The Texas Association of Health Plans

TAHP TRACKED BILLS - MANDATE
4-14-23

04-14-2023 - 10:27:43

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

Mandates

A 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 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

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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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 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 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 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 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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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 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 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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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 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

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 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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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 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 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

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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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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HB 1337 Hull, Lacey SMI Step Therapy Mandate

Companions: SB 452 Menendez, Jose (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human

Services

Remarks: SUMMARY: This bill limits step therapy for drugs prescribed to treat a serious mental illness to trying only one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug. For continued therapy of an SMI drug that someone is already taking, a health benefit plan issuer may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only once in a plan year and only if the equivalent drug is added to the plan's drug formulary.

TAHP POSITION: Neutral (negotiated language)

COVERAGE TYPES: Commercial

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

MANDATE:Benefit

POSITION STATEMENT: TAHP negotiated language with the authors to add these new step therapy exceptions but ensure that lower cost generic and pharmaceutical equivalent drugs can still be used to lower costs. TAHP will be neutral on this bill as long as language is not added to freeze the formulary or go beyond the agreement with the authors as reflected in the filed bill. Health plans must continue to be able to update drug formularies to bring patients the most affordable prescription drug options including lower cost alternatives.

DATE UPDATED: 3/8 BH

3/14/23 hearing- Neutral, testimony BH

Bill History: 04-12-23 H Passed (Vote: Y:146/N: 1)
04-12-23 S Received in the Senate
04-13-23 S Referred to Senate Committee on Senate Health and Human Services

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HB 1364 Munoz, Sergio OON Out of Pocket Cost Mandate

Companions: SB 583 Hughes, Bryan (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would state that a health care provider may not be prohibited from accepting directly from an enrollee full payment for a health care service in lieu of submitting a claim. A health care provider's discounted cash price would be considered full payment. The plan issuer would then be required to apply the charge towards the

enrollee's out-of-pocket maximum, unless it was a payment for an uncovered service. The bill would apply to plans despite the fact that they require referrals for specialists, such as HMOs, and plans that do not have out-of-pocket costs, like Medicaid and CHIP. The bill also does not address whether the service is medically necessary or covered, whether it is actually a shoppable service, or whether the patient is shopping for a lower price.

TAHP POSITION: OPPOSED without guardrails added

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

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

TAHP POSITION STATEMENT: TAHP supports market-driven incentives for patients to choose the lowest cost and highest value health providers. The bill requires any out-of-network health care service to be counted towards a patient's out-of-pocket maximum regardless of whether or not that service was a covered service or provided at a lower cost than the in-network rate. Further, the bill does not consider whether these services are medically necessary or shoppable. TAHP opposes this bill unless guardrails are added that would require the service to be medically necessary, shoppable, and less expensive than it would otherwi se be with a network provider. TAHP also opposes the bill unless HMOs, Medicaid, and CHIP, are removed. HMOs require referrals from primary care providers, so allowing a patient to go directly to a specialty provider would undermine the entire purpose of an HMO, making it function like an EPO. Medicaid and CHIP do not have out-of-pocket maximums, so the bill does not make sense in those contexts. TAHP supports encouraging patients to shop for lower cost, medically necessary services and would not oppose legislation that rewards that shopping. However, the bill lacks the necessary guardrails to ensure that the result of the bill is to reward patients that find lower cost services.

DATE UPDATED: 3/7 KS

Bill History: 01-17-23 H Filed
03-03-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 1452 Anchia, Rafael Fetal tissue Disposition Mandate

Remarks: SUMMARY:This bill creates a new unfunded benefit mandate to cover the cost of disposition of embryonic and fetal tissue remains with a post-fertilization age of 20 weeks or more. The manner of disposition for which coverage is required includes:

(1) interment; (2) cremation; (3) incineration followed by interment; and (4) steam disinfection followed by interment.

TAHP POSITION:Opposed

COVERAGE TYPES:HMO, EPO/PPO, CC

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

Position Statement: Covering funeral, burial, or cremation expenses has never been the role of health insurance, and doing so would increase health insurance costs for Texas employers.

Additionally, the insurance activities of Texas health plans are limited by their licenses, issued by the Department of Insurance, to the lines of business for which they are licensed. HMOs are authorized only to provide benefits for the cost of "health care services," defined in the Insurance Code as "services provided to an individual to prevent, alleviate, cure, or heal human illness or injury."

MANDATE:Benefit

Bill History:

01-19-23 H Filed
03-03-23 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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HB 1647 Harris, Cody White Bagging Prohibition Mandate

Remarks:

SUMMARY: This bill prohibits issuers, for an enrollee with a chronic, complex, rare, or life-threatening condition from: (1) requiring clinician-administered drugs to be dispensed by only by in-network pharmacies; (2) if a clinician-administered drug is otherwise covered, limit or exclude coverage for such drugs when not dispensed by an in-netowork pharmacy; (3) reimburse at a lesser amount clinician-administered drugs based on the patient's choice of pharmacy; or (4) require that an enrollee pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other form of price increase for clinician-administered drugs when not dispensed by a network.

Nothing in the new section may be construed as: (1) authorizing a person to administer a drug when otherwise prohibited under law; or (2) modifying drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration.

TAHP POSITION: Neutral on CS

COVERAGE TYPES: Commercial, CC

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

POSITION STATEMENT: TAHP opposes HB 1647 without amendments that would ensure the bill does not reward price gouging and is aimed only at patient protections. The most expensive drugs are injectables and infusion drugs provided at a hospital, cancer center, or doctor's office. These "specialty drugs" are typically covered under your medical benefits (not pharmacy benefits). New State and Federal transparency laws show that hospitals, cancer centers, and other clinics have been caught marking up drugs at excessive amounts, on average 200% and up to 634% for cancer drugs. By comparison, Medicare allows a 6% markup or profit margin.Health plans are responding with competition by bringing in the same drug from lower cost specialty pharmacies but without the big markup. That's "white bagging" and it saves patients money. Massachusetts found the process saved 38% on average. The legislation would stop health plans from using lower cost drugs from outside pharmacies through a new mandate that prohibits a "white bagging" policy. The bill as filed also mandates that health plans and patients have to pay whatever prices are set by hospitals' and physicians' at in-house pharmacies. Importantly, patients pay for these markups through out-of-pocket costs and higher premiums. A white bagging prohibition would add over $300 million in Texas drug spending in the first year and over 3.7 billion in the next decade. No state has adopted a white bagging restriction with a payment mandate that rewards price gouging.

MANDATE: Contracting

3/28/23 hearing- Neutral, 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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HB 1649 Button, Angie C Fertility Preservation Mandate

Companions:

HB 389	Collier, Nicole	(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: Delivered, issued for delivery, or renewed on or 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. Government mandates and overregulation hinder innovation and add costs to an already expensive system. This expense is 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.

UPDATED: 2/3 BH

4/4/23 hearing- Oppose

Bill History:

03-07-23 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 1696 Buckley, Brad Relationship between managed care plans

Companions:

SB 860 Hughes, Bryan (Identical)
3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:

SUMMARY: This bill adds vision benefit plan issuers and administrators to the definition of "managed care plan" under this section. It also adds to the current prohibitions against a managed care plan - a managed care plan may not, with respect to optometrists, therapeutic optometrists, or ophthalmologists: 1) deny participation as a participating practitioner if they meets the credentialing requirements and agrees to the plan's terms; 2) use a fee schedule that reimburses differently based on professional degree held; 3) identify differently based on any characteristic other than professional degree held; or 4) encourage enrollees to obtain services at a particular provider or retail establishment. The bill would also require issuers to share with these providers complete immediate access to plan coverage information, publish complete plan information, allow providers to utilize third-party claim filing services that uses the standardized claim protocol, and allow the providers to receive reimbursement through an automated clearinghouse. The bill repeals the current provision that a network therapeutic optometrist must comply with the requirements of the Controlled Substances Registration Program operated by DPS. The bill provides that a contract between a managed care plan and an optometrist or therapeutic optometrist may not provide for a chargeback (defined as "a dollar amount, administrative fee, processing fee, surcharge, or item of value that reduces or offsets the patient responsibility or provider reimbursement for a covered product or service) if, for a covered product or service that is not supplied by the health plan or for a reimbursement fee schedule for a covered product or service that is different from the fee schedule applicable to another optometrist or therapeutic optometrist because of provider's choice of optical laboratory or other source or supplier of services or materials. Finally, the bill would prohibit contracts with these providers that require prior authorization, require the provider to provide covered services at a loss, or require a reimbursement that has an applicable processing fee

except a nominal fee for an EFT. It would also prohibit issuers from using extrapolation to audit optometrists or therapeutic optometrists. A violations of the subchapter be considered a deceptive act by the issuer for the purposes of Chapter 541.

TAHP Position: Neutral

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

TAHP POSITION STATEMENT: This mandate would restrict private market negotiations by forcing health plans to contract with any vision provider willing to meet the plan's terms without regard to whether there is a need for additional providers in the plan's network. "Any willing provider" mandates increase administrative costs but also raise network provider rates by removing incentives to negotiate reimbursements. There are numerous economic studies and Federal Trade Commission statements about the negative impact of any willing provider laws on the private market including elimination of competition and consumer choice and increased health care costs.

According to the Federal Trade Commission, any willing provider laws "can limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of choice. These restrictions on competition may result in insurance companies paying higher fees to providers, which, in turn generally results in higher premiums, and may increase the number of people without coverage."

Furthermore, this bill mandates payment parity to providers regardless of education, training, and licensed scope of practice. Payment parity mandates raise costs for Texas businesses and families and ignore the variation in training and experience among various providers.

DATE UPDATED: 3/5 BH

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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HB 1726 Hernandez, Ana Telemedicine Payment Parity Mandate

Companions: SB 724 Lamantia, Morgan (F) (Identical)

	3- 1-23 S Introduced and referred to committee on Senate Health and Human Services
SB 1043	Blanco, Cesar (Identical)
	3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:

SUMMARY:This bill would require health plans to pay for a covered service provided as a telemedicine, telehealth, or teledentistry service on the same basis and at least at the same rate that the plan provides reimbursement to that provider for the service in an in-person setting. In submitting claims, the provider could not be required to provide any documentation beyond what is required for an in-person setting. The bill also adds mental health professionals to the current telehealth coverage mandate in Texas.

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

TAHP POSITION STATEMENT: Mandating the same payment for brick-and-mortar office visits and telehealth visits is government rate setting and undermines telehealth's promises of efficiency and innovation. Independent experts across the political spectrum, including Brookings, the John Locke Foundation, Americans for Prosperity, TCCRI, the Foundation for Government Accountability, and the Progressive Policy Institute, have all said that telemedicine payment parity mandates are harmful to the future of telehealth and do nothing to improve the value of health care or increase access to telehealth. Payment parity mandates act as price floors for telemedicine by pegging the service to more expensive ones. They essentially require higher reimbursement rates for telehealth than would be negotiated without the mandate. That makes them price controls and keeps patients from benefiting from separately negotiated rates. Parity mandates prevent any telehealth cost savings from being passed along to patients in the form of lower premiums, deductibles, copayments or coinsurance. Telehealth access is expanding without government interference and rate setting. Patients are asking for telehealth access and the market for insurance coverage is responding with numerous options for $0 copay telehealth visits. A payment parity mandate risks interfering in the market response to these patient needs.

DATE UPDATED: 2/18 BH

Bill History: 01-26-23 H Filed
03-07-23 H Introduced and referred to committee on House Insurance

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HB 1754 Smithee, John RX Formulary API Mandate

Companions: SB 622 Parker, Tan (F) (Identical)
4-12-23 S Voted favorably from committee as substituted Senate Health and Human Services

Remarks: SUMMARY: This bill would require issuers to provide information regarding prescription drugs to enrollees, including the drug formulary, eligibility, cost-sharing information, and utilization management requirements. The issuer must respond in real time to a request made through a standard API, allow the use of integrated technology as necessary, ensure information is current not later than one day after a change is made, and provide information if the request is made using the drug's unique billing code. The issuer may not deny or delay a response, restrict providers from communicating the information, or discourage access to the information.

TAHP POSITION: Neutral/Negotiating

COVERAGE TYPES: EPO/PPO, HMO, CC, TRS/ERS.

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

DATE UPDATED: 2/13 KS

4/11/23 hearing- Neutral

Bill History: 04-11-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
04-11-23 H Committee action pending House Insurance
04-13-23 H Voted favorably from committee as substituted House Insurance

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HB 1803 Rose, Toni Medicare Supplemental Under Age 65

Companions: SB 1790 Zaffirini, Judith (Identical)
3-20-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would require entities that offer Medicare supplemental plans to offer the same coverage to individuals enrolled in Medicare due to disability or end stage renal disease. The plan must have the same premium rate and policies as a plan

offered to someone 65 or older.

TAHP POSITION: Neutral

COVERAGE TYPES: Med Supp.

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

POSITION STATEMENT: TAHP is concerned about increased costs for Medicare enrollees over 65.

DATE UPDATED: 12/13 KS, 2/19 BH

Bill History:

01-30-23 H Filed
03-07-23 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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HB 1902 Smithee, John TDI Rec - Provider Directories

Companions: SB 1003 Johnson, Nathan (Identical)
4-10-23 H Referred to House Committee on House Insurance

Remarks:

SUMMARY: This bill would expand the requirement for issuers to list facility-based providers in their provider directories. It would add non-physician providers, including CRNAs, nurse midwives, surgical assistants, physical therapists, among others. It was a recommendation in TDI's Biannual Report. This bill should be amended to clarify that providers only need to be listed if they are not employed by the hospital and bill separately.

