The Texas Association of Health Plans

TAHP TRACKED REPORT - SENATE HHS

03-17-2023 - 07:18:36

Select All Deselect All

SB 25 Kolkhorst, Lois — Support nursing- postsecondary education

Last Action: 3-13-23 S Introduced and referred to committee on Senate Health and Human Services

SB 39 Zaffirini, Judith — Medicaid expansion

Companions:

HB 132	Bucy, John(D)	(Identical)
	2-23-23 H Introduced and referred to committee on House Select on Health Care Reform	
SB 71	Johnson, Nathan(D)	(Identical)
	2-15-23 S Introduced and referred to committee on Senate Health and Human Services	
SJR 6	Zaffirini, Judith(D)	(Enabling)
	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: 11/15 by JL

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

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

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

Remarks:

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

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

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

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

EFFECTIVE DATES: September 1, 2023

DATE UPDATED: 2/3 KS

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

SB 71 Johnson, Nathan Medicaid expansion

Companions:	HB 132	Bucy, John(D)	(Identical)
		2-23-23 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	
	SJR 10	Johnson, Nathan(D)	(Enabling)
		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: 11/15 by JL

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

SB 72 Johnson, Nathan Medicaid expansion

Companions:

HB 226	Bernal, Diego(D)	(Identical)
	2-23-23 H Introduced and referred to committee on House Select on Health Care Reform	
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. 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: 11/15 by JL

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

SB 73 Johnson, Nathan 12 month postpartum Medicaid coverage

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: 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.

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

SB 74 Johnson, Nathan Medicaid community health worker expenses

Companions:

HB 113	Ortega, Lina(D)	(Identical)
	3-14-23 H Voted favorably from committee on House Human Services	

Remarks: SUMMARY: Allows MCOs to categorize community health workers as a medical expense instead of an administrative expense.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

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

TAHP POSITION STATEMENT: Community health workers play a vital role in connecting Medicaid members to health care and community services--critical components of managed care. They help increase health knowledge and self-sufficiency through a range of activities such as outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research.

DATE UPDATED: 1/11 by JL

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

SB 76 Johnson, Nathan Health literacy advisory committee

Companions:

HB 733	Plesa, Mihaela (F)(D)	(Identical)
	2-28-23 H Introduced and referred to committee on House Public Health	

Remarks: SUMMARY: Requires the Statewide Health Coordinating Council to establish an advisory committee on health literacy. The advisory committee must develop a long-range plan and update it every two years. Requires the advisory committee to include in the state plan strategies for improving health literacy that attain greater cost-effectiveness and better patient outcomes.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/13 by JL

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

SB 124 Alvarado, Carol 12 month postpartum Medicaid coverage

Remarks:

SUMMARY: Builds on HB 133 last session by extending postpartum coverage to 12 months from 6 months. Removes language passed last session in HB 133 that limits eligibility to pregnant women who deliver or experience an involuntary miscarriage. Requires HHSC to actively seek, apply for, accept, and spend any federal money that is available, including FMAP. Requires the state to provide Medicaid for pregnant women who are lawfully present or lawfully residing in the US.

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: 1/17 by JL

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

SB 125 Alvarado, Carol Medicaid expansion

Companions:

HB 1062	Guerra, Bobby(D)	(Identical)
	3- 2-23 H Introduced and referred to committee on House Select on Health Care Reform	
HB 2903	Martinez Fischer, Trey(D)	(Identical)
	3-14-23 H Introduced and referred to committee on House Select on Health Care Reform	

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

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

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

SB 127 Alvarado, Carol Possession of cannabis

Remarks: SUMMARY: This bill would create a licensure for the dispensing of cannabis and create an online medical use registry. An individual could be added to the registry if a physician believes cannabis is the best available treatment for a patient's condition.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED: 2/22 KS

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

SB 134 West, Royce 12 month postpartum Medicaid coverage

Companions:

HB 133	Rose, Toni(D)	(Refiled from 87R Session)
HB 146	Thierry, Shawn(D)	(Refiled from 87R Session)
SB 121	Johnson, Nathan(D)	(Refiled from 87R Session)

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

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2021 (note, exact refile from last session)

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.

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

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

Remarks:

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

TAHP POSITION: Support

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

EFFECTIVE DATES: 1/1/23

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

SB 161 Perry, Charles Provider licensure complaint reciprocity

Companions:

HB 3735	Howard, Donna(D)	(Refiled from 87R Session)
HB 724	Howard, Donna(D)	(Identical)

2-28-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: Requires a licensing entity that receives a complaint regarding a provider who holds a license issued by a different licensing entity to forward the complaint to the appropriate licensing entity. Prohibits a licensing entity from taking disciplinary action against a provider who holds a license issued by a different licensing entity unless that licensing entity refers the complaint back to the licensing entity that received the complaint for investigation and resolution.

TAHP POSITION: Neutral

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

DATE UPDATED: 2/13 by JL

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

SB 180 Miles, Borris Office of health equity

Remarks: SUMMARY: Renames the Center for Elimination of Disproportionality and Disparities to the Office for Health Equity. (Note the Center became the HHSC Office of Minority Health Statistics and Engagement and then closed in 2018.) Expands the duties of the office, in part, to investigate and report on issues related to health and health access disparities and monitor trends in behavioral health, morbidity, and mortality rates among women and racial, multicultural, disadvantaged, ethnic, and regional populations, and across age brackets and linguistic groups.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/21 by JL

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

SB 195 Johnson, Nathan Medicaid expansion

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

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

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

TAHP POSITION: Neutral

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 1/11 by JL

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

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

Companions:

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

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

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/24

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

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

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

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

SB 251 Alvarado, Carol — Emergency telemedicine pilot

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

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

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/3 KS

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

SB 290 Johnson, Nathan — Texas Health Services information

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

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

Remarks: SUMMARY: This bill would allow physicians who are not a member of the facility medical staff to

provide care at the hospital at the patient's request. It would also ensure that the hospital is not liable to a patient or another person for damages resulting from that care.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/20 JB

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

SB 303 Hall, Bob No immunization discrimination in Medicaid

Remarks: SUMMARY: Prohibits providers from refusing to provide services to Medicaid and CHIP recipients who are not vaccinated. Requires HHSC to disenroll providers who do not comply and prohibits provider reimbursement. Gives HHSC rulemaking authority to implement.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid, CHIP

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/19 by JL

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

SB 344 Johnson, Nathan Texas State Based Exchange

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

TAHP POSITION: Neutral monitor

COVERAGE TYPES: Commercial

TAHP POSITION STATEMENT: Texas should ensure that any efforts to build on the state's high-performing individual market do not create market instability or coverage disruptions. Texas has made substantial gains in increasing access to insurance coverage in the individual market. The number of Texans with marketplace plans doubled

in the last two years, and 15 plans are offering coverage in Texas—a record number. Policies like a state-based exchange or 1332 coverage waiver should not be implemented in a way that would create market instability, increase costs or reduce competition and access. The state should look for reforms in the insurance market that further reduce the uninsured and lower costs.

