The Texas Association of Health Plans

TAHP TRACKED BILLS - SELECT COMMITTEE

03-17-2023 - 07:13:52

T - *Indicates **Tracked** Legislation*

Select All Deselect All

T HB 12 Rose, Toni 12 months postpartum Medicaid coverage

Remarks: SUMMARY: Extends continuous eligibility for pregnant and postpartum women to not less than 12 months from 60 days. Retains current statute that allows for continuous eligibility for postpartum women for 6 months after the date the women delivers or experiences an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

TAHP POSITION STATEMENT: How we administer Medicaid pregnancy coverage dramatically affects the overall wellbeing of Texas mothers and infants. Unfortunately, we rank 15th nationally for maternal mortality with even more significant disparities in minority communities. The postpartum period is critical, and longer coverage allows for continued access to essential health services and preventative care, reducing maternal health complications that arise after the 60-day limit. Texas should join the majority of states and extend Medicaid postpartum coverage to a full year.

DATE UPDATED: 2/26 by JL

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

HB 25	Talarico, James	Wholesale prescription drug importation

Remarks:

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

TAHP POSITION: Support

EFFECTIVE DATE: 9/1/23

DATE UPDATED: 2/3 JB 2/21 JL

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

HB 56	Ortega, Lina	12 month postpartum Medicaid coverage

Remarks:

SUMMARY: Extends continuous eligibility for pregnant and postpartum women to not less than 12 months from 60 days. Repeals language passed last session in HB 133 that limits eligibility to pregnant women who deliver or experience an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

TAHP POSITION STATEMENT: How we administer Medicaid pregnancy coverage dramatically affects the overall wellbeing of Texas mothers and infants. Unfortunately, we rank 15th nationally for maternal mortality with even more significant disparities in minority communities. The postpartum period is critical, and longer coverage allows for continued access to essential health services and preventative care, reducing maternal health complications that arise after the 60-day limit. Texas should join the majority of states and extend Medicaid postpartum coverage to a full year.

DATE UPDATED: 1/10 by JL

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

HB 132	Bucy, John	Medicaid expansion

Companions:	HJR 7	Bucy, John(D)	(Enabling)
		2-28-23 H Introduced and referred to committee on House Select on Health Care Reform	
	SB 39	Zaffirini, Judith(D)	(Identical)
		2-15-23 S Introduced and referred to committee on Senate Health and Human Services	
	SB 71	Johnson, Nathan(D)	(Identical)
		2-15-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: Expands Medicaid to all individuals eligible under the ACA. Requires HHSC to produce a report on expanded eligibility. Requires a constitutional amendment.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Jan. 1, 2024

DATE UPDATED: 1/9 by JL

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

HB 204 Bernal, Diego Medicaid Expansion

Companions:	HB 143	Bernal, Diego(D)	(Refiled from 87R Session)

Remarks: SUMMARY: Requires HHSC to request an amendment to the 1115 waiver to expand Medicaid to counties that request it. Allows counties to expand Medicaid to all individuals eligible under the ACA. The waiver must also identify the sources of money to be used to pay the state's share, but the bill is silent on which entity is required to pay the state's share.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Effective immediately if it receives two-thirds vote, otherwise Sept. 1, 2023

DATE UPDATED: 1/11 by JL

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

HB 226 Bernal, Diego Medicaid expansion

Companions:

SB 72	Johnson, Nathan(D)	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	
SB 671	West, Royce(D)	(Identical)
	2-17-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks:

SUMMARY: Expands Medicaid to all individuals eligible under the ACA. Gives HHSC rulemaking authority. Requires HHSC to produce a report on expanded eligibility.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Jan. 1, 2024

DATE UPDATED: 3/7 by JL

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

HB 487 Thompson, Senfronia 12 month postpartum Medicaid coverage

Companions:

HB 1824	Thierry, Shawn(D)	(Identical)
	3- 7-23 H Introduced and referred to committee on House Select on Health Care Reform	

Remarks:

SUMMARY: Builds on HB 133 last session by extending postpartum coverage to 12 months from six months and removes language passed last session in HB 133 that limits eligibility to pregnant women who deliver or experience an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: How we administer Medicaid pregnancy coverage dramatically affects the overall wellbeing of Texas mothers and infants. Unfortunately, we rank 15th nationally for maternal mortality with even more significant disparities in minority communities. The postpartum period is critical, and longer coverage allows for continued access to essential health services and preventative care, reducing maternal health complications that arise after the 60-day limit. Texas should join the majority of states and extend Medicaid postpartum coverage to a full year.

