88th Session Health Care Highlights

88th Texas Legislative Session

June 2023

TAHP
The Texas Association of Health Plans

About TAHP

TAHP is dedicated to promoting affordable health care for all Texans through advocacy and education. It is our goal to increase public awareness about our members' services, health care delivery benefits, and contributions to communities throughout the state. TAHP strives to build and foster valuable relationships with its members, industry, and community stakeholders, as well as with representatives of the Texas Legislature and state agencies.

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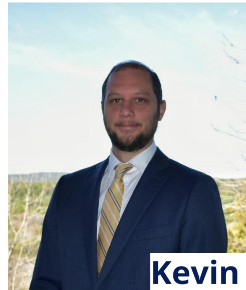

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88th End-of-Session Highlights Guide

TAHP's end-of-session guide highlighting key pieces of legislation from the 88th Legislative Session impacting Texas Medicaid and the health insurance industry:

READ THE GUIDE

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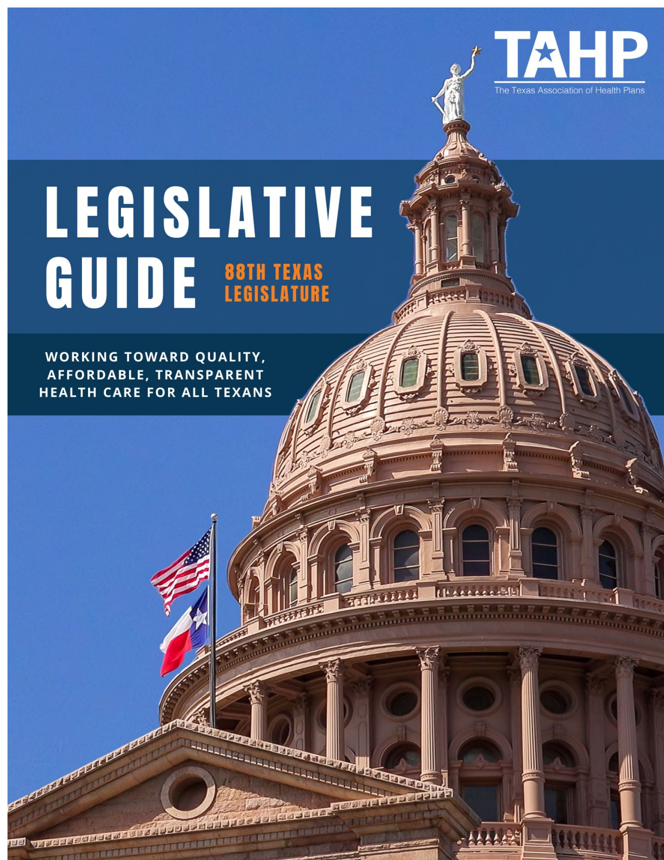

88th Legislative Session Guide

TAHP's legislative guide gives a comprehensive explanation of Texas Medicaid and health insurance issues for this legislative session. The agenda focuses on key, priority, proactive items:

READ THE GUIDE

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88th Legislative Session

This session, TAHP
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...monitored **560 BILLS,** of which **190 RECEIVED A HEARING**

...actively supported **57 BILLS**

...actively opposed **34 BILLS**

...submitted **51 WRITTEN TESTIMONIES**

...negotiated **47 BILLS**

...submitted **44 POSITION CARDS**

...testified **61 TIMES**

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Mandate Count

This session,

- Over 120 health plan mandate bills were filed,
- 77 received a hearing,
- 47 passed out of a committee,
- and 17 passed both chambers.

10 Health Coverage Things You Need to Know

1. **New Network Adequacy Requirements:**
   With HB 3359, Texas health insurers have increased standards for network adequacy, along with new requirements for obtaining access waivers, including public hearings.

2. **Medicaid Rx Reforms:**
   The Medicaid statewide preferred drug list will continue to be managed by HHSC for another 10 years (HB 1283). However, under HB 3286, the program now includes crucial patient safeguards to prevent patients from being switched away from effective medications or being denied due to shortages. Health plans will also now have three voting members in the decision-making process for determining preferred drugs.

3. **Bans on Anti-Competitive Contracting:**
   Texas is now a leader among states working to ban anti-competitive contracting between providers and health plans with the passage of HB 711. The bill includes prohibitions on anti-tiering, anti-steering, gag clauses, and most-favored nations provisions.

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10 Health Coverage Things You Need to Know

4. Texas Pharmaceutical Initiative:

HB 4990 establishes a new initiative, funded with an $150 million appropriation, to develop a "business plan" for the potential creation of a statewide PBM, drug manufacturer, and pharmacy network to serve state-funded health programs.

5. Increased Flexibility for Medicaid Texting:

HB 2802 aligns state law with federal guidance, streamlining the process for Texans to receive text messages and emails about changes to their Medicaid eligibility and other vital health care updates.

6. Itemized Hospital Billing Transparency:

Texas took on the widespread medical debt collection crisis with a new law, SB 490, that ensures patients have access to an itemized hospital bill before being referred to collections.

7. Ambulance Surprise Billing Banned in Texas:

SB 2476 builds upon existing surprise billing laws by implementing a temporary prohibition on out-of-network ambulance bills, aimed at protecting patients
while Congress crafts
a permanent solution.

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10 Health Coverage Things You Need to Know

8. **Formulary Transparency:**
SB 622 creates a new requirement for health plans to provide real-time data to providers on patient out-of-pocket expenses and coverage information for prescription drugs.

9. **Focus on Women's Health:**
This session Texas lawmakers expanded postpartum medicaid coverage to 12 months (HB 12), created a new mandate for fertility services associated with cancer treatment (HB 1649), ensured women can receive a single, 12-month supply of contraceptives (HB 916), and established non-medical drivers of health (NDOH) screening criteria to assist pregnant women in accessing more medicaid services (HB 1575).

10. **Increased APCD Price Transparency:**
Building upon the All Payor Claims Database (APCD) established in the 87th Legislative Session, Texas law now permits third-party researchers to access data and publicly post price transparency reports identifying specific health care providers and health plans.