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

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

SB 358 Kolkhorst, Lois Right to Shop Mandate

Remarks:

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

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

COVERAGE TYPES: Commercial, ERS

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

MANDATE: Benefit

TAHP POSITION STATEMENT: While new Federal rules encourage health plan arrangements that incentivize patients to shop for low-cost, high-value providers, Texas prohibits these benefit designs. Insurers can’t use innovative solutions like lower out-of-pocket costs to reward patients for being smart shoppers. Texas should open up the door to private market innovations that can motivate patients to be savvy health care shoppers. However, government mandates don’t lead to innovation and can’t keep pace with consumer behavior. Lawmakers should avoid mandates that prescribe right-to-shop programs with one-size-fits all designs. Instead, focus on removing barriers that hinder innovative attempts to motivate patients to high-value care.

DATE MODIFIED: 2/3/23 JB

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

SB 401 Kolkhorst, Lois — Medical staffing services in disasters

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

SB 407 Eckhardt, Sarah — CHIP birth control coverage

Companions:

HB 141	Howard, Donna(D)	(Identical)
	2-23-23 H Introduced and referred to committee on House Public Health	
SB 2436	Lamantia, Morgan (F)(D)	(Identical)
	3-10-23 S Filed	

Remarks: SUMMARY: Requires CHIP to cover prescription contraceptive drugs, supplies, or devices for children under 18 with written content. Prohibits CHIP from covering abortifacients or any other drug or device that terminates a pregnancy.

TAHP POSITION: Neutral

COVERAGE TYPES: CHIP

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

DATE UPDATED: 1/9 by JL

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

SB 447 Menendez, Jose — Fertility preservation mandate

Companions:

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

Remarks: SUMMARY: This bill mandates coverage for "fertility preservation services" to a covered person who will receive a medically necessary treatment that may impair fertility. The coverage mandate applies to any medically necessary treatment, including surgery, chemotherapy, and radiation, that the American Society of Clinical Oncology (ASCO) or the American Society for Reproductive Medicine (ASRM) has established may directly or indirectly cause impaired fertility. The fertility preservation services must be standard procedures to preserve fertility

consistent with established medical practices or professional guidelines published by the ASCO or the ASRM. These organizations consider sperm, oocyte, and embryo cryopreservation standard practices. If those procedures are not options for the patient, ovarian tissue cryopreservation and ovarian suppression with gonadotropin-releasing hormones have shown evidence of efficacy. The bill does not contemplate the long-term storage of embryos and related costs if an enrollee no longer has coverage from a state regulated health plan.

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial

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

MANDATE: Benefit

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

UPDATED: 2/3 BH

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

SB 451 Menendez, Jose Preexisting Condition Protections

Remarks: SUMMARY: This bill would prohibit plans from denying coverage for specific preexisting conditions unless the application for enrollment requires disclosure of the condition or of prior medical treatment. It would also prohibit termination except for failure to pay the premium, failure to abide by the rules of the plan, fraud, cancellation, or a cause for termination that the

commissioner determines is not objectionable. Finally, it would require disclosure by the issuer upon a termination as the specific reason the policy was terminated and how the enrollee can file a complaint with the department.

TAHP POSITION: Neutral

COVERAGE TYPES: Individual, group, STLD

EFFECTIVE DATES: 1/1/24

MANDATE: Coverage

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

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

SB 452 Menendez, Jose SMI Step Therapy Mandate

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

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

TAHP POSITION: Neutral (negotiated language)

COVERAGE TYPES: Commercial

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

MANDATE:Benefit

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

prescription drug options including lower cost alternatives.

DATE UPDATED: 3/8 BH

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

SB 457 Menendez, Jose Consumer Disclosures for Alternative Coverage

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

TAHP POSITION: Support

COVERAGE TYPES: Alternative coverage

EFFECTIVE DATES: 1/1/24

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

DATE UPDATED: 2/17 BH

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

SB 490 Hughes, Bryan Itemized billing before debt collection

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

Remarks: SUMMARY: This bill requires a health care provider, before pursuing any debt collection against a patient for whom the provider provided a health care service or related supply, to issue to the patient a written itemized bill of charges for all health care services and supplies provided to the patient during the visit to the provider. The bill

must include the amount charged for each service and supply provided to the patient by that provider or any other provider during that visit. The appropriate licensing authority may take disciplinary action against a health care provider that violates this chapter as if the provider violated an applicable licensing law.

TAHP POSITION: Support

EFFECTIVE DATES: 9/1/23

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

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

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

SB 504 Miles, Borris Medicaid block grant - Expansion

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

SB 524 West, Royce Statewide IDD Coordinating Council

Companions: HB 729 Rose, Toni(D) (Identical)
3-14-23 H Committee action pending House Human Services

Remarks: SUMMARY: Establishes a statewide intellectual and developmental disability coordinating council to ensure a strategic approach for services. The council must develop a 5-year IDD strategic plan, publish available services and programs, and the number of individuals on the wait lists.

TAHP POSITION: Support

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

DATE UPDATED: 3/8 by JL

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

SB 534 Paxton, Angela Allows Midwifes to Administer L&D Drugs

Remarks: SUMMARY: This bill would allow midwives to administer drugs commonly used in labor or postpartum care and prophylactic drugs for newborns. In order for a midwife to do so, they would need to complete continuing education in pharmacology.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/13 KS

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

SB 550 Johnson, Nathan Medicaid Eligibility Express Lane

Remarks: SUMMARY: Requires HHSC to enroll children who are eligible for CHIP, SNAP, or other programs, as well as any federal programs including WIC or Head Start, as determined by the

submission of any eligibility applications.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept.1, 2023

DATE UPDATED: 2/1 by JL

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

SB 583 Hughes, Bryan OON Out of Pocket Cost Mandate

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

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

TAHP POSITION: OPPOSED without guardrails added

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

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

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

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

DATE UPDATED: 3/7 KS

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

SB 584 Hughes, Bryan No Referral for 30 PT Visits

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

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

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 9/1/23

MANDATE: Benefit

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

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

that primary care providers provide a crucial role in health care in coordinating patient care.

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

LAST UPDATED: 3/11 BH

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

SB 589 Johnson, Nathan Health literacy plan

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

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

TAHP POSITION: Support

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

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

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

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

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

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

TAHP POSITION: Support

COVERAGE TYPES: Commercial

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

TAHP POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to "Establish new alternative coverage option that allows insurers to offer 'Consumer Choice' plans that forego certain state-imposed regulations and mandates." Texas should build more affordable insurance coverage options that avoid over-regulation and excessive mandates. New health care products added last session avoid government mandates and provide more choices for some Texans. In the past, Texans had mandate-lite insurance options through the Consumer Choice of Benefits model, but that’s been eroded by a continuous stream of new mandates over two decades. Updated “Consumer Choice” plans would be similar to new affordable

alternatives established through the Farm Bureau and Texas Mutual, but there are a few key differences. These plans would still be considered insurance under state law, meaning that they would be required to meet solvency requirements, be subject to TDI oversight, and meet federal benefit and coverage requirements like pre-existing conditions protections and medical loss ratio rules required by the Affordable Care Act. Additionally, HB 1001 indicates that these plans must also meet any requirements imposed on the coverage elected officials and state employees have through ERS.