DATE UPDATED: 11/15 by JL

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

HB 512 Bernal, Diego Medicaid expansion

Companions:

HB 171	Bernal, Diego(D)	(Refiled from 87R Session)
HB 389	Israel, Celia(D)	(Refiled from 87R Session)
HB 398	Bucy, John(D)	(Refiled from 87R Session)
HB 4406	Ramos, Ana-Maria(D)	(Refiled from 87R Session)
SB 38	Zaffirini, Judith(D)	(Refiled from 87R Session)
SB 118	Johnson, Nathan(D)	(Refiled from 87R Session)

Remarks: SUMMARY: Expands Medicaid to all individuals eligible under the ACA. Requires HHSC to produce a report on expanded eligibility. Requires a constitutional amendment.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Jan. 1, 2024

DATE UPDATED: 1/11 by JL

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

HB 592 Shaheen, Matt Telehealth Across State Lines

Remarks: SUMMARY: This bill allows health professionals that are licensed in a different state to provide telemedicine and telehealth services in Texas if they hold an unrestricted license, have not been subject to disciplinary proceedings, and register with the applicable licensing agency in Texas. It would also add mental health providers to the definition of "health professional" in the telemedicine chapter of the insurance code.

TAHP POSITION: Support

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

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

DATE UPDATED:2/3/23 JB

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

HB 617 Darby, Drew Emergency telemedicine pilot

Companions: SB 251 Alvarado, Carol(D) (Identical)
2-15-23 S Introduced and referred to committee on Senate Health and Human Services

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

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 -KS

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

HB 633 Frank, James Lowest Contract Rate For Uninsured

Remarks: SUMMARY: The bill provides that a physician or provider may not be prohibited from accepting directly from an enrollee full payment for a health care service in lieu of submitting a claim to the enrollee's health benefit plan. Notwithstanding section 552.003 or any other law, the charge for a health care service for which a physician or provider accepts a payment in lieu of submitting a claim to the enrollee's health benefit plan, or from a patient without insurance, may not exceed the lowest contract rate for the service allowable under any health benefit plan with which the physician or provider is in-network.

TAHP POSITION: Support

COVERAGE TYPES: Commercial, ERS/TRS

EFFECTIVE DATES: 9/1/23

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

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

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

HB 652 Johnson, Julie Medicaid expansion

Companions: SB 195 Johnson, Nathan(D) (Identical)
2-15-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Requires HHSC to request an 1115 waiver to implement the Live Well Texas program

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

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/11 by JL

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

HB 700 Oliverson, Tom Health Insurance Exchange

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

Remarks: SUMMARY: This bill would create the Texas Health Insurance Exchange. It would be an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange, as authorized by the ACA. The exchange would have an eleven-member board, with five appointed by the governor, three by the lieutenant governor, and three by the governor from a list provided by the speaker. The board would employ an executive director and other necessary employees to assist the exchange in carrying out its functions. The board would not have any providers or issuers on it, but the board could create an advisory committee to allow for the involvement of health insurance industries and other stakeholders, which would provide recommendations to the board. The exchange may provide an integrated uniform consumer directory of health care providers and which issuers the provider contracts with. The exchange could also establish methods for health care

providers to transmit relevant data, rather than an issuer. Not later than July 1, 2024, the exchange would be required to make recommendations to the Senate Business and Commerce Committee and the House Insurance Committee regarding the feasibility of implementing a subsidy program for individuals, families, and small employers to purchase coverage. With the input and approval of those committees, the exchange may develop and implement the subsidy program. The board would also make recommendations on state innovation waivers to the Senate Business and Commerce Committee and House Health Insurance committee, including recommendations on risk stabilization, coverage arrangements for employees, financial assistance for different types of coverage, including non-qualified health plans, and the establishment of account-based premium credits. With the input and approval from the legislative committees, the exchange would be able to apply for necessary federal waivers. For the purposes of the chapter, small employers would include entities that employ at least two and on average no more than 50 employees during the preceding calendar year until 2025, and then no more than 100 employees starting in 2026. That calculation would include part-time employees who are not eligible for coverage through the employer. The exchange may charge issuers an assessment of reasonable and necessary fees to cover the exchange's organizational and operating expenses. The exchange may also accept grants from a public or private organization and accept federal funds, but general revenue may not be appropriated for the exchange. Assessments, gifts or donations, and any federal funding would be stored in a trust fund outside the state treasury. The exchange would be required to provide a detailed financial report to the governor, the legislature, and HHSC not later than January 31 of each year. TAHP POSITION: Neutral with changes to ensure market stability and state read iness.

