

86th Texas Legislative Session

TAHP
The Texas Association of Health Plans

S E S S I O N H I G H L I G H T S

HEALTH PLAN HIGHLIGHTS

from
the **86th**

**LEGISLATIVE
SESSION**



TAHP 2019 Legislative Session Statistics

- TAHP monitored 516 pieces of legislation. Of these filed bills, TAHP actively supported 91 bills and opposed 109 bills.
- Out of these bills, 281 received a committee hearing in the House or Senate. TAHP provided testimony 52 times, including 11 times in support and 26 times in opposition. TAHP registered a position or “submitted” a card 80 times, including 60 times in support and 20 times in opposition. Overall, TAHP submitted written testimony 71 times.
- TAHP successfully advocated for 9 pieces of priority legislation that have been signed by Gov. Greg Abbott.



Texas Association of Health Plans

Letter From the CEO	6
Health Plan Highlights From the 86th Texas Legislature	7
TAHP Priority Legislation.....	8
Protecting Texans From Surprise Medical Billing.....	8
SB 1264: Surprise Billing Ban.....	8
SB 1037: Consumer Credit Surprise Billing Protection.....	11
Reigning in Freestanding Emergency Rooms	12
HB 2041: FSER Network and Price Transparency	12
HB 1941: FSER Price-Gouging Protection.....	13
HB 1112: FSER “Emergency” Signage Removal	13
Prescription Drug Price Transparency	14
HB 2536: Prescription Drug Price Transparency Reporting	14
Combating the Opioid Crisis	16
HB 2174: Opioid Dispensing Restrictions.....	16
HB 3284: Electronic Prescribing System Reforms	16
Additional Priority Legislation	17
SB 1153: Texas Life and Health Guaranty Association Act Modernization.....	17
SB 1852: “Consumer Choice” Health Plan Renewal Process Efficiency.....	17
SB 1940: Temporary “Risk Pool” Reauthorization.....	18
Key Legislation Affecting the Health Insurance Industry.....	19
SB 1742: Health Plan Provider Directory, Prior Authorization Transparency, and UR Requirements.....	19
HB 3911: PPO Network Adequacy Examination.....	21
HB 3041: Prior Authorization Renewal Requests.....	21
HB 1584: Stage IV Advanced Metastatic Cancer Step Therapy Prohibition	21
HB 170: Diagnostic Mammogram Coverage Cost-Sharing Removal.....	21
HB 29: Physical Therapy Referral Requirements	22
HB 2486: Dental Plan Operational Reforms	22
HB 3345: Telemedicine Claim Denial Prohibitions.....	23
SB 747: Newborn Screening Reimbursement Requirement	23
SB 1739: Chiropractor Discrimination Prohibition	23
SB 1056: Physician to Pharmacist Drug Therapy Protocol Delegation.....	24
HB 3441: Pharmacist Discrimination Prohibition.....	24
HB 1757: Enrollee Pharmacist Selection.....	24
HB 1455: Health Plan and PBM Pharmacy Audit Prohibitions.....	24
HB 3496: Independent Pharmacy Transparency Requirements	25
HB 3306: Corporate Governance Structure Disclosure Requirements	25
HB 2694: Insurer Investment Authorization	25
HB 3934: HCC Rural Hospital Inclusion	25
Key Legislation Affecting Medicaid Managed Care.....	26
SB 1207: Medicaid Program Reforms.....	26
SB 1096: STAR Kids Prescription Drug Formulary Requirements.....	28
HB 1576: Rideshare and Transportation Carve-In	29

Texas Association of Health Plans

HB 4533: IDD Pilot and Carve-In Delay.....	29
SB 750: Maternal Health Reforms	30
SB 748: Newborn Screening Preservation Account and Pregnancy Home Pilot	31
SB 943: State Contracting Transparency	31
SB 1564: MAT Reimbursement.....	31
SB 1283: Antiretroviral Drug Prior Authorization Prohibition	31
SB 1991: Electronic Visit Verification Systems and Recoupment Processes.....	31
SB 670: Teleservices Benefits.....	32
HB 1063: Telemonitoring Benefits	32
SB 1177: “In Lieu of” Behavioral Health Benefits.....	32
HB 25: Maternal Transportation Pilot	32
SB 170: Rural Hospital Reimbursement Standards.....	33
SB 22: Abortion and Affiliate Provider Restrictions.....	33
HB 72: Adoptive Parents STAR Health Option.....	33
Key Legislation Affecting Public Health.....	34
SB 11: Mental Health Access	34
HB 253: Postpartum Strategic Plan Development.....	34
SB 436: Maternal Opioid Use Disorder Assessment and Treatment	34
SB 2132: HTW Program Promotion	34
SB 2150: Pregnancy-Associated Death Reporting	35
SB 749: Maternal Level-of-Care Designation Appeals.....	35
HB 2050: Antipsychotic Medications Nursing Facility Consent Requirement.....	35
SB 1780: Value-Based Drug Purchasing Agreement Authorization	35
HB 871: Trauma Designation via Telemedicine for Rural Facilities	35
SB 1621: Limited Services Rural Hospital Licensure	35
HB 1504: TMB Reforms and Renewal	36
Preventing Costly Government Mandates and Regulations.....	37
HB 2099 & SB 580: Formulary Freeze.....	37
HB 2327 & SB 1186 / HB 2387 & SB 1187: Prior Authorization Restrictions.....	37
HB 1832 & SB 1282: Emergency Care UR Prohibition.....	37
HB 2817 & SB 846: PBM Contracting Mandate.....	38
HB 2231 & SB 2261: PBM Contracting Restrictions	38
HB 1880 & SB 1188: Provider Directory Mandate.....	38
HB 1905 & SB 744: Provider Termination Prohibition	39
HB 1914: Out-of-Network Prompt Pay Penalties	39
HB 2367: ERS and TRS Prohibition.....	39
HB 12 & SB 2225 / HB 1295 / HB 1635 & SB 1956: Early Childhood Intervention Benefit Mandate.....	39
HB 2631 & SB 1796: Expedited Physician Credentialing.....	39
HB 2520 & SB 1740: Facility-Based Provider Cost Estimates.....	39
HB 317: Lab Management Limitations	40
HB 2632 & SB 1795: Direct Notice Mandate.....	40
HB 3058: HIV and AIDS Prior Authorization Prohibition	40
HB 501 & SB 314: Serious Emotional Disturbance Benefit Mandate.....	40

Texas Association of Health Plans

HB 670: Ovarian Cancer Treatment Benefit Mandate.....	40
HB 762: HIV and AIDS Testing Benefit Mandate.....	40
HB 923: Alternative Treatment Mandate.....	40
HB 4277: SOAH Complaint Appeals Process Change.....	41
HB 701: Call Center Regulatory Mandate.....	41
HB 2408 & SB 1741: Mandated Benefit Prior Authorization Prohibition.....	41
HB 217: Hair Prosthesis Benefit Mandate.....	41
HB 1278: FSER Scope of Practice and Licensure Expansion.....	41
HB 698 & SB 469: Pharmacy Cost Discussion Prohibition.....	41
HB 2151 & SB 1508: Audit Extrapolation Prohibition.....	41
HB 1718: Out-of-Network “Right to Shop” Mandate.....	42
HB 1124: “Delisting” Private Cause of Action.....	42
SB 1509: OPIC Network Adequacy Authorization.....	42
HB 4404: FSER Advisement Prohibition.....	42
HB 2962 & SB 1886: Network Adequacy Waiver Restrictions.....	42
HB 1156: Individual Coverage Disclosure Regulatory Mandate.....	42
HB 4351: Emergency Care Prior Authorization and UR Restrictions.....	42
SB 344: Campus-Based Mental Health Services Contract Mandate.....	42
HB 2658: Hearing Aid Benefit Mandate.....	43
SB 2020: Health Underwriting Prohibition.....	43
HB 937 & SB 795: Contraceptive Supply Mandate.....	43
HB 1968: Craniofacial Benefit Mandate.....	43
HB 4391: Health Plan Network Elimination.....	43
HB 1511: Eating Disorders Treatment Benefit Mandate.....	43
HB 2114 & SB 1645: Pre-Existing Conditions Mandate.....	43
HB 2682 & SB 959: Fertility Preservation Services Benefit Mandate.....	43
HB 3039: Bacterial Meningitis Vaccine Benefit Mandate.....	44
SB 145: ACA Benefit Mandate.....	44
HB 4393: Chemical Dependency Benefit Mandate.....	44
HB 4420: Embryonic and Fetal Tissue Remains Disposition Benefit Mandate.....	44
HB 4442: General Anesthesia Mandate.....	44
SB 107: PTSD Mandate.....	44
HB 3984: Scalp Cooling Benefit Mandate.....	44
SB 825: Pre-Existing Conditions Mandate.....	44
SB 2218: Serious Mental Illness Mandate.....	45
HB 3064: Third-Party Liability Claim Delay Prohibition.....	45
HB 3232: Network Provider Prior Authorization Prohibition.....	45
HB 3338: ID Card HMO Identifier Requirement.....	45
86th Texas Legislature Medicaid Budget Highlights.....	46
SB 500: FY 2019 Supplemental Appropriations Act.....	46
HB 1: FY 2020-2021 General Appropriations Act.....	46
Budget Cost Containment Provision.....	47
Additional Health and Human Services Budget Highlights.....	47

Texas Association of Health Plans



Dear Colleagues,

The 86th Session of the Texas Legislature has come to a close. While the spotlight this session was on fixing school finance and property taxes, I'm pleased to report that 2019 has been a landmark session for protecting Texas consumers from surprising billing, freestanding emergency rooms, exorbitant prices, the opioid epidemic, and rapidly rising drug prices.

TAHP used every tool at our disposal, including targeted meetings at the Capitol, committee testimony, educational materials, and our Texans for Affordable Healthcare and Texas Medicaid Works campaigns, to advocate for a wide range of policy changes with the overall goal of ensuring every Texan has access to high quality, affordable health coverage.

Thanks to the hard work of our members, allies, and staff, TAHP was able to successfully work with legislators to create, shape, and pass bills that create the nation's strongest consumer protections against surprise medical billing (SB 1264), freestanding emergency rooms (HBs 2041 and 1941), and high drug prices (HB 2536).

TAHP and the Medicaid health plans also worked closely with legislators, the Health and Human Services Commission, clients, families, and the entire health care community this session to develop recommendations that strengthen and modernize the Medicaid program while ensuring Medicaid managed care plans continue providing high quality health coverage to the millions of Texans that depend on the Medicaid program.

In this guide you will find a detailed report on Texas' 86th Legislative Session. We can't say "Thank you" enough to all our members for the invaluable collaboration and support you provided over the past six months, but please know we are truly grateful and appreciative of your hard work. Please continue to stay in touch with us and never hesitate to share your ideas for how we can better represent the health insurance industry and make a positive difference for the millions of Texas consumers who depend on you for affordable coverage.

Sincerely,

Jamie Dudensing

Texas Association of Health Plans

Health Plan Highlights from the 86th Texas Legislature

During the 86th Legislature, the Texas Association of Health Plans advocated to maintain a competitive health insurance market and strong Medicaid managed care program in Texas. By actively monitoring the progress of several hundred bills and staying in close contact with legislators and their staffs throughout session, TAHP and its members secured a number of key legislative victories that support our overall goals of ensuring an affordable and stable health insurance market and an efficient, cost-effective, and high-quality Medicaid program for taxpayers.

TAHP also worked to educate legislators and their staffs on the negative consequences of overly-prescriptive regulations and burdensome government mandates that stifle innovation in the Medicaid program and drive up the cost of health coverage. TAHP and its member plans were instrumental in preventing many measures, including those that would have restricted private market negotiations, reduced competition, negatively impacted the ability of MCOs to provide high-quality care, increased costs for Texans, and limited affordable health plan coverage options, from advancing this session.

TAHP 2019 Legislative Session Statistics

- TAHP monitored 516 pieces of legislation. Of these filed bills, TAHP actively supported 91 bills and opposed 109 bills.
- Out of these bills, 281 received a committee hearing in the House or Senate. TAHP provided testimony 52 times, 11 times in support and 26 times in opposition. TAHP registered a position or “submitted a card” 80 times, 60 times in support and 20 times in opposition. Overall, TAHP submitted written testimony 71 times.
- TAHP successfully advocated for 9 pieces of priority legislation that have been signed by Gov. Greg Abbott.

Overall, the 86th Legislature produced positive results that will protect Texas consumers and enable health plans to continue providing affordable health coverage. In their passage of sweeping legislation addressing surprise medical bills, reigning in freestanding emergency room abuses, and improving drug price transparency, Texas lawmakers have passed some of the strongest consumer protections and initiatives to lower the cost of health care in the nation. Thank you to all our members for your invaluable support and insight throughout session.

Solutions for Affordable, High-Quality Health Care for Texans



The Texas Association of Health Plans (TAHP) advocates for a sound and competitive health insurance market that maximizes private market competition, consumer choice and affordable coverage options. Health plans play an important role in lowering costs and getting the best possible price for hospital stays, doctor visits and prescription drugs.

Despite efforts by health plans to hold down the cost of monthly premiums, the cost of health care is high and still rising all over the country. Americans are more worried about their health care costs than ever. Now is the time to make sure all Texans have access to high-quality care they can afford no matter how much money they make or if they have pre-existing conditions.

Texas health plans are committed to lowering costs, providing high-quality, affordable coverage that protects Texans and their families, and empowering Texans to take control of their health.

5 Key Solutions to Lower the Cost of Care:



Create Real Price, Quality and Network Transparency:

When Texans have access to the health care information they need, they have the power to care for themselves, protect their families and better manage their health care costs. More than two-thirds of Texans that track comparing health care prices before getting care reported saving money. With more transparency, Texans will be able to shop for quality health care and insurance they can afford.

- TAHP supports increasing transparency and access to health care provider prices, quality standards and network status for all Texans.
- TAHP supports letting health plans easily share quality and value comparison information with Texas consumers participating in their networks.

Recommendations for a Stronger STAR Kids Medicaid Managed Care Program



STAR Kids was implemented in 2016 and is the Medicaid managed care program for the population most recently added to managed care—children, adolescents and young adults with disabilities and complex medical needs. Clients in the STAR Kids program choose a Medicaid managed care organization (MCO) to manage their benefits, which include preventive care, prescription drugs, hospital care, private duty nursing, durable medical equipment and long-term services and supports.

As the Texas Legislators and HHSOC take a closer look at the managed care system and its oversight of the STAR Kids program, the Texas Association of Health Plans (TAHP) and Medicaid health plans offer our full commitment to working with members of the legislature, HHSOC, the health care community, clients and families to help strengthen the oversight and accountability of the program.

Strengthen and Streamline the HHSOC Complaint Process:

- Clients should have a simple, low-cost, door process to register complaints with HHSOC and receive timely information on the resolution of their complaint. HHSOC must also have efficient and streamlined complaint processes to ensure accurate and transparent data to oversee contracts, quickly identify access to care issues and inform policy decisions.
- TAHP supports implementing a no-wrong-door complaint process with consistent tracking and definitions across HHSOC, including an expedited process for urgent access to care issues.

Improve the Medicaid Fair Hearing Process:

- Texas Medicaid clients should have easy access to a simple, transparent Fair Hearing process when they feel they have been wrongfully denied a service or eligibility to a program. The Medicaid Fair Hearing process should not only ensure administrative processes are correctly followed by HHSOC and Medicaid health plans, but also that any denial or reduction of services by HHSOC or a health plan are reviewed by an independent and qualified clinician. Additionally, when HHSOC determines a client does not meet the medical need to be eligible for a program, an independent and qualified clinician should review that decision.
- TAHP supports improving the Medicaid Fair Hearing process for clients through education and the adoption of a clear, consistent and transparent processes.
- TAHP supports including an independent review organization led medical review when a client receives a denial of a service by TAHP or a health plan, or when they are denied eligibility for a program by HHSOC.

Improve the Star Kids Screening Assessment (SK-SAI) Tool:

- It is important for every child to be screened for needed services. HHSOC currently requires Medicaid health plans to assess every child in the STAR Kids program using the STAR Kids assessment tool; however, it is a cumbersome and extremely long form that families and health plan service coordinators find difficult to use, resulting in negative member experiences. The process should be person-centered, include only accurate screening questions, and result in a positive experience for the family.

Solutions for Modernizing Texas Medicaid



Over the past 20 years, Texas transformed an outdated Medicaid system that provided fragmented care into a modern, patient-centered health insurance program that provides more than 4 million Texans with the coverage and care they need. While Texas Medicaid health plans have worked collaboratively with the legislature and HHSOC to increase access to care, improve health outcomes and control the cost of the Medicaid program over the past two decades, the Medicaid managed care system can and should continue to be improved. As the Texas Legislature and HHSOC take a closer look at the managed care system and its oversight, the Texas Association of Health Plans (TAHP) and Medicaid managed care organizations (MCOs) offer our full commitment to work with members of the legislature, HHSOC, the health care community, clients and Texas families to help strengthen the program.

Texas Medicaid health plans collaborate with the best doctors, negotiate the most affordable prices, and focus on prevention, wellness, and care coordination to help their members get healthy, stay healthy and live their lives to the fullest in their own communities. More than 80% of all Texas doctors are currently in Medicaid health plan networks, delivering vital care to some of the most vulnerable Texans. To help maintain and increase access to high-quality care and keep doctors participating in Medicaid, Texas needs to reduce and eliminate unnecessary administrative burdens and red tape. Additionally, modernizing the Medicaid program's policies and processes to better reflect the transition to managed care will ensure more timely, accountable and quality care while eliminating unnecessary and costly administrative processes that do not benefit patients or taxpayers.

5 Key Solutions for Modernizing Medicaid:



Modernize the Medicaid Program:

Texas Medicaid health plans collaborate with the best doctors, negotiate the most affordable prices, and focus on prevention, wellness, and care coordination to help their members get healthy, stay healthy and live their lives to the fullest in their own communities. More than 80% of all Texas doctors are currently in Medicaid health plan networks, delivering vital care to some of the most vulnerable Texans. To help maintain and increase access to high-quality care and keep doctors participating in Medicaid, Texas needs to reduce and eliminate unnecessary administrative burdens and red tape. Additionally, modernizing the Medicaid program's policies and processes to better reflect the transition to managed care will ensure more timely, accountable and quality care while eliminating unnecessary and costly administrative processes that do not benefit patients or taxpayers.

Texas Association of Health Plans

TAHP Priority Legislation

The legislative session yielded a number of patient protections that were top priorities for TAHP members, including surprise billing, rising prescription drug costs, and the opioid epidemic. Texas passed some of the strongest consumer protections on these three topics, but they did not stop there. Texas also passed real protections to address the exorbitant charges and misleading information happening at freestanding ERs. Somewhat unexpectedly, the 86th Session of the Texas Legislature has been one of the most significant health care sessions in Texas' recent history.

Protecting Texans From Surprise Medical Bills

Despite their best efforts, thousands of Texans get slammed with expensive and unexpected surprise medical bills, often for thousands of dollars. In an emergency, patients often must rush to the nearest ER. They usually have no ability to pick the doctors who treat them and do not know if those doctors are in their insurance network. It is nearly impossible for Texans to stay in network for every service they receive in an emergency, even when they make sure to go to the right hospital. Surprise medical bills are a major problem nationally, but the problem is even worse in Texas. As it stands, one in three admissions to a Texas ER results in the patient receiving an expensive surprise medical bill—a rate that is only one in five nationally. Texas' out-of-network (OON) emergency care problem is driving up health care costs for all Texans and causing high rates of surprise medical billing. This session, lawmakers passed two major bills addressing the issue including a ban on surprise billing by OON providers of emergency services and facility-based services at network hospitals.

Surprise Billing Drives Up Costs for All Texans



In an emergency, patients often must rush to the nearest ER. They usually have no ability to pick the doctors who treat them and typically do not know if those doctors are in their insurance network. Too often, in emergencies where patients do not pick their providers, care is followed by expensive surprise medical bills. Texas' out-of-network emergency care problem is driving up health care costs for all Texans and causing high rates of surprise medical billing.