DATE UPDATED: 2/13 KS

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

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

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

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

TAHP POSITION: Neutral if amended

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

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

DATE UPDATED: 2/13 KS

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

SB 630 Menendez, Jose Mixed status families outreach for Medicaid

Companions: SB 2069 Menendez, Jose(D) (Refiled from 87R Session)

HB 3237 Campos, Liz(D) (Identical)
3-15-23 H Introduced and referred to committee on House Select on Health Care Reform

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: 2/1 by JL

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

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

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

TAHP POSITION: Oppose

COVERAGE TYPES: ERS, TRS, Commercial, Medicaid

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

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

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

while Medicaid MCOs estimate an annual cost of over $100 million.

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

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

DATE UPDATED: 2/17 BH

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

SB 651 Perry, Charles Repeals Medicaid Mandatory Contracting

Companions: HB 2401 Oliverson, Tom(R) (Identical)
3-13-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: Repeals mandatory contracting with non-profit MCOs or hospital districts with an MCO in Medicaid.

TAHP POSITION: Neutral

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

DATE UPDATED: 2/1 by JL

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

SB 663 Perry, Charles HCBS strategic plan

Companions: HB 1798 Howard, Donna(D) (Identical)

3- 7-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: Requires the development of a strategic plan to provide home and community-based services in Medicaid and CHIP. The plan must include a proposal for rate methodology, an assessment of unmet needs, and access to care standards for each program and must be submitted by Sept. 1, 2024. Every two years, HHSC must produce a report on strategic plan progress. Establishes an HCBS Advisory Committee, which can be a subcommittee of the Medical Care Advisory Committee

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid, CHIP

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/2 by JL

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

SB 671 West, Royce Medicaid expansion

Companions:

HB 226	Bernal, Diego(D)	(Identical)
	2-23-23 H Introduced and referred to committee on House Select on Health Care Reform	
SB 72	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: 11/15 by JL

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

SB 676 Johnson, Nathan Expansion of in vitro mandate

Companions:

HB 2310	Gonzalez, Jessica(D)	(Refiled from 87R

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

Remarks:

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

TAHP POSITION: Neutral

COVERAGE TYPES: Group (commercial) plans

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

MANDATE: Benefit

DATE UPDATED: 2/19 KS

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

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

Companions:

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

Remarks:

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

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

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

DATE UPDATED: 2/18 BH

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

SB 730 Hinojosa, Chuy Granting privileges at hospitals podiatrists

Companions: HB 1767 Klick, Stephanie(R) (Identical)
3- 7-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: Currently, a facility cannot deny medical staff membership solely because a provider is a podiatrist. This bill would add that facilities cannot deny hospital privileges solely because the provider is a podiatrist.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/22 KS

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

SB 731 Hinojosa, Chuy CAF Holds

Companions:

SB 430	Hinojosa, Chuy(D)	(Refiled from 87R Session)

Remarks:

SUMMARY: Requires that during a hearing against a provider suspected of fraud, the OIG is required to show probable cause that 1) the threat to integrity is due to an ongoing risk that the fraud could result in a provider or another person receiving an unauthorized benefit of more than $100,000; or 2) the provider's conduct having resulted in a serious threat to the health or safety of recipients or the possibility that the provider's conduct may result in that serious threat at any time.

TAHP POSITION: Neutral

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

DATE UPDATED: 2/11 by JL

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

SB 745 Kolkhorst, Lois Expands OAG Fraud Protection

Companions:

HB 3779	Noble, Candy(R)	(Identical)
	3- 7-23 H Filed	

Remarks:

SUMMARY: Expands the definition of Medicaid fraud to include any program funded by this state, the federal government, or both and designed to provide health care services to health care recipients, including a program that is administered in whole or in part through a managed care delivery model.

TAHP POSITION: Neutral

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 2/11 by JL

HEARINGS: 3/08/23- Neutral

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

SB 746 Hughes, Bryan Pediatric long-term care access program

Companions:

HB 1185	Dean, Jay(R)	(Identical)

3- 2-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: Authorizes Upshur County to collect a mandatory payment from each pediatric long-term care facility in the county to be deposited in a local pediatric long-term care access assurance fund. HB 1185 is specific to Truman Smith. Truman Smith cares for about 100 children of Texas who have the highest skilled nursing needs that cannot be cared for at home or in other settings. HB 1185 would provide state authorization for a Medicaid funding mechanism that is available under federal law, but needs both state and local authorization. In 2019, Texas provided authorized for hospitals in any county that wanted to take advantage: HB 4289 (86R). But that authorization was only for hospitals, not skilled nursing or other medical facilities.

TAHP POSITION: Neutral

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

DATE UPDATED: 1/22 by JL

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

SB 749 Flores, Pete — Pharmacist Vaccination Authority

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

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

TAHP Position: Support

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

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

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

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

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

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/19 KS

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

SB 807 Paxton, Angela 12 month contraception mandate

Companions:

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

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

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

COVERAGE TYPES: Commercial, Medicaid

EFFECTIVE DATES: Sept. 1, 2023

MANDATE: Benefit

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

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

DATE UPDATED: 2/19 KS

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

SB 842 Hinojosa, Chuy ERS Bariatric Surgery Coverage

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

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

TAHP POSITION: Neutral

COVERAGE TYPES: ERS

EFFECTIVE DATES: 2024 plan year

DATE UPDATED: 2/19 KS

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

SB 850 Blanco, Cesar Composition the Child Mental Health Care

Remarks: SUMMARY: This bill would add regional education service centers to the composition of the Child Mental Health Care Consortium.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/22 KS

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

SB 860 Hughes, Bryan Any Willing Provider Mandate - Vision

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

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

optometrists. A violations of the subchapter be considered a deceptive act by the issuer for the purposes of Chapter 541.

TAHP Position: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

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

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

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

DATE UPDATED: 3/5 BH

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

SB 861 Hughes, Bryan Coordination vision benefits

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

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

remainder, up to any coverage limits.

COVERAGE TYPES: EPO/PPOs that cover vision services

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

DATE UPDATED: 2/19 KS

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

SB 862 Hughes, Bryan Mandates RAC in managed care

Companions: HB 3891 Harrison, Brian(R) (Identical)
3- 7-23 H Filed

Remarks: SUMMARY: Limits the ability of an MCO to audit claims paid by the MCO to one year after the claim was paid. Mandates that the OIG require the fee-for-service (FFS) recovery audit contractor (RAC) to recover any overpayments in managed care not identified by the MCO. The RAC cannot begin to audit managed care claims until after the MCO audit period has expired. Gives the RAC an additional year to audit claims and then an additional year to recover overpayment.

