency in Texas. It would also

add mental health providers to the definition of "health professional" in the telemedicine chapter of the insurance code.

TAHP POSITION: Support

TAHP POSITION STATEMENT: This bill is a crucial step in increasing access to healthcare and promoting the adoption of telehealth in Texas, particularly in rural and underserved communities. Telemedicine has proven to be an effective and efficient way to provide quality care to patients, reducing costs and time associated with in-person visits. By allowing licensed health professionals to offer telehealth services across state lines, patients will have greater access to specialists and services, regardless of their location, leading to improved patient outcomes and reduced healthcare costs. The demand for remote care is growing, making telemedicine and telehealth increasingly important in the future of healthcare. This bill will help advance telehealth in Texas and maintain its leadership in the U.S.

EFFECTIVE DATES: I,D,R 1/1/24

DATE UPDATED:2/3/23 JB

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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A HB 593 Shaheen, Matt Expands Direct Primary Care to Other Providers

Remarks: SUMMARY: This bill would broaden the current direct primary care law. First, it would expand the types of care by changing "primary" to "patient." Second, it would expand the types of providers who can use the programs, by changing "physician" to "practitioner." Does not create a new insurance mandate.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform
02-28-23 H Rereferred to Committee on House Public Health

A HB 594 Shaheen, Matt Expands Telepharmacy

Remarks: SUMMARY: This bill would remove current restrictions on telepharmacy, such as restrictions on facilities it may be used in, the restrictions on

locations eligible to be remote dispensing sites, and the requirement that pharmacists make at least monthly on-site visits to remote dispensing sites. The bill would also allow remote dispensing of CSIIs and remove the mileage limitations between remote sites and pharmacies.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: Since 2017, Texas has allowed limited access to telepharmacy services in certain rural and underserved communities. TAHP supports removing barriers to pharmacy care. This bill increases access to pharmacists, particularly in rural and underserved communities. Telemedicine has proven to be an effective and efficient way to provide quality care to patients, reducing costs and time associated with in-person visits. By allowing licensed pharmacists to offer telehealth services, patients will have greater access, regardless of their location, leading to improved patient outcomes and reduced healthcare costs. The demand for remote care is growing, making telemedicine and telehealth increasingly important in the future of healthcare. However, TAHP cautions against imposing any payment parity mandates that would undermine potential cost savings and innovation.

DATE UPDATED: 2/1 KS, 2/12 BH

Bill History: 02-23-23 H Introduced and referred to committee on House Select on Health Care Reform
02-28-23 H Rereferred to Committee on House Public Health
04-17-23 H Meeting set for 8:00 A.M., JHR 120 - House Public Health

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A HB 595 Shaheen, Matt Physician Dispensing of Drugs

Companions: HB 456 Shaheen, Matt (Refiled from 87R Session)

Remarks: SUMMARY: This bill allows physicians to dispense prescription devices or drugs to their patients that are not controlled substances, including Schedules I through V or Penalty Groups 1 through 4 of Chapter 481 (Texas Controlled Substances Act). It also allows them to charge their patients for these drugs. The bill also removes important consumer protections. Section 5 of the bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with, including applicable labeling requirements and overseeing compliance with packaging and record-keeping. It also repeals the requirement that physicians who want to dispense dangerous drugs notify the Board of Pharmacy and

the Medical Board of their intention to do so.

TAHP POSITION: Neutral/Monitor

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas Legislature should continue these basic safety protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/12/23 BH

Bill History:

11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform
02-28-23 H Rereferred to Committee on House Public Health

A HB 596 Shaheen, Matt Ad valorem taxes

Companions:

HB 457	Shaheen, Matt	(Refiled from 87R Session)
HJR 45	Shaheen, Matt	(Enabling)
	3-23-23 H Reported favorably from committee on House Ways and Means	

Remarks:

SUMMARY: This bill would create a local option exemption from ad valorem taxation on the value of a homestead for physicians who provide services, without seeking payment, to residents who are indigent or are Medicaid recipients.

TAHP POSITION: Neutral

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/3 KS

3/06/23 hearing- Neutral

Bill History:

03-06-23 H Committee action pending House Ways and Means

03-13-23 H Voted favorably from committee on House Ways and Means
03-23-23 H Reported favorably from committee on House Ways and Means

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HB 605 | Shaheen, Matt | MCO Negotiated Rate Disclosure lege

Remarks: SUMMARY: Requires MCOs and plans who contract with the state to provide to a legislator who requests it information regarding any negotiated rate for health care services included in a contract between the vendor and the state. Prohibits legislators and legislative staff from disclosing the information received to anyone not eligible to receive it. Provides that plans who provide confidential information or information that is otherwise excepted from disclosure do not waive their right to assert exceptions in the future or any right to confidentiality.

TAHP POSITION: Neutral as negotiated

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: TAHP worked with the author to ensure requests for information from legislative offices are directed to state agencies, first, to ensure a trackable chain of command. If the agency does not provide the information, legislators may request it directly from third party vendors. HB 605 will also be amended to strengthen the existing correlation between the appropriate standards of conduct and ethics policies with the requests. Finally, HB 605 will require disclosure of drug rebates to legislators.

DATE UPDATED: 2/24 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House State Affairs

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HB 609 | Vasut, Cody | Liability business for disease exposure

Remarks: SUMMARY: This bill would clarify that a business owner that does not require employees to be vaccinated against a pandemic disease is not liable for injury or death cause by exposure to the employee.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23.

DATE UPDATED: 2/13 KS

Bill History: 03-15-23 H Meeting set for 8:00 A.M., E2.016 - House Judiciary and Civil Jurisprudence
03-15-23 H Voted favorably from committee on House Judiciary and Civil Jurisprudence
03-27-23 H Reported favorably from committee on House Judiciary and Civil Jurisprudence

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HB 617 Darby, Drew Emergency telemedicine pilot

Companions: SB 251 Alvarado, Carol (Identical)
2-15-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would create an emergency telemedicine pilot project. The project would provide emergency medical services instruction and prehospital care instruction to providers in rural areas.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 -KS

3/16/23 hearing- Support, card

Bill History: 04-04-23 H Laid out for consideration in the House at 11:12am
04-04-23 H Passed (Vote: Y:142/N: 2)
04-05-23 S Received in the Senate

HB 624 Harris, Cody Emergency medical transport by fire fighters

Companions: SB 1898 Birdwell, Brian (Identical)
3-20-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would allow fire fighters to transport a sick or injured patient to a health care facility if an EMS provider was notified of the patient's clinical condition and were unable to provide services at the patient's location. It would also require EMS and trauma care systems to develop transport protocols and provide notice of the protocols to EMS and fire fighters in their area.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

3/06/23 hearing- Neutral

Bill History: 03-30-23 H Passed (Vote: Y:147/N: 0)
04-03-23 S Received in the Senate
04-05-23 S Referred to Senate Committee on Senate Health and Human Services

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HB 625 | Harris, Cody | PT Copay Parity Mandate - Primary Care

Companions:

HB 2988	Minjarez, Ina	(Refiled from 87R Session)
SB 939	Gutierrez, Roland (F)	(Refiled from 87R Session)

Remarks: SUMMARY: HB 625 prohibits an insurer or HMO from charging a higher copayment amount for a PT office visit than for a primary care physician office visit.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

POSITION STATEMENT: TAHP opposes this legislation because it restricts choice and competition in the health insurance market by creating government-set provider copays for the first time in Texas. Currently, Texas does not interfere in the benefit design of health plans when it comes to setting specific copay amounts for provider types, specific deductible requirements, or other out-of-pocket costs. Texas employers and families want a choice of benefit options, not one-size-fits-all health coverage.

Every Texan needs routine access to primary care to manage chronic conditions, treat routine illnesses, and stay healthy with regular checkups. Physical therapy is important but like numerous health care specialities, it’s not something every Texan needs routinely, like primary care. Texas doesn’t set copays for providers—for anything—so benefit designs vary widely and businesses and families can choose coverage that fits their needs with a menu of options. Health plans today offer numerous plan options with $0 or very low cost primary care both in person or through telehealth. If the state mandates PT to be covered at the same copay we can anticipate these low copay primary care options to end. The Texas legislature should not force this mandate on employers and individuals when they are exempting their personal health insurance and the insurance of their employees through ERS.

DATE UPDATED: 3/3/23 BH

3/07/23 hearing- Oppose, testimony (BH)

Bill History:
03-07-23 H Committee action pending House Insurance
03-14-23 H Voted favorably from committee on House Insurance
03-23-23 H Reported favorably from committee on House Insurance

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HB 633 | Frank, James | Lowest Contract Rate For Uninsured

Remarks:
SUMMARY: The bill provides that a physician or provider may not be prohibited from accepting directly from an enrollee full payment for a health care service in lieu of submitting a claim to the enrollee's health benefit plan. Notwithstanding section 552.003 or any other law, the charge for a health care service for which a physician or provider accepts a payment in lieu of submitting a claim to the enrollee's health benefit plan, or from a patient without insurance, may not exceed the lowest contract rate for the service allowable under any health benefit plan with which the physician or provider is in-network.