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

COVERAGE TYPES: Commercial

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

POSITION STATEMENT: Texas made substantial gains in increasing access to insurance coverage. The number of Texans with marketplace plans doubled in the last two years and 15 plans are offering coverage in Texas—a record number. Policies like a state-based exchange or 1332 coverage waiver could build on these successes

but should not be implemented in a way that would create market instability, increase costs, or reduce competition and access. The state should look for reforms in the insurance market that further reduce the uninsured and lower costs.

DATE UPDATED: 2/22 KS 3/15 BH

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

HB 711 Frank, James Prohibits Anticompetitive Contracting

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

TAHP POSITION: Support

COVERAGE TYPES: Commercial, ERS/TRS

EFFECTIVE DATES: 9/1/23

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

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

Last Action: 2-28-23 H Introduced and referred to committee on House Select on Health Care Reform

HB 932 Dutton, Harold Medicaid expansion

Companions:

HB 1189	Dutton, Harold(D)	(Refiled from 87R Session)
HB 3962	Morales, Eddie(D)	(Identical)

3- 7-23 H Filed

Remarks: SUMMARY: Expands Medicaid eligibility to include the working parent of a dependent child who applies for the assistance, and for whom federal matching money is available.

TAHP POSITION: Neutral

COVERAGE: Medicaid

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

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

HB 999 Price, Four Co-Pay Accumulator Prohibition Mandate

Companions:

SB 1576	Schwertner, Charles(R)	(Identical)

3-16-23 S Introduced and referred to committee on Senate Health and Human Services

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

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

COVERAGE TYPES: Commercial

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

MANDATE: Contract

TAHP POSITION STATEMENT: Generic medications save Americans more than $300

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

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

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

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

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

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

TAHP POSITION: Support

COVERAGE TYPES: Commercial

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

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Establish new alternative coverage option that allows insurers to offer 'Consumer Choice' plans that forego certain state-imposed regulations and mandates." Texas should build more affordable insurance coverage options that avoid over-regulation and excessive mandates. New health care products added last session avoid government mandates and provide more choices for some Texans. n the past, Texans had mandate-lite insurance options through the

Consumer Choice of Benefits model, but that's been eroded by a continuous stream of new mandates over two decades. Updated "Consumer Choice" plans would be similar to new affordable alternatives established through the Farm Bureau and Texas Mutual, but there are a few key differences. These plans would still be considered insurance under state law, meaning that they would be required to meet solvency requirements, be subject to TDI oversight, and meet federal benefit and coverage requirements like pre-existing conditions protections and medical loss ratio rules required by the Affordable Care Act. Additionally, HB 1001 indicates that these plans must also meet any requirements imposed on the coverage elected officials and state employees have through ERS.

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

HB 1062 Guerra, Bobby — Medicaid expansion

Companions:

HB 2903	Martinez Fischer, Trey(D)	(Identical)
	3-14-23 H Introduced and referred to committee on House Select on Health Care Reform	
SB 125	Alvarado, Carol(D)	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: Expands Medicaid to all individuals eligible under the ACA. TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/3

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

HB 1144 Reynolds, Ron — Medicaid block grant - Expansion

Companions:

HB 922	Reynolds, Ron(D)	(Refiled from 87R Session)

Remarks: SUMMARY: Establishes a future mechanism for a block grant funding for Medicaid, which would allow for Medicaid eligible individuals to use subsidies to purchase insurance on the Marketplace. Would allow for any health plan to participate as a managed care plan and establish minimum coverage requirements. Requires a

reform of long-term services and supports (limited guidance). Requires HHSC and TDI to implement a program that helps connect low-income Texans with health benefit plan coverage through private market solutions. Requires HHSC to develop and implement customized benefits packages designed to prevent the overutilization of services for individuals receiving home and community-based services. Creates a demonstration project for dually eligible individuals to receive long-term services and supports under both Medicaid and Medicare through a single managed care plan. Requires HHSC to provide housing payment assistance for recipients receiving home and community-based services and supports. Grants rulemaking authority to HHSC for implementation.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/1 by JL