TAHP POSITION: Oppose

COVERAGE TYPES: Medicaid

TAHP POSITION STATEMENT: This is a vendor bill backed by private equity. The state's current fee-for-service RAC vendor, HMS, was bought by Gainwell last year. Since then, Gainwell has attempted to pass legislation across the country limiting the ability of MCOs to recover overpayments to providers in an effort for private equity to profit from a new revenue stream. Gainwell claims that because FFS recoveries are high and represent a small portion of Medicaid, there must be more to recover in managed care. This is false and reflects Gainwell's lack of familiarity with managed care: managed care is not the pay-and-chase model that FFS is. MCOs apply many strategies to prevent fraud, waste, and abuse not available in FFS, such as front-end claim edits. MCOs are also required by contract to have special investigative units that conduct post-payment reviews. MCO referrals to the OIG also reflect another component of program integrity. The OIG has the ability to request legislation extending the scope of the fee-for-service RAC, but has intentionally declined to do so. Manage care contracts and alternative payment model arrangements MCOs have with providers are far

more complex than what the RAC has experience with, which will result in significant provider abrasion, risking network adequacy.

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/18 by JL

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

SB 863 Hughes, Bryan ER Verification of Payment Mandate

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

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

TAHP POSITION: Oppose

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

EFFECTIVE DATES: 1/2/24

DATE UPDATED: 2/19 KS

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

SB 905 Perry, Charles Medicaid Coverage of IOP and PHP

Companions: HB 2337 Oliverson, Tom(R) (Identical)
3- 9-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: Adds intensive outpatient services and partial hospitalization services as Medicaid benefits. These are currently in-lieu-of-services (ILOS).

TAHP POSITION: Support

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

TAHP POSITION STATEMENT: TAHP supports this bill, however, the bill should be amended to ensure the language aligns with exiting ILOS services in the Uniform Managed Care Manual to

ensure there is no misinterpretation of intended covered services. Texas Medicaid lacks intensive facility or clinic-based mental health care coverage. Many of these services are already covered in the private health insurance market but are limited in Medicaid. These programs are designed for individuals whose situations do not need full inpatient care nor the length of stay that is typical of residential treatment. Additionally, these services allow youth to continue living in their homes and community. Streamlining coverage for these services as traditional Medicaid benefits across all MCOs will ensure better access to mental health services and may reduce hospitalization costs that result when no alternatives are available.

DATE UPDATED: 2/26 by JL

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

SB 935 Perry, Charles OIG federal share of recoveries

Companions: HB 2307 Hull, Lacey(R) (Identical)
3-21-23 H Meeting set for 8:00 A.M., E2.030, House Human Services

Remarks: SUMMARY: Clarifies that the federal share to be paid on managed care recoveries allows MCOs to retain one-half of recoveries identified by the MCO and recovered by the state. The state's share remains the same.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/19 by JL

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

SB 945 Kolkhorst, Lois Expands Price Transparency

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

TAHP POSITION: Support

EFFECTIVE DATES: Immediately or 9/1/23

POSITION STATEMENT: In 2021, Texas lawmakers created consumer-friendly hospital price transparency laws and required health plans

to publish all of their negotiated prices. But consumers still lack a complete picture to window-shop for most health services. This legislation continues the state's push for price transparency by expanding the price transparency law to include freestanding ERs, ambulatory surgical centers, urgent cares, outpatient clinics, and other facilities.

DATE UPDATED: 3/5 BH

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

SB 954 Perry, Charles Opioid antagonists

Companions: HB 1543 Oliverson, Tom(R) (Identical)
3- 3-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: This bill would allow HHSC to create a statewide standing order for opioid antagonists to persons who are at risk of an overdose or their family member.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: Immediate or 9/1/23

DATE UPDATED: 2/22 KS

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

SB 989 Huffman, Joan Biomarker Coverage Mandate

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

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

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

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

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

DATE UPDATED: 2/19 KS

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

SB 1003 Johnson, Nathan TDI Rec - Provider Directories

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

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

TAHP POSITION: Reviewing

COVERAGE TYPES: HMO, EPO, MEWA.

EFFECTIVE DATES: 1/1/24

DATE UPDATED: 2/18 KS

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

SB 1040 Kolkhorst, Lois Organ Transplants in China

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

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

TAHP Position: Neutral

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

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

DATE UPDATED: 2/22 KS

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

SB 1043 Blanco, Cesar Telemedicine Payment Parity Mandate

Companions:

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

Remarks:

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

TAHP POSITION: Opposed

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 1/1/24

MANDATE: Contracting

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

prevent any telehealth cost savings from being passed along to patients in the form of lower premiums, deductibles, copayments or coinsurance. Telehealth access is expanding without government interference and rate setting. Patients are asking for telehealth access, and the market for insurance coverage is responding with numerous options for $0 copay telehealth visits. A payment parity mandate risks interfering in the market response to these patient needs.

DATE UPDATED: 2/18 BH

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

SB 1051 Hughes, Bryan Health benefit plan questionnaires

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

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

TAHP POSITION: Reviewing

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

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

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

SB 1113 Hughes, Bryan PDL carve-out

Companions: HB 1283 Oliverson, Tom(R) (Identical)
3- 3-23 H Introduced and referred to committee on House Select on Health Care Reform

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: SB 1113 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: BH 2/26

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

SB 1127 Blanco, Cesar MCO texting

Companions: HB 2802 Rose, Toni(D) (Identical)
3-14-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: Aligns state law with recent FCC guidance that makes it easier for Medicaid MCOs to text families about enrollment or eligibility renewal. Also establishes in the application that individuals may "opt-out" of receiving texts and emails regarding important health information such as upcoming appointment reminders. Ensures that MCOs do not have to unnecessarily transmit emails and phone numbers they directly receive from their enrollees back to HHSC and receive confirmation from HHSC that the information was received.

TAHP POSITION: Support

COVERAGE TYPES: Medicaid and CHIP

TAHP POSITION STATEMENT: Currently, the option to "opt-in" to texting and email on the eligibility application is confusing. Texans can easily overlook or misunderstand instructions when filling out preferred contact preferences. The process for Medicaid members to receive text communications from their health insurance plan should be as simple and streamlined as possible. At least 21 states allow texting with implied consent with an option to unsubscribe, and most states have implied consent for email as long as there is an unsubscribe option in each email. 83% of Medicaid beneficiaries in the U.S. own a

smartphone--used effectively, text messaging can both enhance existing forms of communication to Medicaid families and improve the delivery of the State's critical safety net programs. The FCC agrees, and in January of 2023 released guidance that allows MCOs to easily text Medicaid families enrolled with them information relating to their enrollment in Medicaid or any upcoming eligibility changes using contact information received from any application for health care coverage or state benefits.

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/26 by JL

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

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

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

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

TAHP POSITION: Support

COVERAGE TYPES:Commercial

EFFECTIVE DATES: Immediate or 91/23

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

Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) chapter of the Insurance Code. TAHP worked with the Primary Care Consortium to identify policies of shared interest that can make a positive difference in health care payment and delivery innovation. The Consortium endorsed this concept and TAHP supports removing barriers to value-based care.