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial, ERS/TRS

EFFECTIVE DATES: 9/1/23

Bill History:
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform
03-23-23 H Meeting set for 8:00 A.M., E2.028 - House Select on Health Care Reform
03-23-23 H Committee action pending House Select on Health Care Reform

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HB 638 | Toth, Steve | Right to Try Chronic Rx - Not coverage mandate

Remarks:
SUMMARY: This bill would allow patients to access investigational drugs if they have severe chronic disease and the patient's physician has considered all treatment options approved by the FDA and determined that they are unlikely to provide relief. This bill does not create a new insurance mandate.

TAHP POSITION: Neutral as long as a coverage mandate is not added

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/3/23 JB

Bill History:
11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Public Health
04-17-23 H Meeting set for 8:00 A.M., JHR 120 - House Public Health

HB 647 Hinojosa, Gina Advance DNR Order - Pregnancy Directive

Companions: SB 2465 Eckhardt, Sarah (Identical)
3-23-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would allow individuals to specify in an advanced directive the effect that pregnancy has on the directive. Currently, a person may not withhold life-sustaining treatment of a pregnant person.

TAHP POSITION: Netural

EFFECTIVE DATES: 9/1/24

DATE UPDATED: 2/4 KS

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Public Health

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HB 652 Johnson, Julie Medicaid expansion

Companions: SB 195 Johnson, Nathan (Identical)
2-15-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Requires HHSC to request an 1115 waiver to implement the Live Well Texas program to assist individuals in obtaining health coverage through a program health benefit plan or health care financial assistance. The principal objective of the program is to provide primary and preventative health care through a high deductible program health benefit plans. Requires TDI to provide necessary assistance and monitor the quality of services by health plans. HHSC will select (through competitive bidding) health plan issuers licensed through TDI. Providers must be paid a rate at least equal to Medicare. People eligible for Medicaid are not eligible, and once a person is enrolled they must be disenrolled from Medicaid. Requires HHSC to develop and implement a "gateway to work" program under which HHSC must refer each participant who is unemployed or working less than 20 hours a week to available job search and job training programs.

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/11 by JL

Bill History: 11-14-22 H Filed
02-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 663 | Thierry, Shawn | Voluntary Maternal Mortality Reporting

Remarks: SUMMARY: Allows for voluntary and confidential reporting of pregnancy-associated deaths and pregnancy-related deaths. Establishes a work group to establish a secure maternal mortality and morbidity data registry and allows DSHS to establish rules for implementation. Requires a report on the establishment of the registry and any recommendations.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/13 by JL

3/27/23 hearing- Neutral

Bill History: 03-27-23 H Committee action pending House Public Health
04-03-23 H Voted favorably from committee on House Public Health
04-06-23 H Reported favorably from committee on House Public Health

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HB 687 | Cole, Sheryl | Expands Newborn Parent Coverage to 2 Mo.

Remarks: SUMMARY: This bill would extend the required coverage for newborn children of enrollees from 32 days to 61 days.

TAHP POSITION: Neutral

COVERAGE TYPES: Individual, small-employer, and large employer health plans.

EFFECTIVE DATES: D, I or R on or after 1/1/24

MANDATE: Coverage

DATE UPDATED: 2/1 KS

4/4/23 hearing- Neutral

Bill History: 04-04-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
04-04-23 H Committee action pending House Insurance
04-11-23 H Voted favorably from committee on House Insurance

HB 690 | Rosenthal, Jon | Community violence intervention

Companions: HB 1580 Rosenthal, Jon (Refiled from 87R Session)

Remarks: SUMMARY: Establishes the Office of Community Violence Intervention and Prevention at HHSC and allows the agency to establish rules to implement the program. The purpose is to coordinate and expand violence intervention and prevention activities, reduce the incidence of interpersonal violence and homicide, provide assistance to promote effective state and local efforts on reducing preventable injuries and deaths, collaborate with governmental entities and other relevant stakeholders, and award grants. Requires the Office to conduct a statewide public health campaign. Requires the Office to establish an award advisory committee.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 2, 2023

DATE UPDATED: 2/13 by JL

Bill History: 11-15-22 H Filed
02-23-23 H Introduced and referred to committee on House Public Health

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HB 700 | Oliverson, Tom | State Based Health Insurance Exchange

Companions: HB 2554 Oliverson, Tom (Identical)
3-13-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: This bill would create the Texas Health Insurance Exchange. It would be an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange, as authorized by the ACA. The exchange would have an eleven-member board, with five appointed by the governor, three by the lieutenant governor, and three by the governor from a list provided by the speaker. The board would employ an executive director and other necessary employees to assist the exchange in carrying out its functions. The board would not have any providers or issuers on it, but the board could create an advisory committee to allow for the involvement of health insurance industries and other stakeholders, which would provide recommendations to the board.

The exchange may provide an integrated uniform consumer directory of health care providers and which issuers the provider contracts with. The exchange could also establish methods for health

care providers to transmit relevant data, rather than an issuer.

Not later than July 1, 2024, the exchange would be required to make recommendations to the Senate Business and Commerce Committee and the House Insurance Committee regarding the feasibility of implementing a subsidy program for individuals, families, and small employers to purchase coverage. With the input and approval of those committees, the exchange may develop and implement the subsidy program. The board would also make recommendations on state innovation waivers to the Senate Business and Commerce Committee and House Health Insurance committee, including recommendations on risk stabilization, coverage arrangements for employees, financial assistance for different types of coverage, including non-qualified health plans, and the establishment of account-based premium credits. With the input and approval from the legislative committees, the exchange would be able to apply for necessary federal waivers.

For the purposes of the chapter, small employers would include entities that employ at least two and on average no more than 50 employees during the preceding calendar year until 2025, and then no more than 100 employees starting in 2026. That calculation would include part-time employees who are not eligible for coverage through the employer. The exchange may charge issuers an assessment of reasonable and necessary fees to cover the exchange's organizational and operating expenses. The exchange may also accept grants from a public or private organization and accept federal funds, but general revenue may not be appropriated for the exchange. Assessments, gifts or donations, and any federal funding would be stored in a trust fund outside the state treasury. The exchange would be required to provide a detailed financial report to the governor, the legislature, and HHSC not later than January 31 of each year.

TAHP POSITION: Neutral with changes to ensure market stability and state readiness.

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Immediately or 9/1/23, with rules adopted by 1/31/24

POSITION STATEMENT: Texas made substantial gains in increasing access to insurance coverage. The number of Texans with marketplace plans doubled in the last two years and 15 plans are offering coverage in Texas—a record number. Policies like a state-based exchange or 1332 coverage waiver could build on these successes but should not be implemented in a way that would create market instability, increase costs, or reduce competition and access.

The state should look for reforms in the insurance market that further reduce the uninsured and lower costs.

DATE UPDATED: 2/22 KS

3/30/23 hearing- Neutral, testimony

Bill History: 03-13-23 H Introduced and referred to committee on House Select on Health Care Reform
03-30-23 H Meeting set for 8:00 A.M. OR ADJ., E2.028 - House Select on Health Care Reform
03-30-23 H Committee action pending House Select on Health Care Reform

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HB 711 | Frank, James | Prohibits Anticompetitive Contracting

Remarks: SUMMARY: This bill would prohibit all-or-nothing, anti-steering, anti-tiering, most favored nation, and gag clauses in contracts with providers. It is similar to the NASHP model act, but it does not require submission of potential contracts to the Attorney General. The bill would also mandate that contracting entities that encourage enrollees to obtain services from a particular provider has a fiduciary duty to the enrollee to engage in that conduct only for the primary benefit of the enrollee.

TAHP POSITION: Support

COVERAGE TYPES: Commercial, ERS/TRS

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Prohibit anti-competitive contracting terms, such as all-or-nothing contracts, gag clauses, etc." Heavily consolidated hospital systems and private equity-backed physician groups use anti-competitive contracting terms to inflate prices. For example, in some instances health systems want to contract for physician services through the hospital in an “all or nothing” contract, which allows the hospital system to control the referral stream and avoid losing patients to lower-cost, non-hospital-affiliated providers. Health systems may also try to avoid competition through most-favored-nation contracts that restrict the ability of a health plan to bring other providers into the network. Rapid consolidation allows a hospital system to demand these anti-competitive contract terms.TAHP supports a state prohibition on anti-competitive contracting terms, such as all-or-nothing contracts, gag clauses, anti-tiering clauses, anti-steering clauses, and most-favored nation clauses.

DATE UPDATED: 2/3/23 JB, 2/12/23 BH

3/23/23 hearing- Support, card

Bill History: 03-23-23 H Committee action pending House Select on Health Care Reform
03-30-23 H Voted favorably from committee as substituted House Select on Health Care Reform
04-04-23 H Reported from committee as substituted House Select on Health Care Reform

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HB 724 Howard, Donna Provider licensure complaint reciprocity

Companions:

HB 3735	Howard, Donna	(Refiled from 87R Session)
SB 2115	Lucio, Eddie	(Refiled from 87R Session)
SB 161	Perry, Charles	(Identical)
	4-12-23 S Voted favorably from committee on Senate Health and Human Services	

Remarks: SUMMARY: Requires a licensing entity that receives a complaint regarding a provider who holds a license issued by a different licensing entity to forward the complaint to the appropriate licensing entity. Prohibits a licensing entity from taking disciplinary action against a provider who holds a license issued by a different licensing entity unless that licensing entity refers the complaint back to the licensing entity that received the complaint for investigation and resolution.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediately if it receives a two-thirds vote, otherwise Sept. 1, 2023

DATE UPDATED: 2/13 by JL

Bill History: 11-16-22 H Filed
02-28-23 H Introduced and referred to committee on House Public Health

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HB 728 Rose, Toni Interagency aging council

Remarks: SUMMARY: Establishes a statewide coordinating council to ensure a strategic approach to interagency aging services. The council must develop a 5-year strategic plan and an annual list of state-funded interagency aging programs and services with a description of how those programs and services further the purpose of the council's strategic plan.

