ALL REFERRED COMMERCIAL BILLS

03-18-2023 - 09:07:05

Select All Deselect All

HB 25 | Talarico, James | Wholesale prescription drug importation

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

TAHP POSITION: Support

EFFECTIVE DATE: 9/1/23

DATE UPDATED: 2/3 JB 2/21 JL

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

HB 58 | Talarico, James | Local Ambulance Balance Billing

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

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

TAHP POSITION: Neutral

DATE UPDATED: 2/13 KS

Last Action: 2-23-23 H Introduced and referred to committee on House County Affairs

HB 89 | Talarico, James | Local Ambulance Balance Billing

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

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

TAHP POSITION: Neutral

DATE UPDATED: 2/13 KS

Last Action: 2-23-23 H Introduced and referred to committee on House County Affairs

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

Companions: SB 51 | Zaffirini, Judith(D) | (Identical)
2-15-23 S Introduced and referred to committee on Senate Health and Human Services

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

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

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

EFFECTIVE DATES: September 1, 2023

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

DATE UPDATED: 2/3 KS

Last Action: 3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

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

Remarks: SUMMARY: This bill expands the existing state-mandated benefit for prostate cancer to new types

of coverage (small employer groups, MEWAs, ERS, TRS, Medicaid, and CHIP) and adds prohibition for any enrollee cost-sharing to the existing mandate.

TAHP POSITION: Oppose

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

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

MANDATE: Benefit Design Mandate

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

DATE UPDATED: 2/3/23

REFILE: HB 3951 (87th)

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

T HB 134 Bernal, Diego Cranial Helmet Mandate

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

coinsurance factors as coverage for other orthotics under the plan. Defines "cranial remolding orthosis" as a custom-fitted or custom-fabricated medical device that is applied to the head to correct a deformity, improve function, or relieve symptoms of a structural cranial disease.

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial, Medicaid

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

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

DATE UPDATED: 2/2 BH

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

HB 181 Johnson, Jarvis Sickle cell disease registry

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

TAHP POSITION: Support TAHP dropped a card in support 3/16

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

Last Action: 3-13-23 H Committee action pending House Public Health

HB 290 Oliverson, Tom Multiple employer welfare arrangements

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

Remarks: SUMMARY: This bill would apply certain insurance mandates to MEWAs that provide comprehensive health plans. MEWAs would be subject to reserve requirements, asset protection requirements, the selection of providers chapter, and the utilization review chapter. A MEWA that provides a comprehensive health plan that is structured in the same way as a PPO/EPO would also be subject to Chapter 1301 (PPO plan requirements) and Chapter 1467 (surprise billing prohibition). The bill would also modify the application and eligibility requirements for a certificate of authority.

TAHP POSITION: Neutral

COVERAGE TYPES: MEWAs

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/1 KS

HEARINGS: 3/07/23- Neutral

Last Action: 3-14-23 H Voted favorably from committee on House Insurance

HB 340 | Thompson, Senfronia | Emotional Disturbance of a Child Mandate

Companions:

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

Remarks:

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

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

COVERAGE TYPES: ERS, TRS, Commercial

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

TAHP POSITION STATEMENT:TAHP and its member health plans support mental health parity and access to mental health treatment, but we are opposed to the new, undefined, open-ended benefit mandate this bill creates that is vague and not adequately defined. The bill does not adequately define “serious emotional disturbance of a child” or identify the specif ic conditions to be covered. Because this is not a standard insurance benefit, unclear definitions and requirements create uncertainty regarding what a plan is required to cover. This lack of certainty could be abused by providers to file claims for inappropriate care and increase costs for these services. The bill allows a benefit limitation of up to 45 days of inpatient care and 60 outpatient visits, but applying these limits is very likely to violate the mental health parity law. Because these limits are not allowed, the bill is essentially creating an unlimited benefit for “serious emotional disturbance of a child."

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

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

HB 351 | Bell, Cecil | Workers Comp Packaged Plan

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

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/1 KS

Last Action: 3- 7-23 H Committee action pending House Insurance

T HB 389 Collier, Nicole Fertility preservation mandate

Companions:

HB 1649	Button, Angie Chen(R) 3- 7-23 H Introduced and referred to committee on House Insurance	(Identical)
SB 447	Menendez, Jose(D) 2-15-23 S Introduced and referred to committee on Senate Health and Human Services	(Identical)

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

has coverage from a state regulated health plan.

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial

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

MANDATE: Benefit

TAHP POSITION STATEMENT: The bill creates a new unfunded, mandated benefit, fertility preservation services, for a covered person who will receive a treatment that may impair fertility. In the 86th legislative session, this same mandated benefit (HB 2682) would have increased Medicaid costs by $5.2 million a year and TRS-active care costs by $4 million a year. The LBB found that this benefit mandate would also increase health care costs to the TRS, UT systems, and ERS health plans that would result in increased premiums and contributions from the state, employers, or members.

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

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

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

While we recognize the importance of fertility preservation services for patients undergoing medical treatments that could impact their fertility,

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

UPDATED: 2/3 BH

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

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

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

TAHP POSITION: Neutral as long as bill is not amended

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

EFFECTIVE DATES:9/1/23

MANDATE: Benefit

TAHP POSITION STATEMENT: TAHP is neutral on HB 468, which expands the mandated benefit (adopted in 2019 in HB 490) for a hearing aid or cochlear implant to an enrollee who is age 25 or younger instead of the current age 18 or younger. TAHP does not oppose this mandate, as it does not create a significant cost increase.

DATE UPDATED: 2/19 KS

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

T HB 496 | Meza, Terry | Prohibits Conversion Therapy Coverage

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

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

eliminate or reduce the person's sexual or romantic attractions or feelings toward individuals of the same sex.

TAHP POSITION: Neutral

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

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/3 BH

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

HB 526 | Wu, Gene | HIV Testing Mandate

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

TAHP POSITION: Neutral

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

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

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

MANDATE: Benefit

DATE UPDATED: 2/3 BH

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

HB 592 | Shaheen, Matt | Telehealth Across State Lines

Remarks: SUMMARY: This bill allows health professionals that are licensed in a different state to provide

telemedicine and telehealth services in Texas if they hold an unrestricted license, have not been subject to disciplinary proceedings, and register with the applicable licensing agency in Texas. It would also add mental health providers to the definition of "health professional" in the telemedicine chapter of the insurance code.

TAHP POSITION: Support

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

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

DATE UPDATED:2/3/23 JB

Last Action: 2-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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

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

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

Last Action: 2-28-23 H Rereferred to Committee on House Public Health

T HB 617 — Darby, Drew — Emergency telemedicine pilot

Companions: SB 251 — Alvarado, Carol(D) — (Identical)

2-15-23 S Introduced and referred to committee on Senate Health and Human Services

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

TAHP POSITION: Support TAHP submitted a card in support 3/16

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 -KS

Last Action: 3-16-23 H Committee action pending House Select on Health Care Reform

HB 624 Harris, Cody Emergency medical transport by fire fighters

Companions: SB 1898 Birdwell, Brian(R) (Identical)
3- 8-23 S Filed

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

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

HEARINGS: 3/06/23- Neutral

Last Action: 3-15-23 H Reported favorably from committee on House Public Health

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

Companions:

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

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

office visit.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

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

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

Research from other states that have passed similar mandates show a resulting increase in primary care copays. In fact, states are now cautioning against more mandates like this.

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

DATE UPDATED: 3/3/23 BH

HEARINGS: 3/07/23- Oppose, testimony BH

Last Action: 3-14-23 H Voted favorably from committee on House Insurance

T HB 633 — Frank, James — Lowest Contract Rate For Uninsured

Remarks: SUMMARY: The bill provides that a physician or provider may not be prohibited from accepting directly from an enrollee full payment for a health care service in lieu of submitting a claim to the

enrollee's health benefit plan. Notwithstanding section 552.003 or any other law, the charge for a health care service for which a physician or provider accepts a payment in lieu of submitting a claim to the enrollee's health benefit plan, or from a patient without insurance, may not exceed the lowest contract rate for the service allowable under any health benefit plan with which the physician or provider is in-network.

TAHP POSITION: Support

COVERAGE TYPES: Commercial, ERS/TRS

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: Texas leads the nation with the highest rate and number of uninsured. While insured Texans have protections against outrageous billed charges from providers, those without public or private coverage face full inflated prices. Providers should not be profiteering on the backs of vulnerable Texans without health coverage. At a minimum, uninsured patients should have access to the same discounted rates providers agree to with insurers. Without this new law uninsured patients will continue to suffer from abusive provider billing practices and subsequent debt collection.

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

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

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

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

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

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/3/23 JB

Last Action: 2-23-23 H Introduced and referred to committee on House Public Health

T HB 652 Johnson, Julie Medicaid expansion

Companions: SB 195 Johnson, Nathan(D) (Identical)

2-15-23 S Introduced and referred to committee on Senate Health and Human Services

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

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/11 by JL

Last Action: 2-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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

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

TAHP POSITION: Neutral

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

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

MANDATE: Coverage

DATE UPDATED: 2/1 KS

Last Action: 2-23-23 H Introduced and referred to committee on House Insurance

HB 700 Oliverson, Tom Health Insurance Exchange

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

Remarks: SUMMARY: This bill would create the Texas Health Insurance Exchange. It would be an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange, as authorized by the ACA. The exchange would have an eleven-member board, with five appointed by the governor, three by the lieutenant governor, and three by the governor from a list provided by the speaker. The board would employ an executive director and other necessary employees to assist the exchange in carrying out its functions. The board would not have any providers or issuers on it, but the board could create an advisory committee to allow for the involvement of health insurance industries and other stakeholders, which would provide recommendations to the board. The exchange may provide an integrated uniform consumer directory of health care providers and which issuers the provider contracts with. The exchange could also establish methods for health care providers to transmit relevant data, rather than an issuer. Not later than July 1, 2024, the exchange would be required to make recommendations to the Senate Business and Commerce Committee and the House Insurance Committee regarding the feasibility of implementing a subsidy program for individuals, families, and small employers to purchase coverage. With the input and approval of those committees, the exchange may develop and implement the subsidy program. The board would also make recommendations on state innovation waivers to the Senate Business and Commerce Committee and House Health Insurance committee, including recommendations on risk stabilization, coverage arrangements for employees, financial assistance for different types of coverage, including non-qualified health plans, and the establishment of account-based premium credits. With the input and approval from the legislative committees, the exchange would be able to apply for necessary federal waivers. For the purposes of the chapter, small employers would include entities that employ at least two and on average no more than 50 employees during the preceding calendar year until 2025, and then no more than 100 employees starting in 2026. That calculation would include part-time employees who are not eligible for coverage through the employer. The exchange may charge issuers an assessment of reasonable and necessary fees to cover the exchange's organizational and operating expenses. The

exchange may also accept grants from a public or private organization and accept federal funds, but general revenue may not be appropriated for the exchange. Assessments, gifts or donations, and any federal funding would be stored in a trust fund outside the state treasury. The exchange would be required to provide a detailed financial report to the governor, the legislature, and HHSC not later than January 31 of each year. TAHP POSITION: Neutral with changes to ensure market stability and state read iness.

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

COVERAGE TYPES: Commercial

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

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

DATE UPDATED: 2/22 KS 3/15 BH

Last Action: 3-13-23 H Introduced and referred to committee on House Select on Health Care Reform

T HB 711 Frank, James Prohibits Anticompetitive Contracting

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

TAHP POSITION: Support

COVERAGE TYPES: Commercial, ERS/TRS

EFFECTIVE DATES: 9/1/23

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

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

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

T HB 755 | Johnson, Julie | Limits PAs to 1 to Year Autoimmune/Chronic

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

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

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC, ERS/TRS

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

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and

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

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

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

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

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

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

health plan websites

Appealable : Providing extensive rights to appeal to an independent physician

LAST UPDATED: BH 2/20

Last Action: 2-28-23 H Introduced and referred to committee on House Insurance

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

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

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

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 1/19/23

TAHP POSITION: Requiring Texas health plans to have personnel available for prior authorization and payment verification requests 24/7, including weekends and holidays, has several negative consequences. Requiring 24/7 availability for prior authorization and payment verification responses is inconsistent with provider availability and creates unnecessary and costly administrative burden. For example, one of the state's largest health plans received just 6% of PA requests after regular business hours (including holidays) in 2022, showing there is very little demand for after-hours verification. Additionally, Texas already has some of the shortest prior authorization time frames in the country, with a requirement that they be processed in less than 3 calendar days compared to most states' 14 days. Furthermore, Texas already has the broadest exemptions to prior authorization in the country, including "gold-carding," which exempts providers with a history of safe and appropriate care. Hospitals and providers also do not staff utilization review after hours.

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

DATE UPDATED: 2/21 KS

Last Action: 2-28-23 H Introduced and referred to committee on House Insurance

HB 757 | Johnson, Julie | No PA for several mandated benefits

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

TAHP POSITION: Oppose

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

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

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't meet the 90% standard of safe and

appropriate care. Prior authorization helps prevent fraud, waste, and abuse. As much as $800 billion is wasted on excessive and unnecessary testing and treatment every year and 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary. This legislation threatens that assurance for patients for numerous tests and treatments including bone mass density scans as an example. This test has been the subject of significant overuse and fraud directed at encouraging patients to take expensive medications. Medical experts now reject the screenings for many individuals noting that the test is a poor indicator of fractures. Under HB 757, medical necessity could be undermined by removing all prior authorization. Some experts estimate that at least $200 billion is wasted annually on excessive testing and treatment.

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

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

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

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

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

Appealable : Providing extensive rights to appeal to an independent physician

DATE UPDATED: 2/19/23 BH

Last Action: 2-28-23 H Introduced and referred to committee on House Insurance

T HB 814 | Thierry, Shawn | Opioid Warning Label

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

Remarks: SUMMARY: Prohibits pharmacists from dispensing an opioid without providing, receiving, and maintaining an acknowledgment form providing a warning about the risks of opioid addiction and overdose. Requires the Board to

adopt by rules an acknowledgment form to be signed on receipt of an opioid that must include language substantially similar to "WARNING: THIS DRUG IS AN OPIOID. THE USE OF AN OPIOID MAY RESULT IN ADDICTION TO OPIOIDS AND DEATH," in all capital letters and printed in 14-point font.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED:2/3/23 JB

Last Action: 3- 1-23 H Introduced and referred to committee on House Public Health

HB 815 — Thierry, Shawn — Red Cap Opioid Safety Act

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

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

Last Action: 3- 1-23 H Introduced and referred to committee on House Public Health

HB 826 — Lambert, Stan — Permanent Formulary Freeze Mandate

Companions:

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

Remarks: SUMMARY: This bill would prohibit a health plan from ever making any change to a patient's benefits for a drug they are taking. This means a health plan cannot even increase the copay amount by $5 or reduce the maximum drug coverage amount by $5, even at the annual renewal of the benefit plan, and even if the drug has been replaced on the health plan's formulary by a better or lower-priced drug. This mandate is referred to as a "permanent formulary freeze." This formulary freeze would apply to any enrollee taking a drug if: (1) the enrollee was covered by the benefit plan preceding the renewal date, (2) a

physician or other prescribing provider prescribes the drug for the medical condition or mental illness, and (3) the physician or other prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment. The bill also expands notice requirements for modifying drug coverage to include a statement explaining the type of modification and indicating that, on renewal of the benefit plan, the issuer may not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year (formulary freeze).