DATE UPDATED: BH 2/21

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

T SB 1137 Schwertner, Charles ERISA Prescription Drug Mandate

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

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

TAHP POSITION: Oppose

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

POSITION STATEMENT: This bill applies every state created prescription drug mandate (insurance code chapter 1369) to self-funded employer health plans that are currently exempt under Federal ERISA laws. Employers (not health insurers) are harmed by HB 2021. Self-funded employers will suffer the cost of imposing state mandates including limits on narrow pharmacy networks or the use of onsite pharmacies, a one year wait before changing to lower cost generics/biosimilars, and limits on mail order pharmacies. Multi-state employers will have to design special coverage just for Texas employees. These mandates are expensive and cumbersome, that's why the bill exempts coverage for our elected officials personal health insurance and their employee's coverage. Large employers with thousands of employees use self-funded benefits. These are the biggest providers of health coverage and the biggest job creators in Texas. The intent of ERISA preemption is to encourage employers to offer their employees benefit plans. This has worked - 98% of Texas large employers

provide coverage to their employees compared to only 50% of Texas small employers. The Texas Association of Business, Texas Business Leadership Council, Texans for Lawsuit Reform, and individual businesses like Hobby Lobby have all spoken out against ERISA preemption.

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

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

SB 1138 Schwertner, Charles White Bagging Prohibition Mandate

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

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

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

COVERAGE TYPES: Commercial, CC

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

MANDATE: Contracting

POSITION STATEMENT: TAHP opposes HB 1647 without amendments that would ensure the bill does not reward price gouging and is aimed only at patient protections. The most expensive drugs are injectables and infusion drugs provided at a hospital, cancer center, or doctor’s office. These “specialty drugs” are typically covered under your medical benefits (not pharmacy benefits). New State and Federal transparency laws show that hospitals, cancer centers, and other clinics have been caught marking up drugs at excessive

amounts, on average 200% and up to 634% for cancer drugs. By comparison, Medicare allows a 6% markup or profit margin.Health plans are responding with competition by bringing in the same drug from lower cost specialty pharmacies but without the big markup. That's "white bagging" and it saves patients money. Massachusetts found the process saved 38% on average.

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

LAST UPDATED: BH 2/21

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

SB 1139 Schwertner, Charles Prudent Layperson Mandate

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

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

TAHP POSITION: Oppose, negotiating

COVERAGE TYPES: Commercial and Medicaid

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

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

Under the "prudent layperson standard" a person gets to decide based on their own judgment if they

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

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

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

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

SB 1140 Schwertner, Charles OPIC Network Adequacy

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

health care data collection system.

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

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

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

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

TAHP POSITION: Reviewing

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

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

T SB 1141 Schwertner, Charles Prohibits Extrapolation for FWA Audits

Companions:

SB 519	Schwertner, Charles(R)	(Refiled from 87R Session)
HB 895	Munoz, Sergio(D)	(Identical)

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

Remarks:

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

TAHP POSITION: Oppose

COVERAGE TYPES: HMOs and insurers (EPO/PPO)

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

MANDATE: Administrative

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

DATE UPDATED: 2/26 Bh

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

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

Companions:

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

Remarks:

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

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION: Requiring Texas health plans to have personnel available for prior authorization and payment verification requests 24/7, including weekends and holidays, has several negative consequences. Requiring 24/7 availability for prior authorization and payment verification responses is inconsistent with provider availability and cr eates unnecessary and costly administrative burden. For example, one of the state's largest health plans received just 6% of PA requests after regular business hours (including holidays) in 2022, showing there is very little demand for after-hours verification. Additionally, Texas already has some of the shortest prior authorization time frames in the country, with a requirement that they be processed in less than 3 calendar days compared to most states' 14 days. Furthermore, Texas already has the broadest exemptions to prior authorization in the country, including "gold-carding," which exempts providers with a history of safe and appropriate care. Hospitals and providers also do not staff utilization review after hours. Moreover, there is no evidence to suggest that this requirement would improve patient outcomes or reduce healthcare costs, making it a potentially unnecessary burden on the healthcare system. Instead, a better solution would be to follow the federal government's recommended reforms to implement electronic prior authorizations, which could reduce costs and streamline the process, making it easier for providers to obtain necessary approvals. For pharmacy authorizations, around 60% of new prior authorizations are already received electronically, suggesting that there may be limited additional value in requiring health plans to have a 24/7 phone line for receiving new authorizations. By requiring the use of electronic prior authorizations, Texas could stay up to date with current best practices and provide a more effective and efficient prior authorization system for patients and

providers. This approach could improve the overall quality and availability of healthcare in the state while reducing costs for both health plans and patients.

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

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

DATE UPDATED: 2/27 KS

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

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

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

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

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial, CC, ERS/TRS

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

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

LAST UPDATED: BH 2/20

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

SB 1178 Lamantia, Morgan (F) Dental Anesthesia Mandate for kids

Companions: HB 3524 Johnson, Ann(D) (Identical)
3-16-23 H Introduced and referred to committee on House Insurance

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

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

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

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

TAHP POSITION STATEMENT: Inappropriate general anesthesia for pediatric dental has tragically led to the deaths of several children in the United States and in Texas. Texas investigators uncovered numerous instances of fraud in pediatric dental that led to millions in settlements with pediatric dentists. State auditors found that “In total, 28 percent of the Medicaid pediatric dental sedation records randomly selected for review did not have sufficient documentation to justify sedation procedures.” That’s why HHSC implemented strict prior authorization requirements. TAHP is opposed to the bill because under the proposal, health plans would be prohibited from using all prior authorization safety checks to ensure that childhood dental anesthesia is safe and necessary.

DATE UPDATED: 3/11 BH

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

SB 1193 Schwertner, Charles Mandates On Site MD at FSER

Remarks: SUMMARY: This bill would require FEMCs to have at least one physician present at all times. A patient would have a right to request that a physician perform all of the patient's health care services. The facility would be required to display a poster that discloses the name of the physician supervising health care practitioners, the physician's license number, and their board certifications. The poster would have to include a

statement saying the patient could request to see and receive care from the physician at any time.

TAHP POSITION: Neutral

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 2/27 KS

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

SB 1220 Zaffirini, Judith First episode psychosis mandate

Companions: HB 4713 Plesa, Mihaela (F)(D) (Identical)
3-10-23 H Filed

Remarks: SUMMARY: This bill would define "first episode psychosis" as the initial onset of psychosis caused by medical and neurological conditions, serious mental illness, or substance abuse. It would require group health benefit plans to provide coverage, based on medical necessity as determined by a stakeholder group, to an individual who is younger than 26 and who is diagnosed with first episode psychosis. The issuer must include coverage for all generally recognized services, including coordination of specialty care, assertive community treatment, and peer support services. The plan would be required to reimburse providers of coordinated specialty care and assertive community care using a bundled payment model. If requested by an issuer on or after 3/1/29, the department would be required to contract with an independent third party to perform an analysis of the impact of the requirement of covering team-based treatment models described by the bill. If the analysis finds that premiums increased by more than one percent, issuers are not required to comply. The bill would also establish a workgroup of providers and issuers to determine medical necessity criteria and a coding solution for these services. The department will adopt rules by 1/1/24.