TAHP POSITION: Neutral

COVERAGE TYPES: HMO, EPO, MEWA.

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/18 KS

3/14/23 hearing- Neutral

Bill History:

03-14-23 H Committee action pending House Insurance
03-21-23 H Voted favorably from committee on House Insurance
03-28-23 H Reported favorably from committee on House Insurance

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HB 2002 Oliverson, Tom OON OOP Max Shopping Mandate

Remarks:

SUMMARY: This bill would require issuers to credit towards an insured's deductible and annual out-of-pocket maximum an amount the insured pays

directly to a health care provider for a covered medical service. To be counted, the claim must not be submitted to the issuer, and the amount paid by the insured must be less than the average discounted rate for the service under the insured's plan. The bill would require issuers to establish procedures and identify documentation necessary to claim a credit, and post that information on their website.

TAHP POSITION: Negotiating. TAHP will be neutral if the author accepts changes to clarify this is for out-of-network shopping and covered and shoppable services.

COVERAGE TYPES: PPO/EPO

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

POSITION STATEMENT: TAHP supports market-driven incentives for patients to choose the lowest cost and highest value health providers. The bill needs minor changes to clarify that the intent is to encourage patients to shop outside of their insurance network for lower prices and that this new provision applies only to shoppable covered medical services. TAHP supports encouraging patients to shop for lower cost, medically necessary services and would not oppose legislation that rewards that shopping.

DATE UPDATED: 3/8 BH

4/13/23 hearing- Negotiating, testified

Bill History: 03-08-23 H Introduced and referred to committee on House Select on Health Care Reform
04-13-23 H Meeting set for 8:00 A.M., E2.028 - House Select on Health Care Reform
04-13-23 H Committee action pending House Select on Health Care Reform

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HB 2021 Oliverson, Tom ERISA Prescription Drug Mandate

Companions: SB 1137 Schwertner, Charles (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would require a PBM to comply with the provisions of Chapter 1369, Insurance Code, regardless of whether a provision of that chapter is specifically made applicable to the plan. It would create an exception for plans expressly excluded by the applicability of a provision or if the commissioner determines that the nature of third-party administrators renders the provision

inapplicable to PBMs.

TAHP POSITION: Oppose

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

POSITION STATEMENT: HB 2021 applies every state created prescription drug mandate (insurance code chapter 1369) to self-funded employer health plans that are currently exempt under Federal ERISA laws. Employers (not health insurers) are harmed by HB 2021. Self-funded employers will suffer the cost of imposing state mandates including limits on narrow pharmacy networks or the use of onsite pharmacies, a one year wait before changing to lower cost generics/biosimilars, and limits on mail order pharmacies. Multi-state employers will have to design special coverage just for Texas employees. These mandates are expensive and cumbersome, that's why the bill exempts coverage for elected officials personal health insurance. Large employers with thousands of employees use self-funded benefits. These are the biggest providers of health coverage and the biggest job creators in Texas. The intent of ERISA preemption is to encourage employers to offer their employees benefit plans. This has worked - 98% of Texas large employers provide coverage to their employees compared to only 50% of Texas small employers. The Texas Association of Business, Texas Business Leadership Council, Texans for Lawsuit Reform, and individual businesses like Hobby Lobby have all spoken out against ERISA preemption.

DATE UPDATED: 2/13 KS, 2/22 BH

3/21/23 hearing- Oppose, testimony, card

Bill History: 03-08-23 H Introduced and referred to committee on House Insurance
03-21-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
03-21-23 H Committee action pending House Insurance

HB 2180 Harris, Cody Point of Sale Rebate Mandate

Remarks: SUMMARY: This bill would require an enrollee's cost sharing amount for prescription drugs to be calculated at the point of sale, and that price would have to be reduced by any rebates that issuer or PBM receives for the prescription. TAHP POSITION: Oppose unless amended. TAHP will be neutral is it is amended to match Select Committee's recommendation to ensure that 100% of rebates go

to lowering the cost of coverage.

POSITION: Opposed

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

EFFECTIVE DATES: 9/1/23

POSITION STATEMENT: The bill as filed is inconsistent with the Select House Committee on Health Care Reform's interim recommendation to "consider opportunities to ensure rebates are used to lower the cost of coverage." The filed bill prescribes how rebates must be used just for the small group of patients that take very expensive drugs and would prohibit an employer from using rebates to lower the costs of health care for all employees.

TAHP agrees something must be done to lower prescription drug prices. However, taking away employer choice is the wrong way and TAHP opposes the bill without an amendment that the full amount of the rebate go to reduce costs or premiums for the policyholder. This amendment would align the bill with the recommendation from the House Select Committee on Healthcare Reform's interim report to "Consider opportunities to ensure rebates are used to lower the cost of coverage".

We believe employers should have the choice of how to best use rebate savings including lowering premiums for all employees, adding more generous benefits, or further reducing employee costs at the pharmacy counter. Those choices have trade offs and a mandatory point-of-sale, one-size-fits-all policy would actually increase drug costs overall. Under this approach, only a few patients may see their costs go down at the pharmacy counter for one drug, but premiums and out-of-pocket costs go up for all. Moreover, this practice would reduce Pharma's incentive to lower the prices of their drugs by further masking the cost of high priced brand-name drugs.

An independent fiscal review found a similar bill in California was estimated to impact only 3.48% of prescriptions but would have increased health insurance premiums by $200 million annually. The review also found that a point of sale rebate mandate would only help 4% of enrollees but would increase premiums for 100% of enrollees. The California Senate Appropriations Committee refused to advance that bill due to the increased premium cost.

The Congressional Budget Office (CBO) estimated that a Medicare point of sale rebate mandate would increase premiums by $43 billion (25%) over a decade and federal spending by $137 billion, so it was never implemented. Rebates reduce the cost of

prescription drug coverage at the Teacher Retirement System by 30%. Without these savings, Texas would have to replace this cost with taxpayer dollars or by substantially increasing premiums to active and retired teachers. Employers cover the bulk of premiums for employees—more than 80%. They should be able to choose what to do with rebates. Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, as Pharma continues to set very high prices for their prescription drugs and raise them year after year.

DATE UPDATED: 2/19 KS, BH 2/21

3/23/23 hearing- Oppose, testimony (JD)

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

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HB 2216 Cortez, Philip 1 year Medicaid continuous eligibility

Companions: SB 1692 Blanco, Cesar (Identical)
3-16-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Requires continuous eligibility for children for the lesser of one year or until the child reaches 19.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/19 by JL

Bill History: 02-13-23 H Filed
03-09-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 2797 Bucy, John Health benefit coverage certain procedures

Remarks: SUMMARY: This bill would require issuers that provide coverage for hysterectomy or myomectomy to also cover laproscopic removal of uterine fibroids, including ultrasound guidance and monitoring and radiofrequency ablation.

TAHP POSITION: Oppose

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

EFFECTIVE DATES:

TAHP POSITION STATEMENT:

Bill History:

02-24-23 H Filed
03-13-23 H Introduced and referred to committee on House Insurance

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HB 2985 Jones, Venton (Prohibits PAs for HIV Prescription Drugs

Remarks:

SUMMARY: This bill would prohibit issuers that provide prescription drug benefits from requiring enrollees to receive prior authorization for a drug prescribed to prevent HIV infection. It would apply to group plans provided to a resident of the state, regardless of whether the policy is delivered in the state, and it would not apply to plans that have not had any significant changes since the passage of the ACA.

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, HMO, MEWA, CC, ERS/TRS/University, Medicaid/CHIP EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24

TAHP POSITION STATEMENT: AHP 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.

DATE UPDATED: 3/9 KS 3/29 BH

Bill History:

02-28-23 H Filed
03-14-23 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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HB 3034 Talarico, James Notice regarding nonemergency ambulance

Remarks: SUMMARY: This bill would require a plan that does not provide coverage for nonemergency services provided by EMS personnel to provide written notice in an explanation of benefits that the plan does not cover nonemergency ambulance or nonemergency health care services provided by EMS personnel.

TAHP POSITION: Neutral

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

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/8 KS

Bill History: 02-28-23 H Filed
03-14-23 H Introduced and referred to committee on House Insurance

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HB 3091 Lalani, Suleman HMO ID Card

Companions: HB 620 Johnson, Julie (Refiled from 87R Session)

Remarks: SUMMARY: This bill requires a plan issued by Health Maintenance Organizations to include "HMO" and Preferred Provider Benefit Plans to include "PPO" on applicable ID cards. The identifiers would indicate that the coverage does not ensure the enrollee has access to out-of-network health care services at a discounted rate or other fee discounts available under the delivery network.

TAHP POSITION: Neutral

COVERAGE TYPES:

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/8 KS

Bill History: 03-01-23 H Filed
03-14-23 H Introduced and referred to committee on House Insurance

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HB 3098 Johnson, Ann Health Plan Affiliated Provider Mandate

Companions: SB 1502 Middleton, Mayes (F) (Identical)
3-16-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:

SUMMARY: This bill would define "affiliate provider" to mean a provider that directly or indirectly controls, or is controlled by, a health benefit plan issuer. A "nonaffiliated provider" would mean a provider that does not directly or indirectly control, and is not controlled by, a health benefit plan issuer. The bill would prohibit an issuer from offering a higher reimbursement to a practitioner who is a member of a nonaffiliated provider based on the condition that the practitioner agrees to join an affiliated provider. It would also prohibit an issuer from paying an affiliated provider a reimbursement amount that is more than the amount paid to a nonaffiliated provider for the same health care service.

The bill would prohibit issuers from encouraging or directing a patient to use an affiliated provider through any communications, including online messaging and marketing materials. The bill would prohibit issuers from requiring that a patient use an affiliated provider for the patient to receive the maximum benefit under the plan; offer or implement a plan that requires or induces a patient to use an affiliated provider; or solicit a patient or prescriber to transfer a prescription to an affiliated provider.

TAHP POSITION: Opposed

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

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

TAHP POSITION STATEMENT: Patients need access to lower cost treatment options. This legislation would create new limits that restrict patients from utilizing the most cost effective providers and protect high cost providers from lower cost competition. Provider consolidation has resulted in increasingly higher prices for physician and hospital services as private equity backed physician staffing firms have acquired provider groups. For example, in Fort Worth one gastroenterology group controls half of the market for all colonoscopies. In Houston, one anesthesia staffing firm owns 70% of all anesthesia providers. This means higher prices for patients. This bill would restrict competition from lower cost services if those cheaper providers have any affiliation with a health plan. This anticompetitive approach will result in higher prices for patients and Texas employers. The legislation should be amended to clarify that the bill's provisions do not apply for provider services offered at a lower cost to patients.

DATE UPDATED: 3/8 KS

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

4/4/23 hearing- Oppose, testified

Bill History:

03-27-23 H Removed from hearing 03/28/23 - 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 3188 Bonnen, Greg Biomarker Coverage Mandate

Companions:

SB 989 Huffman, Joan (Identical)
4-13-23 H Received in the House

Remarks:

SUMMARY: This bill would require issuers to cover biomarker screenings if the test is evidence-based, scientifically valid, outcome-focused, and predominantly addresses the acute issue for which the test is being ordered. The test also must be supported by medical and scientific evidence.

TAHP POSITION: Neutral as long as bill is not amended (negotiated language)

COVERAGE TYPES: EPO, HMO, MEWA, small employer, CC, ERS/TRS/UT, Medicaid/CHIP

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

DATE UPDATED: 2/19 KS

Bill History:

03-01-23 H Filed
03-15-23 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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HB 3195 Bonnen, Greg Overpayment and Audit Appeal

Remarks:

SUMMARY: Currently, issuers are not allowed to retaliate against providers for filing complaints or appealing decisions of the issuer. This bill would add that terminating the participation in a plan, refusing to renew a contract, implementing penalties in the negotiation process, engaging in unfair deceptive practices, arbitrarily reducing the provider's fee schedule, and otherwise making adverse changes to the terms of a contract are considered retaliatory action.

The bill would also require issuers to respond to electronically submitted clean claims electronically and request or provide information to electronically submitted claims electronically.

The bill would prohibit an issuer from recovering a payment on an audited claim before the final audit is completed if the claim was submitted by a preferred provider other than a freestanding emergency medical care facility (FEMC). An issuer would be required to provide written notice to the preferred provider, other than an FEMC, if the issuer fails to complete not later than the 15th day after the day on which the issuer is required to complete the audit.

After an audit, an issuer would be required to provide a reasonable mechanism for a requested appeal by a preferred provider other than an FEMC. The mechanism would have to include a review panel, which would have to be composed of at least three preferred provider representatives in the same or similar specialty of the preferred provider. The issuer would be required to share with the affected provider the panel's composition and recommendation and the written explanation of the issuer's determination if different from the panel.

The bill would require TDI to create a procedure for a preferred provider, other than an FEMC, to submit a request to review an audit, which would be considered a contested case. If TDI determined that an audit resulted in unreasonable costs for the provider, unnecessarily delayed payment, or otherwise violated laws applicable to audits, TDI would award compensatory damages to the provider and order the issuer to pay the department costs incurred by the department.

