The Texas Association of Health Plans

TAHP TRACKED BILLS - INSURANCE COMMITTEE

03-03-2023 - 10:43:30

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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: 2-23-23 H Introduced and referred to committee on 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) i

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)
2-28-23 S Filed		

Remarks:

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

TAHP POSITION: Neutral

COVERAGE TYPES: MEWAs

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/1 KS

Last Action: 3- 7-23 H Meeting set for 8:00 A.M., E2.014, 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: Opposed, but 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 specific 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 Meeting set for 8:00 A.M., E2.014, House Insurance

HB 389 Collier, Nicole Fertility preservation mandate

Companions:	HB 1649	Button, Angie Chen(R)	(Identical)
		1-25-23 H Filed	
	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

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.

Every Texan needs routine access to primary care to manage chronic conditions, treat routine

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

DATE UPDATED: 3/3/23 BH

Last Action: 3- 7-23 H Meeting set for 8:00 A.M., E2.014, 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)
2-23-23 S Filed

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)
2-23-23 S Filed

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)
		2-27-23 S Filed	

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

HB 838 Gonzalez, Jessica Expands Fertilization Donors

Companions:

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

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

TAHP POSITION: Neutral

COVERAGE TYPES: Group (commercial) plans

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

MANDATE: Benefit

DATE UPDATED: 2/1 KS

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

HB 839 Gonzalez, Jessica No PA mandate for infectious diseases

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

TAHP POSITION: Oppose

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

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

MANDATE: Plan Design

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

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

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

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

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

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

Appealable : Providing extensive rights to appeal to an independent physician

DATE UPDATED: 2/1 KS

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

HB 895 Munoz, Sergio Prohibits Extrapolation for FWA audits

Companions:

SB 519	Schwertner, Charles(R)	(Refiled from 87R Session)
SB 1141	Schwertner, Charles(R) 2-23-23 S Filed	(Identical)

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 contraception 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- 2-23 H Introduced and referred to committee on 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: HB 1026 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) 2-23-23 S Filed

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 Availability benefits under health plan

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: HB 1026 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

	All	Track
Total Bills:	26	26

Track(s): (Master List Only)
Position: (None)

Add to Track