TAHP
The Texas Association of Health Plans

SESSION HIGHLIGHTS

88TH TEXAS LEGISLATURE

WORKING TOWARD QUALITY, AFFORDABLE, TRANSPARENT HEALTH CARE FOR ALL TEXANS

LETTER FROM THE CEO

Dear Texan,

We are pleased to present the Texas Association of Health Plans' (TAHP) end of session highlights guide, offering a comprehensive summary of the health care legislation passed in the recent 88th Texas Legislature.

Texas lawmakers focused on various crucial health issues, notably increasing funding for mental health services, building our nursing workforce, and insurance market reforms.

The Legislature took on expanding access to care this session and extended postpartum Medicaid coverage for new moms to 12 months—a step that greatly improves health outcomes for both mothers and infants in Texas. Medicaid prescription drug reforms passed that will increase access to medications, reduce administrative burdens, and improve continuity of care. Reforms also passed aimed at streamlining the process for Texans to receive timely updates on changes to their Medicaid eligibility via text messages and emails.

Lawmakers made progress in promoting healthier market reforms by prohibiting anti-competitive contracting terms and furthering price transparency. Texas also took further steps to protect patients from surprise medical bills with new protections against ambulance balance bills and a new law that ensures patients receive itemized bills prior to any debt collection.

At TAHP, we advocated for a robust, competitive health insurance market. By collaborating with diverse stakeholders, we successfully pushed for reforms that lower health care costs, increase access, and stimulate competition. We remain committed to educating legislators on the negative impacts of overly restrictive regulations and government mandates on both the private market and Medicaid. TAHP worked to mitigate the negative impact of bills and pushed back on mandates that add costs to employers and families.

Looking ahead, we will continue advocating for health plans in Texas, striving for policies that increase access to more affordable health care for every Texan.

This guide offers a comprehensive overview of health care policies that are now law in the State of Texas. TAHP stands as your resource for Texas health care policy. We invite you to visit our website, www.tahp.org, or contact us directly with your inquiries.

Sincerely,

Jamie Dudensing

Jamie Dudensing, RN
Chief Executive Officer
Texas Association of Health Plans

ABOUT TAHP

Led by a team of experienced health care policy experts, the Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, Medicaid plans, Medicare Advantage plans, and other related health care entities operating in Texas.

For three decades, TAHP has been a leader on issues that improve the lives of Texans and strengthen health care in Texas.

TAHP is dedicated to promoting affordable health care for all Texans through advocacy and education. It is our goal to increase public awareness about our members' services, health care delivery benefits, and contributions to communities throughout the state. TAHP strives to build and foster valuable relationships with its members, industry, and community stakeholders, as well as with representatives of the Texas Legislature and state agencies.

TAHP TEAM

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This session, TAHP
The Texas Association of Health Plans

...monitored **560 BILLS**, of which
190 RECEIVED A HEARING

...actively supported
57 BILLS

...actively opposed
34 BILLS

...testified
61 TIMES

...submitted
51 WRITTEN TESTIMONIES

...negotiated **47 BILLS**

...submitted
44 POSITION CARDS

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10 THINGS YOU

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New Network Adequacy Requirements:

With HB 3359, Texas health insurers have increased standards for network adequacy, along with new requirements for obtaining access waivers, including public hearings.

2

Medicaid Rx Reforms:

The Medicaid statewide Preferred Drug List (PDL) will continue to be managed by HHSC for another 10 years (HB 1283). However, under HB 3286, the program now includes crucial patient safeguards to prevent patients from being switched away from effective medications or being denied due to shortages. Health plans will also now have three voting members in the decision-making process for determining preferred drugs.

3

Bans on Anti-Competitive Contracting:

Texas is now a leader among states working to ban anti-competitive contracting between providers and health plans with the passage of HB 711. The bill includes prohibitions on anti-tiering, anti-steering, gag clauses, and most favored nation provisions.

4

Texas Pharmaceutical Initiative:

HB 4990 establishes a new initiative, funded with an $150 million appropriation, to develop a "business plan" for the potential creation of a statewide PBM, drug manufacturer, and pharmacy network to serve state-funded health programs.

5

Increased Flexibility for Medicaid Texting:

HB 2802 aligns state law with federal guidance, streamlining the process for Texans to receive text messages and emails about changes to their Medicaid eligibility and other vital health care updates.

NEED TO KNOW

Itemized Hospital Billing Transparency:

6

Texas took on the widespread medical debt collection crisis with a new law, SB 490, that ensures patients have access to an itemized hospital bill before being referred to collections.

Ambulance Surprise Billing Banned in Texas:

7

SB 2476 builds upon existing surprise billing laws by implementing a temporary prohibition on out-of-network ambulance bills, aimed at protecting patients while Congress crafts a permanent solution.

Formulary Transparency:

8

SB 622 creates a new requirement for health plans to provide real-time data to providers on patient out-of-pocket expenses and coverage information for prescription drugs.

Focus on Women's Health:

9

This session Texas lawmakers expanded postpartum Medicaid coverage to 12 months (HB 12), created a new mandate for fertility services associated with cancer treatment (HB 1649), ensured women can receive a single 12-month supply of contraceptives (HB 916), and established non-medical drivers of health (NDOH) screening criteria to assist pregnant women in accessing more resources (HB 1575).

Increased APCD Price Transparency:

10

Building upon the All Payor Claims Database (APCD) established in the 87th Legislative Session, Texas law now permits third-party researchers to access data and publicly post price transparency reports identifying specific health care providers and health plans.

Key Health Care Legislation

TAHP
The Texas Association of Health Plans

Throughout the 88th Legislature, the Texas Association of Health Plans (TAHP) advocated for maintaining a robust, competitive health insurance market in Texas. TAHP worked diligently to educate legislators and their staff on the negative consequences of overly-prescriptive regulations and burdensome government mandates that threaten to raise costs and stifle innovation in the private market and Medicaid. Recognizing the urgent need to address out-of-control health care prices, TAHP also collaborated with a diverse group of stakeholders to successfully advocate for reforms that lower health care prices, increase access to health care, and increase competition.

Healthier Texans Through Healthier Markets

Texans deserve access to affordable, high-quality health coverage and care. But health care prices continue to escalate, making coverage and care unaffordable for too many. Price increases alone account for 75% of the increase in health insurance premiums. During the 88th Legislature, TAHP championed healthier market reforms, supporting bills prohibiting anti-competitive contracting terms, enhancing price transparency, and ensuring patients receive itemized bills prior to any debt collection.

Bans Anti-competitive Contracting Terms

HB 711 by Rep. Frank & Sen. Kolkhorst

Consolidation in the health care market is increasing, and this consolidation has played a role in the skyrocketing costs of health care. Studies show that regulating anti-competitive contract provisions will help restore competition and drive down prices. This bill prohibits anti-steering, anti-tiering, gag clauses, and most favored nation clauses in contracts with providers. The bill renders such provisions in provider contracts void and unenforceable. Finally, the bill establishes that issuers that encourage enrollees to obtain services from a particular provider have a fiduciary duty to the enrollee to engage in that conduct only for the primary benefit of the enrollee.

Effective immediately, but existing clauses can stay in effect until December 31, 2023.

Enhanced Price Transparency through APCD Expansion

HB 3414 by Rep. Oliverson & Sen. Hancock

The All Payor Claims Database (APCD) is a database of health care claims files created by HB 2090 during the 87th Legislative Session. All payors that are subject to Texas law must submit claims data to the database. The APCD is administered by the Center for Health Care Data at the UT Health Science Center at Houston and overseen by TDI. This bill removes a provision that prohibited commercial use of APCD data and replaces it with a provision that allows the reporting or publication of data that identifies providers, plans, or other payors, so long as the report or publication is made available to the public at no cost.

The bill also creates an application process for entities seeking to access data that is not

currently available in the public data portal, which requires the submission of the names of individuals who may have access to the data, the proposed research, and how the research will be used to further the purposes of improving quality or reducing costs. Also, if access to the data would require an Institutional Review Board determination letter, the application must also include an approval letter. The bill adds the UT System health plan as a contributor and adds a spot on the advisory committee for a representative of an institution of higher education. Finally, the bill clarifies that the Center may not require the submission of data not collected by a payor, either through claims forms, provider files, or eligibility files.

Signed by the governor. Effective immediately.

Patient's Right to Receive an Itemized Bill Prior to Debt Collection

SB 490 by Sen. Hughes & Rep. Caroline Harris

In some cases, medical providers issue bills to patients with only a single "balance due" amount, without providing a detailed breakdown of the services received and their corresponding charges. To ensure patient protection and promote transparency, it is important for patients to have access to an itemized bill. SB 490 addresses this issue by requiring health care providers, before pursuing any debt collection against a patient, to issue a written itemized bill that outlines charges for all health care services and supplies provided to the patient. The itemized bill must include the amount charged for each service and supply provided to the patient. The legislation also grants state licensing authorities the power to take disciplinary action against providers who fail to comply with these requirements. This new law ensures patients have a clear understanding of the charges being billed and enables them to verify the accuracy of the medical bill before any debt collection proceedings are initiated.

Signed by the governor. Effective September 1, 2023.

Increasing Access to Health Care

Acknowledging Texas' ongoing challenge with provider access, particularly in the face of a rapidly expanding population and underserved rural communities, the Legislature adopted multiple strategies aimed at expanding and simplifying patients' access to health care during this session.

Rural Emergency Services Telehealth Pilot

HB 617 by Rep. Darby & Sen. Alvarado

Residents in rural areas of Texas often face significant challenges in accessing critical care as they may have to travel more than 60 miles to reach a Level 1 Trauma Facility. To address this issue, HB 617 aims to enhance health care access in these communities by reinstating the next generation 9-1-1 telemedicine medical services pilot project. This project, which previously expired on January 1, 2021, will be reestablished by the Commission on State Emergency Communications (CSEC) in collaboration with Texas Tech University Health Sciences Center. The pilot project will focus on providing emergency medical services instruction and emergency prehospital care instruction to health care providers in rural area trauma facilities and emergency medical services providers in rural areas through regional trauma resource centers. By leveraging the remote delivery of services, this

initiative aims to facilitate access to critical care for Texans who must travel long distances to receive medical treatment. The bill includes a provision mandating the evaluation of the pilot program by the Center, in cooperation with CSEC, and requires a report on its findings to be submitted by December 31, 2028. The provisions reestablishing and governing the pilot project are set to expire on September 1, 2029, but it can be extended by future legislative action.

Signed by the governor. Effective September 1, 2023.

Authorizes Firefighter EMS Patient Transport

HB 624 by Rep. Cody Harris & Sen. Birdwell

In the state's vast rural areas, critical patient transport may be delayed when an ambulance is unable to provide transfer immediately. Under this bill, trauma service area regional advisory councils will develop guidelines that allow firefighters to transport sick or injured patients to the hospital when an ambulance is unavailable.

Signed by the governor. Effective September 1, 2023. Guidelines must be developed by January 1, 2024.