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Health Insurance Legislative Highlights

Bills Aimed at Helping Consumers & Lowering Costs & Prices

- **HB 711** - Bans Anti-Competitive Contracting Terms
- **HB 2002** - Mandates Applying Cash Pay for Lower Prices to Deductibles
- **HB 3414** - Enhanced Price Transparency through All Payor Claims Database Expansion
- **SB 490** - Patient's Right to Receive an Itemized Bill Prior to Debt Collection
- **SB 1003** - Expands Provider Directory Transparency Requirements
- **SB 2193** - Authorizes Direct Primary Care for FQHC's
- **SB 2476** - Temporary Ambulance Surprise Billing Ban

HB 711 - Anticompetitive Contracting Terms

Rep. Frank & Sen. Kolkhorst

- **Goal of the Legislation:** Around the country, courts and lawmakers have been raising concerns about anti-competitive contracting terms in contracts between health systems and health plans.
- **What's new?** The bill prohibits many of those terms, including **anti-steering, anti-tiering, gag clauses, and most favored nation clauses.**
- **The Impact:** Provisions in provider contracts now deemed anti-competitive will now be void and unenforceable.
- **Guardrails Included:** Insurers that encourage enrollees to obtain services from a particular provider have a fiduciary duty to the enrollee to engage in that conduct **only for the primary benefit of the enrollee.**
- TAHP worked with a coalition to pass the legislation.

HB 711 for Healthy Markets

Unanimous Senate and House Committee Votes; Overwhelming House Vote

HB 711 restores competition to Texas' health care markets by prohibiting contracts that include:

- Anti-steering clauses that restrict employers and health plans from encouraging enrollees to obtain services at a competitor or from offering incentives to use specific providers
- Anti-tiering clauses that require employers and health plans to place all physicians, hospitals, and other facilities associated with a hospital system in the most favorable tier of providers
- Gag clauses that prohibit any party from disclosing relevant price or quality information to the government, enrollees, treating providers, plan sponsors, and potential enrollees and plan sponsors
- Most favored nation clauses that prevent providers from offering prices below those contracted with a particular carrier

HB 711 also imposes a fiduciary duty on health benefit plans: If they encourage enrollees to obtain a service from a particular provider, including offering incentives to encourage specific providers, introducing or modifying a tiered network plan, or assigning providers into tiers, they must do it for the primary benefit of the enrollees, not themselves.

Organizations Testifying for HB 711:

Learn more at www.texas2036.org/healthy-markets TEXAS 2036

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HB 711 - Anticompetitive Contracting Terms

Rep. Frank & Sen. Kolkhorst

- **Anti-steering:** a provision in a contract that restricts the ability to encourage an enrollee to obtain a service from a competitor.
- **Anti-tiering:** a provision that restricts the ability to introduce or modify a tiered network plan or assign providers into tiers; or requires all members of a provider to be in the same tier.
- **Gag clause:** a provision that restricts the disclosure of: price or quality information to an enrollee, treating provider, plan sponsor, or potential enrollees and plan sponsors; or out-of-pocket costs to an enrollee.
- **Most favored nation clause:** a provision that prohibits a provider from contracting with another entity to provide services at a lower rate or an entity from contracting with another provider to provide services at a higher rate.

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HB 2002 - Counting Cash Pay towards Insurance

Rep. Oliverson & Sen. Hancock

- **Goal of the Legislation:** Several bills this session aimed at getting patients to be smart shoppers of health care. One way to do this is by rewarding patients that make deals with health care providers for cash payments.
- **The Details:** Requires EPOs and PPOs to credit cash payments to providers, regardless of whether they are in-network or out-of-network, towards an insured's deductible and out-of-pocket maximum.
- **How it works:** Claims must not be submitted to the insurer, and the amount paid by the insured must be less than the average discounted rate for the service under the insured's plan.
- **New Process:** Requires insurers to establish procedures and identify documentation necessary to claim a credit and post that information on their website.
- Applies to commercial plans starting on or after January 1, 2024.

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HB 3414 - All Payor Claims Database Expansion

Rep. Oliverson & Sen. Hancock

- **Goal of the Legislation:** Allow researchers greater access to data collected by the APCD and increase transparency of individual provider and insurer prices.
- **Background:** Created last session, the APCD is hosted at the UT Health Science Center and collects and analyzes data submitted by health insurers and other payers then publishes data on a public portal.
- **What's new?** This bill creates an application process for research entities to access data that is not available on the portal. The applicant must provide detailed information on any proposed study that will use the data.
- **One Big Change:** Researchers and the APCD will be allowed to publish data identifying providers or insurers, but those reports must be available to the public at no cost and patient data is protected.
- APCD data will now also be available for commercial use.
- The legislation is effective immediately.

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SB 490 – Itemized Bills

Sen. Hughes & Rep. Harris

- **Goal of the Legislation:** Medical debt is a leading cause of bankruptcy. Patients have little information about prices ahead of procedures, and medical bills can be insurmountable for patients.
- **The big picture:** The bill requires hospitals to issue an itemized bill before pursuing debt collection. Late in session, bills from physicians were exempted from the law.
- **The details:** Bills must detail charges for all health care services and supplies provided to the patient, including the amount charged for each.
- **Enforcement:** Allows licenses agencies to take disciplinary action against providers who fail to comply with the requirements.
- Protections start September 1, 2023.

SB 1003 - Provider Directories

Sen. Johnson & Rep. Smithee

- **Goal of the Legislation:** As part of the state's long term effort to help patients with surprise bills, Texas previously required health plans to have transparent provider directories to help patients looking to learn which providers are in-network at hospitals and other facilities.
- **Building on that work:** This legislation adds to the provider directory mandate to require directories to include certain facility-based, non-physician specialists, like certified registered nurse anesthetists (CRNAs), anesthesiologist assistants, nurse midwives, surgical assistants, and physical therapists.
- **One clarification:** Directory is not required to list physicians or health care providers who are employed by the facility, because they do not bill separately.
- TDI forthcoming rules will name other provider types for inclusion. Provider directories for commercial insurers must be updated by January 1, 2024.

SB 2193 – Authorizing Direct Primary Care for FQHCs

Sen. LaMantia & Rep. Frank

- **Goal of the Legislation:** Direct primary care is a model of providing health care services in which the care is paid for by a monthly, flat membership fee per patient. The patient then receives unrestricted access to the physician for primary care services, a big benefit to many patients but not allowed at FQHCs.
- **New authorization at community health centers:** This bill creates FQHC direct primary care programs. These FQHC programs would provide services to employees of participating employers and uninsured or underinsured groups.
- **The details:** Federally qualified health centers (FQHCs) are required to ensure that employees and their dependents are screened for eligibility for other state programs and federal subsidies in the insurance marketplace.
- **Checkup required:** The bill also requires TDI to review all FQHC programs to evaluate their success and provide reports to the legislature biennially.
- The new law is effective immediately.

