The Texas Association of Health Plans

TAHP TRACKED BILLS - INSURANCE COMMITTEE

03-17-2023 - 07:21:39

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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

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 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

HB 389 Collier, Nicole Fertility preservation mandate

Companions:

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

Remarks:

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

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial

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

MANDATE: Benefit

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

costs by $4 million a year. The LBB found that this benefit mandate would also increase health care costs to the TRS, UT systems, and ERS health plans that would result in increased premiums and contributions from the state, employers, or members.

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

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

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

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

UPDATED: 2/3 BH

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

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

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

TAHP POSITION: Neutral as long as bill is not amended

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

EFFECTIVE DATES:9/1/23

MANDATE: Benefit

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

DATE UPDATED: 2/19 KS

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

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 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

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 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

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

HB 826 Lambert, Stan Permanent Formulary Freeze Mandate

Companions:

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

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

T 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

T 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

SB 1141	Schwertner, Charles(R)	Session) (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 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 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

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

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

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

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

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 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

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)

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 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 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 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

HB 1649 Button, Angie Chen Fertility Preservation Mandate

Companions:

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

Remarks:

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

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial

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

MANDATE: Benefit

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

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

UPDATED: 2/3 BH

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

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)

SB 1043	3- 1-23 S Introduced and referred to committee on Senate Health and Human Services 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- 7-23 H Introduced and referred to committee on House Insurance

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 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 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

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 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

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 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 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 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 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

	All	Track
Total Bills:	61	61

Track(s): (Master List Only)

Position: (None)

Add to Track