TAHP POSITION: Opposed - requested changes to be neutral

COVERAGE TYPES: EPO/PPO EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: This bill would make changes to the current prompt payment laws that would essentially result in a "guarantee of payment" for virtually all complete claims submitted to health plans, with a de facto prohibition on investigating claims for fraud or even to assure that they include accurate information.

This bill will make it impossible for health plans to review claims after required "prompt payments" and recoup money for claims that are fraudulent or even simply not covered. Prompt payment laws already limit pre-payment investigations for fraud, and now this bill will effectively prohibit those investigations after the required payment has been made. Fraud, waste, and abuse is already 50% larger in the commercial market than in Medicaid. Pricing failures, overtreatment, low-value care, and fraud and abuse are responsible for 50% of wasteful spending. Fraudulent claims constitute only a small fraction of

overall claims, but they carry a very high price tag and translate directly into higher premiums and out-of-pocket expenses for Texas employers and families. Texas should strengthen and prioritize enforcement of anti-fraud laws and expand efforts to hold providers accountable for fraud, waste, and abuse—especially in the private market. It should not restrict health plans from investigating potentially fraudulent claims, as this bill would do.

DATE UPDATED: 3/8 KS 3/29 BH

4/11/23 hearing- Opposed, written testified

Bill History: 04-04-23 H Not heard in committee 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

HB 3359 Bonnen, Greg Network Adequacy and OOP Max Mandate

Remarks: SUMMARY: The bill would create a definition of "post-emergency stabilization care" to mean services furnished by an out-of-network provider or facility after the insured is stabilized and as part of an inpatient or outpatient stay with respect to a visit in which emergency services are furnished. The bill would require PPOs (not EPOs) to include benefits for emergency and post-emergency stabilization care. Post-emergency stabilization care would become subject to ch. 1467 (mediation and arbitration provisions) in the same manner as emergency care, except for claims excepted from the post-stabilization care provisions of the federal No Surprises Act.

The bill would allow PPOs and EPOs to use service areas that include noncontiguous geographic areas, but service areas may not divide a county and must include at least one trauma service area in its entirety.

The bill would require PPOs (not EPOs) to credit any cost-sharing amount paid for by or on behalf of an insured for out-of-network services provided to any out-of-pocket maximum. It would prohibit an insurer from having separate out-of-pocket maximums for in-network and out-of-network services, and it would require TDI to set a reasonable cap on out-of-pocket maximums.

The bill would make multiple changes to network adequacy standards for PPO and EPO plans. First, it would require an insurer to monitor compliance with standards on an ongoing basis, report any material changes to TDI within 30 days and promptly take any corrective action to ensure compliance.

It would amend the requirement that insurers ensure availability and accessibility to a full range of network providers to also require submission of current and projected utilization of services for both adult and minor insureds. The bill would also allow waivers only after a public hearing where good cause is shown, and for a period not to exceed one year.

It would also require TDI to post on its website each affected county, and the specific network adequacy standards waived. The issuer would also be required to share such information in all promotion and advertising material. The bill allows any policyholder to seek (de novo) judicial review of a decision to grant a waiver. TDI would be prohibited from issuing a waiver to a PPO or EPO plan more than twice consecutively for the same standard in the same county unless the insurer demonstrates, in addition to good cause, multiple good faith attempts to bring the plan into compliance. It would prohibit waivers to a plan more than a total of four times within a 21-year period for each county in a service area for issuers that may be remedied through good-faith efforts.

The bill would also create new adequacy standards for PPOs and EPOs. Issuers would be required to ensure sufficient choice, access, and quality of physicians by conducting an actuarial projection of utilization of services and providers within the counties. It would require a sufficient number of network providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist and diagnostic services, including radiology and laboratory services at each network hospital, ambulatory surgical center or freestanding emergency medical care facility with credentials for these specialties to ensure all insureds are able to receive covered benefits at that location. The bill would also require that emergency care is accessible 24 hours a day, seven days a week, and urgent care is available within 24 hours for medical and behavioral health conditions. Finally, the bill expressly lists travel time and distance standards for each specialty, as well as wait time standards for medical conditions, behavioral health conditions, and preventative services. The list of specialties and provider types and the distance and drive time limits for each are based on those adopted in the federal regulations. Prior to offering a plan, insurers would be required to submit searchable and sortable databases of network providers, actuarial data of projected number of insureds by county, projected utilization by county, and other information deemed necessary by TDI.

The bill provides that when necessary due to utilization or supply patterns,TDI may adopt rules to decrease the base maximum time and distance

standards for specific counties. Upon a request by an issuer to receive a waiver from a network requirement, the Insurance Commissioner would be required to set a public hearing for a determination of whether there is good cause for a waiver. TDI would notify affected providers, and they would be allowed to submit evidence and attend the hearing. A physician or physician group referenced in an insurer's waiver may not be identified by name at the hearing without advance consent. TDI would review all evidence, including the total number of providers, population density and geographical information, and availability of services in the area to determine whether a good faith effort was made. The commissioner would be prohibited from considering the prohibition on balance billing and could not grant a waiver without a public hearing. A policyholder would be entitled to seek judicial review of the commissioner's decision. In their annual reports, issuers would be required to include any waiver requests made and granted, any material deviations from adequacy standards reported to TDI and any corrective actions, sanctions, or penalties assessed. The bill would also prohibit any "adverse material changes" to a preferred provider contract during the term of the contract unless there was mutual agreement of the parties, and it would make any provisions stating that an insurer can make changes unilaterally void and unenforceable. "Adverse material change" is defined to mean a change in a preferred provider contract that would decrease compensation, a change to a less preferred tier, or a change in any administrative procedures that would increase the provider's expenses. "Adverse material change" would not include a decrease in payment based solely on a change in a published fee schedule, a decrease in payment that was anticipated in the terms of a contract, or an administrative change that was identified in the contract. Under the bill an adverse material change may not go into effect until 120 days after the provider agrees to the change. A proposed change by an insurer must include a notice that clearly identifies the change, with a statement that the provider may choose not to agree. Failure to agree would not affect the terms of the existing contract or participation in other plans. If the issuer does not include the required notice with the proposed amendment, an otherwise agreed-to adverse material change would be void and unenforceable.

TAHP POSITION: Oppose as filed; Neutral with changes made in cs

COVERAGE TYPES: EPO/PPO EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24

TAHP POSITION STATEMENT:

DATE UPDATED: 3/8 KS

4/11/23 hearing- Neutral, testified

Bill History: 04-11-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance
04-11-23 H Committee action pending House Insurance
04-13-23 H Voted favorably from committee as substituted House Insurance

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HB 3413 Frank, James PBM and Health Plan Relationships

Remarks: SUMMARY: This bill would prohibit health benefit plans that have an ownership or investment interest in a pharmacy benefit manager (PBM) from requiring the use of that PBM for the administration of pharmacy benefit.

TAHP POSITION: Opposed

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

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

TAHP POSITION STATEMENT: When health plans are licensed at the department they must identify things the pharmacy benefit manager used. Therefore changing a PBM would require a cumbersome licensure change. TAHP is concerned about the impact of this bill.

DATE UPDATED: 3/12 KS 3/29 BH

Bill History: 03-03-23 H Filed
03-16-23 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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HB 3467 Martinez, Arman Emergency medical services personnel coverage

Bill History: 03-03-23 H Filed
03-16-23 H Introduced and referred to committee on House Public Health

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HB 3502 Leach, Jeff Gender transition Reversal Coverage Mandate

Remarks: SUMMARY: This bill would require an issuer that provides coverage for gender transition procedures to provide coverage for all possible adverse consequences related to gender transition, testing or screening necessary to monitor the enrollee, and any procedure necessary to reverse the gender transition

procedure. It would also require the issuer to provide coverage to an enrollee who has undergone a gender transition procedure regardless of whether the enrollee was enrolled in the plan at the time of the procedure or treatment.

TAHP POSITION: Neutral

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 9/1/23

DATE UPDATED: 3/8 KS

4/11/23 hearing- Neutral

Bill History: 03-16-23 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

HB 3524 Johnson, Ann Dental Anesthesia Mandate for kids

Companions: SB 1178 Lamantia, Morgan (F) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would require insurers to cover general anesthesia in connection with dental services provided to individuals under 13 years old if, as determined by the physician or dentist, the patient is unable to undergo dental treatment without it and the anesthesia is performed by an anesthesiologist or a dentist anesthesiologist. The bill would not require coverage of dental care or procedures.

TAHP POSITION: Oppose-Amend - require anesthesia to be medically necessary

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

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

TAHP POSITION STATEMENT: Inappropriate general anesthesia for pediatric dental has tragically led to the deaths of several children in the United States and in Texas. Texas investigators uncovered numerous instances of fraud in pediatric dental that led to millions in settlements with pediatric dentists. State auditors found that "In total, 28 percent of the Medicaid pediatric dental sedation records randomly selected for review did not have sufficient documentation to justify sedation procedures." That's why HHSC implemented strict prior authorization requirements. TAHP is opposed to the bill because

under the proposal, health plans would be prohibited from using all prior authorization safety checks to ensure that childhood dental anesthesia is safe and necessary.

DATE UPDATED: 2/27 KS 3/11 BH

4/11/23 hearing- Neutral, testified

Bill History: 03-16-23 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

HB 3566 Bucy, John Substance and addiction treatment standards

Remarks: SUMMARY: This bill would require HHSC to use and encourage the use of the most recently published standards on substance use and addiction treatment. It would also require issuers that provide coverage for mental health or substance use disorders to use the DSM 5th edition, for the purposes of classifying and determining coverage for mental illness.

TAHP POSITION: Oppose

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History: 03-06-23 H Filed
03-16-23 H Introduced and referred to committee on House Insurance

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HB 3586 Cole, Sheryl Coverage provision abortion and contraception

Companions: SB 1623 Eckhardt, Sarah (Identical)
3-16-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would allow Medicaid to provide abortion services and FDA approved forms of contraception regardless of whether federal matching funds are available. The bill would prohibit utilization review and other delays of coverage in the Medicaid program for those services.

The bill also applies to commercial insurers. Currently, certain health benefit issuers may provide

coverage for elective abortions. This bill would require them to do so, and it would require coverage of all FDA forms of contraception, including voluntary sterilization. The services would not be subject to any cost sharing, utilization review, or step-therapy requirements.

TAHP POSITION: This is a non-Lege Council draft and under review

COVERAGE TYPES: Medicaid, Commercial

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/16 KS, 3/23 JL

Bill History: 03-06-23 H Filed
03-16-23 H Introduced and referred to committee on House Human Services

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HB 3767 Bucy, John Health benefit coverage lung cancer exams

Remarks: SUMMARY: This bill would require issuers that provide coverage for diagnostic medical procedures to provide coverage for annual medically recognized examinations for the early detection of lunch cancer for each person who is at least 50 years old and is a current smoker or has a family history, genetic risk factor, or occupational exposure that would increase the risk of lung cancer. It would also require each issuer to provide notice of the coverage to each person enrolled in the plan.

TAHP POSITION: Neutral

COVERAGE TYPES: EPO/PPO, HMO, MEWA

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

DATE UPDATED: 3/16 KS

Bill History: 03-07-23 H Filed
03-20-23 H Introduced and referred to committee on House Insurance

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HB 3773 Johnson, Julie Out of Network Prompt Pay Mandate

Remarks: SUMMARY: This bill would require issuers to accept relevant clinical records submitted by a treating provider. Also, it would clarify that for the purposes of a penalty under the clean claims law, the contracted rate for health care services is the usual and customary rate for the service in the relevant geographic area. It would also expand the prompt pay law to all out-of-network providers.

TAHP POSITION: Oppose

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

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History: 03-07-23 H Filed
03-20-23 H Introduced and referred to committee on House Insurance

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HB 3800 King, Ken AWP School Based MH Providers Mandate

Remarks: SUMMARY: This bill would prohibit issuers from denying participation of school campus-based mental health professionals in plan networks if they meet credentialing requirements. Campus-based mental health professional would include social workers, counselors, psychological associates, or psychologists who provider services on school campuses.

TAHP POSITION: Oppose

COVERAGE TYPES: PPO/EPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: We are concerned about the workability of this concept. Under the proposal, a small segment of students, roughly 17%, would have a new benefit at schools covered under their state regulated health plan. We are unclear if school districts or health providers entering into schools would bill for these services. We are also unclear how parent involvement and consent would work for these mental health visits. Additionally, the bill creates an "any willing provider" requirements essentially giving one party in a contract power over another. TAHP has identified solutions for increasing behavioral health care access. 50% of Texas kids are covered through Medicaid, however, these publicly funded programs do not offer the same level of coverage in the commercial insurance market.

DATE UPDATED: 3/16 KS, 4/7 BH

4/10/23 hearing- Oppose, testified

Bill History: 03-07-23 H Filed
03-20-23 H Introduced and referred to committee on House Select on Youth Health & Safety
04-10-23 H Meeting set for 2:30 P.M. OR ADJ., E2.026 - House Select on Youth Health & Safety

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HB 3846 Toth, Steve E-Verify for all employers

Companions: SB 1621 Kolkhorst, Lois (Identical)
4-11-23 S Committee action pending Senate Business and Commerce

Remarks: SUMMARY: Requires all employers in the state to use E-Verify for new employees. Prohibits the state from contracting with vendors or subcontractors that do not use e-Verify.