Hospital at Home Licensure

HB 1890 by Rep. Jetton & Sen. Menendez

In November 2020, as part of the COVID-19 Public Health Emergency, CMS established waivers that allowed hospitals to provide some acute hospital care services to patients in their homes. This bill allows approved hospitals to continue operating these hospital-at-home programs. However, in order for the program to continue in Texas, HHSC must adopt minimum operating standards that are at least as stringent as those imposed by CMS. HB 1890 allows a hospital to operate a hospital at home program if the program is approved by the CMS Centers for Medicare Acute Hospital Care at Home Program and HHSC.

Signed by the governor. Effective immediately.

Family Support Programs

SB 24 by Sen. Kolkhorst & Rep. Frank

The new law makes changes to several programs aimed at family support services and assistance for new mothers, including the creation of the "Thriving Texas Families Program" as a continuation of the Alternatives to Abortion program. The program is a statewide support network for women with unexpected pregnancies, and it provides numerous services, including:

- Counseling and mentoring on pregnancy, education, parenting skills, adoption services, life skills, and employment
- Care coordination for prenatal, perinatal, and postnatal services, including connecting participants to health services
- Educational materials and information about pregnancy, parenting, and adoption services
- Referrals to governmental and social service programs, including child care, housing, transportation, and state and federal benefit programs
- Classes on life skills like personal finance and parenthood
- Supplies for infant care and pregnancy, including car seats, cribs, maternity clothes, infant diapers, and formula
- Housing services

Additionally, the bill replaces the Prevention and Early Intervention division of DFPS with the Family Support Program, which will administer grants and contracts for services aimed at "at-risk families." The program will focus on several opportunities for intervention for at-risk

families, including services for families experiencing challenges that may threaten the birth or health of a baby and services for families at risk of abuse or neglect. The legislation also makes changes to the Nurse Family Partnership Program, including the addition of employment assistance for new moms.

Signed by the governor. Effective September 1, 2023.

Nursing Workforce & Education Grant Programs

SB 25 by Sen. Kolkhorst & Rep. Klick

Texas is facing a major crisis in health care staff. Prior to the COVID-19 pandemic, the state was projecting a shortage in the number of registered nurses needed to keep pace with population growth and demand. The Texas Center for Nursing Workforce Studies at the Department of State Health Services estimates that the supply of registered nurses is projected to grow by 30.5% between 2018 and 2032, while demand will grow by 38.8%. The Nurse Faculty Loan Repayment Program (NFLRP) and the Nursing Innovation Grant Program (NIGP) are two key programs that were created to help address this shortage. The NFLRP improves access to nursing education programs by encouraging qualified nurses to serve as faculty at eligible Texas institutions of higher education through loan repayment assistance. The NIGP was established to provide grants to higher education institutions to promote the education, recruitment, and retention of nursing students and qualified faculty. This bill maintains the NIGP until 2027 and allows part-time nursing faculty to be eligible for loan repayment assistance. The changes in this bill work in tandem with an unprecedented investment in nursing education through funding in the appropriations bill. The NFLRP nearly doubled to $7 million per biennium; a separate program, the Nursing Shortage Reduction Program, also nearly doubled to $46.8 million for the biennium; and a previously unfunded program, the Nursing Scholarship Program, received $25 million for the biennium.

Signed by the governor. Effective immediately.

Sales Tax Exemption for Feminine Hygiene & Other Products

SB 379 by Sen. Huffman & Rep. Howard

Texas law makes exceptions for certain products from sales tax requirements. This bill adds several categories of products to the list of items exempt from sales tax, including: adult and child diapers, feminine hygiene products, maternity clothing, breast milk pumping products, and baby bottles. Texas joins a growing list of states with no sales tax for feminine hygiene products, with more than half of states now that have no sales tax for these products. The bill also codified existing Texas Comptroller policy exempting wound care dressings, such as adhesive bandages, gauze pads, and medical tape.

Signed by the governor. Effective September 1, 2023.

Child Mental Health Consortium Expansion

SB 850 by Sen. Blanco & Rep. Price

The 86th Texas Legislature established the Texas Child Mental Health Care Consortium to address urgent mental health challenges throughout the state by leveraging the expertise and capacity of mental health-related institutions. This bill removes The University of Texas M.D. Anderson Cancer Center from the consortium, as they do not provide mental health services, and adds rural regional education service centers.

Signed by the governor. Effective September 1, 2023.

Living Organ Donor Education Program

SB 1249 by Sen. Hancock & Rep. Oliverson

Although the Department of Public Safety has provided Texans applying for a driver's license or identification card the option to register as an organ donor for more than a decade, prior to this bill, there was not a similar program to register individuals as a living donor or to provide information on how to become a living donor. This bill requires the Department of State Health Services (DSHS) to establish a living organ donor education program, which will educate residents about the need for living donors, the requirements for registration, and the availability of information in various facilities. DSHS is also tasked with developing the informational materials, and in addition to being available in facilities, it will be posted on the agency's website.

Signed by the governor. Effective immediately.

Forensic Mental Health Competency Restoration

SB 1677 by Sen. Perry & Rep. Price

This bill is an important step in addressing the state's ongoing shortage of available hospital beds for mental health patients. In 2017, the state established a grant program to reduce recidivism, arrest, and incarceration among individuals with mental illness and reduce wait times for forensic commitments. SB 1677 requires HHSC, by rule, to establish procedures to assist communities with populations of less than 250,000 to apply to the grant program. The bill also ensures that when the state appropriates dollars to the grant program that exceed the previous fiscal year, HHSC will select communities that were not previously selected or communities that were selected but require additional funding.

HB 1 includes a contingency rider that appropriates $1.5 million annually in General Revenue for implementation of the bill. Because the fiscal note for SB 1677 indicates HHSC requires only $700,000 annually in General Revenue for implementation, it is assumed the remainder is intended for the grant program.

The bill also allows HHSC, in coordination with rural local mental health authorities, to establish or expand regional behavioral health or jail diversion centers when funding is appropriated. The centers must:

- Provide additional forensic hospital beds and competency restoration services
- Provide inpatient and outpatient mental health services to adults and children
- Provide services to reduce recidivism and the frequency of arrest, incarceration, and emergency detentions among persons with mental illness

SB 1677 requires the State Auditor's Office (SAO) to conduct an audit of the inmates in county jails who are waiting for a forensic hospital bed and identify any issues and inefficiencies in the commitment process. The SAO must include a review of the history and status of the waitlist since September 2018 and identify any disparities in treatment.

Signed by the governor. Effective September 1, 2023. SAO report due December 1, 2024.

Authorizing Direct Primary Care for FQHCs

SB 2193 by Sen. LaMantia & Rep. Frank

This bill creates federally qualified health center (FQHC) primary care access programs. Direct primary care is a model of providing health care services in which the care is paid for by a monthly, flat membership fee per patient. The patient then receives unrestricted access to the physician for primary care services. This bill creates FQHC direct primary care programs. These FQHC programs would provide services to employees of participating employers and uninsured or underinsured groups. The FQHCs are required to ensure that employees and their dependents are screened for eligibility for other state programs and federal subsidies in the insurance marketplace. The bill also requires TDI to review all FQHC programs to evaluate their success and provide reports to the legislature biennially.

Signed by the governor. Effective immediately.

Key Legislation Affecting the Health Insurance Industry

TAHP
The Texas Association of Health Plans

Over recent legislative sessions, Texas has imposed expensive new mandates on health coverage that are passed on to employers and families. In fact, Texas surpasses almost every state in the number of mandates that exceed the Affordable Care Act. TAHP and our member plans worked throughout the session to ensure bills adopted by the Legislature did not adversely affect the health insurance market and the Texans it serves. There was an unprecedented number of regulatory and benefit mandates filed this session that increased the cost of coverage. Overall, over 120 benefit and regulatory mandate bills were filed: 60 had a hearing, 46 passed out of a committee, and 17 ultimately passed both chambers. TAHP worked with legislators and stakeholders on several of these bills throughout the session to limit the negative impact of bills and to oppose legislation that would significantly increase costs. By the end of the session, TAHP had negotiated or remained neutral on 37 of these bills.

Hearing Aid Coverage Above Allowed Amounts

HB 109 by Rep. Julie Johnson & Sen. Zaffirini

Health plans typically have dollar limit caps, also known as "allowed amounts," for hearing aid coverage. In some instances, a patient could be denied coverage if they choose to buy a hearing aid that goes above this allowed amount, even if they agree to pay the difference. HB 109 prohibits commercial plans that provide coverage for hearing aids from denying a claim for hearing aids solely on the basis that the aid is more expensive than the benefit available under the plan. However, it does not require a plan to pay a claim in an amount that is more than the benefit available under the plan. In addition to commercial plans, this bill applies to ERS, TRS, and University plans.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Expansion of Association Health Plans

HB 290 by Rep. Oliverson & Sen. Hancock

The U.S. Department of Labor adopted rules under the Trump Administration establishing flexible criteria for Multiple Employer Welfare Agreements (MEWAs) also known as "association health plans." However, the rules were invalidated by a court in 2019, leaving those association health plans null and void. The case is being appealed, but the federal rules are not currently in effect and will only become effective if the initial ruling is overturned. This bill aligns state law with the federal proposal, although the state flexibilities will only be usable if the federal rules become effective. If this case were to be overturned, two major changes would go into effect. First, sole proprietorships would be eligible to participate in MEWAs. Second, businesses could form a MEWA if they can show a commonality of interest, which broadens the existing geographical and commonality requirements for MEWAs.

The bill also applies existing consumer protections in the insurance market to MEWAs that provide comprehensive health plans. Under the bill, MEWAs are subject to reserve requirements, asset protection requirements, selection of providers requirements, and the utilization review requirements that currently apply to insurers. A MEWA that provides a health plan that is structured in the same way as PPO/EPOs are also subject to Chapter 1301 of the Texas Insurance Code (TIC), which is the general PPO/EPO chapter, and Chapter 1467 of the TIC, which is the state surprise billing prohibition. Finally, the bill modifies the application and eligibility requirements for a certificate of authority for MEWAs, providing additional flexibility for entities that may establish a MEWA.

Signed by the governor. Effective September 1, 2023.

ERISA Opt-In for Texas Surprise Billing Laws

HB 1592 by Rep. Oliverson & Sen. Hancock

The 86th Texas Legislature established protections against surprise medical billing. This legislation took effect in January of 2020 and only applied to health insurance plans regulated by TDI. The law did not regulate health insurance plans that are self-funded, because those are regulated by the federal Employee Retirement Income Security Act (ERISA) of 1974.

In December 2020, the federal No Surprises Act passed, giving patients with self-funded, ERISA-regulated health insurance plans, which cover a majority of insured Texans, protection from surprise medical billing. The law enacted by the 86th Legislature was not preempted by these federal protections and will continue to apply with respect to state-regulated plans.

HB 1592 allows, but does not require, self-funded, ERISA-regulated plans to opt into the state law rather than the federal No Surprises Act.

Signed by the governor. Effective September 1, 2023. TDI must adopt rules by December 1, 2023.