TAHP POSITION: Oppose

COVERAGE TYPES: EPO/PPO, MEWA, Medicaid, ERS/TRS

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

MANDATE:

TAHP POSITION STATEMENT:

UPDATED:

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

SB 1221 Zaffirini, Judith Permanent Formulary Freeze Mandate

Companions:

HB 1646	Lambert, Stan(R)	(Refiled from 87R Session)
SB 1142	Zaffirini, Judith(D)	(Refiled from 87R Session)
HB 826	Lambert, Stan(R)	(Identical)
	3- 1-23 H Introduced and referred to committee on House Insurance	

Remarks:

SUMMARY: This bill would prohibit a health plan from ever making any change to a patient's benefits for a drug they are taking. This means a health plan cannot even increase the copay amount by $5 or reduce the maximum drug coverage amount by $5, even at the annual renewal of the benefit plan, and even if the drug has been replaced on the health plan's formulary by a better or lower-priced drug. This mandate is referred to as a "permanent formulary freeze." This formulary freeze would apply to any enrollee taking a drug if: (1) the enrollee was covered by the benefit plan preceding the renewal date, (2) a physician or other prescribing provider prescribes the drug for the medical condition or mental illness, and (3) the physician or other prescribing provider in consultation with the enrollee determines that the drug is the most appropriate course of treatment. The bill also expands notice requirements for modifying drug coverage to include a statement explaining the type of modification and indicating that, on renewal of the benefit plan, the issuer may not modify an enrollee's contracted benefit level for any prescription drug that was approved or covered under the plan in the immediately preceding plan year (formulary freeze).

TAHP POSITION: Oppose

COVERAGE TYPE: Commercial, Exempts ERS and TRS

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

TAHP POSITION STATEMENT: TAHP is opposed to any new government mandate that permanently freezes health plan formularies and undermines

important efforts by health plans to negotiate lower drug prices, ultimately driving up the cost of coverage for Texas employers, families, and taxpayers. Texas already leads the nation with the strongest patient protections against non-medical switching and step therapy. For example, Texas has a one year formulary freeze law that only two other states have. That means that when an expensive name brand drug has a lower cost competitor enter the market, health plans are not allowed to update the formulary to reflect this cost savings for a full year. That's the case now in 2023 with the launch of new biosimilar alternatives to the very expensive rheumatoid arthritis drug Humira. Further, Texas has the most extensive step therapy protections in the nation. A physician can simply document that a patient is stable on a drug and the patient can't be taken off by step therapy protocols, even if they change insurers. Under this proposal, the formulary would be permanently frozen if any patient is on a particular drug. This is an unprecedented, costly, and unworkable mandate. Under a permanent "formulary freeze," plans cannot replace drugs with new clinically appropriate and more affordable alternatives. Instead, plans will have to continue coverage of a drug, at the same copay or coinsurance level, even if the price increases or if a more affordable, more effective, or even safer option comes out. An insurer couldn't make a change as simple as a $5 copay increase on brand-name drugs in between plan years. Pharma stands to gain from a formulary freeze because once they have a patient on a drug, they'll be immune from competition from lower cost alternatives and any pressure to lower the price of that drug. Employers and families paying premiums would see increased costs of $481 million over $5 years. Certain city employee estimates include San Antonio with an additional $3 million in drug spending and $2 million for Dallas employees. TRS would owe $70 million more per year if the bill were applied to the program.

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

Texas is already one of the most heavily regulated states when it comes to health care, ranking third in the nation for regulations that go beyond the

federal requirements of the Affordable Care Act (ACA). As a result, small business owners in Texas consistently rank the cost of health insurance as their single biggest problem since 1986. Additionally, approximately three-quarters of Texas employers oppose legislative mandates that interfere with how they design employee benefits. Instead, they want more flexibility to contain costs and provide the best coverage for their employees.

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

DATE UPDATED: 2/3/23 BH

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

SB 1239 Lamantia, Morgan (F) FFS reimbursement rates for eye care

Companions: HB 3778 Hernandez, Ana(D) (Identical)
3- 7-23 H Filed

Remarks: SUMMARY: Eliminates the ability for MCOs to negotiate rates in managed care for eye care providers and requires providers be reimbursed at a rate that is at least equal to the Medicaid fee-for-service rate.

TAHP POSITION: Oppose

COVERAGE: Medicaid

EFFECTIVE DATE: Sept. 1, 2023

TAHP POSITION STATEMENT: Medicaid managed care rate setting is efficient, saves money, and is accountable. The financial protections currently built into contracts have resulted in more than $5 billion of savings. Texas is one of the few states which require MCOs to assume all the financial downside risk (losses) and share profits and savings to the state. MCOs take on full financial risk— if in any given year a plan incurs losses, that plan absorbs those losses. Reverting to a fee-for-service rate setting process stifles the cost effectiveness that Texas managed care plans provide.

DATE UPDATED: 3/6 by JL

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

SB 1272 Johnson, Nathan Study on reforms to Indigent Health Care

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

SB 1275 Hancock, Kelly Prohibits Abusive Facility Fees

Companions: HB 1692 Frank, James(R) (Identical)
3- 7-23 H Introduced and referred to committee on House Select on Health Care Reform

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

TAHP POSITION: Support

EFFECTIVE DATES: Immediate or 9/1/23

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

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

system explained that they moved the infusion clinic from an “office-based practice” to a “hospital-based setting” as the excuse for adding the facility fee. Providers are even charging facility fees in some instances for telehealth visits.

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

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

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

SB 1277 Parker, Tan (F) Fertility Preservation Mandate

Remarks: SUMMARY: This bill would define "fertility preservation services" as the cryopreservation of sperm, unfertilized oocytes, and ovarian tissue. This bill would require coverage of fertility preservation for a covered person who will receive a medically necessary treatment that may impair fertility. The coverage mandate applies to any medically necessary treatment, including surgery, chemotherapy, and radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility. The fertility preservation services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. The bill does not contemplate cost of long term storage and related costs if an enrollee no longer has coverage from a state regulated health plan.

TAHP POSITION: Oppose

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

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

MANDATE: Benefit

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

UPDATED: 3/2 KS

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

SB 1285 Johnson, Nathan Newborn infant testing

Remarks:

SUMMARY: Currently, birthing centers are required to provide newborn hearing screening, tracking, and intervention before a newborn can be discharged. This bill would add testing for congenital cytomegalovirus to that requirement.