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

HB 1283 Oliverson, Tom PDL carve-out

Companions: SB 1113 Hughes, Bryan(R) (Identical)
3- 9-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Permanently carves out the management of the PDL by MCOs. TAHP POSITION: Oppose

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: HB 1283 is inconsistent with Select House Committee on Health Care Reform's recommendation to "Ensure that Medicaid prescription drugs maintain continuity of care for members who move between managed care plans and minimizes administrative burden for physicians." Under a permanent carve out, physicians and patients experience significant hurdles with non-medical switching and prior authorizations. While Texans in commercially insured products have step therapy protections, Medicaid enrollees do not.

TAHP opposes any further delays in the PDL carve-in. Pharmaceutical companies have already delayed this implementation for 10 years through

heavy lobbying. It is crucial that Texas prioritize improving patient care and saving taxpayer dollars over protecting Pharma profits. Further delays will continue to harm health outcomes and timely access to prescription drugs, negatively impact efforts to modernize and improve patient outcomes, and substantially increase Medicaid costs for taxpayers.

It is worth noting that prior to 2011, Medicaid drug costs in Texas were out of control, almost doubling in a decade and growing more than 6.5% on average each year. In response, the legislature passed SB 7, which carved prescription drug coverage into managed care in order to slow the rapid growth in Medicaid drug spending. This measure was successful in reducing drug cost growth in Texas Medicaid by 50%.The second step in this process, allowing managed care organizations (MCOs) to develop formularies and PDLs, was originally scheduled for 2013 but has been repeatedly delayed due to pharmaceutical company lobbying. A Center for Public Integrity and NPR investigation found that these companies have a history of successfully lobbying state Medicaid drug boards in order to boost their profits and waste taxpayer dollars. Under the current system, the state chases rebate dollars from big drug companies, resulting in a formulary that is heavily reliant on brand name drugs rather than cheaper generics. This creates administrative burdens for physicians, pharmacists, and insurers, and leads to frustrations and delays in access to necessary prescription drugs for patients. It is clear that the current system is not working for Texas patients, doctors, or taxpayers. But patients really suffer. Medicaid families lack consumer protections that exist in the commercial market. Patients are routinely forced off of medications when they are stable and physicians are put through excessive administrative burdens. In testimony, physicians have called the state's formulary "nonsensical", "counterintuitive", and "just nuts". Allowing MCOs to fully manage the PDL will provide a more stable drug benefit that better reflects what physicians routinely prescribe and pharmacists stock. It will also give MCOs the tools they need to control costs and improve health outcomes, as is done in the private market and in Medicare.

Texas patients deserve better access to prescription drugs, and it is crucial that we prioritize their needs and well-being. By supporting the planned implementation of full PDL management by MCOs, we can save taxpayer dollars, improve patient care, and modernize our Medicaid system.

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

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

HB 1364 Munoz, Sergio OON Out of Pocket Cost Mandate

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

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

TAHP POSITION: OPPOSED without guardrails added

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

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

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

of-pocket maximums, so the bill does not make sense in those contexts. TAHP supports encouraging patients to shop for lower cost, medically necessary services and would not oppose legislation that rewards that shopping. However, the bill lacks the necessary guardrails to ensure that the result of the bill is to reward patients that find lower cost services.

DATE UPDATED: 3/7 KS

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

HB 1377 Walle, Armando 24 months postpartum Medicaid coverage

Remarks: SUMMARY: Extends continuous eligibility for pregnant and postpartum women to not less than 24 months from 60 days. Repeals language passed last session in HB 133 that limits eligibility to pregnant women who deliver or experience an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: Healthy women lead to healthier mothers and children. In fact, research concludes that extending coverage improves health outcomes. However, six months postpartum, 77% of women on Texas Medicaid become uninsured and only 16% remain enrolled in the program for a full 12 months. This is alarming because 13% of women report a negative change in their health at either the 6- or 12-month mark. An important way to improve maternal health is to ensure access to health care coverage post-delivery. Texas Medicaid currently covers more than 50% of births in Texas. Providing Medicaid access to low-income mothers for a longer period also promotes continuity and access to preventive services such as contraception and intrapartum care. Texas should provide full coverage for women on Medicaid a full 12 months post-delivery to improve maternal health and ensure healthier babies.