Fertility Preservation Benefit Mandate

HB 1649 by Rep. Button & Sen. Parker

Certain cancer treatments can cause impaired fertility in both men and women. HB 1649 requires commercial health plans and MEWAs to cover fertility preservation services for patients who will receive medically necessary treatment for cancer that may directly or indirectly cause impaired fertility. It does not require coverage of fertilized genetic materials or any ongoing storage. The mandate applies only to fertility preservation services that are 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. Finally, the bill requires facilities to provide notice to children who will be receiving chemotherapy to notify legal guardians of the risk of impaired fertility from the treatment.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Mandates Applying Cash Pay For Lower Price Providers to Deductibles

HB 2002 by Rep. Oliverson & Sen. Hancock

In some circumstances, the cash price that a doctor or medical facility offers for a treatment, test, or procedure is less costly than a health plan's negotiated rate. However, patients are not currently incentivized to seek out these deals because their cash payments do not

count toward their deductible or maximum out-of-pocket expenses. This bill requires EPO and PPO plans, but not HMOs, to credit cash payments to providers, regardless of whether they are in-network or out-of-network, towards an insured's deductible and annual out-of-pocket maximum. 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.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Strengthens Network Adequacy Requirements

HB 3359 by Rep. Bonnen & Sen. Schwertner

The provisions in this bill can be broken up into two major categories. First, the bill creates contracting requirements between insurers and providers and limits the insurer's ability to make changes to that contract without express agreement from the provider. Second, the bill changes network adequacy standards and waivers for state-regulated plans. Some of these provisions are simply a codification of existing TDI or federal rules, but others, such as mandatory public hearings for waivers, go beyond what is otherwise required.

Limits Contract Changes: HB 3359 prohibits EPOs and PPOs, but not HMOs, from making any "adverse material changes" to a preferred provider contract during the term of the contract unless there is mutual agreement between the parties. "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. It does not include changes required by federal law, termination for cause, or termination without cause at the end of a contract term. Even if both parties agreed to the change, the bill would prohibit the change from going into effect for 120 days. However, these requirements do not apply in two circumstances. First, the requirements do not apply to contracts with hospitals and other facilities, as it only applies to contracts with physicians, health care practitioners, or organizations of physicians or practitioners. Second, the requirements do not apply to evergreen contracts, which are contracts with an unspecified duration, with no stated or automatic renewal period, and that may only be terminated by notice from one party to another.

New Network Adequacy Requirements: HB 3359 codifies the latest federal network adequacy standards for PPOs and EPOs, including travel distance and appointment wait time standards. However, the bill delays the implementation of wait time standards until January 1, 2025, to align with federal delays to their rule adoption. The bill also codifies existing TDI network adequacy rules, albeit with some changes. First, the bill requires issuers to give special consideration to contracting with teaching hospitals that provide care to the

uninsured as a significant percentage of their overall patient load. TDI rules already require this, although those rules include a provision clarifying that contracting with those facilities is not required if it is not feasible to do so. The bill also requires the prioritization of teaching facilities that specialize in rare conditions, which was not in TDI rule at all. While these requirements do stray from existing TDI rules, the bill clarifies that they do not apply to plans that contract with enough hospitals to meet projected utilization rates or receive a waiver. Also, within a facility, the bill requires a sufficient number of preferred specialty providers to ensure all insureds are able to receive covered benefits at that location. Issuers would be required to monitor compliance with standards on an ongoing basis, report any material changes to TDI within 30 days, and promptly take corrective action or apply for a waiver to ensure compliance.

Network Adequacy Waiver Restrictions: TDI would be required to place certain restrictions on waivers unless there are no uncontracted providers in the area. First, waivers would be allowed only after a public hearing where good cause is shown. Next, 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 multiple good faith attempts to bring the plan into compliance. Finally, the bill does not allow more than four waivers within a 21-year period if the underlying issue could have been resolved through good-faith efforts.
At a hearing for a network adequacy waiver, 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. "Good faith effort" is defined by the bill as honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patients' access to in-network care. TDI would be prohibited from considering the prohibition on balance billing to justify granting a waiver, but an issuer could reference balance billing in an access plan to show how the enrollee would be held harmless. A policyholder would be entitled to seek judicial review of TDI's decision.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024. Maximum appointment wait times apply to plans delivered, issued for delivery, or renewed on or after January 1, 2025.

ER Verification of Benefits

HB 4500 by Rep. Caroline Harris & Sen. Hughes

This legislation requires health insurers to maintain a portal that lets providers in hospitals or freestanding ERs determine whether a patient is covered and any cost sharing requirements for which the patient is responsible. The information may be provided by an existing portal hosted by the health plan or a third-party vendor; however, the portal must be available at all times.

Signed by the governor. Effective January 1, 2024.

Bans ESG in Insurance Ratemaking

SB 833 by Sen. King & Rep. Oliverson

Certain lines of insurance may face pressure to refuse certain clients. For example, some insurance companies may refuse to insure the fossil fuel industry. This bill seeks to combat this issue by prohibiting any insurance

company doing business in Texas from using an environmental, social, or governance (ESG) model, score, factor, or standard to charge a rate different than the rate charged to another business or risk in the same class for essentially the same hazard.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Biomarker Screening Benefit Mandate

SB 989 by Sen. Huffman & Rep. Bonnen

Biomarker testing is a feature of precision medicine that allows doctors to use information about a person's specific genetic variations to inform better diagnosis, prognosis, and therapy selection for cancer or rare disease patients. Prior to this bill, health insurance coverage for biomarker testing, while common, was not guaranteed.

This bill requires coverage, but only when the test predominantly addresses the acute or chronic disease for which the test is being ordered. In other words, this mandate does not require reimbursement for multi-panel tests or full genetic sequencing when a single-panel test would be sufficient, as the broader tests would not predominantly address the acute issue for which the test is being ordered. The test also must be supported by medical and scientific evidence. This bill applies to commercial plans; ERS, TRS, and University plans; MEWAs; and Medicaid and CHIP.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Expands Provider Directory Transparency Requirements

SB 1003 by Sen. Johnson & Rep. Smithee

In its most recent Biennial Report, TDI recommended expanding the current law relating to facility provider directories, which applies to commercial plans and MEWAs. These directories must list certain information for specified types of facility-based physicians, but current law omits certain other facility-based specialists. This bill expands the requirement for issuers to list facility-based providers in their provider directories. It would add non-physician providers, including certified registered nurse anesthetists, nurse midwives, surgical assistants, and physical therapists, among others. However, the bill clarifies that a directory is not required to list physicians or health care providers who are employed by the facility.

Signed by the governor. Effective September 1, 2023. Plans must update provider directories and websites by January 1, 2024.

Prohibits Organ Transplant Coverage Involving Harvesting

SB 1040 by Sen. Kolkhorst & Rep. Oliverson

This bill prohibits health plans, including commercial, ERS and TRS, and Medicaid managed care plans, from covering human organ transplants that are performed in China or in another country known to participate in forced organ harvesting. It also prohibits health plans from covering human organ transplants where the sale or donation originated in China or in another country known to participate in forced organ harvesting. It allows DSHS to designate additional countries that are known to participate in organ harvesting.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Allows Prompt Pay Flexibility During a Catastrophic Event

SB 1286 by Sen. Schwertner & Rep. Ann Johnson

In March 2020, Governor Abbott suspended select claim-handling deadlines and TDI extended claim-handling deadlines for a total of 15 additional days in response to the COVID-19 pandemic. Effective September 2021, Governor Abbott rescinded the rule suspensions, canceling the temporary claim-handling deadline extension. In its Biennial Report, TDI recommended that the Legislature grant the agency similar statutory authority. This bill allows TDI to extend prompt payment deadlines to a later date due to a catastrophic event. It also allows TDI to approve a request by a provider for an extension due to a catastrophic event.

Signed by the governor. Effective September 1, 2023.

Mandates Third-Party Insurers Honor Medicaid Prior Authorization

SB 1342 by Sen. Perry & Rep. Smithee

Some Medicaid beneficiaries have additional insurance, known as third-party insurance coverage. To ensure Medicaid is the payer of last resort, the HHSC Office of Inspector General's Third-Party Recoveries Division is responsible for third-party liability. CMS recently made federal changes to third-party liability requirements that must be adopted by states.

SB 1342 reflects those changes and requires third parties (other than Medicare) to accept a state's authorization that an item or service is covered under the state plan as if it were the prior authorization made by the third party. The bill also imposes a 60-day timeliness requirement in which the third party must respond to a state's inquiry about a claim, and that a third party must agree not to deny the state's claim for failure to obtain prior authorization.

Signed by the governor. Effective September 1, 2023.

Extends TDI Sunset Review to 2029

SB 1659 by Sen. Schwertner & Rep. Holland

Sunset reviews regularly assess the need for a state agency or program to exist. In Texas, the Sunset process works by setting an expiration (Sunset) date in law for state agencies. An agency will automatically be abolished on its Sunset date unless the Legislature passes a bill to continue it, typically for another 12 years. The Sunset review is a rigorous evaluation process that provides the Legislature a unique opportunity to closely examine an agency's mission, priorities, and performance and take action to address the problems identified. The Sunset schedule bill is filed each session to better align the agencies scheduled for review by the Sunset Advisory Commission. One of the agencies that this bill applied to is TDI, which had its Sunset date moved from the 2024-2025 to the 2028-2029 review cycle.

Signed by the governor. Effective immediately.

Temporary Ambulance Surprise Billing Ban

SB 2476 by Sen. Zaffirini & Rep. Oliverson

In 2019, the Texas Legislature passed the Surprise Billing Act. However, that legislation did not cover services performed by out-of-network emergency medical services (EMS) providers, which continue to engage in such balance billing. This bill adds EMS providers to the state's ban on balance billing, which applies to EPO/PPO, HMO, ERS, and TRS plans. It requires TDI to establish a publicly accessible

database to which municipalities can submit their regulated rates. If a rate has been submitted, issuers are required to reimburse non-network transport (besides air ambulance transport) at the submitted rate. If a rate has not been submitted, issuers are required to reimburse the lesser of the provider's billed charge or 325% of the current Medicare rate. The issuer is required to adjust payments each plan year by at least the Medicare Inflation Index, or 10% of the previous year's rate, whichever is lower. The payment must be made not later than the 30th day after an electronic clean claim is submitted and the 45th day after a nonelectronic clean claim is submitted. However, this new law is set to expire on September 1, 2025, in anticipation of federal balance billing protections being negotiated.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024. TDI may create the portal after January 1, 2024.

Key Legislation Affecting Medicaid, CHIP, and Managed Care

TAHP
The Texas Association of Health Plans

Through Medicaid managed care, millions of Texans—including children and pregnant women—have better health outcomes while Texas taxpayers enjoy significant savings; over $5 billion since 2009. The continued use of free-market Medicaid solutions is at the foundation of the program's success in maintaining affordable, high-quality coverage for those in need.

TAHP and Texas Medicaid managed care plans worked closely with legislators, HHSC, and the broader health care community to advocate successfully for legislation that further strengthens and modernizes Texas' Medicaid and CHIP. This includes working to ensure that all low-income Texans have access to affordable, high-quality health coverage. Additionally, TAHP works hand in hand with MCOs to advocate for maintaining the necessary flexibility to continue innovating, improving quality, and ensuring access to cost-effective care in the Texas Medicaid program.