TAHP POSITION: In review

EFFECTIVE DATES: Sept. 1, 2023. State agencies who contract with vendors have until Oct. 1, 2023 to establish procedures.

DATE UPDATED: 3/8 by JL

Bill History: 03-07-23 H Filed
03-20-23 H Introduced and referred to committee on House State Affairs

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HB 3848 Oliverson, Tom Ambulance Network Adequacy

Remarks: SUMMARY: This bill would add EMS providers to the definition of "provider." It would also require TDI to establish minimum access standards for nonemergency ambulance transport services. Issuers offering plans that cover nonemergency ambulance transport services would be prohibited from denying reimbursement to an in-network EMS provider solely because the service is provided by an EMS provider. The bill would create a penalty of up to $1,000 for each unpaid claim.

TAHP POSITION: Reviewing

COVERAGE TYPES: HMO, PPO/EPO

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED: 3/16 KS

4/4/23 hearing- Oppose, testified

Bill History: 03-20-23 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 3912 Morales Shaw, P Insulin Copay Cap Mandate Expansion

Remarks: SUMMARY: This bill would expand the applicability of the current prescription insulin copay cap of $25 per prescription for a 30-day supply to other coverage.

The law would include Lloyd's plans, small employer coverage, consumer choice plans, agricultural organizations, Texas Mutual Insurance, church benefits, and other small products.

TAHP POSITION: Neutral

COVERAGE TYPES: Lloyd's plans, small employer coverage, consumer choice plans, agricultural organizations, Texas Mutual Insurance, church benefits, and other small products.

EFFECTIVE DATES: Delivered, issued for delivery, or renewed on or after 1/1/24 DATE UPDATED: 3/17 KS

Bill History: 03-07-23 H Filed
03-20-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 3942 Bhojani, Salman Health benefit plan coverage telemedicine

Remarks: SUMMARY: This bill would require coverage of telemedicine and telehealth services when the originating or distant site is located outside of the state on the same basis and to the same extent that the plan providers coverage for telemedicine and telehealth services with an originating or distant site is located in the state.

TAHP POSITION: Neutral

COVERAGE TYPES:

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History: 03-20-23 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

HB 3948 Bernal, Diego Dyslexia screening

Remarks: SUMMARY: This bill would require coverage for the screening, diagnosis, and treatment of dyslexia for children between 4 and 10 years old. The coverage would have to include screening and by a validated tool or parental questionnaire and a complete evaluation upon referral by a person conducting the screening.

TAHP POSITION:

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History: 03-07-23 H Filed
03-20-23 H Introduced and referred to committee on House Insurance

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HB 3985 Raney, John MDCP Private Coverage Continuity of care

Companions: SB 1666 Parker, Tan (F) (Identical)
3-16-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Currently, if a person who is enrolled in Medicaid and private insurance has a relationship with a provider, and the private insurer terminates its contract with that provider, Medicaid is required to contract with the provider to ensure an enrollee has continuity of care. This bill would require the insurer, when the enrollee has complex medical needs, to continue reimbursing the provider for an additional 90 days after the end of the original contract, until they are contracted with Medicaid.

Expands the definition of speciality provider to include durable medical equipment providers.

TAHP POSITION: Oppose DME providers are NOT providers at all and should not be considered specialty providers.

COVERAGE TYPES: PPO/EPO

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

DATE UPDATED: 4/7 by JL

4/11/23 hearing- Oppose, testified

Bill History: 03-20-23 H Introduced and referred to committee on House Human Services
04-11-23 H Meeting set for 8:00 A.M., E2.030 - House Human Services
04-11-23 H Committee action pending House Human Services

HB 4067 Vo, Hubert Examinations health maintenance organizations

Remarks: SUMMARY: This bill would require TDI to examine HMOs and PPOs to determine if they are in compliance with utilization review requirements. TDI would be allowed to conduct reviews as often as necessary, but at least once annually.

TAHP POSITION: Oppose

COVERAGE TYPES: PPO/EPO, HMO, Medicaid, CHIP

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

4/4/23 hearing- Oppose, testified

Bill History: 03-20-23 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 4291 Swanson, Valore Treatment patient by a physical therapist

Companions: SB 584 Hughes, Bryan (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would increase the number of days that a physical therapy could treat a patient without a referral from 10 to 30. It would also delete the current carveout that allows PTs to treat for up to 15 days if they have a doctoral degree and have completed residency/certification.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 9/1/23

MANDATE: Benefit

POSITION STATEMENT: Following the passage of HB 29 in the 86th legislative session PTs now have direct access to treat patients without a licensure requirement to obtain a physician referral for 10 or 15 days. TAHP is concerned that PTs are taking advantage of this new law to dramatically increase the number of PT visits that can be achieved in the short time frame without a physician referral. PTs have admitted that the direct access law change now accounts for 50% of their practice revenue. Further, TAHP is concerned about claims from physical therapists that HB 29 converted their licensure to

primary care providers in their arguments to mandate their services be covered at typically lower copays that insurers set for primary care provider. Those primary care copays are typically lower as a means to encourage patients to seek primary care and in recognition that primary care providers provide a crucial role in health care in coordinating patient care. PTs are not primary care providers and are not licensed or trained to provide the services of primary care providers. TAHP is concerned that further removing licensure requirements to skip physician involvement in patient care when combined with a new copay cap mandate will open patients up to inappropriate treatment and strain benefit design to increase primary care copays.

LAST UPDATED: 3/11 BH

Bill History: 03-09-23 H Filed
03-21-23 H Introduced and referred to committee on House Public Health

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HB 4300 Guillen, Ryan Expedited credentialing physician assistants

Remarks: SUMMARY: This bill would require an issuer to create an expedited credentialing process for PAs and NPs who join an established medical group that has a contract with the issuer. It would require an issuer to treat an applicant as if they are a participating provider for payment purposes after they apply. If the provider fails to meet credentialing requirements, the issuer may recover the difference between payments for in-network and out-of-network benefits.

TAHP POSITION: Neutral

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/17 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
04-13-23 H Voted favorably from committee as substituted House Insurance

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HB 4326 Bonnen, Greg Direction utilization review by physicians

Remarks: SUMMARY: This bill would prohibit physicians who direct utilization review from holding an administrative license. It would also state that the

direction of utilization review would be considered the practice of medicine.

The bill would allow the Texas Medical Board (TMB) to determine whether a physician has directed utilization review in an arbitrary manner or without a medical basis. It would allow the TMB to restrict, suspend, or revoke the license of a physician that the TMB determines has directed utilization review in an arbitrary manner or without medical basis. If the utilization review results in serious injury or death of an individual, TDI would be allowed to temporarily prohibit a physician from directing utilization review and the TMB would be allowed to temporarily suspend the physician's license. The suspension would be effective until the TMB can conclude a proceeding to determine whether the utilization review was directed arbitrarily or without medical basis.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History: 03-09-23 H Filed
03-21-23 H Introduced and referred to committee on House Public Health

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HB 4343 Bonnen, Greg Health benefit plan preauthorization

Remarks: SUMMARY: This bill would prohibit physicians who direct utilization review from holding an administrative license. It would also state that the direction of utilization review would be considered the practice of medicine.

The bill would allow the Texas Medical Board (TMB) to determine whether a physician has directed utilization review in an arbitrary manner or without a medical basis. It would allow the TMB to restrict, suspend, or revoke the license of a physician that the TMB determines has directed utilization review in an arbitrary manner or without medical basis. If the utilization review results in serious injury or death of an individual, TDI would be allowed to temporarily prohibit a physician from directing utilization review and the TMB would be allowed to temporarily suspend the physician's license. The suspension would be effective until the TMB can conclude a proceeding to determine whether the utilization review was directed arbitrarily or without medical basis.

The bill would also state that, to qualify for an exemption from preauthorization, a physician would not have to perform a health care service a minimum number of times. Additionally, a physician reviewing a denial or rescission of a preauthorization exemption would be prohibited from holding an administrative license. Also, a decision to deny a preauthorization exemption would be appealable to a physician. The bill would require issuers to submit reports to TDI on the exemptions granted by the issuer and determinations to rescind or deny exemptions.

TAHP POSITION: Opposed as filed/Negotiating with bill author

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/16 KS

Bill History:

03-09-23 H Filed
03-21-23 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 4347 Harrison, Brian Point of Sale Rebates Mandate

Remarks:

SUMMARY: This bill would require a PBM that obtains a reduction in price on a prescription drug from a manufacturer that the reduction is reflected completely in the price when it is dispensed to an enrollee at a pharmacy. Charging the patient a fixed-dollar copayment less than the net price negotiated by the PBM satisfies the section. Any coinsurance charged by the PBM must reflect the reduction in price. The PBM or issuer my provide the price reduction directly to the dispensing pharmacy or require the manufacturer through a point-of-sale chargeback. Finally, the bill would make PBMs liable to state of three times the amount of the price reduction plus $5,000 for each violation that occurs.

TAHP POSITION: Oppose

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

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

TAHP POSITION STATEMENT: The bill as filed is inconsistent with the Select House Committee on Health Care Reform's interim recommendation to "consider opportunities to ensure rebates are used to lower the cost of coverage." The filed bill prescribes how rebates must be used just for the small group of patients that take very expensive drugs and would prohibit an employer from using rebates to lower the

costs of health care for all employees. TAHP agrees something must be done to lower prescription drug prices. However, taking away employer choice is the wrong way. We believe employers should have the choice of how to best use rebate savings including lowering premiums for all employees, adding more generous benefits, or further reducing employee costs at the pharmacy counter. Those choices have trade offs and a mandatory point-of-sale, one-size-fits-all policy would actually increase drug costs overall. Under this approach, only a few patients may see their costs go down at the pharmacy counter for one drug, but premiums and out-of-pocket costs go up for all. Moreover, this practice would reduce Pharma's incentive to lower the prices of their drugs by further masking the cost of high priced brand-name drugs. An independent fiscal review found a similar bill in California was estimated to impact only 3.48% of prescriptions but would have increased health insurance premiums by $200 million annually. The review also found that a point of sale rebate mandate would only help 4% of enrollees but would increase premiums for 100% of enrollees. The California Senate Appropriations Committee refused to advance that bill due to the increased premium cost. The Congressional Budget Office (CBO) estimated that a Medicare point of sale rebate mandate would increase premiums by $43 billion (25%) over a decade and federal spending by $137 billion, so it was never implemented. Rebates reduce the cost of prescription drug coverage at the Teacher Retirement System by 30%. Without these savings, Texas would have to replace this cost with taxpayer dollars or by substantially increasing premiums to active and retired teachers. Employers cover the bulk of premiums for employees—more than 80%. They should be able to choose what to do with rebates. Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, as Pharma continues to set very high prices for their prescription drugs and raise them year after year.

DATE UPDATED: 3/16 KS 3/29 BH

Bill History: 03-09-23 H Filed
03-21-23 H Introduced and referred to committee on House Select on Health Care Reform

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HB 4367 Cortez, Philip Preauthorization medical health care services

Remarks: SUMMARY: Currently, health plans are prohibited from reviewing a claim for medical necessity if the plan has already preauthorized the service. This bill would prohibit plans from reviewing for eligibility or coverage determinations if the service is provided within 31 days of the preauthorization unless the

provider has materially misrepresented the service or substantially failed to perform.

TAHP POSITION: TAHP does not have concerns with the overall goal of the bill. When a service is preauthorized, a plan will typically check for eligibility and coverage before responding. However, as the bill is currently drafted, it could require a health plan to cover services for an enrollee who has terminated their coverage. For example, consider a situation where a service is preauthorized on December 15th, the enrollee selects a new plan starting January 1st, and then the service is provided on January 10th. Under this bill, the service would have been preauthorized, so the plan could not check for eligibility or coverage when the service was provided on January 10th, as 31 days would not have passed. This would have the unintended consequence of requiring reimbursement for service provided to individuals who are no longer enrolled in the plan. The bill should be amended to create an exception for plans that have terminated.

COVERAGE TYPE: EPO/PPO, HMO

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

DATE UPDATED: 3/31 KS

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

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HB 4377 Harless, Sam Relationship between managed care plans

Bill History:

03-09-23 H Filed
03-21-23 H Introduced and referred to committee on House Insurance

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HB 4500 Harris, Carolin ER Verification of Payment Mandate

Companions:

SB 863 Hughes, Bryan (Identical)
3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:

SUMMARY: This bill would require issuers to maintain a website that would allow providers in hospitals or Freestanding ERs to determine whether a patient is covered, whether the issuer will pay the provider for a proposed health service and any cost sharing

requirements for which the patient is responsible.

TAHP POSITION: Oppose as filed|offered redline to author

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

EFFECTIVE DATES: 1/2/24

TAHP POSITION STATEMENT: TAHP is concerned that this mandate creates a payment guarantee before health plans can determine if services meet payment requirements. For example, under the bill health plans would be forced to make payments for outrageous charges at freestanding ERs that billed $10,000+ for asymptomatic COVID-19 testing throughout the COVID-19 pandemic. Additionally, we are concerned about being able to create an appropriately secure, HIPAA compliant member eligibility tool that would be available on a website. Health plans use provider portals, which provide all necessary security requirements and verification needed to validate identity and provider status as a part of that security protocol.