TAHP POSITION: Oppose

COVERAGE TYPE: Commercial, Exempts ERS and TRS

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

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

Texas already leads the nation with the strongest patient protections against non-medical switching and step therapy. For example, Texas has a one year formulary freeze law that only two other states have. That means that when an expensive name brand drug has a lower cost competitor enter the market, health plans are not allowed to update the formulary to reflect this cost savings for a full year. That’s the case now in 2023 with the launch of new biosimilar alternatives to the very expensive rheumatoid arthritis drug Humira. Further, Texas has the most extensive step therapy protections in the nation. A physician can simply document that a patient is stable on a drug and the patient can’t be taken off by step therapy protocols, even if they change insurers. Under this proposal, the formulary would be permanently frozen if any patient is on a particular drug. This is an unprecedented, costly, and unworkable mandate. Under a permanent “formulary freeze,” plans cannot replace drugs with new clinically appropriate and more affordable alternatives. Instead, plans will have to continue coverage of a drug, at the same copay or coinsurance level, even if the price increases or if a more affordable, more effective, or even safer option comes out. An insurer couldn’t make a change as simple as a $5 copay increase on brand-name drugs in between plan years. Pharma stands to gain from a

formulary freeze because once they have a patient on a drug, they'll be immune from competition from lower cost alternatives and any pressure to lower the price of that drug. Employers and families paying premiums would see increased costs of $481 million over $5 years. Certain city employee estimates include San Antonio with an additional $3 million in drug spending and $2 million for Dallas employees. TRS would owe $70 million more per year if the bill were applied to the program.

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

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

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

DATE UPDATED: 2/3/23 BH

Last Action: 3- 1-23 H Introduced and referred to committee on House Insurance

T HB 831 | Johnson, Julie | Prohibition insurance discrimination

Companions: HB 1111 | Johnson, Julie(D) | (Refiled from 87R Session)

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

TAHP POSITION: Neutral

COVERAGE TYPES: commercial

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED:2/3/23 JB

Last Action: 3- 1-23 H Introduced and referred to committee on House Insurance

HB 838 | Gonzalez, Jessica | Expands Fertilization Donors

Companions:

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

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

TAHP POSITION: Neutral

COVERAGE TYPES: Group (commercial) plans

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

MANDATE: Benefit

DATE UPDATED: 2/1 KS

Last Action: 3- 1-23 H Introduced and referred to committee on House Insurance

HB 839 | Gonzalez, Jessica | No PA mandate for infectious diseases

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

TAHP POSITION: Oppose

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

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

MANDATE: Plan Design

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

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

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

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

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

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

Appealable : Providing extensive rights to appeal to an independent physician

DATE UPDATED: 2/1 KS

Last Action: 3- 1-23 H Introduced and referred to committee on House Insurance

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

Companions:

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

Remarks:

SUMMARY: HB 895 creates a new government mandate that prohibits an HMO or insurer from using extrapolation to complete an audit of a network physician or provider. The bill requires that any additional payment due a network physician or provider or any refund due the HMO or insurer must be based on the actual overpayment or underpayment and may not be based on an extrapolation. "Extrapolation" means a mathematical process or technique used by an HMO or insurer in the audit of a network physician or provider to estimate audit results or findings for a larger batch or group of claims not reviewed by the HMO or insurer.

TAHP POSITION: Oppose

COVERAGE TYPES: HMOs and insurers (EPO/PPO)

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

MANDATE: Administrative

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

DATE UPDATED: 2/19

Last Action: 3- 1-23 H Introduced and referred to committee on House Insurance

HB 916 | Ordaz, Claudia (F) | 12 month contraceptive mandate

Companions:

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

Remarks:

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

TAHP POSITION:Opposed. TAHP will propose an initial 3 month supply and subsequent 6 months supply. If the author accepts this amendment TAHP will be neutral.

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE:Benefit

TAHP POSITION STATEMENT: This bill creates an unfunded government mandate to cover a 12-month supply of contraceptive drugs at one time. The Insurance Code already mandates coverage for prescription contraceptives for any plan that covers prescription drugs. The Affordable Care Act also already requires most insurance plans to cover prescription contraceptives with no out-of-pocket costs. Additionally, health plans already offer 90-day supplies. TAHP believes there would be a negative fiscal impact to the commercial market due to the expected waste of dispensed but unused drugs, and for coverage of drugs dispensed to participants who receive a 12-month supply but leave the plan and do not pay premiums for the full year. ERS previously estimated this mandate would cost more than $4 million. Based on these numbers, the private commercial market would see a similar impact with increased costs of more than $30 million. These types of unfunded government mandates significantly drive up the cost of coverage for Texas employers and families.

DATE UPDATED: 2/3 BH

Last Action: 3-14-23 H Committee action pending House Insurance

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

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

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

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

COVERAGE TYPES: Commercial

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

MANDATE: Contract

TAHP POSITION STATEMENT: Generic medications save Americans more than $300 billion per year. In order to control costs for employers and families, health plans steer patients to affordable generic options thro ugh lower out-of-pocket costs. That’s a problem for drug companies whose primary goal is to keep patients hooked on higher cost brand name drugs. Copay coupons are utilized by drug manufacturers to encourage the use of expensive brand name drugs over cheaper generics, biosimilars, or therapeutic alternatives. Through coupons, a manufacturer aims to pay off the patient’s out-of-pocket costs to encourage them to avoid lower cost alternatives and choose a brand name drug. Health insurers respond by only counting actual patient payments, not coupons, to the patient’s out-of-pocket limits. The bill would allow health plans to continue this practice when a generic or biosimilar is available, however, the bill needs clarification to includ e “therapeutic alternatives” to high cost brand drugs.

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

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

HB 1001 | Capriglione, Giovanni | Mandate-lite coverage - consumer choice

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

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

TAHP POSITION: Support TAHP testified in support and submitted written testimony 3/16

COVERAGE TYPES: Commercial

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

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Establish new alternative coverage option that allows insurers to offer 'Consumer Choice' plans that forego certain state-imposed regulations and mandates." Texas should build more affordable insurance coverage options that avoid over-regulation and excessive mandates. New health care products added last session avoid government mandates and provide more choices for some Texans. n the past, Texans had mandate-lite insurance options through the Consumer Choice of Benefits model, but that's been eroded by a continuous stream of new mandates over two decades. Updated “Consumer Choice” plans would be similar to new affordable alternatives established through the Farm Bureau and Texas Mutual, but there are a few key differences. These plans would still be considered insurance under state law, meaning that they would be required to meet solvency requirements, be subject to TDI oversight, and meet federal benefit and coverage requirements like pre-existing conditions protections and medical loss ratio rules required by the Affordable Care Act. Additionally, HB 1001 indicates that these plans must also meet any requirements imposed on the coverage elected officials and state employees have through ERS.

Last Action: 3-16-23 H Committee action pending House Select on Health Care Reform

HB 1026 | Gervin-Hawkins, Barbara | Hair prosthesis mandate

Remarks: SUMMARY: Creates a new mandated benefit for a hair prosthesis for an enrollee who is undergoing

or has undergone medical treatment for cancer, determined by the treating physician. The benefit amount is $100 for a new prosthesis, or for repair or replacement.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial and Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Unfunded commercial mandate

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

DATE UPDATED: 2/12/23 BH

Last Action: 3- 2-23 H Introduced and referred to committee on House Insurance

HB 1032 Noble, Candy Prohibited vaccination status discrimination

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

TAHP POSITION: Reviewing

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

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

MANDATE: Coverage

Last Action: 3- 2-23 H Introduced and referred to committee on House State Affairs

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

Companions: SB 1135 Schwertner, Charles(R) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY:This bill would clarify that self-funded health benefit plans that enter into value-based risk sharing arrangements are not engaged in the business of insurance for the purposes of state

law. It would also allow PPO/EPO plans to enter into risk-sharing and capitation arrangements.

TAHP POSITION: Support

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Immediate or 9/1/23

POSITION STATEMENT: Health care is rapidly moving towards capitated value-based care arrangements like advanced primary care and direct primary care, where providers take on the risk of caring for patients for a set monthly fee. These models are quickly gaining traction for employees, employers, and doctors. For example, more than 80% of employees say they would sign up for an all-inclusive direct primary care plan if given the option. However, as these models evolve, Texas law, written decades ago, limits payment and benefit design. HMOs are the only type of health plan in Texas that can partner with doctors for risk-based, value-based payments. Unfortunately, PPO plans and EPO plans cannot pay a primary care doctor a flat, monthly payment for risk-based direct primary care or advanced primary care. Under current law, Health Maintenance Organizations (HMOs) are expressly allowed to make capitated payments. However, that same language does not appear in the Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) chapter of the Insurance Code. TAHP worked with the Primary Care Consortium to identify policies of shared interest that can make a positive difference in health care payment and delivery innovation. The Consortium endorsed this concept and TAHP supports removing barriers to value-based care.

DATE UPDATED: BH 2/21

Last Action: 3- 2-23 H Introduced and referred to committee on House Insurance

T HB 1105 Price, Four Pharmacist Vaccination Authority

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

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

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 2-23 H Introduced and referred to committee on House Public Health

HB 1128 Martinez Fischer, Trey Affordable Care Act Guaranteed Issue

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

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

TAHP POSITION: Neutral with concerns

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

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

MANDATE: Coverage

TAHP POSITION STATEMENT: TAHP is supportive of preexisting condition protections so long as they are coupled with continuous coverage requirements for Individual coverage. The position of health insurance providers is clear: Every Texan deserves affordable, comprehensive coverage—regardless of their income, health status or preexisting conditions. No one should be denied or priced out of affordable coverage because of their health status. However, we are concerned with some provisions in HB 1128, including allowing the Insurance Commissioner to unilaterally establish special enrollment periods and the language that that Sec. 1511.151 may not be construed to prevent a health benefit plan issuer "from appropriately utilizing reasonable medical management techniques" - the bill should

allow medical management in accordance with the Insurance Code .

Last Action: 3- 2-23 H Introduced and referred to committee on House Insurance

T HB 1129 Martinez Fischer, Trey Health insurance risk pool

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

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

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

Assessments: The Pool board may assess health plan issuers, including th rough advance interim assessments, "as reasonable and necessary for the pool's organizational and interim operating expenses." The pool board will recover an amount equal to the funding required by assessing each

health plan issuer an amount determined annually based on information in annual statements, annual reports to the board, and any other reports filed with the board. The board will use the total number of enrolled individuals reported by all health plan issuers under as of the preceding December 31 to compute the amount of an issuer's assessment, if any. It will allocate the total amount to be assessed based on the total number of enrolled individuals covered by excess loss, stop-loss, or reinsurance policies and on the total number of other enrolled individuals as determined under Section 1511.0252.

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

Assessments do not apply to Small Employer benefit plans.

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES:Immediate or 9/1/23

MANDATE: Assessment

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

Last Action: 3- 2-23 H Introduced and referred to committee on House Insurance

T HB 1164 | Gervin-Hawkins, Barbara | Hair prosthesis mandate

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

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial and Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Unfunded commercial mandate

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

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

Last Action: 3- 2-23 H Introduced and referred to committee on House Insurance

T HB 1190 | Klick, Stephanie | APRN/PA Controlled Substances Rx

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

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

TAHP POSITION: Support TAHP dropped a cared in support 3/16

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/21 by JL

Last Action: 3-13-23 H Committee action pending House Public Health

HB 1236 | Oliverson, Tom | Prudent Layperson mandate

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

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

TAHP POSITION: Oppose, negotiating

COVERAGE TYPES: Commercial and Medicaid

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

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

Under the “prudent layperson standard” a person gets to decide based on their own judgment if they are having a medical emergency. Essentially, if you believe you need emergency care, that can’t be questioned and that goes for your insurance coverage as well. In 2021, new rules clarified the prudent layperson standard, how it applies to emergency care coverage, and what rules health plans have to follow. The rules clarified that a patient’s final diagnosis can’t solely be used to deny a claim for emergency care. That’s a reasonable approach, but HB 1236 goes much further and stops state investigators and health

insurers from rooting out fraud by saying that an investigator can't look at a pattern of upcoding or outlier billing to flag claims for a case by case review. Texas Medicaid uses diagnosis codes to stop this bad behavior and save taxpayer dollars for years. In, 2021, a "data led initiative" by the OIG resulted in nearly $20 million in fines for inappropriate ER billing.

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

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

Last Action: 3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

T HB 1239 Oliverson, Tom ESG Insurance Rates

Companions: SB 833 King, Phil (F)(R) (Identical)
3- 1-23 S Introduced and referred to committee on Senate Business and Commerce

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

TAHP POSITION: Neutral

COVERAGE TYPES:commercial

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

Last Action: 3-14-23 H Committee action pending House Insurance

HB 1240 Oliverson, Tom Physician Dispensing

Companions:

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

Remarks:

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

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

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas

Legislature should continue these basic safety protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/3 KS

Last Action: 3- 3-23 H Introduced and referred to committee on House Public Health

T HB 1288 Lopez, Ray ECI Coverage Mandate

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

number of visits to a physician under the plan.

TAHP POSITION: Opposed

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

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

MANDATE: Benefit

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

DATE UPDATED: 3/7 KS

Last Action: 3- 3-23 H Introduced and referred to committee on House Insurance

HB 1322 Buckley, Brad Coordination vision eye care benefits

Companions: SB 861 Hughes, Bryan(R) (Identical)
3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

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

TAHP POSITION: Still Determining

COVERAGE TYPES: EPO/PPOs that cover vision services

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

TAHP POSITION STATEMENT: The Texas Insurance Code addresses coordination of benefits as it relates to dental coverage. This bill

should more closely align vision coordination of benefits with the process laid out for dental benefits.

DATE UPDATED: BH 3/9

Last Action: 3- 3-23 H Introduced and referred to committee on House Insurance

T HB 1337 Hull, Lacey SMI Step Therapy Mandate

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

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

TAHP POSITION: Neutral (negotiated language)
TAHP testified on the bill 3/14

COVERAGE TYPES: Commercial

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

MANDATE:Benefit

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

DATE UPDATED: 3/8 BH

Last Action: 3-14-23 H Committee action pending House Insurance

T HB 1364 | Munoz, Sergio | OON Out of Pocket Cost Mandate

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

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

TAHP POSITION: OPPOSED without guardrails added

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

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

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

ensure that the result of the bill is to reward patients that find lower cost services.