Mediation Works When Triggered

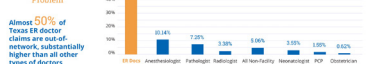
- **Consumers can count on mediation protections:** Consumers who are able to access mediation and challenge surprise medical bills can save thousands. Providers are prohibited from billing patients once mediation is triggered and patients do not have to participate in the mediation process.
- **Mediation solves disputes and saves money:** Since 2015, more than 11,000 Texans have saved over \$25 million in expensive surprise medical bills for an average of \$2,200 in savings per bill according to TD.
- **The problem:** While mediation protects some Texans from expensive surprise medical bills, few Texans understand the process or even know it exists. According to TD, out of the 250,000 Texans that receive surprise medical bills every year, fewer than 10,000 use the mediator process.

Texans Still Has a Surprise Billing Problem, Particularly in the ER

Surprise Bills Are Inevitable in Texas. In an emergency, it is nearly impossible for Texans to stay in-network for every service they receive, even when they make sure they go to a network hospital. In fact, more than 65% of out-of-network ER doctor claims occur at network hospitals.



Texas Has a Chronic Out-of-Network ER Problem



Source: TDHHS, Texas Health Care Cost Transparency Report, 2018. TDHHS, Texas Health Care Cost Transparency Report, 2018. TDHHS, Texas Health Care Cost Transparency Report, 2018.

TEXAS ASSOCIATION OF HEALTH PLANS JANUARY 2020

HEALTH INC.
His \$109K Heart Attack Bill Is Now Down To \$332 After NPR Told His Story

CHAD TERPINE
August 31, 2018 1:04 AM ET
Heard on All Things Considered
FROM NPR

A Texas hospital that charged a teacher \$108,951 for care after a 2017 heart attack told the patient Thursday it would slash the bill to \$332.29 — but not before a story about the huge charge sparked a national conversation over what should be done to combat surprise medical bills that afflict a growing number of Americans.

State Lawmakers Approve Legislation Shielding Most Texans From Surprise Medical Bills

By ASHLEY LOPEZ, KUT MAY 21, 2019

Share Tweet Email

A surprise medical bill may be a thing of the past for many Texans. In a unanimous vote, the Texas House approved a Senate bill banning health care providers from sending steep medical bills to insured Texans in emergencies.

Senate Bill 1264 passed the Texas House on a 146-0 vote. If signed into law, it would remove patients from

Surprise Billing Ban

Senate Bill 1264 by Sen. Hancock & Rep. Oliverson

SB 1264 builds upon a law passed by Sen. Hancock in 2009 that made mediation available to consumers who received surprise balance bills from one of six specific types of facility-based providers.

Prohibition on Surprise Balance Billing

SB 1264 protects Texas consumers by prohibiting surprise balance billing by out-of-network (OON) providers of emergency services, facility-based services at a network hospital, and lab and diagnostic imaging services that

are related to a network service. These providers may not “balance bill” for any amount greater than the applicable copayment, coinsurance, or deductible under the benefit plan based on the initial amount determined payable by the health plan (the initial “allowed amount”), or, if applicable, a modified amount determined under the plan’s internal appeal process.

The prohibition on balance billing does not apply to elective non-emergency health care services when the patient has received advanced written notice of the service and their potential financial responsibility from each OON provider associated with the service.

Texas Association of Health Plans

Usual and Customary Rates

SB 1264 applies to claims covered by commercial HMO, EPO, and PPO plans and to ERS and TRS (non-HMO) plan administrators. These plans must process claims at the “usual and customary rate” for OON emergency services, facility-based services at a network hospital, and lab and diagnostic imaging services that are related to a network service. They must provide explanations of benefits (EOBs) to enrollees and OON providers stating that balance billing is prohibited in these situations and specifying the amount the provider may bill the enrollee as copayment, coinsurance, or deductible amount under the benefit plan. The Texas Department of Insurance (TDI) will adopt rules on notification language to be included in provider EOBs advising of the OON dispute resolution process. The bill requires health plans to pay these claims directly to the OON provider within 30 days for an electronic claim and 45 days for a non-electronic claim if they are “clean” claims (as defined by TDI prompt payment rules) and include all information necessary to pay the claim. SB 1264 includes language clarifying that these provisions may not be construed to require prompt payment penalties to OON providers.

Dispute Resolution Process

SB 1264 establishes dispute resolution processes to determine a reasonable payment amount for OON services or supplies when providers believe the original payment was insufficient. TDI must establish a web portal to accept requests for dispute resolution and maintain lists of qualified mediators and arbitrators. The party requesting dispute resolution must notify TDI and the other party of the request. Because consumers cannot be balance billed or assigned additional liability through the dispute resolution process, they are not required to participate.

As with the current mediation process, OON providers and health plans must participate in an informal settlement teleconference within 30 days of the dispute resolution request unless extended by agreement. Currently, over 95% of disputes are settled prior to or during the informal teleconference.

If there is no resolution during the informal settlement process, the bill provides an alternate dispute resolution process. The type of process available is based on provider type. Claims from OON facilities, including freestanding

emergency room (FSER) claims and facility lab and imaging claims, may be disputed through a mediation process. Applicable claims from OON non-facility providers such as physicians may be disputed through “baseball-style” arbitration.

Mediation Process for Facility Claims

TDI must establish and administer a mediation program for qualifying OON facility claim disputes. Both parties must participate, and TDI will assign a mediator if the parties do not agree on one. Information submitted by the parties to the mediator is confidential and not subject to disclosure in response to an open records request. Mediation deadlines may be extended by agreement of the parties.

In a mediation, the parties must evaluate whether the amount charged by the OON facility is excessive and whether the amount paid by the health plan or administrator represents the usual and customary rate or is unreasonably low.

The bill repeals current provisions in the mediation chapter that refer disputes to the State Office of Administrative Hearings if not settled during the initial informal settlement stage. Instead, the bill creates a new section allowing either party to file a civil action to determine the amount due to an OON provider if the mediation did not result in a settlement. Neither party may bring a civil action before the conclusion of the mediation process.

Arbitration Process for Non-Facility Claims

TDI must also establish and administer an arbitration program. In arbitration, the only issue to be decided is which proposed level of payment is closest to the “reasonable amount” for the OON services or supplies. The arbitrator must choose either the provider’s billed charge or the health plan’s payment, as those amounts were last modified during the health plan’s internal appeal process or during the informal settlement teleconference.

Determination of whether the charge or payment (as modified) is the closest to the reasonable amount must take into account the following factors:

- Whether there is a gross disparity between the fee billed by the OON provider and:
 - fees paid to the same OON provider for the same services or supplies rendered to other enrollees for which the provider is an OON provider and

Texas Association of Health Plans

- o fees paid by the same health benefit plan issuer to reimburse similarly qualified OON providers for the same services or supplies in the same region.
- OON provider's training, education, and experience.
- OON provider's usual billed charges for comparable services or supplies to other enrollees for which the provider is an OON provider.
- Circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service or supply.
- Individual enrollee characteristics.
- 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in the benchmarking database.
- 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in the benchmarking database.
- History of network contracting between the parties.
- Historical data for the 80th percentile of all billed charges and 50th percentile of rates.
- An offer made during the required informal settlement teleconference.

Arbitration for applicable claims may be requested by a health plan, administrator, or OON physician or other non-facility provider within 90 days of the initial payment's receipt. The health plan issuer must make a reasonable effort to arrange the initial settlement teleconference within 30 days of the arbitration request.

If the parties do not agree on an arbitrator within 30 days, the party requesting arbitration must notify TDI, which will select an arbitrator from its list of approved arbitrators giving preference to an arbitrator "who is knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally." The arbitrator must set a date for submission of all information to be considered. Deadlines may be extended upon agreement of all parties. Discovery is not available in connection with arbitration. The parties will evenly split and pay the arbitrator's fees and expenses.

TDI will adopt rules regarding submission of multiple claims in one arbitration proceeding. Only claims from the same OON provider may be included, and the total amount in controversy for multiple claims in one proceeding may not exceed \$5,000. TDI is also responsible for selecting an organization to maintain a benchmarking database that contains information necessary to calculate the 80th percentile of billed amounts of all physicians or health care providers and the 50th percentile of rates paid to network providers for each geographical area in the state.

TAHP Supports SB 1264



Protect Texans From Surprise Medical Billing – End Surprise Billing in Emergencies and When Patients Do Not Choose Their Providers

Despite their best efforts, thousands of Texans are getting saddled with expensive and unexpected surprise medical bills, often for thousands of dollars. In an emergency, patients often must rush to the nearest ER. They usually have no ability to pick the doctors who treat them and do not know if those doctors are in their insurance network. It is nearly impossible for Texans to say in-network for every service they receive in an emergency, even when they make sure they go to the right hospital. Surprise medical bills are a major problem nationally, but the problem is even worse in Texas. As it stands, 1 in 3 admissions to a Texas emergency room results in a patient receiving an expensive surprise medical bill, higher than the rest of the nation.

These unjustifiably high priced and unexpected bills for medical treatment create tremendous financial burdens for families. In addition, Texas providers' inflated prices lead to health plans and employers paying far more for out-of-network services than the regulated market rates, which increases costs for all Texans. Texas has already seen the increased costs and out-of-network problems with surprise billing. Texas' emergency care prices have almost doubled over the past four years, with prices increasing from 500 percent to 900 percent of Medicare. Meanwhile, more than 44 percent of ER physicians are out-of-network, and Texas now has the most expensive emergency care prices in the country. Patients should never be financially penalized when they receive care from an out-of-network provider that did not choose. In these circumstances, providers should be prohibited by law from billing patients for costs not covered by their health plan. Instead, health plans, doctors and hospitals should be held responsible for initiating medication and using Texas' options to reach an agreement on prices.

SB 1264 Would Protect Consumers:

- Prohibits surprise billing and holds consumers harmless from surprise billing if they have commercial health coverage (HMO, EPO, & PPO) or ER/STRS plans.
- Protects consumers from having to pay more than their applicable co-pay, coinsurance or deductible responsibilities from the first bill.
- Protects consumers' credit by prohibiting the issuance of a consumer report as a result of surprise billing if the patient has health coverage.
- Reduces out-of-pocket costs for consumers.
- Protects consumers and employers from premium increases and high out-of-pocket costs from excessive billing and charges in Texas.
- Relies on private market negotiations instead of a government-mandated payment standard or single-payer standard.
- Forces medical providers and health insurers to mediate payment disputes instead of sending these bills to patients.

SB 1264 Protections Only Apply to Surprise Billing:

- SB 1264's protections only apply when patients cannot reasonably choose their providers.
- When patients are treated by out-of-network providers in an emergency.
- When patients are treated by out-of-network providers at an in-network facility.

TEXAS ASSOCIATION OF HEALTH PLANS | MARCH 2019
This is a legislative advertising paid for by the Texas Association of Health Plans (TAHP), 1001 Congress Ave., Suite 300, Austin, TX 78701. www.taahp.org

www.taahp.org
@taahporg
#taahp1919
facebook.com/taahp.org



Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.475.2051
www.taahp.org

Texas Association of Health Plans Testimony Senate Committee on Business & Commerce Re: Senate Bill 1264

March 21, 2019

Chairman Hancock, Committee Members:

The Texas Association of Health Plans (TAHP) represents health insurers, health maintenance organizations and other related health care entities that operate in Texas through employer-sponsored coverage, the individual insurance market and public programs such as Medicare and Medicaid. Our members are committed to improving access to affordable, quality health care in Texas.

Please consider this written testimony in support of SB 1264, which would prohibit and hold consumers harmless from surprise medical billing if they have commercial health coverage (HMO, EPO or PPO) or coverage through ER/STRS plans. Texas patients are being surprise billed through no fault of their own, and this bill would force medical providers and health insurers to mediate payment disputes instead of providers sending these excessive bills directly to patients.

Surprise medical bills are a major problem nationally, but the problem is even worse in Texas. In Texas, one in three admissions to an emergency room results in a surprise bill, while the national rate is one in five.¹ Over and over again, research has shown that staying out of network is a lucrative business model for ER doctors and freestanding ER (FSE/ER) in Texas. According to Yale's Zach Cooper, "this is a specific niche of providers who have found this unethical, narrow profit in the system where they can make significant amounts of money off the backs of patients."²

Unlike most other states, out-of-network ER providers in Texas are often paid three times the amount negotiated by in-network ER providers, then turn around and additionally surprise bill patients, often for thousands of dollars. Texas has already seen the increased costs and out-of-network problems caused by surprise billing. Texas' emergency care prices have almost doubled over the past four years — with prices increasing from 500 percent to 900 percent of Medicare. Meanwhile, more than 44 percent of ER physicians are out of network, and Texas now has the most expensive emergency care charges in the country.³

¹ Health Affairs, "The Top 10 National Emergency Department Costs: How Bad Is the Surprise Medical Bills Problem?", <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.37.11>

² Alan. "No Fault for the Surprise Emergency Care Costs," <https://www.aetna.com/surprise-billing-bills/health-insurance-providers/>

³ Healthcare, "The 100 Most Expensive ER Visits in 2018," <https://www.healthcare.com/news/100-most-expensive-er-visits-in-2018/>

⁴ "TAHP: TARP for Health Care Crisis Response," https://www.taahp.org/wp-content/uploads/2018/04/TAHP-ER-2018-04-28-0819-Texas-Justice-PHC-Cramer_Paid_3-15-19-compromised.pdf

HOUSTON CHRONICLE

Home Local Weather Politics ReNew Houston US & World Texas Sports Nation Sports Business

Jenny Deam

April 2, 2019 | Updated: April 2, 2019 7:05 p.m.



A woman waits for her husband to be treated in the trauma room at the University Hospital Emergency Room in San Antonio. New proposed Texas legislation would shield unsuspecting patients from surprise emergency room medical bills.

Jennifer Whitney/jwhitney@express-news.net

The Texas Senate's Committee on Business and Commerce approved legislation Tuesday to protect patients from surprise medical billing, advancing the measure to a full Senate vote and moving it closer to becoming law.

Testimony on complementary legislation was also heard in the House Insurance Committee, but no vote was taken as committee members said they would continue to re-tune their version of bill.

Texas Association of Health Plans

The arbitrator must provide the parties with a written decision within 51 days of the arbitration request. This deadline may be extended upon agreement of all parties. An arbitrator's decision is binding and may not be modified by the arbitrator. A plan issuer must pay any additional amount necessary to satisfy a binding award within 30 days of the arbitrator's decision. Within 45 days of the decision, a party not satisfied may file an action to determine the payment due to an OON provider. In such an action, the court will determine whether the arbitrator's decision is proper based on a substantial evidence standard of review. An OON provider or health plan issuer may not file suit for a claim subject to the law until the arbitration's conclusion.

Enforcement Authority

SB 1264 provides that the Texas Attorney General may bring a civil action for an injunction against a party for violating the balance billing prohibition upon referral by a state agency and gives TDI authority to take disciplinary action against health plans for failure to provide notice of the balance billing prohibition or a related disclosure.

Study on Impact to the Market

SB 1264 also calls for a study on the legislation's impact on Texas consumers and health coverage in Texas, including

trends in billed amounts for health care services—especially emergency services—and a comparison of the total amount spent on OON emergency services.

The bill is effective Sept. 1, 2019, and applies to services and supplies provided on or after Jan. 1, 2020.

Consumer Credit Surprise Billing Protection

Senate Bill 1037 by Sen. Taylor & Rep. Lucio III

SB 1037 helps protect consumers from long-term financial damage that can result from surprise balance bills. The bill prohibits consumer credit reporting agencies from including medical debt information in consumer reports as long as the consumer had health coverage at the time of service and the outstanding balance is owed to an out-of-network emergency or facility-based provider. Any applicable copayment, deductible, or coinsurance is not included in the prohibition. This protection applies to consumers covered under any health benefit plan and is not limited to commercial health plan enrollees.

The bill is effective immediately.



Texas Association of Health Plans

Reigning in Freestanding Emergency Rooms

Texas freestanding emergency rooms (FSERs) are a relatively new, lucrative business model. They often mislead patients about how much they cost and whether they are in network, which causes huge health care costs for Texans and Texas businesses. FSERs are some of the worst offenders when it comes to surprise balance billing, outrageously high prices, and misleading information. Because FSERs may look like urgent care centers, patients tend to visit them for care for minor, non-emergency conditions. The problem is that independent FSERs are rarely in network and charge emergency care prices. In most cases, patients who receive care at FSERs could have been treated at a significantly lower cost in a different facility. These unnecessary high prices and surprise balance bills drive up the cost of health care and insurance premiums for all Texans. FSERs are responsible for over \$3 billion in unnecessary health care costs in Texas each year. Texas legislators targeted abusive FSER practices this session through legislation that will punish facilities for engaging in price-gouging and using deceptive advertising and confusing language to mislead patients.

Protect Texans From Freestanding Emergency Rooms



Texas freestanding emergency rooms (FSERs) are a relatively new, lucrative business model. They mislead patients about how much they cost and whether they are in network, which causes huge health care costs for Texans and Texas businesses. FSERs are some of the worst offenders when it comes to surprise balance billing, outrageously high prices and misleading information. In fact, 83% of all out-of-network emergency room services occur at FSERs. Because FSERs usually look like urgent care centers, patients tend to visit them for care for minor, non-emergency conditions. The problem is that FSERs are rarely in-network, and they charge emergency care prices. In most cases, patients who receive care at FSERs could have been treated at a significantly lower cost in a different facility. These unnecessary high prices and surprise balance bills drive up the cost of health care and insurance premiums for all Texans. FSERs are responsible for more than \$3 billion in unnecessary health care costs in Texas each year.



TAHP Position

- TAHP supports protecting Texans from outrageous billing practices by increasing pricing and network status transparency in FSER advertising.
- TAHP supports holding FSERs accountable for price-gouging and deceptive advertising.
- TAHP supports banning FSER charges for emergency care fees for urgent care and physician office services.
- TAHP supports protecting Texans from FSER surprise balance billing by ending surprise billing for all emergency care.

Freestanding ERs Intentionally Mislead Texans

A recent AARP investigation found that FSERs are not following Texas transparency laws. Instead, they are misleading Texans about being in-network and putting them at risk for surprise billing. FSERs use confusing advertising and language like "take" or "accept" that misleads patients into believing they accept their insurance plans for full payment. But, in reality, they are commonly out-of-network and consumers are at extreme risk of receiving surprise medical bills. The AARP investigation found 30% of Texas FSERs were not complying with state transparency laws, and more than 60% were using misleading and confusing language.



FSERs Don't Improve Access to Care

It may seem like having more medical facilities in more places can only be good for improving access to health care in Texas, but that's not the case for FSERs. Texas FSERs are usually located in areas where there are a lot of other options for care, including hospital-based ERs and doctor offices—so in areas of Texas where there is reduced access to care.

TAHP Supports HB 2041



Greater Transparency and Accountability From Freestanding ERs

Freestanding ERs (FSERs) are a relatively new, lucrative business model that is leaving patients with sticker shock from outrageously expensive medical bills. Texans continue to experience confusion and frustration with misleading advertising and important costs when they seek care from FSERs. Many of these facilities have demonstrated a pattern of withholding important information from patients regarding their network status or the fees they will charge for their services.

FSERs often use confusing advertising to intentionally mislead patients into believing they accept their insurance plans for full payment, but in reality, most choose not to be in-network in order to charge higher prices. Patients often get surprised with a bill that can be 20x what an urgent care center would charge for the same services. In Texas, FSERs are responsible for over 60% of all out-of-network facility services, leaving patients stuck with expensive surprise medical bills, often for thousands of dollars.

These unnecessary high prices and surprise balance bills drive up the cost of health care and insurance premiums for all Texans. FSERs are responsible for more than \$3 billion in unnecessary health care costs in Texas every year.

TAHP Supports Pro-Consumer HB 2041 by Oliverson

- Protects consumers from price-gouging and surprise bills by strengthening transparency requirements for FSERs.
- Prohibits FSERs from using deceptive marketing or misleading statements that may cause a patient to incorrectly believe the facility is in-network.
- Requires a new written disclosure that lists the facility's observation and facility fees.
- Plugs an end to the use of confusing and misleading language that confuses consumers about the network status of FSERs.
- Prohibits FSERs from using phrases like "we take" or "accept" all insurance if they are not in-network with insurers.
- Prohibits FSERs from using a health plan's logo or name if the facility is not in-network with that plan.

Freestanding ERs Are Intentionally Misleading Texans

A recent AARP investigation found that many FSERs are not following Texas transparency laws. Instead, they are misleading Texans about being in-network and putting them at risk for expensive surprise medical bills.