TAHP POSITION: Support

EFFECTIVE DATE: Immediately if it receives a 2/3 vote, otherwise Sept. 1, 2023

DATE UPDATED: 3/9 by JL

3/14/23 hearing- Support, card

Bill History: 04-12-23 H Laid out for consideration in the House at 11:14am
04-12-23 H Passed (Vote: Y: 97/N: 47)
04-12-23 S Received in the Senate

HB 729 Rose, Toni Statewide IDD Coordinating Council

Companions: SB 524 West, Royce (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Establishes a statewide intellectual and developmental disability coordinating council to ensure a strategic approach for services. The council must develop a 5-year IDD strategic plan, publish available services and programs, and the number of individuals on the wait lists.

TAHP POSITION: Support

EFFECTIVE DATE: Effective immediately if it receives a 2/3 vote, otherwise Sept. 1, 2023

DATE UPDATED: 3/3 by JL

3/14/23 hearing- Support, card

Bill History: 04-05-23 H Passed (Vote: Y:108/N: 38)
04-05-23 S Received in the Senate
04-12-23 S Referred to Senate Committee on Senate Health and Human Services

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HB 733 Plesa, Mihaela Health literacy advisory committee

Companions: SB 76 Johnson, Nathan (Identical)
2-15-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Requires the Statewide Health Coordinating Council to establish an advisory committee on health literacy. The advisory committee must develop a long-range plan and update it every two years. Requires the advisory committee to include in the state plan strategies for improving health literacy that attain greater cost-effectiveness and better patient outcomes.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/13 by JL

Bill History:
11-16-22 H Filed
02-28-23 H Introduced and referred to committee on House Public Health

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HB 737 Walle, Armando Increases Minimum Wage

Companions:

HB 60	Reynolds, Ron	(Refiled from 87R Session)
HB 731	Gonzalez, Jessica	(Refiled from 87R Session)
HB 1917	Turner, Chris	(Refiled from 87R Session)
HB 4484	Walle, Armando	(Refiled from 87R Session)
HB 169	Reynolds, Ron	(Identical)
	2-23-23 H Introduced and referred to committee on House International Relations/Economic Dev	

Remarks:
SUMMARY: Establishes the minimum wage in Texas to be the greater of $15/hour or federal minimum wage. Applies to wages in private employment via a repealer.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/14 by JL

Bill History:
11-16-22 H Filed
02-28-23 H Introduced and referred to committee on House International Relations/Economic Dev

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HB 755 Johnson, Julie Limits PA to 1/Year Autoimmune/Chronic Mandate

Companions:

SB 1150	Menendez, Jose	(Identical)
	3- 9-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:
SUMMARY: This bill would prohibit issuers that provide prescription drug benefits from requiring more than one preauthorization annually for a drug prescribed to treat a chronic or autoimmune disease.

TAHP POSITION: Neutral with CS

COVERAGE TYPES: Commercial, CC, ERS/TRS

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to

ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and appropriate care. Health plans have a comprehensive view of a patient's medication history. That view plus the use of prior authorizations allows health plans to prevent dangerous drug interactions, especially when patients have multiple prescribers. Related legislation focusing on severely restricting PAs from the prior legislative session created a fiscal note of $169 million for TRS & ERS alone. Prior authorizations for prescription drugs are safety checks for appropriateness and patient risk based on FDA guidelines and medical guardrails. For example, in response to concerns about the number of low-income Texas kids being prescribed dangerous antipsychotic drugs like Seroquel and Risperdal — medications that can have serious side effects in children — in 2011, Medicaid begin requiring prescribing doctors to receive a prior authorization from the state to protect those children. Accutane, a common medication for chronic acne, can cause birth defects and should never be used in pregnant women. Prior authorization safety checks can flag these issues and protect patients, however, moving to a single annual prior authorization for all chronic conditions would put patients at risk of missed drug interactions and other safety concerns. Prior authorizations for prescription drugs protect patients from opioid abuse and severe drug interactions or reactions. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors. These adverse drug events (ADEs) account for more than 3.5 million physician office visits and 1 million emergency department visits each year.

Texas also has some of the strongest patient protections for PAs. Prior authorizations are required to be:

Evidence based: All prior authorization criteria must be based on evidence-based care developed and adopted by the medical community

Heavily regulated: Each step of the process is regulated, starting with TDI licensure or certification as a Utilization Review (UR) Agent

Reviewed quickly: Most prior authorizations are required to be processed in Texas within 3 calendar days—some of the shortest time fram es in the country

Transparent: All prior authorization requirements are required to be transparent and posted on health plan websites

Appealable : Providing extensive rights to appeal to an independent physician

LAST UPDATED: BH 2/20

3/28/23 hearing- Oppose, testimony

Bill History:
03-28-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-28-23 H Committee action pending House Insurance
04-04-23 H Voted favorably from committee as substituted House Insurance

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A HB 756 Johnson, Julie Mandates 24/7 Telephone Access for PAs/UR

Companions: SB 1149 Menendez, Jose (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill expands the hours during which issuers must have appropriate personnel available to receive requests for payment verification and requests for preauthorization to 24 hours a day and 365 days a year, including weekends and legal holidays. Currently, issuers must have personnel available 6am to 6pm, Monday through Friday, and 9am to 12pm on weekends and holidays, and outside of those hours be able to respond to requests within 24 hours.

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 1/19/23

TAHP POSITION: Requiring Texas health plans to have personnel available for prior authorization and payment verification requests 24/7, including weekends and holidays, has several negative consequences. Requiring 24/7 availability for prior authorization and payment verification responses is inconsistent with provider availability and creates unnecessary and costly administrative burden. For example, one of the state's largest health plans received just 6% of PA requests after regular business hours (including holidays) in 2022, showing there is very little demand for after-hours verification. Additionally, Texas already has some of the shortest prior authorization time frames in the country, with a requirement that they be processed in less than 3 calendar days compared to most states' 14 days. Furthermore, Texas already has the

broadest exemptions to prior authorization in the country, including "gold-carding," which exempts providers with a history of safe and appropriate care. Hospitals and providers also do not staff utilization review after hours.

Moreover, there is no evidence to suggest that this requirement would improve patient outcomes or reduce healthcare costs, making it a potentially unnecessary burden on the healthcare system. Instead, a better solution would be to follow the federal government's recommended reforms to implement electronic prior authorizations, which could reduce costs and streamline the process, making it easier for providers to obtain necessary approvals. For pharmacy authorizations, around 60% of new prior authorizations are already received electronically, suggesting that there may be limited additional value in requiring health plans to have a 24/7 phone line for receiving new authorizations. By requiring the use of electronic prior authorizations, Texas could stay up to date with current best practices and provide a more effective and efficient prior authorization system for patients and providers. This approach could improve the overall quality and availability of healthcare in the state while reducing costs for both health plans and patients.

DATE UPDATED: 2/21 KS

Bill History: 11-17-22 H Filed
02-28-23 H Introduced and referred to committee on House Insurance

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HB 757 Johnson, Julie No PA for several mandated benefits

Remarks: SUMMARY: Prohibits preauthorization requirements for several mandated benefits: low-dose mammography; reconstruction of a breast incident to mastectomy; minimum inpatient care following a mastectomy or lymph node dissection for the treatment of breast cancer; diabetes equipment, supplies, or self-management training; bone mass measurement; and colorectal cancer screenings.

TAHP POSITION: Oppose

COVERAGE TYPES: Mostly commercial, but other types depending on what the underlying mandate applies to.

EFFECTIVE DATES: D, I, or R after 1/1/24

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already

has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and appropriate care. Prior authorization helps prevent fraud, waste, and abuse. As much as $800 billion is wasted on excessive and unnecessary testing and treatment every year and 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary. This legislation threatens that assurance for patients for numerous tests and treatments including bone mass density scans as an example. This test has been the subject of significant overuse and fraud directed at encouraging patients to take expensive medications. Medical experts now reject the screenings for many individuals noting that the test is a poor indicator of fractures. Under HB 757, medical necessity could be undermined by removing all prior authorization. Some experts estimate that at least $200 billion is wasted annually on excessive testing and treatment.