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SB 2476 – EMS Surprise Billing

Sen. Zaffirini & Rep. Oliverson

- **Goal of the Legislation:** Texas' Surprise Billing Act and the federal No Surprises Act both failed to cover services performed by out-of-network emergency medical services (EMS) providers.
- **What's new:** This bill adds EMS providers to the state ban on balance billing but takes a different approach to resolving any payment disputes between insurers and ambulance providers.
- **The details:** Under the new law insurers are required to reimburse non-network transport at the rate set by municipalities.
- **But what if there isn't a rate?** In that case insurers are required to reimburse the lesser of the provider's billed charge or 325% of the Medicare rate.
- **Sunset date:** DC lawmakers are working on a federal solution so SB 2476 sunsets in September 2025 in anticipation of a solution that will cover all Texans.
- The prohibition against surprise ambulance billing starts January 1, 2024.

Promoting Women's Health

Bills Aimed at Family Planning, Maternity, & Women's Health

- **HB 12** - 12 Months Medicaid Postpartum Coverage
- **HB 916** - 12 Month Contraceptive Mandate
- **HB 1575** - NDOH Screening for Pregnant Women in Medicaid
- **HB 1649** - Fertility Preservation Mandate
- **SB 379** - Sales Tax Exemption for Feminine Hygiene & Other Products
- **SB 24** - Family Support Programs

HB 12 - 12 Months Postpartum Medicaid Coverage

Rep. Rose & Sen. Kolkhorst

- **Goal of the Legislation:** Expanding the Medicaid coverage period for new moms is backed by research that shows reduced maternal mortality, unexpected pregnancy, and medical debt, among other benefits.
- **The background:** Under the COVID-19 public health emergency, new mom's who qualify have been covered by 12 or more months of Medicaid. That's set to end as the public health emergency winds down.
- **Around the country:** To date, 36 states and D.C. have been approved for 12-month coverage and 6 states are pending.
- **Implementation:** A Medicaid state plan amendment (SPA) will be submitted for 12-month coverage for all postpartum women.
- TAHP joined a broad coalition in support of the legislation.

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HB 916 – 12 Month Contraceptive Mandate

Rep. Ordaz & Sen. Paxton

- **Goal of the Legislation:** The bill aims to remove barriers to family planning by requiring health insurer coverage for a single dispensing of a 12 month supply of prescription contraceptives.
- **One clarification:** A full 12 month supply can only be dispensed after that same prescription was dispensed for a three-month supply. This helps control waste and ensures that the prescription is the right fit for the woman.
- **Applies even under a new health plan:** If you switch insurers you can keep getting your 12 month supply.
- **Restrictions Apply:** A person can only receive one 12 month supply per year for each covered prescription contraceptive drug.
- The law applies to commercial health plans, TRS, ERS, and Medicaid that start on or after January 1, 2024.

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HB 1575 - NDOH Medicaid Screening & Doula Coverage for Pregnant Women

Rep. Hull & Sen. Alvarado

- **Goal of the Legislation:** Pregnant women facing nonmedical health needs like food, housing, and transportation are twice as likely to experience high-risk pregnancies and have elevated rates of maternal morbidity. Those nonmedical drivers of health (NDOH) are the focus of HB 1575.
- **The details:** Requires HHSC to develop a standardized screening tool for Medicaid MCOs and Alternatives to Abortion providers to identify nonmedical health-related needs of pregnant women.
- **Informed consent** is required and must include an explanation that any information collected will be reflected in the woman's medical record or care plan.
- **Care coordination:** If non-medical needs are identified, requires STAR service coordinators to coordinate any non-covered services, community supports, and other resources to improve health outcomes.
- **Adds community health workers and doulas to the provider types** permitted to provide case management services for nonmedical needs.

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New Benefit Mandates

Texas has More Benefit Mandates than Most States, several new benefit mandates became law.

- **HB 1649** - Fertility Preservation Benefit Mandate
- **HB 109** - Hearing Aid Coverage Above Allowed Amounts
- **SB 989** - Biomarker Screening Benefit Mandate

HB 1649 - Fertility Preservation Mandate

Rep. Button & Sen. Parker

- **Goal of the Legislation:** Certain cancer treatments can cause impaired fertility in both men and women. This bill requires certain health care plans to cover fertility preservation services for patients
- **The details:** Coverage applies to medically necessary cancer treatments that may directly or indirectly cause impaired fertility.
- **Limitations:** Does not require coverage of fertilized genetic materials or ongoing storage.
- **Plus:** Services must be consistent with established medical practices or professional guidelines.
- **Applicability**: Applies to private insurance plans starting on or after January 1, 2024, but not state funded TRS, ERS, or Medicaid plans.

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HB 109 - Hearing Aid Coverage

Rep. J. Johnson & Sen. Zaffirini

- **Goal of the Legislation:** Health plans typically have dollar limit caps, also known as "allowed amounts," for hearing aid coverage. In some instances, a patient could be denied coverage if they choose to buy a hearing aid that goes above this allowed amount, even if they agree to pay the difference.
- **The details:** Prohibits plans that provide coverage for hearing aids from denying a claim for hearing aids solely on the basis that the aid is more expensive than the benefit available.
- **Limitations:** Does not require a plan to pay a claim in an amount that is more than the benefit available under the plan.
- Applies to commercial, ERS, TRS, and University plans that start on or after January 1, 2024.

SB 989 – Biomarker Mandate

Sen. Huffman & Rep. Bonnen

- **Goal of the Legislation:** Biomarker testing is a feature of precision medicine that allows doctors to use information about a person's specific genetic variations to inform better diagnosis, prognosis, and therapy selection for cancer or rare disease patients. Prior to this bill, health insurance coverage for biomarker testing was not guaranteed.
- **The details:** Requires coverage of biomarker testing for diagnosis, treatment, management, or monitoring of medical conditions.
- **Coverage is only required when:**
  - Evidence based
  - Scientifically valid
  - Informs the patient's outcome or provider's clinical decision
  - Predominantly address the acute or chronic issue
- **Applies to** commercial insurance plus TRS, ERS, and Medicaid plans that start on or after January 1, 2024.