TEXAS ASSOCIATION OF HEALTH PLANS MARCH 2019
This is a registered trademark used by the Texas Association of Health Plans (TAHP).
Copyright 2019. All rights reserved. www.taahp.org

THE TEXAS TRIBUNE

Texas has more than 200 freestanding ERs. Lawmakers just passed bills to combat patient confusion and price gouging.

One of the biggest catches by the governor will require freestanding emergency rooms to clearly disclose the in-network health plans they accept and the fees patients may be charged.

ELIZABETH BYRNE | L.A. Daily News | 3/14/19



A freestanding emergency room provides 20-hour, 24-hour care in the Mueller neighborhood of Austin on July 10, 2017. (Gay Photos for The Texas Tribune)

Ten years ago, Texas became the first state to allow licenses for independent freestanding emergency rooms. Since then, just over 200 have opened their doors around Texas, according to state data. The facilities go by names like First Choice Emergency Room. They resemble urgent care clinics but some regularly charge hospital emergency room prices.

FSER Network and Price Transparency House Bill 2041 by Rep. Oliverson & Sen. Taylor

Texas freestanding emergency rooms (FSERs) have a history of misleading patients about their prices and network status. According to a recent AARP investigation, 77% of independent Texas FSERs use confusing language such as stating they “take” or “accept” insurance when they are out of network for any major health plan, nearly 30% claimed they were in Blue Cross and Blue Shield of Texas’ network when they were not, and 30% of FSER websites do not comply with state network transparency laws. HB 2041 protects Texas consumers and helps lower health care costs by requiring Texas FSERs, including those affiliated with hospitals, to be transparent about their prices and network status. The bill requires these facilities to provide their prices to patients in a written disclosure at the time of service or on their website. The written disclosure must notify patients that the FSER charges facility and

observation fees for medical treatment and must also include the facility’s median facility and observation fees, a range of possible facility and observation fees, and the facility and observation fees for each level of care the FSER provides. A facility that posts and appropriately updates its standard charges, including facility and observation fees, on its website in a manner that is easily accessible and readable will be in compliance with this requirement.

The bill also protects consumers from FSERs’ use of confusing language and deceptive advertising by prohibiting FSERs from using phrases like “we take” or “accept” all insurance and displaying a health plan’s name or logo unless they are in network with the health plan mentioned. By holding FSERs more accountable, consumers will be better equipped to make informed decisions and protect themselves and their families.

The bill is effective Sept. 1, 2019.

Texas Association of Health Plans

TAHP Supports HB 1941



Protect Texans Against Price-Gouging in Emergency Medical Situations – Bill Gives State Authority to Protect Consumers From Being Exploited by FSERs

Freestanding ERs (FSERs) are a relatively new, lucrative business model that is leaving patients with sticker shock from outrageously expensive medical bills. Texans continue to experience confusion and frustration with misleading advertising and exorbitant prices when they seek care from freestanding ERs. Many of these facilities have demonstrated a pattern of withholding important information from patients regarding their network status or the exorbitant fees they will charge for their services.

FSERs often use confusing advertising to intentionally mislead patients into believing they accept their insurance plans for full payment, but in reality, most choose not to be in network in order to charge higher prices. Patients often get slapped with a bill that can be 20x what an urgent care center would charge for the same services. In Texas, FSERs are responsible for over 88% of all ER out-of-network facility services, leaving patients stuck with expensive surprise medical bills, often for thousands of dollars.

TAHP Supports Pro-Consumer HB 1941 by Phelan

HB 1941 would help ensure that Texans are protected against price gouging in personal emergency medical situations. Many Texans are being price-gouged by FSERs at a time when they need it least—in an emergency medical situation. One Texan recently received an astronomical \$71,000 total bill from an FSER for eight stitches. Under current state law, Texans are protected against price-gouging in natural disasters; the same should apply in emergency medical situations. FSERs should not be permitted to exploit Texans for financial gain in times of crisis.

Specifically, HB 1941 Would:

- Base the protection for medical emergencies on the current statutory provision addressing the sale of necessities such as fuel, food or medicine at exorbitant or excessive prices in a natural disaster situation.
- Use the definition of “medical emergency” already adopted in the Insurance Code and the Health and Safety Code and allow the Texas Attorney General to pursue FSERs that charge unconscionable prices.
- NOT set a price or ceiling, it would only grant authority to the AG to take action on prices above a certain threshold.
- Grant the AG the authority to take action to protect consumers who are victims of price-gouging in a medical emergency as in declared natural disasters, unless the price alleged to be unconscionable is less than 200% of the average charge.
- Allow the AG discretion in seeking a restraining order or monetary penalties (up to \$20,000 per violation with a potential additional amount if an elderly person is the victim).
- NOT create a private cause of action.

Many Freestanding ERs Intentionally Mislead Texans

A recent AARP investigation found that many FSERs are not following Texas transparency laws. Instead, they are misleading Texans about being in network and putting them at risk for expensive surprise medical bills.



Source: AARP, The Truth About Freestanding ERs, 12/15

FSER “Emergency” Signage Removal House Bill 1112 by Rep. Sarah Davis & Sen. Kolkhorst

In some cases, freestanding emergency rooms (FSERs) that are no longer in operation continue prominently displaying large “Emergency” signage outside their facilities, inadvertently drawing in patients rushing to seek care in an emergency situation and leading to delays in receiving much-needed care. HB 1112 requires FSERs to remove signs from the public view immediately after the facility closes or loses its license.

The bill is effective Sept. 1, 2019.

FSER Price-Gouging Protection

House Bill 1941 by Rep. Phelan & Sen. Watson

Many Texas freestanding emergency rooms (FSERs) have demonstrated a pattern of withholding important information from patients regarding their network status and the exorbitant fees they charge. One Texan recently received an astronomical \$71,000 total bill from an FSER for eight stitches. HB 1941 protects Texans against this type of price-gouging in emergency care situations. The bill grants the Texas Attorney General (AG) power to take action against FSERs that charge consumers more than 200% of average charges for emergency care in the area, similar to the AG’s authority to protect Texans from price-gouging during a natural disaster. HB 1941 protects all Texans—even those who are uninsured—from price-gouging at FSERs.

Recently, some FSERs have attempted to skirt patient protection laws like HB 1941—which typically apply exclusively to FSER facilities—by making minor additions to their facilities so they can obtain hospital licensure. HB 1941 was drafted to include hospitals that are not accredited Medicare providers, as facilities that apply for Medicare approval are usually in network with major insurers and are not “bad actors”. Hospitals that have been operating for less than a year and are in the process of seeking Medicare approval are not included.

The bill is effective Sept. 1, 2019.

Texas Association of Health Plans

Prescription Drug Price Transparency

Prescription drug affordability is a major issue in Texas and across the country. Drug costs have risen at an astronomical rate in recent years and now make up about \$350 billion a year in total health care costs. In fact, almost 25 cents of every health insurance dollar goes to prescription drugs—more than all other health care costs such as doctor visits and hospital stays. Thanks to a bill passed this session, drug manufacturers will have to publicly report their detailed reasoning for significant drug price increases, and PBMs and health plans will also file reports to help determine the state of prescription drug costs moving forward.

Fighting For Lower Drug Prices For You TAHP

It's a Fact: Drug Prices Are out of Control
Big Pharma controls drug prices—and Big Pharma can lower them for Americans, including the 25 million who have no prescription drug coverage. But when it comes to the rest of us, drug prices are out of control. Drug prices have risen so fast that a prescription drug can cost more than a house in some parts of the country.

The problem is the price, not health plans or PBMs

- 652% Price Hike** for a drug that has been on the market for 10 years or more
- 596% Price Hike** for a drug that has been on the market for 5 years or more
- 248% Price Hike** for a drug that has been on the market for 1 year or more

Price-Gouging Americans by Taking Advantage of a Broken System
Too many Americans must choose between paying their bills and paying for their medications.

Drug makers are making record profits through their record prices—not because they are producing more medications.

Pharmaceutical companies have increased their profits by 100% in the last 10 years. That's more than any other industry.

Pharmaceutical companies have increased their profits by 100% in the last 10 years. That's more than any other industry.

Pharmaceutical companies have increased their profits by 100% in the last 10 years. That's more than any other industry.

PhRMA-Funded Myths About Pharmacy Benefit Managers (PBMs) TAHP

Leans the Facts: While pharmaceutical manufacturers have been increasing list prices for drugs, PBMs deliver savings and keep costs down.

Myth: PBMs are to blame for rising drug prices
Drug companies set and raise the list price for drugs. The price of the 25 most prescribed drugs in Medicare Part D increased by 10% to 15% from 2011 to 2015, even after accounting for savings in 2015 from the rollout of the Medicare Part D coverage gap.

Myth: PBMs increase costs to seniors and low-income patients
PBMs save Medicare Part D 2.7 billion in 2015. Over the next decade, PBMs are projected to save Medicare Part D nearly \$500 billion—paid for by requiring discounts from drug manufacturers—\$200 billion by encouraging the use of clinically equivalent, lower cost drugs—\$400 billion through pharmacy management tools and programs.

Myth: PBMs are to blame for rising drug prices
Drug companies set and raise the list price for drugs. The price of the 25 most prescribed drugs in Medicare Part D increased by 10% to 15% from 2011 to 2015, even after accounting for savings in 2015 from the rollout of the Medicare Part D coverage gap.

HOUSTON CHRONICLE

LOCAL / TEXAS POLITICS
Texas House passed one of the nation's toughest drug-pricing bills. But will it stand?

Home Local Weather Politics Business Houston US World Texas Sports Nation Sports Sciences
Recently Deleted and Deleted Items
May 15, 2019 11:04AM MDT (10:39 AM CDT)

AP Photo/Chris Wedel
Photo: Rick & Beverly, 2017 / Associated Press

Drug prices had been shooting through the roof. So early this legislative session, Republican Rep. Tim O'Brien, a physician from Cypress, filed a bill in the Texas House that would demand transparency from pharmaceutical companies every time the price of their drugs rises more than 50 percent in a single year.

It wasn't perfect. The legislation wouldn't have caught huge spikes in insulin prices in recent years, or those for common cholesterol and blood pressure medication that millions of Texans

CBS EVENING NEWS

1 in 10 Americans skipping doses as prescription drug prices rise

Watch CBS News Live
Watch CBS News Live
Watch CBS News Live

Patients skipping expensive prescriptions

WATCH CBS LIVE

1 in 10 Americans skipping doses as prescription drug prices rise

1 in 10 Americans skipping doses as prescription drug prices rise

1 in 10 Americans skipping doses as prescription drug prices rise

Prescription Drug Price Transparency Reporting House Bill 2536 by Rep. Oliverson & Sen. Hancock

HB 2536 requires drug companies to report drug price increases and account for exorbitant price hikes. The bill also applies retroactively, meaning companies that ratcheted up prices in 2017 and 2018 will have to explain their reasoning. HB 2536 requires drug manufacturers to report drug price increases of at least 15% within one calendar year and at least 40% over three calendar years. In addition to the required drug manufacturer reporting, pharmacy benefit managers (PBMs) and health plans must

also submit annual reports with information such as PBMs' aggregated rebates, fees, and "price protection payments" and health plans' 25 most-frequently prescribed drugs, increases in annual drug spending, and premium increases attributable to drugs. The Houston Chronicle reported that HB 2536 is "one of the nation's toughest drug-pricing bills."

Drug Manufacturer Reporting

Drug manufacturer reports, which are to be submitted to HHSC and are required for an increase in wholesale acquisition cost of at least 15% within one calendar year or at least 40% over three calendar years, must contain:

Texas Association of Health Plans

- A statement regarding the factor or factors that caused the increase and an explanation of the role of each factor's impact on the cost.
- The name of the drug.
- Whether the drug is brand name or generic.
- The effective date of the change in wholesale acquisition cost.
- Aggregate, company-level research and development costs for the most recent year.
- The name of all the manufacturer's drugs approved by the U.S. FDA in the previous five calendar years.
- The name of each of the manufacturer's drugs that lost patent exclusivity in the U.S. in the previous five calendar years.

The first reports with the required information for the preceding three calendar years will be due by Feb. 1, 2020. HHSC must provide drug price information, including these manufacturer reports, to the general public on its website.

PBM Reporting

PBM reports, which are to be submitted annually to the Texas Department of Insurance (TDI) by Feb. 1, must include the following information for the preceding calendar year:

- The aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers.
- The aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:

- o passed to health benefit plan issuers or enrollees at the point of sale or

- o retained as revenue by the PBM.

TDI will publish an aggregated report each year by May 1 on its website but may not disclose or tend to disclose any PBM's proprietary or confidential information.

Health Plan Reporting

Health plan issuer reports, which are to be submitted annually to TDI by Feb. 1, must include the following information for the preceding calendar year:

- The names of the 25 most-frequently prescribed prescription drugs across all plans.
- The percent increase in annual net spending for prescription drugs across all plans.
- The percent increase in premiums that were attributable to prescription drugs across all plans.
- The percentage of specialty drugs with utilization management requirements across all plans.
- The premium reductions that were attributable to specialty drug utilization management.

TDI will publish an aggregated report each year by May 1 on its website but may not disclose or tend to disclose any issuer's proprietary or confidential information.

The bill is effective Sept. 1, 2019, but reports are not required to be submitted before Jan. 1, 2020.

Texas Association of Health Plans

Combating the Opioid Crisis

Even though opioid abuse has been a major topic of national discussion for only a few years, the misuse of prescription drugs has long been a problem in our state and nation. In 2015, nearly half of the opioid overdose deaths in Texas involved a prescription opioid. In late 2017, the federal government took action. President Trump officially declared the opioid epidemic a national emergency in October of that year, noting that 2 million Americans were suffering from painkiller addiction. Substance abuse has increased dramatically in the United States with devastating consequences for our communities, governmental agencies, and health care providers. This year, Texas lawmakers continued passing legislation to help overcome this challenge. New laws passed this year seek to reduce opioid-related overdoses and deaths—especially maternal deaths—by increasing the use of prescription drug monitoring.

Opioid Dispensing Restrictions

House Bill 2174 by Rep. Zerwas & Sen. Kolkhorst

HB 2174 addresses concerns about the increasing number of deaths related to opioid and prescription drug abuse in Texas, particularly in light of a recent report from the Maternal Mortality and Morbidity Task Force that found drug overdose is a leading cause of maternal deaths. The bill seeks to help combat the growing rate of prescription drug abuse in Texas by making changes to the Texas Controlled Substances Act and other applicable statutes. The bill sets a prescribing limit of a 10-day supply of an opioid for acute pain and exempts prescriptions for chronic pain and for cancer, palliative, and hospice patients. The prescribing limit does not apply to opioids prescribed for substance use disorder, and the bill prohibits prior authorization for medication assisted therapy treatment in Medicaid.

The bill also develops standards for the electronic prescribing of opioids and grants exceptions to allow for written or telephonic prescriptions in certain circumstances. These exceptions, which dispensing pharmacists are not required to verify, include when:

- Electronic prescribing is not available.
- A pharmacy is located outside this state.
- The prescriber and dispenser are in the same location or under the same license.
- The FDA requires additional information on the prescription that is not possible with electronic prescribing.
- There is a standing order, approved protocol for drug therapy, collaborative drug management, or comprehensive medication management.

- The prescription is in response to a public health emergency.
- The drug is under a research protocol.
- The practitioner reasonably determines that it would be impractical for the patient to obtain the drugs prescribed under the electronic prescription in a timely manner and that a delay would adversely impact the patient's medical condition.

The bill is effective Sept. 1, 2019.

Electronic Prescribing System Reforms

House Bill 3284 by Rep. Sheffield & Sen. Nelson

HB 3284 addresses the opioid crisis by providing for better prescription monitoring and increased use of technology. The bill requires the Texas Medical Board to establish an advisory committee to recommend improvements to the electronic prescribing system, identify and improve the data reported through and stored in the system, and improve system security and integrity. The bill also makes it a criminal offense to misuse any information in the system.

The bill is effective Sept. 1, 2019.

Texas Association of Health Plans

Additional Priority Legislation

Texas Life and Health Guaranty Association Act Modernization

Senate Bill 1153 by Sen. Hancock & Rep. Smithee

Like other states, Texas uses a system of “Guaranty Associations” (GAs) to protect consumers in the event of an insurance company insolvency. The GA provides coverage for claims against insolvent insurers and is funded by the insurance industry. There are separate GAs in Texas for life and health insurance, property and casualty insurance, and title insurance. In 2017, the costliest long-term care insurance failure ever led insurers and state regulators to reevaluate the current assessment methodology and to develop an updated approach that ensures a more equitable allocation among member insurers. SB 1153 modernizes the provisions of the Texas Life and Health Insurance Guaranty Association Act by including HMOs as a type of insurer required to participate in and be subject to assessments as a member of the Guaranty Association. The bill also revises the assessment methodology to provide for a 50% allocation to accident and health member insurers and a 50% allocation to life and annuity member insurers. This reallocation will level the playing field and increase the fairness of the safety net structure. It also requires the Texas Department of Insurance to consider, among other things, whether the appointed directors of the Texas GA fairly represent the HMO and life, health, and annuity member insurers.

The bill is effective Sept. 1, 2019, and the changes apply to an insurer impairment or insolvency on or after the effective date.

“Consumer Choice” Health Plan Renewal Process Efficiency

Senate Bill 1852 by Sen. Paxton & Rep. Smithee

“Consumer choice” health plans were designed to give consumers more flexibility when selecting a health coverage option. Current consumer choice statutes and regulations require policyholder signatures not only at the inception of a policy, but also upon renewal. This step is burdensome and unnecessary. Insurers and agents encounter difficulties in obtaining signatures from busy customers and tracking signed authorizations is an unneeded administrative

burden for everyone involved. SB 1852 simply removes the signature requirement for renewals.

The bill includes disclosure requirements for short-term limited-duration insurance policies. It requires the commissioner of insurance to prescribe a statement to be included with each policy and application that includes:

- Duration of the coverage.
- Number of times the policy may be renewed.
- Expiration of coverage is not a qualifying life event for purposes of special enrollment.
- Policy may expire outside of open enrollment.
- Dates of the next three open enrollment periods following the date the policy expires.
- Any limitations or exclusions to pre-existing conditions.
- Maximum dollar amount payable under the policy.
- Deductibles under the policy and services to which they apply.
- Whether prescription drug, mental health, substance abuse treatment, maternity care, hospitalization, surgery, emergency care, and preventive services are covered.
- Any other information the commissioner determines is important for a purchaser of a policy.

The bill also requires insurers to adopt procedures, according to Texas Department of Insurance (TDI) rule, to obtain a signed form from the enrollee acknowledging receipt of the disclosure statement, including electronic receipt. It requires insurers to retain the acknowledgment for five years and to make it available to TDI upon request.

The portion of the bill regarding consumer choice plans is effective Sept. 1, 2019, and applies to consumer choice plans renewed on or after that date.

The portion of the bill regarding short-term limited-duration plans requires TDI to prescribe the disclosure form by Jan. 1, 2020, and applies to policies delivered, issued, or renewed after Jan. 1, 2020.

Texas Association of Health Plans

Temporary “Risk Pool” Reauthorization

Senate Bill 1940 by Sen. Hancock & Rep. Oliverson

The Affordable Care Act (ACA) faces a number of lawsuits that, if successful, could essentially rewrite our nation’s health care laws. This environment of uncertainty has led to an unstable health insurance market. SB 2087 by Sen. Hancock, which was passed by the 85th Legislature, sought to stabilize this uncertainty by authorizing the insurance commissioner to apply for a federal State Innovation Waiver and to establish and administer a temporary health insurance “risk pool” with any available federal funds. SB 1940 reauthorizes that legislation to maximize any available federal funding that would help Texas residents obtain access to quality health care at minimum cost. The pool may not be used in a manner that would require Texas to assume functions currently performed by federal agencies under the ACA, including establishing an exchange

or administering premium tax credits. Subject to any requirements for obtaining federal funds, the commissioner may increase access to guaranteed issue health coverage by:

- Establishing a high risk pool that provides alternative health insurance coverage to eligible individuals but does not diminish enrollment in traditional commercial health care coverage.
- Providing funding to individual health benefit plan issuers to cover individuals with certain health or cost characteristics in exchange for lower enrollee premium rates.
- Providing a reinsurance program for health plan issuers in the individual market in exchange for lower enrollee premium rates.