DATE UPDATED: 3/7 KS

Last Action: 3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

HB 1390 Shaheen, Matt Telemedicine Mental Health Benefit

Remarks: SUMMARY: This bill adds mental health professionals to the current telehealth coverage mandate in Texas. The bill also prohibits the Texas State Board of Dental Examiners from requiring in-person counseling of patients for prescription drugs or devices.

TAHP POSITION: Neutral

Last Action: 3- 3-23 H Introduced and referred to committee on House Insurance

HB 1411 Rogers, Glenn Practitioner drug and device prescriptions

Remarks: SUMMARY: This bill would add persons authorized by the acupuncture, chiropractic, counseling, and psychology boards to prescribe or administer dangerous drugs to the definition of "practitioner."

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediately or 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 3-23 H Introduced and referred to committee on House Public Health

HB 1452 Anchia, Rafael Fetal tissue Disposition Mandate

Remarks: SUMMARY:This bill creates a new unfunded benefit mandate to cover the cost of disposition of embryonic and fetal tissue remains with a post-fertilization age of 20 weeks or more. The manner of disposition for which coverage is required includes: (1) interment; (2) cremation; (3) incineration followed by interment; and (4) steam disinfection followed by interment.

TAHP POSITION:Opposed

COVERAGE TYPES:HMO, EPO/PPO, CC

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

MANDATE:Benefit

Last Action: 3- 3-23 H Introduced and referred to committee on House Insurance

HB 1527 | Oliverson, Tom | Dental Overpayments and Networks

Companions: SB 1981 | Zaffirini, Judith(D) | (Identical)
3- 8-23 S Filed

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

TAHP POSITION: Neutral

COVERAGE TYPES:

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

Last Action: 3- 3-23 H Introduced and referred to committee on House Insurance

HB 1562 | Gamez, Erin (F) | Border public health initiative

Remarks: SUMMARY: Requires DSHS to develop an initiative to reduce the adverse health impacts of diabetes, hypertension, and obesity for adults and children in border counties. The initiative must promote educational resources, screenings, referrals to providers and treatment. Requires DSHS to conduct bilingual, culturally appropriate outreach campaigns in partnership with other organizations. Requires a report by Jan. 1, 2027 to the legislature.

TAHP POSITION: Support

TAHP POSITION STATEMENT: While quality of care plays an important role, health outcomes are also driven by the conditions that people live, learn, work, and play. Individuals with inadequate access to food are at greater risk of developing chronic conditions and managing these conditions. They also utilize more services and face increased health care costs that might otherwise be avoidable. These conditions are

known as non-medical drivers of health and can drive as much as 80% of health outcomes.

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

Last Action: 3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

T HB 1578 Allison, Steve Health literacy plan

Companions: SB 589 Johnson, Nathan(D) (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Requires the Statewide Health Coordinating Council to develop a long-range plan for improving health literacy in this state that must be updated every two years and submitted to the legislature. Requires the Council to study the economic impact of low health literacy. Requires the Council to identify primary risk factors contributing to low health literacy, examine ways to address literacy, examine the potential to use quality measures in state-funded programs, and identify strategies to expand the use of plain language. Requires the State Health Plan to identify the prevalence of low health literacy among health care consumers and propose cost-effective strategies that also attain better patient outcomes.

TAHP POSITION: Support

TAHP POSITION STATEMENT: An estimated 90 million Americans have low health literacy. Health literacy helps people make healthy choices. People without high healthy literacy may not be able to read food or prescription labels, describe their symptoms to health providers, and understand insurance documents or medical bills. Low health literacy can result in medical errors, increased illness and disability, loss of wages, and compromised public health. The impact is estimated to cost the U.S. up to $236 billion every year.

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

Last Action: 3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

T HB 1592 Oliverson, Tom Surprise Billing ERISA Opt In

Companions: SB 1306 Hancock, Kelly(R) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY:This bill would allow sponsors of health benefit plans that are self-insured or self-funded under ERISA to elect to apply Texas' prohibition on balance billing.

TAHP POSITION: Neutral/Watch

COVERAGE TYPES: Commercial

EFFECTIVE DATES:9/1/23

TAHP POSITION STATEMENT: TAHP is neutral on this proposal to allow employers to decide if they would prefer to use the state or federal balance billing dispute process as employers pay their own claims and the costs associated with the arbitration & mediation systems through either approach. However, TAHP continues to be concerned about inflationary provisions in the state's dispute resolution system which utilizes billed charges in an arbiters determination. Billed charges are inflated prices that don't reflect what anyone actually pays for health care. As one researcher noted, "Billed charges are effectively just made up." Studies show taking billed charges into account during arbitration only incentivizes providers to make up higher and higher numbers. A new report by the Texas Department of Insurance found that average billed charges in arbitration increased by threefold from 2020 to 2022 resulting in final arbitration amounts more than doubling during the period. These costs ultimately drive up health care spending for businesses and families.

DATE UPDATED: 2/3/23 JB

Last Action: 3- 3-23 H Introduced and referred to committee on House Insurance

T HB 1647 Harris, Cody White Bagging Prohibition Mandate

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

copay, higher coinsurance, second copay, second coinsurance, or any other form of price increase for clinician-administered drugs when not dispensed by a network.

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

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC

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

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

MANDATE: Contracting

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

T HB 1649 Button, Angie Chen Fertility Preservation Mandate

Companions:	HB 389	Collier, Nicole(D) 2-23-23 H Introduced and referred to committee on House Insurance	(Identical)
	SB 447	Menendez, Jose(D) 2-15-23 S Introduced and referred to committee on Senate Health and Human Services	(Identical)

Remarks:

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

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial

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

MANDATE: Benefit

TAHP POSITION STATEMENT: The bill creates a new unfunded, mandated benefit, fertility preservation services for a covered person who will receive a treatment that may impair fertility. In the 86th legislative session, this same mandated benefit (HB 2682) would have increased Medicaid costs by $5.2 million a year and TRS-active care costs by $4 million a year. The LBB found that this benefit mandate would also increase health care costs to the TRS, UT systems and ERS health plans that would result in increased premiums and contributions from the state, employers, or members. Typical costs for fertility preservation services are in excess of $10,000 with hundreds more in added monthly storage charges. Government mandates and overregulation hinder

innovation and add costs to an already expensive system. This expense is borne by employers and families through increasingly unaffordable premiums. Texas already ranks third in the nation when it comes to regulations that go beyond the federal requirements of the ACA.

UPDATED: 2/3 BH

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

T HB 1692 Frank, James Prohibits Abusive Facility Fees

Companions: SB 1275 Hancock, Kelly(R) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would prohibit facility fees in outpatient settings and for services identified by the HHSC commissioner, which can be safely and effectively provided outside of a hospital setting. The bill would also require providers to submit a report to the department detailing any facility fees charged by the provider. Finally the bill would give DSHS the authority to audit a provider for compliance with this chapter and assess $1,000 administrative penalties for violations.

TAHP POSITION: Support

EFFECTIVE DATES:Immediate or 9/1/23

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Explore ways to prohibit hospitals from charging facility fees for services not provided on a hospital's campus."

Hidden facility fees are the latest negative trend in health care. The original purpose of a facility fee was to help hospitals cover the stand-by costs associated with emergency departments and inpatient care. However, as health systems have expanded and acquired physician practices, these facility fees have been inappropriately applied to outpatient medical bills. The fees are also one of the primary components of outrageous freestanding emergency room bills including price gouging for COVID-19 tests. After physician group acquisition, hospital systems may add facility fees to the groups bills even though the practice location hasn’t changed and isn’t physically connected in any way to a hospital. In one example, the cost of a woman’s arthritis treatment increased by 1000% when a hospital system

takeover added a facility fee to the bill. While the treating physician and the practice location had not changed, the billing codes did. The hospital system explained that they moved the infusion clinic from an "office-based practice" to a "hospital-based setting" as the excuse for adding the facility fee. Providers are even charging facility fees in some instances for telehealth visits.

While it's unlikely that consolidation will easily or quickly unwind, removing incentives like inappropriate facility fees mitigates the impacts to health care spending and may disincentivize new acquisitions. The Medicare program has a site neutral payment policy. In order for hospital billing levels to apply, the outpatient facility must be within 250 yards of the hospital campus. This reasonable approach ensures that when hospital systems acquire physician practices, facility fees are not added when the practice is not part of the main hospital campus. The Committee for a Responsible Federal Budget estimates that a site neutral payment policy applied throughout health care could reduce "total national health expenditures by a range of $346 to $672 billion" over a 10 year period.

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

Last Action: 3- 7-23 H Introduced and referred to committee on House Select on Health Care Reform

T HB 1696 | Buckley, Brad | Relationship between managed care plans

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

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

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

TAHP Position: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

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

According to the Federal Trade Commission, any willing provider laws “can limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of choice. These restrictions on competition may

result in insurance companies paying higher fees to providers, which, in turn generally results in higher premiums, and may increase the number of people without coverage."

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

DATE UPDATED: 3/5 BH

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

T HB 1726 Hernandez, Ana Telemedicine Payment Parity Mandate

Companions:

SB 724	Lamantia, Morgan (F)(D)	(Identical)
	3- 1-23 S Introduced and referred to committee on Senate Health and Human Services	
SB 1043	Blanco, Cesar(D)	(Identical)
	3- 3-23 S Introduced and referred to committee on Senate Health and Human Services	

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

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

TAHP POSITION STATEMENT: Mandating the same payment for brick-and-mortar office visits and telehealth visits is government rate setting and undermines telehealth’s promises of efficiency and innovation. Independent experts across the political spectrum, including Brookings, the John Locke Foundation, Americans for Prosperity, TCCRI, the Foundation for Government Accountability, and the Progressive Policy Institute, have all said that telemedicine payment

parity mandates are harmful to the future of telehealth and do nothing to improve the value of health care or increase access to telehealth. Payment parity mandates act as price floors for telemedicine by pegging the service to more expensive ones. They essentially require higher reimbursement rates for telehealth than would be negotiated without the mandate. That makes them price controls and keeps patients from benefiting from separately negotiated rates. Parity mandates prevent any telehealth cost savings from being passed along to patients in the form of lower premiums, deductibles, copayments or coinsurance. Telehealth access is expanding without government interference and rate setting. Patients are asking for telehealth access and the market for insurance coverage is responding with numerous options for $0 copay telehealth visits. A payment parity mandate risks interfering in the market response to these patient needs.

DATE UPDATED: 2/18 BH

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

T HB 1754 Smithee, John RX Formulary API Mandate

Companions: SB 622 Parker, Tan (F)(R) (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

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

TAHP POSITION: Neutral if amended

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

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

DATE UPDATED: 2/13 KS

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

HB 1803 Rose, Toni — Medicare Supplemental Under Age 65

Companions: SB 1790 Zaffirini, Judith(D) (Identical)
3- 7-23 S Filed

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

TAHP POSITION: Neutral

COVERAGE TYPES: Med Supp.

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

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

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

Last Action: 3- 7-23 H Introduced and referred to committee on House Insurance

HB 1902 Smithee, John — TDI Rec - Provider Directories

Companions: SB 1003 Johnson, Nathan(D) (Identical)
3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would expand the requirement for issuers to list facility-based providers in their provider directories. It would add non-physician providers, including CRNAs, nurse midwives, surgical assistants, physical therapists, among others.

TAHP POSITION: Neutral with amendment to clarify the mandate doesn't apply to providers employed directly by the facility that do not bill separately.

COVERAGE TYPES: HMO, EPO, MEWA.

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/18 KS

Last Action: 3-14-23 H Committee action pending House Insurance

HB 1973 | Harris, Caroline (F) | Itemized billing before debt collection

Companions: SB 490 | Hughes, Bryan(R) | (Identical)
2-17-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Requires providers to issue a written itemized bill of charges for all health care services and supplies provided to the patient before a health care provider pursues any debt collection against a patient. The itemized bill must include the amount charged for each service, a plain-language description of the service, and billing codes submitted to the payor. The appropriate licensing authority may take disciplinary action against a health care provider that violates this chapter as if the provider violated an applicable licensing law.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

POSITION STATEMENT: Health care prices are irrationally high and vary greatly, even for routine care. Rapidly consolidating hospital systems in Texas charge employers double what it costs to break even—more than 3 times Medicare—forcing employers and families to pay millions of dollars more than necessary. Patients deserve access to a detailed list of charges from hospital visits so they can confirm charges, dispute fees, and negotiate discounts.

DATE UPDATED: 2/13 KS, 2/23 BH

Last Action: 3- 8-23 H Introduced and referred to committee on House Public Health

HB 1998 | Johnson, Julie | Texas Medical Board

Remarks: SUMMARY: This bill would require the TMB to search the National Practitioner Data Bank (NPDB) monthly and update new disciplinary information as needed. It would also require peer review committees to report to the NPDB and prohibit the TMB from granting a license is a physician had their license revoked in another state.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

Last Action: 3-20-23 H Meeting set for 8:00 A.M., JHR 120, House Public Health

HB 2002 | Oliverson, Tom | OON Deductible Mandate

Remarks: SUMMARY: This bill would require issuers to credit towards an insured's deductible and annual out-of-pocket maximum an amount the insured pays directly to a health care provider for a covered medical service. To be counted, the claim must not be submitted to the issuer, and the amount paid by the insured must be less than the average discounted rate for the service under the insured's plan. The bill would require issuers to establish procedures and identify documentation necessary to claim a credit, and post that information on their website.

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

COVERAGE TYPES: PPO/EPO

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

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

DATE UPDATED: 3/8 BH

Last Action: 3- 8-23 H Introduced and referred to committee on House Select on Health Care Reform

HB 2017 | Oliverson, Tom | Sandbox Insurance Flexiblity

Companions: SB 2340 | Middleton, Mayes (F)(R) (Identical) | 3-10-23 S Filed

Remarks: SUMMARY: This NCOIL model act would allow TDI to grant waivers of specific insurance laws and rules if the regulated person can demonstrate that the law or rule prohibits innovation, the public policy goals of the law or rule are met, the waiver will not increase risk to consumers, and the waiver

is in the public interest. TDI could not waive solvency requirements, trade practices, taxes or fees, or any requirement of national accreditation. The bill would also create an application process, public notice requirements, extension limitations, and revocation procedures.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

Last Action: 3- 8-23 H Introduced and referred to committee on House Insurance

HB 2021 Oliverson, Tom ERISA Prescription Drug Mandate

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

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

TAHP POSITION: Oppose

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

POSITION STATEMENT: HB 2021 applies every state created prescription drug mandate (insurance code chapter 1369) to self-funded employer health plans that are currently exempt under Federal ERISA laws. Employers (not health insurers) are harmed by HB 2021. Self-funded employers will suffer the cost of imposing state mandates including limits on narrow pharmacy networks or the use of onsite pharmacies, a one year wait before changing to lower cost generics/biosimilars, and limits on mail order pharmacies. Multi-state employers will have to design special coverage just for Texas employees.