Expands Postpartum Medicaid Coverage to 12 Months

HB 12 by Rep. Rose & Sen. Kolkhorst

Medicaid plays a crucial role as the largest single payer of maternity care, covering 50% of all births in the state. However, the short timeframe for Medicaid eligibility after pregnancy has been a major barrier to improving care for new mothers. Presently, Texas offers Medicaid coverage to pregnant women only up to 60 days postpartum. To help improve maternal health, a provision in the American Rescue Plan Act of 2021 gives states a new option to extend Medicaid postpartum coverage to 12 months via a state plan amendment. This new option took effect on April 1, 2022, and is available to states for five years. So far, 34 states have implemented 12 months of postpartum Medicaid coverage. HB 12 expands Texas Medicaid postpartum coverage to 12 months.

Signed by the governor. Effective immediately.

Prohibits Vaccination Discrimination by Medicaid Providers

HB 44 by Rep. Swanson & Sen. Middleton

This bill prohibits Medicaid and CHIP providers, other than oncologists and organ transplant specialists, from refusing to provide health care services to a Medicaid recipient or CHIP enrollee based solely on the patient's refusal or failure to obtain a vaccine or immunization. If a provider has a policy that requires patients to be vaccinated or immunized, the provider must allow for exceptions for patients who are not vaccinated or immunized because of a sincerely held religious belief, observance, or practice or a recognized medical condition for which the vaccination or immunization is contraindicated. Providers who violate this policy are not allowed to receive reimbursement until HHSC finds they are in compliance. HB 44 only applies to an individual physician; HHSC may not refuse to provide reimbursement to a provider who did

not violate the prohibition based on the provider's membership in a provider group or medical organization with an individual physician who did violate the prohibition. HHSC has rulemaking authority to implement HB 44, and must also draft rules establishing the right of an accused provider to seek administrative and judicial review.

Signed by the governor. Effective September 1, 2023.

Increases the Personal Needs Allowance for Nursing Home Residents

HB 54 by Rep. S. Thompson & Sen. Zaffirini

HB 54 increases the personal needs allowance to $75 from $60 for residents on Medicaid in long-term care facilities. These residents are allowed to keep a set amount of their social security income for their needs—also known as the personal needs allowance. Despite the dramatic increase in the cost of living the last few years, the allowance has not increased since 2005.

Signed by the governor. Effective September 1, 2023.

Expands the Use of Community Health Workers for Medicaid MCOs

HB 113 by Rep. Ortega & Sen. Blanco

Community health workers play a vital role in connecting Medicaid members to health care and community services—critical components of managed care. They help increase health knowledge and self-sufficiency through a range of activities such as outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research. HB 113 allows services provided by a community health worker to be categorized by MCOs as a quality improvement cost instead of as an administrative expense.

Signed by the governor. Effective immediately.

Employer Immunity for Unvaccinated Employees

HB 609 by Rep. Vasut & Sen. Creighton

This bill clarifies that a business owner that does not require employees to be vaccinated against a pandemic disease is not liable for injury or death caused by exposure to the employee.

Signed by the governor. Effective September 1, 2023.

Establishes the Statewide Interagency Aging Coordinating Council

HB 728 by Rep. Rose & Sen. Zaffirini

The population of Texans 65 and older is projected to increase from 3.3 million in 2020 to 5.8 million in 2040. HB 728 establishes the Statewide Interagency Aging Services Coordinating Council to ensure a strategic statewide approach to interagency aging services. The goals of the Council are to address service duplication, coverage gaps, confusion for people seeking services, and inadequate care for aging Texans. The Council is required to develop a five-year strategic plan and an annual inventory of state-funded interagency aging programs and services that describes how each program and service furthers the strategic plan. The Council must hold its initial meeting by March 31, 2024, and the first five-year plan must be submitted by March 1, 2025.

Signed by the governor. Effective immediately.

Extends Statewide Medicaid PDL for Ten Years

HB 1283 by Rep. Oliverson & Sen. Hughes

In 2011, the Legislature enacted SB 7 to integrate prescription drug coverage into managed care and curb the rapid expansion of Medicaid drug spending. This resulted in MCOs assuming control of the drug benefit administration, effectively reducing drug cost growth in Texas Medicaid by 50%. The next step, allowing MCOs to establish formularies and preferred drug lists, was set for 2013, but faced delays in both 2013 and 2017. HB 1283 further postpones this integration by prolonging the existing single statewide Medicaid drug formulary and preferred drug list for another ten years, through August 31, 2033.

Signed by the governor. Effective September 1, 2023.

Repeals Sunset & Establishes Permanent MAT Medicaid Coverage

HB 1357 by Rep. Holland & Sen. Huffman

Texas Medicaid currently provides coverage for medication-assisted treatment (MAT) for opioid or substance abuse. MAT includes the use of medications such as methadone, buprenorphine, oral buprenorphine/naloxone, and naltrexone to treat opioid or substance use disorders. However, in Texas, MAT coverage was initiated as a pilot program and was scheduled to end on August 31, 2023. HB 1357 removes this Sunset date, thereby ensuring the continuation of MAT coverage under Medicaid. This legislation establishes ongoing Medicaid coverage for medication-assisted opioid or substance abuse treatment, reinforcing the state's commitment to addressing substance use disorders.

Signed by the governor. Effective immediately.

Enhancing Medicaid Sickle Cell Disease Coverage

HB 1488 by Rep. Rose & Sen. Miles

HB 1488 takes significant strides towards addressing disparities in sickle cell disease awareness, a chronic condition that predominantly affects the Black community. The bill builds upon the efforts of the Sickle Cell Task Force, established in 2019, by expanding its role, extending its mission until 2035, and requiring its annual report to include suggestions for enhancing health care provider education on sickle cell disease.

Additionally, the bill directs HHSC to improve sickle cell disease education for Medicaid providers, including emergency department staff. HHSC is also required to leverage existing Medicaid member data to identify opportunities to improve health outcomes, reduce hospital admissions and readmissions, and connect members to a sickle cell disease health home or expert. The bill further requires HHSC to support initiatives assisting MCOs in promoting timely, evidence-based services for members diagnosed with sickle cell disease, in alignment with national clinical practice guidelines and protocols for treatment.

Lastly, HB 1488 requires that Texas medical schools and graduate medical education programs establish curriculum requirements on sickle cell disease and sickle cell trait. It also encourages the Texas Education Agency to share information on sickle cell to school districts and explore ways to enhance education and awareness.

Signed by the governor. Effective September 1, 2023.

NDOH Medicaid Screening and Doula Coverage for Pregnant Women

HB 1575 by Rep. Hull & Sen. Alvarado

Pregnant women facing nonmedical health needs like food, housing, and transportation are twice as likely to experience high-risk pregnancies and have elevated rates of maternal morbidity. HB 1575 aims to address this issue and improve health outcomes by:

- Requiring Medicaid MCOs and Alternatives to Abortion (A2A) providers to conduct an initial screening for health needs and nonmedical drivers of health (NDOH) for pregnant women
- Authorizing Medicaid to offer case management services for nonmedical needs that will improve health outcomes for pregnant women and their children
- Adding community health workers and doulas to the provider types permitted to provide case management services

Standardized Screening Questions: HHSC is tasked with developing standardized screening questions to identify nonmedical health-related needs of pregnant women. MCOs and A2A providers are required to screen pregnant women using these questions, provided consent is given. To obtain consent, a provider must inform the woman about the data to be collected during the screening, which will become part of her medical record or service plan. This improved screening process will help identify nonmedical health-related needs affecting birth and maternal health outcomes by providing policymakers with reported data on these women's needs. HHSC is required to submit a report summarizing this data to the Legislature by December 1 of odd-numbered years.

Medicaid Managed Care Screening: For each pregnant woman enrolled in STAR, an MCO must conduct an initial health needs and nonmedical health-related needs screening using HHSC's standardized screening questions to determine if the woman is eligible for service coordination benefits or needs a referral for program services. A woman can decline the screening or services or choose to discontinue them at any time. If the woman consents, the screening must be used to determine if a more comprehensive assessment is required for service coordination benefits or program services. The service coordination benefits must include identifying and coordinating any non-covered services, community supports, and other resources the MCO determines will improve the woman's health outcomes.

Case Management for Children & Pregnant Women: Case Management for Children and Pregnant Women is a Medicaid benefit that provides health-related case management services to children with a health condition from birth through 20 years of age and to high-risk pregnant women of any age. Case managers help clients gain access to needed medical, social, educational, and other services. HB 1575 authorizes Medicaid to offer case management services for nonmedical needs to enhance health outcomes for pregnant women and their children. These services can only be provided by an advanced practice nurse, registered nurse, social worker, community health worker, or doula who has undergone additional HHSC training. Training must be trauma-informed and include knowledge about social services, community assistance programs (including nutrition and housing), counseling and parenting, substance use disorder, domestic violence, and coercive control dynamics. HHSC will need to establish new provider types for community health workers and doulas who provide these services.

Reporting: Any data collected by the MCO or A2A provider must be submitted to HHSC. The commission is required to publish a biannual report summarizing the data from the past two years. HHSC also needs to produce an initial report, due December 1, 2024, including information on the nonmedical health-related needs of the women receiving case management services, the number and types of referrals made to nonmedical community assistance programs and providers, and birth outcomes.

Signed by the governor. Effective September 1, 2023.

Expands Medicaid Coverage for Home Telemonitoring Services

HB 2727 by Rep. Price & Sen. Perry

Building upon prior legislation (HB 4) from last session that increased access to telemonitoring in Medicaid, HB 2727 further expands telemonitoring services to additional patient groups and providers.

Telemonitoring for End-Stage Renal Disease: HB 2727 adds end-stage renal disease and any condition that requires dialysis to the existing list of conditions that may be eligible for telemonitoring. Eligibility is also dependent upon risk factors; the bill reduces the number of required risk factors from two to one and eliminates some of the existing factors. Now, a patient must exhibit only one of the following factors:

- Two or more hospitalizations in the last 12 months
- Frequent or recurrent emergency room admissions
- History of poor adherence to medications
- Documented risk of falls
- History of care access challenges

HHSC must establish rules and determine if allowing home telemonitoring services is cost-effective and clinically beneficial before these services can be covered.

Telemonitoring for High-Risk Pregnancy: The bill requires HHSC to assess whether high-risk pregnancy qualifies for home telemonitoring, based on cost and clinical effectiveness. If deemed appropriate, rules will identify high-risk pregnant patients who could benefit from at-home monitoring equipment, including uterine and hypertension monitoring equipment. The bill also stipulates specific utilization review requirements for these services. Providers caring for high-risk pregnant patients must obtain prior authorization for the first month and monthly subsequent authorizations based on documented ongoing medical necessity. Prior authorization requests must be based on an in-person assessment. Providers are not eligible for reimbursement when the equipment remains unused due to patient hospitalization or absence from home.