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

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

SB 1286 Schwertner, Charles Health claims affected by catastrophic event

Companions: HB 3196 Johnson, Ann(D) (Identical)

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

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

TAHP POSITION:

COVERAGE TYPES: EPO/PPO, HMO

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

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

SB 1298 Hughes, Bryan Requests arbitration billing disputes

Remarks: SUMMARY: This bill would define bad faith in a balanced billing dispute as failing to provide the material facts necessary or failing to send a representative to the mediation. If a party engages in bad faith mediation, the opposing party may request arbitration. Upon the request, TDI would select an arbitrator and require a determination not less than 30 days after the arbitrator receives the necessary information. Not later than 30 days after the arbitrator's written decision is provided, the issuer would be required to pay the facility.

TAHP POSITION: Oppose

COVERAGE TYPES: Commercial

EFFECTIVE DATES: Claims submitted after 1/1/24

TAHP POSITION STATEMENT: SB 1264 from the 86th legislative session was thoroughly negotiated to create dispute resolution systems including keeping facilities in the mediation system for disputing surprise bills. Instead of providing fair and honest billing and attempting to reach in-network agreements, freestanding ERs continue to harm patients and are now asking for special treatment that goes against SB 1264.

Over 80% of mediation requests come from FSERs as these companies have hired vendors to go back years to find more claims to take to mediation. But even with this volume of claims, over 90% are resolved in an informal phone call and just 1% of claims remain unresolved after

mediation. For those very small number of claims SB 1264 allowed providers to pursue a civil action. SB 1264 painstakingly envisioned all scenarios including bad faith mediation. This legislation goes against that legislation to reward freestanding ERs that have continuously price gouged for basic health care services including $10,000 COVID-19 Tests. DATE UPDATED: 3/5 KS 3/13 BH

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

SB 1306 Hancock, Kelly Surprise Billing ERISA Opt In

Companions: HB 1592 Oliverson, Tom(R) (Identical)
3- 3-23 H Introduced and referred to committee on House Insurance

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

TAHP POSITION: Neutral/Watch

COVERAGE TYPES: Commercial

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT: TAHP is neutral on this proposal to allow employers to decide if they would prefer to use the state or federal balance billing dispute process as employers pay their own claims and the costs associated with the arbitration & mediation systems through either approach. However, TAHP continues to be concerned about inflationary provisions in the state's dispute resolution system which utilizes billed charges in an arbiters determination.

Billed charges are inflated prices that don't reflect what anyone actually pays for health care. As one researcher noted, "Billed charges are effectively just made up." Studies show taking billed charges into account during arbitration only incentivizes providers to make up higher and higher numbers. A new report by the Texas Department of Insurance found that average billed charges in arbitration increased by threefold from 2020 to 2022 resulting in final arbitration amounts more than doubling during the period. These costs ultimately drive up health care spending for businesses and families.

DATE UPDATED: 2/3/23 JB

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

SB 1307 Hancock, Kelly Multiple employer welfare arrangements

Companions: HB 290 Oliverson, Tom(R) (Identical)
3-14-23 H Voted favorably from committee on House Insurance

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

TAHP POSITION: Neutral

COVERAGE TYPES: MEWAs

EFFECTIVE DATES: 9/1/23

DATE UPDATED: 2/1 KS

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

SB 1342 Perry, Charles OIG third party liability

Companions: HB 3119 Smithee, John(R) (Identical)
3-14-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: In March 2022, federal third party liability requirements were updated. This bill requires third parties (other than Medicare) to accept the state's "authorization" that the item or service is covered under the state plan as if the authorization were the prior authorization made by the third party for the item or service. It also adds a 60-day timeliness requirement in which the third party must respond to a state's inquiry about a claim, and adds that a third party must agree not to deny a state's claim for failure to obtain prior authorization for the item or service.

TAHP POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/5 by JL

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

SB 1354 Miles, Borris Rita Littlefield Resource Center

Companions: HB 1876 Guillen, Ryan(R) (Identical)
3- 7-23 H Introduced and referred to committee on House Public Health

Remarks: SUMMARY: This bill would establish the Rita Littlefield Resource Center, which would create a centralized system for persons to obtain information about kidney disease and enroll in clinical trials.

TAHP POSITION: Neutral

EFFECTIVE DATES: 9/1/25

DATE UPDATED: 2/22 KS

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

SB 1359 Schwertner, Charles Telemedicine services

Remarks: SUMMARY: This bill would require issuers to submit an annual report to TDI on whether each participating provider provide services in person in the area in which the plan's enrollees reside or through the use of telemedicine or telehealth services.

TAHP POSITION:

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

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/5 KS

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

SB 1365 Hinojosa, Chuy Grant program for children's mental health

Companions: HB 1898 Jetton, Jacey(R) (Identical)
3-20-23 H Meeting set for 2:30 P.M. OR ADJ., E2.026, House Select on Youth Health & Safety

Remarks: SUMMARY: Establishes a new grant program for children's hospitals to increase capacity to provide mental and behavioral health care services.

Requires a biannual report listing grant recipients and award amounts.

POSITION: Neutral

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 2/10 by JL

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

SB 1408 Miles, Borris Establishment Rare Disease Advisory Council

Companions: HB 4619 Johnson, Ann(D) (Identical)
3- 9-23 H Filed

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

SB 1411 Miles, Borris End stage renal Medicaid coverage

Remarks: SUMMARY: Provides Medicaid coverage for individuals who have endstage renal disease and is eligible for Medicaid because of an emergency medical condition.

TAHP POSITION: Neutral

COVERAGE TYPES: Medicaid

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/5 by JL

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

SB 1458 Miles, Borris Newborn Medicaid ID

Companions: HB 4476 Campos, Liz(D) (Identical)
3- 9-23 H Filed

Remarks: SUMMARY: Requires HHSC to provide annual written notice to providers stating that when a newborn child of a woman receiving Medicaid has not been assigned a Medicaid ID number, the provider may use the mother's ID when filing for reimbursement. The notice must encourage providers to inform pregnant moms of this information. Requires a hospital, birthing center, physician, nurse midwife, or midwife to provide eligibility information in English and Spanish.

TAHP POSITION: Support

EFFECTIVE DATE: DSHS must include the informational materials by Dec. 1, 2023 and providers are required to comply Jan. 1, 2024

TAHP POSITION STATEMENT: It is estimated that roughly 70,000 newborns whose mothers receive Medicaid are not enrolled in Medicaid upon birth. These children are eligible for benefits, but not enrolled.

DATE UPDATED: 3/16 by JL

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

SB 1496 Johnson, Nathan Using exchange data for CHIP eligibility

Remarks: SUMMARY: Repeals language in statute that prohibits accepting Medicaid eligibility determinations from the exchange. Allows HHSC to automatically enroll children in CHIP if income information used for the exchange indicated eligibility.

TAHP POSITION: Neutral

COVERAGE TYPES: CHIP

EFFECTIVE DATES: Sept. 1, 2023

DATE UPDATED: 3/6 by JL

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

SB 1502 Middleton, Mayes (F) Health Plan Affiliated Providers

Companions: HB 3098 Johnson, Ann(D) (Identical)
3-21-23 H Meeting set for 8:00 A.M., E2.014, House Insurance

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

same health care service.