These mandates are expensive and cumbersome, that’s why the bill exempts coverage for elected officials personal health insurance. Large employers with thousands of employees use self-funded benefits. These are the biggest providers of health coverage and the biggest job creators in Texas. The intent of ERISA preemption is to

encourage employers to offer their employees benefit plans. This has worked - 98% of Texas large employers provide coverage to their employees compared to only 50% of Texas small employers. The Texas Association of Business, Texas Business Leadership Council, Texans for Lawsuit Reform, and individual businesses like Hobby Lobby have all spoken out against ERISA preemption.

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

Last Action: 3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

HB 2025 | Oliverson, Tom | Health benefit plan coverage transplant

Companions: SB 1040 | Kolkhorst, Lois(R) | (Identical)
3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would prohibit issuers from covering organ transplants if the transplant operation is performed in China or another country known to have participated in organ harvesting, or if the organ was procured by a sale or donation originating in one of those countries. It would allow DSHS to designate additional countries known to have participated in organ harvesting.

TAHP POSITION: Neutral

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

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

DATE UPDATED: 2/13 KS

Last Action: 3- 8-23 H Introduced and referred to committee on House Public Health

HB 2078 | Jetton, Jacey | Physician Dispensing of Drugs

Remarks: SUMMARY: This bill would allow physicians to dispense, and delegate the dispensing of, dangerous drugs to their patients. The physician could then bill for the cost of the drug and all other actual costs of dispensing. The physician must notify the patient that the prescription may be filled in a pharmacy. It would also require physicians to notify the Texas State Board of Pharmacy that the physician is dispensing dangerous drugs.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

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

DATE UPDATED: 2/13 KS

Last Action: 3- 8-23 H Introduced and referred to committee on House Public Health

T HB 2079 | Jetton, Jacey | Allow Pharmacists to Test/Treat

Remarks: SUMMARY: This bill would allow physicians to dispense, and delegate the dispensing of, dangerous drugs to their patients. The physician could then bill for the cost of the drug and all other actual costs of dispensing. The physician must notify the patient that the prescription may be filled in a pharmacy. It would also require physicians to notify the Texas State Board of Pharmacy that the physician is dispensing dangerous drugs.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required, but we do have concerns with some of the provisions of the legislation that could put Texas patients at risk for billing and safety issues. The bill repeals the safety requirements that physicians who dispense dangerous drugs must comply with and removes the requirement to notify the Board of Pharmacy and the Medical Board. The Texas Legislature should continue these basic safety

protections. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors, and at least half of these physician errors are corrected by pharmacists. Patients could also be at risk of surprise billing. The legislation should limit how much a physician can charge for the drugs they dispense and include patient notice requirements.

DATE UPDATED: 2/13 KS

Last Action: 3- 8-23 H Introduced and referred to committee on House Public Health

T HB 2082 Jetton, Jacey Insurance regulation prepaid health care plan

Remarks: SUMMARY: This bill would allow for prepaid health plans for low-income individuals, which would not be considered the business of insurance. Eligibility would be limited to individuals not covered under any other health plan arrangement, whose incomes are below 400 FPL, and who are either employed by a business employing 200 or fewer eligible individuals or are engaged in domestic service in private households. The plan would have to be operated on a nonprofit basis, and covered primary care services would have to be provided for nominal reimbursement by practitioners on staff with the sponsoring organization or by volunteers. The plan would need endorsement by the county medical society in consultation with TMA. The sponsoring organization would have to file an annual report with the commissioner, detailing the number of plan enrollees, the number of services provided, financial statements, and administrative costs and salaries plaid under the plan. Payments made to outside contractors for marketing, claims administration, and similar services could not total more than 10 percent total charges imposed by the plan.

POSITION: Neutral with guardrails added to clarify the bill creates low income assistance plans.

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

Last Action: 3- 8-23 H Introduced and referred to committee on House Select on Health Care Reform

T HB 2180 Harris, Cody Point of Sale Rebate mandate

Remarks: SUMMARY: This bill would require an enrollee's cost sharing amount for prescription drugs to be calculated at the point of sale, and that price

would have to be reduced by any rebates that issuer or PBM receives for the prescription.

TAHP POSITION: Oppose unless amended. TAHP will be neutral is it is amended to match Select Committee's recommendation to ensure that 100% of rebates go to lowering the cost of coverage.

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

EFFECTIVE DATES: 9/1/23

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

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

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

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

The California Senate Appropriations Committee refused to advance that bill due to the increased premium cost.

The Congressional Budget Office (CBO) estimated that a Medicare point of sale rebate mandate would increase premiums by $43 billion (25%) over a decade and federal spending by $137 billion, so it was never implemented. Rebates reduce the cost of prescription drug coverage at the Teacher Retirement System by 30%. Without these savings, Texas would have to replace this cost with taxpayer dollars or by substantially increasing premiums to active and retired teachers. Employers cover the bulk of premiums for employees—more than 80%. They should be able to choose what to do with rebates. Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, as Pharma continues to set very high prices for their prescription drugs and raise them year after year.

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

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

T HB 2403 Paul, Dennis Mandate Fiscal Note - HIMARC

Remarks: SUMMARY: This bill would establish the Health Insurance Mandate Advisory Review Center (HIMARC) within the Center for Healthcare Data at UT Health Science Center at Houston. Regardless of whether the legislature is in session, the lt. governor, speaker, or chair of an appropriate committee may request an analysis of a health insurance mandate. The analysis would include the extent to which the mandate increases total health care spending, the expected increase in utilization, the increase in administrative expenses to issuers and expenses to enrollees or sponsors, the cost to private sector and public sector policyholders, the extent to which the service is already covered, and relevant scientific evidence. The cost of administering the program would be paid for through fees assessed to health benefit plan issuers.

EFFECTIVE DATES: 1/1/24

TAHP POSITION: Support

POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to “Consider opportunities to leverage the Texas All-Payor Claims Database to determine the true cost impact of benefit mandates.”

Texas lawmakers don’t have the information they need on the cost and impact of health insurance mandates and regulations on Texas employers and families. Texas regulations and mandates hinder innovation and add costs to an already expensive system—forcing employers and families to bear the cost of one-size-fits-all coverage. Each mandate raises costs that are passed on in higher premiums. In 2021, Texas reached a high-water mark for the number of mandates placed on health insurance. Following the session, Texans saw a 13% increase in premiums, while around the nation, year-over-year premiums were flat. Before approving a new mandate, other states have processes to carefully review the full impact of mandates on businesses and families, health care costs, and health needs. Those states arm lawmakers with the info they need to make informed decisions.

The legislation would establish the Texas Health Insurance Mandate Advisory Review Committee (HIMARC). As drafted, it would live at the Center for Healthcare Data at The University of Texas Health Science Center at Houston, where they currently manage the All Payor Claims Database (APCD) and have the data and knowledge to do this level of review.

DATE UPDATED: 2/19 KS, 2/23 BH

Last Action: 3-13-23 H Introduced and referred to committee on House State Affairs

T HB 2414 — Frank, James — Health Plan Shopping Incentives

Remarks: SUMMARY: This bill would also allow HMOs and PPO/EPOs to create incentives to use certain providers through modified cost-sharing, sometimes called "tiering." The bill would also allow PPO/EPOs to enter into capitation arrangements, as HMOs are currently allowed to do. Finally, the bill would allow ERISA plans to access capitation arrangements between state-regulated issuers and physicians.

TAHP POSITION: Support

COVERAGE TYPES: PPO/EPO, HMO

EFFECTIVE DATES: 9/1/23

POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to “address that insurance plans are currently prohibited from offering enrollees lower cost-sharing amounts for seeking more-efficient, high-quality care”.

Patients lack incentives to choose the lowest cost and highest value health providers, and health plans are prohibited from creating shopping incentive programs. However, health insurers don't need a mandate, they need the flexibility to innovate. State laws and rules currently prohibit insurers from incentivizing patients to "shop for" or use low-cost, high-quality providers. That includes innovative cost-sharing models like lower deductibles, copayments, and coinsurance within the same type of provider class, even if there is huge variation in the negotiated provider prices. These antiquated state laws protect the highest cost providers from competition. HB 2414 removes these barriers and allows state regulated health plans to offer the same incentives to health plan members that big employers are doing in self-funded health plans.The bill also reforms state law to allow health plans and doctors to enter into value-based and capitated payment arrangements in the private market. These types of payment arrangements are the future of health care, including in Medicaid, where providers have incentives to manage patient care in the highest quality and most affordable manner.

DATE UPDATED: 2/19 KS, 2/23 BH

Last Action: 3-13-23 H Introduced and referred to committee on House Insurance

T HB 2529 — Talarico, James — Insulin VDP Reporting - Pay for Delay

Companions: SB 241 — Perry, Charles(R) (Identical)
3-15-23 S Voted favorably from committee as substituted Senate Health and Human Services

Remarks: SUMMARY: This bill would require manufacturers of name-brand drugs, for which a generic is available and that is included on the Medicaid VDP, to submit to HHSC a written verification stating whether the unavailability of a generic is due to pay for delay, legal strategies to extend a patent, or manipulation of a patent.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/24

TAHP POSITION STATEMENT: Pharmaceutical manufacturers utilize numerous tactics to delay competition from generic competition. Patent games like pay-for-delay slow the advancement of more affordable generic drugs by slowing the entrance of lower cost generic options. In these co mplex schemes a generic manufacturer sues a patent holder who then countersues and the

parties settle with a pay-for-delay deal and a financial reward to the generic manufacturer. Pay for Delay deals cost consumers and taxpayers $3.5 billion in higher drug costs every year.Using “evergreening” strategies to extend patent periods to either delay generic drug market entry or limit the number of patients who switch to a new generic. Drug companies exploit the patent system to delay competition. An analysis of the 10 best-selling drugs of 2019 found that on average these drugs held more than 69 patents with 37.5 years of patent protection, well past the 20 years of patent life intended by Congress. Furthermore, the prices for these drugs increased 71 percent over the previous five years. A federal ban saves $20 billion. The legislation simply requires these companies to disclose if these tactics have been used to delay the entrance of lower cost insulin medications.

DATE UPDATED: 2/1 KS, 2/16 BH

Last Action: 3-13-23 H Introduced and referred to committee on House Public Health

HB 2551 | Shaheen, Matt | Licensing regulation associate physicians

Remarks: SUMMARY: This bill would create a licensure for "associate physicians." Associate physicians would be required to practice under a collaborative agreement, under which they could dispense and administer drugs. The delegating physician would be liable for any medical act performed by the associate physician. An insured would be allowed to select an associate physician to provide covered services that are within the associate physician's scope of practice. If, after five years of practicing under a collaborative agreement, an associate physician achieves a passing score on their licensure and endorsement examinations, they would be eligible for full licensure to practice medicine. If they do not meet those requirements, they would be eligible for licensure as a physician assistant.

TAHP POSITION: Neutral

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

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

Last Action: 3-13-23 H Introduced and referred to committee on House Select on Health Care Reform

HB 2554 | Oliverson, Tom | Health Insurance Exchange

Companions: HB 700 Oliverson, Tom(R) (Identical)
3-13-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: This bill would create the Texas Health Insurance Exchange. It would be an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange, as authorized by the ACA. The exchange would have an eleven-member board, with five appointed by the governor, three by the lieutenant governor, and three by the governor from a list provided by the speaker. The board would employ an executive director and other necessary employees to assist the exchange in carrying out its functions. The board would not have any providers or issuers on it, but the board could create an advisory committee to allow for the involvement of health insurance industries and other stakeholders, which would provide recommendations to the board. The exchange may provide an integrated uniform consumer directory of health care providers and which issuers the provider contracts with. The exchange could also establish methods for health care providers to transmit relevant data, rather than an issuer. Not later than July 1, 2024, the exchange would be required to make recommendations to the Senate Business and Commerce Committee and the House Insurance Committee regarding the feasibility of implementing a subsidy program for individuals, families, and small employers to purchase coverage. With the input and approval of those committees, the exchange may develop and implement the subsidy program. The board would also make recommendations on state innovation waivers to the Senate Business and Commerce Committee and House Health Insurance committee, including recommendations on risk stabilization, coverage arrangements for employees, financial assistance for different types of coverage, including non-qualified health plans, and the establishment of account-based premium credits. With the input and approval from the legislative committees, the exchange would be able to apply for necessary federal waivers. For the purposes of the chapter, small employers would include entities that employ at least two and on average no more than 50 employees during the preceding calendar year until 2025, and then no more than 100 employees starting in 2026. That calculation would include part-time employees who are not eligible for coverage through the employer. The exchange may charge issuers an assessment of reasonable and necessary fees to cover the exchange's organizational and operating expenses. The

exchange may also accept grants from a public or private organization and accept federal funds, but general revenue may not be appropriated for the exchange. Assessments, gifts or donations, and any federal funding would be stored in a trust fund outside the state treasury. The exchange would be required to provide a detailed financial report to the governor, the legislature, and HHSC not later than January 31 of each year. TAHP POSITION: Neutral with changes to ensure market stability and state readiness.

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

COVERAGE TYPES: Commercial

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

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

DATE UPDATED: 2/22 KS, 3/15 BH

Last Action: 3-13-23 H Introduced and referred to committee on House Select on Health Care Reform

T HB 2556 Oliverson, Tom Licensing regulation physician graduates

Remarks: SUMMARY: This bill would create a "physician graduate" license. To get the license, a person would have to be a graduate of a medical school but not enrolled in a board-approved postgraduate program. The physician graduate would have to practice under the supervision of another physician, and they would only be able to provide primary care services. They would be considered a general practitioner for the purposes of CMS regulations, and an insured would be allowed to select a physician graduate to provide covered services that are within their scope of practice.

TAHP POSITION: Neutral

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

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

Last Action: 3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

HB 2640 Herrero, Abel ERS coverage bariatric surgery

Companions: SB 842 Hinojosa, Chuy(D) (Identical)
3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Currently, The board of ERS is required to develop a cost-positive plan for providing bariatric surgery to current employee enrollees. This bill would require the same coverage for annuitants and former employees that are eligible for ERS coverage.

COVERAGE TYPES: ERS

EFFECTIVE DATES: 2024 plan year

DATE UPDATED: 2/27 KS

Last Action: 3-13-23 H Introduced and referred to committee on House Pensions/Investments/Financial Services

HB 2690 Toth, Steve Civil Liability Abortion Drugs

Remarks: SUMMARY: This bill would prohibit manufacturing, possessing, distributing, or delivering abortion inducing drugs in this state. It would create civil liability for persons who cause a wrongful death of an unborn child or injury of an unborn child or pregnant person by taking those actions. It would also create civil liability for persons who host an interactive website that allows persons in Texas to access information that facilitates efforts to obtain elective abortions or abortions inducing drugs.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

Last Action: 3-13-23 H Introduced and referred to committee on House State Affairs

HB 2797 | Bucy, John | Health benefit coverage certain procedures

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

TAHP POSITION: Oppose

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

EFFECTIVE DATES:

TAHP POSITION STATEMENT:

Last Action: 3-13-23 H Introduced and referred to committee on House Insurance

HB 2982 | Oliverson, Tom | Physician agreements

Remarks: SUMMARY: This bill would allow physicians, or groups of physicians, to enter into a written agreement with management service organizations (MSOs) for management and administrative services. An MSO may provide: facilities; certain supplies and equipment; accounting and other clerical services; advertising and marketing services; payer and other relevant contract negotiation services; licensure and legal assistance; business consulting and financial planning services; establishment of prices to be charged for goods and supplies, other than for drugs or medical devices; and the employment of other personnel.