DATE UPDATED: 1/29/23 by JL

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

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

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

TAHP POSITION: Support

TAHP POSITION STATEMENT: While quality of care plays an important role, health outcomes are also driven by the conditions that people live, learn, work, and play. Individuals with inadequate access to food are at greater risk of developing chronic conditions and managing these conditions. They also utilize more services and face increased health care costs that might otherwise be avoidable. These conditions are known as non-medical drivers of health and can drive as much as 80% of health outcomes.

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

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

T HB 1575 Hull, Lacey NDOH Screening for pregnant women in Medicaid

Remarks: SUMMARY: Requires HHSC to adopt standardized assessment questions designed to screen for, identify, and aggregate data regarding nonmedical health-related needs of pregnant women who are eligible for Medicaid or the alternatives to abortion program. Service coordination benefits must include identifying and coordinating the provision of non-covered services, community supports, and other resources an MCO or provider has determined will improve health outcomes. MCO must use screening findings to determine if more services are needed.

TAHP POSITION: Support

TYPES OF COVERAGE: Medicaid

DATES EFFECTIVE: Sept. 1, 2023

DATE UPDATED: 3/14 by JL

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

HB 1578 Allison, Steve Health literacy plan

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

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

TAHP POSITION: Support

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

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

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

HB 1599 Bucy, John Express lane eligibility

Remarks: SUMMARY: Requires HHSC to enroll children who are eligible for CHIP, SNAP, or other programs, as determined by the submission of any eligibility applications.

TAHP POSITION: Support

EFFECTIVE DATES: Sept.1, 2023

TAHP POSITION STATEMENT: The CHIP Reauthorization Act of 2009 (CHIPRA) created an

express lane eligibility option for states as an important new avenue to ensure that children eligible for Medicaid or CHIP have a fast and simplified process for having their eligibility determined or renewed.

DATE UPDATED: 3/12 by JL

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

HB 1641 Meza, Terry Medicaid expansion for mental illness

Remarks: SUMMARY: Requires Medicaid expansion to individuals with bipolar disorder, dysthymia, schizophrenia, or severe chronic depression and whose family income does not exceed 133% of the federal poverty level, if federal matching funds are available.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/1 by JL

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

HB 1692 Frank, James Prohibits Abusive Facility Fees

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

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

TAHP POSITION: Support

EFFECTIVE DATES:Immediate or 9/1/23

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Explore ways to prohibit hospitals from charging facility

fees for services not provided on a hospital's campus."

Hidden facility fees are the latest negative trend in health care. The original purpose of a facility fee was to help hospitals cover the stand-by costs associated with emergency departments and inpatient care. However, as health systems have expanded and acquired physician practices, these facility fees have been inappropriately applied to outpatient medical bills. The fees are also one of the primary components of outrageous freestanding emergency room bills including price gouging for COVID-19 tests. After physician group acquisition, hospital systems may add facility fees to the groups bills even though the practice location hasn't changed and isn't physically connected in any way to a hospital. In one example, the cost of a woman's arthritis treatment increased by 1000% when a hospital system takeover added a facility fee to the bill. While the treating physician and the practice location had not changed, the billing codes did. The hospital system explained that they moved the infusion clinic from an "office-based practice" to a "hospital-based setting" as the excuse for adding the facility fee. Providers are even charging facility fees in some instances for telehealth visits.

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

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

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

HB 1824 Thierry, Shawn 12 months postpartum

Companions:

HB 487	Thompson, Senfronia(D) (Identical) 2-23-23 H Introduced and referred to committee on House Select on Health Care Reform

Remarks: SUMMARY: Builds on HB 133 last session by extending postpartum coverage to 12 months from six months and removes language passed last session in HB 133 that limits eligibility to pregnant women who deliver or experience an involuntary miscarriage.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: How we administer Medicaid pregnancy coverage dramatically affects the overall wellbeing of Texas mothers and infants. Unfortunately, we rank 15th nationally for maternal mortality with even more significant disparities in minority communities. The postpartum period is critical, and longer coverage allows for continued access to essential health services and preventative care, reducing maternal health complications that arise after the 60-day limit. Texas should join the majority of states and extend Medicaid postpartum coverage to a full year.