Texas also has some of the strongest patient protections for PAs. Prior authorizations are required to be:

Evidence based: All prior authorization criteria must be based on evidence-based care developed and adopted by the medical community

Heavily regulated: Each step of the process is regulated, starting with TDI licensure or certification as a Utilization Review (UR) Agent

Reviewed quickly: Most prior authorizations are required to be processed in Texas within 3 calendar days—some of the shortest time frames in the country

Transparent: All prior authorization requirements are required to be transparent and posted on health plan websites

Appealable : Providing extensive rights to appeal to an independent physician

DATE UPDATED: 2/19/23 BH

Bill History:
11-17-22 H Filed
02-28-23 H Introduced and referred to committee on House Insurance

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HB 790 Patterson, Jare Workers Comp Claims Mandates

Remarks: SUMMARY: This bill would place new requirements on workers compensation carriers, such as requiring them to provide a reason when contesting a claim,

prohibiting denials after 60 days, and making the carrier liable to the employee if an administrative law judge finds that a denial was inappropriate.

TAHP POSITION: Neutral

COVERAGE TYPES: Worker's Comp

EFFECTIVE DATES: Immediately or 9/1/23

DATE UPDATED: 2/4 KS

Bill History:
03-20-23 H Meeting set for 10:00 A.M., E2.012 - House Business and Industry
03-20-23 H Committee action pending House Business and Industry
04-05-23 H Voted favorably from committee as substituted House Business and Industry

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HB 814 Thierry, Shawn Opioid Warning Label

Companions: HB 849 Thierry, Shawn (Refiled from 87R Session)

Remarks: SUMMARY: Prohibits pharmacists from dispensing an opioid without providing, receiving, and maintaining an acknowledgment form providing a warning about the risks of opioid addiction and overdose. Requires the Board to adopt by rules an acknowledgment form to be signed on receipt of an opioid that must include language substantially similar to "WARNING: THIS DRUG IS AN OPIOID. THE USE OF AN OPIOID MAY RESULT IN ADDICTION TO OPIOIDS AND DEATH," in all capital letters and printed in 14-point font.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED:2/3/23 JB

Bill History:
11-29-22 H Filed
03-01-23 H Introduced and referred to committee on House Public Health

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HB 815 Thierry, Shawn Red Cap Opioid Safety Act

Remarks: SUMMARY: "Red Cap Opioid Safety Act" - Requires pharmacists to dispense opioids in "distinctive packaging" (a bottle with a distinctive red cap or a container with a conspicuous red label).

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

Bill History:
11-29-22 H Filed
03-01-23 H Introduced and referred to committee on House Public Health

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(A) HB 826 Lambert, Stan Permanent Formulary Freeze Mandate

Companions:

HB 1646	Lambert, Stan	(Refiled from 87R Session)
SB 1142	Zaffirini, Judith	(Refiled from 87R Session)
SB 1221	Zaffirini, Judith	(Identical)
	3- 9-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:
SUMMARY: This bill would prohibit a health plan from ever making any change to a patient's benefits for a drug they are taking. This means a health plan cannot even increase the copay amount by $5 or reduce the maximum drug coverage amount by $5, even at the annual renewal of the benefit plan, and even if the drug has been replaced on the health plan's formulary by a better or lower-priced drug. This mandate is referred to as a "permanent formulary freeze." This formulary freeze would apply to any enrollee taking a drug if: (1) the enrollee was covered by the benefit plan preceding the renewal date, (2) a physician or other prescribing provider prescribes the drug for the medical condition or mental illness, and (3) the physician or other prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment. The bill also expands notice requirements for modifying drug coverage to include a statement explaining the type of modification and indicating that, on renewal of the benefit plan, the issuer may not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year (formulary freeze).

TAHP POSITION: Oppose

COVERAGE TYPE: Commercial, Exempts ERS and TRS

EFFECTIVE DATES: D, I, R 1/1/24

TAHP POSITION STATEMENT: TAHP is opposed to any new government mandate that permanently freezes health plan formularies and undermines important efforts by health plans to negotiate lower drug prices, ultimately driving up the cost of coverage for Texas employers, families, and taxpayers.

Texas already leads the nation with the strongest patient protections against non-medical switching and step therapy. For example, Texas has a one year

formulary freeze law that only two other states have. That means that when an expensive name brand drug has a lower cost competitor enter the market, health plans are not allowed to update the formulary to reflect this cost savings for a full year. That's the case now in 2023 with the launch of new biosimilar alternatives to the very expensive rheumatoid arthritis drug Humira. Further, Texas has the most extensive step therapy protections in the nation. A physician can simply document that a patient is stable on a drug and the patient can't be taken off by step therapy protocols, even if they change insurers. Under this proposal, the formulary would be permanently frozen if any patient is on a particular drug. This is an unprecedented, costly, and unworkable mandate. Under a permanent "formulary freeze," plans cannot replace drugs with new clinically appropriate and more affordable alternatives. Instead, plans will have to continue coverage of a drug, at the same copay or coinsurance level, even if the price increases or if a more affordable, more effective, or even safer option comes out. An insurer couldn't make a change as simple as a $5 copay increase on brand-name drugs in between plan years. Pharma stands to gain from a formulary freeze because once they have a patient on a drug, they'll be immune from competition from lower cost alternatives and any pressure to lower the price of that drug. Employers and families paying premiums would see increased costs of $481 million over $5 years. Certain city employee estimates include San Antonio with an additional $3 million in drug spending and $2 million for Dallas employees. TRS would owe $70 million more per year if the bill were applied to the program.

New mandates and overregulation hinder innovation, increase costs, and often provide no additional value for Texans and Texas employers. Employers and families bear the additional expense through increasingly unaffordable premiums. This is particularly true for small employers who have limited resources to absorb added costs. Moreover, families face increasingly unaffordable premiums as a result of overregulation.

Texas is already one of the most heavily regulated states when it comes to health care, ranking third in the nation for regulations that go beyond the federal requirements of the Affordable Care Act (ACA). As a result, small business owners in Texas consistently rank the cost of health insurance as their single biggest problem since 1986. Additionally, approximately three-quarters of Texas employers oppose legislative mandates that interfere with how they design employee benefits. Instead, they want more flexibility to contain costs and provide the best coverage for their employees.

Furthermore, TAHP opposes expensive mandates like this that raise costs for employers and families but do not apply to elected officials' personal health insurance and their employees' coverage through ERS. Texas legislators should not force costly regulations and mandates on employees and families when they are not willing to pay for it with their personal coverage.

DATE UPDATED: 2/3/23 BH

Bill History:
11-29-22 H Filed
03-01-23 H Introduced and referred to committee on House Insurance

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HB 831 Johnson, Julie Prohibition insurance discrimination

Companions:

HB 1111	Johnson, Julie	(Refiled from 87R Session)

Remarks:
SUMMARY:HB 831 adds sexual orientation and gender identity or expression to prohibited insurance discrimination provisions.

TAHP POSITION: Neutral

COVERAGE TYPES: commercial

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED:2/3/23 JB

Bill History:
11-30-22 H Filed
03-01-23 H Introduced and referred to committee on House Insurance

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HB 838 Gonzalez, Jessi Expands Fertilization Donors

Companions:

HB 2310	Gonzalez, Jessica	(Refiled from 87R Session)
SB 676	Johnson, Nathan	(Identical)
	2-17-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:
SUMMARY: HB 838 expands the current in vitro mandate to repeal the requirement that the fertilization or attempted fertilization of the patient's oocytes be made only with the sperm of the patient's spouse and to reduce the required history of infertility from at least 5 continuous years' duration to 3 (or caused by certain listed conditions that are not amended).

TAHP POSITION: Neutral

COVERAGE TYPES: Group (commercial) plans

EFFECTIVE DATES: D, I, or R on or after 1/1/24

MANDATE: Benefit

DATE UPDATED: 2/1 KS

Bill History:
12-01-22 H Filed
03-01-23 H Introduced and referred to committee on House Insurance
04-18-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance

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A HB 839 Gonzalez, Jessi No PA mandate for infectious diseases

Remarks:
SUMMARY: This bill would prohibit plan issuers that provide prescription drug benefits from requiring an enrollee to receive a prior authorization for a drug prescribed to treat infectious disease.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC, ERS/TRS, Medicaid/CHIP

EFFECTIVE DATES: D, I, or R on or after 1/1/24

MANDATE: Plan Design

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and appropriate care. Health plans have a comprehensive view of a patient's medication history. That view plus the use of prior authorizations allows health plans to prevent dangerous drug interactions, especially when patients have multiple prescribers. Prior authorization helps prevent fraud, waste, and abuse. As much as $800 billion is wasted on excessive and unnecessary testing and treatment every year and 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary.

Texas also has some of the strongest patient protections for PAs. Prior authorizations are required to be:

Evidence based: All prior authorization criteria must be based on evidence-based care developed and adopted by the medical community

Heavily regulated: Each step of the process is regulated, starting with TDI licensure or certification as a Utilization Review (UR) Agent

Reviewed quickly: Most prior authorizations are required to be processed in Texas within 3 calendar days—some of the shortest time frames in the country

Transparent: All prior authorization requirements are required to be transparent and posted on health plan websites

Appealable : Providing extensive rights to appeal to an independent physician

DATE UPDATED: 2/1 KS

Bill History: 12-01-22 H Filed
03-01-23 H Introduced and referred to committee on House Insurance

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HB 840 | Gates, Gary | ERS Bundled-Pricing Program

Remarks: SUMMARY: This bill would create a bundled-pricing program within ERS. The program would contract with providers at a consolidated rate for surgical procedures. The consolidated rate would include all fees related to the procedure, including laboratory, anesthesia, and pharmacy services. The board would contract with a TPA to implement the program, and the enrollee would not be responsible for cost-sharing.