The bill is effective Sept. 1, 2019.



Texas Association of Health Plans

Key Legislation Affecting the Health Insurance Industry

TAHP and its member plans worked throughout session to ensure bills adopted by the legislature did not adversely affect the health insurance market. TAHP worked with legislators and stakeholder groups on a number of bills throughout session and negotiated key amendments to prevent new protections and requirements from negatively impacting the health insurance market.

Solutions for Affordable, High-Quality Health Care for Texans

86th Texas Legislature

TAHP
THE TEXAS ASSOCIATION OF HEALTH PLANS

The Texas Association of Health Plans (TAHP) advocates for a sound and competitive health insurance market that maximizes private market competition, consumer choice and affordable coverage options. Health plans play an important role in lowering costs and getting the best possible price for hospital stays, doctor visits and prescription drugs.

Despite efforts by health plans to hold down the cost of monthly premiums, the cost of health care is high and still rising all over the country. Americans are more worried about their health care costs than ever. Now is the time to make sure all Texans have access to high-quality care they can afford no matter how much money they make or if they have pre-existing conditions.

Texas health plans are committed to lowering costs, providing high-quality, affordable coverage that protects Texans and their families, and empowering Texans to take control of their health.

5 Key Solutions to Lower the Cost of Care:



Create Real Price, Quality and Network Transparency:

When Texans have access to the health care information they need, they have the power to care for themselves, protect their families and better manage their health care costs. More than two-thirds of Texans that used comparing health care prices before getting care reported saving money. With more transparency, Texans will be able to shop for quality health care and insurance they can afford.

- TAHP supports increasing transparency and access to health care provider prices, quality standards and network status for all Texans.
- TAHP supports letting health plans readily share quality and value comparison information with Texas consumers participating in their networks.

Solutions for Affordable, High-Quality Health Care for Texans

TAHP
THE TEXAS ASSOCIATION OF HEALTH PLANS

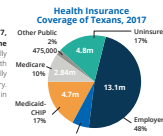
The Texas Association of Health Plans advocates for a sound and competitive health insurance market that maximizes private market competition, consumer choice and affordable coverage options. Health plans play an important role in lowering costs and getting the best possible price for hospital stays, doctor visits and prescription drugs.

Despite efforts by health plans to hold down the cost of monthly premiums, the cost of health care is high and still rising all over the country. Americans are more worried about their health care costs than ever. Now is the time for us to make sure all Texans have access to high-quality health care they can afford no matter how much money they make or if they have pre-existing conditions.

Texas health plans are committed to lowering costs, providing high-quality, affordable coverage that protects Texans and their families, and empowering Texans to take control of their health.

Health Coverage Keeps Texans Healthy

Health insurance helps keep families and communities healthy. In 2017, **83 percent of Texans had some form of health insurance and the other 17 percent did not.** People with health insurance are usually healthier, live longer and receive important preventive health care services. People with health insurance are also better off financially because they are protected in the event of a serious illness or injury. Health insurance providers coordinate care for their members, invest in communities and make sure their members get the care they need.



The Truth About the High Cost of Health Care

The cost of health care is high and still rising, and health insurance costs too much for many hardworking families. As the cost of health care services like hospital stays, medical screenings and prescription drugs continues to increase, the price of insurance has to go up to cover these costs. The truth is that all these problems are worse in Texas. Texas has some of the highest prices, highest health care costs and highest rates of surprise medical bills in the country.

Texas' Surprise Billing Problem:

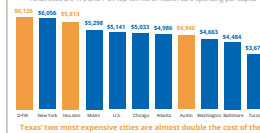
One in three admissions to a Texas emergency room results in a surprise balance bill, while the national average is only one in five.

Some of the highest rates of out-of-network ER physicians

Almost 50% of Texas ER Physician Claims are Out-of-Network

Texas' big spending on health care

Texas cities are 1, 3 and 7 on top ten list of health care spending per capita



Texas' two most expensive cities are almost double the cost of the 10th most expensive city in the country

Health Plan Provider Directory, Prior Authorization Transparency, and UR Requirements

Senate Bill 1742 by Sen. Menéndez & Rep. Julie Johnson

SB 1742 updates provider directory requirements for health plans with a focus on in-network facility-based providers practicing at in-network hospitals. These provisions apply to commercial HMO, EPO, and PPO benefit plans.

Provider Directory Requirements

Provider directories must include specific information for each network hospital:

- Under each facility name, separate headings must be included for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, and assistant surgeons. Each in-network facility-based physician must be listed under the appropriate heading. The directory must clearly indicate each of the issuer's benefit plans that may provide coverage for the services provided by that facility or physician.
- The directory must include a list of network facilities indicating for each:
 - The name of the facility.
 - The municipality in which the facility is located (or county if it is in an unincorporated area).
 - The specialty of facility-based physicians practicing at the facility, including the name, street address, and telephone number of any in-network facility-based physician or of the physician group in which the physician practices.
 - Each of the issuer's health benefit plans that may provide coverage for the facility's services.
 - Each of the issuer's health benefit plans that may provide coverage for the services provided by each facility-based physician group.

The directory must list facility-based physicians both individually and, if the physician belongs to a physician group, as part of the group.

SB 1742 also requires provider directories to include the specialty, if any, of each in-network physician and health care provider in addition to information currently required (name, contact information, and an indication of whether each is accepting new patients).

Texas Association of Health Plans

Prior Authorization Transparency

Health plans that use a prior authorization process for health care services must conspicuously post, except as otherwise provided, the requirements and information about the process in a public part of their websites that is easily searchable and accessible. Except for screening criteria, the information must be written in plain language and easily understood by enrollees, the general public, and physicians and other providers. The information must include a detailed description of the prior authorization process and procedures and a current list of health care services for which prior authorization is required.

The website notice must include the following information specific to each prior authorization requirement:

- The effective date.
- A list or description of any supporting documentation the health plan requires from the physician or provider ordering or requesting the service to approve a request for that service.
- The applicable screening criteria, which may include Current Procedural Terminology codes and International Classification of Diseases codes.
- Statistics regarding prior authorization approval and denial rates for the service in the preceding calendar year, including statistics in the following categories:
 - o Physician or provider type and specialty.
 - o Indication offered.
 - o Reasons for request denial.
 - o Denials that are overturned on internal appeal.
 - o Denials that are overturned by an independent review organization.
 - o Total annual prior authorization requests, approvals, and denials for the service.

If posting information about prior authorizations creates a copyright or proprietary issue, the health plan can comply with the posting requirement using a nonpublic secured Internet website link or other protected, nonpublic electronic option.

A health plan must provide at least 60 days' advance notice of new or amended prior authorization requirements on

its website and in its newsletter or network bulletin if any exist. For a change in a requirement or process that is less burdensome to enrollees or in-network providers or that removes a prior authorization requirement for a service, a health plan must give at least five days' notice. Websites must include the effective date of the changes.

In addition to any other penalty or remedy provided by law, a health plan that fails to comply with any applicable deadline for a required prior authorization publication, notice, or response must provide an expedited appeal under Section 4201.357 for any health care service affected by the violation. The bill does not include the "deemed approval" provision included in earlier versions of the legislation.

These provisions apply to commercial HMO, EPO, and PPO benefit plans.

New Utilization Review Requirements

SB 1742 imposes a new requirement that Texas-licensed physicians must review utilization review (UR) plans and direct UR programs. The final provisions passed do not provide that performing UR is the practice of medicine and does not require all physician reviewers to maintain a Texas medical license.

Current law allows for a review by a physician of the same or a similar specialty, which must be completed within 15 working days of a request by a treating provider, following the denial of an appeal of an adverse determination. SB 1742 amends this provision to make this specialty provider review process available upon request as part of an appeal of an adverse determination rather than requiring the enrollee to complete the appeal process before being provided a specialty review. The bill also makes the current expedited appeal process available if a requesting health care provider includes with the appeal a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient.

These provisions apply to commercial HMO, EPO, and PPO benefit plans. The Health and Human Services Commission indicates that federal rules address prior authorization requirements for Medicaid and CHIP managed care organizations; therefore, it is assumed these provisions would not apply and there would be no impact.

Texas Association of Health Plans

Prior Authorization and UR Interim Charge Study

SB 1742 creates a joint interim committee to study, review, and report on the use of prior authorization and UR processes by private health benefit plan issuers in this state and to propose reforms related to the transparency and improvement of patient outcomes under these processes. The joint interim committee must be appointed within 60 days of the Sept. 1 effective date and will be composed of four senators appointed by the lieutenant governor and four representatives appointed by the speaker of the house. The committee will obtain data and other information available from the Texas Department of Insurance, the Office of Public Insurance Counsel, and other sources it determines relevant. The committee must submit a report including recommendations of specific statutory and regulatory changes by Dec. 1, 2020.

The bill is effective Sept. 1, 2019, and applies to plans issued or renewed on or after Jan. 1, 2020. Websites must be updated by Jan. 1, 2020.

PPO Network Adequacy Examination

House Bill 3911 by Rep. Vo & Sen. Campbell

HB 3911 requires the commissioner of insurance to examine and determine the quality and adequacy of an insurer's PPO or EPO plan networks at least once every three years or when the commissioner considers an examination necessary. TDI rules already require a separate annual review process of network adequacy for PPO, EPO and HMO plans.

The bill is effective Sept. 1, 2019.

Prior Authorization Renewal Requests

House Bill 3041 by Rep. Chris Turner & Sen. Buckingham

HB 3041 allows a physician or health care provider to request renewal of an existing prior authorization at least 60 days before it expires. The health plan must issue a determination, if practicable, before the existing prior authorization expires. The bill applies to ERS and TRS plans and to Medicaid and CHIP plans in addition to commercial HMO, EPO, and PPO plans.

The bill is effective Sept. 1, 2019, and applies to health plans issued or renewed on or after Jan. 1, 2020.

Stage IV Advanced Metastatic Cancer Step Therapy Prohibition

House Bill 1584 by Rep. Senfronia Thompson & Sen. Buckingham

HB 1584 prohibits step therapy for prescription drugs used to treat stage four advanced metastatic cancer. Health plans that cover treatment of stage four advanced metastatic cancer (cancer that has spread from the primary or original site to nearby tissues, lymph nodes, or other areas of the body) may not require that enrollees fail to successfully respond to a different drug or prove a history of failure of a different drug in order to obtain coverage for an FDA-approved prescription drug. This mandate applies only to an FDA-approved drug when its use is consistent with best practices for the treatment of stage four advanced metastatic cancer or an associated condition and is supported by peer-reviewed, evidence-based literature. The bill applies to Medicaid and CHIP plans in addition to commercial HMO, EPO, and PPO plans.

The bill is effective Sept. 1, 2019, and applies to health plans issued or renewed on or after Jan. 1, 2020.

Diagnostic Mammogram Coverage Cost-Sharing Removal

House Bill 170 by Rep. Bernal & Sen. Alvarado

Health plans generally cover diagnostic mammograms the same as other non-preventive imaging services, with applicable cost-sharing under the benefit plan applied. HB 170 mandates coverage for a diagnostic mammogram that is no less favorable than coverage for a screening mammogram. This "no less favorable" requirement mandates that diagnostic mammograms, like screening mammograms, be covered with no enrollee cost-sharing. Because screening mammograms are considered preventive care, no enrollee cost-sharing may be applied to these services under the Affordable Care Act (i.e., no deductible, copayment, or coinsurance may be applied to coverage of a screening mammogram). This mandate will not apply

Texas Association of Health Plans

to high-deductible HSA-compatible plans so they can maintain eligibility under federal tax rules. The bill applies the mandates for screening and diagnostic mammograms to Medicaid and CHIP plans.

The bill is effective Sept. 1, 2019, and applies to health plans issued or renewed on or after Jan. 1, 2020.

Physical Therapy Referral Requirements

House Bill 29 by Rep. Minjarez & Sen. Hughes

Current law requires patients to obtain a physician referral before accessing a physical therapist. HB 29 allows physical therapists to provide services without a referral for up to 10 consecutive business days if the physical therapist:

- has been licensed for at least a year;
- is covered by professional liability insurance in the minimum amount required by board rule; and
- either has a doctoral physical therapy degree from an accredited program or has completed at least 30 hours of continuing competence activities in the area of differential diagnosis.

Physical therapists who have a doctoral degree and have completed a residency or fellowship may provide services without a referral for up to 15 consecutive business days.

Physical therapists who provide services without a referral must obtain a signed disclosure informing patients that:

- physical therapy is not a substitute for a medical diagnosis by a physician,
- physical therapy is not based on radiological imaging,
- physical therapists cannot diagnose an illness or disease, and
- their health insurance may not include coverage for the services.

The bill is effective Sept. 1, 2019, and requires rulemaking by Nov. 1, 2019.

Dental Plan Operational Reforms

House Bill 2486 by Rep. Goldman & Sen. Schwertner

HB 2486 requires dental plans to disclose any fees associated with payment and prohibits fees for access to payments. It limits overpayment recovery and makes predeterminations binding on payments. The bill requires dental plans to have websites with information for patients and dentists on the types of services that are covered and any fees associated with the methods of payment or reimbursement under the plan. It allows recoupment of overpayments through deductions on other claim payments only to the same dentist. Except as otherwise provided, plans may not pay or reimburse dentists in an amount less than the amount stated in the prior authorization. A plan that preauthorizes a dental care service may deny a claim for the service or reduce payment or reimbursement to the dentist for the service only if:

- The denial or reduction is in accordance with the patient's benefit plan, including an annual maximum or frequency of treatment limitation, and the patient met the benefit limitation after the date the prior authorization was issued.
- The documentation for the claim fails to reasonably support the claim as preauthorized.
- The preauthorized dental care service was not medically necessary based on the prevailing standard of care on the date of the service, or is subject to denial under the conditions for coverage under the patient's plan in effect at the time the service was preauthorized because of a change in the patient's condition or because the patient received additional dental services after the date the prior authorization was issued.
- Another payor is responsible for payment of the claim.
- The dentist received full payment for the preauthorized dental service on which the claim is based.
- The claim is fraudulent.
- The prior authorization was based wholly or partly on a material error in information provided to the plan by an unrelated person.
- The patient was otherwise ineligible for the service

Texas Association of Health Plans

under the patient's plan, and the plan did not know and could not reasonably have known that the patient was ineligible for the service on the date of the prior authorization.

The website requirements do not apply to an indemnity plan that pays based on a fixed schedule regardless of the cost of the dental care service and does not provide for a copayment, a deductible, a network, or contracting provider dentists.

The bill is effective Sept. 1, 2019, and applies only to an employee benefit plan or health insurance policy that provides benefits for dental care services that is delivered, issued for delivery, renewed, or contracted after the effective date.

Telemedicine Claim Denial Prohibitions

House Bill 3345 by Rep. Price & Sen. Hughes

HB 3345 prohibits health plans from limiting or denying coverage for telemedicine claims based on providers' "choice of platform" for delivering the service. It also prohibits a separate annual or lifetime maximum benefit limit for telemedicine or telehealth services.

"Platform" is defined as the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service or telehealth service. The bill keeps in place TAHP-negotiated provisions included in SB 1107 from the 85th Legislative Session that the mandate applies only to network providers and that health plans are not required to provide coverage for a telemedicine or telehealth service provided only by synchronous or asynchronous audio interaction, including an audio-only telephone consultation, a text-only email message, or a facsimile transmission.

The bill is effective Sept. 1, 2019, and applies to health plans issued or delivered on or after Jan. 1, 2020.

Newborn Screening Reimbursement Requirement

Senate Bill 747 by Sen. Kolkhorst & Rep. Lucio III

SB 747 prohibits health plans from excluding coverage for newborn screenings and the cost of test kits. The bill requires the Department of State Health Services (DSHS) to publish the cost of newborn screening test kits on its website along with instructions for the full claim and reimbursement process for the kits. The bill allows DSHS to publish any change to cost data "not later than the 90th day before the date the department publishes notice of the change" on its website. It also requires DSHS to keep a record of previous costs for one year.

The bill is effective Sept. 1, 2019, and applies to health plans issued or renewed on or after Jan. 1, 2020. The Health and Human Services Commission must adopt rules as soon as practicable after the effective date.

Chiropractor Discrimination Prohibition

Senate Bill 1739 by Sen. Menéndez & Rep. Lucio III

SB 1739 prohibits HMOs or insurers from refusing to provide reimbursement for a covered service within a chiropractor's scope of practice solely because the service was provided by a chiropractor. The bill does not mandate any services or create a private cause of action against health plans as included in the filed version. It allows the Texas Department of Insurance to bring an enforcement action against HMOs or insurers for an administrative penalty of not more than \$1,000 a day for each claim that remains unpaid in violation of this law.

The bill is effective Sept. 1, 2019, and applies to health plans issued or delivered on or after Jan. 1, 2020.

Texas Association of Health Plans

Physician to Pharmacist Drug Therapy Protocol Delegation

Senate Bill 1056 by Sen. Zaffirini & Rep. Raney

SB 1056 allows a physician's delegation to a pharmacist to include the implementation or modification of a patient's drug therapy under a protocol if the delegation follows a diagnosis, initial patient assessment, and drug therapy order by the physician. The pharmacist must maintain a copy of the protocol for inspection until at least seven years after its expiration.

The bill is effective Sept. 1, 2019, and requires the Texas State Board of Pharmacy to adopt rules no later than Dec. 1, 2019.

Pharmacist Discrimination Prohibition

House Bill 3441 by Rep. Lucio III & Sen. Schwertner

HB 3441 prohibits health plans, pharmacy benefit managers, and third-party administrators from denying a claim from a pharmacist for the provision of a service or procedure within the scope of the pharmacist's license if the service would be covered if provided by a physician, advanced practice registered nurse, or physician assistant. The bill does not create an any-willing pharmacy mandate. It does not apply to Medicaid or CHIP plans.

The bill is effective Sept. 1, 2019, and applies to health plans issued or renewed on or after Jan. 1, 2020.

Enrollee Pharmacist Selection

House Bill 1757 by Rep. Lucio III & Sen. Schwertner

HB 1757 provides that an enrollee may select a pharmacist to provide covered services that are within the scope of the pharmacist's license. The legislation does not create an any-willing pharmacy mandate.

The bill is effective Sept. 1, 2019, and applies to health plans issued or renewed on or after Jan. 1, 2020.

Health Plan and PBM Pharmacy Audit Prohibitions

House Bill 1455 by Rep. Hunter & Sen. Buckingham

HB 1455 prohibits health plans or pharmacy benefit managers (PBMs) auditing a pharmacy's wholesale invoices from auditing the pharmacy's claims from another health plan or PBM during the audit.

The bill requires health benefit plan issuers or PBMs to reverse audit findings if:

- the National Drug Code (NDC) for the dispensed drug was in a quantity that was a subunit or multiple of the drug purchased by the pharmacist or pharmacy as supported by a wholesale invoice;
- the pharmacist or pharmacy dispensed the correct quantity of the drug according to the prescription; and
- the dispensed drug shared all but the last two digits of the drug's NDC reflected on the supplier invoice.

Under the bill, health plans or PBMs must accept certain documents as evidence to support the validity of a pharmacy claim relating to a dispensed drug for an audit. These documents include reports required by any state board or agency and copies of validated supplier invoices in the pharmacist's or pharmacy's possession, including:

- supplier invoices issued before the date the drug was dispensed and not earlier than 60 days before the first day of the audit period; and
- invoices and any supporting documents from any supplier authorized to transfer ownership of the drug acquired by the pharmacist or pharmacy.

The bill is effective Sept. 1, 2019, and applies to audits conducted on or after that date.

Texas Association of Health Plans

Independent Pharmacy Transparency Requirements

House Bill 3496 by Rep. Sheffield & Sen. Creighton

HB 3496 adds financial disclosure licensing requirements for independent (non-publicly traded) pharmacies that are not wholly owned by a retail grocery store chain.

The bill is effective Jan. 1, 2020, and applies only to pharmacy license applications submitted on or after that date.

Corporate Governance Structure Disclosure Requirements

House Bill 3306 by Rep. Smithee & Sen. Zaffirini

The National Association of Insurance Commissioners (NAIC) issued a new Corporate Governance Disclosure Model Law and Regulation that must be codified by 2020 in order for a state to be accredited. HB 3306 enacts the NAIC model law in Texas and provides that insurers must file a disclosure of their corporate governance structure only in their domiciliary state to satisfy disclosure requirements in other states that have adopted the model law. The bill applies to domestic insurers except Texas-only insurers with no out-of-state affiliates. It will impact insurance companies based in Texas that do business in other states. The bill provides for confidentiality and does not impose additional standards or procedures.