DATE UPDATED: 2/10 by JL

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

HB 1958 Thierry, Shawn Expands Maternal Review Committee

Remarks: SUMMARY: Expands the Texas Maternal Mortality and Morbidity Review Committee to include an MCO and additional provider types. Allows for voluntary and confidential reporting of pregnancy-associated deaths and pregnancy-related deaths. Establishes a work group to establish a secure maternal mortality and morbidity data registry and allows DSHS to establish rules for implementation. Requires a report on the establishment of the registry and any recommendations. Also establishes a doula pilot program in Medicaid and a report of the pilot's outcomes by 2028.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATE: immediately if it receives a two-thirds vote, or Sept. 1, 2023

DATE UPDATED: 2/11 by JL

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

HB 2002 Oliverson, Tom OON Deductible Mandate

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

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

COVERAGE TYPES: PPO/EPO

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

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

DATE UPDATED: 3/8 BH

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

HB 2047 Zwiener, Erin Medicaid expansion for under 26

Remarks: SUMMARY: Expands Medicaid eligibility for individuals under 26. TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 2/11 by JL

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

on House Select on Health Care Reform

HB 2080 Jetton, Jacey — Out of State Nurses

Companions:

HB 1780	Jetton, Jacey (F)(R)	(Refiled from 87R Session)
SB 963	Hughes, Bryan(R)	(Refiled from 87R Session)

Remarks:

SUMMARY: This bill would allow physicians and nurses who have a license in good standing in another state to practice in Texas after notifying the applicable Texas state board. It would require Texas state boards to identify states that have substantially similar licensing requirements, making their licensees eligible to practice in Texas.

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

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

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

Remarks:

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

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

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

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

HB 2124 Gonzalez, Jessica Medicaid expansion

Remarks: SUMMARY: Expands eligibility to include individuals who entered the US on or after August 22, 1996; and have resided in the US for a period of five years after entering as a qualified alien.

TAHP POSITION: Neutral

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 2/11 by JL

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

HB 2180 Harris, Cody Point of Sale Rebate mandate

Remarks: SUMMARY: This bill would require an enrollee's cost sharing amount for prescription drugs to be calculated at the point of sale, and that price would have to be reduced by any rebates that issuer or PBM receives for the prescription.

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

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

EFFECTIVE DATES: 9/1/23

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

TAHP agrees something must be done to lower prescription drug prices. However, taking away employer choice is the wrong way and TAHP opposes the bill without an amendment that the full amount of the rebate go to reduce costs or

premiums for the policyholder. This amendment would align the bill with the recommendation from the House Select Committee on Healthcare Reform's interim report to "Consider opportunities to ensure rebates are used to lower the cost of coverage".

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

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

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

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

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

HB 2216 Cortez, Philip 1 year Medicaid continuous eligibility

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

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

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/19 by JL

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

HB 2551 Shaheen, Matt Licensing regulation associate physicians

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

TAHP POSITION: Neutral

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

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

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

HB 2554 Oliverson, Tom Health Insurance Exchange

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

Health Care Reform

Remarks:

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

exchange. Assessments, gifts or donations, and any federal funding would be stored in a trust fund outside the state treasury. The exchange would be required to provide a detailed financial report to the governor, the legislature, and HHSC not later than January 31 of each year. TAHP POSITION: Neutral with changes to ensure market stability and state readiness.

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

COVERAGE TYPES: Commercial

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

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

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

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

HB 2556 Oliverson, Tom Licensing regulation physician graduates

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

TAHP POSITION: Neutral

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

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

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

HB 2587 Howard, Donna — Breast and cervical cancer FPL

Remarks: SUMMARY: Establishes a ceiling for breast and cervical cancer services to women with family income of 250% above federal poverty level standards (currently 200% FPL).

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATE: Immediate if it receives a 2/3 vote, otherwise Sept. 1, 2023

DATE UPDATED: 2/24 by JL

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

HB 2873 Howard, Donna — Maternal health strategic plan

Remarks: SUMMARY: Requires HHSC to develop and implement a single strategic plan for improving maternal health outcomes within existing programs. The strategic plan must address perinatal depression, hyperemesis gravidarum, and other major pregnancy-related health complications; improve the quality of maternal health care under Medicaid for Pregnant Women, CHIP perinatal; and reduce pregnancy-related deaths. HHSC must produce the strategic plan every two years. Accordingly, the bill repeals duplicative reports on pregnancy-related deaths, severe maternal morbidity, and postpartum depression; the postpartum strategic plan; hyperemesis gravidarum strategic plan; report on statewide initiative to improve the quality of health care in managed care; report on actions to address maternal mortality rates; and report on prenatal and postpartum care through teleservices.