Telemonitoring for Other Risk Factors: HB 2727 also allows MCOs and HHSC to reimburse providers for telemonitoring services for patients who have other risk factors or conditions not expressly listed in statute if HHSC determines they are cost-effective and clinically effective. The MCO is no longer responsible for determining effectiveness.

Includes Federally Qualified Health Centers & Rural Health Clinics as Providers: HB 2727 also broadens the range of providers allowed to deliver home telemonitoring services to include federally qualified health centers and rural health clinics.

These providers must establish a care plan featuring outcome measures, which, alongside the data, must be shared with the patient's physician.

Signed by the governor. Effective immediately.

Expands Medicaid MCO Texting Options

HB 2802 by Rep. Rose & Sen. Blanco

HB 2802 builds on previous legislation aimed at improving electronic communication between MCOs and Medicaid enrollees. The bill streamlines the process for enrollees choosing to opt-in or opt-out of receiving critical health care updates and eligibility information through emails and text messages from MCOs.

HB 2802 responds to the concern that the current way to opt-in to texting and email on the eligibility application is confusing. Texans report overlooking or misunderstanding instructions when filling out their preferred contact preferences. Additionally, in January of 2023, the Federal Communications Commission released guidance that confirms that MCOs may call or text a person regarding their Medicaid eligibility or enrollment if they include their phone number on any application for health insurance without obtaining additional consent.

To address these issues, HB 2802 requires HHSC to establish guidelines permitting MCOs to communicate electronically with their members about eligibility, enrollment, and other legally permissible health care matters. In doing so, HHSC is required to revise the Medicaid application by incorporating eligibility and enrollment options, simplifying the selection process for preferred contact methods, and updating notifications that inform members of their right to opt-out of electronic communication by notifying their MCO.

The updated application must be implemented by January 1, 2024. Notably, MCOs will not be required to submit collected contact preferences of their members to HHSC.

Signed by the governor. Effective September 1, 2023.

Reduces the Number & Frequency of HHSC Reports

HB 3265 by Rep. Manuel & Sen. Alvarado

HB 3265 reduces the frequency of some of HHSC's reporting requirements. HHSC requested the adjustments due to a substantial increase in reports—HHSC has seen a 60% increase in required legislative reports since 2021, without associated staffing or funding necessary to meet the demand. The bill allows HHSC to produce a semi-annual report on the Medically Dependent Children Program, instead of quarterly. It also eliminates the requirement that the report be submitted within a specific amount of time following the reporting period. The bill also requires HHSC to incorporate its Statewide Initiatives to Improve Quality of Maternal Health Care Report and Quality Assurance Early Warning System for Long-Term Care Facilities with its Annual Report on Quality Based Measures and Value-Based Payments.

Signed by the governor. Effective September 1, 2023.

Medicaid Vendor Drug Patient Protections & PDL Exceptions

HB 3286 by Rep. Klick & Sen. Hancock

This session, the Legislature approved a bill that extends the statewide Medicaid Preferred Drug List (PDL) for an additional decade (HB 1283). At the same time, there was a discussion around the need to address the substantial number of prescription drug denials

in the Medicaid program linked to the PDL and the state's drug formulary. To resolve these issues, HB 3286 introduces new Medicaid prescription drug reforms and patient protections by adding exceptions to the state's PDL, broadening access to prescribed medications on the state's formulary and PDL, as well as promoting greater accountability within the state's Vendor Drug Program (VDP) and Drug Utilization Review (DUR) Board.

DUR Board Participation: HB 3286 promotes greater accountability by allowing three voting members on the state's DUR Board from Medicaid MCOs. Unlike the other members of the state's drug board, MCOs are at full risk of cost and quality of care. As a result, MCO pharmacy experts will help ensure that drug coverage decisions are based on patient needs and total costs, not manufacturer rebates. All MCO representatives must be physicians or pharmacists. Representatives will also be able to attend any portions of the executive sessions in which confidential drug pricing information is not shared.

Broadening Access to Prescription Drugs: During session, health plan pharmacists testified that Texas is one of the only states that does not include all drugs on the federal formulary, on its state formulary. HB 3286 addresses this by granting temporary formulary status to all drugs and national drug codes available under the federal Medicaid Drug Rebate Program if the manufacturer submits a certificate of information (COI) form to HHSC. If the drug can be dispensed through an outpatient pharmacy, as determined by HHSC, then the drug must be included on the state's formulary for 90 days or until HHSC makes a determination whether to approve or deny the drug's inclusion on the state's formulary based on the COI, whichever happens first.

The bill also requires HHSC to grant temporary non-preferred status to new drugs that have not yet been reviewed by the DUR Board and establish criteria for authorizing drugs with temporary non-preferred status, allowing a prior authorization to be imposed before the drug has been considered at a meeting of the DUR Board.

HB 3286 also requires the PDL to include all equivalent generics when only one generic is listed as preferred. The bill also requires HHSC to develop an expedited review process to consider requests from MCOs and providers to add medicines to the PDL.

Reducing Prescription Drug Denials: As a result of a formulary that prioritizes rebates, patients in Medicaid are often forced off medications that work for them, causing delays and denials of care. While HHSC has a short list of exceptions to the PDL in policy, the policy has not been reviewed in ten years and Medicaid patients lacked comprehensive protections in statute. HB 3286 requires HHSC to establish rules that allow for exceptions to the PDL (meaning a patient cannot be denied access to the drug that are prescribed) if:

- The drug required under the preferred drug list is contraindicated, will likely cause an adverse reaction or physical or mental harm, or is expected to be ineffective
- The patient previously discontinued taking the preferred drug at any point because the drug was not effective, had a diminished effect, or resulted in an adverse event
- Before being discharged, the patient was prescribed a non-preferred antidepressant or antipsychotic drug, and is stable on the drug and at risk of experiencing complications from switching

- The preferred drug is not available for reasons outside of the MCO's control, including because the drug is in short supply according to the Food and Drug Administration Drug Shortages Database or the manufacturer has placed the drug on backorder or allocation

HB 3286 also protects MCOs from liquidated damages for providing patients with the exceptions listed above. This addresses concerns with recent contract changes that would have subjected health plans to penalties for failing to achieve 95% compliance with the PDL, forcing plans to choose between contract compliance and patient needs.

Signed by the governor. Effective September 1, 2023.

Consolidates Statutes Governing HHSC's Ombudsman Programs

HB 3462 by Rep. Noble & Sen. Sparks

The 84th Texas Legislature enacted legislation implementing the Sunset Commission's recommendation to consolidate the various ombudsman offices administered by HHSC. While the offices were consolidated, their statutes remained unconsolidated. This has resulted in conflicting statutory authority and procedures for the ombudsman programs administered by HHSC and has led to confusion among clients needing the assistance of an ombudsman, as well as among ombudsman staff and HHSC program staff. HB 3462 seeks to consolidate the statutes governing the five ombudsman offices:

- The Health and Human Services Office of the Ombudsman
- The Ombudsman for Children and Youth in Foster Care
- The Ombudsman for Managed Care Assistance
- The Ombudsman for Behavioral Health Access to Care
- The Ombudsman for Individuals with an Intellectual or Developmental Disability (IDD)

The bill clarifies that it is the HHSC Executive Commissioner who appoints an ombudsman for each of the ombudsman programs and that appointed ombudsmen serve at the will of the Executive Commissioner.

HB 3462 also ensures that it is the Ombudsman for Managed Care Assistance program that is responsible for providing support and information services for individuals enrolled in or applying for Medicaid coverage who are experiencing barriers to care. However, HHSC will no longer be able to contract with nonprofit organizations that are not involved in providing health care, health insurance, or health benefits. The Ombudsman will no longer be required to report quarterly on statistical information on a regional basis regarding calls received by the assistance lines.

The bill also codifies the existing Ombudsman for Behavioral Health Access to Care program to provide support and information services to a consumer enrolled in or applying for a behavioral health program.

HB 3462 also codifies the Ombudsman for Individuals with an IDD to assist with a complaint or grievance regarding the infringement of the rights of an individual with an IDD or the delivery of IDD services.

The legislation also adds that the existing annual report required by each ombudsman or ombudsman program contains a description of any systemic issues identified in the investigation of individual complaints.

Signed by the governor. Effective immediately.

Prescribed Pediatric Extended Care Center Medicaid Reimbursement

HB 3550 by Rep. Rose & Sen. LaMantia

Prescribed pediatric extended care centers (PPECCs) allow children with complex medical needs (through age 20) to receive daily care in their communities instead of their homes. The community-like setting can reduce the need for private duty nurses and also allow parents to work. However, Texas' strict Medicaid reimbursement requirements have resulted in the establishment of fewer than ten PPECCs. By comparison, Florida has close to 300. A significant concern has been adherence to an administratively cumbersome 15-minute increment daily timesheet, which must be submitted several months in advance to be eligible for reimbursement.

HB 3550 requires HHSC to adopt rules that clearly identify documentation a PPECC must obtain and maintain to be eligible for Medicaid reimbursement. The rules cannot require a PPECC to combine documentation for transportation with documentation for other services or condition reimbursement of non-transportation services on whether a child uses the PPECC's transportation services or whether it maintains transportation documentation.

The bill also requires HHSC to establish transportation standards via rule. The rules must allow the PPECC to determine the child's transportation schedule (in coordination with the child's family) and the type of provider that must be present with the child (in coordination with the child's physician). The rules must also permit a child's family to decline transportation services as needed. Finally, the rules may not require the child's care plan or physician's order to indicate the need for transportation services in order for the PPECC to provide services or for transportation services to be considered nursing services in the child's care plan.

In rulemaking, HHSC may limit the maximum amount of authorized services. HHSC cannot limit the ability of a child's family to make treatment decisions.

As it relates to nursing services, HB 3550 allows PPECCs to provide services in a group setting, consistent with staffing ratios determined by HHSC.

Finally, PPECCS are required to obtain all necessary parental consent on one document.

Signed by the governor. Effective September 1, 2023.

Prevocational Services in Medicaid Waiver Programs

HB 4169 by Rep. Price & Sen. Sparks

HHSC recently made several changes to its Home and Community-Based Services and Texas Home Living waivers for people with intellectual and developmental disabilities living in the community that impacted day and employment services. This included replacing existing day services, formerly called "day habilitation," with a new service called individualized skills and socialization, effective March 1, 2023. Services that were offered as part of day habilitation prevocational programs included preparing an individual for employment.

Individuals previously participating in these day habilitation prevocational programs could be paid—a practice HHSC ended in March based on its interpretation of CMS' new rules, much to the concern of stakeholders and participants, who disagree with HHSC's interpretation. HB 4169 allows HHSC to pursue a new waiver with new program requirements, in an effort to address stakeholder concerns.

If a waiver is not granted, HB 4169 requires HHSC to work with stakeholders to establish a service similar to prevocational services.

HB 4169 requires HHSC to design prevocational services for waiver program recipients that assist them in getting employment in their community that pays at or above minimum wage. HHSC must establish by rule clearly stated, service-related performance standards for providers who will provide these services. Reimbursement for the services may not exceed the reimbursement rate for individualized skills and socialization services. If the service is combined with individualized skills and socialization services, the service may not exceed the total allowable hours or total costs for individualized skills and socialization services provided under a person's service plan.