The bill is effective Sept. 1, 2019, but disclosure filings may not be required before June 1, 2020.

Insurer Investment Authorization

House Bill 2694 by Rep. Lucio III & Sen. Creighton

HB 2694 authorizes insurers to invest funds in excess of minimum capital and surplus in shares of a registered bond exchange-traded fund if certain conditions are met and to deposit such shares with the Texas Department of Insurance as a statutory deposit. These conditions include:

- The exchange-traded fund must be solvent and have reported at least \$100 million of net assets in its latest annual or more-recently certified audited financial statement.
- The securities valuation office has designated the exchange-traded fund as meeting the criteria to be placed on the list promulgated by the securities valuation office of exchange-traded funds eligible for reporting as a long-term bond in the Purposes and Procedures Manual of the securities valuation office or a successor publication.
- The amount of the insurer's investment in the exchange-traded fund does not exceed 15% of the insurer's capital and surplus.

The bill is effective Sept. 1, 2019.

HCC Rural Hospital Inclusion

House Bill 3934 by Rep. Frank & Sen. Perry

A "health care collaborative" (HCC) under the Texas Insurance Code is an entity comprised of health care providers that arranges for medical and health care services for insurers, HMOs, and other payors in exchange for payments; accepts and distributes payments for medical and health care services; and is certified by the Texas Department of Insurance to lawfully accept and distribute payments to physicians and other health care providers using certain authorized reimbursement methodologies. HB 3934 allows an HCC to include rural hospitals. If the HCC participants are all rural hospitals, each member of the HCC board of directors must be a representative of a rural hospital participant.

The bill is effective immediately.

Texas Association of Health Plans

Key Legislation Affecting Medicaid Managed Care

Over the past 20 years, Texas transformed an outdated Medicaid program into a modern, patient-centered health insurance program that provides over 4 million Texans with the coverage and care they need. As a result of Texas' transition to managed care, millions of Texans have seen improved outcomes and increased access to preventive and timely care. Medicaid health plans have also improved care coordination for Texans with complex medical needs reducing hospital stays and ER visits. The focus on prevention, wellness, care coordination, and medication adherence—getting Texans the care they need to get healthy, stay healthy, and live in their communities—has translated into lower costs for Texas taxpayers.

Our mission is ensuring vulnerable Texans get the care they need, when they need it, and we take this responsibility seriously. While the Medicaid health plans have clearly demonstrated the ability to improve health outcomes and increase savings, there is always room for improvement in the program. TAHP and the Medicaid health plans worked closely with legislators, the Health and Human Services Commission, clients, families, and the entire health care community this session to develop recommendations that strengthen and modernize the Medicaid program.

Medicaid Program Reforms

Senate Bill 1207 by Sen. Perry & Rep. Krause

SB 1207 is a comprehensive Medicaid reform bill that modernizes the Texas Medicaid program by reducing or eliminating unnecessary administrative burdens and red tape, strengthening patient protections, and improving care coordination. The bill includes several TAHP recommendations to ensure quality care for Texas families that rely on Medicaid. To implement the majority of the provisions in the bill, the Health and Human Services Commission (HHSC) will need to adopt rules and amend the Uniform Managed Care Contract.

Prior Authorization Reforms

- Timeframes and Reviews: Gives HHSC the authority to establish prior authorization timeframes for Medicaid

managed care that allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care. Managed care organizations (MCOs) are required to allow physicians requesting prior authorization a reasonable opportunity to discuss the request with an MCO physician who practices in the same or a similar specialty—although not necessarily the same subspecialty—and has experience in treating the same category of population as the recipient for whom the request is submitted.

- Reconsideration Process: Requires HHSC to establish a process similar to the process established under the “Alberto N.” settlement agreement for MCOs to reconsider an adverse determination on a prior authorization that is solely the result of the provider not submitting sufficient or adequate documentation. The bill requires a notification process for providers and

Texas Association of Health Plans

clients when insufficient documentation is provided. The notice must include:

- o a list of documentation necessary to make a decision,
 - o information about how to contact the MCO to discuss the situation, and
 - o a timeframe by which the MCO must make a determination.
- **Transparency:** MCOs must make prior authorization requirements and information about the prior authorization process readily accessible by posting the requirements and information on their website. Requires HHSC to adopt rules requiring MCOs to maintain on their website, in an easily searchable format:
 - o Timelines for prior authorization decisions.
 - o Description of the notice MCOs are required to provide under the prior authorization reconsideration process.
 - o Accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including for a prior authorization requirement first imposed on or after Sept. 1, 2019 (the effective date of the requirement).
 - o List or description of any supporting or other documentation necessary to obtain prior authorization for a specific service.
 - **Annual Reviews:** Requires MCOs to annually review their prior authorization requirements in consultation with their provider advisory group and ensure each prior authorization is based on “accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted.” The bill requires HHSC to periodically review MCOs for compliance with this new provision.

Client Protection Reforms

- **Denial Letters:** Requires letters sent by HHSC and MCOs to clients and providers for a denial, partial denial, reduction of services, or eligibility to include:

o For Medicaid enrollees:

- + A clear and easy-to-understand explanation of the reason and medical basis for the decision, applying the policy or accepted standard of medical practice to the recipient’s particular medical circumstances.
- + Educational information about how to appeal and request a Fair Hearing.

o For providers:

- + A thorough and detailed clinical explanation of the reason for the decision.

- **External Medical Review:** Requires HHSC to contract with an external medical review organization that has experience providing private duty nursing and long-term services and supports. Clients can opt-in to a review if they have been denied a service or Medicaid medical eligibility. The external review will take place after the appeal process and before a Medicaid Fair Hearing. If a client chooses the external medical review option, the MCO will be responsible for submitting a detailed reason for the service reduction or denial along with supporting documentation. The bill requires HHSC to post data and statistics on the rate of reviews.
- **Coordination of Medicaid and Private Health Insurance Coverage:** Requires HHSC, in coordination with MCOs and consultation with the STAR Kids Advisory Committee, to develop and adopt clear policies ensuring the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage. The bill directs HHSC to consider requiring MCOs to allow recipients with primary coverage to continue receiving a prescription drug authorized under their primary coverage without requiring additional prior authorization. It also directs HHSC to include information on eligibility files necessary for MCOs to wrap benefits. The bill directs HHSC to explore a waiver in order to reimburse providers referring, ordering, or prescribing services to a recipient through primary health benefit plan coverage without having to fully enroll in Texas Medicaid. Finally, it directs HHSC to develop a clear, simple process that allows recipients with complex medical needs who have established a relationship with a specialty provider to continue

Texas Association of Health Plans

receiving care from that provider.

- **STAR Kids Assessment Tool:** Requires HHSC to post a plan for public comment no later than March 1, 2020, to improve the STAR Kids assessment tool. The bill specifies that HHSC should consider changes that will reduce the amount of time needed to complete the care needs assessment initially and at reassessment, as well as improve MCO training and consistency.

MDCP Reforms

- **MDCP Assessments and Reassessments:** Requires the STAR Kids Care Coordinator to provide a Medically Dependent Childrens Program (MDCP) family the results of the annual MDCP assessment and reassessment and allows the family to request a peer-to-peer discussion with their provider of choice and the MCO Medical Director to dispute the findings. The bill requires HHSC (to the extent allowable under federal law) to streamline the annual MDCP reassessment for clients who have not had a significant change in function to ensure clients that need home and community-based services are not being denied eligibility. This provision applies to assessments or reassessments made on or after Dec. 1, 2019.
- **MDCP Interest Lists:** Allow a legally authorized representative of a child who was notified by HHSC that the child was no longer eligible for MDCP to request that the child be returned to the MDCP interest list, unless the child was ineligible due to age, or to place the child on the interest list for another Section 1915(c) waiver program. This provision applies only to clients who become eligible for MDCP on or after Dec. 1, 2019.
- **MDCP and DBMD Escalation Hotline:** Requires HHSC to operate an escalation hotline for MDCP and Deaf Blind with Multiple Disabilities (DBMD) clients and families that is operational at all times, including evenings, weekends, and holidays. The bill requires MCOs to create a single point of contact to work with HHSC on issues that are escalated through the hotline.
- **MDCP Quality Monitoring:** Expands the External Quality Review Organization's role by requiring it to conduct annual surveys of Medicaid recipients in MDCP. It requires HHSC to conduct annual recipient focus groups. The new measures will be required in the report for the state fiscal quarter ending Aug. 31, 2020.

The bill is effective Sept. 1, 2019, but allows HHSC to delay implementation pending federal approval. There are several specific implementation dates in the bill outlined above, and all other new requirements must be added to contracts no later than Sept. 1, 2020.

Recommendations for a Stronger STAR Kids Medicaid Managed Care Program 86th Texas Legislature



STAR Kids was implemented in 2016 and is the Medicaid managed care program for the population most recently added to managed care—children, adolescents and young adults with disabilities and complex medical needs. Clients in the STAR Kids program choose a Medicaid managed care organization (MCO) to manage their benefits, which include preventive care, prescription drugs, hospital care, private duty nursing, durable medical equipment and long-term services and supports.

As the Texas Legislature and HHSC take a closer look at the managed care system and its oversight of the STAR Kids program, the Texas Association of Health Plans (TAHP) and Medicaid health plans offer our full commitment to working with members of the legislature, HHSC, the health care community, clients and families to help strengthen the oversight and accountability of the program.

Strengthen and Streamline the HHSC Complaint Process:

Clients should have a simple, no-wrong door process to register complaints with HHSC and receive timely information on the resolution of their complaint. HHSC must also have efficient and streamlined complaint processes to ensure accurate and transparent data to oversee contracts, quickly identify access to care issues and inform policy decisions.

- TAHP supports implementing a no-wrong door complaint process with consistent tracking and definitions across HHSC, including an expedited process for urgent access to care issues

Improve the Medicaid Fair Hearing Process:

Texas Medicaid clients should have easy access to a simple, transparent Fair Hearing process when they feel they have been wrongfully denied a service or eligibility to a program. The Medicaid Fair Hearing process should not only ensure administrative processes are correctly followed by HHSC and Medicaid health plans, but also that any denials or reductions of services by HHSC or a health plan are reviewed by an independent and qualified clinician. Additionally, when HHSC determines a client does not meet the medical need to be eligible for a program, an independent and qualified clinician should review that decision.

- TAHP supports improving the Medicaid Fair Hearing process for clients through education and the adoption of a clear, consistent and transparent processes
- TAHP supports including an independent review organization-led medical review when a client receives a denial of a service by TMHP or a health plan, or when they are denied eligibility for a program by HHSC

Improve the Star Kids Screening Assessment (SK-SAI) Tool:

It is important for every child to be screened for needed services. HHSC currently requires Medicaid health plans to assess every child in the STAR Kids program using the STAR Kids assessment tool; however, it is a cumbersome and extremely long form that families and health plan service coordinators find difficult to use, resulting in negative member experiences. The process should be person-centered, include only actionable screening questions and result in a positive experience for the family.

STAR Kids Prescription Drug Formulary Requirements

Senate Bill 1096 by Sen. Perry & Rep. Oliverson

SB 1096 requires managed care organizations (MCOs) to strictly follow the Health and Human Services Commission's (HHSC's) prescription drug formulary and prohibits MCOs and pharmacy benefit managers from requiring a prior authorization, with the exception of clinical prior authorizations imposed under the Vendor Drug Program (the state's formulary), and from imposing any other barriers to a drug that is prescribed to a STAR Kids program client. MCOs will be required to provide continued access to a drug prescribed to a child enrolled in the STAR Kids program regardless of whether the drug is on the formulary. Federal law prohibits HHSC from using federal Medicaid funds for a drug that is not on the formulary, so implementation of this provision will require discussion with the Centers for Medicare and Medicaid Services. The bill also prohibits MCOs from requiring a child in STAR Kids to use a prescription drug or sequence of prescription drugs other than the drug recommended by

Texas Association of Health Plans

the child's physician. HHSC will need to amend managed care contracts. The bill requires MCOs to pay liquidated damages if they are not in compliance with the new requirements.

The bill includes additional provisions:

- Directs HHSC to explore the feasibility of developing a tool to determine private duty nursing hours and streamline prior authorization processes.
- Requires HHSC to conduct a review on a sample of cases for children enrolled in the STAR Kids program at least once every two years to ensure all prior authorization requirements are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care.
- Directs HHSC to implement prior authorization timeframes for MCOs within federal limits including 72 hours for services requested for a hospital discharge.

The bill is effective Sept. 1, 2019, but allows HHSC to delay implementation pending federal approval. All other new requirements must be added to contracts no later than Sept. 1, 2020.

Rideshare and Transportation Carve-In

House Bill 1576 by Rep. Phelan & Sen. Buckingham

HB 1576 fully carves the medical transportation program and all non-emergency transportation services into Medicaid managed care. The bill establishes a new Medicaid benefit, "non-medical transportation services," defined as "curb-to-curb" transportation to or from a medically necessary, non-emergency covered health care service in a standard passenger vehicle that is scheduled not more than 48 hours before the transportation occurs. This includes transportation related to:

- Discharge of a recipient from a health care facility.
- Receipt of urgent care.
- Obtaining pharmacy services and prescription drugs.
- Other transportation to or from a medically necessary, non-emergency covered health care service the Health and Human Services Commission (HHSC) considers appropriate to be provided by a transportation vendor.

The new benefit will be provided through managed care by a "transportation network company" (TNC), and the bill prohibits HHSC from requiring TNC drivers to individually enroll as a Medicaid provider and prohibits MCOs from credentialing the drivers. The bill allows MCOs to contract directly with a TNC for the provision of non-medical transportation services or to contract with a medical transportation organization or broker to manage all or part of the transportation benefits, including subcontracting with a TNC.

Implementation will require contract changes, rule development, and negotiations with Centers for Medicare and Medicaid Services. The bill directs HHSC to pilot the new rideshare transportation benefit in three to four service delivery areas starting Jan. 1, 2020. All Medicaid products will go live with the new transportation benefit and the carve-in of all non-emergency transportation services statewide by Sept. 1, 2020, depending on MCO readiness and federal approval.

The bill is effective Sept. 1, 2019, but allows HHSC to delay implementation pending federal approval and readiness of MCOs to administer the transportation benefits.

IDD Pilot and Carve-In Delay

House Bill 4533 by Rep. Klick & Sen. Kolkhorst

HB 4533 directs the Health and Human Services Commission (HHSC) to establish a pilot program within the STAR+PLUS program to test managed care's delivery of long-term services and supports (LTSS) and home and community-based services (HCBS) for clients with an intellectual or developmental disability (IDD). The bill includes additional Medicaid reforms and establishes a pilot program offering cost-effective dental benefits that reduce ER visits and in-patient hospital admissions to adults in Medicaid.

IDD Pilot Workgroup

The bill extends the IDD advisory committee and establishes a pilot workgroup. The advisory committee and workgroup will develop recommendations related to:

- Criteria for MCO and client participation.
- Evaluation criteria.

Texas Association of Health Plans

- Pilot goals.
- Transition plan into managed care for the Texas Home Living (2027), Community Living Assistance and Support Services (2029), HCBS (2031), and Deaf Blind with Multiple Disabilities (2031) waiver program services.

IDD Pilot Requirements

The pilot program must include clients currently receiving acute care services under STAR+PLUS who have IDD or a traumatic brain injury that occurred after the age of 21. The bill includes the following requirements:

- HHSC must not contract with more than two MCOs.
- The pilot must test alternative payment models.
- Clients must be allowed to opt out of—and not have to opt in to—the pilot.
- Clients participating in the pilot must not lose their position on any interest list.

The bill details the benefits offered under the pilot, including existing STAR+PLUS benefits, HCBS waiver benefits and additional LTSS benefits. The bill also creates provider protections and allows a comprehensive LTSS provider to deliver services in the pilot only if they also deliver the services under an existing waiver program.

Additional Reforms

HB 4533 includes Medicaid reform provisions originally included in SB 1105 by Sen. Kolkhorst, including requirements for HHSC to:

- Eliminate the Texas Provider Indicator number no later than Sept. 1, 2023.
- Implement a new Medicaid provider enrollment system no later than Sept. 1, 2020.
- Improve the HHSC complaint process by adopting a standard definition of grievance.
- Increase transparency and oversight of MCOs by posting quality of care information on the HHSC website.
- Improve information in denial letters for both providers and clients similar to requirements in SB 1207.
- Ensure the consumer-directed service option is

available for clients in the Medically Dependent Childrens Program.

- Improve the STAR Kids Assessment Tool using the same criteria as in SB 1207.
- Determine the feasibility of providing services to clients in the STAR Kids program under an accountable care organization or alternative payment model and provide a report to the legislature by Dec. 1, 2022.
- Issue a request for information on a statewide STAR Kids managed care plan.
- Ensure MCOs are nationally accredited by Sept. 1, 2022. The bill gives HHSC authority to determine if MCOs must use one accrediting entity or can choose from multiple organizations.
- Develop a report on the impacts of the 30-day inpatient spell of illness limitation in STAR+PLUS by Dec. 1, 2020.

The bill is effective Sept. 1, 2019, but allows HHSC to delay implementation pending federal approval and readiness of MCOs.

Maternal Health Reforms

Senate Bill 750 by Sen. Kolkhorst & Rep. Button

SB 750 addresses findings and recommendations of the Maternal Mortality and Morbidity Task Force and extends the committee until 2027. The bill requires the Health and Human Services Commission (HHSC) to:

- Assess the feasibility and cost-effectiveness of providing Healthy Texas Women (HTW) program services through Medicaid managed care.
- Offer a limited postpartum care services package for enrolled women to be provided after the first 60 days postpartum and for a maximum of 12 months after their date of enrollment in the HTW program. Rider 176 in the Budget appropriates \$1,029,200 for fiscal year 2020 and \$13,643,638 for fiscal year 2021 from General Revenue to implement the limited postpartum package.
- Develop and implement cost-effective, evidence-based, and enhanced prenatal services for high-risk pregnant women covered under Medicaid managed care.

Texas Association of Health Plans

- Develop initiatives to improve maternal health care service quality and outcomes, require managed care organizations to implement the initiatives, and require HHSC to publish a related annual report.
- Apply for federal funds to implement a model of care that improves the quality and accessibility of care for pregnant women with opioid use disorder that are enrolled in Medicaid during the prenatal and postpartum periods and for their children after birth.

The bill is effective Sept. 1, 2019, and allows HHSC to delay implementation pending federal approval.

Newborn Screening Preservation Account and Pregnancy Home Pilot

Senate Bill 748 by Sen. Kolkhorst & Rep. Sarah Davis

SB 748 requires the Health and Human Services Commission (HHSC) to adopt rules ensuring amounts charged for newborn screenings are sufficient to cover the costs and creates a preservation account. The bill requires HHSC to prepare a report no later than September 2020 on the benefits and costs of permitting reimbursement for prenatal and postpartum care provided via telemedicine in the Medicaid program. HHSC will establish a pregnancy medical home pilot program that provides a maternity management team.

The bill is effective Sept. 1, 2019, and allows HHSC to delay implementation pending federal approval.

State Contracting Transparency

Senate Bill 943 by Sen. Watson & Rep. Capriglione

SB 943 makes certain contracting information accessible under the Texas Public Information Act but exempts proprietary information submitted through the Health and Human Services Commission (HHSC's) RFP process from. The process to make an open records request related to a managed care organization (MCO) will remain the same—the requestor submits the request to HHSC, and the MCO maintains the right to object and request an opinion on the information's release from the Attorney General.

The bill is effective Jan. 1, 2020.

MAT Reimbursement

Senate Bill 1564 by Sen. West & Rep. Klick

Under federal law, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives have authority to prescribe buprenorphine as a medication assisted therapy (MAT) treatment for substance use disorders. SB 1564 aligns the state's Medicaid policy with federal law by providing Medicaid medical benefits reimbursement for the prescribing of buprenorphine by certain advanced practice registered nurses. The bill also prohibits the Health and Human Services Commission or a Medicaid managed care organization from requiring a prior authorization for MAT for substance use disorder.