TAHP POSITION: Support

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/15 by JL

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

HB 2903 Martinez Fischer, Trey — Medicaid expansion

Companions: HB 1062 Guerra, Bobby(D) (Identical)

SB 125	Alvarado, Carol(D)	3- 2-23 H Introduced and referred to committee on House Select on Health Care Reform (Identical) 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

Remarks: SUMMARY: Expands Medicaid to all individuals eligible under the ACA. Provides rulemaking authority to HHSC.

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Jan. 1, 2024

DATE UPDATED: 3/4 by JL

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

HB 3026 Oliverson, Tom — Administration prescription drug manufacturer

Remarks: SUMMARY: HHSC is currently required to establish and administer a prescription drug savings program. This bill would make doing so permissive. HHSC would instead be required to create a prescription drug assistance program. HHSC would oversee implementation of the program, and would be allowed to contact with a third-party to administer it. HHSC would integrate assistance programs by drug manufacturers and other third parties into the program. HHSC would create a community outreach program to provide education to the public on eligibility. A person would be eligible if they meet criteria as determined by a drug manufacturer or another third-party prescription assistance program. The program would be funded by state and federal appropriations. The third-party administrator would be required to report to HHSC, and HHSC would provide annual reports to the legislature on implementation.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 3/5 KS

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

HB 3077 Jones, Jolanda (F) — Medicaid postpartum depression services

Remarks: SUMMARY: Requires screening and treatment for postpartum depression for 12 months following childbirth or a miscarriage in CHIP Perinatal and

Medicaid. Gives HHSC rulemaking authority. Also extends Medicaid for Pregnant Women to 12 months for women who give birth or experience a miscarriage.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid, CHIP Perinatal

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/5 by JL

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

HB 3226 Allison, Steve — Live Well Texas

Remarks: SUMMARY: Requires HHSC to seek an 1115 waiver for the Live Well Texas program. The program would provide high-deductible coverage for eligible adults between 19-65 with an emphasis on producing better health outcomes, requiring unemployed individuals to actively seek work, and creating incentives for participants to transition from receiving public assistance benefits to achieving stable employment. The program is not an entitlement program, but HHSC is required to coordinate the program with Medicaid. Eligible individuals must not be eligible for Medicaid or Marketplace Insurance.

TAHP POSITION: Neutral

DATE EFFECTIVE: Immediately if it receives a 2/3 vote, otherwise Sept. 1

DATE UPDATED: 3/15 by JL

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

HB 3237 Campos, Liz — Mixed status families outreach for Medicaid

Companions:

SB 2069	Menendez, Jose(D)	(Refiled from 87R Session)
SB 630	Menendez, Jose(D)	(Identical)
	2-17-23 S Introduced and referred to committee on Senate Health and Human Services	

Remarks: SUMMARY: Requires HHSC to conduct a public outreach and education campaign to educate and inform mixed-status families about eligibility requirements under Medicaid and CHIP.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/5 by JL

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

HB 3267 Talarico, James Medicaid buy-in program

Companions: HB 4084 Talarico, James(D) (Refiled from 87R Session)

Remarks: SUMMARY: Establishes a new Medicaid buy-in program. Requires HHSC to establish rules regarding income eligibility, a requirement that the individual not be eligible for Medicaid and a requirement that the individual not have access to an alternative health plan, including an employer-sponsored plan. The program must be substantially identical to the existing Medicaid buy-in program, except to the extent there may be differences based on populations served and the plan is not required to include nonmedical transportation services.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Immediately if it receives a 2/3 vote,, otherwise Sept. 1, 2023