Signed by the governor. Effective immediately.

Medicaid Coverage for Non-Opioid Treatments

HB 4888 by Rep. Hefner & Sen. Perry

HB 4888 requires HHSC to establish rules to ensure a hospital provider that provides outpatient department services to a Medicaid patient is reimbursed separately for any non-opioid treatment provided as a part of those services. The bill defines non-opioid treatment as a drug or biological product that is indicated to produce analgesia without acting on the body's opioid receptors. HB 4888 applies to drugs and biologicals in the outpatient setting–the Vendor Drug Program (VDP) benefit.

According to HHSC, drugs and biologicals within the VDP benefit are already reimbursed separately. Therefore, in the outpatient hospital setting, there will be no change to current practice for what HHSC covers or pays.

Signed by the governor. Effective September 1, 2023.

Ban on Gender-Affirming Care & Medicaid Coverage

SB 14 by Sen. Campbell & Rep. Oliverson

This bill prohibits a state-licensed physician or other health care provider from performing procedures on a child for the purpose of transitioning the child's biological sex. It also prohibits Medicaid and CHIP from covering or providing reimbursement for services that transition a child's biological sex. Finally, the bill prohibits public money from going to any individual or entity that provides or facilitates the provision of such a procedure or treatment to a child. The legislation provides that if a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

Signed by the governor. Effective September 1, 2023.

Key Legislation Affecting Drug Coverage & PBMs

TAHP
The Texas Association of Health Plans

Today, 22 cents of every health care premium dollar is spent on prescription drugs, more than any other expense in health care and an amount that far outpaces any other nation. TAHP focused this session on fighting back against high drug prices and new regulations that exacerbate the problem. While Texans are urging for lower drug prices, several proposed bills would have, instead, increased the cost of drugs for insured Texans. TAHP advocated against misguided legislation that would raise the cost of drug coverage for Texas employers and families, rewarding the actors that drive up drug prices. This included successful efforts to protect the flexibility under the Employee Retirement Income Security Act (ERISA) and oppose any attempts to introduce costly drug mandates for self-funded employers. TAHP also successfully advocated in support of solutions that control prescription drug costs.

Establishes Wholesale Prescription Drug Importation Program in Texas

HB 25 by Rep. Talarico & Sen. Kolkhorst

In 2020, the Trump Administration established a pathway for states to import prescription drugs from Canada after finding that it would result in significant cost savings for patients and could be done safely, and the Biden Administration later ordered the Food and Drug Administration (FDA) to help states implement related programs. HB 25 creates a wholesale prescription drug importation program in Texas, allowing the importation of prescription drugs from Canadian suppliers.

The bill places guardrails on the program to ensure safety, and it requires annual reporting on participation, savings, and implementation. HHSC is required to develop a registration process for health benefit plan issuers, health care providers, and pharmacies to obtain and dispense prescription drugs imported under the program. The FDA must first approve a state's plan before taking effect and several states have plans pending approval.

Signed by the governor. Effective September 1, 2023.

Limits Prior Authorization for Autoimmune Disease Drugs

HB 755 by Rep. Julie Johnson & Sen. Menendez

In some instances, patients have reported having to undergo the prior authorization process to refill their medication, even though their disease requires consistent, lifelong treatment. This bill seeks to address that concern by prohibiting multiple prior authorizations in a single year for a drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease. The bill applies to commercial insurance, MEWAs, ERS, TRS, and University plans. However, the bill does not apply in certain circumstances. First, it does not apply to opioids, benzodiazepines, barbiturates, or carisoprodol. Second, it does not apply to prescription drugs that have a typical treatment period of less than 12 months.

Third, it does not apply to drugs that have a boxed warning from the Food and Drug Administration (FDA) that requires specific provider assessment. Finally, it does not apply to the use of a drug that is in a manner not approved by the FDA.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Single 12 Month Supply of Contraceptives Mandate

HB 916 by Rep. Ordaz & Sen. Paxton

Under current regulations, insurance, Medicaid, and CHIP are required to provide contraceptive coverage. This bill expands the existing coverage mandate by requiring insurers, ERS, TRS, University plans, and Medicaid (but not CHIP) to cover a three-month dispensing of a prescription contraceptive drug when it is first prescribed, and a full 12-month dispensing for subsequent prescriptions of the same drug if the patient chooses. The requirement for subsequent 12 month supplies of prescription contraceptive drugs applies regardless of whether the enrollee was previously covered by the health plan for the first prescription. An enrollee can only receive one 12 month supply per year for each covered prescription contraceptive drug.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Limits Use of Copay Coupon Accumulators

HB 999 by Rep. Price & Sen. Schwertner

Patients may receive copay assistance coupons from drug manufacturers to help with payment for copays or out-of-pocket costs for prescription drugs. However, these coupons are not always counted toward a patient's deductible responsibility since the patient is not paying these costs. This bill requires commercial health plans, MEWAs, 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 covered prescription drug to the enrollee's applicable deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum, so long as there is no generic or biosimilar available.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Creates Step Therapy Exceptions for Serious Mental Illness

HB 1337 by Rep. Hull & Sen. Menendez

Insurers often impose step therapy requirements to encourage the use of lower-cost prescription drugs before covering a more expensive one, which can help lower health insurance premiums and out-of-pocket costs. However, in the context of serious mental illness, it can be important for a patient to receive a specific prescription without having to try lower-cost options.

Under this bill, health plans and MEWAs may not require enrollees to fail to successfully respond to more than one different drug, excluding generic or pharmaceutical equivalents for the prescribed drug. If a generic or pharmaceutical equivalent is added to a plan's drug formulary, a plan may impose step therapy once in the plan year.

These step therapy protections are in addition to existing protections against non-medical switching. Current law prohibits step therapy when a physician provides documentation

stating that a required drug is not in the patient's best interest, could cause an adverse reaction, will likely not be effective, or could create mental or physical harm. Patients can also get an exemption to step therapy requirements when they have tried the drug and it did not work, it could cause an adverse reaction, a physician believes a patient is unlikely to take the new drug, or it could worsen a different condition.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Prohibits Mandatory "White Bagging" in Physician Offices

HB 1647 by Rep. Cody Harris & Sen. Schwertner

HB 1647 creates limits on when health plans can require physicians to use lower-cost prescription drugs from outside specialty pharmacies, often referred to as white bagging, instead of medications stocked by a provider's own pharmacy and potentially provided at a marked-up price. "White bagging" is the practice of delivering drugs, typically infusion drugs, from a specialty pharmacy to a hospital, physician's office, or another site of service where a provider can administer the drugs to the patient. This bill prohibits commercial insurers and MEWAs, for an enrollee with a chronic, complex, rare, or life-threatening condition, from requiring clinician-administered drugs to be dispensed only by certain pharmacies or in-network pharmacies.

Health plans are also prohibited from limiting or excluding coverage for clinician-administered drugs when not dispensed by certain pharmacies or an in-network pharmacy or requiring a provider to be reimbursed through the pharmacy benefit instead of the medical benefit without consent from the patient.

Patients also cannot be required to 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 pharmacy.

The bill does not apply to a prescription drug administered in a hospital, hospital facility-based practice, or hospital outpatient infusion center. The bill also only applies in cases where:

- The patient's physician determines that a delay of care would make disease progression probable
- The use of a network pharmacy would make death or patient harm probable
- The use of a network pharmacy would potentially cause a barrier to adherence to the plan of care
- Timeliness of delivery necessitates delivery by a different pharmacy

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2024.

Expands Donation of Unused Drugs

HB 4331 by Rep. Klick & Sen. Hancock

HB 4331 expands the types of entities that can donate unused prescription drugs to include a prescription drug manufacturer or a health care facility, including a pharmacy. Previously, only an individual could make a donation. This piece of legislation complements HB 4332, which allows for the redistribution of donated prepackaged prescription drugs. Collectively, the bills are intended to expand access to donated medications.

Signed by the governor. Effective September 1, 2023.

Allows Dispensing of Donated Unused Drugs

HB 4332 by Rep. Klick & Sen. Hancock

This bill allows for the redistribution of donated prepackaged prescription drugs. Current law allows providers to redistribute prescription drugs that have been donated, but providers face a challenge with donated drugs that are not in their original packaging.

In accordance with rules adopted by the Texas Board of Pharmacy, providers will be able to dispense repacked donated drugs if the new label includes:

- The drug's name and manufacturer
- The appropriate dosage of the drug
- The drug's lot number
- The earliest expiration date of the drug based on the lot number
- The quantity of the drug, based on dosage

The provider must keep a record of the drug, as well. The record must include:

- The drug's name, quantity, and dosage
- The provider's lot number for the drug and expiration dates
- The drug's manufacturer or distributor and manufacturer's lot number
- The number of prepackaged units that include the drug and the date the drug was prepackaged
- The name of the individual who prepackaged the drug and the signature of the pharmacist responsible for the drug's prepackaging

Signed by the governor. Effective September 1, 2023.

Texas Pharmaceutical Initiative

HB 4990 by Rep. Bonnen & Sen. Kolkhorst

HB 4990 establishes the Texas Pharmaceutical Initiative "to provide cost-effective access to prescription drugs and medical supplies" for members enrolled in ERS and TRS; people confined in Texas Department of Criminal Justice or Texas Juvenile Justice Department facilities; employees, dependents, and retirees of the state's public higher education systems and institutions; and enrollees and beneficiaries of any program administered by HHSC. A related budget rider appropriates $150 million for the Initiative over the biennium.

The Initiative will be governed by a board of three individuals appointed by the Governor. A person may not be appointed if they have held public office in the last five years or if they are an employee at an agency that could be served by the Initiative. Further, no more than one board member may derive more than 10% of their annual income from the health care, insurance, or pharmaceutical industry.

The Board is administratively attached to HHSC. The Board has the power to develop and implement the Initiative and related programs and establish administrative procedures and policies, including procedures to document compliance with conflict of interest disclosure requirements. The Board also has the authority to hire an executive director and administrative support staff.

The primary focus of the Board is to develop a "business plan" by October 1, 2024, that:

- Implements the Initiative, including its organizational structure and programs
- Establishes procedures that document compliance with conflict of interest laws
- Establishes the conditions for participation in the Initiative
- Identifies potential cost savings
- Provides other board recommendations, with supporting documentation, on the continuation of the Initiative

- Identifies the funding and resources needed for implementation
- Establishes administrative procedures and policies for the Initiative, including documenting the process and resources required for: (1) establishing or contracting for statewide PBM services; (2) operating or contracting for the operation of a distribution network, central service center, and associated network of satellite distribution facilities to distribute drugs and supplies; and (3) providing advanced pharmaceutical preparation and related services, including manufacturing generic drugs and generic biological products; providing gene therapies and precision medicine; and providing advanced laboratories for quality control, preparation, and compounding of drugs in support of innovative therapeutics and drug research

HB 4990 also establishes an advisory council. The Council is comprised of the HHSC Executive Commissioner, the executive directors of ERS and TRS, and the chancellors of The University of Texas System and The Texas A&M University Systems, or their designees.