TAHP POSITION: Neutral

COVERAGE TYPES: ERS

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/4 KS

Bill History: 12-01-22 H Filed
03-01-23 H Introduced and referred to committee on House Pensions/Investments/Financial Services

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HB 895 | Munoz, Sergio | Prohibits Extrapolation for FWA audits

Companions:

SB 519	Schwertner, Charles	(Refiled from 87R Session)
SB 1141	Schwertner, Charles	(Identical)
	3- 9-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: HB 895 creates a new government mandate that prohibits an HMO or insurer from using extrapolation to complete an audit of a network

physician or provider. The bill requires that any additional payment due a network physician or provider or any refund due the HMO or insurer must be based on the actual overpayment or underpayment and may not be based on an extrapolation. "Extrapolation" means a mathematical process or technique used by an HMO or insurer in the audit of a network physician or provider to estimate audit results or findings for a larger batch or group of claims not reviewed by the HMO or insurer.

TAHP POSITION: Oppose

COVERAGE TYPES: HMOs and insurers (EPO/PPO)

EFFECTIVE DATES: Delivered, issued for delivery, or renewed after 1/1/24

MANDATE: Administrative

TAHP POSITION STATEMENT: Health plans should be allowed to use extrapolation as a method to review medical claims for fraud, waste, and abuse because it is a powerful tool that allows them to identify potentially fraudulent or abusive billing patterns in a more efficient and cost-effective way. Extrapolation involves analyzing a sample of medical claims to estimate the prevalence of fraud, waste, and abuse across an entire population of claims. This can help health plans detect and prevent fraudulent activities on a larger scale, reducing the burden of fraudulent claims on the healthcare system as a whole. Furthermore, if extrapolation is considered an effective tool to give a provider an exemption from all prior authorizations (gold carding), it should also be considered an effective tool to review fraud, waste, and abuse.

DATE UPDATED: 2/19

3/28/23 hearing- Oppose, testimony

Bill History:
03-28-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-28-23 H Committee action pending House Insurance
04-04-23 H Voted favorably from committee on House Insurance

A HB 901 Klick, Stephani Support nursing- postsecondary education

Companions: SB 244 Kolkhorst, Lois (Identical)
2-15-23 S Introduced and referred to committee on Senate Subcommittee on Higher Education

Remarks: SUMMARY: This bill would repeal references to the nursing matching fund program. It would also allow

part-time faculty to access the nursing faculty loan repayment program. Finally, the bill would extend the date through which innovation grants shall go to nursing programs from 2023 to 2027.

TAHP POSITION: Support

COVERAGE TYPES:

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/20 KS

Bill History:

12-07-22 H Filed
03-02-23 H Introduced and referred to committee on House Higher Education

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HB 916 Ordaz, Claudia 12 month contraceptive mandate

Companions:

HB 2651	Gonzalez, Jessica	(Refiled from 87R Session)
SB 807	Paxton, Angela	(Identical)
	3- 1-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:

SUMMARY: Requires a health plan with benefits for a prescription contraceptive drug to provide: (1) a three-month supply of the covered drug at one time the first time the enrollee obtains the drug; and (2) a 12-month supply of the covered drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the health plan the first time she obtained the drug. An enrollee may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Benefit

DATE UPDATED: 3/24 by JL

3/14/23 hearing - neutral

Bill History:

03-21-23 H Voted favorably from committee on House Insurance
04-05-23 H Reported favorably from committee on House Insurance
04-17-23 H Set on the House Calendar

HB 932 | Dutton, Harold | Medicaid expansion

Companions:

HB 1189	Dutton, Harold	(Refiled from 87R Session)
HB 3962	Morales, Eddie	(Identical)
	3-20-23 H Introduced and referred to committee on House Select on Health Care Reform	

Remarks:

SUMMARY: Expands Medicaid eligibility to include the working parent of a dependent child who applies for the assistance, and for whom federal matching money is available.

TAHP POSITION: Neutral

COVERAGE: Medicaid

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

Bill History:

12-08-22 H Filed
03-02-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 999 | Price, Four | Co-Pay Accumulator Prohibition Mandate

Companions:

SB 1576	Schwertner, Charles	(Identical)
	3-16-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:

SUMMARY: HB 999 creates a new contract mandate that prohibits plans from using co-pay accumulators. The bill requires health plans and PBMs to apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's applicable deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum.

TAHP POSITION: Negotiating. TAHP will be neutral if bill author accepts addition of "therapeutic alternative"as an exception.

COVERAGE TYPES: Commercial

EFFECTIVE DATES: D, I, or R after 1/1/24

MANDATE: Contract

TAHP POSITION STATEMENT: Generic medications save Americans more than $300 billion per year. In order to control costs for employers and families, health plans steer patients to affordable generic options through lower out-of-pocket costs. That’s a problem for drug companies whose primary goal is

to keep patients hooked on higher cost brand name drugs. Copay coupons are utilized by drug manufacturers to encourage the use of expensive brand name drugs over cheaper generics, biosimilars, or therapeutic alternatives. Through coupons, a manufacturer aims to pay off the patient's out-of-pocket costs to encourage them to avoid lower cost alternatives and choose a brand name drug. Health insurers respond by only counting actual patient payments, not coupons, to the patient's out-of-pocket limits. The bill would allow health plans to continue this practice when a generic or biosimilar is available, however, the bill needs clarification to include "therapeutic alternatives" to high cost brand drugs.

DATE UPDATED: 1/19/23 (KS), 2/12/23

3/23/23 hearing- Neutral

Bill History:
03-23-23 H Committee action pending House Select on Health Care Reform
03-30-23 H Voted favorably from committee as substituted House Select on Health Care Reform
04-04-23 H Reported from committee as substituted House Select on Health Care Reform

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A HB 1001 Capriglione, Gi Mandate-lite coverage - consumer choice

Companions: SB 605 Springer, Drew (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:
SUMMARY: This bill would remove mandates on consumer choice benefit plans that exceed what is required by federal law or required under the Employees Retirement System group benefits plan.

TAHP POSITION: Support

COVERAGE TYPES: Commercial

EFFECTIVE DATES:D, I, R 1/1/24

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Establish new alternative coverage option that allows insurers to offer 'Consumer Choice' plans that forego certain state-imposed regulations and mandates." Texas should build more affordable insurance coverage options that avoid over-regulation and excessive mandates. New health care products added last session avoid government mandates and provide more choices for some Texans. n the past, Texans had mandate-lite insurance options through the Consumer Choice of Benefits model, but that's been

eroded by a continuous stream of new mandates over two decades. Updated "Consumer Choice" plans would be similar to new affordable alternatives established through the Farm Bureau and Texas Mutual, but there are a few key differences. These plans would still be considered insurance under state law, meaning that they would be required to meet solvency requirements, be subject to TDI oversight, and meet federal benefit and coverage requirements like pre-existing conditions protections and medical loss ratio rules required by the Affordable Care Act. Additionally, HB 1001 indicates that these plans must also meet any requirements imposed on the coverage elected officials and state employees have through ERS.

3/16/23 hearing- Support, testimony (JD)

Bill History:
03-02-23 H Introduced and referred to committee on House Select on Health Care Reform
03-16-23 H Meeting set for 8:00 A.M., E2.028 - House Select on Health Care Reform
03-16-23 H Committee action pending House Select on Health Care Reform

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HB 1026 Gervin-Hawkins, Hair prosthesis mandate

Remarks:
SUMMARY: Creates a new mandated benefit for a hair prosthesis for an enrollee who is undergoing or has undergone medical treatment for cancer, determined by the treating physician. The benefit amount is $100 for a new prosthesis, or for repair or replacement.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial and Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Unfunded commercial mandate

TAHP POSITION STATEMENT: This bill creates a new unfunded benefit mandate for hair prostheses. These types of mandates add coverage requirements that go beyond the purpose of health insurance and instead mandate coverage for items that are not medical treatments. Numerous non-profit organizations offer free or low cost hair prosthesis for low income patients receiving treatment for cancer or other illnesses.

DATE UPDATED: 2/12/23 BH

Bill History:
12-16-22 H Filed
03-02-23 H Introduced and referred to committee on House Insurance

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HB 1032 Noble, Candy Prohibited vaccination status discrimination

Remarks: SUMMARY:This bill would prohibit group health benefit plan issuers from taking any action that would adversely affect an individual's eligibility for coverage based on COVID-19 vaccination status.

TAHP POSITION: Reviewing

COVERAGE TYPES: Commercial, ERS/TRS, CC, Medicaid.