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

TAHP POSITION:

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

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

TAHP POSITION STATEMENT:

DATE UPDATED: 3/8 KS

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

SB 1534 Schwertner, Charles Non Compete Clauses

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

TAHP POSITION:

COVERAGE TYPES:

EFFECTIVE DATES: 9/1/23

TAHP POSITION STATEMENT:

DATE UPDATED: 3/12 KS

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

SB 1576 Schwertner, Charles Co-Pay Accumulator Prohibition Mandate

Companions: HB 999 Price, Four(R) (Identical)
3- 2-23 H Introduced and referred to committee on House Select on Health Care Reform

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

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

COVERAGE TYPES: Commercial

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

MANDATE: Contract

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

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

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

SB 1580 Bettencourt, Paul Right to try cutting-edge treatments

Companions: HB 4059 King, Ken(R) (Identical)

HB 4348	3- 8-23 H Filed Harrison, Brian(R) 3- 9-23 H Filed	(Identical)

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

SB 1581 Bettencourt, Paul Establishment the Health Insurance Mandate

Remarks:

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

EFFECTIVE DATES: 1/1/24

TAHP POSITION: Support

POSITION STATEMENT: This bill aligns with the Select House Committee on Health Care Reform's interim recommendation to “Consider opportunities to leverage the Texas All-Payor Claims Database to determine the true cost impact of benefit mandates.” Texas lawmakers don’t have the information they need on the cost and impact of health insurance mandates and regulations on Texas employers and families. Texas regulations and mandates hinder innovation and add costs to an already expensive system—forcing employers and families to bear the cost of one-size-fits-all coverage. Each mandate raises costs that are passed on in higher premiums. In 2021, Texas reached a high-water mark for the number of mandates placed on health insurance. Following the session, Texans saw a 13% increase in premiums, while around the nation, year-over-year premiums were flat. Before approving a new mandate, other states have processes to carefully review the full impact of mandates on businesses and families, health care costs, and health needs. Those states arm lawmakers with the info they need to make informed decisions. The legislation would establish the Texas Health Insurance Mandate

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

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

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

SB 1588 Blanco, Cesar — Variances from DSHS

Companions: HB 5117 Morales, Eddie(D) (Identical)
3-10-23 H Filed

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

SB 1619 Perry, Charles — VDP reimbursements

Companions: HB 3214 Howard, Donna(D) (Identical)
3-15-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: Prohibits VDP from including any discount price offered for the prescription drug, including a discount offered through a third party discount card, in determining the usual and customary price of a prescription drug for purposes of determining the reimbursement amount.

TAHP POSITION: Neutral

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/8 by JL

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

SB 1623 Eckhardt, Sarah — Coverage provision abortion and contraception

Companions: HB 3586 Cole, Sheryl(D) (Identical)
3-16-23 H Introduced and referred to committee on House Human Services

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

SB 1666 Parker, Tan (F) — Continuity of care

Companions: HB 3985 Raney, John(R) (Identical)
3- 8-23 H Filed

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

SB 1667 Parker, Tan (F) Newborn screening

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

SB 1669 Lamantia, Morgan (F) Newborn Medicaid ID study

Companions: HB 4253 Campos, Liz(D) (Identical)
3- 8-23 H Filed

Remarks: SUMMARY: Requires HHSC to conduct a study to assess whether it is providing Medicaid coverage to infants born to mothers on Medicaid, in compliance with federal guidelines and requirements.

TAHP POSITION: Neutral

EFFECTIVE DATES: The study must be submitted by Sept. 1, 2024

DATE UPDATED: 3/8 by JL

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

SB 1675 Johnson, Nathan Food is Medicine pilot

Companions: HB 2983 Oliverson, Tom(R) (Identical)
3-14-23 H Introduced and referred to committee on House Human Services

Remarks: SUMMARY: Establishes a 5-year food is medicine pilot program with FQHCs or other managed care providers. Eligible individuals are those who have chronic disease, including diabetes, congestive heart failure, chronic pulmonary disease, kidney disease, that is impacted by the individual's diet and limits at least one activity of the individual's daily living; and who experience food insecurity and have at least one chronic health condition directly impacted by the nutritional quality of food that would support treatment and management of the condition. The pilot is limited to no more than 6 service areas and is available to the 10 largest counties and Hidalgo County. Gives HHSC rulemaking authority to establish eligibility criteria. Requires reporting at three different intervals; the final report must include medical outcomes, a cost

analysis, and a recommendation by the agency on next steps.

TAHP POSITION: In review

COVERAGE TYPE: Medicaid

EFFECTIVE DATE: Sept. 1, 2023

DATE UPDATED: 3/5 by JL

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

SB 1692 Blanco, Cesar Medical assistance program

Companions: HB 2216 Cortez, Philip(D) (Identical)
3- 9-23 H Introduced and referred to committee on House Select on Health Care Reform

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

SB 1694 Blanco, Cesar Medicaid vagus nerve stim therapy

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

SB 1695 Blanco, Cesar MCOs as case assistance affiliates

Companions: HB 3571 Lujan, John(R) (Identical)
3-16-23 H Introduced and referred to committee on House Human Services

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

SB 1696 Blanco, Cesar Family member attendants and wages

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

SB 1700 Blanco, Cesar Practicing nurses

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

SB 1715 Perry, Charles Family health aides in Medicaid

Companions:

HB 3807	Klick, Stephanie(R)	(Identical)
	3- 7-23 H Filed	

Remarks: SUMMARY: Requires HHSC to enable a parent, legal guardian, or family member of a STAR Kids recipient receiving private duty nursing services to provide those services as a licensed health aide. The family member must become licensed as a health aide and requires HHSC to establish a training aide program. The family member must be employed by the home and community support services agency that employs the nurse providing private duty nursing services to the member. Services must be performed under supervision. Gives HHSC rulemaking authority. Requires HHSC to establish a registry of licensed family health aides. Reimbursement is subject to an enhanced reimbursement rate of a certified nursing assistant.

COVERAGE TYPE: Medicaid

EFFECTIVE DATE: HHSC must implement the program by Sept. 1, 2024

TAHP POSITION STATEMENT: In review

DATE UPDATED: 3/8 by JL

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

SB 1723 Paxton, Angela Backdating referrals managed care health

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

SJR 6 Zaffirini, Judith 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

SJR 14	Johnson, Nathan(D)	Session) (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: 2-15-23 S Introduced and referred to committee on Senate Health and Human Services

SJR 10 Johnson, Nathan Medicaid Expansion constitutional amendment

Companions:

HJR 9	Reynolds, Ron(D)	(Refiled from 87R Session)
HJR 23	Israel, Celia(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	
HJR 17	Bernal, Diego(D)	(Identical)
	2-28-23 H Introduced and referred to committee on House Select on Health Care Reform	

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

	All	Track
Total Bills:	120	120

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

Add to Track