DATE UPDATED: 2/19 KS, BH 3/11

Bill History:

03-09-23 H Filed
03-21-23 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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HB 4501 Harris, Carolin Uniform coordination benefits questionnaire

Companions:

SB 1051 Hughes, Bryan (Identical)
4- 5-23 S Committee action pending Senate Health and Human Services

Remarks:

SUMMARY: This bill would require TDI to adopt rules establishing a uniform coordination of benefits questionnaire to be used by all health benefit plan issuers and administrators. Issuers would be required to use the uniform questionnaire and make it available to health care providers.

TAHP POSITION: Reviewing

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

EFFECTIVE DATES: Questionnaire adopted by 1/1/24 and used by 2/1/24

DATE UPDATED: 3/16 KS

Bill History:

03-09-23 H Filed
03-22-23 H Introduced and referred to committee on

House Insurance

HB 4505 Cortez, Philip Health benefit plan coverage treatment autism

Remarks: SUMMARY: This bill would require issuers to cover any medically necessary treatment of autism spectrum disorder. "Medically necessary" would mean a service or product that addresses the needs of a patient, is delivered in accordance with recognized standards, is clinically appropriate, and is not provided primarily for the economic benefit of a health benefit plan issuer. This bill would prohibit issuers from screening for autism spectrum disorder more than once every 10 years, placing a limitation on screenings, or restricting settings in which a screening could take place. It would also expand the current coverage requirement to include persons who were diagnosed after their 10th birthday.

TAHP POSITION:

COVERAGE TYPES: Commercial (group only), MEWAs, ERS/TRS

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History: 03-09-23 H Filed
03-22-23 H Introduced and referred to committee on House Insurance

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HB 4506 Cortez, Philip Health benefit plan coverage treatment

Companions: SB 2176 Lamantia, Morgan (F) (Identical)
3-22-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would prohibit issuers from screening for autism spectrum disorder more than once every 10 years, and would expand the current coverage requirement to include persons who were diagnosed after their 10th birthday.

TAHP POSITION: Opposed as filed|Offering redline to be neutral

COVERAGE TYPES: Commercial (group only), MEWAs, ERS/TRS

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History:

03-09-23 H Filed
03-22-23 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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HB 4713 Plesa, Mihaela First episode psychosis mandate

Companions:

SB 1220 Zaffirini, Judith (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks:

SUMMARY: This bill would define "first episode psychosis" as the initial onset of psychosis caused by medical and neurological conditions, serious mental illness, or substance abuse. It would require group health benefit plans to provide coverage, based on medical necessity as determined by a stakeholder group, to an individual who is younger than 26 and who is diagnosed with first episode psychosis. The issuer must include coverage for all generally recognized services, including coordination of specialty care, assertive community treatment, and peer support services. The plan would be required to reimburse providers of coordinated specialty care and assertive community care using a bundled payment model. If requested by an issuer on or after 3/1/29, the department would be required to contract with an independent third party to perform an analysis of the impact of the requirement of covering team-based treatment models described by the bill. If the analysis finds that premiums increased by more than one percent, issuers are not required to comply. The bill would also establish a workgroup of providers and issuers to determine medical necessity criteria and a coding solution for these services. The department will adopt rules by 1/1/24.

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, MEWA, Medicaid, ERS/TRS

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

MANDATE: Benefit

TAHP POSITION STATEMENT: An almost identical proposal in California estimated that this mandate would cost $70 million per year for the state to implement in the commercial and state coverage market for the treatment of just 5,000 enrollees. This legislation goes further to require Medicaid programs to cover this mandate. Further, California's independent mandate review commission noted that the proposal "does not appear to be more effective than outpatient treatment-as-usual for other outcomes (relapse rates, psychotic and depressive symptoms, and quality of life)." TAHP opposes expensive mandates particularly when they demonstrate little or no value to patients.

UPDATED: 3/11 BH

4/11/23 hearing- Oppose, testified

Bill History: 03-22-23 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

HB 4773 Bonnen, Greg Any Willing Provider at 90% of Highest Rate

Companions: SB 2442 Perry, Charles (Identical)
3-23-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would allow physicians to apply for designation as a participating provider and would require issuers to designate them as participating providers. The issuer would be required to reimburse the physician at 90% of the highest contracted rate for the same service.

TAHP POSITION:

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/17 KS

Bill History: 03-10-23 H Filed
03-22-23 H Introduced and referred to committee on House Insurance

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HB 4798 Talarico, James Governmental health benefit plan coverage

Remarks:

SUMMARY: This bill would require governmental health benefit plans to provide coverage for opioid antagonists and associated devices.

TAHP POSITION: Neutral

COVERAGE TYPES: ERS/TRS/University, Medicaid/CHIP

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

DATE UPDATED: 3/17 KS

Bill History:

03-10-23 H Filed
03-22-23 H Introduced and referred to committee on House Insurance

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HB 4893 Bonnen, Greg Any Willing Hospital at 90% of highest rate

Remarks:

SUMMARY: This bill would allow hospitals to apply for designation as a participating provider and would require issuers to designate them as participating providers. The issuer would be required to reimburse the provider at 90% of the highest contracted rate for the same service.

TAHP POSITION:

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/129KS

Bill History:

03-10-23 H Filed
03-23-23 H Introduced and referred to committee on House Insurance

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HB 4912 Martinez Fische Availability benefits provided under health

Companions:

HB 1529	Martinez Fischer, Trey	(Refiled from 87R Session)
HB 1541	Johnson, Julie	(Refiled from 87R Session)
SB 459	Johnson, Nathan	(Refiled from 87R Session)

Remarks:

SUMMARY: This bill requires health plans 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. It would also require coverage of Essential Health Benefits

TAHP POSITION:

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

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/29 KS

Bill History: 03-10-23 H Filed
03-23-23 H Introduced and referred to committee on House Insurance

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HB 5113 Johnson, Julie No UR/PA for In-network providers

Companions: HB 1145 Johnson, Julie (Refiled from 87R Session)

Remarks: SUMMARY: This bill would prohibit utilization review, including preauthorization, of a health care service provided to an enrollee by a participating provider. It would also either repeal the existing utilization review requirements in law or amend them so that they only apply to out-of-network providers.

TAHP POSITION:

COVERAGE TYPES: PPO/EPO, HMO

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/20 KS

Bill History: 03-10-23 H Filed
03-24-23 H Introduced and referred to committee on House Insurance

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HB 5121 Turner, Chris Health benefit plan coverage treatment

Remarks: SUMMARY: This bill would expand the current requirements for coverage parity for chemical dependency to individual plans and ERS/TRS/University plans. The bill would also

prohibit lifetime limits on coverage for chemical dependency services and require that the services be provided at an appropriate level of care.

TAHP POSITION:

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/20 KS

Bill History: 03-10-23 H Filed
03-24-23 H Introduced and referred to committee on House Insurance

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HB 5211 Thompson, Senfr Health benefit plan coverage certain formulas

Bill History: 03-10-23 H Filed
03-24-23 H Introduced and referred to committee on House Insurance

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HB 5230 Bucy, John Health benefit plan coverage prescription

Remarks: SUMMARY: This bill prohibits health benefit plans that cover serious mental illness (SMI) to fail to successfully respond to a different drug or prove a history of failure in order to get coverage for a prescribed drug. The bill would only apply to FDA-approved drugs, and would not apply to enrollees who are under 18. The bill would also prohibit prior authorizations for medication-assisted substance use disorder treatment, except as needed to minimize the opportunity for fraud, waste, and abuse. Finally, the bill would remove the current sunset date for the current medication-assisted treatment mandate.

TAHP POSITION: Oppose

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/29 KS

Bill History: 03-10-23 H Filed
03-24-23 H Introduced and referred to committee on House Insurance
04-18-23 H Meeting set for 8:00 A.M., E2.014 - House Insurance

HB 5233 Bucy, John Expedited credentialing licensed behavior

Remarks: SUMMARY: This bill would require health benefit plans to expedite the credentialing for behavioral analysts who join an established professional practice that contracts with the plan. For expedited credentialing, the provider must be licensed and in good standing, submit all documentation, and agree to comply with the terms of the existing preferred provider contract. After an applicant has submitted the required information, the issuer would be required to begin reimbursing the provider, but the issuer may recover payments if the provider fails to meet credentialing requirements.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/29 KS

Bill History: 03-10-23 H Filed
03-24-23 H Introduced and referred to committee on House Insurance

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SB 358 Kolkhorst, Lois Right to Shop Mandate

Remarks: SUMMARY: SB 358 provides for increased provider price transparency and requires sharing "savings" with enrollees who obtain services for less than the average network cost from out-of-network providers. Health plans must establish toll-free number and website to allow enrollees to obtain average network payments. If an enrollee receives services that are less expensive, the health plan must pay the enrollee 50% of the difference (less applicable deductible, co-pay, coinsurance) if saved cost is over $50.

TAHP POSITION: Amend to make it optional in the private market.

COVERAGE TYPES: Commercial, ERS

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

MANDATE: Benefit

TAHP POSITION STATEMENT: While new Federal rules encourage health plan arrangements that incentivize patients to shop for low-cost, high-value providers, Texas prohibits these benefit designs. Insurers can’t use innovative solutions like lower out-of-pocket costs to reward patients for being smart shoppers. Texas should open up the door to

private market innovations that can motivate patients to be savvy health care shoppers. However, government mandates don't lead to innovation and can't keep pace with consumer behavior. Lawmakers should avoid mandates that prescribe right-to-shop programs with one-size-fits all designs. Instead, focus on removing barriers that hinder innovative attempts to motivate patients to high-value care.

DATE MODIFIED: 2/3/23 JB

Bill History: 01-05-23 S Filed
02-15-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 447 Menendez, Jose Fertility preservation mandate

Companions:

HB 389	Collier, Nicole	(Identical)
	4- 4-23 H Committee action pending House Insurance	
HB 1649	Button, Angie Chen	(Identical)
	4- 4-23 H Committee action pending House Insurance	

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: Delivered, issued for delivery, or renewed on or 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. Government mandates and overregulation hinder innovation and add costs to an already expensive system. This expense is 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.

UPDATED: 2/3 BH

Bill History: 01-12-23 S Filed
02-15-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 452 Menendez, Jose SMI Step Therapy Mandate

Companions: HB 1337 Hull, Lacey (Identical)
4-13-23 S Referred to Senate Committee on Senate Health and Human Services

Remarks: SUMMARY: This bill limits step therapy for drugs prescribed to treat a serious mental illness to trying only one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug. For continued therapy of an SMI drug that someone is already taking, a health benefit plan issuer may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only once in a plan year and only if the equivalent drug is added to the plan's drug formulary.

TAHP POSITION: Neutral (negotiated language)

COVERAGE TYPES: Commercial

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

MANDATE:Benefit

POSITION STATEMENT: TAHP negotiated language with the authors to add these new step therapy exceptions but ensure that lower cost generic and pharmaceutical equivalent drugs can still be used to

lower costs. TAHP will be neutral on this bill as long as language is not added to freeze the formulary or go beyond the agreement with the authors as reflected in the filed bill. Health plans must continue to be able to update drug formularies to bring patients the most affordable prescription drug options including lower cost alternatives.

DATE UPDATED: 3/8 BH

Bill History: 01-12-23 S Filed
02-17-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 583 Hughes, Bryan OON Out of Pocket Cost Mandate

Companions: HB 1364 Munoz, Sergio (Identical)
3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: This bill would state that a health care provider may not be prohibited from accepting directly from an enrollee full payment for a health care service in lieu of submitting a claim. A health care provider's discounted cash price would be considered full payment. The plan issuer would then be required to apply the charge towards the enrollee's out-of-pocket maximum, unless it was a payment for an uncovered service. The bill would apply to plans despite the fact that they require referrals for specialists, such as HMOs, and plans that do not have out-of-pocket costs, like Medicaid and CHIP. The bill also does not address whether the service is medically necessary or covered, whether it is actually a shoppable service, or whether the patient is shopping for a lower price.

TAHP POSITION: OPPOSED without guardrails added

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

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

TAHP POSITION STATEMENT: TAHP supports market-driven incentives for patients to choose the lowest cost and highest value health providers. The bill requires any out-of-network health care service to be counted towards a patient's out-of-pocket maximum regardless of whether or not that service was a covered service or provided at a lower cost than the in-network rate. Further, the bill does not consider whether these services are medically necessary or shoppable. TAHP opposes this bill unless guardrails are added that would require the service to be medically necessary, shoppable, and less expensive

than it would otherwise be with a network provider. TAHP also opposes the bill unless HMOs, Medicaid, and CHIP, are removed. HMOs require referrals from primary care providers, so allowing a patient to go directly to a specialty provider would undermine the entire purpose of an HMO, making it function like an EPO. Medicaid and CHIP do not have out-of-pocket maximums, so the bill does not make sense in those contexts. TAHP supports encouraging patients to shop for lower cost, medically necessary services and would not oppose legislation that rewards that shopping. However, the bill lacks the necessary guardrails to ensure that the result of the bill is to reward patients that find lower cost services.