Signed by the governor. Effective immediately. The chapter establishing the Texas Pharmaceutical Initiative expires on September 1, 2025.

Insulin Market Manipulation Reporting Rules

SB 241 by Sen. Perry & Rep. Talarico

Just three drug manufacturing companies provide insulin in the U.S. market and there are no biosimilar competitors, despite the drug's existence for almost 100 years. SB 241 requires insulin manufacturers whose drug appears on the Medicaid formulary to submit a written verification to HHSC stating whether or not the unavailability of a generic or biosimilar insulin on the market is due to the manufacturer being engaged in market manipulation through "pay to delay" schemes, "evergreening," or patent manipulation tactics–either first hand or via facilitation of another entity.

Signed by the governor. Effective September 1, 2024.

Rx Formulary Transparency & API Mandate

SB 622 by Sen. Parker & Rep. Smithee

When prescribing medication to a patient, a health care provider may not have information regarding the financial impact that filling the prescription might have on the patient. This bill requires health plans to provide real-time information regarding prescription drugs to patients or their prescribing doctor on request, including the drug formulary, eligibility, cost-sharing information, and utilization management requirements. The health plan must respond in real-time to a request made through a standard application programming interface (API) and ensure information is current no later than one day after a change is made.

The legislation also prevents a health plan from taking action to prevent access to this information. This includes restricting the provider from communicating the required information or discouraging access to the information through fees, failing to respond to a request, or using other means to discourage access to the information. The bill does not go into effect until January 1, 2025, and issuers with fewer than 10,000 enrollees are eligible for extensions. This bill applies to commercial insurers, MEWAs, ERS, TRS, University plans, and plans issued by Texas Mutual.

Signed by the governor. Effective September 1, 2023. Applies to plans delivered, issued for delivery, or renewed on or after January 1, 2025.

Access to Investigational Drugs

SB 773 by Sen. Parker & Rep. Toth

In May 2018, the federal Right to Try Act was signed into law, creating a federal framework for patients to access new investigational drugs and biologics. In Texas, patient advocates have made calls to provide more treatment options for those suffering from chronic disease. This bill, the Medical Freedom Act, allows HHSC to designate severe chronic diseases, for which a patient may take an investigational drug upon recommendation by a physician. Use of the drug requires informed consent, the provider is immune from liability, and the state is prohibited from interfering with the treatment. This does not affect the coverage of enrollees in clinical trials, nor does it create a new insurance mandate.

Signed by the governor. Effective immediately. HHSC shall make rules as soon as practicable.

Key Legislation Affecting the Dental & Vision Insurance Industry

TAHP
The Texas Association of Health Plans

TAHP advocates for affordable vision and dental coverage in addition to bills affecting health plans and drug coverage. Several bills were filed and changed throughout the legislative process which impact how Texans are covered for dental and vision care.

Dental Overpayments & Dental Network Leases

HB 1527 by Rep. Oliverson & Sen. Zaffirini

HB 1527 limits when health plans and dental plans can recover overpayments from dentists, prohibits contract clauses that allow an insurer to deny a service that is ordinarily covered, and establishes transparency requirements for dentists when an insurer is leasing a dental network to a third party.

Recovery of Overpayments: Under the bill, issuers are prohibited from recovering an overpayment made to a dentist unless the issuer provides written notice of overpayment within 180 days after payment and the dentist fails to object within 45 days of receiving the notice or exhausts all appeals options. The issuer must have policies and procedures to allow for an appeal. This aligns dental plans with current commercial insurance requirements.

Prohibits Denial of Covered Dental Services: The bill also prohibits 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 then prohibits the dentist from billing the patient for the amount owed.

Requirements for Leasing a Dental Network: HB 1527 also establishes new restrictions for when an insurer is able to lease a dental network to a third party, such as another health plan or dental plan. These requirements are similar, but not identical, to the requirements for leasing medical networks. First, at the time of contracting with the dentist or entering into an agreement with a third party to access a dental network, the dentist has the ability to elect not to participate in the third-party access of an insurer's dental network. Second, an issuer may only grant third-party access to the dentist's services and discounts if this agreement is transparent, the dentist has the option not to participate, and the third-party honors all of the original contract terms. However, the restrictions in this section do not apply if a third party is operating under the same brand license as the issuer or if the third party is an affiliate of the issuer.

Signed by the governor. Effective September 1, 2023. Applies to plains delivered, issued for delivery, or renewed on or after January 1, 2024.

Limits on Vision Plan Steering, etc.

HB 1696 by Rep. Buckley & Sen. Hughes

HB 1696 sets requirements for how health plans and vision plans can discriminate based on vision provider type, creates prohibitions on steering, establishes limits on chargebacks, places limits on contract changes, creates marketing requirements, and limits vision plans from using extrapolation in claims recovery.

Prohibitions on Discrimination & Steering: In existing insurance law, there is a subchapter

dedicated to access to optometrists and ophthalmologists that applies to health benefit plans. That chapter prohibits insurers from discriminating, restricting, or excluding those providers solely because of their licenses. HB 1696 removes ophthalmologists from that subchapter, while also adding vision benefit plans to the applicability. The bill then prohibits a vision or health plan from identifying participating optometrists differently—such as provider directory placement—based on: discounts offered for products that are not covered, the dollar amount, volume amount, or percent usage amount of any product or good purchased by the optometrist; or the brand, source, or supplier of a product used by the optometrist. The bill also prohibits plans from incentivizing or encouraging enrollees to obtain a service from a particular participating optometrist, at a retail establishment affiliated with the insurer, or at a virtual provider affiliated with the insurer.

Marketing Requirements: There is also an existing section of law that requires insurers to include optometrists and ophthalmologists as participating health care providers and give equal prominence to their name in any list of participating providers. This bill removes ophthalmologists from those provisions. The bill then adds that insurers must provide coverage information of enrollees to optometrists, publish complete plan information with marketing materials, allow optometrists to utilize third-party claim filing services, and allow optometrists to receive reimbursement through an electronic funds transfer.

Contracting Changes: The bill then has provisions relating specifically to contracts between vision or health plans and optometrists. The bill provides that a contract between a vision or health plan and an optometrist may not authorize a chargeback for a covered product or service that the insurer does not incur the cost to produce, deliver, or provide to the patient or optometrist. The bill also prohibits differing fee schedules based on the optometrist's choice of laboratory, supplier, equipment, or affiliation. The bill prohibits plans from changing contract terms with optometrists unless the insurer provides at least a 90 day notice, and it prohibits provisions requiring optometrists to provide a covered service at a loss.

Prohibited Conduct: The bill also has a section on prohibited conduct by an insurer. This section lists out the prohibited contract provisions described above, but then adds some new prohibitions. For example, insurers are prohibited from applying restrictions on an optometrist's choice of health record software or claim-filing service. Similarly, it prohibits insurers from requiring optometrists to disclose a medical history or diagnosis as a condition to file a claim for a routine wellness exam. A plan also cannot require an optometrist to disclose a patient's glasses prescription to submit a claim, or submit any information other than what is required on a standard claim form.

Extrapolation Limits: Finally, the bill prohibits vision plans, but not all insurers, from using extrapolation to complete an audit of a participating optometrist. Any overpayments must be based on actual overpayments rather than extrapolation.

Signed by the governor. Effective September 1, 2023. Applies to plains delivered, issued for delivery, or renewed on or after January 1, 2024.

Coordination of Vision Benefits

SB 861 by Sen. Hughes & Rep. Buckley

Commonly, a patient will have medical insurance with a medical benefit plan and a vision care benefit from a separate vision benefit plan company. But some vision benefit plan companies do not allow patients to have their benefits coordinated with a patient's medical plan. This bill aligns the coordination of vision benefits with existing requirements applicable to the coordination of dental benefits. Under the bill, when an enrollee has coverage from both a commercial insurer and a vision plan, the issuer of the primary plan is responsible for coverage up to the full amount of any coverage limit. After the primary coverage limit is met, the secondary plan issuer is responsible for any additional expenses for services covered by both plans up to the coverage limit of the secondary plan.

The primary and secondary issuers are determined by the coordination of benefits provisions in the plan documents. The bill also prohibits plans from excluding or reducing coverage solely because the benefits are payable under another plan, although the bill does not require a secondary plan issuer to pay an amount that when added to the payment by the primary plan issuer, would exceed usual and customary billed charges.

Signed by the governor. Effective September 1, 2023. Applies to plains delivered, issued for delivery, or renewed on or after January 1, 2024.

Budget Highlights

The Texas Legislature started the 88th Regular Session with a record-breaking surplus of $32.7 billion, positioning the two chambers for once-in-a-lifetime budgeting and prioritizing. Unlike last session's anticipated budget shortfalls due to the pandemic and related economic downturn, budget discussions this session focused on how the state should best use the massive surplus to build a sustainable budget for Texas' future. The state capitalized on the historical cash windfall by investing unprecedented amounts of money into areas like tax cuts, mental health, state parks, colleges and universities, the energy grid, broadband, and water infrastructure. The state budget, combined with a separate supplemental budget agreement, uses just under half of the historic $32.7 billion cash surplus.

The Legislature ultimately appropriated $18 billion more than the previous biennium, resulting in a final budget of $321 billion – a 5% increase from the last biennium. Included in this budget is a 5% pay raise each year for state employees to address challenges related to state workforce retention. The House and Senate have agreed to spend $17.6 billion on property tax relief. Of that, $12.3 billion is new spending, while $5.3 billion is to maintain tax cuts approved in previous years. But how exactly lawmakers intend to deploy that money remains to be seen. Legislators can only spend that extra $12.3 billion if they work out a deal during a special session.

Medicaid Funding - General Appropriations Act

General Appropriations Act for 2024-2025

HB 1 by Rep. Bonnen

HB 1 includes $75.4 billion in All Funds for the 2024-25 biennium for Medicaid client services, a decrease from $79.9 billion in 2022-23. The change is driven by the gradual loss in both members and enhanced federal matching funds (6.2%) now that the unwinding of continuous Medicaid coverage has begun. By state fiscal year 2025, HB 1 assumes a return to 3.9 million enrollees. At its peak in May 2023, the state's Medicaid program had 6 million enrollees as a result of the three-year continuous eligibility requirements to receive the enhanced federal funding match. As in previous years, there may be a supplemental need which would be funded next session.

Across all agencies, appropriations in HB 1 related to the Medicaid program total $80.8 billion in All Funds and $30.5 billion in General Revenue. This includes Medicaid program client services, programs providing client services with Medicaid funding, and Medicaid funding for administration across HHSC, DFPS, and DSHS.