MSOs would not be allowed to control or intervene in the practice of medicine, employ a physician to practice medicine; dictate or otherwise make final decisions on the compensation of a physician; intervene in diagnosis, treatment, or prevention of disease; determine the amount of time a physician may spend with a patient; or require the physician to make referrals.

An MSO may charge a physician a flat, fair fee for the provision of management services. A physician or group of physicians that enters an agreement would be required to have copies of the agreement for inspection by the Texas Medical Board (TMB) and make the agreement available if the TMB opens an investigation. The agreement would otherwise by confidential and not subject to disclosure.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/8/23

Last Action: 3-14-23 H Introduced and referred to committee on House Public Health

HB 2985 | Jones, Venton (F) | Prior authorization prescription drug

Last Action: 3-14-23 H Introduced and referred to committee on House Insurance

HB 3034 | Talarico, James | Notice regarding nonemergency ambulance

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

TAHP POSITION: In review

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

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/8 KS

Last Action: 3-14-23 H Introduced and referred to committee on House Insurance

HB 3091 | Lalani, Suleman (F) | HMO ID Card

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

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

TAHP POSITION:

COVERAGE TYPES:

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/8 KS

Last Action: 3-14-23 H Introduced and referred to committee on House Insurance

T HB 3098 | Johnson, Ann | Health Plan Affiliated Providers

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

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

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

TAHP POSITION:

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

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

TAHP POSITION STATEMENT: Patients need access to lower cost treatment options. This legislation would create new limits that restrict patients from utilizing the most cost effective

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

DATE UPDATED: 3/8 KS

Last Action: 3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

HB 3139 | Jetton, Jacey | No compete clauses doctors

Last Action: 3-14-23 H Introduced and referred to committee on House Public Health

HB 3152 | Price, Four | Identification the country of origin of drug

Last Action: 3-15-23 H Introduced and referred to committee on House Public Health

HB 3188 | Bonnen, Greg | Biomarker Coverage Mandate

Companions: SB 989 | Huffman, Joan(R) | (Identical)
3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

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

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

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

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

DATE UPDATED: 2/19 KS

Last Action: 3-15-23 H Introduced and referred to committee on House Insurance

HB 3195 Bonnen, Greg Overpayment and Audit Appeal

Last Action: 3-15-23 H Introduced and referred to committee on House Insurance

HB 3196 Johnson, Ann Prompt payment catastrophic - TDI

Companions: SB 1286 Schwertner, Charles(R) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: This bill would allow TDI to extend prompt payment deadlines to a later date due to a catastrophic event. It would also allow TDI to approve a request by a provider for an extension due to a catastrophic event. This was a recommendation from TDI's annual report.

TAHP POSITION:

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

Last Action: 3-15-23 H Introduced and referred to committee on House Insurance

HB 3218 Klick, Stephanie Price Transparency

Remarks: SUMMARY: This bill would define “estimate” as a written statement outlining a consumer’s total expected billed charges for a nonemergency elective medical service or procedure. It would require a facility to provide an estimate of the facility’s charges for services within 24 hours when a consumer presents the facility a valid medical order for the services. The bill would require that the facility’s final billed charges not exceed the amount specified in the estimate by more than 5% unless the additional charges are related to complications that arose during the procedure as a result of a change in diagnosis. If the final billed charges exceeds 5% off the estimate, the facility would be required to provide a written statement describing the difference in the billed charges and the complications that resulted in the difference. If a facility violates the provisions

of the bill, they may not collect or take any collection action against a consumer, report the consumer to a credit bureau, or pursue an action against the consumer. The bill would also repeal a requirement that DSHS make available a “consumer guide to healthcare” website.

TAHP POSITION: SUPPORT

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: Health care prices are irrationally high and vary greatly, even for routine care. Rapidly consolidating hospital systems in Texas charge employers double what it costs to break even—more than 3 times Medicare —forcing employers and families to pay millions of dollars more than necessary. New price transparency laws help patients be better health care consumers. The bill creates an important consumer protection to accompany price transparency so patients can get an upfront price estimate that won't vary substantially on the final bill. If hospitals bait and switch then the consumer won't be on the hook for unexplained price changes, including p rotections against debt collection.

DATE UPDATED: 3/8 KS 3/13 BH

Last Action: 3-15-23 H Introduced and referred to committee on House Public Health

T HB 3317 | Frank, James | Direct Primary Care for FQHC

Companions: SB 2193 | Lamantia, Morgan (F)(D) (Identical)
3- 9-23 S Filed

Remarks: SUMMARY: This bill would create federal qualified health center (FQHC) primary care access programs. The programs would provide primary health care services to employees of participating employers who are located in the service area of an FQHC and other uninsured or underinsured groups. An FQHC would be allowed to establish criteria for participation and may require that an employer and employees who receive care pay a share of the costs of the program. The FQHC would be 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 would allow FQHCs to accept state funding, gifts, grants, and donations to operate the access program, and it would require the FQHC to actively solicit gifts,

grants, and donations.

An access program must be developed to reduce the number of individuals without primary care access, address rising health care costs for small employers, promote preventative care, and serve as a model for innovative use of health information technology. The programs would be required to provide primary care directly to employees, would allow FQHCs to require participants to receive only primary care services from the FQHC, and would clarify that an access program is not an insurer or HMO. TDI would be allowed to accept gifts that finance the access programs.

Not later than 12/1/26, TDI would be required to complete a review of each program that receives grants and submit it to the legislature.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED: 3/8 KS

Last Action: 3-15-23 H Introduced and referred to committee on House Select on Health Care Reform

T HB 3351 Harris, Caroline (F) Quality of Care Transparency

Remarks: SUMMARY: State law currently prohibits issuers from ranking physicians or comparing them to national standards or other physicians unless: the standards used by the plan are transparent and valid, have physicians in clinical practice actively involved in their development, and follow national standards; the standards are disclosed to all physicians before any evaluation period; and the issuer provides at least 45 days advance written notice before publication and offers each affected physician an appeal process, including an in-person “reconsideration proceeding.” This bill would remove the requirements that the standards be disclosed before evaluation periods and that the plan provide notice of publication and offer an appeal process. The bill would also clarify that the requirements of the section do not apply to physician-specific cost comparison information provided to network physicians whose payment is partly based on costs of other health care providers.

TAHP POSITION: SUPPORT

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT: Federal and state laws have expanded price transparency yet Texans lack a full picture of health care value because quality of care transparency laws lag price transparency. In order to share nationally recognized quality standards developed by third parties, health plans must follow an onerous process that allows physicians to appeal poor rankings and effectively hold up quality transparency. This bill would remove these barriers and allow health plans to share quality of care data along with pricing information.

DATE UPDATED: 3/8 KS, 3/11 BH

Last Action: 3-15-23 H Introduced and referred to committee on House Insurance

HB 3359 | Bonnen, Greg | Network Adequacy

Last Action: 3-15-23 H Introduced and referred to committee on House Insurance

HB 3377 | Jones, Venton (F) | HIV AIDS tests

Last Action: 3-15-23 H Introduced and referred to committee on House Public Health

HB 3411 | Bonnen, Greg | Non Compete

Remarks: SUMMARY: This bill would modify the law that applies to physician non-competes. Currently, non-competes must include a buy-out provision. This bill would require that the buyout amount not be greater than the physician's total annual salary at the time of termination. The bill would also require that non-competes expire within one year and that the geographic area subject to the restriction does not exceed five miles. The bill would also require any non-competes with dentists, nurses, and physician assistants to include a buyout amount of not great than their annual salary, that it expire in one year, and that the geographical radius not exceed five miles.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/12 KS

Last Action: 3-16-23 H Introduced and referred to committee on House Public Health

HB 3413 | Frank, James | PBM and Health Plan Relationships

Remarks:

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

TAHP POSITION:

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/12 KS

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3414 | Oliverson, Tom | APCD Reforms

Companions: SB 2045 | Hancock, Kelly(R) | (Identical)
3- 9-23 S Filed

Remarks:

SUMMARY: This bill would create "qualified market consultant entities" and "qualified market participant entities" that could access APCD data, in addition to the existing "qualified research entity." An entity that wants to access data would be required to submit an application that includes the sources of all funding, the names of all individuals who will have access to the data, the proposed project and how it will improve access or reduce costs of care, and a statement of what type of entity they are. The Center would review the application, and if it is rejected, would have to state the specific deficiency. If it is not granted in 31 days, the application is considered approved. Qualified research entities would be prohibited from selling or sharing the data, but they could report or publish data that identifies providers and payors.

A qualified market participant would only be allowed to access data of their own patients or enrollees. They would be prohibited from selling or sharing data, and would not be allowed to publicly report or publish any data that identifies a provider or payor.

A qualified market consultant would be able to access all data, but they would not be allowed to sell or share the data, and would not be allowed to publish data that identifies a provider or payor.

The bill would also give appointment power of the APCD advisory committee to the governor rather than the Center and clarify that the Center may not require the submission of data that is not included in a standard claim form.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/12 KS

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3460 | Price, Four | Mental Health Parity ERS

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3467 | Martinez, Armando | Emergency medical services personnel coverage

Last Action: 3-16-23 H Introduced and referred to committee on House Public Health

HB 3502 | Leach, Jeff | Gender transition coverage

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3524 | Johnson, Ann | Dental Anesthesia Mandate for kids

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

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

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

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3566 | Bucy, John | Substance and addiction treatment standards

Last Action: 3-16-23 H Introduced and referred to committee on House Insurance

HB 3586 | Cole, Sheryl | Coverage provision abortion and contraception

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

Last Action: 3-16-23 H Introduced and referred to committee on House Human Services

SB 51 | Zaffirini, Judith | Hearing Aids in Excess of Allowed Amounts

Companions: HB 109 | Johnson, Julie(D) | (Identical)
3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

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

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

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

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

EFFECTIVE DATES: September 1, 2023

DATE UPDATED: 2/3 KS

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

SB 160 | Perry, Charles | Pharmacist Test/Treat & Physician Dispensing

Remarks: SUMMARY: This bill would allow a pharmacist, under a physician's written protocol, to treat an acute condition identified through a strep test, influenza test, or COVID-19 test. The bill would also allow physicians to dispense medications to treat conditions identified by one of those tests.

TAHP POSITION: Support

TAHP POSITION STATEMENT: Strep and influenza commonly afflict Texans every year. TAHP believes there is a need to make access to treatments for these illnesses more efficient, especially for low-income Texans, who often visit pharmacies rather than physicians' clinics to seek treatment. SB 160 seeks to address this issue by authorizing pharmacists to administer treatment for strep and influenza under an appropriate physician-approved protocol if a patient tests positive for those diseases at the pharmacy location. TAHP and its member health plans are not opposed to physicians having the ability to dispense non-controlled substances to their own patients if it is not tied to a payment mandate and appropriate patient protections are required.

EFFECTIVE DATES: 1/1/23

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 195 Johnson, Nathan Medicaid expansion

Companions: HB 652 Johnson, Julie(D) (Identical)
2-23-23 H Introduced and referred to committee on House Select on Health Care Reform

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

to available job search and job training programs.

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/11 by JL

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 241 Perry, Charles Insulin VDP Reporting - Pay for Delay

Companions:

HB 2529	Talarico, James(D)	(Identical)
	3-13-23 H Introduced and referred to committee on House Public Health	
HB 5050	Button, Angie Chen(R)	(Identical)
	3-10-23 H Filed	

Remarks: SUMMARY: This bill would require manufacturers of name-brand drugs, for which a generic is available and that is included on the Medicaid VDP, to submit to HHSC a written verification stating whether the unavailability of a generic is due to pay for delay, legal strategies to extend a patent, or manipulation of a patent.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/24

TAHP POSITION STATEMENT: Pharmaceutical manufacturers utilize numerous tactics to delay competition from generic competition. Patent games like pay-for-delay slow the advancement of more affordable generic drugs by slowing the entrance of lower cost generic options. In these co mplex schemes a generic manufacturer sues a patent holder who then countersues and the parties settle with a pay-for-delay deal and a financial reward to the generic manufacturer. Pay for Delay deals cost consumers and taxpayers $3.5 billion in higher drug costs every year.Using “evergreening” strategies to extend patent periods to either delay generic drug market entry or limit the number of patients who switch to a new generic. Drug companies exploit the patent system to delay competition. An analysis of the 10 best-selling drugs of 2019 found that on average these drugs held more than 69 patents with 37.5 years of patent protection, well past the 20 years of patent life intended by Congress. Furthermore, the prices for these drugs increased 71 percent over the previous five years. A federal ban saves $20 billion. The legislation simply requires these

companies to disclose if these tactics have been used to delay the entrance of lower cost insulin medications.

DATE UPDATED: 2/1 KS, 2/16 BH

Last Action: 3-15-23 S Voted favorably from committee as substituted Senate Health and Human Services

SB 251 | Alvarado, Carol | Emergency telemedicine pilot

Companions: HB 617 | Darby, Drew(R) | (Identical)
3-16-23 H Committee action pending House Select on Health Care Reform

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

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/3 KS

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

SB 299 | Hall, Bob | Hospital liability for non-hospital physicians

Remarks: SUMMARY: This bill would allow physicians who are not a member of the facility medical staff to provide care at the hospital at the patient's request. It would also ensure that the hospital is not liable to a patient or another person for damages resulting from that care.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/20 JB

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

SB 304 | Hall, Bob | Prohibited immunization status discrimination

Remarks: SUMMARY: This bill would prohibit issuers, among others, from discriminating against an individual based on their vaccination history or immunity status. A person would file a complaint with the attorney general, and the attorney general

would have the authority to seek equitable relief.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediately or 9/1/23

DATE UPDATED: 2/3 KS

Last Action: 2-15-23 S Introduced and referred to committee on Senate State Affairs

SB 308 — Hall, Bob — Prohibited vaccination status discrimination

Remarks: SUMMARY: This bill would prohibit insurers, among others, from discriminating against individuals based on COVID-19 vaccination status.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediately or 9/1/23

Last Action: 2-15-23 S Introduced and referred to committee on Senate State Affairs

SB 334 — Schwertner, Charles — Authority emergency services district

Companions: HB 4922 — Oliverson, Tom(R) — (Identical)
3-10-23 H Filed

Remarks: SUMMARY: This bill would allow emergency service districts to provide preventative health care services to reduce reliance on emergency transports.