DATE UPDATED: 3/7 KS

Bill History: 01-24-23 S Filed
02-17-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 584 Hughes, Bryan No Referral for 30 PT Visits

Companions: HB 4291 Swanson, Valoree (Identical)
3-21-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: This bill would increase the number of days that a physical therapy could treat a patient without a referral from 10 to 30. It would also delete the current carveout that allows PTs to treat for up to 15 days if they have a doctoral degree and have completed residency/certification.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 9/1/23

MANDATE: Benefit

POSITION STATEMENT: Following the passage of HB 29 in the 86th legislative session PTs now have direct access to treat patients without a licensure requirement to obtain a physician referral for 10 or 15 days. TAHP is concerned that PTs are taking advantage of this new law to dramatically increase the number of PT visits that can be achieved in the short time frame without a physician referral. PTs have admitted that the direct access law change now accounts for 50% of their practice revenue.

Further, TAHP is concerned about claims from physical therapists that HB 29 converted their licensure to primary care providers in their arguments to mandate their services be covered at typically lower copays that insurers set for primary care provider. Those primary care copays are

typically lower as a means to encourage patients to seek primary care and in recognition that primary care providers provide a crucial role in health care in coordinating patient care.

PTs are not primary care providers and are not licensed or trained to provide the services of primary care providers. TAHP is concerned that further removing licensure requirements to skip physician involvement in patient care when combined with a new copay cap mandate will open patients up to inappropriate treatment and strain benefit design to increase primary care copays.

LAST UPDATED: 3/11 BH

Bill History: 01-24-23 S Filed
02-17-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 622 Parker, Tan (F) RX Formulary API Mandate

Companions: HB 1754 Smithee, John (Identical)
4-13-23 H Voted favorably from committee as substituted House Insurance

Remarks: SUMMARY: This bill would require issuers to provide information regarding prescription drugs to enrollees, including the drug formulary, eligibility, cost-sharing information, and utilization management requirements. The issuer must respond in real time to a request made through a standard API, allow the use of integrated technology as necessary, ensure information is current not later than one day after a change is made, and provide information if the request is made using the drug's unique billing code. The issuer may not deny or delay a response, restrict providers from communicating the information, or discourage access to the information.

TAHP POSITION: Neutral if amended

COVERAGE TYPES: EPO/PPO, HMO, CC, TRS/ERS.

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

DATE UPDATED: 2/13 KS

4/5/23 hearing- Neutral

Bill History: 04-05-23 S Meeting set for 8:30 A.M., SENATE CHAMBER - Senate Health and Human Services
04-05-23 S Committee action pending Senate Health and Human Services

04-12-23 S Voted favorably from committee as substituted Senate Health and Human Services

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SB 634 Menendez, Jose Prohibits PAs for Autoimmune/Chronic Drugs

Remarks:

SUMMARY: Prohibits prior authorizations for prescription drugs for chronic or autoimmune disease

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial, Medicaid

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. Previous estimates show that eliminating prior authorizations for prescription drugs could cost ERS and TRS a combined $169 million over the next biennium, while Medicaid MCOs estimate an annual cost of over $100 million.

Most importantly, 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 the number of low-income Texas kids being prescribed dangerous antipsychotic drugs like Seroquel and Risperdal, in 2011 Texas Medicaid begin requiring prescribing doctors to receive a prior authorization from the state to protect these children from drugs with serious side effects.

Prior authorizations for prescription drugs protect patients from opioid abuse and severe drug interactions or reactions. Medical errors, including adverse drug events, are now the third leading cause of death in the United States, leading to more than 3.5 million physician office visits and 1 million

emergency department visits each year. Prior authorizations for prescription drugs are an important tool in preventing unnecessary medical care and ensuring patient safety.

DATE UPDATED: 2/17 BH

Bill History:

01-26-23 S Filed
02-17-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 676 Johnson, Nathan Expansion of in vitro mandate

Companions:

HB 2310	Gonzalez, Jessica	(Refiled from 87R Session)
HB 838	Gonzalez, Jessica	(Identical)
	4-18-23 H Meeting set for 8:00 A.M., E2.014, House Insurance	

Remarks:

SUMMARY: This bill 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: Delivered, issued for delivery, or renewed on or after 1/1/24

MANDATE: Benefit

DATE UPDATED: 2/19 KS

Bill History:

02-03-23 S Filed
02-17-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 724 Lamantia, Morga Telemedicine Payment Parity Mandate

Companions:

HB 1726	Hernandez, Ana	(Identical)
	3- 7-23 H Introduced and referred to committee on House Insurance	
SB 1043	Blanco, Cesar	(Identical)
	3- 3-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:

SUMMARY: This bill would require health plans to pay for a covered service provided as a telemedicine, telehealth, or teledentistry service on the same basis and at least at the same rate that the plan provides

reimbursement to that provider for the service in an in-person setting. In submitting claims, the provider could not be required to provide any documentation beyond what is required for an in-person setting. The bill also adds mental health professionals to the current telehealth coverage mandate in Texas.

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

TAHP POSITION STATEMENT: Mandating the same payment for brick-and-mortar office visits and telehealth visits is government rate setting and undermines telehealth's promises of efficiency and innovation. Independent experts across the political spectrum, including Brookings, the John Locke Foundation, Americans for Prosperity, TCCRI, the Foundation for Government Accountability, and the Progressive Policy Institute, have all said that telemedicine payment parity mandates are harmful to the future of telehealth and do nothing to improve the value of health care or increase access to telehealth. Payment parity mandates act as price floors for telemedicine by pegging the service to more expensive ones. They essentially require higher reimbursement rates for telehealth than would be negotiated without the mandate. That makes them price controls and keeps patients from benefiting from separately negotiated rates. Parity mandates prevent any telehealth cost savings from being passed along to patients in the form of lower premiums, deductibles, copayments or coinsurance. Telehealth access is expanding without government interference and rate setting. Patients are asking for telehealth access, and the market for insurance coverage is responding with numerous options for $0 copay telehealth visits. A payment parity mandate risks interfering in the market response to these patient needs.

DATE UPDATED: 2/18 BH

Bill History:

02-06-23 S Filed
03-01-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 807 Paxton, Angela 12 month contraception mandate

Companions:

HB 2651	Gonzalez, Jessica	(Refiled from 87R Session)
HB 916	Ordaz, Claudia (F)	(Identical)
	4-17-23 H Set on the House Calendar	

Remarks: SUMMARY: This bill would requires a health plan that provides 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

Bill History: 02-09-23 S Filed
03-01-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 860 Hughes, Bryan Any Willing Provider Mandate - Vision

Companions: HB 1696 Buckley, Brad (Identical)
4-11-23 H Voted favorably from committee as substituted House Insurance

Remarks: SUMMARY: This bill adds vision benefit plan issuers and administrators to the definition of "managed care plan" under this section. It also adds to the current prohibitions against a managed care plan - a managed care plan may not, with respect to optometrists, therapeutic optometrists, or ophthalmologists: 1) deny participation as a participating practitioner if they meets the credentialing requirements and agrees to the plan's terms; 2) use a fee schedule that reimburses differently based on professional degree held; 3) identify differently based on any characteristic other than professional degree held; or 4) encourage enrollees to obtain services at a particular provider or retail establishment. The bill would also require issuers to share with these providers complete immediate access to plan coverage information, publish complete plan information, allow providers to utilize third-party claim filing services that uses the standardized claim protocol, and allow the providers to receive reimbursement through an automated clearinghouse. The bill repeals the current provision that a network therapeutic optometrist must comply with the requirements of the Controlled Substances

Registration Program operated by DPS. The bill provides that a contract between a managed care plan and an optometrist or therapeutic optometrist may not provide for a chargeback (defined as "a dollar amount, administrative fee, processing fee, surcharge, or item of value that reduces or offsets the patient responsibility or provider reimbursement for a covered product or service) if, for a covered product or service that is not supplied by the health plan or for a reimbursement fee schedule for a covered product or service that is different from the fee schedule applicable to another optometrist or therapeutic optometrist because of provider's choice of optical laboratory or other source or supplier of services or materials. Finally, the bill would prohibit contracts with these providers that require prior authorization, require the provider to provide covered services at a loss, or require a reimbursement that has an applicable processing fee except a nominal fee for an EFT. It would also prohibit issuers from using extrapolation to audit optometrists or therapeutic optometrists. A violations of the subchapter be considered a deceptive act by the issuer for the purposes of Chapter 541.

TAHP Position: Oppose introduced - Neutral on House Substitute

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

TAHP POSITION STATEMENT: This mandate would restrict private market negotiations by forcing health plans to contract with any vision provider willing to meet the plan’s terms without regard to whether there is a need for additional providers in the plan’s network. “Any willing provider” mandates increase administrative costs but also raise network provider rates by removing incentives to negotiate reimbursements. There are numerous economic studies and Federal Trade Commission statements about the negative impact of any willing provider laws on the private market including elimination of competition and cons umer choice and increased health care costs.

According to the Federal Trade Commission, any willing provider laws “can limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of choice. These restrictions on competition may result in insurance companies paying higher fees to providers, which, in turn generally results in higher premiums, and may increase the number of people without coverage."

Furthermore, this bill mandates payment parity to providers regardless of education, training, and

licensed scope of practice. Payment parity mandates raise costs for Texas businesses and families and ignore the variation in training and experience among various providers.

DATE UPDATED: 3/5 BH

Bill History: 02-13-23 S Filed
03-01-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 861 Hughes, Bryan Coordination vision benefits

Companions: HB 1322 Buckley, Brad (Identical)
4-11-23 H Voted favorably from committee as substituted House Insurance

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

DATE UPDATED: 2/19 KS

4/12/23 hearing- Neutral

Bill History: 03-01-23 S Introduced and referred to committee on Senate Health and Human Services
04-12-23 S Meeting set for 8:30 A.M., SENATE CHAMBER - Senate Health and Human Services
04-12-23 S Voted favorably from committee as substituted Senate Health and Human Services

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SB 863 Hughes, Bryan ER Verification of Payment Mandate

Companions: HB 4500 Harris, Caroline (F) (Identical)
4-18-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

Remarks: SUMMARY: This bill would require issuers to maintain a website that would allow providers in hospitals or FEMCs to determine whether a patient is covered, whether the issuer will pay the provider for a proposed health service, and any cot sharing

requirements for which the patient is responsible.

TAHP POSITION: Oppose

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

EFFECTIVE DATES: 1/2/24

DATE UPDATED: 2/19 KS

Bill History: 02-13-23 S Filed
03-01-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 989 Huffman, Joan Biomarker Coverage Mandate

Companions: HB 3188 Bonnen, Greg (Identical)
4-18-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

Remarks: SUMMARY: This bill would require issuers to cover biomarker screenings if the test is evidence-based, scientifically valid, outcome-focused, and predominantly addresses the acute issue for which the test is being ordered. The test also must be supported by medical and scientific evidence.

TAHP POSITION: Neutral as long as bill is not amended (negotiated language)

COVERAGE TYPES: EPO, HMO, MEWA, small employer, CC, ERS/TRS/UT, Medicaid/CHIP

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

DATE UPDATED: 2/19 KS

3/29/23 hearing- Neutral, testimony

Bill History: 04-12-23 S 1 Floor amendment(s) adopted
04-12-23 S Passed (Vote: Y: 26/N: 4)
04-13-23 H Received in the House

SB 1003 Johnson, Nathan TDI Rec - Provider Directories

Companions: HB 1902 Smithee, John (Identical)
3-28-23 H Reported favorably from committee on House Insurance

Remarks: SUMMARY: This bill would expand the requirement for issuers to list facility-based providers in their provider directories. It would add non-physician providers, including CRNAs, nurse midwives, surgical assistants, physical therapists, among others. It was a recommendation in TDI's Biannual Report. This bill should be amended to clarify that providers only

need to be listed if they are not employed by the hospital and bill separately.

TAHP POSITION: Neutral with changes

COVERAGE TYPES: HMO, EPO, MEWA.

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/18 KS

3/29/23 hearing- Neutral

Bill History: 04-05-23 S Passed (Vote: Y: 31/N: 0)
04-06-23 H Received in the House
04-10-23 H Referred to House Committee on House Insurance

SB 1043 Blanco, Cesar Telemedicine Payment Parity Mandate

Companions:

HB 1726	Hernandez, Ana	(Identical)
	3- 7-23 H Introduced and referred to committee on House Insurance	
SB 724	Lamantia, Morgan (F)	(Identical)
	3- 1-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: This bill would require health plans to pay for a covered service provided as a telemedicine, telehealth, or teledentistry service on the same basis and at least at the same rate that the plan provides reimbursement to that provider for the service in an in-person setting. In submitting claims, the provider could not be required to provide any documentation beyond what is required for an in-person setting. The bill also adds mental health professionals to the current telehealth coverage mandate in Texas.

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

TAHP POSITION STATEMENT: Mandating the same payment for brick-and-mortar office visits and telehealth visits is government rate setting and undermines telehealth's promises of efficiency and innovation. Independent experts across the political spectrum, including Brookings, the John Locke Foundation, Americans for Prosperity, TCCRI, the Foundation for Government Accountability, and the Progressive Policy Institute, have all said that telemedicine payment parity mandates are harmful to the future of telehealth and do nothing to improve the value of health care or increase access to

telehealth. Payment parity mandates act as price floors for telemedicine by pegging the service to more expensive ones. They essentially require higher reimbursement rates for telehealth than would be negotiated without the mandate. That makes them price controls and keeps patients from benefiting from separately negotiated rates. Parity mandates prevent any telehealth cost savings from being passed along to patients in the form of lower premiums, deductibles, copayments or coinsurance. Telehealth access is expanding without government interference and rate setting. Patients are asking for telehealth access, and the market for insurance coverage is responding with numerous options for $0 copay telehealth visits. A payment parity mandate risks interfering in the market response to these patient needs.