New Health Insurance Regulatory Mandates

Several Bills Impact How Health Insurers Contract with Providers

- **HB 3359** - Strengthens Network Adequacy Regulations
- **SB 14** - Prohibition on Gender-Affirming Care
- **SB 833** - Bans ESG in Insurance Ratemaking
- **SB 1040** - Prohibits Organ Transplant Coverage Involving Harvesting
- **SB 1342** - Mandates Third-Party Insurers Honor Medicaid Prior Authorization
- **HB 4500** - ER Verification of Benefits through an Online Portal

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HB 3359 – Network Adequacy

Rep. Bonnen & Sen. Schwertner

- **Goal of the Legislation:** Texas network adequacy laws allow health plans to apply for a "waiver" when they aren't able to meet standards in a service area. Lawmakers sought to toughen that waiver process and create more transparency.
- **A little background:** Health plans can't meet network adequacy standards in counties that lack sufficient health care providers. Contract disputes may also lead to inadequate networks. Under either of these circumstances, a waiver is required.
- **One big change:** Under the new law, waivers can be approved only after a public hearing where good cause is shown.
- **More on waivers:** Consecutive waivers will also be limited unless plans can show multiple "good faith" attempts to contract with providers.
- **Contract changes** now have several new restrictions.
- **Network adequacy changes:** The law codifies existing state and federal network adequacy requirements.

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HB 3359 – Network Adequacy

Rep. Bonnen & Sen. Schwertner

- **More on waiver restrictions:**
  - Doesn't apply when there are no uncontracted providers.
  - Waivers only after a public hearing where good cause is shown.
  - Prohibits waivers more than twice consecutively unless the insurer demonstrates multiple good-faith attempts for compliance.
  - No more than four waivers within a 21-year period if the underlying issue could have been resolved through good-faith efforts.
- "**Good faith effort**" is defined as honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patients' access to in-network care.
- Prohibits TDI from accepting balance billing prohibition as a justification for a waiver, but it can be referenced in access plans.
- Policyholders can seek judicial review of waiver decision.
- Applies to plans starting on or after January 1, 2024.

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HB 3359 – Network Adequacy

Rep. Bonnen & Sen. Schwertner

- **More on contract changes:** Prohibits EPOs and PPOs from making any "adverse material changes" to a preferred provider contract during the term of the contract **unless there is mutual agreement between the parties.** "Adverse material change" is a change that:
  - decreases compensation;
  - moves the provider to a less preferred tier;
  - increases the provider's administrative expenses.
- Even prohibits agreed-to changes from going into effect for 120 days.
- Requirements **do not apply** to:
  - contracts with hospitals and other facilities; and
  - evergreen contracts (unspecified duration and no automatic renewal)
- Applies to contracts entered into after September 1, 2023.

HB 3359 – Network Adequacy

Rep. Bonnen & Sen. Schwertner

- **More on network adequacy standards:** Codifies the latest federal network adequacy standards for PPOs and EPOs and existing TDI network adequacy rules with some changes:
  - Requires insurers to give special consideration to teaching hospitals that provide significant care to the uninsured regardless of feasibility.
  - Requires prioritization of teaching facilities that specialize in rare conditions.
  - These requirements do not apply to EPOs that contract with enough hospitals to meet projected utilization rates or receive a waiver.
- Requires a sufficient number of preferred specialty providers.
- Requires insurers to monitor compliance, report material changes within 30 days, and promptly take corrective action.
- Applies to plans starting on or after January 1, 2024, but delays the implementation of wait time standards until January 1, 2025.

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SB 14 - Prohibition on Gender-Affirming Care

Sen. Campbell & Rep. Oliverson

- **Goal of the Legislation:** Texas lawmakers sought to create limits on gender transitioning health services including what physicians can do.
- **Prohibition on Doctors:** Prohibits a state-licensed physician or other health care provider from performing procedures for the purpose of transitioning a child's biological sex.
- **Prohibition on State Health Programs:** The new law prohibits Medicaid and CHIP from covering or providing reimbursement for services that transition a child's biological sex.
- **Prohibition on public money:** The law stops any individual or entity that provides or facilitates the provision of such a procedure or treatment to a child from receiving state funding.
- **Question Mark:** Unclear how this will apply to ERISA plans or plans issued out of state.

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SB 833 - Bans ESG in Ratemaking

Sen. King & Rep. Oliverson

- **Goal of the Legislation:** Certain lines of insurance have been pressured to refuse to insure or increase rates for certain clients based on environmental, social, or governance (ESG) factors.
- **More details on ESG:** ESG is a business framework for considering environmental issues and social issues in the context of corporate governance.
- **The New Law:** SB 833 prohibits insurance companies (all lines of business) doing business in Texas from using an ESG model, score, factor, or standard to charge a rate different than the rate charged to another business or risk in the same class for essentially the same hazard.
- **Health Care Limited Impact:** Health insurance companies already have restrictions on rating people differently so the law is unlikely to have a major impact on health insurance.

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SB 1040 - Organ Transplant Coverage

Sen. Kolkhorst & Rep. Oliverson

- **Goal of the Legislation:** United Nations human rights experts have raised concerns about forced organ harvesting in some countries. SB 1040 seeks to address that problem from the standpoint of health plan coverage.
- **How does it work:** The bill prohibits plans from covering human organ transplants:
  - that are performed in China or in another country known to participate in forced organ harvesting;
  - or when the organ was procured from China or in another country known to participate in forced organ harvesting.
- **Going further:** Allows DSHS to designate additional countries that are known to participate in organ harvesting.

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SB 1342 - Third-Party Payors and Medicaid PAs

Sen. Perry & Rep. Smithee

- **Goal of the Legislation:** Patients can be covered by both a public plan—like Medicaid—as well as private insurance, which is the case for many Medicaid fragile kids. Those plans may have differing prior authorization processes. Lawmakers sought to make sure patients that these patients don't have differing prior authorization requirements between these plans.
- **The details:** Requires insurers to accept a state's authorization that an item or service is covered under the state plan as if it were the prior authorization made by the third party.
- **Important:** Medicaid must be the payor of last resort & insurers must agree not to deny the state's claim for failure to obtain prior authorization.
- **But also,** commercial plans can't add prior authorizations if not required in Medicaid.
- Follows recent CMS federal changes to third-party liability requirements that must be adopted by states.

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HB 4500 - ER Verification of Benefits

Rep. Caroline Harris & Sen. Hughes

- **Goal of the Legislation:** Lawmakers have recently focused on increased transparency including coverage. This legislation aims to help emergency providers understand patient insurance coverage.
- **Patient Protections already in Place:** Federal and state laws require emergency care providers to treat and stabilize patients without regard to insurance coverage.
- **This bill** requires health insurers to maintain a portal that lets provider in hospitals or freestanding ERs determine whether a patient is covered and any cost sharing requirements for which the patient is responsible.
- **Small Change:** Most plans already have this function so existing portals will comply with the new law as long as they are available at all times.
- Applies to all state regulated health plans (commercial, ERS, TRS, university, Medicaid) that start on or after 1/1/2024.