The bill is effective Sept. 1, 2019.

Antiretroviral Drug Prior Authorization Prohibition

Senate Bill 1283 by Sen. Miles & Rep. Wu

SB 1283 prohibits the Medicaid Vendor Drug Program and managed care organizations from implementing a clinical prior authorization (PA), non-preferred PA, step therapy requirement, or any other protocol or PA requirement that could restrict or delay the dispensing of any antiretroviral drug used to treat HIV or prevent AIDS.

The bill is effective Sept. 1, 2019.

Electronic Visit Verification Systems and Recoupment Processes

Senate Bill 1991 by Sen. Buckingham & Rep. Klick

SB 1991 allows providers to use their own proprietary electronic visit verification (EVV) system and establishes a workgroup to inform rules governing EVV data submission and provider reimbursement. The bill requires managed care organizations (MCOs) to provide written notice to a provider of intent to recoup overpayments related to EVV and allows providers at least 60 days to cure any defect in a claim that mismatches with an EVV transaction.

The bill is effective Sept. 1, 2019.

Texas Association of Health Plans

Teleservices Benefits

Senate Bill 670 by Sen. Buckingham & Rep. Price

SB 670 makes necessary changes to the regulation and payment of telemedicine and telehealth services provided through the Texas Medicaid program that align with SB 1107 from the 85th Legislative Session. The bill aligns Medicaid statute with current policy by prohibiting the Health and Human Services Commission (HHSC) and managed care organizations (MCOs) from denying reimbursement for a Medicaid-covered procedure delivered by a contracted provider solely because the covered service or procedure is not provided through an in-person consultation. The bill also requires HHSC to allow teleservices reimbursement to Federally Qualified Health Centers serving as either the patient site or distant site.

Additionally, the bill requires the Medicaid program to promote and support patient-centered medical homes by requiring a teleservices provider that is not a Medicaid recipient's primary care physician to give notice to the Medicaid recipient's primary care provider, if they have one, regarding the teleservice. The notice, which is given when the recipient or, if appropriate, the recipient's parent or legal guardian, consents to sending it, will include a summary of the service, exam findings, a list of prescribed or administered medications, and patient instructions. The bill directs HHSC to implement a monitoring process to ensure MCOs promote and support patient-centered medical homes and care coordination in accordance with the new requirement.

The bill is effective Sept. 1, 2019.

Telemonitoring Benefits

House Bill 1063 by Rep. Price & Sen. Buckingham

HB 1063 repeals the scheduled expiration of the Medicaid home telemonitoring benefit. The bill adds more conditions to the current, limited list of conditions (described in statute) for which the Health and Human Services Commission (HHSC) can add telemonitoring benefits and requires HHSC to add telemonitoring services for pediatric patients who are diagnosed with end-stage solid organ disease, have received an organ transplant, or require mechanical ventilation. These benefits have been tested and shown

to be cost effective by programs at Children's Medical Center hospital. The bill also requires that HHSC include telemonitoring cost savings in its annual telemedicine report.

The bill is effective Sept. 1, 2019, and allows HHSC to delay implementation pending federal approval.

"In Lieu of" Behavioral Health Benefits

Senate Bill 1177 by Sen. Menéndez & Rep. Rose

SB 1177 requires the Health and Human Services Commission (HHSC) to allow managed care organizations (MCOs) the option to provide cost-effective, evidence-based services "in lieu of" mental health or substance use disorder benefits currently covered by Medicaid. The State Medicaid Managed Care Advisory Committee will develop a list of benefits that will qualify as "in lieu of" under the managed care contract. The bill directs HHSC to take the actual cost and use of any services from the list included in the contract that are offered by MCOs into consideration when setting the capitation rates. The bill also requires HHSC to submit an annual report to the legislature on the implementation and use of "in-lieu of" services.

The bill is effective Sept. 1, 2019, and allows HHSC to delay implementation pending federal approval.

Maternal Transportation Pilot

House Bill 25 by Rep. Mary González & Sen. Zaffirini

HB 25 requires the Health and Human Services Commission (HHSC) to create a pilot program in at least one service delivery area that allows pregnant and postpartum women in the STAR program to travel with their children through the Medicaid transportation program. Managed transportation organizations participating in the pilot program will be required to provide program services in a manner that does not result in additional costs and may pilot the use of rideshare options to achieve the purpose of the pilot.

The bill is effective Sept. 1, 2019, and the pilot program must be implemented by Sept. 1, 2020.

Texas Association of Health Plans

Rural Hospital Reimbursement Standards

Senate Bill 170 by Sen. Perry & Rep. Price

SB 170 establishes a reimbursement methodology and standards for rural hospitals to ensure rural hospitals are reimbursed in a way that allows them to fully recover their costs. The bill allows for the Health and Human Services Coalition (HHSC) to direct managed care organizations on how to pay rural hospitals without carving them out of managed care. It requires HHSC to recalculate the prospective cost-based reimbursement rates once every two years. The 2020-2021 Budget includes funding for the bill in an Article IX contingency rider.

The bill is effective Sept. 1, 2019.

Abortion and Affiliate Provider Restrictions

Senate Bill 22 by Sen. Campbell & Rep. Noble

SB 22 prohibits any Texas state agency or governmental entity from using state funds to pay for any service provided by an abortion or affiliated provider. An affiliate includes entities that have:

- Any legal relationship with an abortion provider.
- Any common ownership, management, or control by an abortion provider.
- A franchise or agreement with an abortion provider authorizing the common use of a brand name, trademark, or service mark.

The bill applies to the Medicaid program. The Health and Human Services Commission will need to seek a waiver because federal law prohibits a state from restricting Medicaid clients' choice of family planning provider.

The bill is effective Sept. 1, 2019.

Adoptive Parents STAR Health Option

House Bill 72 by Rep. White & Sen. Paxton

HB 72 allows children who are adopted from the foster care system and have a chronic health condition to either continue receiving services through STAR Health or to receive services through the STAR Kids or STAR programs upon their adoption.

The bill is effective Sept. 1, 2019, and allows the Health and Human Services Commission to delay implementation pending federal approval.



Texas Association of Health Plans

Key Legislation Affecting Public Health

While TAHP concentrated most of its attention throughout session on bills that directly affect our members, we also tracked a number of important pieces of legislation aimed at improving all Texans' health and well-being, such as bills addressing maternal and mental health. While many of the following bills indirectly impact the Medicaid program or commercial health plans, they generally focus on improving the health of Texas' overall population.

Mental Health Access

Senate Bill 11 by Sen. Taylor & Rep. Greg Bonnen

SB 11 establishes a mental health consortium tasked with creating mental health initiatives, facilitating stronger collaboration among medical schools, improving mental health research, and expanding mental health telemedicine for children. The consortium will be comprised of medical schools, the Health and Human Services Commission, mental health nonprofits, and other types of organizations. The consortium is tasked with a variety of duties including:

- Creating mental health hubs in each region of the state comprised of psychiatrists, social workers, and other mental health professionals.
- Requiring judges to be educated about mental health resources in their community.
- Establishing Child Psychiatry Access Networks, which are networks of comprehensive child psychiatry access centers that provide consultation services and training opportunities for pediatricians and primary care providers.
- Creating the Texas Child Health Access Through Telemedicine program, which consists of telemedicine or telehealth programs that identify and assess behavioral health needs and provide access to mental health care services for children and youth.
- Expanding the Child Psychiatry Workforce by creating funding for a psychiatrist who treats children and adolescents to serve as an academic medical director for a community mental health provider plus two resident rotations positions.
- Creating the Child and Adolescent Psychiatry Fellowships, which involves funding for physician fellowship positions that will lead to a medical specialty in child and adolescent psychiatry.

The bill is effective immediately.

Postpartum Strategic Plan Development

House Bill 253 by Rep. Farrar & Sen. Kolkhorst

HB 253 requires the Health and Human Services Commission to develop a five-year plan to improve access to postpartum depression screening, referral, treatment, and support. The bill provides for increasing public awareness of postpartum depression.

The bill is effective Sept. 1, 2019.

Maternal Opioid Use Disorder Assessment and Treatment

Senate Bill 436 by Sen. Nelson & Rep. Price

SB 436 directs the Department of State Health Services to work with the Maternal Mortality and Morbidity Task Force to develop the tools and best practices necessary to assess and treat opioid use disorders among pregnant women and to prevent opioid-related overdose among pregnant and postpartum women.

The bill is effective Sept. 1, 2019.

HTW Program Promotion

Senate Bill 2132 by Sen. Powell & Rep. Button

SB 2132 improves awareness of the Healthy Texas Women (HTW) program by adding information, specifically a list of local HTW-participating providers and information about covered services, to the notice sent to new mothers enrolled in HTW after having a baby. The bill requires the Health and Human Services Commission to examine the frequency of sending notices and alternative methods for sending the notice such as text or email.

The bill is effective Sept. 1, 2019.

Texas Association of Health Plans

Pregnancy-Associated Death Reporting

Senate Bill 2150 by Sen. Kolkhorst & Rep. Thierry

SB 2150 requires the Department of State Health Services (DSHS) to allow voluntary and confidential reporting of pregnancy-associated and pregnancy-related deaths by family members and other appropriate individuals associated with a deceased patient. The bill requires DSHS to post the contact information for a report on the agency's website and conduct outreach to local health organizations on the availability of the Maternal Mortality and Morbidity Review Committee to review and analyze the deaths. The bill aligns state law with federal law by adding a definition of "pregnancy-associated death" so Texas may apply for grant funding. The bill also changes the name of the Maternal Mortality and Morbidity Task Force to the Maternal Mortality and Morbidity Review Committee.

The bill is effective Sept. 1, 2019.

Maternal Level-of-Care Designation Appeals

Senate Bill 749 by Sen. Kolkhorst & Rep. Price

SB 749 addresses level-of-care designations for hospitals that provide maternal and neonatal care. The bill establishes a process through which hospitals may appeal to an independent third party regarding the level-of-care designation assigned to the hospital.

The bill is effective Sept. 1, 2019.

Antipsychotic Medications Nursing Facility Consent Requirement

House Bill 2050 by Rep. Paddie & Sen. Kolkhorst

Nursing home residents may be receiving antipsychotic or neuroleptic medications without a medical need and often without the resident's or legal representative's consent. These drugs may pose serious or life-threatening risks when administered to some residents, especially those with dementia. HB 2050 requires nursing facility residents' consent when prescribed these medications.

The bill is effective Sept. 1, 2019.

Value-Based Drug Purchasing Agreement Authorization

Senate Bill 1780 by Sen. Paxton & Rep. Parker

SB 1780 allows the Health and Human Services (HHSC) Vendor Drug Program to enter into a value-based bulk purchasing arrangement with a manufacturer based on outcome data or other metrics to which the state and manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus, or any other thing of value.

The bill is effective Sept. 1, 2019, and allows HHSC to delay implementation pending federal approval.

Trauma Designation via Telemedicine for Rural Facilities

House Bill 871 by Rep. Price & Sen. Perry

HB 871 allows health care facilities in a county with less than 30,000 people to receive a Level IV trauma designation requirement for physicians through the use of telemedicine.

The bill is effective Sept. 1, 2019.

Limited Services Rural Hospital Licensure

Senate Bill 1621 by Sen. Kolkhorst & Rep. Price

SB 1621 requires the Health and Human Services Commission to issue rules and licenses for limited services rural hospitals if a federal law is passed to create a payment program for these hospitals. A "limited services rural hospital" is a general or special hospital that is or was licensed under the Texas Hospital Licensing Law; is located in a rural area or designated as a critical access hospital, rural referral center, or sole community hospital; and otherwise meets requirements for designation as a limited services rural hospital or a similarly designated hospital under federal law for purposes of the payment program.

The bill is effective Sept. 1, 2019.

Texas Association of Health Plans

TMB Reforms and Renewal

House Bill 1504 by Rep. Paddie & Sen. Nichols

HB 1504 extends the “sunset” date for the Texas Medical Board (TMB) from Sept. 1, 2019, to Sept. 1, 2031. The bill also:

- Requires TMB to remove a remedial plan from its profile of a physician after five years if the complaint was related to the delivery of health care or if more than one remedial plan has been issued relating to the same violation (including a complaint not related to the delivery of health care).
- Provides for an expedited licensing process for out-of-state applicants who have met exam requirements.
- Creates exceptions to exam attempt limits for certain out-of-state applicants who have met specific requirements (including licensure in good standing, active practice, etc.).
- Amends TMB inspection law to provide that it may establish a risk-based inspection process or “equipment and office procedures” (change from “practice”) based on the length of time since the equipment and outpatient setting were last inspected and since the physician submitted to inspection.

- Adds physician anesthesia reporting.
- Adds to complaint investigation procedure that if the complaint includes an allegation that the license holder has violated the standard of care, the panel conducting the informal proceeding consider whether the physician was practicing complementary and alternative medicine.
- Requires TMB to redact identifying expert physician information.
- Imposes a new fingerprinting requirement for criminal history review on acupuncture license renewals.
- Creates a “radiologist assistant” certificate. A radiologist assistant may perform radiologic procedures only under the supervision of a radiologist and may not interpret images, make diagnoses, or prescribe any medication or therapy.

The bill is effective Sept. 1, 2019.



Texas Association of Health Plans

Preventing Costly Government Mandates and Regulations

Working together with our members, TAHP was instrumental in preventing a number of new and burdensome government mandates from advancing. While often well-intended, government mandates typically have unintended consequences on health insurance costs that directly lead to higher premiums for Texans. Health insurance benefit, regulatory, and contract mandates drive up the cost of insurance coverage for employers and consumers often without any corresponding benefits for them. If passed, many of these bills would have restricted private market negotiations—reducing competition, increasing costs for Texas consumers and businesses, and limiting affordable health plan coverage options.

Government Mandates Make Health Care Less Affordable for Texans

TAHP

The Truth About the High Cost of Health Care

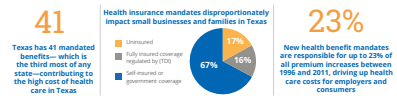
The cost of health care is high and still rising, and health insurance costs too much for many hardworking families. As the cost of health care services like hospital stays, medical screenings and prescription drugs continues to increase, the price of insurance has to go up to cover these costs. One of the most significant threats to health coverage affordability for Texans is the increasing number of government mandates related to provider payments, provider contracting and benefits. These mandates not only drive up the costs of health care, but also limit innovation, private market negotiations and consumer choice. In a survey of NFIB members, the cost of health insurance was ranked as the number one problem and priority for small business owners. While often well-intended, government mandates typically have unintended consequences on health insurance costs, which lead directly to higher premiums for Texans. When the government creates a health care mandate to help a small, specific group of people, premiums go up for everyone. While a single mandate may increase premiums by as much as 5% even a 1% premium increase has a large financial impact on families and employers. Every 1% premium increase costs consumers and employers an estimated \$238 million a year in the fully insured market.

Texas employers shoulder the biggest burden when it comes to government mandates because most Texans receive health coverage through their employer. Adding expensive new mandates to health plans increases the costs for business and employers and adds to the growing number of uninsured Texans. Employees ultimately pay the high price of mandated benefits through high premiums, co-pays, reduced wages and benefit reductions. Most large businesses receive their health care benefits under self-funded arrangements, which are exempted from state regulation under ERISA and so are exempted from state mandated benefits. As a result, health benefit mandates disproportionately impact costs for small employer and individual policies.

Too Many Mandates, Too Much Money

Texas has more than 40 mandated insurance benefits, which is third most in the country. New mandates make health care less affordable and on each case the cost of monthly premiums by up to 5%. For every 1% increase in premium costs, Texas and Texas employers are on the hook for an estimated \$228 million in the fully insured market each year.

Health Insurance Mandates Hurt Small Businesses by Driving Up Costs in the Fully-Insured Market



Any Willing Provider Mandates: Eliminating Competition & Increasing Costs

TAHP

One of the most significant threats to health coverage affordability for Texans and Texas businesses is the increasing number of government mandates related to provider payments, provider contracting and benefits. These mandates not only drive up the cost of health care, but also limit innovation, private market negotiations and consumer choice. While often well-intended, government mandates typically have unintended consequences on health insurance costs, which lead directly to higher premiums for Texans.

What Are Any Willing Provider Mandates?

Any Willing Provider (AWP) mandates restrict private market negotiations by forcing health plans to contract with any health care provider or pharmacy willing to meet the plan's contract terms—regardless of whether that provider meets quality standards, whether there is already enough patient access, or whether it will increase the cost of health care for consumers and businesses.

The Texas Association of Health Plans Opposes Any Willing Provider Mandates

AWP and pharmacy mandates undermine competition in the private market and increase costs for Texans and Texas businesses.

Did You Know?

The Federal Trade Commission Weighed in on Any Willing Provider Mandates and Found They Increase Cost and Reduce Competition:

- According to the Federal Trade Commission, networks and selective contracting generate significant savings that are passed on to consumers in the form of lower premiums, lower out-of-pocket costs and better services, while AWP laws lead to higher drug prices.
- These laws can make it more difficult for health insurers or PBMs to negotiate discounts from providers; if plans cannot give providers any assurance of favorable treatment or greater volume in exchange for lower prices, then the incentive for providers to bid aggressively for the plans' business—to offer better rates—is undercut. AWP and Freedom of Choice (FOC) laws also 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. —FTC letter to Hon. James L. Seward, 2011.

Consumers Have Unprecedented Levels of Access to Retail Pharmacies:

- According to Medicare, 90 percent of Medicare Part D beneficiaries live within 5 miles of a retail pharmacy and within 11 miles in urban areas.
- Put simply, there is no evidence that consumer access to pharmacies is a problem. Preferred pharmacy networks benefit both plan sponsors and patients.

FTC Letter to Hon. James L. Seward, 2011. Available at <http://www.ftc.gov/om/lineitem/20110303awpcommentary>. Accessed 04/04/2014. The information staff contained within this web site was obtained from the information provided by the Texas Association of Health Plans.

TEXAS ASSOCIATION OF HEALTH PLANS

ANY WILLING PROVIDER MANDATES: ELIMINATING COMPETITION & INCREASING COSTS

March 2013

This is a legislative advertising asset for the Texas Association of Health Plans (TAHP)

Jason Basker, Dir. of Gov. Relations, basker@tahp.org

www.tahp.org

[Facebook](https://www.facebook.com/tahpplans)

[Facebook.com/tahpplans](https://www.facebook.com/tahpplans)

[Twitter](https://www.facebook.com/tahpplans)

[Phone](https://www.facebook.com/tahpplans)

(512) 475-2001

Formulary Freeze

House Bill 2099 by Rep. Lambert & Senate Bill 580 by Sen. Campbell

HB 2099 would have restricted health plans' ability to make changes to drug benefits, including prohibiting certain modifications even at annual plan renewal, permanently "freezing" the formulary and benefits for a person taking a drug.

HB 2099 passed the House and was heard in the Senate Business & Commerce Committee, where it was left pending.

Prior Authorization Restrictions

House Bill 2327 by Rep. Greg Bonnen & Senate Bill 1186 by Sen. Buckingham

House Bill 2387 by Rep. Greg Bonnen & Senate Bill 1187 by Sen. Buckingham

HB 2327 would have created new prior authorization posting requirements and waived health plans' ability to require prior authorization (i.e., created a "deemed approval" of any impacted prior authorization request)

for any violation of those requirements. The bill would have required all physicians performing utilization review (UR) on Texas residents to be licensed in the state and declared performing any UR activities to be "engaging in the practice of medicine" requiring a license and subject to the jurisdiction of the Texas Medical Board. It would have required that only physicians of the same or a similar specialty as the treating physician perform all reviews and conduct all required peer-to-peer discussions.

HB 2327 went to conference committee. The conference committee report was adopted by the House, but was not adopted by the Senate.

HB 2387 passed the House, but was not heard in a Senate committee.

Emergency Care UR Prohibition

House Bill 1832 by Rep. Julie Johnson & Senate Bill 1282 by Sen. Campbell

HB 1832 would have created a new private cause of action against insurers and HMOs, making it an unfair method of competition or an unfair or deceptive act or practice in the

Texas Association of Health Plans

business of insurance to make coverage for an emergency claim dependent on a utilization review (UR) determination that the patient's medical condition required emergency care. It would have applied to both commercial health plans and Medicaid managed care organizations.

HB 1832 passed the House and was heard in the Senate Business & Commerce Committee, where it was left pending.