DATE UPDATED: 2/18 BH

Bill History:

02-17-23 S Filed
03-03-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1051 Hughes, Bryan Health benefit plan questionnaires

Companions:

HB 4501 Harris, Caroline (F) (Identical)
3-22-23 H Introduced and referred to committee on House Insurance

Remarks:

SUMMARY: This bill would require TDI to adopt rules establishing a uniform coordination of benefits questionnaire to be used by all health benefit plan issuers and administrators. Issuers would be required to use the uniform questionnaire and make it available to health care providers.

TAHP POSITION: Neutral

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

EFFECTIVE DATES: Questionnaire adopted by 1/1/24 and used by 2/1/24

DATE UPDATED: 2/22 KS

4/5/23 hearing- Neutral

Bill History:

03-03-23 S Introduced and referred to committee on Senate Health and Human Services
04-05-23 S Meeting set for 8:30 A.M., SENATE CHAMBER - Senate Health and Human Services
04-05-23 S Committee action pending Senate Health and Human Services

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SB 1137 Schwertner, Cha ERISA Prescription Drug Mandate

Companions: HB 2021 Oliverson, Tom (Identical)
3-21-23 H Committee action pending
House Insurance

Remarks: SUMMARY: This bill would require a PBM to comply with the provisions of Chapter 1369, Insurance Code, regardless of whether a provision of that chapter is specifically made applicable to the plan. It would create an exception for plans expressly excluded by the applicability of a provision or if the commissioner determines that the nature of third-party administrators renders the provision inapplicable to PBMs.

TAHP POSITION: Oppose

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

POSITION STATEMENT: This bill applies every state created prescription drug mandate (insurance code chapter 1369) to self-funded employer health plans that are currently exempt under Federal ERISA laws. Employers (not health insurers) are harmed by HB 2021. Self-funded employers will suffer the cost of imposing state mandates including limits on narrow pharmacy networks or the use of onsite pharmacies, a one year wait before changing to lower cost generics/biosimilars, and limits on mail order pharmacies. Multi-state employers will have to design special coverage just for Texas employees. These mandates are expensive and cumbersome, that's why the bill exempts coverage for our elected officials personal health insurance and their employee's coverage. Large employers with thousands of employees use self-funded benefits. These are the biggest providers of health coverage and the biggest job creators in Texas. The intent of ERISA preemption is to encourage employers to offer their employees benefit plans. This has worked - 98% of Texas large employers provide coverage to their employees compared to only 50% of Texas small employers. The Texas Association of Business, Texas Business Leadership Council, Texans for Lawsuit Reform, and individual businesses like Hobby Lobby have all spoken out against ERISA preemption.

DATE UPDATED: 2/13 KS, 2/22 BH

Bill History: 02-23-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1139 Schwertner, Cha Prudent Layperson Mandate

Companions: HB 1236 Oliverson, Tom (Identical)

3-30-23 H Voted favorably from committee as substituted House Insurance

Remarks:

SUMMARY: This bill 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 unless protections for monitoring for fraud, waste, and abuse are added.

COVERAGE TYPES: Commercial and Medicaid

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

TAHP POSITION STATEMENT: TAHP opposes this bill 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 this bill would interfere in going after this abuse.

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

Bill History: 02-23-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1140 Schwertner, Cha OPIC Network Adequacy

Remarks: SUMMARY: This bill would apply the requirements related to the statewide health care data collection system, which currently applies to HMOs, to EPO/PPO plans, requiring them to submit health care charges, utilization data, provider quality data, and outcome data to HHSC's statewide health care data collection system.

The bill would also give the Office of Public Insurance Counsel (OPIC) the power to monitor the adequacy of networks offered by plans in the state and advocate to strengthen the overall adequacy or oversight of networks by opposing filings, applications, or requests related to adequacy and submitting complaints to TDI regarding the failure of plans to satisfy requirements.

The bill expands OPIC's authority to appear or intervene in a proceeding or hearing before TDI in a matter relating to the adequacy of a network and file objections and request a TDI hearing regarding any application, filing, or request related to an access plan or waiver. It would also require plans to file waiver requests and access plan filings with OPIC at the same time that they are filed with TDI.

The bill entitles OPIC to all health plan filings relating to network adequacy and allows them to submit written comments to TDI and otherwise participate regarding individual network adequacy filings. It allows OPIC to file complaints with TDI regarding whether a health plan operates with an inadequate network in this state, is potentially in violation of has been in violation of a state network adequacy law or regulation, or potentially has an inaccurate provider network directory, and to post on its website any complaint filed with TDI.

The bill requires OPIC to compare HMOs to HMOs, PPO plans to PPO plans and EPO plans to EPO plans

and to issue annual consumer report cards that evaluate and compare health plans' network adequacy.

TAHP POSITION: Neutral

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

3/29/23 hearing- Neutral, testimony

Bill History: 04-06-23 S Reported favorably from committee on Senate Health and Human Services
04-13-23 S First placement on Senate Intent Calendar for
04-17-23 S Placed on the Senate Calendar for

SB 1141 Schwertner, Cha Prohibits Extrapolation for FWA Audits

Companions:

SB 519	Schwertner, Charles	(Refiled from 87R Session)
HB 895	Munoz, Sergio	(Identical)
	4- 4-23 H Voted favorably from committee on House Insurance	

Remarks: SUMMARY: This bill 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 extrapola tion 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: 2/26 Bh

Bill History: 02-23-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1149 Menendez, Jose Mandates 24/7 Telephone Access for PAs/UR

Companions: HB 756 Johnson, Julie (Identical)
2-28-23 H Introduced and referred to committee on House Insurance

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: 9/1/23

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 cr eates 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.

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: 2/27 KS

Bill History: 02-23-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1150 Menendez, Jose Limits PA to 1/Year Autoimmune/Chronic Mandate

Companions: HB 755 Johnson, Julie (Identical)
4- 4-23 H Voted favorably from committee as substituted House Insurance

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: Oppose

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.

LAST UPDATED: BH 2/20

Bill History: 02-23-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1178 Lamantia, Morga Dental Anesthesia Mandate for kids

Companions: HB 3524 Johnson, Ann (Identical)
4-11-23 H Committee action pending House Insurance

Remarks: SUMMARY: This bill would require insurers to cover general anesthesia in connection with dental services provided to individuals under 13 years old if, as determined by the physician or dentist, the patient is unable to undergo dental treatment without it and the anesthesia is performed by an anesthesiologist or a dentist anesthesiologist. The bill would not require coverage of dental care or procedures.

TAHP POSITION: Oppose-Amend - require anesthesia to be medically necessary

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

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

TAHP POSITION STATEMENT: Inappropriate general anesthesia for pediatric dental has tragically led to the deaths of several children in the United States and in Texas. Texas investigators uncovered numerous instances of fraud in pediatric dental that led to millions in settlements with pediatric dentists. State auditors found that "In total, 28 percent of the Medicaid pediatric dental sedation records randomly selected for review did not have sufficient documentation to justify sedation procedures." That's why HHSC implemented strict prior authorization requirements. TAHP is opposed to the bill because under the proposal, health plans would be prohibited from using all prior authorization safety checks to ensure that childhood dental anesthesia is safe and necessary.

DATE UPDATED: 3/11 BH

Bill History: 02-23-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1220 Zaffirini, Judi First episode psychosis mandate

Companions: HB 4713 Plesa, Mihaela (F) (Identical)
4-11-23 H Committee action pending House Insurance

Remarks: SUMMARY: This bill would define "first episode psychosis" as the initial onset of psychosis caused by medical and neurological conditions, serious mental illness, or substance abuse. It would require group health benefit plans to provide coverage, based on medical necessity as determined by a stakeholder group, to an individual who is younger than 26 and who is diagnosed with first episode psychosis. The issuer must include coverage for all generally recognized services, including coordination of specialty care, assertive community treatment, and peer support services. The plan would be required to reimburse providers of coordinated specialty care and assertive community care using a bundled payment model. If requested by an issuer on or after 3/1/29, the department would be required to contract with an independent third party to perform an analysis of the impact of the requirement of covering team-based treatment models described by the bill. If the analysis finds that premiums increased by more than one percent, issuers are not required to comply. The bill would also establish a workgroup of providers and issuers to determine medical necessity criteria and a coding solution for these services. The department will adopt rules by 1/1/24.

TAHP POSITION: Opposed

COVERAGE TYPES: EPO/PPO, MEWA, Medicaid, ERS/TRS

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

MANDATE: Benefit

TAHP POSITION STATEMENT: An almost identical proposal in California estimated that this mandate would cost $70 million per year for the state to implement in the commercial and state coverage market for the treatment of just 5,000 enrollees. This legislation goes further to require Medicaid programs to cover this mandate. Further, California's independent mandate review commission noted that the proposal "does not appear to be more effective than outpatient treatment-as-usual for other outcomes (relapse rates, psychotic and depressive

symptoms, and quality of life)." TAHP opposes expensive mandates particularly when they demonstrate little or no value to patients.

UPDATED: 3/11 BH

Bill History:

02-27-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1221 Zaffirini, Judi Permanent Formulary Freeze Mandate

Companions:

HB 1646	Lambert, Stan	(Refiled from 87R Session)
SB 1142	Zaffirini, Judith	(Refiled from 87R Session)
HB 826	Lambert, Stan	(Identical)
	3- 1-23 H Introduced and referred to committee on House Insurance	

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: Delivered, issued for delivery, or renewed after 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: 02-27-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1277 Parker, Tan (F) Fertility Preservation Mandate

Remarks: SUMMARY: This bill would define "fertility preservation services" as the cryopreservation of sperm, unfertilized oocytes, and ovarian tissue. This bill would require coverage of fertility preservation for 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 or the American Society for Reproductive Medicine 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 American Society of Clinical Oncology or the American Society for Reproductive Medicine. The bill does not contemplate cost of long term storage and related costs if an enrollee no longer has coverage from a state regulated health plan.

TAHP POSITION: Oppose

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: 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. Government mandates and overregulation hinder innovation and add costs to an already expensive system. This expense is 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.

UPDATED: 3/2 KS

Bill History: 02-27-23 S Filed
03-09-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1298 Hughes, Bryan Requests arbitration billing disputes

Remarks: SUMMARY: This bill would define bad faith in a balanced billing dispute as failing to provide the material facts necessary or failing to send a representative to the mediation. If a party engages in bad faith mediation, the opposing party may request arbitration. Upon the request, TDI would select an arbitrator and require a determination not less than 30 days after the arbitrator receives the necessary information. Not later than 30 days after the arbitrator's written decision is provided, the issuer would be required to pay the facility.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Claims submitted after 1/1/24

TAHP POSITION STATEMENT: SB 1264 from the 86th legislative session was thoroughly negotiated to create dispute resolution systems including keeping facilities in the mediation system for disputing surprise bills. Instead of providing fair and honest billing and attempting to reach in-network agreements, freestanding ERs continue to harm patients and are now asking for special treatment that goes against SB 1264.

Over 80% of mediation requests come from FSERs as these companies have hired vendors to go back years to find more claims to take to mediation. But even with this volume of claims, over 90% are resolved in an informal phone call and just 1% of claims remain unresolved after mediation. For those

very small number of claims SB 1264 allowed providers to pursue a civil action. SB 1264 painstakingly envisioned all scenarios including bad faith mediation. This legislation goes against that legislation to reward freestanding ERs that have continuously price gouged for basic health care services including $10,000 COVID-19 Tests.

DATE UPDATED: 3/5 KS 3/13 BH

4/12/23 hearing- Oppose, testified

Bill History: 03-09-23 S Introduced and referred to committee on Senate Health and Human Services
04-12-23 S Meeting set for 8:30 A.M., SENATE CHAMBER - Senate Health and Human Services
04-12-23 S Committee action pending Senate Health and Human Services

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SB 1359 Schwertner, Cha Telemedicine services

Remarks: SUMMARY: This bill would require issuers to submit an annual report to TDI on whether each participating provider provide services in person in the area in which the plan's enrollees reside or through the use of telemedicine or telehealth services.

TAHP POSITION: Neutral

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

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/5 KS

Bill History: 03-01-23 S Filed
03-16-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1502 Middleton, Maye Health Plan Affiliated Providers

Companions: HB 3098 Johnson, Ann (Identical)
4- 4-23 H Committee action pending House Insurance

Remarks: SUMMARY: This bill would define "affiliate provider" to mean a provider that directly or indirectly controls, or is controlled by, a health benefit plan issuer. A "nonaffiliated provider" would mean a provider that does not directly or indirectly control, and is not controlled by, a health benefit plan issuer. The bill would prohibit an issuer from offering a higher reimbursement to a practitioner who is a member of a nonaffiliated provider based on the condition that the practitioner agrees to join an affiliated provider. It would also prohibit an issuer

from paying an affiliated provider a reimbursement amount that is more than the amount paid to a nonaffiliated provider for the same health care service.