More Insurance Market Bills

While not major changes, these bills impact the insurance market in unique ways.

- **HB 290** - Expansion of Association Health Plans
- **HB 1592** - ERISA Opt-in for Texas Surprise Billing Laws
- **SB 1659** - Extends TDI Sunset Review to 2029
- **SB 1286** - Allows Prompt Pay Flexibility During a Catastrophic Event

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HB 290 – Association Health Plans

Rep. Oliverson & Sen. Hancock

- **Goal of the Legislation:** Small businesses and sole proprietors don't have the same ability as large businesses to spread risk and lower health care costs and often struggle to provide coverage to employees or for themselves.
- **What's a MEWA:** Multiple employer welfare arrangements are association health plans that allow businesses to join together to buy coverage.
- **Legal Background:** In 2019, courts invalidated federal rules that would have provided flexibility for MEWAs., but the case is being appealed.
- **The details:** Bill aligns state law with the federal proposal, but will only be effective if courts overturn existing decision.
- **Two major changes:**
  - Sole proprietorships would be eligible to participate in MEWAs.
  - Businesses could form a MEWA if they can show a commonality of interest.
- **Consumer Protections** like surprise billing laws will apply to MEWAs.

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HB 1592 - Surprise Billing ERISA Opt-In

Rep. Oliverson & Sen. Hancock

- **Goal of the Legislation:** The 86th Texas Legislature established protections against surprise medical billing. In December 2020, the federal No Surprises Act passed. While both laws protect patients from surprise bills, there are important differences and this law aims to give employers a choice.
- **The details:** ERISA plans operating in Texas are subject to the No Surprises Act instead of the state's surprise billing law.
- **How does it work?** HB 1592 allows, but does not require, self-funded, ERISA-regulated plans to opt into the state law rather than the federal No Surprises Act.
- This "opt-in" approach avoids federal preemption issues.

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SB 1659 & SB 1286: TDI Related Bills

SB 1659 by Sen. Schwertner & Rep. Holland

- This bill moved the sunset dates back for multiple agencies to better align the agencies and ensure sufficient resources for a thorough review.
- One of the agencies that this bill applied to is TDI, which had its Sunset date moved from the 2024-2025 review cycle to the 2028-2029 review cycle.

SB 1286 by Sen. Schwertner & Rep. Ann Johnson

- Provides authority to TDI to extend prompt payment deadlines to a later date due to a catastrophic event.
- Allows TDI to approve a request by a provider for an extension due to a catastrophic event.

This data represents how your commercial health plan premiums pay for medical care, as well as related services and essential operations. This data includes employer-provided coverage as well as coverage you purchase on your own in the individual market. Data reflects averages for the 2018-20 benefit years. Percentages do not add up to 100% due to rounding. Content and Design AHIP—All Rights Reserved: © AHIP 2022

Legislation Affecting Drug Coverage

Lowering Prescription Drug Prices

- **HB 25** - Establishes Wholesale Prescription Drug Importation Program
- **HB 4990** - Texas Pharmaceutical Initiative
- **SB 241** - Insulin Market Manipulation Reporting Rules

Increasing Prescription Drug Access and Coverage

- **HB 755** - Limits Prior Authorization for Autoimmune Disease Drugs
- **HB 1337** - Creates Step Therapy Exceptions for Serious Mental Illness (Private Insurance)
- **HB 4331** - Expands Donation of Unused Drugs
- **HB 4332** - Allows Dispensing of Donated Unused Drugs
- **SB 773** - Access to Investigational Drugs

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Legislation Affecting Drug Coverage

Prescription Drug Regulatory Mandates

- **HB 999** - Limits Use of Copay Coupon Accumulators
- **HB 1647** - Prohibits Mandatory "White Bagging" in Physician Offices
- **SB 622** - Rx Formulary Transparency & API Mandate

New Medicaid Prescription Drug Requirements

- **HB 1283** - Extends Statewide Medicaid Preferred Drug List for Ten Years
- **HB 3286** - Medicaid Vendor Drug Patient Protections & PDL Exceptions (Medicaid)
- **HB 1357** - Repeals Sunset and Establishes Permanent MAT Medicaid Coverage
- **HB 4888** - Medicaid Coverage for Non-Opioid Treatments

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HB 25 - Prescription Drug Importation

Rep. Talarico & Sen. Kolkhorst

- **Goal of the Legislation:** Americans pay more for drugs than any other country, including developed nations. That's partly a result from lack of competition and lack of negotiations. HB 25 aims to bring competition in from cheaper drugs.
- **How does it work?** Creates a wholesale prescription drug importation program in Texas, allowing the importation of prescription drugs from Canadian suppliers.
- **Requires annual reporting** on participation, savings, and implementation.
- **HHSC will develop a registration process** for health benefit plan insurers, health care providers, and pharmacies to obtain and dispense prescription drugs imported under the program.
- **Bottleneck in DC:** The Food and Drug Administration must first approve a state's plan before taking effect and several states have plans pending approval.

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HB 4990 – Texas Pharmaceutical Initiative

Rep. Bonnen & Sen. Kolkhorst

- **Goal of the Legislation:** The complex drug supply chain includes manufacturers, wholesalers, PSAOs, PBMs, pharmacies, and much more. State leaders are aiming for transparency and affordability throughout that supply chain.
- **How does it work?** Establishes the Texas Pharmaceutical Initiative "to provide cost-effective access to prescription drugs and medical supplies" for state run health programs including ERS & TRS.
- **The Board:** The Initiative will be governed by a board of three individuals appointed by the Governor and administratively attached to HHSC. The board can hire an executive director and staff.
- **The focus of the Board** is to develop a "business plan" by October 1, 2024 regarding:
  - establishing or contracting for statewide PBM services
  - operating or contracting for a distribution network
  - providing manufacturing and compounding of drugs
  - identifying potential cost savings, funding, and resources needed
- **$150 million** appropriated for the plan. Chapter expires September 1, 2025.