PBM Contracting Mandate

[House Bill 2817 by Rep. Lucio III](#)
[& Senate Bill 846 by Sen. Hughes](#)

HB 2817 would have restricted health plan and pharmacy benefit manager (PBM) performance-based contracting with pharmacies, requiring all performance evaluations to use a nationally-recognized performance tool that provides standardized, benchmarked data to improve pharmacy performance.

It required PBM network contracts to specify a separate fee schedule and provide it electronically in an easily accessible and complete spreadsheet format and, on request, in writing to each contracted pharmacist and pharmacy. Pharmacies that are a member of a pharmacy services administration organization (PSAO) would be entitled to receive a copy of a PBM or health plan contract from the PSAO. It prohibited health plans and PBMs from prohibiting a network pharmacy from mailing or delivering drugs to a patient as an ancillary service or charging a shipping and handling fee.

Significantly, the bill would have prohibited any accreditation standards more stringent than licensure requirements, even for specialty pharmacies.

HB 2817 passed the House Insurance and Senate Business & Commerce committees. It was placed on the Senate intent calendar, but was not heard by the full Senate.

PBM Contracting Restrictions

[House Bill 2231 by Rep. Oliverson](#)
[& Senate Bill 2261 by Sen. Kolkhorst](#)

HB 2231 would have created an onerous regulatory framework for pharmacy benefit managers (PBMs) and provided for government interference in private contracts between PBMs and independent pharmacists. The bill would have:

- Prohibited PBMs from using value-based contracting.
- Provided for an appeals process through the Texas Department of Insurance (TDI) for any payments the pharmacy thinks may be less than the lowest possible acquisition cost and allows them to appeal to guarantee a profit.
- Given pharmacist on the State Board of Pharmacy access to confidential and proprietary information submitted by PBMs to TDI.
- Created an “any willing provider” mandate.
- Prohibited plans from requiring common quality standards and independent, nationally-recognized accreditation for specialty pharmacies.
- Required PBMs to be fiduciaries.
- Created a new cause of action.

HB 2231 was heard in the House Insurance Committee, where it was left pending.

Provider Directory Mandate

[House Bill 1880 by Rep. Sarah Davis](#)
[& Senate Bill 1188 by Sen. Buckingham](#)

HB 1880 would have created unreasonable regulatory and administrative burdens relating primarily to health plan provider directory updates. The bill would have required Texas Department of Insurance (TDI) exams based on number of mediation requests and required reporting of all “not for cause” provider terminations to TDI.

HB 1880 passed the House, but was not heard in a Senate committee.

Texas Association of Health Plans

Provider Termination Prohibition

[House Bill 1905 by Rep. Klick](#)
& [Senate Bill 744 by Sen. Perry](#)

HB 1905 would have prohibited health plans from notifying their members that a pharmacy has been suspended for suspected fraud or malfeasance until a final determination following the appeal process to terminate the provider.

HB 1905 passed the House Insurance Committee, but died in the House Calendars Committee.

Out-of-Network Prompt Pay Penalties

[House Bill 1914 by Rep. Moody](#)

HB 1914 would have substantially changed Texas' prompt pay laws by expanding prompt pay contract requirements to out-of-network providers even though there is no contractual agreement.

The bill passed the House, but was not heard in a Senate committee.

ERS and TRS Bid Prohibition

[House Bill 2367 by Rep. Greg Bonnen](#)

HB 2367 would have prohibited insurers from submitting a bid to be the administrator or benefit provider of the Employees Retirement System of Texas (ERS) or Teacher Retirement System of Texas (TRS) health benefit plans for two bidding cycles (up to 12 years) if the ERS or TRS board "finds that the carrier has terminated a contract with a physician or provider solely because the physician or provider informed an enrollee... of the full range of physicians and providers, including out-of-network providers, available to the enrollee."

The bill passed the House, but was not heard in a Senate committee.

Early Childhood Intervention Benefit Mandate

[House Bill 12 by Rep. Sarah Davis](#)
& [Senate Bill 2225 by Sen. Zaffirini](#)

[House Bill 1295 by Rep. Sarah Davis](#)

[House Bill 1635 by Rep. Miller](#)
& [Senate Bill 1956 by Sen. Zaffirini](#)

HB 12 would have created new benefit mandates related to habilitative and rehabilitative services for early childhood developmental delays.

HB 12 passed the House, but was not heard in a Senate committee.

HB 1295 was not heard in committee.

HB 1635 passed the House, but was not heard in a Senate committee.

Expedited Physician Credentialing

[House Bill 2631 by Rep. Julie Johnson](#)
& [Senate Bill 1796 by Sen. Zaffirini](#)

HB 2631 would have required health plans to treat physicians and other health care providers as being in network before the providers are credentialed as qualified.

HB 2631 passed the House, but was not heard in a Senate committee.

Facility-Based Provider Cost Estimates

[House Bill 2520 by Rep. Julie Johnson](#)
& [Senate Bill 1740 by Sen. Menéndez](#)

HB 2520 would have required health plans to disclose the network status and service cost estimate of any facility-based provider, including out-of-network providers, that health plans reasonably expect will provide and charge for a service.

HB 2520 passed the House Insurance Committee, but died in the House Calendars Committee.

Texas Association of Health Plans

Lab Management Limitations

House Bill 317 by Rep. Raymond

HB 317 would have prohibited health plans from implementing appropriate laboratory management that helps improve the quality of outpatient laboratory services, supports evidence-based guidelines for patient care, and lowers costs for enrollees through better network utilization.

The bill was passed the House Insurance Committee, but died in the House Calendars Committee.

Direct Notice Mandate

House Bill 2632 by Rep. Julie Johnson & Senate Bill 1795 by Sen. Zaffirini

HB 2632 would have required advance “direct” notice of fee schedule rate changes to each network physician and provider to be sent in a manner that is trackable and indicates the date and time the notice was sent, either by certified mail or to an email address specified by the physician or provider.

HB 2632 passed the House, but was not heard in a Senate committee.

HIV and AIDS Prior Authorization Prohibition

House Bill 3058 by Rep. Julie Johnson

HB 3058 would have prohibited any prior authorization requirements for a prescription drug prescribed to treat HIV or AIDS.

The bill passed the House Insurance Committee, but died in the House Calendars Committee.

Serious Emotional Disturbance Benefit Mandate

House Bill 501 by Rep. Senfronia Thompson & Senate Bill 314 by Sen. Zaffirini

HB 501 would have mandated coverage by large employer group plans and created a mandated offer for small group plans for treatment of serious emotional disturbance of a child of at least 45 days inpatient and 60 visits outpatient.

HB 501 passed the House Insurance Committee, but died in the House Calendars Committee.

Ovarian Cancer Treatment Benefit Mandate

House Bill 670 by Rep. Ken King

HB 670 would have created a mandated benefit for ovarian cancer testing and screening that included “any other test or screening approved by the FDA for the detection of ovarian cancer.”

The bill passed the House Insurance Committee, but died in the House Calendars Committee.

HIV and AIDS Testing Benefit Mandate

House Bill 762 by Rep. Wu

HB 762 would have required all blood samples to be screened for HIV unless the patient opts out and mandated health plan coverage for the costs.

The bill was heard in the House Insurance Committee, where it was left pending.

Alternative Treatment Mandate

House Bill 923 by Rep. Zedler

HB 923 would have mandated coverage of FDA-approved “alternative services” in place of services that have been approved by the health plan if the cost does not exceed the cost of the approved services.

The bill passed the House Insurance Committee, but died in the House Calendars Committee.

Texas Association of Health Plans

SOAH Complaint Appeals Process Change

House Bill 4277 by Rep. Yvonne Davis

HB 4277 would have created a new complaint review panel process at the State Office of Administrative Hearings (SOAH) for appeals of all Texas Department of Insurance complaints.

The bill was heard in the House Insurance Committee, where it was left pending.

Call Center Regulatory Mandate

House Bill 701 by Rep. Lucio III

HB 701 would have required insurers and other businesses to submit reports of terminated customer service employee positions and mandated that call centers be located in Texas.

The bill passed the House Business & Industry Committee, but died in the House Calendars Committee.

Mandated Benefit Prior Authorization Prohibition

House Bill 2408 by Rep. Julie Johnson & Senate Bill 1741 by Sen. Menéndez

HB 2408 would have prohibited prior authorizations for several mandated benefits:

- Low-dose mammography.
- Reconstruction of a breast incident to mastectomy.
- Minimum inpatient care following a mastectomy or lymph node dissection for the treatment of breast cancer.
- Diabetes equipment, supplies, or self-management training
- Bone mass measurement.
- Colorectal cancer screenings.

HB 2408 passed the House Insurance Committee, but died in the House Calendars Committee.

Hair Prosthesis Benefit Mandate

House Bill 217 by Rep. Gervin-Hawkins

HB 217 would have required coverage for a hair prosthesis for enrollees undergoing medical treatment for cancer.

The bill passed the House, but was not heard in a Senate committee.

FSER Scope of Practice and Licensure Expansion

House Bill 1278 by Rep. White

HB 1278 would have expanded the licensure for freestanding emergency rooms (FSERs) to include “outpatient acute care services” in addition to emergency care.

The bill passed the House Public Health Committee, but died in the House Calendars Committee.

Pharmacy Cost Discussion Prohibition

House Bill 698 by Rep. Blanco & Senate Bill 469 by Sen. Kolkhorst

HB 698 would have prohibited insurers and pharmacy benefit managers from restricting a pharmacy or pharmacist from providing cost information to enrollees, including informing enrollees that the charge is less than the drug benefit plan cost-sharing, or from selling a covered drug for less than the cost-sharing amount.

HB 698 passed the House Insurance Committee, but died in the House Calendars Committee.

Audit Extrapolation Prohibition

House Bill 2151 by Rep. Muñoz, Jr. & Senate Bill 1508 by Sen. Schwertner

HB 2151 would have prohibited HMOs and insurers from using extrapolation to complete a claim audit of a network physician or provider.

HB 2151 passed the House Insurance Committee and was referred to the Senate Business & Commerce Committee, where it was not heard.

Texas Association of Health Plans

Out-of-Network “Right to Shop” Mandate

House Bill 1718 by Rep. Muñoz, Jr.

HB 1718 would have mandated that health plans pay the median network rate to any out-of-network provider that agreed to not charge the enrollee more than the network cost-sharing amount.

The bill was heard in the House Insurance Committee, where it was left pending.

“Delisting” Private Cause of Action

House Bill 1124 by Rep. Muñoz, Jr.

HB 1124 would have created new private causes of action for violations relating to provider termination provisions of the Insurance Code that are already enforced by the Texas Department of Insurance.

The bill passed the House Judiciary & Civil Jurisprudence Committee, but died in the House Calendars Committee.

OPIC Network Adequacy Authorization

Senate Bill 1509 by Sen. Schwertner

SB 1509 would have given the Office of Public Insurance Counsel (OPIC) the power to oppose and intervene in network adequacy approvals.

The bill was referred to the Senate Business & Commerce Committee, where it was not heard.

FSER Advisement Prohibition

House Bill 4404 by Rep. Miller

HB 4404 would have created a private cause of action and made it an unfair method of competition or an unfair or deceptive act or practice under the Texas Insurance Code for insurers to encourage their members to not use freestanding emergency rooms (FSERs).

The bill was referred to the House Insurance Committee, where it was not heard.

Network Adequacy Waiver Restrictions

House Bill 2962 by Rep. Lambert
& Senate Bill 1886 by Sen. Kolkhorst

HB 2962 would have added new restrictions to the Texas Department of Insurance’s network adequacy “waiver” process for PPO plans.

HB 2962 was not heard in committee.

Individual Coverage Disclosure Regulatory Mandate

House Bill 1156 by Rep. Collier

House bill 1156 would have required health plans to provide extensive, duplicative information to agents and agents to provide it to individuals purchasing health coverage.

The bill was not heard in committee.

Emergency Care Prior Authorization and UR Restrictions

House Bill 4351 by Rep. Martinez Fischer

HB 4351 would have required coverage of emergency care with no prior authorization, which is already required, and a review of the enrollee’s medical record for any utilization review (UR) of emergency claims.

The bill was not heard in committee.

Campus-Based Mental Health Services Contract Mandate

Senate Bill 344 by Sen. Watson

SB 344 would have provided that any HMO, health care collaborative, or PPO or EPO plan issuer that covers mental health care services may not reject a campus-based mental health professional’s initial application to provide mental health care services “on behalf of” the health plan based on a determination that it has contracted with sufficient qualified mental health care providers in the area. The bill provided for an expedited decision on the application.

The bill was not heard in committee.

Texas Association of Health Plans

Hearing Aid Benefit Mandate

House Bill 2658 by Rep. Julie Johnson

HB 2658 would have prohibited health plans from denying a claim solely on the basis that the price of the hearing aid is more than the available benefit.

The bill passed the House, but was not heard in a Senate committee.

Health Underwriting Prohibition

Senate Bill 2020 by Sen. Miles

SB 2020 would have prohibited health plans from taking an adverse action with respect to an enrollee or prospective enrollee based on the individual's health risk score or any health risk information derived from a health risk report.

The bill was not heard in committee.

Contraceptive Supply Mandate

House Bill 937 by Rep. Sarah Davis & Senate Bill 795 by Sen. Alvarado

HB 937 would have mandated that health plans cover up to a 12-month supply of prescription contraceptive drugs at one time. The bill would have applied to commercial health plans, "consumer choice" plans, school districts, ERS and TRS plans, and Medicaid and CHIP plans.

HB 937 passed the House Insurance Committee and was placed on the House General State Calendar, but was not heard by the full House.

Craniofacial Benefit Mandate

House Bill 1968 by Rep. Anderson

HB 1968 would have expanded the mandate for craniofacial abnormalities beyond surgery to include orthodontic treatment and management, as well as genetic assessment counseling for the parents and child.

The bill passed the House, but was not heard in a Senate committee.

Health Plan Network Elimination

House Bill 4391 by Rep. Sheffield

HB 4391 would have prohibited health insurers and HMOs from using provider networks.

The bill was not heard in committee.

Eating Disorders Treatment Benefit Mandate

House Bill 1511 by Rep. Coleman

HB 1511 would have mandated coverage for treatment of eating disorders.

The bill was heard in the House Insurance Committee, where it was left pending.

Pre-Existing Conditions Mandate

House Bill 2114 by Rep. Martinez Fischer & House Bill 1645 by Rep. Beckley

HB 2114 would have prohibited health plans from denying coverage or enrollment in a health benefit plan on the basis of a pre-existing condition, limiting or excluding coverage for treatment of a pre-existing condition otherwise covered, and charging more for coverage based on a pre-existing condition.

HB 2114 was heard in the House Insurance Committee, where it was left pending.

Fertility Preservation Services Benefit Mandate

House Bill 2682 by Rep. Collier & Senate Bill 959 by Sen. Menéndez

HB 2682 would have mandated coverage of "fertility preservation services" for a covered person receiving medically necessary treatment that may impair fertility.

HB 2682 passed the House Insurance Committee, but died in the House Calendars Committee.

Texas Association of Health Plans

Bacterial Meningitis Vaccine Benefit Mandate

House Bill 3039 by Rep. Chris Turner

HB 3039 would have mandated coverage with no cost-sharing for all bacterial meningitis vaccinations recommended under generally accepted standards of medical practice, including any booster doses of the vaccine.

The bill was not heard in committee.

ACA Benefit Mandate

Senate Bill 145 by Sen. Rodríguez

SB 145 included many provisions of the Affordable Care Act (ACA), including mandating coverage of essential health benefits and pre-existing conditions. It also required the Texas Department of Insurance to adopt rules implementing the National Association of Insurance Commissioners External Review Model Act and increased the eligibility of a child enrolled in the STAR Health program until age 26.

The bill was not heard in committee.

Chemical Dependency Benefit Mandate

House Bill 4393 by Rep. Sheffield

HB 4393 would have mandated coverage of an inpatient rehabilitation program for not less than 90 days to provide the necessary care and treatment of chemical dependency.

The bill was not heard in committee.

Embryonic and Fetal Tissue Remains Disposition Benefit Mandate

House Bill 4420 by Rep. Anchia

HB 4420 would have mandated coverage for the cost of disposition of embryonic and fetal tissue remains in the manner required under Section 697.004, Health and Safety Code.

The bill passed the House, but was not heard in a Senate committee.

General Anesthesia Mandate

House Bill 4442 by Rep. Lucio III

HB 4442 would have mandated coverage of general anesthesia services for dental services provided to a covered individual who is younger than 18 years of age and unable to undergo the service in an office setting or under local anesthesia due to a documented physical, mental, or medical reason determined by the physician or dentist providing the care.

The bill was not heard in committee.

PTSD Mandate

Senate Bill 107 by Sen. Menéndez

SB 107 would have mandated coverage of treatment for post traumatic stress disorder (PTSD) by adding PTSD to the definition of “Serious Mental Illness” in the Texas Insurance Code.

The bill was not heard in committee.

Scalp Cooling Benefit Mandate

House Bill 3984 by Rep. Leach

HB 3984 would have mandated coverage of scalp cooling to reduce hair loss in patients undergoing chemotherapy.

The bill passed the House, but was not heard in a Senate committee.

Pre-Existing Conditions Mandate

Senate Bill 825 by Sen. Watson

SB 825 would have mandated guaranteed issuance of individual and large employer group coverage (in addition to the current requirements for small groups) and prohibited any benefit limits, exclusions, or rates based on pre-existing conditions.

The bill was not heard in committee.

Texas Association of Health Plans

Serious Mental Illness Mandate

Senate Bill 2218 by Sen. Zaffirini

SB 2218 would have expanded the current “Serious Mental Illness” mandate to apply to individual and “consumer choice” plans and for small employer groups as a mandated benefit rather than a mandated offer.

The bill was not heard in committee.

Third-Party Liability Claim Delay Prohibition

House Bill 3064 by Rep. Julie Johnson

HB 3064 would have prohibited health plans from delaying payment of a claim on the basis that the enrollee may be able to recover under a third party’s liability insurance.

The bill passed the House Insurance Committee, but died in the House Calendars Committee.

Network Provider Prior Authorization Prohibition

House Bill 3232 by Rep. Julie Johnson

HB 3232 would have prohibited health insurance providers from requiring any prior authorization or other utilization reviews for network providers.

The bill was heard in the House Insurance Committee, where it was left pending.

ID Card HMO Identifier Requirement

House Bill 3338 by Rep. Julie Johnson

HB 3338 would have required an “HMO” identifier on applicable ID cards in order to indicate that the coverage does not ensure the enrollee access to out-of-network services at a discounted rate.

The bill passed the House, but was not heard in a Senate committee.



Texas Association of Health Plans

86th Texas Legislature Medicaid Budget Highlights

The Texas Legislature passed a \$250.7 billion budget focused on the session's two highest priorities: public school funding and property tax relief. The General Appropriations Act for 2020-2021 also includes \$84 billion in All Funds for health and human services programs, an increase of only 1% from the previous two-year budget cycle.

Legislative Budget Board Summary of Conference Committee Report for HB 1: FY 20-21

FY 2019 Supplemental Appropriations Act

Senate Bill 500 by Sen. Nelson & Rep. Zerwas

SB 500 is this session's supplemental spending bill, which adjusts the FY 2019 budget for additional funding needs. The legislature typically adjusts the current budget to help meet additional spending needs, including Medicaid costs. SB 500 includes \$4.1 billion in All Funds for the FY 2019 Medicaid shortfall and money from the Economic Stabilization Fund, also known as the "Rainy Day" Fund, mostly to pay for large-scale infrastructure, school safety projects, and Hurricane Harvey recovery. Because the supplemental bill pays for full FY 2019 Medicaid costs, the Health and Human Services Commission (HHSC) will not be required to defer the managed care organizations' August 2019 premium payment, which was an option if Medicaid was underfunded due to the \$563 million transfer from HHSC to the Texas Education Agency per HB 21 and SB 30 of the 85th Special Session.

FY 2020-2021 General Appropriations Act

House Bill 1 by Rep. Zerwas & Sen. Nelson

Appropriations for the Health and Human Services Commission encompass many programs, but spending is driven primarily by Medicaid, CHIP, and foster care. The 2020-2021 General Appropriations Act Medicaid appropriations includes \$66.5 billion in All Funds for the Texas Medicaid program. This is an overall net increase from the 2018-2019 budget of \$0.8 billion in All Funds, but a decrease of \$1.9 billion in General Revenue due to a higher federal medical assistance percentage (FMAP).