EFFECTIVE DATES:D, I, R 1/1/24

MANDATE: Coverage

Bill History: 12-19-22 H Filed
03-02-23 H Introduced and referred to committee on House State Affairs

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HB 1050 Hinojosa, Gina Authority pharmacists dispense some drugs

Remarks: SUMMARY: This bill would allow physicians to issue protocols allowing pharmacists to dispense self-administered hormonal contraceptives to patients over 18.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/4 KS

Bill History: 12-19-22 H Filed
03-02-23 H Introduced and referred to committee on House Public Health

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HB 1060 Guerra, Bobby Telehealth at certain schools

Companions: SB 662 Lamantia, Morgan (F) (Identical)
3-28-23 S Removed from hearing 03/29/23, Senate Education

Remarks: SUMMARY: This bill would require any school district that does not have a full-time school nurse to implement a telehealth services program at each campus in the district. The services would be provided for free, and would require consent of the parent or guardian. The bill would also create a task force to study and evaluate telehealth service programs.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediately if it receives a 2/3 vote or Sept. 1, 2023

DATE UPDATED: 2/13 KS

Bill History: 12-20-22 H Filed
03-02-23 H Introduced and referred to committee on House Public Education

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HB 1062 Guerra, Bobby Medicaid expansion

Companions:

HB 2903	Martinez Fischer, Trey 3-14-23 H Introduced and referred to committee on House Select on Health Care Reform	(Identical)
SB 125	Alvarado, Carol 2-15-23 S Introduced and referred to committee on Senate Health and Human Services	(Identical)

Remarks: SUMMARY: Expands Medicaid to all individuals eligible under the ACA. TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/3

Bill History: 12-20-22 H Filed
03-02-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 1073 Hull, Lacey Value Based Payment Reform - Capitated Payment

Companions:

SB 1135	Schwertner, Charles 4-12-23 S Committee action pending Senate Health and Human Services	(Identical)

Remarks: SUMMARY:This bill would clarify that self-funded health benefit plans that enter into value-based risk sharing arrangements are not engaged in the business of insurance for the purposes of state law. It would also allow PPO/EPO plans to enter into risk-sharing and capitation arrangements.

TAHP POSITION: Support

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Immediate or 9/1/23

POSITION STATEMENT: Health care is rapidly moving towards capitated value-based care arrangements like advanced primary care and direct primary care, where providers take on the risk of caring for patients for a set monthly fee. These models are quickly gaining traction for employees, employers, and doctors. For example, more than 80% of employees say they would sign up for an all-inclusive direct primary care plan if given the option. However, as these models evolve, Texas law, written decades

ago, limits payment and benefit design. HMOs are the only type of health plan in Texas that can partner with doctors for risk-based, value-based payments. Unfortunately, PPO plans and EPO plans cannot pay a primary care doctor a flat, monthly payment for risk-based direct primary care or advanced primary care. Under current law, Health Maintenance Organizations (HMOs) are expressly allowed to make capitated payments. However, that same language does not appear in the Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) chapter of the Insurance Code. TAHP worked with the Primary Care Consortium to identify policies of shared interest that can make a positive difference in health care payment and delivery innovation. The Consortium endorsed this concept and TAHP supports removing barriers to value-based care.

DATE UPDATED: BH 2/21

4/4/23 hearing- Support, testified

Bill History:

04-04-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
04-04-23 H Committee action pending House Insurance
04-13-23 H Voted favorably from committee as substituted House Insurance

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A HB 1105 Price, Four Pharmacist Vaccination Authority

Companions:

SB 749 Flores, Pete (Identical)
3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:

SUMMARY: This bill would broaden pharmacists' vaccination authority in various ways, including by allowing them to provide immunizations and vaccinations to patients younger than three, but only if they are referred by a physician.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

Bill History:

12-22-22 H Filed
03-02-23 H Introduced and referred to committee on House Public Health
04-17-23 H Meeting set for 8:00 A.M., JHR 120 - House Public Health

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A HB 1111 Meza, Terry Autism study

Companions:	HB 4058	Meza, Terry	(Refiled from 87R Session)

Remarks:

SUMMARY: Requires HHSC to conduct a cost-benefit analysis comparing the cost to the state of providing applied behavior analysis services to children with autism with the effectiveness of the services. Report due Sept. 1, 2024.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/17 by JL

Bill History:

12-27-22 H Filed
03-02-23 H Introduced and referred to committee on House Human Services

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A HB 1128 Martinez Fische Affordable Care Act Guaranteed Issue

Companions:	HB 1529	Martinez Fischer, Trey	(Refiled from 87R Session)

Remarks:

SUMMARY: HB 1128 requires health plans in the market to guarantee issue for group and Individual coverage but may restrict Individual guaranteed enrollment to annual and special enrollment periods designated by TDI rules. Rules must be consistent with the ACA. The bill prohibits any restrictions, limitations, or price impact for pre-existing conditions. Health plans may not use a benefit design that will have the effect of discouraging the enrollment of individuals with significant health need. Health plans may appropriately utilize reasonable medical management techniques. The bill requires commercial Individual and SG (except grandfathered plans), CCPs, ERS, and Medicaid/CHIP to provide the ten essential health benefits (EHBs) listed in the ACA. TDI rules must be consistent with the ACA.

TAHP POSITION: Neutral with concerns

COVERAGE TYPES: MEWA, CC, SG, LG, I

EFFECTIVE DATES:D, I, R 1/1/24

MANDATE: Coverage

TAHP POSITION STATEMENT: TAHP is supportive of preexisting condition protections so long as they are coupled with continuous coverage requirements for Individual coverage. The position of health insurance providers is clear: Every Texan deserves affordable, comprehensive coverage—regardless of their income, health status or preexisting conditions. No one should be denied or priced out of affordable

coverage because of their health status. However, we are concerned with some provisions in HB 1128, including allowing the Insurance Commissioner to unilaterally establish special enrollment periods and the language that that Sec. 1511.151 may not be construed to prevent a health benefit plan issuer "from appropriately utilizing reasonable medical management techniques" - the bill should allow medical management in accordance with the Insurance Code .

Bill History: 12-29-22 H Filed
03-02-23 H Introduced and referred to committee on House Insurance

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A HB 1129 Martinez Fische Health insurance risk pool

Companions: HB 3851 Martinez Fischer, Trey (Refiled from 87R Session)

Remarks: SUMMARY:HB 1129 requires TDI to apply for a section 1312 federal waiver (for reinsurance) and implement a state plan meeting the requirements of the waiver if granted. To the extent that federal money is available and the is waiver is granted, TDI must: (1) apply for federal money; (2) use federal money to establish a pool; and (3) authorize the board to use the federal money to administer a pool. The purpose of the pool is to provide a reinsurance mechanism to: (1) meaningfully reduce health plan premiums in the individual market by mitigating the impact of high-risk individuals on rates; (2) maximize available federal money to assist residents of this state to obtain guaranteed issue health benefit coverage without increasing the federal deficit; and (3) increase enrollment in guaranteed issue, individual market health plans that provide benefits and coverage and cost-sharing protections against out-of-pocket costs comparable to and as comprehensive as health benefit plans that would be available without the pool.

Subject to any requirements to obtain federal money, the board may use pool money to achieve lower premiums by establishing a reinsurance mechanism for health plan issuers writing comprehensive, guaranteed issue coverage in the individual market. The board must use pool money to increase enrollment in guaranteed issue coverage in the individual market in a manner ensuring that the benefits and cost-sharing protections available in the individual market are maintained in the same manner as without the waiver. The Pool board may contract for administration and may exercise the legal authority of a reinsurer. The board must file annual reports with the Gov, Lt. Gov and Speaker.

Assessments: The Pool board may assess health plan issuers, including th rough advance interim assessments, "as reasonable and necessary for the pool's organizational and interim operating expenses." The pool board will recover an amount equal to the funding required by assessing each health plan issuer an amount determined annually based on information in annual statements, annual reports to the board, and any other reports filed with the board. The board will use the total number of enrolled individuals reported by all health plan issuers under as of the preceding December 31 to compute the amount of an issuer's assessment, if any. It will allocate the total amount to be assessed based on the total number of enrolled individuals covered by excess loss, stop-loss, or reinsurance policies and on the total number of other enrolled individuals as determined under Section 1511.0252.

To compute the amount of an issuer's assessment: (1) for the issuer's enrolled individuals covered by an excess loss, stop-loss, or reinsurance policy, the board shall: (A) divide the allocated amount to be assessed by the total number of enrolled individuals covered by excess loss, stop-loss, or reinsurance policies, to determine the per capita amount; and (B) multiply the number of an issuer's enrolled individuals covered by an excess loss, stop-loss, or reinsurance policy by the per capita amount to determine the amount assessed to that issuer; and (2) for the issuer's enrolled individuals not covered by excess loss, stop-loss, or reinsurance policies, the board will, using the gross plan premiums reported for the preceding calendar year by issuers: (A) divide the gross premium collected by an issuer by the gross premium collected by all issuers; and (B) multiply the allocated amount to be assessed by the fraction computed under (A) to determine the amount assessed to that issuer. Issuers will be required to report annually on the number of Texas-resident enrollees under Individual or employer group plans. For reinsurance providers, issuers must include each employee for whom a premium is paid and coverage is provided under an excess loss, stop-loss, or reinsurance policy issued to an employer or group plan providing coverage for Texas employees. An issuer providing excess loss insurance, stop-loss insurance, or reinsurance for a primary health plan issuer may not report individuals reported by the primary plan issuer. Ten employees covered by an issuer under a policy of excess loss insurance, stop-loss insurance, or reinsurance count as one employee for purposes of determining that issuer's assessment. In determining the number of individuals to report, the issuer excludes dependents of the policyholder or subscriber, Med Supp enrollees, and individuals who are retired employees age 65 or older.