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SB 241 - Insulin Market Manipulation

Sen. Perry & Rep. Talarico

- **Goal of the Legislation:** Researchers have highlighted strategies used by pharmaceutical companies to delay market entry from lower cost generic or biosimilar medication. This legislation aims to bring transparency to those strategies related to insulin.
- **How does it work?** Requires insulin manufacturers whose drug appears on the Medicaid formulary to **submit a written verification to HHSC** stating whether a generic is unavailable due to market manipulation
- **The details:** Includes "pay to delay" schemes, "evergreening," and patent manipulation tactics, and applies to entities acting on behalf of the manufacturer

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HB 755 - Preauthorizations for Autoimmune Drugs

Rep. Julie Johnson & Sen. Menendez

- **Goal of the Legislation:** Some patients with autoimmune conditions take the same medication for years. Health plans have prior authorization requirements to ensure safety and appropriateness.. This bill helps ensure that prior authorizations aren't unnecessarily required for patients on long term courses of treatment.
- **The details:** Prohibits multiple prior authorizations in a single year for a drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease.
- **Of note:** Health plans often only require one PA per year.
- **TAHP identified several scenarios where a prior authorization would still be needed: The new limitation on PAs does not apply to:**
  - opioids, benzodiazepines, barbiturates, or carisoprodol;
  - prescription drugs that have a typical treatment period of less than 12 months;
  - drugs that have a boxed warning from the FDA that requires specific provider assessment; and
  - the use of a drug that is in a manner not approved by the FDA.
- Applies to commercial plans and ERS/TRS starting on or after January 1, 2024.

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HB 1337 - Step Therapy Exceptions for Serious Mental Illness

Rep. Hull & Sen. Menendez

- **Goal of the Legislation:** Texas state law imposes some of the nation's strongest patient protections through exceptions to "step therapy," where patients try a lower cost drug before a more expensive alternative. Advocates identified additional patient protection needed for serious mental illness (SMI).
- **The details:** Prohibits plans from requiring enrollees to fail to respond to more than one different drug, excluding generic or pharmaceutical equivalents.
- **If a generic or pharmaceutical equivalent** is added to a plan's drug formulary, a plan may impose step therapy once in the plan year.
- **The new requirements** are in addition to existing protections against non-medical switching.
- Applies to commercial health plans starting on or after 1/1/24 but does not apply to state funded programs through ERS/TRS or Medicaid.

HB 4331 & HB 4332 – Donation of Unused Drugs

Rep. Klick & Sen. Hancock

- **Goal of the Legislation:** 22 cents of every health care collar goes to prescription drugs with billions wasted annually on unused prescriptions. These bills work in tandem to try to make use of that waste.
- **The details:** Allows a drug manufacturer or a health care facility to donate unused prescription drugs and allows health care providers to redistribute those drugs.
- **The guardrails:** Drugs must be repackaged with a new label that includes:
  - The drug's brand or generic name and manufacturer
  - The appropriate dosage of the drug
  - The drug's lot number
  - The earliest expiration date of the drug based on the lot number
  - The quantity of the drug, based on dosage
- Providers must keep a record of the repackaged drug, including the information on the label.

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SB 773 - Access to Investigational Drugs

Sen. Parker & Rep. Toth

- **Goal of the Legislation:** Allows HHSC to designate severe chronic diseases, for which a patient may take an investigational drug upon recommendation by a physician.
- **The details:** Use of the drug requires informed consent, the provider is immune from liability, and the state is prohibited from interfering with the treatment.
- **This does not affect coverage** of enrollees in clinical trials, nor does it create a new insurance mandate.
- Also known as the "Medical Freedom Act," the bill builds on a federal law known as the "Right to Try Act" that focused on life threatening conditions.

HB 999 - Copay Coupon Accumulators

Rep. Price & Sen. Schwertner

- **Goal of the Legislation:** Drug companies give patients coupons to cover the out-of-pocket costs for prescriptions. Some health plans don't count those coupons to deductibles and other cost sharing limits because the patient did not make the payment. This legislation creates rules on when those coupons must be applied to cost sharing limits.
- **The details:** Requires insurers to apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses for a covered drug to the enrollee's applicable deductible, copayment, cost-sharing, or out-of-pocket maximum.
- **Coupons still won't be required to accrue towards out-of-pocket limits when:**
  - A generic or interchangeable product exists; or
  - A generic or interchangeable doesn't exist but the enrollee obtained access to the drug using PA process, step therapy protocol, or an appeal process
- **Worth noting:** Similar to other state imposed mandates that add costs to health care premiums, the law does not apply to coverage through ERS and TRS.
- Applies to commercial plans that start on or after 1/1/24 but not ERS/TRS/Medicaid.

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HB 1647 – White Bagging

Rep. Cody Harris & Sen. Schwertner

- **Goal of the Legislation:** The most expensive drugs are infusion drugs provided in hospitals and physician offices. Health plans create savings by bringing lower cost drugs in from specialty pharmacies through a process called white bagging. This legislation puts limits on when white bagging can be required.
- **The details**: Prohibits plans from requiring white bagging for prescription drugs provided at a physician's offices (but not at a hospital). Insurers may not require the use of certain pharmacies or limit coverage based on the pharmacy.
- **Only applies** in situations where any delay in treatment would make disease progression worse, result in patient harm or death, or create a barrier to adhering to the medication.
- **Does not apply** in hospitals or hospital facility-based practices. Evidence shows that hospitals often excessively mark-up drugs, whitebagging combat this price gouging.
- Applies to commercial plans that start on or after 1/1/24 but not ERS/TRS/Medicaid.

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SB 622 - Rx Formulary Transparency & API Mandate

Sen. Parker & Rep. Smithee

- **Goal of the Legislation:** When prescribing medication to a patient, a health care provider may not have information regarding the financial impact that filling the prescription might have on the patient. This bill aims to create that transparency.
- **The details:** Requires insurers to provide real-time prescription information to patients and providers, including: drug formulary; eligibility, cost sharing details, and any utilization management requirements.
- **The big change:** Requires a standard application programming interface (API) to receive requests, and information must be current no later than one day after a change is made.
- **The bill does not go into effect until January 1, 2025**, and insurers with fewer than 10,000 enrollees are eligible for extensions.

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Medicaid Vendor Drug Patient Protections

HB 1283 by Rep. Oliverson & Sen. Hughes

- **Extension Granted:** This bill extends the statewide Medicaid Preferred Drug List (PDL) for 10 years, to Aug. 31, 2033.
- **That means** the state continues to set the formulary for Medicaid patients, instead of allowing Medicaid managed care plans to manage it as was initially intended in 2011.

HB 3286 by Rep. Klick & Sen. Hancock

- **Reforms Approved:** While HHSC will continue to manage the formulary, lawmakers recognized major flaws in the program and patient protections were needed.
- **Patient Protections First:** Patients can now skip the strict formulary if:
  - The drug required under the PDL is contraindicated, will cause an adverse reaction or harm, or is expected to be ineffective
  - The preferred drug did not previously work for the patient
  - The preferred drug is in short supply according to the FDA Drug Shortages Database or the manufacturer has placed the drug on backorder or allocation
  - The patient was prescribed a non-preferred antidepressant or antipsychotic drug in the hospital, and is stable on the drug.