The federal government matches state spending for eligible beneficiaries and qualifying services using a formula based on a state's per capita income. The formula is designed so that the federal government pays a larger share of program costs in poorer states. Each quarter, states report their Medicaid costs to the federal government, which matches those costs at the state's FMAP. The higher FMAP in the 2020-2021 budget results in an increase in federal funds offsetting and decreasing the need for state General Revenue Funds.

The 2020-2021 Medicaid budget includes \$61.5 billion All Funds for Medicaid client services, \$3.1 billion All Funds for administration of Medicaid and other programs, and \$1.8 billion All Funds for programs supported by Medicaid funding. These funds support caseload growth with an estimated 3,925,224 average full benefit Medicaid recipients per month in 2020 and 3,984,836 in 2021, 94% of which are estimated to be enrolled in Medicaid managed care. The 2020-2021 Medicaid funds maintain fiscal year 2019 average costs and do not include funding for medical inflation, higher utilization, or increased acuity.

The budget also includes funding for 1,628 additional home and community based waiver slots and provides rate increases for inpatient services provided by rural hospitals, labor and delivery services provided by rural hospitals, intermediate care facilities for individuals with intellectual disabilities, Texas Health Steps private duty nursing, and certain therapy services. These rate increases are offset by assumed savings associated with the Medicaid cost containment rider of \$900 million in All Funds.

Texas Association of Health Plans

Budget Cost Containment Provision

For many years, the legislature has included a cost containment provision in the Medicaid budget. Rider 19 is the cost containment rider for the 2020-2021 budget. While it is less prescriptive on how to achieve savings than in previous budgets, it does direct the Health and Human Services Commission (HHSC) to develop and implement cost containment initiatives to achieve a savings of at least \$350 million in General Revenue for the 2020-21 biennium. The rider states that the initiatives cannot adjust the amount, scope, or duration of services or otherwise negatively impact access to care. The rider directs the agency to focus on increasing fraud, waste, and abuse prevention maximizing federal flexibility under the Medicaid program and achieving other programmatic and administrative efficiencies.

The rider also requires HHSC to submit an annual report on the implementation of cost containment initiatives to the Legislative Budget Board by Dec. 1, 2019, and clarifies that it is the intent of the legislature that HHSC shall consider stakeholder input prior to making changes.

Additional Health and Human Services Budget Highlights

HHSC Rider 12: Medicaid Medical Transportation. Requires the Health and Human Services Commission (HHSC) to determine unmet transportation needs based on client survey data and report on the number of clients that had a difficult time obtaining transportation to medical appointments.

HHSC Rider 13: Increase CDS. Directs HHSC to educate STAR+PLUS home and community based services consumers about the consumer directed services (CDS) option and collect data from managed care organizations (MCOs) on the percent of clients enrolled in CDS to establish benchmarks. Information on metrics must be published on HHSC's website.

HHSC Rider 14: Community Integration Performance Indicators. Requires HHSC to collect data for community integration outcomes to measure the STAR+PLUS and STAR Kids programs. Information on metrics must be published on HHSC's website.

HHSC Rider 15: Medicaid Therapy Services Reporting. Directs HHSC to submit a quarterly report on pediatric acute care therapy services (including physical, occupational, and speech therapies) by service delivery area that includes data on provider and member complaints, appeals, provider terminations, utilization, waiting lists, and providers accepting new clients. Also requires HHSC to consider stakeholder feedback when developing the report criteria.

HHSC Rider 16: Evaluation of Medicaid Data. Directs HHSC to annually evaluate data submitted by MCOs to determine whether the data continues to be useful or if additional data is needed to oversee contracts and evaluate effectiveness of Medicaid.

HHSC Rider 18: MDCP. Removes language regarding Medically Dependent Childrens Program (MDCP) enrollment that previously prevented HHSC from increasing enrollment above 5,480 or increasing enrollment in the Youth Empowerment Services program above 1,450.

HHSC Rider 20: Expansion of Community Based Services. Allocates funding to reduce waiting list for Home and Community Based Services (HCBS) waivers (60 MDCP slots, 240 Community Living Assistance and Support Services slots, 1,320 HCBS slots, 8 Deaf Blind with Multiple Disabilities slots).

Texas Association of Health Plans

HHSC Rider 27: Study Relating to Cost Drivers in STAR Kids. Directs HHSC to study the cost impact of STAR Kids members with high utilization and cost drivers, including private duty nursing, in each MCO to determine if adjustments to the current rate setting methodology would more appropriately align capitation rates with relative acuity without reducing the incentive for MCOs to manage utilization. Authorizes HHSC to make the adjustments if it will not result in increased expenditures.

HHSC Rider 28: Rural Labor and Delivery Medicaid Add-On Payment. Appropriates funds for HHSC to provide a Medicaid add-on payment for labor and delivery services provided to rural hospitals.

HHSC Rider 30: Study on Cost Savings for Medicaid Prescription Drugs. Directs HHSC to evaluate strategies to achieve cost savings for Medicaid prescription drugs and to submit a report by Sept. 1, 2020.

HHSC Rider 32: Intensive Behavioral Intervention. Provides HHSC the authority to expend Medicaid funds to provide intensive behavioral intervention for persons under the age of 20 in Medicaid with a diagnosis of Autism Spectrum Disorder.

HHSC Rider 33: MCO Services for Adults With Serious Mental Illness. Directs HHSC to identify claims and expenditures by MCOs for clients with a serious mental illness to evaluate any inappropriate variation in delivery of services by an MCO and to submit a report no later than August 2020.

HHSC Rider 34: Evaluation of Opioid Drug Prescribing Practices Under Medicaid. Directs HHSC to evaluate the prescribing practices for opioid drugs in Medicaid and assess the extent to which those practices align with the Centers for Disease Control and Prevention recommendations and to submit a report by September 1, 2020.

HHSC Rider 36: Evaluation of Children's Hospital Reimbursement. Directs HHSC to evaluate reimbursement methodology for Medicaid and CHIP for free-standing, non-profit children's hospitals.

HHSC Rider 39: Emergency Medical Services Enhanced Payment Model. Directs HHSC to conduct a study on the feasibility and cost-effectiveness of establishing an enhanced payment model for public, non-state government providers of ground EMT services.

HHSC Rider 42: Medicaid Waiver Program Interest List Study. Requires HHSC to conduct a study regarding interest lists for certain Medicaid waiver programs and to include strategies to reduce interest lists and measure outcomes in the statewide IDD Strategic Plan developed in relation the annual Statewide Behavioral Health Strategic Plan.

HHSC Rider 43: Quality and Efficiency-Based Enrollment Incentive Program. Requires HHSC to create an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on performance, quality of care, efficiency, and effectiveness of service provision.

HHSC Rider 45: Information on Funding Provided for Attendant Wages and Rate Enhancements. Appropriates funds for an increase in the base wage of personal attendants to \$8.11 per hour in fiscal years 2020 and 2021. Also fully funds the rate enhancement programs for community care and intellectual and developmental disabilities providers.

HHSC Rider 46: Medicaid Private Duty Nursing Rate Increase. Appropriates funds for a 2.5% rate increase for Texas Health Steps private duty nursing services.

Texas Association of Health Plans

HHSC Rider 47: Medicaid Therapy Rate Increases. Allocates funds for rate increases for occupational, physical, and speech therapy services.

HHSC Rider 77: Long-Acting Reversible Contraceptive Devices. Directs HHSC to coordinate with the State Board of Pharmacy to determine the feasibility of implementing a process to transfer unused long-acting reversible contraceptive devices to clients enrolled in Medicaid or the Healthy Texas Women (HTW) program. If found to be cost effective and feasible, HHSC can implement the program.

HHSC Rider 112: OIG Report. Directs the Office of Inspector General (OIG) to submit a quarterly report related to the expansion of managed care to include compliance of MCOs with program integrity requirements, quality and accuracy of encounter data, collaborative efforts with Special Investigation Units, and audits of MCOs.

HHSC Rider 114: MCO Performance and Reporting Requirement. Requires OIG to collaborate with MCOs to review cost avoidance and waste prevention activities and to submit a report by March 1, 2020.

HHSC Rider 115: Dental and Orthodontia Providers in the Texas Medicaid Program. Requires HHSC to strengthen the capacity of OIG to detect, investigate, and prosecute abuse by dentists and orthodontists in Medicaid and to conduct more extensive reviews of medical necessity for orthodontia services.

HHSC Rider 170: Clear Process for Including Prescription Drugs on the Texas Drug Code Index. Directs HHSC to clarify the process for the inclusion of prescription drugs in the Medicaid program and CHIP and ensure that the timeline for review, including initiation of drug review, clinical evaluation, rate setting, Legislative Budget Board (LBB) notification, and making the product available, does not extend past the 90th day of receipt of the completed application for coverage on the Texas Drug Code Index.

HHSC Rider 171: Change in Ownership Processing Timeliness. Directs HHSC to review the process for completing nursing facility change of ownership, including timeframes for application processing, survey, contracting, licensure, and payments following the completed change of ownership, and to submit a report by March 1, 2020.

HHSC Rider 175: Information Technology and Data Services Modernization Plan. Requires HHSC to prepare and post on their website a 10-year system-wide plan outlining the manner in which the commission intends to transition its information technology and data-related services and capabilities into a more modern, integrated, secure, and effective environment.

HHSC Rider 176: Contingency for Senate Bill 750. Appropriates \$1 million for FY 2020 and \$13.6 million for FY 2021 to implement a limited postpartum care package in the HTW program.

Special Provisions Sec. 14: Rate Limitations and Reporting Requirements. a) Requires HHSC, within seven calendar days of the establishment of MCO preliminary premium rates, to submit certain information in writing to the LBB, governor and state auditor and directs them to submit the final proposed rates no later than 45 calendar days prior to implementation. b) Requires HHSC to provide notification of a new or increased rate for an orphan drug within 60 calendar days if MCO rates are to be adjusted.

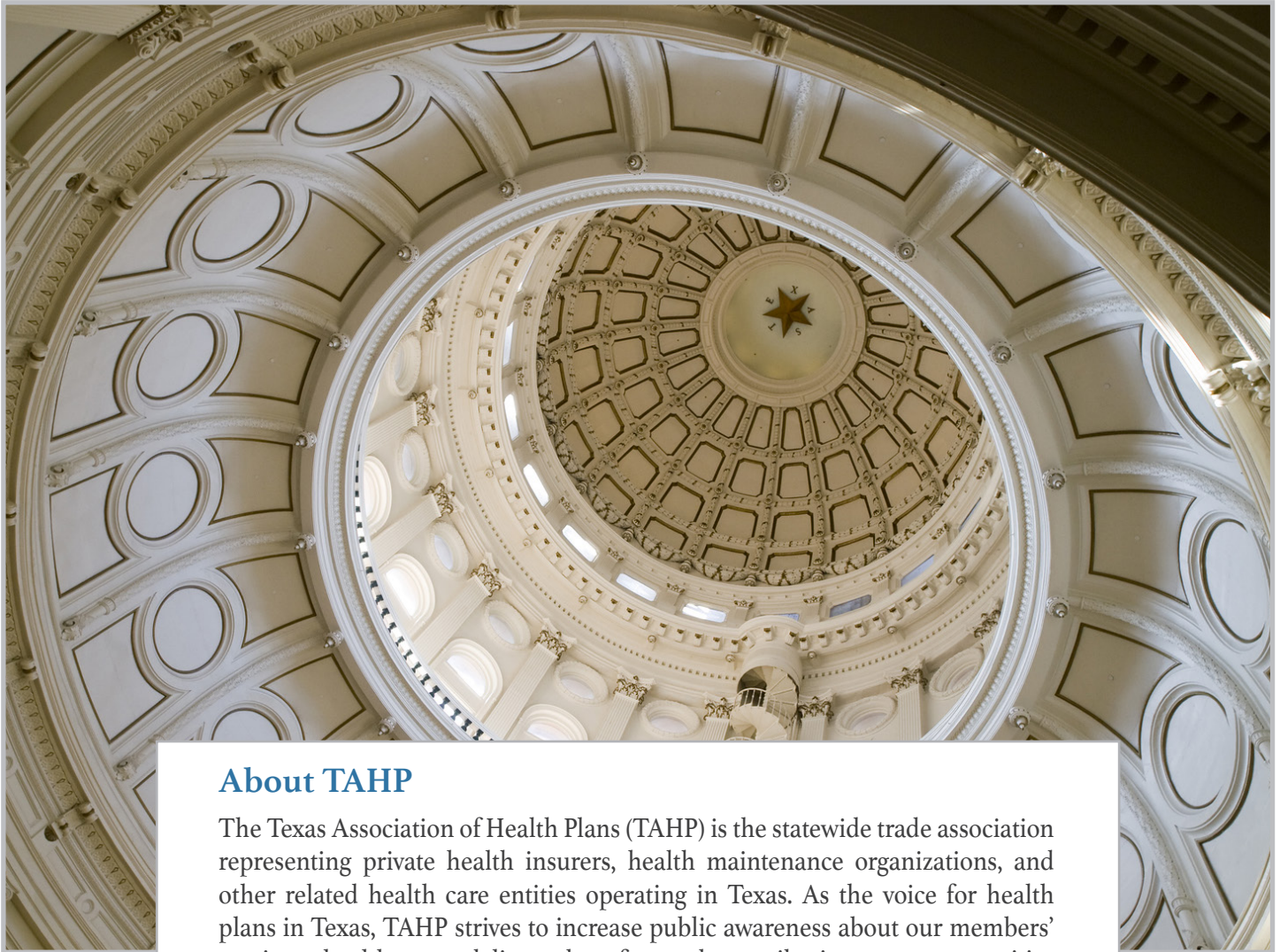
Texas Association of Health Plans

Article IX Contingency Riders

- **Contingency for Senate Bill 1096:** Contingent on enactment of SB 1096, relating to pharmacy benefits provided through the Medicaid managed care program, HHSC shall implement the provisions of the bill out of funds appropriated elsewhere to the agency.
- **Contingency for Senate Bill 1207:** Contingent on enactment of SB 1207, relating to the operation and administration of Medicaid, including the Medicaid managed care program and the Medically Dependent Childrens Program, HHSC shall implement the provisions of the bill out of funds appropriated elsewhere to the agency.
- **Contingency for Senate Bill 170:** Contingent on enactment of SB 170, relating to reimbursement of rural hospitals under Medicaid, HHSC shall implement the provisions of the bill out of funds appropriated elsewhere to the agency.
- **Contingency for Senate Bill 1780:** Contingent on enactment of SB 1780, relating to value-based arrangements in the Medicaid Vendor Drug Program, HHSC shall implement the provisions of the bill out of funds appropriated to HHSC in Strategy B.1.I, Medicaid Contracts & Administration.
- **Contingency for Senate Bill 1991:** Contingent on enactment of SB 1991, relating to claims and overpayment recoupment processes imposed on health care providers under Medicaid, HHSC shall implement the provisions of the bill out of funds appropriated elsewhere to the agency.
- **Contingency for House Bill 1063:** Contingent on enactment of HB 1063, relating to telemedicine medical, telehealth, and home telemonitoring services under Medicaid, HHSC shall implement the provisions of the bill out of funds appropriated elsewhere to the agency.
- **Sec. 10.05. Funding for Autism Services:** Appropriated elsewhere in this act for autism services is \$22,392,870 in General Revenue Funds for the 2020-21 biennium, which is allocated to HHSC, among others agencies, for the following purpose:
 - o HHSC: General Revenue Funds totaling \$14,292,870 for the biennium for focused Applied Behavior Analysis treatment services.



Texas Association of Health Plans



About TAHP

The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas. As the voice for health plans in Texas, TAHP strives to increase public awareness about our members' services, health care delivery benefits and contributions to communities throughout the state.

Jamie Dudensing
CEO
jdudensing@tahp.org

Jason Baxter
Director of
Government Relations
jbaxter@tahp.org

Tania Colon
Director of Health Plan
Operations
tcolon@tahp.org

Patti Doner
Director of Operations
pdoner@tahp.org

Melissa Eason
Regulatory Counsel
meason@tahp.org

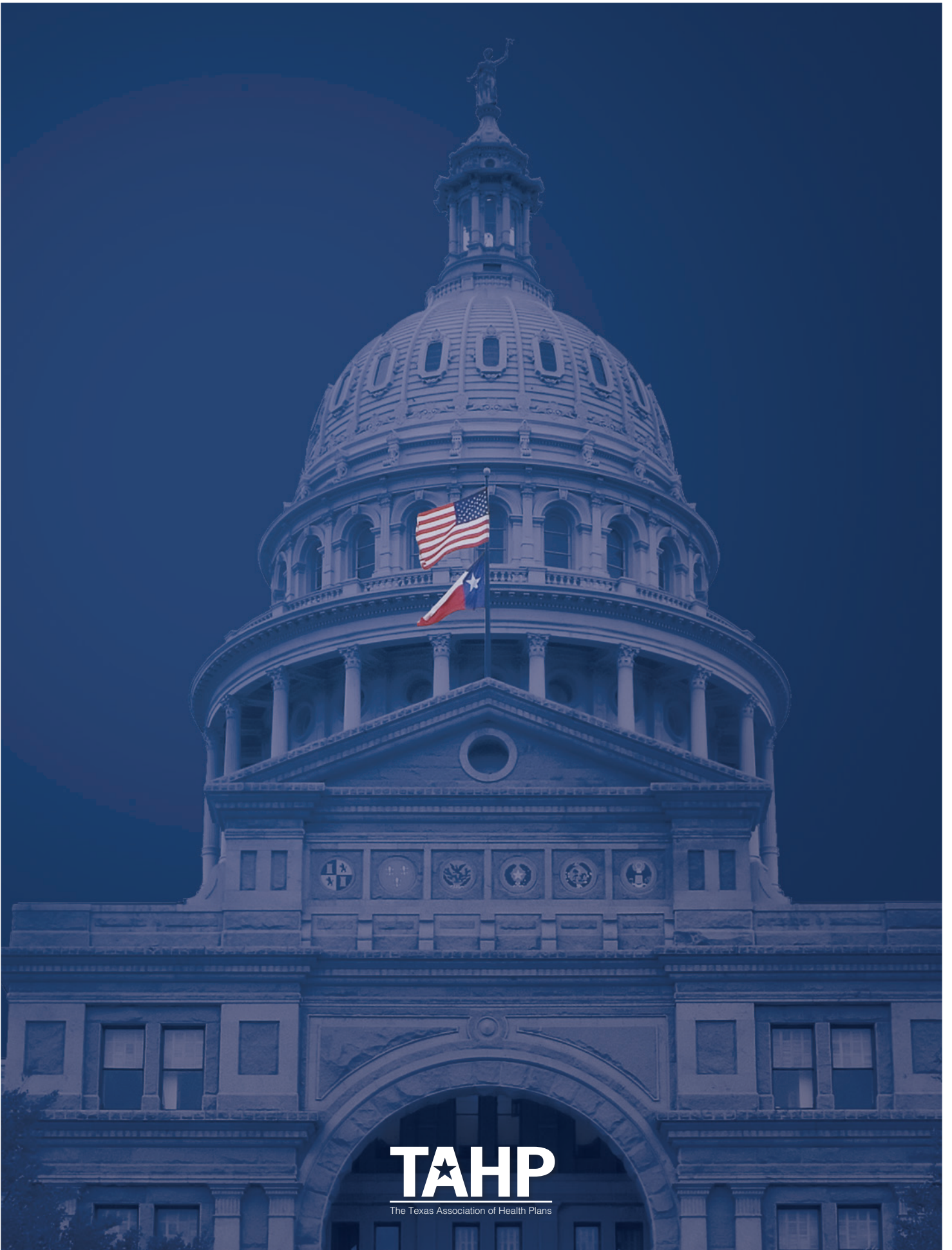
John Ford
Director of Communications
jford@tahp.org

Amanda Hudgens
Director of Special Projects
ahudgens@tahp.org

Laurie Vanhose
Director of Policy and
Government Programs
lvanhose@tahp.org

Dorin Shams
Project Assistant
dshams@tahp.org

Follow us on twitter @txhealthplans or visit www.tahp.org



TAHP

The Texas Association of Health Plans