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED: 2/3 KS

Last Action: 2-15-23 S Introduced and referred to committee on Senate Local Government

SB 344 — Johnson, Nathan — Texas State Based Exchange

Remarks: SUMMARY: SB 344 would create the Texas Health Insurance Exchange Authority to implement the Texas Health Insurance Exchange as an American Health Benefit Exchange authorized under the ACA. It authorizes an exchange user fee of up to 3.5 percent, a percentage of which will be set aside to increase subsidies. Subsidies will go to premium assistance and cost-sharing reduction programs. The exchange will cease operations if the ACA is

repealed, defunded, or invalidated.

TAHP POSITION: Neutral monitor

COVERAGE TYPES: Commercial

TAHP POSITION STATEMENT: Texas should ensure that any efforts to build on the state's high-performing individual market do not create market instability or coverage disruptions. Texas has made substantial gains in increasing access to insurance coverage in the individual market. The number of Texans with marketplace plans doubled in the last two years, and 15 plans are offering coverage in Texas—a record number. Policies like a state-based exchange or 1332 coverage waiver should not be implemented in a way that would create market instability, increase costs or reduce competition and access. The state should look for reforms in the insurance market that further reduce the uninsured and lower costs.

EFFECTIVE DATES: 9/1/23, with rules adopted not later than 3/1/24.

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 358 Kolkhorst, Lois Right to Shop Mandate

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

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

COVERAGE TYPES: Commercial, ERS

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

MANDATE: Benefit

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

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

DATE MODIFIED: 2/3/23 JB

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 447 Menendez, Jose Fertility preservation mandate

Companions:

HB 389	Collier, Nicole(D) 2-23-23 H Introduced and referred to committee on House Insurance	(Identical)
HB 1649	Button, Angie Chen(R) 3- 7-23 H Introduced and referred to committee on House Insurance	(Identical)

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

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial

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

MANDATE: Benefit

TAHP POSITION STATEMENT: The bill creates a new unfunded, mandated benefit, fertility preservation services for a covered person who will receive a treatment that may impair fertility. In the 86th legislative session, this same mandated benefit (HB 2682) would have increased Medicaid costs by $5.2 million a year and TRS-active care costs by $4 million a year. The LBB found that this benefit mandate would also increase health care costs to the TRS, UT systems and ERS health plans that would result in increased premiums and contributions from the state, employers, or members. Typical costs for fertility preservation services are in excess of $10,000 with hundreds more in added monthly storage charges. Government mandates and overregulation hinder innovation and add costs to an already expensive system. This expense is borne by employers and families through increasingly unaffordable premiums. Texas already ranks third in the nation when it comes to regulations that go beyond the federal requirements of the ACA.

UPDATED: 2/3 BH

Last Action: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 451 — Menendez, Jose — Preexisting Condition Protections

Remarks: SUMMARY: This bill would prohibit plans from denying coverage for specific preexisting conditions unless the application for enrollment requires disclosure of the condition or of prior medical treatment. It would also prohibit termination except for failure to pay the premium, failure to abide by the rules of the plan, fraud, cancellation, or a cause for termination that the commissioner determines is not objectionable. Finally, it would require disclosure by the issuer upon a termination as the specific reason the policy was terminated and how the enrollee can file a complaint with the department.

TAHP POSITION: Neutral

COVERAGE TYPES: Individual, group, STLD

EFFECTIVE DATES: 1/1/24

MANDATE: Coverage

DATE UPDATED: 2/3/23, 2/17 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 452 — Menendez, Jose — SMI Step Therapy Mandate

Companions: HB 1337 — Hull, Lacey(R) (Identical)
3-14-23 H Committee action pending House Insurance

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

TAHP POSITION: Neutral (negotiated language)

COVERAGE TYPES: Commercial

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

MANDATE:Benefit

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

DATE UPDATED: 3/8 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 457 — Menendez, Jose — Consumer Disclosures for Alternative Coverage

Remarks: SUMMARY: This bill requires TDI to create a standardized disclosure form for alternative types of health coverage that are sold to individuals. This is similar to the disclosures that were created for short term limited duration plans. It would apply to direct primary care plans, discount health plans, health care sharing ministries, and any other plan or arrangement that the commissioner determines could be marketed to an individual as an

alternative or supplement to health insurance.

TAHP POSITION: Support

COVERAGE TYPES: Alternative coverage

EFFECTIVE DATES: 1/1/24

TAHP POSITION STATEMENT: Recent years have seen a proliferation of alternative coverage options that are not regulated under the same requirements as insurers subject to the Affordable Care Act and its disclosure requirements. TAHP supports requiring upfront disclosure of any health coverage arrangement so consumers know what they are buying and any limitations. This includes informing consumers if the product they are purchasing is not an insurance product and may have significant coverage limitations.

DATE UPDATED: 2/17 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 490 | Hughes, Bryan | Itemized billing before debt collection

Companions: HB 1973 | Harris, Caroline (F)(R) | (Identical)
3- 8-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: This bill requires a health care provider, before pursuing any debt collection against a patient for whom the provider provided a health care service or related supply, to issue to the patient a written itemized bill of charges for all health care services and supplies provided to the patient during the visit to the provider. The bill must include the amount charged for each service and supply provided to the patient by that provider or any other provider during that visit. The appropriate licensing authority may take disciplinary action against a health care provider that violates this chapter as if the provider violated an applicable licensing law.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

POSITION STATEMENT: Health care prices are irrationally high and vary greatly, even for routine care. Rapidly consolidating hospital systems in Texas charge employers double what it costs to break even—more than 3 times Medicare—forcing employers and families to pay millions of dollars more than necessary. Patients deserve access to a detailed list of charges from hospital visits so

they can confirm charges, dispute fees, and negotiate discounts.

DATE UPDATED: 2/3/23 JB 2/17 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

SB 583 | Hughes, Bryan | OON Out of Pocket Cost Mandate

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

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

TAHP POSITION: OPPOSED without guardrails added

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

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

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

directly to a specialty provider would undermine the entire purpose of an HMO, making it function like an EPO. Medicaid and CHIP do not have out-of-pocket maximums, so the bill does not make sense in those contexts. TAHP supports encouraging patients to shop for lower cost, medically necessary services and would not oppose legislation that rewards that shopping. However, the bill lacks the necessary guardrails to ensure that the result of the bill is to reward patients that find lower cost services.

DATE UPDATED: 3/7 KS

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

SB 584 | Hughes, Bryan | No Referral for 30 PT Visits

Companions: HB 4291 | Swanson, Valoree(R) | (Identical)
3- 9-23 H Filed

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

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 9/1/23

MANDATE: Benefit

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

Further, TAHP is concerned about claims from physical therapists that HB 29 converted their licensure to primary care providers in their arguments to mandate their services be covered at typically lower copays that insurers set for primary care provider. Those primary care copays are typically lower as a means to encourage patients to seek primary care and in recognition that primary care providers provide a crucial role in health care in coordinating patient care.

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

LAST UPDATED: 3/11 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

SB 589 Johnson, Nathan Health literacy plan

Companions: HB 1578 Allison, Steve(R) (Identical)
3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: Requires the Statewide Health Coordinating Council to develop a long-range plan for improving health literacy in this state that must be updated every two years and submitted to the legislature. Requires the Council to study the economic impact of low health literacy. Requires the Council to identify primary risk factors contributing to low health literacy, examine ways to address literacy, examine the potential to use quality measures in state-funded programs, and identify strategies to expand the use of plain language. Requires the State Health Plan to identify the prevalence of low health literacy among health care consumers and propose cost-effective strategies that also attain better patient outcomes.

TAHP POSITION: Support

TAHP POSITION STATEMENT: An estimated 90 million Americans have low health literacy. Health literacy helps people make healthy choices. People without high healthy literacy may not be able to read food or prescription labels, describe their symptoms to health providers, and understand insurance documents or medical bills. Low health literacy can result in medical errors, increased illness and disability, loss of wages, and compromised public health. The impact is estimated to cost the U.S. up to $236 billion every year.

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 605 Springer, Drew Mandate-lite coverage - consumer choice

Companions: HB 1001 Capriglione, Giovanni(R) (Identical)
3-16-23 H Committee action pending House Select on Health Care Reform

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

TAHP POSITION: Support

COVERAGE TYPES: Commercial

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

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Establish new alternative coverage option that allows insurers to offer 'Consumer Choice' plans that forego certain state-imposed regulations and mandates." Texas should build more affordable insurance coverage options that avoid over-regulation and excessive mandates. New health care products added last session avoid government mandates and provide more choices for some Texans. In the past, Texans had mandate-lite insurance options through the Consumer Choice of Benefits model, but that’s been eroded by a continuous stream of new mandates over two decades. Updated “Consumer Choice” plans would be similar to new affordable alternatives established through the Farm Bureau and Texas Mutual, but there are a few key differences. These plans would still be considered insurance under state law, meaning that they would be required to meet solvency requirements, be subject to TDI oversight, and meet federal benefit and coverage requirements like pre-existing conditions protections and medical loss ratio rules required by the Affordable Care Act. Additionally, HB 1001 indicates that these plans must also meet any requirements imposed on the coverage elected officials and state employees have through ERS.

DATE UPDATED: 2/13 KS

Last Action: 2-17-23 S Introduced and referred to committee

on Senate Health and Human Services

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

Companions: HB 1754 Smithee, John(R) (Identical)
3- 7-23 H Introduced and referred to committee on House Insurance

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

TAHP POSITION: Neutral if amended

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

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

DATE UPDATED: 2/13 KS

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

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

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

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial, Medicaid

TAHP POSITION STATEMENT: TAHP opposes blanket prior authorization exemptions, including those for prescription drugs. Prior authorizations are crucial to ensuring that patients receive safe, effective care at a reasonable cost. Texas already has the broadest exemptions to prior authorization in the country including "gold-carding," which exempts providers with a history of safe and appropriate care. Bills that create blanket exemptions to prior authorizations could lead to patient harm by rewarding providers who don't

meet the 90% standard of safe and appropriate care.

Health plans have a comprehensive view of a patient's medication history. That view plus the use of prior authorizations allows health plans to prevent dangerous drug interactions, especially when patients have multiple prescribers.

Prior authorization helps prevent fraud, waste, and abuse. As much as $800 billion is wasted on excessive and unnecessary testing and treatment every year and 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary. Previous estimates show that eliminating prior authorizations for prescription drugs could cost ERS and TRS a combined $169 million over the next biennium, while Medicaid MCOs estimate an annual cost of over $100 million.

Most importantly, prior authorizations for prescription drugs are safety checks for appropriateness and patient risk based on FDA guidelines and medical guardrails. For example, in response to the number of low-income Texas kids being prescribed dangerous antipsychotic drugs like Seroquel and Risperdal, in 2011 Texas Medicaid begin requiring prescribing doctors to receive a prior authorization from the state to protect these children from drugs with serious side effects.

Prior authorizations for prescription drugs protect patients from opioid abuse and severe drug interactions or reactions. Medical errors, including adverse drug events, are now the third leading cause of death in the United States, leading to more than 3.5 million physician office visits and 1 million emergency department visits each year. Prior authorizations for prescription drugs are an important tool in preventing unnecessary medical care and ensuring patient safety.

DATE UPDATED: 2/17 BH

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 676 | Johnson, Nathan | Expansion of in vitro mandate

Companions:

HB 2310	Gonzalez, Jessica(D)	(Refiled from 87R Session)
HB 838	Gonzalez, Jessica(D)	(Identical)
	3- 1-23 H Introduced and referred to committee on House Insurance	

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

TAHP POSITION: Neutral

COVERAGE TYPES: Group (commercial) plans

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

MANDATE: Benefit

DATE UPDATED: 2/19 KS

Last Action: 2-17-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 724 Lamantia, Morgan (F) Telemedicine Payment Parity Mandate

Companions:

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

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

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

TAHP POSITION STATEMENT: Mandating the same payment for brick-and-mortar office visits and telehealth visits is government rate setting and undermines telehealth’s promises of efficiency and innovation. Independent experts across the

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

DATE UPDATED: 2/18 BH

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 749 — Flores, Pete — Pharmacist Vaccination Authority

Companions: HB 1105 — Price, Four(R) — (Identical)
3- 2-23 H Introduced and referred to committee on House Public Health

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

TAHP Position: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 773 — Parker, Tan (F) — Right to Try Chronic Rx - Not coverage mandate

Remarks: SUMMARY: This bill would allow the HHSC Commissioner to designate severe chronic diseases, for which a patient could take an

investigational drug upon recommendation by a physician. Use of the drug would require informed consent, the provider would be immune from liability, and the state would be prohibited from interfering with the treatment. This bill would not affect the coverage of enrollees in clinical trials. This bill does not create a new insurance mandate.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

SB 807 | Paxton, Angela | 12 month contraception mandate

Companions:

HB 2651	Gonzalez, Jessica(D)	(Refiled from 87R Session)
HB 916	Ordaz, Claudia (F)(D)	(Identical)
	3-14-23 H Committee action pending House Insurance	

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

TAHP POSITION: Opposed. TAHP will propose an initial 3 month supply and subsequent 6 months supply. If the author accepts this amendment TAHP will be neutral.

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Benefit

TAHP POSITION STATEMENT: Creates mandate to cover a 12-month supply of contraceptive drugs at one time. The Insurance Code already mandates coverage for prescription contraceptives for any plan that covers prescription drugs. The Affordable Care Act also already requires most insurance plans to cover prescription contraceptives with no out-of-pocket

costs. Additionally, health plans already offer 90-day supplies. TAHP believes there would be a negative fiscal impact to the commercial market due to the expected waste of dispensed but unused drugs, and for coverage of drugs dispensed to participants who receive a 12-month supply but leave the plan and do not pay premiums for the full year. ERS previously estimated this mandate would cost more than $4 million. Based on these numbers, the private commercial market would see a similar impact with increased costs of more than $30 million. These types of mandates significantly drive up the cost of coverage for Texas employers and families.

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

SB 833 | King, Phil (F) | Prohibits Social Insurance Rating

Companions: HB 1239 | Oliverson, Tom(R) | (Identical) | 3-14-23 H Committee action pending House Insurance

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

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial

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

DATE UPDATED: 2/19 KS

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

SB 842 | Hinojosa, Chuy | ERS Bariatric Surgery Coverage

Companions: HB 2640 | Herrero, Abel(D) | (Identical) | 3-13-23 H Introduced and referred to committee on House Pensions/Investments/Financial Services

Remarks: SUMMARY: Currently, The board of ERS is required to develop a cost-positive plan for providing bariatric surgery to current employee enrollees. This bill would require the same coverage for annuitants and former employees

that are eligible for ERS coverage.