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HB 3286: But Wait, There's More

- **DUR Board Participation:** Allows for 3 MCO voting members, all of whom must be pharmacists or physicians. MCO members will be able to attend any portions of DUR Board executive sessions in which confidential drug pricing information is not shared.
- **Formulary Changes:** Grants 90-day temporary formulary status to drugs on the federal Medicaid Drug Rebate Program if the manufacturer submits a certificate of information form to HHSC. HHSC must approve/deny the drug within the 90 days.
- **Liquidated Damages:** Prohibits HHSC from assessing liquidated damages against MCOs who provide statutory exceptions to the PDL.
- **Generic Drugs:** Requires HHSC to include all equivalent generics on the PDL when only one generic is listed as preferred.
- **Expedited Review:** Requires HHSC to develop an expedited review process to consider requests from MCOs and providers to add medicines to the PDL.
- **New Drugs:** Requires HHSC to grant temporary non-preferred status to new drugs that have not yet been reviewed by the DUR Board and establish criteria for authorizing the drugs.

Additional Medicaid Drug Legislation

HB 1357 by Rep. Holland & Sen. Huffman

- **Establishes permanent Medicaid coverage** for medication-assisted opioid or substance abuse treatment. Coverage currently exists as part of a pilot program that was set to expire Aug. 31.

HB 4888 by Rep. Hefner & Sen. Perry

- **What's new:** Requires MCOs to reimburse hospitals separately for any non-opioid treatment provided as a part of outpatient services.
- **The details:** Non-opioid treatment includes a drug or biological product that is indicated to produce analgesia without acting on the body's opioid receptors.
- **Implementation:** Gives HHSC rulemaking authority. However, according to HHSC, drugs and biologicals are already reimbursed separately. Therefore, in the outpatient hospital setting, there will be no change to current practice for what HHSC covers or pays.

Legislation Affecting the Vision and Dental Industry

Changes related to vision and dental benefits which are sometimes included in a health plan and sometimes stand alone policies.

- **HB 1527** - Dental Overpayments & Dental Network Leases
- **HB 1696** - Limits on Vision Plan Steering, etc.
- **SB 861** - Coordination of Vision Benefits

HB 1527 - Dental Overpayments & Network Leasing

Rep. Oliverson & Sen. Zaffirini

- **Overpayment Recoveries:** Prohibits insurers from recovering an overpayment made to a dentist unless the insurer provides written notice of overpayment within 180 days after payment and the dentist fails to object within 45 days. Similar to commercial health plan overpayment recovery rules.
- **Insurer Prohibitions:** Prohibits insurers from including contract provisions that deny payment for a covered service, and prohibits dentists from billing patients for the amount owed.
- **Third party leasing dental network,** new restrictions: :
  - Must give dentist the ability to not to participate
  - Agreement must be transparent and the third-party must honor all original contract terms.
  - Restrictions in this section do not apply if a third party is an affiliate of or under the same brand as the insurer
  - Similar to rules on leasing out health plan networks.

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HB 1696 – Vision Plan Steering & Contracting

Rep. Buckley & Sen. Hughes

- **Anti-Steering Requirements:**
  - Prohibits insurers from identifying participating optometrists differently based on discounts, usage of certain products, or usage of certain suppliers.
  - Prohibits insurers from encouraging enrollees to use affiliated optometrists.
  - Requires insurers to provide optometrists with coverage & plan information.
- **Contracting:**
  - Prohibits chargebacks for a covered product or service that the insurer does not incur the cost to produce, deliver, or provide to the patient or optometrist.
  - Prohibits differing fee schedules based on the optometrist's choice of laboratory, supplier, equipment, or affiliation.
  - Prohibits plans changing contract terms unless there is 90 day notice.
- **Prohibited Conduct:** Prohibits insurers from requiring an optometrist to disclose a medical history or diagnosis for routine wellness exams. Plus, plans aren't required to disclose a patient's glasses prescription in order to submit a claim.
- **Extrapolation Limits:** Prohibits vision plans from using extrapolation for audits.

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SB 861 – Coordination of Vision Benefits

Sen. Hughes & Rep. Buckley

- **Goal of the Legislation:** Oftentimes patients have both medical insurance and a separate vision care plan. But some vision benefit plan companies do not allow patients to have their benefits coordinated with a patient's medical plan. This bill address that need for a coordination of benefits.
- **How it works:** Insurer of the primary plan is responsible for coverage up to the full amount of any coverage limit, then the secondary plan insurer is responsible for any additional expenses up to the coverage limit of the secondary plan.
- **Primary and secondary insurers** are determined by the coordination of benefits provisions in the plan documents.
- **New prohibition:** Plans may not exclude or reduce coverage solely because the benefits are payable under another plan.
- Similar to coordination of benefits rules for commercial health plans.

Legislation Affecting Mental Health

Legislation

- SB 1677: Forensic Mental Health Competency Restoration
- SB 850: Child Mental Health Consortium Expansion

SB 1677: Forensic Mental Health Competency Restoration

Sen. Perry & Rep. Price

- **Goal of the Legislation:** This bill is an important step in addressing the state's ongoing shortage of available hospital beds for mental health patients. In 2017, the state established a grant program to reduce recidivism, arrest, and incarceration among individuals with mental illness and reduce wait times for forensic commitments.
- **The details:** Assists communities under 250,000 population to apply to the grant program. Ensures HHSC will use additional appropriations to select new communities or support communities that were selected but require additional funding.
- **HB 1 contingency rider** of $1.5 million annually in GR for implementation of the bill.
- **There's more:** The bill also allows HHSC,to establish or expand regional behavioral health or jail diversion centers when funding is appropriated.
- **Audit required:** SB 1677 requires the State Auditor's Office (SAO) to conduct an audit of the inmates in county jails who are waiting for a forensic hospital bed and identify any issues and inefficiencies in the commitment process.
- Effective September 1, 2023. SAO report due December 1, 2024.