HB 1 includes:

- $2.0 billion to support community attendant services and raise the base wage to $10.60 an hour
- An additional $50 million in General Revenue to increase waiver slots and reduce interest lists
- $206.8 million to increase rates for pediatric services and women's health-related surgeries by 6%, private duty nursing by 2%, and ground ambulances by 25%
- $5 million for HHSC to study hospital revenue and expenses, including charity care
- Funding for the ongoing costs for improvements to the Medicaid and CHIP Provider Enrollment and Credentialing Portal (PEMS+)
- An additional $178.2 million for rural hospitals, including increased funding for rural labor and delivery add-on and a new rural hospital grant program
- $302 million for mental health community hospitals, $199.4 million for mental health state hospital operations, and $83 million for community mental health grant programs
- $150 million to pay for the Texas Pharmaceutical Initiative

Legislative Budget Board Summary of HB 1

Article II - HHSC Budget Riders

Medicaid Enterprise Systems

Rider 6

Requires HHSC to maintain an Executive Steering Committee for the contracts supporting the Texas Medicaid Management Information System (MMIS) capital project. This rider is critically important this biennium, as the current Accenture contract for the Texas Medicaid & Healthcare Partnership (TMHP) system expires August 31, 2023, and is replaced with three vendor contracts for a new Medicaid Enterprise Systems (MES). The MES Executive Steering Committee (formerly the TMPH Executive Steering Committee) shall provide executive-level strategic direction and commitment to the MES contracts and MMIS projects. Strategic direction includes a review of contract terms prior to execution of a new contract or amendment and reports from third-party quality assurance and independent verification and validation vendors.

In addition, the rider requires the committee to report any anticipated contract or project cost overruns or delays to the Legislative Budget Board.

Increase Consumer Directed Services

Rider 9

Requires MCOs to educate STAR+PLUS members about the consumer directed services (CDS) option, and seek to increase the percentage of members who choose CDS. Requires HHSC to collect information annually from each MCO on the percent of clients enrolled in CDS and shall establish incremental benchmarks for improvement and include the information on their website.

Therapy Reporting

Rider 10

Requires HHSC to continue biannual reporting on therapy services access.

Evaluation of Medicaid Data

Rider 11

Requires HHSC to annually evaluate data submitted by MCOs to determine whether the data continues to be useful or if additional data, such as measurements of recipient services, is needed to oversee contracts or evaluate the effectiveness of Medicaid.

Rural Labor & Delivery Medicaid Add-on Payment

Rider 16

Increases to $1,500 the Medicaid add-on payment for labor and delivery services provided by rural hospitals. This was previously $500. The rider also updates the definition of rural hospital to hospitals located in a county with 68,750 or fewer persons according to the 2020 U.S. Census.

Interest List Reporting

Rider 19

Requires HHSC to post on its website the following information regarding Home and Community-Based Services, Community Living Assistance and Support Services, Deaf-Blind Multiple Disabilities, Texas Home Living, and Medically Dependent Children Program waivers and STAR+PLUS:

- Interest list releases
- Interest list counts, by years on list
- Average number of individuals on the interest list per month
- Average number of individuals on the interest list receiving other services per month
- Percent declined services or found to be ineligible for services at the end of the fiscal year
- The unduplicated number of persons on each interest list, broken out by program, by month (new this biennium)

HHSC Cost Containment

Rider 21

Requires HHSC to find $450 million in General Revenue (up from $350 million) in cost containment through:

- Fraud, waste, and abuse prevention and detection
- Maximizing federal flexibility under the Medicaid program
- Programmatic and administrative efficiencies
- Savings from services that include emergency telemedicine services for individuals with intellectual and developmental disabilities (new this biennium)

Nursing Facility Wage Increases

Rider 24

Provides $325 million to increase the wages and benefits of direct care staff. HHSC must implement the rate increases in a manner that ensures that at least 90% of the funds are expended for the benefit of direct care staff wages and benefits and recoup from providers who do not utilize the funds as intended. In order to receive the funds, nursing facilities must report on their biennial cost report information regarding the use of the funds, including information related to efforts to improve or maintain client care and quality of services, and to demonstrate that at least 90% of the funds were expended for their intended purpose.

Nursing Facility Patient Driven Payment Model

Rider 25

Requires HHSC, by September 1, 2024, to implement a Texas version of the Patient Driven Payment Model (PDPM) methodology for the reimbursement of long-term stay nursing facility services in the Medicaid program to achieve improved care for long-term stay nursing facility services. This does not include services provided by a pediatric care facility or any state-owned facilities. The rates should incentivize client care and quality of services over resource utilization. Nursing facilities should utilize reimbursement rate increases to improve staff-to-client ratios, staff training and education, and wages for direct care staff. The rider includes $40 million in General Revenue for reimbursement rate increases for nursing facility services reimbursed using the new PDPM methodology.

Funding to Support the Medicaid Unwinding

Rider 27

Provides $37.8 million in General Revenue to HHSC for temporary full-time equivalents (FTEs) and to support the increased workload of the Eligibility Support Services contractors due to the unwinding of continuous Medicaid coverage. All temporary FTEs must be phased out by June 30, 2024.

Funding for 2-1-1 Improvements

Rider 28

Provides $375,000 in General Revenue for staff retention and hiring at contracted Area 2-1-1 Information Centers and $375,000 in General Revenue to improve 2-1-1 analytics and functionality.

Increases for Attendant Wages

Rider 30

Increases the base wage for personal attendant services to $10.60 per hour. Provides $9.4 million in General Revenue for the Attendant Care Rate Enhancement Program. Increases the individualized and specialized services rate enhancement program to 5 cents per level. Requires HHSC to evaluate and report on the rate enhancement programs and make recommendations by October 1, 2024.

Rate Increases for Pediatric Services & Women's Health Related Surgeries

Rider 31

Increases reimbursement rates to improve access by children to physician and clinic services, especially well child visits, by 6%. Increases reimbursement rates for birth and women's health related surgeries by 6%. Requires HHSC to report on MCO compliance on allocating the additional funds and whether there are distinctions in the level of access to care available to children ages 0 to 4 as compared to children ages 5 to 20. The report is due September 1, 2024.

Managed Care Transition for Dually Eligible Individuals

Rider 32

Requires HHSC to transition Medicaid-only services for dually eligible people enrolled in Medicaid managed care from services currently provided through fee-for-service to services provided through managed care, without imposing cost sharing on those dually eligible people.

Ground Ambulance Reimbursement Rates

Rider 33

Increases the Medicaid ground ambulance mileage reimbursement rate by 25%.

Private Duty Nursing

Rider 34

Increases the Medicaid private duty nursing reimbursement rate by 2%.

Medicaid Pediatric Long-Term Care Facility Rate Increase

Rider 35

Provides $1.5 million in General Revenue to increase the reimbursement rate for pediatric long-term care facilities.

Medicaid & CHIP Provider Enrollment and Credentialing Portal

Rider 36

Provides $500,000 in General Revenue in fiscal year 2025 for the ongoing costs for the Medicaid and CHIP Provider Enrollment and Credentialing Portal, also known as PEMS+.

Report on Uncompensated Trauma Care

Rider 37

Requires HHSC to report on the amount of funds hospitals receive through governmental entities for uncompensated trauma care and payments received by physicians or physician groups for providing medical care to uninsured trauma patients. The report is due December 1, 2024.

Additional HB 1 Medicaid Riders

Actuarial Analysis of HHS Managed Care Rates

State Auditor's Office, Rider 5

Requires the State Auditor's Office (SAO) to conduct an actuarial analysis of the fiscal year 2024 rates for Medicaid managed care. Within 45 days after HHSC submits the rates to the Legislative Budget Board, the SAO is required to file a report on the actuarial soundness of the rates, as well as an analysis of key factors that affect the rates. Further, no later than November 1, 2023, the SAO must provide an audit report on the rate making process used by HHSC. The report should identify improvements that can be made to the rate making process, including identifying significant cost drivers in the rate setting process, and identifying improvements to the process of communicating rates with oversight entities. In evaluating the rate making process, the SAO must determine if the HHSC followed appropriate procurement processes in obtaining vendors.

Contract Management and Oversight

Art. IX, Art. 17.09

Requires all agencies and institutions of higher education to establish effective processes and controls to manage contracts and ensure the cost-effective use of state appropriations for contracted goods and services. Requires agencies to make a good faith effort to identify and execute savings and efficiencies in their use of contracted goods and services. Prohibits an agency or institution of higher education from using monies appropriated elsewhere in HB 1 to pay for a contract for goods or services unless it conducts a cost benefit analysis. HHSC is exempt from seeking competitive bids or proposals for its Medicaid and CHIP managed care contracts before renewing or extending a contract that has been in effect more than

five years and is valued at the lesser of $10 million or 10% of the agency's All Funds budget for the 2024-25 biennium. Also encourages agencies and institutions to minimize the use of extensions that extend a contract beyond the base term and any optional extensions provided in a contract and prohibits money available in HB 1 to be used for the extension unless specific requirements are met.

Medicaid Reimbursement Rate Review for Pediatric Care Center Services

Art. IX, Sec. 17.29

Requires HHSC to conduct an annual review of reimbursement rates for pediatric care center services delivered to children under Medicaid.

Charity Care & Hospital Transparency

Art. IX, Sec. 17.34

Appropriates $5 million in General Revenue for HHSC to report on the financial and utilization data of licensed Texas hospitals that generate revenue from public sources and programs and/or benefit from tax exemptions or the use of public debt. The report is due December 1, 2024.

Contingency for House Bill 1575

Art. IX, Sec. 18.15

Appropriates $3.9 million in General Revenue and 6 FTEs for the implementation of HB 1575, which requires NDOH Medicaid screening and doula coverage for pregnant women in Medicaid and the Alternatives to Abortion program.

Contingency for House Bill 4990

Art. IX, Sec. 18.35

Appropriates $150 million in General Revenue for implementation of HB 4990, which establishes the Texas Pharmaceutical Initiative. The rider also gives the Legislative Budget Board the authority to increase HHSC's FTEs, as needed.

Professional Nursing Shortage Reduction Program

Higher Education Coordinating Board, Rider 26

Appropriates $23.4 million each fiscal year for the Professional Nursing Shortage Reduction Program. Of the funds, the Texas Higher Education Coordinating Board (THECB) must distribute $14 million annually to institutions with nursing programs, including those graduating their first nursing class, based on increases in the numbers of nursing students graduating. $4 million annually must be distributed based on the total number of nursing students graduating from a program each year. $5.4 million annually must be distributed based on the total number of doctoral level and master's in nursing education students graduating from a program each year.

Medicaid Funding - Supplemental Budget

Supplemental Budget for 2022-23

SB 30 by Sen. Huffman

Each session, the Texas Legislature passes a bill that helps finalize the budget for the current biennium, it includes both supplemental appropriations and reductions in appropriations, and provides direction and adjustment authority regarding appropriations. SB 30 included $2.5 billion in General Revenue to cover the Medicaid shortfall. This shortfall occurs nearly every session and addresses differences in caseload growth.

Of the amount appropriated, $5 million must be transferred to the Home and Community-Based Services - Adult Mental Health program.

SB 30 also includes $1.6 billion for new construction of mental health state hospitals, $0.5 billion for new construction at mental health community facilities, and $0.1 billion for maintenance and information technology projects related to mental health services.

The legislation has immediate effect.

Legislative Budget Board Summary of SB 30

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