TAHP POSITION: Neutral

COVERAGE TYPES: ERS

EFFECTIVE DATES: 2024 plan year

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 860 | Hughes, Bryan | Any Willing Provider Mandate - Vision

Companions: HB 1696 | Buckley, Brad(R) | (Identical)
3- 7-23 H Introduced and referred to committee on House Insurance

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

provider's choice of optical laboratory or other source or supplier of services or materials. Finally, the bill would prohibit contracts with these providers that require prior authorization, require the provider to provide covered services at a loss, or require a reimbursement that has an applicable processing fee except a nominal fee for an EFT. It would also prohibit issuers from using extrapolation to audit optometrists or therapeutic optometrists. A violations of the subchapter be considered a deceptive act by the issuer for the purposes of Chapter 541.

TAHP Position: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

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

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

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

DATE UPDATED: 3/5 BH

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 861 Hughes, Bryan Coordination vision benefits

Companions: HB 1322 Buckley, Brad(R) (Identical)
3- 3-23 H Introduced and referred to committee on House Insurance

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

COVERAGE TYPES: EPO/PPOs that cover vision services

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

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 863 Hughes, Bryan ER Verification of Payment Mandate

Companions: HB 4500 Harris, Caroline (F)(R) (Identical)
3- 9-23 H Filed

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

TAHP POSITION: Oppose

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

EFFECTIVE DATES: 1/2/24

DATE UPDATED: 2/19 KS

Last Action: 3- 1-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 945 Kolkhorst, Lois Expands Price Transparency

Remarks: SUMMARY: This bill would expand current price transparency requirements that apply to hospitals to FEMCs, urgent care, retail clinics, birthing centers, ASCS, and other facilities.

TAHP POSITION: Support

EFFECTIVE DATES: Immediately or 9/1/23

POSITION STATEMENT: In 2021, Texas lawmakers created consumer-friendly hospital price transparency laws and required health plans to publish all of their negotiated prices. But consumers still lack a complete picture to window-shop for most health services. This legislation continues the state's push for price transparency by expanding the price transparency law to include freestanding ERs, ambulatory surgical centers, urgent cares, outpatient clinics, and other facilities.

DATE UPDATED: 3/5 BH

Last Action: 3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

SB 989 | Huffman, Joan | Biomarker Coverage Mandate

Companions: HB 3188 | Bonnen, Greg(R) | (Identical)
3-15-23 H Introduced and referred to committee on House Insurance

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

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

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

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

DATE UPDATED: 2/19 KS

Last Action: 3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1003 | Johnson, Nathan | TDI Rec - Provider Directories

Companions: HB 1902 | Smithee, John(R) | (Identical)
3-14-23 H Committee action pending House Insurance

Remarks: SUMMARY: This bill would expand the requirement for issuers to list facility-based providers in their provider directories. It would add non-physician providers, including CRNAs, nurse midwives, surgical assistants, physical therapists, among others.

TAHP POSITION: Reviewing

COVERAGE TYPES: HMO, EPO, MEWA.

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/18 KS

Last Action: 3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1029 Hall, Bob Public funding gender modification liability

Remarks: SUMMARY: This bill would create strict liability for costs associated with the reversal of gender modification for the physician who provides the treatment and an issuer that covers it. It would also prohibit coverage of gender modification services by public plans.

TAHP POSITION: Neutral

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

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/22 KS

Last Action: 3-16-23 S Committee action pending Senate State Affairs

T SB 1040 Kolkhorst, Lois Organ Transplants in China

Companions: HB 2025 Oliverson, Tom(R) (Identical)
3- 8-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: This bill would prohibit issuers from covering organ transplants if the transplant operation is performed in China or another country known to have participated in organ harvesting, or if the organ was procured by a sale or donation originating in one of those countries. It would allow DSHS to designate additional countries known to have participated in organ harvesting.

TAHP Position: Neutral

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

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

DATE UPDATED: 2/22 KS

Last Action: 3- 3-23 S Introduced and referred to committee

on Senate Health and Human Services

SB 1043 Blanco, Cesar Telemedicine Payment Parity Mandate

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

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

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

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

market for insurance coverage is responding with numerous options for $0 copay telehealth visits. A payment parity mandate risks interfering in the market response to these patient needs.

DATE UPDATED: 2/18 BH

Last Action: 3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1051 — Hughes, Bryan — Health benefit plan questionnaires

Companions: HB 4501 — Harris, Caroline (F)(R) — (Identical)
3- 9-23 H Filed

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

TAHP POSITION: Reviewing

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

EFFECTIVE DATES: Questionnaire adopted by 1/1/24 and used by 2/1/24 DATE UPDATED: 2/22 KS

Last Action: 3- 3-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1135 — Schwertner, Charles — Value Based Payment Reform - Capitated Payment

Companions: HB 1073 — Hull, Lacey(R) — (Identical)
3- 2-23 H Introduced and referred to committee on House Insurance

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

TAHP POSITION: Support

COVERAGE TYPES:Commercial

EFFECTIVE DATES: Immediate or 91/23

POSITION STATEMENT: Health care is rapidly moving towards capitated value-based care arrangements like advanced primary care and

direct primary care, where providers take on the risk of caring for patients for a set monthly fee. These models are quickly gaining traction for employees, employers, and doctors. For example, more than 80% of employees say they would sign up for an all-inclusive direct primary care plan if given the option. However, as these models evolve, Texas law, written decades ago, limits payment and benefit design HMOs are the only type of health plan in Texas that can partner with doctors for risk-based, value-based payments. Unfortunately, PPO plans and EPO plans cannot pay a primary care doctor a flat, monthly payment for risk-based direct primary care or advanced primary care. Under current law, Health Maintenance Organizations (HMOs) are expressly allowed to make capitated payments. However, that same language does not appear in the Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) chapter of the Insurance Code. TAHP worked with the Primary Care Consortium to identify policies of shared interest that can make a positive difference in health care payment and delivery innovation. The Consortium endorsed this concept and TAHP supports removing barriers to value-based care.

DATE UPDATED: BH 2/21

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1137 Schwertner, Charles ERISA Prescription Drug Mandate

Companions: HB 2021 Oliverson, Tom(R) (Identical)
3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

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

TAHP POSITION: Oppose

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

POSITION STATEMENT: This bill applies every state created prescription drug mandate (insurance code chapter 1369) to self-funded employer health plans that are currently exempt under Federal ERISA laws. Employers (not health

insurers) are harmed by HB 2021. Self-funded employers will suffer the cost of imposing state mandates including limits on narrow pharmacy networks or the use of onsite pharmacies, a one year wait before changing to lower cost generics/biosimilars, and limits on mail order pharmacies. Multi-state employers will have to design special coverage just for Texas employees. These mandates are expensive and cumbersome, that's why the bill exempts coverage for our elected officials personal health insurance and their employee's coverage. Large employers with thousands of employees use self-funded benefits. These are the biggest providers of health coverage and the biggest job creators in Texas. The intent of ERISA preemption is to encourage employers to offer their employees benefit plans. This has worked - 98% of Texas large employers provide coverage to their employees compared to only 50% of Texas small employers. The Texas Association of Business, Texas Business Leadership Council, Texans for Lawsuit Reform, and individual businesses like Hobby Lobby have all spoken out against ERISA preemption.

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

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1138 | Schwertner, Charles | White Bagging Prohibition Mandate

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

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

TAHP POSITION: Opposed unless amended to not mandate excessive prescription drug mark ups by doctors and hospitals

COVERAGE TYPES: Commercial, CC

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

MANDATE: Contracting

POSITION STATEMENT: TAHP opposes HB 1647 without amendments that would ensure the bill does not reward price gouging and is aimed only at patient protections. The most expensive drugs are injectables and infusion drugs provided at a hospital, cancer center, or doctor's office. These "specialty drugs" are typically covered under your medical benefits (not pharmacy benefits). New State and Federal transparency laws show that hospitals, cancer centers, and other clinics have been caught marking up drugs at excessive amounts, on average 200% and up to 634% for cancer drugs. By comparison, Medicare allows a 6% markup or profit margin.Health plans are responding with competition by bringing in the same drug from lower cost specialty pharmacies but without the big markup. That's "white bagging" and it saves patients money. Massachusetts found the process saved 38% on average.

The legislation would stop health plans from using lower cost drugs from outside pharmacies through a new mandate that prohibits a "white bagging" policy. The bill as filed also mandates that health plans and patients have to pay whatever prices are set by hospitals' and physicians' at in-house pharmacies. Importantly, patients pay for these markups through out-of-pocket costs and higher premiums. A white bagging prohibition would add over $300 million in Texas drug spending in the first year and over 3.7 billion in the next decade. No state has adopted a white bagging restriction with a payment mandate that rewards price gouging.

LAST UPDATED: BH 2/21

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1139 | Schwertner, Charles | Prudent Layperson Mandate

Companions: HB 1236 | Oliverson, Tom(R) (Identical) | 3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

Remarks: SUMMARY: This bill amends the "prudent layperson" definition of "emergency care" in the Insurance Code to add "regardless of the final diagnosis of the conditions,...." The bill would also make a coverage determination of the Prudent

Layperson standard subject to the current UR review process.

TAHP POSITION: Oppose, negotiating

COVERAGE TYPES: Commercial and Medicaid

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

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

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

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

and patients as if the care was an emergency. That's fraud and this bill would interfere in going after this abuse.

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

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1140 Schwertner, Charles OPIC Network Adequacy

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

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

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

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

The bill requires OPIC to compare HMOs to HMOs, PPO plans to PPO plans and EPO plans to EPO plans and to issue annual consumer report cards that evaluate and compare health plans' network adequacy.

TAHP POSITION: Reviewing

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1141 Schwertner, Charles Prohibits Extrapolation for FWA Audits

Companions:

SB 519	Schwertner, Charles(R)	(Refiled from 87R Session)
HB 895	Munoz, Sergio(D)	(Identical)
	3- 1-23 H Introduced and referred to committee on House Insurance	

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

TAHP POSITION: Oppose

COVERAGE TYPES: HMOs and insurers (EPO/PPO)

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

MANDATE: Administrative

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

effective tool to give a provider an exemption from all prior authorizations (gold carding), it should also be considered an effective tool to review fraud, waste, and abuse.

DATE UPDATED: 2/26 Bh

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

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

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

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

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION: Requiring Texas health plans to have personnel available for prior authorization and payment verification requests 24/7, including weekends and holidays, has several negative consequences. Requiring 24/7 availability for prior authorization and payment verification responses is inconsistent with provider availability and cr eates unnecessary and costly administrative burden. For example, one of the state's largest health plans received just 6% of PA requests after regular business hours (including holidays) in 2022, showing there is very little demand for after-hours verification. Additionally, Texas already has some of the shortest prior authorization time frames in the country, with a requirement that they be processed in less than 3 calendar days compared to most states' 14 days. Furthermore, Texas already has the broadest exemptions to prior authorization in the country, including "gold-carding," which exempts providers with a history of safe and appropriate care. Hospitals and providers also do not staff utilization review after hours. Moreover, there is no evidence to suggest that this requirement would improve patient

outcomes or reduce healthcare costs, making it a potentially unnecessary burden on the healthcare system. Instead, a better solution would be to follow the federal government's recommended reforms to implement electronic prior authorizations, which could reduce costs and streamline the process, making it easier for providers to obtain necessary approvals. For pharmacy authorizations, around 60% of new prior authorizations are already received electronically, suggesting that there may be limited additional value in requiring health plans to have a 24/7 phone line for receiving new authorizations. By requiring the use of electronic prior authorizations, Texas could stay up to date with current best practices and provide a more effective and efficient prior authorization system for patients and providers. This approach could improve the overall quality and availability of healthcare in the state while reducing costs for both health plans and patients.

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

Texas is already one of the most heavily regulated states when it comes to health care, ranking third in the nation for regulations that go beyond the federal requirements of the Affordable Care Act (ACA). As a result, small business owners in Texas consistently rank the cost of health insurance as their single biggest problem since 1986. Additionally, approximately three-quarters of Texas employers oppose legislative mandates that interfere with how they design employee benefits. Instead, they want more flexibility to contain costs and provide the best coverage for their employees. Furthermore, TAHP opposes expensive mandates like this that raise costs for employers and families but do not apply to elected officials’ personal health insurance and their employees’ coverage through ERS. Texas legislators should not force costly regulations and mandates on employees and families when they are not willing to pay for it with their personal coverage.

DATE UPDATED: 2/27 KS

Last Action: 3- 9-23 S Introduced and referred to committee

on Senate Health and Human Services

SB 1150 | Menendez, Jose | Limits PAs to 1 to Year Autoimmune/Chronic

Companions: HB 755 Johnson, Julie(D) (Identical)
2-28-23 H Introduced and referred to committee on House Insurance

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

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC, ERS/TRS

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

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

missed drug interactions and other safety concerns. Prior authorizations for prescription drugs protect patients from opioid abuse and severe drug interactions or reactions. According to a study by the Institutes of Medicine, most adverse drug events that patients experience are caused by prescriber errors. These adverse drug events (ADEs) account for more than 3.5 million physician office visits and 1 million emergency department visits each year.

LAST UPDATED: BH 2/20

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1178 Lamantia, Morgan (F) Dental Anesthesia Mandate for kids

Companions: HB 3524 Johnson, Ann(D) (Identical)
3-16-23 H Introduced and referred to committee on House Insurance

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

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

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

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

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

childhood dental anesthesia is safe and necessary.

DATE UPDATED: 3/11 BH

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1193 | Schwertner, Charles | Mandates On Site MD at FSER

Remarks: SUMMARY: This bill would require FEMCs to have at least one physician present at all times. A patient would have a right to request that a physician perform all of the patient's health care services. The facility would be required to display a poster that discloses the name of the physician supervising health care practitioners, the physician's license number, and their board certifications. The poster would have to include a statement saying the patient could request to see and receive care from the physician at any time.

TAHP POSITION: Neutral

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1220 | Zaffirini, Judith | First episode psychosis mandate

Companions: HB 4713 | Plesa, Mihaela (F)(D) | (Identical)
3-10-23 H Filed

Remarks: SUMMARY: This bill would define "first episode psychosis" as the initial onset of psychosis caused by medical and neurological conditions, serious mental illness, or substance abuse. It would require group health benefit plans to provide coverage, based on medical necessity as determined by a stakeholder group, to an individual who is younger than 26 and who is diagnosed with first episode psychosis. The issuer must include coverage for all generally recognized services, including coordination of specialty care, assertive community treatment, and peer support services. The plan would be required to reimburse providers of coordinated specialty care and assertive community care using a bundled payment model. If requested by an issuer on or after 3/1/29, the department would be required to contract with an independent third party to perform

an analysis of the impact of the requirement of covering team-based treatment models described by the bill. If the analysis finds that premiums increased by more than one percent, issuers are not required to comply. The bill would also establish a workgroup of providers and issuers to determine medical necessity criteria and a coding solution for these services. The department will adopt rules by 1/1/24.