Assessments do not apply to Small Employer benefit plans.

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES:Immediate or 9/1/23

MANDATE: Assessment

TAHP POSITION STATEMENT:TAHP supports expansion of access to quality health coverage but we believe this responsibility should be shared and not placed solely on health insurers and health plans through assessments. Such assessments are a hidden tax on Texas employers.

Bill History: 12-29-22 H Filed
03-02-23 H Introduced and referred to committee on House Insurance

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A HB 1144 Reynolds, Ron Medicaid block grant - Expansion

Companions: HB 922 Reynolds, Ron (Refiled from 87R Session)

Remarks: SUMMARY: Establishes a future mechanism for a block grant funding for Medicaid, which would allow for Medicaid eligible individuals to use subsidies to purchase insurance on the Marketplace. Would allow for any health plan to participate as a managed care plan and establish minimum coverage requirements. Requires a reform of long-term services and supports (limited guidance). Requires HHSC and TDI to implement a program that helps connect low-income Texans with health benefit plan coverage through private market solutions. Requires HHSC to develop and implement customized benefits packages designed to prevent the overutilization of services for individuals receiving home and community-based services. Creates a demonstration project for dually eligible individuals to receive long-term services and supports under both Medicaid and Medicare through a single managed care plan. Requires HHSC to provide housing payment assistance for recipients receiving home and community-based services and supports. Grants rulemaking authority to HHSC for implementation.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/1 by JL

Bill History: 12-29-22 H Filed
03-02-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 1164 Gervin-Hawkins, Hair prosthesis mandate

Remarks: SUMMARY: Creates a new mandated benefit for a hair prosthesis for an enrollee who is undergoing or has undergone medical treatment for breast cancer specifically, determined by the treating physician. The benefit amount is $100 for a new prosthesis, or for repair or replacement.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial and Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Unfunded commercial mandate

TAHP POSITION STATEMENT: This bill creates a new unfunded benefit mandate for hair prostheses. These types of mandates add coverage requirements that go beyond the purpose of health insurance and instead mandate coverage for items that are not medical treatments. Numerous non-profit organizations offer free or low cost hair prosthesis for low income patients receiving treatment for cancer or other illnesses.

DATE UPDATED: 1/16 by JL, 2/12/23

Bill History: 01-03-23 H Filed
03-02-23 H Introduced and referred to committee on House Insurance

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HB 1185 Dean, Jay Pediatric long-term care access program

Companions: SB 746 Hughes, Bryan (Identical)
3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Authorizes Upshur County to collect a mandatory payment from each pediatric long-term care facility in the county to be deposited in a local pediatric long-term care access assurance fund. HB 1185 is specific to Truman Smith. Truman Smith cares for about 100 children of Texas who have the highest skilled nursing needs that cannot be cared for at home or in other settings. HB 1185 would provide state authorization for a Medicaid funding mechanism that is available under federal law, but needs both state and local authorization. In 2019, Texas provided authorized for hospitals in any county that wanted to take advantage: HB 4289 (86R). But

that authorization was only for hospitals, not skilled nursing or other medical facilities.

TAHP POSITION: Neutral

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

DATE UPDATED: 1/22 by JL

Bill History:
03-02-23 H Introduced and referred to committee on House Human Services
03-28-23 H Meeting set for 8:00 A.M., E2.030 - House Human Services
03-24-23 H Removed from hearing 03/28/23 - House Human Services

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A HB 1190 Klick, Stephani APRN/PA Controlled Substances Rx

Companions: HB 1524 Lucio III, Eddie (Refiled from 87R Session)

Remarks:
SUMMARY: This bill would allow APRNs and PAs to prescribe Schedule II substances, regardless of the setting. Currently, they can only prescribe Schedule IIs in hospital and palliative care settings.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/21 by JL

3/13/23 hearing- Support, card

Bill History:
03-02-23 H Introduced and referred to committee on House Public Health
03-13-23 H Meeting set for 9:00 A.M., JHR 120 - House Public Health
03-13-23 H Committee action pending House Public Health

A HB 1236 Oliverson, Tom Prudent Layperson mandate

Companions: SB 1139 Schwertner, Charles (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:
SUMMARY: HB 1236 amends the "prudent layperson" definition of "emergency care" in the Insurance Code to add "regardless of the final diagnosis of the conditions,...." The bill would also make a coverage determination of the Prudent Layperson standard subject to the current UR review process.

TAHP POSITION: Oppose, negotiating

COVERAGE TYPES: Commercial and Medicaid

EFFECTIVE DATES: D, I, or R after 1/1/24

TAHP POSITION STATEMENT: TAHP opposes HB 1236 as filed because the bill would create a definition of prudent layperson that is inconsistent with new federal rules, prohibits investigating claims for fraud, and inappropriately uses a medical necessity process to review a person's decision to seek emergency care.

Under the "prudent layperson standard" a person gets to decide based on their own judgment if they are having a medical emergency. Essentially, if you believe you need emergency care, that can't be questioned and that goes for your insurance coverage as well. In 2021, new rules clarified the prudent layperson standard, how it applies to emergency care coverage, and what rules health plans have to follow. The rules clarified that a patient's final diagnosis can't solely be used to deny a claim for emergency care. That's a reasonable approach, but HB 1236 goes much further and stops state investigators and health insurers from rooting out fraud by saying that an investigator can't look at a pattern of upcoding or outlier billing to flag claims for a case by case review. Texas Medicaid uses diagnosis codes to stop this bad behavior and save taxpayer dollars for years. In, 2021, a "data led initiative" by the OIG resulted in nearly $20 million in fines for inappropriate ER billing.

Upcoding is one type of billing abuse that happens when an emergency care staffing company falsely claims a higher severity code for a patient than what should apply. ER firms have a choice of 5 levels of severity to apply to a patient's bills. The highest severity codes should only be used for the most complicated patients and are reimbursed at significantly higher rates. A recent study found that the proportion of emergency room visits billed as "high intensity" that don't result in a hospitalization grew from 4.8% in 2006 to 19.2% in 2019. Under the legislation, a health plan or state investigator couldn't use a pattern of unusual upcoding to further investigate those claims. Federal law doesn't prevent this type of fraud protection and Texas is ground zero for fraudulent emergency care claims through freestanding ERs. For example, freestanding ERs routinely provided non-emergency, asymptomatic COVID testing throughout the pandemic and then billed insurers and patients as if the care was an emergency. That's fraud and HB 1236 would interfere in going after this abuse.

DATE UPDATED: 2/3/23 JB, 2/22/23 BH

3/21/23 hearing- Oppose, testimony (BH)

Bill History: 03-21-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-21-23 H Committee action pending House Insurance
03-30-23 H Voted favorably from committee as substituted House Insurance

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HB 1238 VanDeaver, Gary SHARS parental consent and advisory committee

Remarks: SUMMARY: Requires parental consent before a student can receive services through SHARS. Establishes a SHARS Advisory Council at HHSC by Oct. 1, 2023. Requires 60-day notice of any changes to the TMPPM and a comment period similar to HHSC's rulemaking process. Requires HHSC to consult with the SHARS Advisory Council before any changes can be made to the TMPPM. Requires HHSC to update the TMPPM by Oct. 1, 2023.

TAHP POSITION: Neutral, Amendments offered

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

TAHP POSITION STATEMENT: The bill should be amended to ensure that only the SHARS Handbook is impacted by the legislation and not the entire Texas Medicaid Providers Procedures Manual, which addresses all of fee-for-service. We also encourage an MCO on the advisory committee. It's much more difficult to determine which students received which exact services in SHARS than with Medicaid FFS and managed care. Managed care organizations do not receive a list of services provided to their members who receive SHARS services, and thus duplication of services is always a risk. Allowing MCOs to be part of the advisory committee can reduce any unintended consequences resulting from committee recommendations.

DATE UPDATED: 2/21 by JL

3/28/23 hearing- Neutral

Bill History: 03-28-23 H Meeting set for 8:00 A.M., E2.030 - House Human Services
03-28-23 H Committee action pending House Human Services
04-11-23 H Voted favorably from committee as substituted House Human Services

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HB 1239 Oliverson, Tom ESG Insurance Rates

Companions: SB 833 King, Phil (F) (Identical)

3- 1-23 S Introduced and referred to committee on Senate Business and Commerce

Remarks: SUMMARY: This bill would prohibit insurers from considering a customer's environmental, social, and governance score or their diversity, equity, and inclusion factors when establishing rates.

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24

3/14/23 hearing- Neutral

Bill History:
03-14-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-14-23 H Committee action pending House Insurance
03-28-23 H Voted favorably from committee as substituted House Insurance

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A HB 1240 Oliverson, Tom Physician Dispensing

Companions:

HB 1778	Oliverson, Tom	(Refiled from 87R Session)
SB 1503	Buckingham, Dawn	(Refiled from 87R Session)

Remarks: SUMMARY: This bill adds that a physician may "dispense" and delegate "dispensing." Provides that a physician may: (1) provide or dispense dangerous drugs to the physician's patients; and (2) be reimbursed for the cost of providing or dispensing those drugs without obtaining a license as a pharmacist.