DATE UPDATED: 3/6 by JL

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

HB 3286 Klick, Stephanie Step therapy protections under Medicaid

Companions: SB 2201 Hancock, Kelly(R) (Identical)
3- 9-23 S Filed

Remarks: SUMMARY: Establishes step therapy protocols and protections that exist on the commercial market. Requires a process through which a step therapy protocol exception request may be submitted by a provider. Step therapy protocol requires a patient to use a prescription drug or sequence of drugs other than the drug the physician recommends before a MCO provides coverage for the recommended drug. Exceptions include if the drug is contraindicated, will likely cause an adverse reaction, is expected to be ineffective, the patient previously tried the drug and it caused a reaction or was ineffective or had a diminished effect. There are also exceptions if

the drug is not in the best interest of the patient or if the member is stable on the drug. MCOs must respond to provider exceptions within 72, or 24 hours if the drug required by step therapy is expecting to cause harm or serious death of the patient. Finally, the bill requires MCOs to post their preferred drug lists online.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid, CHIP

EFFECTIVE DATE: Sept. 1, 2023

TAHP POSITION STATEMENT: Many Texans on Medicaid are required to follow strict step therapy requirements for medications on the state's Medicaid preferred drug list. This restricts their access to necessary medications and can lead to serious health consequences. In contrast, patients in the commercial market have access to mandatory exception processes to step therapy. Health plans in the private market must grant an exception to their step therapy protocol for a patient who is stable on a drug if the change is expected to be ineffective or cause harm to the patient. Unfortunately, Texas Medicaid patients do not have these same protections, and are often forced off of medications that are working for them.

For example, if a patient on Medicaid requires a non-preferred drug that is not on the state's Medicaid preferred drug list, they may have to try and fail on several other medications before being able to access the necessary medication. This process can be time-consuming, expensive, and, in some cases, even dangerous. Furthermore, if a patient is stable on a particular medication, they may still be forced to switch to a different medication simply because it is on the preferred drug list.

This lack of step therapy protections for Texas Medicaid patients creates barriers to accessing necessary medications and can lead to serious health consequences. To address this issue, this bill will add step therapy exceptions protections to the Texas Medicaid program. This will give Medicaid patients the same mandatory exception processes to step therapy as patients in the commercial market, ensuring they have access to the necessary medications they need.

DATE UPDATED: 3/6 by JL

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

T HB 3317	Frank, James	Direct Primary Care for FQHC

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

Remarks:

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

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

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

TAHP POSITION: Neutral

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED: 3/8 KS

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

N HB 3626	Lalani, Suleman (F)	Maternal health care workforce campaign

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

T HJR 7	Bucy, John	Medicaid eligibility

Companions:	HJR 9	Reynolds, Ron(D)	(Refiled from 87R Session)
	HJR 23	Israel, Celia(D)	(Refiled from 87R Session)
	HJR 24	Bucy, John(D)	(Refiled from 87R Session)
	SJR 11	Zaffirini, Judith(D)	(Refiled from 87R Session)
	SJR 14	Johnson, Nathan(D)	(Refiled from 87R Session)
	HB 132	Bucy, John(D)	(Enabling)
		2-23-23 H Introduced and referred to committee on House Select on Health Care Reform	

Last Action: 2-28-23 H Introduced and referred to committee on House Select on Health Care Reform

HJR 17 Bernal, Diego Medicaid expansion

Companions:	HJR 9	Reynolds, Ron(D)	(Refiled from 87R Session)
	HJR 23	Israel, Celia(D)	(Refiled from 87R Session)
	HJR 24	Bucy, John(D)	(Refiled from 87R Session)
	SJR 11	Zaffirini, Judith(D)	(Refiled from 87R Session)
	SJR 14	Johnson, Nathan(D)	(Refiled from 87R Session)
	HB 512	Bernal, Diego(D)	(Enabling)
		2-23-23 H Introduced and referred to committee on House Select on Health Care Reform	

Last Action: 2-28-23 H Introduced and referred to committee on House Select on Health Care Reform

HJR 117 Reynolds, Ron Proposing constitutional amendment expand

Companions:	HJR 9	Reynolds, Ron(D)	(Refiled from 87R Session)

HJR 23	Israel, Celia(D)	(Refiled from 87R Session)
HJR 24	Bucy, John(D)	(Refiled from 87R Session)
SJR 11	Zaffirini, Judith(D)	(Refiled from 87R Session)
SJR 14	Johnson, Nathan(D)	(Refiled from 87R Session)
HJR 7	Bucy, John(D)	(Identical)
	2-28-23 H Introduced and referred to committee on House Select on Health Care Reform	

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

	All	Track
Total Bills:	54	53

Track(s): (Master List Only)

Position: (None)

Add to Track