TAHP POSITION: Oppose

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

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

MANDATE:

TAHP POSITION STATEMENT:

UPDATED:

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1221 Zaffirini, Judith Permanent Formulary Freeze Mandate

Companions:

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

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

requirements for modifying drug coverage to include a statement explaining the type of modification and indicating that, on renewal of the benefit plan, the issuer may not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year (formulary freeze).

TAHP POSITION: Oppose

COVERAGE TYPE: Commercial, Exempts ERS and TRS

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

TAHP POSITION STATEMENT: TAHP is opposed to any new government mandate that permanently freezes health plan formularies and undermines important efforts by health plans to negotiate lower drug prices, ultimately driving up the cost of coverage for Texas employers, families, and taxpayers. Texas already leads the nation with the strongest patient protections against non-medical switching and step therapy. For example, Texas has a one year formulary freeze law that only two other states have. That means that when an expensive name brand drug has a lower cost competitor enter the market, health plans are not allowed to update the formulary to reflect this cost savings for a full year. That’s the case now in 2023 with the launch of new biosimilar alternatives to the very expensive rheumatoid arthritis drug Humira. Further, Texas has the most extensive step therapy protections in the nation. A physician can simply document that a patient is stable on a drug and the patient can’t be taken off by step therapy protocols, even if they change insurers. Under this proposal, the formulary would be permanently frozen if any patient is on a particular drug. This is an unprecedented, costly, and unworkable mandate. Under a permanent “formulary freeze,” plans cannot replace drugs with new clinically appropriate and more affordable alternatives. Instead, plans will have to continue coverage of a drug, at the same copay or coinsurance level, even if the price increases or if a more affordable, more effective, or even safer option comes out. An insurer couldn’t make a change as simple as a $5 copay increase on brand-name drugs in between plan years. Pharma stands to gain from a formulary freeze because once they have a patient on a drug, they’ll be immune from competition from lower cost alternatives and any pressure to lower the price of that drug. Employers and families paying premiums would see increased costs of $481 million over $5 years. Certain city employee

estimates include San Antonio with an additional $3 million in drug spending and $2 million for Dallas employees. TRS would owe $70 million more per year if the bill were applied to the program.

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

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

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

DATE UPDATED: 2/3/23 BH

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1275 | Hancock, Kelly | Prohibits Abusive Facility Fees

Companions: HB 1692 | Frank, James(R) | (Identical)
3- 7-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: This bill would prohibit facility fees in outpatient settings and for services identified by the HHSC commissioner, which can be safely and effectively provided outside of a hospital setting. The bill would also require providers to submit a report to the department detailing any facility fees

charged by the provider. Finally the bill would give DSHS the authority to audit a provider for compliance with this chapter and assess $1,000 administrative penalties for violations.

TAHP POSITION: Support

EFFECTIVE DATES: Immediate or 9/1/23

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Explore ways to prohibit hospitals from charging facility fees for services not provided on a hospital's campus."

Hidden facility fees are the latest negative trend in health care. The original purpose of a facility fee was to help hospitals cover the stand-by costs associated with emergency departments and inpatient care. However, as health systems have expanded and acquired physician practices, these facility fees have been inappropriately applied to outpatient medical bills. The fees are also one of the primary components of outrageous freestanding emergency room bills including price gouging for COVID-19 tests. After physician group acquisition, hospital systems may add facility fees to the groups bills even though the practice location hasn't changed and isn't physically connected in any way to a hospital. In one example, the cost of a woman's arthritis treatment increased by 1000% when a hospital system takeover added a facility fee to the bill. While the treating physician and the practice location had not changed, the billing codes did. The hospital system explained that they moved the infusion clinic from an "office-based practice" to a "hospital-based setting" as the excuse for adding the facility fee. Providers are even charging facility fees in some instances for telehealth visits.

While it's unlikely that consolidation will easily or quickly unwind, removing incentives like inappropriate facility fees mitigates the impacts to health care spending and may disincentivize new acquisitions. The Medicare program has a site neutral payment policy. In order for hospital billing levels to apply, the outpatient facility must be within 250 yards of the hospital campus. This reasonable approach ensures that when hospital systems acquire physician practices, facility fees are not added when the practice is not part of the main hospital campus. The Committee for a Responsible Federal Budget estimates that a site neutral payment policy applied throughout health care could reduce "total national health expenditures by a range of $346 to $672 billion" over a 10 year period.

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

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1277 Parker, Tan (F) Fertility Preservation Mandate

Remarks: SUMMARY: This bill would define "fertility preservation services" as the cryopreservation of sperm, unfertilized oocytes, and ovarian tissue. This bill would require coverage of fertility preservation for a covered person who will receive a medically necessary treatment that may impair fertility. The coverage mandate applies to any medically necessary treatment, including surgery, chemotherapy, and radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility. The fertility preservation services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. The bill does not contemplate cost of long term storage and related costs if an enrollee no longer has coverage from a state regulated health plan.

TAHP POSITION: Oppose

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

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

MANDATE: Benefit

TAHP POSITION STATEMENT: The bill creates a new unfunded, mandated benefit, fertility preservation services for a covered person who will receive a treatment that may impair fertility. In the 86th legislative session, this same mandated benefit (HB 2682) would have increased Medicaid costs by $5.2 million a year and TRS-active care costs by $4 million a year. The LBB found that this benefit mandate would also increase health care costs to the TRS, UT systems and ERS health plans that would result in increased premiums and contributions from the state, employers, or members. Typical costs for fertility preservation services are in excess of $10,000 with hundreds more in added monthly storage charges. Government mandates and overregulation hinder innovation and add costs to an already expensive system. This expense is borne by employers and families through increasingly unaffordable premiums. Texas already ranks third in the nation when it comes to regulations that go beyond the federal requirements of the ACA.

UPDATED: 3/2 KS

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1285 Johnson, Nathan Newborn infant testing

Remarks: SUMMARY: Currently, birthing centers are required to provide newborn hearing screening, tracking, and intervention before a newborn can be discharged. This bill would add testing for congenital cytomegalovirus to that requirement.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1286 Schwertner, Charles Health claims affected by catastrophic event

Companions: HB 3196 Johnson, Ann(D) (Identical)
3-15-23 H Introduced and referred to committee on House Insurance

Remarks: SUMMARY: This bill would allow TDI to extend prompt payment deadlines to a later date due to a catastrophic event. It would also allow TDI to approve a request by a provider for an extension due to a catastrophic event

TAHP POSITION:

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1298 Hughes, Bryan Requests arbitration billing disputes

Remarks: SUMMARY: This bill would define bad faith in a balanced billing dispute as failing to provide the material facts necessary or failing to send a representative to the mediation. If a party engages in bad faith mediation, the opposing party may request arbitration. Upon the request, TDI would select an arbitrator and require a determination

not less than 30 days after the arbitrator receives the necessary information. Not later than 30 days after the arbitrator's written decision is provided, the issuer would be required to pay the facility.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Claims submitted after 1/1/24

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

Over 80% of mediation requests come from FSERs as these companies have hired vendors to go back years to find more claims to take to mediation. But even with this volume of claims, over 90% are resolved in an informal phone call and just 1% of claims remain unresolved after mediation. For those very small number of claims SB 1264 allowed providers to pursue a civil action. SB 1264 painstakingly envisioned all scenarios including bad faith mediation. This legislation goes against that legislation to reward freestanding ERs that have continuously price gouged for basic health care services including $10,000 COVID-19 Tests. DATE UPDATED: 3/5 KS 3/13 BH

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1306 Hancock, Kelly Surprise Billing ERISA Opt In

Companions: HB 1592 Oliverson, Tom(R) (Identical)
3- 3-23 H Introduced and referred to committee on House Insurance

Remarks: SUMMARY: This bill would allow sponsors of health benefit plans that are self-insured or self-funded under ERISA to elect to apply Texas' prohibition on balance billing.

TAHP POSITION: Neutral/Watch

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is neutral on this proposal to allow employers to decide if

they would prefer to use the state or federal balance billing dispute process as employers pay their own claims and the costs associated with the arbitration & mediation systems through either approach. However, TAHP continues to be concerned about inflationary provisions in the state's dispute resolution system which utilizes billed charges in an arbiters determination.

Billed charges are inflated prices that don't reflect what anyone actually pays for health care. As one researcher noted, "Billed charges are effectively just made up." Studies show taking billed charges into account during arbitration only incentivizes providers to make up higher and higher numbers. A new report by the Texas Department of Insurance found that average billed charges in arbitration increased by threefold from 2020 to 2022 resulting in final arbitration amounts more than doubling during the period. These costs ultimately drive up health care spending for businesses and families.

DATE UPDATED: 2/3/23 JB

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1307 Hancock, Kelly Multiple employer welfare arrangements

Companions: HB 290 Oliverson, Tom(R) (Identical)
3-14-23 H Voted favorably from committee on House Insurance

Remarks: SUMMARY: This bill would apply certain insurance mandates to MEWAs that provide comprehensive health plans. MEWAs would be subject to reserve requirements, asset protection requirements, the selection of providers chapter, and the utilization review chapter. A MEWA that provides a comprehensive health plan that is structured in the same way as a PPO/EPO would also be subject to Chapter 1301 (PPO plan requirements) and Chapter 1467 (surprise billing prohibition). The bill would also modify the application and eligibility requirements for a certificate of authority.

TAHP POSITION: Neutral

COVERAGE TYPES: MEWAs

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/1 KS

Last Action: 3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1359 | Schwertner, Charles | Telemedicine services

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

TAHP POSITION:

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

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

Last Action: 3-16-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1502 | Middleton, Mayes (F) | Health Plan Affiliated Providers

Companions: HB 3098 | Johnson, Ann(D) | (Identical)
3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

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

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

TAHP POSITION:

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/8 KS

Last Action: 3-16-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1534 | Schwertner, Charles | Non Compete Clauses

Remarks: SUMMARY: This bill would modify the law that applies to physician non-competes. Currently, non-competes must include a buy-out provision. This bill would require that the buyout amount not be greater than the physician's total annual salary at the time of termination. The bill would also require that non-competes expire within one year and that the geographic area subject to the restriction does not exceed five miles. The bill would also require any non-competes with dentists, nurses, and physician assistants to include a buyout amount of not great than their annual salary, that it expire in one year, and that the geographical radius not exceed five miles.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/12 KS

Last Action: 3-16-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1576 | Schwertner, Charles | Co-Pay Accumulator Prohibition Mandate

Companions: HB 999 | Price, Four(R) | (Identical)
3-23-23 H Meeting set for 8:00 A.M., E2.028, House Select on Health Care Reform

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

cost-sharing responsibility, or out-of-pocket maximum.

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

COVERAGE TYPES: Commercial

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

MANDATE: Contract

TAHP POSITION STATEMENT: Generic medications save Americans more than $300 billion per year. In order to control costs for employers and families, health plans steer patients to affordable generic options through lower out-of-pocket costs. That's a problem for drug companies whose primary goal is to keep patients hooked on higher cost brand name drugs. Copay coupons are utilized by drug manufacturers to encourage the use of expensive brand name drugs over cheaper generics, biosimilars, or therapeutic alternatives. Through coupons, a manufacturer aims to pay off the patient's out-of-pocket costs to encourage them to avoid lower cost alternatives and choose a brand name drug. Health insurers respond by only counting actual patient payments, not coupons, to the patient's out-of-pocket limits. The bill would allow health plans to continue this practice when a generic or biosimilar is available, however, the bill needs clarification to include "therapeutic alternatives" to high cost brand drugs.

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

Last Action: 3-16-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1580 — Bettencourt, Paul — Right to try cutting-edge treatments

Companions:

HB 4059	King, Ken(R)	(Identical)
	3- 8-23 H Filed	
HB 4348	Harrison, Brian(R)	(Identical)
	3- 9-23 H Filed	

Last Action: 3-16-23 S Introduced and referred to committee on Senate Health and Human Services

SB 1581 — Bettencourt, Paul — Establishment the Health Insurance Mandate

Remarks: SUMMARY: This bill would establish the Health Insurance Mandate Advisory Review Center (HIMARC) within the Center for Healthcare Data at UT Health Science Center at Houston. Regardless of whether the legislature is in

session, the lt. governor, speaker, or chair of an appropriate committee may request an analysis of a health insurance mandate. The analysis would include the extent to which the mandate increases total health care spending, the expected increase in utilization, the increase in administrative expenses to issuers and expenses to enrollees or sponsors, the cost to private sector and public sector policyholders, the extent to which the service is already covered, and relevant scientific evidence. The cost of administering the program would be paid for through fees assessed to health benefit plan issuers.

EFFECTIVE DATES: 1/1/24

TAHP POSITION: Support

POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to “Consider opportunities to leverage the Texas All-Payor Claims Database to determine the true cost impact of benefit mandates.” Texas lawmakers don’t have the information they need on the cost and impact of health insurance mandates and regulations on Texas employers and families. Texas regulations and mandates hinder innovation and add costs to an already expensive system—forcing employers and families to bear the cost of one-size-fits-all coverage. Each mandate raises costs that are passed on in higher premiums. In 2021, Texas reached a high-water mark for the number of mandates placed on health insurance. Following the session, Texans saw a 13% increase in premiums, while around the nation, year-over-year premiums were flat. Before approving a new mandate, other states have processes to carefully review the full impact of mandates on businesses and families, health care costs, and health needs. Those states arm lawmakers with the info they need to make informed decisions. The legislation would establish the Texas Health Insurance Mandate Advisory Review Committee (HIMARC). As drafted, it would live at the Center for Healthcare Data at The University of Texas Health Science Center at Houston, where they currently manage the All Payor Claims Database (APCD) and have the data and knowledge to do this level of review.

DATE UPDATED: 2/19 KS, 2/23 BH

Last Action: 3-16-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1621 | Kolkhorst, Lois | E-Verify for all employers

Companions:	HB 3846 Toth, Steve(R) (Identical) 3- 7-23 H Filed
Remarks:	SUMMARY: Requires all employers in the state to use E-Verify for new employees. Prohibits the state from contracting with vendors or subcontractors that do not use e-Verify. TAHP POSITION: In review EFFECTIVE DATES: Sept. 1, 2023. State agencies who contract with vendors have until Oct. 1, 2023 to establish procedures. DATE UPDATED: 3/8 by JL
Last Action:	3-16-23 S Introduced and referred to committee on Senate Business and Commerce

T SB 1623 Eckhardt, Sarah Coverage provision abortion and contraception

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

T SB 1666 Parker, Tan (F) Continuity of care

Companions:	HB 3985 Raney, John(R) (Identical) 3- 8-23 H Filed
Last Action:	3-16-23 S Introduced and referred to committee on Senate Health and Human Services

T SB 1723 Paxton, Angela Backdating referrals managed care health

Last Action:	3-16-23 S Introduced and referred to committee on Senate Health and Human Services

	All	Track
Total Bills:	179	179

Track(s): (Master List Only)
Position: (None)

Add to Track

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