A physician may not provide or dispense controlled substance listed in Schedules II through V. A physician who provides or dispenses dangerous drugs must oversee compliance with state and federal law relating to those dangerous drugs. Before providing or dispensing dangerous drugs, a physician must notify the patient that the prescription may be filled at a pharmacy. The notification requirement may be satisfied by a written notice placed conspicuously in the office. Not later than the 30th day after the date a physician first provides or dispenses dangerous drugs, the physician must notify the TSBP and TMB that the physician is providing or dispensing dangerous drugs. A physician who notifies the board and who intends to continue to provide or dispense dangerous drugs must include notice of that intent in any subsequent registration permit renewal application. Amends the definition of

"pharmacy" to include a location where a physician provides or dispenses a dangerous drug or a person provides or dispenses a dangerous drug under a physician's supervision, but "retailing of prescription drugs" does not include a physician's collection of a reimbursement for cost.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas Legislature should continue these basic safety protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/3 KS

Bill History:
01-09-23 H Filed
03-03-23 H Introduced and referred to committee on House Public Health
04-17-23 H Meeting set for 8:00 A.M., JHR 120 - House Public Health

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HB 1283 Oliverson, Tom PDL carve-out

Companions: SB 1113 Hughes, Bryan (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:
SUMMARY: Permanently carves out the management of the PDL by MCOs. TAHP POSITION: Neutral with concerns, negotiating

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: HB 1283 is inconsistent with Select House Committee on Health Care Reform's recommendation to "Ensure that Medicaid prescription drugs maintain continuity of care for

members who move between managed care plans and minimizes administrative burden for physicians." Under a permanent carve out, physicians and patients experience significant hurdles with non-medical switching and prior authorizations. While Texans in commercially insured products have step therapy protections, Medicaid enrollees do not.

TAHP opposes any further delays in the PDL carve-in. Pharmaceutical companies have already delayed this implementation for 10 years through heavy lobbying. It is crucial that Texas prioritize improving patient care and saving taxpayer dollars over protecting Pharma profits. Further delays will continue to harm health outcomes and timely access to prescription drugs, negatively impact efforts to modernize and improve patient outcomes, and substantially increase Medicaid costs for taxpayers.

It is worth noting that prior to 2011, Medicaid drug costs in Texas were out of control, almost doubling in a decade and growing more than 6.5% on average each year. In response, the legislature passed SB 7, which carved prescription drug coverage into managed care in order to slow the rapid growth in Medicaid drug spending. This measure was successful in reducing drug cost growth in Texas Medicaid by 50%.The second step in this process, allowing managed care organizations (MCOs) to develop formularies and PDLs, was originally scheduled for 2013 but has been repeatedly delayed due to pharmaceutical company lobbying. A Center for Public Integrity and NPR investigation found that these companies have a history of successfully lobbying state Medicaid drug boards in order to boost their profits and waste taxpayer dollars. Under the current system, the state chases rebate dollars from big drug companies, resulting in a formulary that is heavily reliant on brand name drugs rather than cheaper generics. This creates administrative burdens for physicians, pharmacists, and insurers, and leads to frustrations and delays in access to necessary prescription drugs for patients. It is clear that the current system is not working for Texas patients, doctors, or taxpayers. But patients really suffer. Medicaid families lack consumer protections that exist in the commercial market. Patients are routinely forced off of medications when they are stable and physicians are put through excessive administrative burdens. In testimony, physicians have called the state's formulary "nonsensical", "counterintuitive", and "just nuts". Allowing MCOs to fully manage the PDL will provide a more stable drug benefit that better reflects what physicians routinely prescribe and pharmacists stock. It will also give MCOs the tools they need to control costs and improve health outcomes, as is done in the private market and in Medicare.

Texas patients deserve better access to prescription drugs, and it is crucial that we prioritize their needs and well-being. By supporting the planned implementation of full PDL management by MCOs, we can save taxpayer dollars, improve patient care, and modernize our Medicaid system.

DATE UPDATED:1/16 by JL, BH 2/23

4/6/23 hearing- Neutral with concerns, negotiating, testified

Bill History: 04-06-23 H Meeting set for 7:30 A.M., E2.028 - House Select on Health Care Reform
04-06-23 H Committee action pending House Select on Health Care Reform
04-13-23 H Voted favorably from committee on House Select on Health Care Reform

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A HB 1288 Lopez, Ray ECI Coverage Mandate

Remarks: SUMMARY: The bill creates a new unfunded benefit mandate for early childhood intervention (ECI) services. Currently, issuers are required to offer plans that include coverage for rehabilitative and habilitative therapies. The bill would instead require coverage of those services and expand the mandate to include ECI services. This bill would also expand the applicability of the law to consumer choice plans. The bill would amend the statutory definition of "rehabilitative and habilitative therapies" to include: (1) specialized skills training by a person certified as an early intervention specialist, (2) applied behavior analysis treatment by a licensed behavior analyst or licensed psychologist, and (3) case management provided by a licensed practitioner of the healing arts or a person certified as an early intervention specialist. Currently, these services to be covered in the amount, duration, scope and service setting established in the child's individualized family service plan (ISP). This bill would add that the issuer's prior authorization requirement would be considered satisfied if the service is specified in the ISP. The bill would allow health plans to limit annual coverage for specialized skills training, including case management costs, to $9,000 per year per child. (Note that application of this limit may violate state and federal mental health parity requirements). This limit may not be applied to coverage for other rehabilitative and habilitative therapies required by the mandate or coverage required by any other law, including section 1355.015 (the mandated benefit for autism spectrum disorder) or the Medicaid program. Pursuant to federal law, the child would be required to exhaust all available coverage under the law before receiving benefits provided to the state. The bill would also prohibit issuers from counting visits to physicians under this coverage towards any

maximum allowable number of visits to a physician under the plan.

TAHP POSITION: Opposed

COVERAGE TYPES: EPO/PPO, HMO, MEWA, CC

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24

MANDATE: Benefit

TAHP POSITION STATEMENT: TAHP opposes a new, unfunded benefit mandate for early childhood intervention services (ECI). The federal government and states are already responsible for the operation and cost of ECI services in Texas through a program operated at HHSC that receives significant federal funding. Texas should not shift these costs to Texas employers. This mandate is so expensive it was estimated to cost TRS active care $45 million per biennium. As a result, this proposal doesn't apply to the health coverage elected officials have for themselves, other state employees, and teachers through TRS and ERS. TAHP believes that elected officials should not pass mandates that they are not willing to apply to their own health coverage.

DATE UPDATED: 3/7 KS

Bill History:
01-12-23 H Filed
03-03-23 H Introduced and referred to committee on House Insurance

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A HB 1293 Rose, Toni NADAC

Remarks: SUMMARY: Dictates the methodology and reimbursement rate Medicaid and CHIP MCOs and PBMs use to pay pharmacies. The reimbursement would be the lesser of: (1) the average of actual acquisition cost (AAC) which must be consistent with actual prices pharmacists pay to acquire a drug and may be based on NADAC plus a dispensing fee established by the Commission, or (2) the amount claimed by the pharmacy including the gross amount due or the usual and customary charge for the drug.

TAHP POSITION: Oppose - Seeking amendments

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: March 1, 2024

TAHP POSITION STATEMENT: Medicaid/CHIP MCO pharmacy reimbursement rates are currently based on negotiated contracts in the private market – not on government mandated rates. Government price-setting takes away the MCOs' ability to negotiate with pharmacies and negates opportunities for cost

savings. When dispensing fees are set too high by the state, taxpayers pay pharmacies more than they would in a competitive market. NADAC is based on a national survey of pharmacies who voluntarily submit their drug invoices to CMS, making this an unreliable data source. NADAC does not reflect a pharmacy's actual net acquisition cost because the survey excludes off-invoice discounts, rebates and price concessions. Passage would result in additional costs to the Medicaid program. In 2015, HHSC estimated an average increase of $0.25 per prescription, or $4.6 million AF in FY16 and $9.6 million FY17 with additional increases in subsequent years as the number of prescriptions increases. CMS predicts from 2016-2025 prescription drug spending is projected to grow at an average rate of 6.7%.

DATE UPDATED: 1/17 by JL

Bill History: 01-12-23 H Filed
03-03-23 H Introduced and referred to committee on House Human Services

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HB 1322 Buckley, Brad Coordination vision eye care benefits

Companions: SB 861 Hughes, Bryan (Identical)
4-12-23 S Voted favorably from committee as substituted Senate Health and Human Services

Remarks: SUMMARY: If an enrollee is covered by at least two different plans that provide eye coverage benefits, this bill would require the plan that received the claim to cover up to any coverage limit then the subsequent plan to cover the remainder, up to any coverage limits.

TAHP POSITION: Neutral

COVERAGE TYPES: EPO/PPOs that cover vision services

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24

TAHP POSITION STATEMENT: The Texas Insurance Code addresses coordination of benefits as it relates to dental coverage. This bill should more closely align vision coordination of benefits with the process laid out for dental benefits.

DATE UPDATED: BH 3/9

3/28/23 hearing- Neutral

Bill History: 03-28-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-28-23 H Committee action pending House

Insurance
04-11-23 H Voted favorably from committee as substituted House Insurance

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