The bill would prohibit issuers from encouraging or directing a patient to use an affiliated provider through any communications, including online messaging and marketing materials. The bill would prohibit issuers from requiring that a patient use an affiliated provider for the patient to receive the maximum benefit under the plan; offer or implement a plan that requires or induces a patient to use an affiliated provider; or solicit a patient or prescriber to transfer a prescription to an affiliated provider.

TAHP POSITION: Opposed unless amended

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

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

TAHP POSITION STATEMENT: Patients need access to lower cost treatment options. This legislation would create new limits that restrict patients from utilizing the most cost effective providers and protect high cost providers from lower cost competition. Provider consolidation has resulted in increasingly higher prices for physician and hospital services as private equity backed physician staffing firms have acquired provider groups. For example, in Fort Worth one gastroenterology group controls half of the market for all colonoscopies. In Houston, one anesthesia staffing firm owns 70% of all anesthesia providers. This means higher prices for patients. This bill would restrict competition from lower cost services if those cheaper providers have any affiliation with a health plan. This anticompetitive approach will result in higher prices for patients and Texas employers. The legislation should be amended to clarify that the bill's provisions do not apply for provider services offered at a lower cost to patients.

DATE UPDATED: 3/8 KS

Bill History:

03-02-23 S Filed
03-16-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1576 Schwertner, Cha Co-Pay Accumulator Prohibition Mandate

Companions:

HB 999 Price, Four (Identical)
4- 4-23 H Reported from committee as substituted House Select on Health Care Reform

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: Neutral

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

Bill History: 03-03-23 S Filed
03-16-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1623 Eckhardt, Sarah Coverage provision abortion and contraception

Companions: HB 3586 Cole, Sheryl (Identical)
3-16-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: This bill would allow Medicaid to provide abortion services and FDA approved forms of contraception regardless of whether federal matching funds are available. The bill would prohibit utilization review and other delays of coverage in the Medicaid

program for those services.

The bill also applies to commercial insurers. Currently, certain health benefit issuers may provide coverage for elective abortions. This bill would require them to do so, and it would require coverage of all FDA forms of contraception, including voluntary sterilization. The services would not be subject to any cost sharing, utilization review, or step-therapy requirements.

COVERAGE TYPES: Medicaid, Commercial

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/16 KS, 3/23 JL

Bill History: 03-06-23 S Filed
03-16-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1666 Parker, Tan (F) MDCP Private Coverage Continuity of care

Companions: HB 3985 Raney, John (Identical)
4-11-23 H Committee action pending House Human Services

Remarks: SUMMARY: Currently, if a person who is enrolled in Medicaid and private insurance has a relationship with a provider, and the private insurer terminates its contract with that provider, Medicaid is required to contract with the provider to ensure an enrollee has continuity of care. This bill would require the insurer, when the enrollee has complex medical needs, to continue reimbursing the provider until they are contracted with Medicaid.

Expands the definition of speciality provider to include durable medical equipment providers.

TAHP POSITION: Oppose DME providers are NOT providers at all and should not be considered specialty providers.

COVERAGE TYPES: PPO/EPO

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

DATE UPDATED: 4/7 by JL

Bill History: 03-06-23 S Filed
03-16-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1692 Blanco, Cesar Medical assistance program

Companions: HB 2216 Cortez, Philip (Identical)

3- 9-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: Requires continuous eligibility for children for the lesser of one year or until the child reaches 19.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/19 by JL

Bill History: 03-07-23 S Filed
03-16-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1765 Schwertner, Cha Network Adequacy Mandates

Remarks: SUMMARY: The bill would create a definition of "post-emergency stabilization care" to mean services furnished by an out-of-network provider or facility after the insured is stabilized and as part of an inpatient or outpatient stay with respect to a visit in which emergency services are furnished. The bill would require PPOs (not EPOs) to include benefits for emergency and post-emergency stabilization care. Post-emergency stabilization care would become subject to ch. 1467 (mediation and arbitration provisions) in the same manner as emergency care, except for claims excepted from the post-stabilization care provisions of the federal No Surprises Act.

The bill would allow PPOs and EPOs to use service areas that include noncontiguous geographic areas, but service areas may not divide a county and must include at least one trauma service area in its entirety.

The bill would require PPOs (not EPOs) to credit any cost-sharing amount paid for by or on behalf of an insured for out-of-network services provided to any out-of-pocket maximum. It would prohibit an insurer from having separate out-of-pocket maximums for in-network and out-of-network services, and it would require TDI to set a reasonable cap on out-of-pocket maximums.

The bill would make multiple changes to network adequacy standards for PPO and EPO plans. First, it would require an insurer to monitor compliance with standards on an ongoing basis, report any material changes to TDI within 30 days and promptly take any corrective action to ensure compliance. It would amend the requirement that insurers ensure

availability and accessibility to a full range of network provide rs to also require submission of current and projected utilization of services for both adult and minor insureds. The bill would also allow waivers only after a public hearing where good cause is shown, and for a period not to exceed one year. It would also require TDI to post on its website each affected county, and the specific network adequacy standards waived. The issuer would also be required to share such information in all promotion and advertising material. The bill allows any policyholder to seek (de novo) judicial review of a decision to grant a waiver.

TDI would be prohibited from issuing a waiver to a PPO or EPO plan more than twice consecutively for the same standard in the same county unless the insurer demonstrates, in addition to good cause, multiple good faith attempts to bring the plan into compliance. It would prohibit waivers to a plan more than a total of four times within a 21-year period for each county in a service area for issuers that may be remedied through good-faith efforts.

The bill would also create new adequacy standards for PPOs and EPOs. Issuers would be required to ensure sufficient choice, access, and quality of physicians by conducting an actuarial projection of utilization of services and providers within the counties. It would require a sufficient number of network providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist and diagnostic services, including radiology and laboratory services at each network hospital, ambulatory surgical center or freestanding emergency medical care facility with credentials for these specialties to ensure all insureds are able to receive covered benefits at that location.

The bill would also require that emergency care is accessible 24 hours a day, seven days a week, and urgent care is available within 24 hours for medical and behavioral health conditions. Finally, the bill expressly lists travel time and distance standards for each specialty, as well as wait time standards for medical conditions, behavioral health conditions, and preventative services. The list of specialties and provider types and the distance and drive time limits for each are based on those adopted in the federal regulations. Prior to offering a plan, insurers would be required to submit searchable and sortable databases of network providers, actuarial data of projected number of insureds by county, projected utilization by county, and other information deemed necessary by TDI. The bill provides that when necessary due to utilization or supply patterns,TDI may adopt rules to decrease the base maximum time and distance standards for specific counties.

Upon a request by an issuer to receive a waiver from a network requirement, the Insurance Commissioner would be required to set a public hearing for a determination of whether there is good cause for a waiver. TDIwould notify affected providers, and they would be allowed to submit evidence and attend the hearing. A physician or physician group referenced in an insurer's waiver may not be identified by name at the hearing without advance consent.

TDI would review all evidence, including the total number of providers, population density and geographical information, and availability of services in the area to determine whether a good faith effort was made. The commissioner would be prohibited from considering the prohibition on balance billing and could not grant a waiver without a public hearing. A policyholder would be entitled to seek judicial review of the commissioner’s decision.

In their annual reports, issuers would be required to include any waiver requests made and granted, any material deviations from adequacy standards reported to TDI and any corrective actions, sanctions, or penalties assessed.

The bill would also prohibit any “adverse material changes” to a preferred provider contract during the term of the contract unless there was mutual agreement of the parties, and it would make any provisions stating that an insurer can make changes unilaterally void and unenforceable. “Adverse material change” is defined to mean a change in a preferred provider contract that would decrease compensation, a change to a less preferred tier, or a change in any administrative procedures that would increase the provider’s expenses. “Adverse material change” would not include a decrease in payment based solely on a change in a published fee schedule, a decrease in payment that was anticipated in the terms of a contract, or an administrative change that was identified in the contract. Under the bill an adverse material change may not go into effect until 120 days after the provider agrees to the change. A proposed change by an insurer must include a notice that clearly identifies the change, with a statement that the provider may choose not to agree. Failure to agree would not affect the terms of the existing contract or participation in other plans. If the issuer does not include the required notice with the proposed amendment, an otherwise agreed-to adverse material change would be void and unenforceable.

TAHP POSITION: Opposed

COVERAGE TYPES: EPO/PPO

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

TAHP POSITION STATEMENT: TBD

DATE UPDATED: 3/16 KS

Bill History: 03-07-23 S Filed
03-20-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1790 Zaffirini, Judi Eligibility individuals to purchase Medicare

Companions: HB 1803 Rose, Toni (Identical)
4-18-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

Remarks: SUMMARY: This bill would require entities that offer Medicare supplemental plans to offer the same coverage to individuals enrolled in Medicare due to disability or end stage renal disease. The plan must have the same premium rate and policies as a plan offered to someone 65 or older.

TAHP POSITION: Neutral with concerns

COVERAGE TYPES: Med Supp.

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

POSITION STATEMENT: TAHP is concerned about increased costs for Medicare enrollees over 65.

DATE UPDATED: 12/13 KS, 2/19 BH

Bill History: 03-07-23 S Filed
03-20-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 1981 Zaffirini, Judi Relationship between dentists employee

Companions: HB 1527 Oliverson, Tom (Identical)
4-11-23 H Voted favorably from committee as substituted House Insurance

Remarks: SUMMARY: This bill would prohibit issuers from recovering an overpayment made to a dentist unless, 1) not later than 180 days after payment, the issuer provides written notice of overpayment; and 2) the dentist fails to object within 45 days of receiving the notice or exhausts all appeals options. The issuer must have policies and procedure to allow for an appeal. The bill would also prohibit insurers from including provisions in a contract with a dentist that allows the insurer to deny payment to the dentist for a covered service and prohibit the dentist from billing the patient for the amount owed. The bill would place restrictions on third-party access to

dentist network contracts.

TAHP POSITION: Neutral

COVERAGE TYPES:

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

Bill History: 03-08-23 S Filed
03-21-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 2065 Bettencourt, Pa Recovery overpayments made to dentists

Remarks: SUMMARY: This bill would prohibit issuers from recovering an overpayment made to a dentist unless, 1) not later than 180 days after payment, the issuer provides written notice of overpayment; and 2) the dentist fails to object within 45 days of receiving the notice or exhausts all appeals options. The issuer must have policies and procedure to allow for an appeal. The bill would also require issuers to provide a dentist with an oppurtinity to challenge an overpayment recovery and establish written procedures that would allow the dentist to have access to claims information in dispute.

TAHP POSITION: Neutral

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

DATE UPDATED: 3/17 KS

Bill History: 03-09-23 S Filed
03-21-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 2176 Lamantia, Morga Health benefit plan coverage treatment

Companions: HB 4506 Cortez, Philip (Identical)
4-18-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

Remarks: SUMMARY: This bill would prohibit issuers from screening for autism spectrum disorder more than once every 10 years, and would expand the current coverage requirement to include persons who were diagnosed after their 10th birthday.

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial (group only), MEWAs, ERS/TRS

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

Bill History: 03-09-23 S Filed
03-22-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 2247 Johnson, Nathan No Cost Sharing for USPSTF Preventive Services

Remarks: SUMMARY: This bill would prohibit deductibles, copayments, coinsurance, or other cost-sharing for services given an "A" or "B" by the US Preventative Services Task Force; recommended immunizations; and preventative care and screenings supported by the US Health Resources and Service Administration guidance.

TAHP POSITION: Neutral

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

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

DATE UPDATED: 3/29 KS

Bill History: 03-10-23 S Filed
03-22-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 2402 Kolkhorst, Lois Texas Pharmaceutical Initiative

Companions: HB 4990 Bonnen, Greg (Identical)
4-13-23 H Committee action pending House Select on Health Care Reform

Remarks: SUMMARY: This bill would create the Texas Pharmaceutical Initiative. The initiative would provide cost effective prescription drug access to public programs and would be administratively attached to HHSC. The initiative would implement a statewide PBM, establish a service center and network of satellite distribution facilities, and a pharmaceutical preparation facility to provide compounding and manufacturing of medicines. The initiative would contract to provide advanced health care cost and claims analytic services and support population health research. The initiative would also be allowed to enter into an agreement to establish a facility for the manufacturing of generic drugs. The bill would also establish the Texas Pharmacy Initiative Fund, which would be a trust fund outside of the treasury consisting of gifts, grants, donations, and appropriations. The initiative would be required to submit an annual report to the legislature that outlines their activities and objectives, as well as

cost savings delivered by state agencies as a result of their efforts.

TAHP POSITION: Opposed to Medicaid carve out of drugs

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/17 KS

Bill History: 03-10-23 S Filed
03-23-23 S Introduced and referred to committee on Senate Health and Human Services

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SB 2442 Perry, Charles Any Willing Provider for Physicians

Companions: HB 4773 Bonnen, Greg (Identical)
3-22-23 H Introduced and referred to committee on House Insurance

Remarks: SUMMARY: This bill would allow physicians to apply for designation as a participating provider and would require issuers to designate them as participating providers. The issuer would be required to reimburse the physician at 90% of the highest contracted rate for the same service.

TAHP POSITION: Opposed

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

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

TAHP POSITION STATEMENT: TBD

DATE UPDATED: 3/17 KS

Bill History: 03-10-23 S Filed
03-23-23 S Introduced and referred to committee on Senate Health and Human Services

Total Bills: 122