SB 850: Child Mental Health Consortium Expansion

Sen. Blanco & Rep. Blanco

- **The Background:** The 86th Texas Legislature established the Texas Child Mental Health Care Consortium to address urgent mental health challenges throughout the state by leveraging the expertise and capacity of mental health-related institutions.
- **The details:** This bill removes The University of Texas M.D. Anderson Cancer Center from the consortium, as they do not provide mental health services, and adds rural regional education service centers.
- **Why that matters:** Data indicates that rural children are more likely to abuse substances and attempt suicide and are less likely to have access to behavioral health care in a mental health emergency.
- Effective September 1, 2023.

Medicaid Legislation and Budget Highlights

Telemedicine & Telecommunications

- HB 2727 - Expands Medicaid Coverage for Home Telemonitoring Services
- HB 2802 - Expands Medicaid MCO Texting Options

Long-Term Services & Supports

- HB 3550 - Prescribed Pediatric Extended Care Center Medicaid Reimbursement
- HB 4169 - Prevocational Services in Medicaid Waiver Programs

Provider Requirements

- HB 44 - Prohibits Vaccination Discrimination by Medicaid Providers

Budget

- HB 1 - 2024-25 General Appropriations Act
- SB 30 - 2023 Supplemental Funding Bill

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HB 2727 - Expands Medicaid Coverage for Home Telemonitoring Services

Rep. Price & Sen. Perry

- **Goal of the Legislation:** Studies show that telemonitoring is an effective tool for managing patient health. This legislation adds items to the list of conditions that qualify for telemonitoring.
- **The details:** Adds end-stage renal disease to the existing list of conditions that may be eligible for telemonitoring and reduces the number of required risk factors.
- **There's more:** Requires HHSC to assess whether high-risk pregnancy qualifies for home telemonitoring, based on cost and clinical effectiveness.
- **Cost-Effectiveness:** Requires HHSC to determine if home telemonitoring services are cost-effective and clinically beneficial before they can be covered; the MCO is no longer responsible for determining effectiveness.
- **New provider types:** Adds federally qualified health centers and rural health clinics as providers.
- Effective immediately.

HB 2802 – Expands Medicaid MCO Texting Options

Rep. Rose & Sen. Blanco

- **Goal of the Legislation:** HB 2802 builds on previous legislation aimed at improving electronic communication between MCOs and Medicaid enrollees. The bill streamlines the process for enrollees choosing to opt-in or opt-out of receiving critical health care updates and eligibility information through emails and text messages from MCOs.
- **The details:** Ensures marketing guidelines allow MCOs to communicate through any electronic means regarding eligibility, enrollment, and other health matters.
- **Application changes:** Requires HHSC to revise the "Preferred Method of Contact" section of the Medicaid application:
  - By incorporating eligibility and enrollment options
  - To simplify the selection process for preferred contact methods
  - To update notifications that inform members of their right to opt-out of electronic communication by notifying their MCO
- Requires change to Medicaid application by Jan. 1, 2024

HB 3550 - Prescribed Pediatric Extended Care Center (PPECC) Medicaid Reimbursement

Rep. Rose & Sen. LaMantia

- **Background:** PPECCs are day opportunities for community private duty nursing services for medically fragile children so that parents can work; also easing the nursing workforce burden.
- **However,** Texas' strict Medicaid reimbursement requirements and regulations have resulted in the establishment of just 6 PPECCs. By comparison, Florida has over 150.
- **A major hurdle** is that a child's care plan must be submitted several months in advance and broken into 15-minute segments resulting in reimbursement denials when the real-time schedule does not match the schedule from months prior.
- **Changes made:**
  - Makes several changes related to transportation reporting requirements.
  - Prohibits conditional reimbursement of non-transportation services on the use of the PPECC's transportation services.
  - Requires PPECCS to obtain all necessary parental consents on one document.
  - Allows PPECCs to provide nursing services in a group setting.
- Effective September 1, 2023

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HB 4169 - Prevocational Services in Medicaid Waiver Programs

Rep. Price & Sen. Sparks

- **Goal of the Legislation:** HHSC recently made several changes to its Home and Community-Based Services and Texas Home Living waivers for people with intellectual and developmental disabilities living in the community that impacted day and employment services. This bill aims to allow paid prevocational services for these Texans.
- **The details:** HB 4169 requires HHSC to design prevocational services for waiver program recipients that assist them in getting employment in their community that pays at or above minimum wage.
- **More on the program:** If a waiver that includes prevocational services as part of individualized skills and socialization services is not granted, HHSC is required to create a service similar to prevocational services that will be approved.
- **Caps on reimbursement:** Reimbursement for the services may not exceed the reimbursement rate for individualized skills and socialization services.
- **Note:** Applies to Medicaid fee for service not managed care.

HB 44 – Prohibits Vaccination Discrimination by Medicaid Providers

Rep. Swanson & Sen. Middleton

- **Goal of the Legislation:** Some provider offices may limit access to patients that have not received routine vaccinations. This bills uses Medicaid participation as a means to limit this practice among providers, particularly pediatricians.
- **The details:** Prohibits Medicaid or CHIP providers, other than oncologists and organ transplant specialists, from refusing to provide services based solely on the patient's refusal or failure to obtain a vaccine or immunization.
- **Exceptions allowed:** Providers must have exception policies for a sincerely held religious belief or a recognized medical condition for which a vaccination is contraindicated.
- **Providers are prohibited from reimbursement** until HHSC finds they are in compliance.
- **Relief Possible:** Requires HHSC to establish the right of an accused provider to seek administrative and judicial review.

Budget Highlights

- SB 30 includes **$2.5 billion** in new funding to cover the 2022-23 Medicaid shortfall.
- The Legislature appropriated $18 billion more than the previous biennium, resulting in a **final budget of $321 billion** – a 5% increase from the last biennium.
- HB 1 includes **$75.4 billion in All Funds for the Medicaid program.**
  - This funds caseload, but not cost growth.
  - This is a $4 billion decrease, driven by the gradual loss in both members and enhanced federal matching funds (6.2%) now that the unwinding of continuous Medicaid coverage has begun.
  - The Medicaid program assumes a **return to 3.9 million Texans** by 2025—down from nearly 6 million in May 2023.

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Medicaid Reimbursement Rate Changes

- $2.0 billion to **support community attendant services** and raise the base wage to $10.60 an hour, up from $8.11 (Rider 30)
- Increases rates for **pediatric services and women's health-related surgeries** by 6% (Rider 31)
- Increases rates for **private duty nursing** by 2% (Rider 34)
- Increases rates for **ground ambulances** by 25% (Rider 33)
- $325 million for a **nursing facility wage** increase (Rider 24)
- Increases the **rural labor and delivery Medicaid add-on payment** for rural hospitals to $1,500 from $500 (Rider 16)
- $178.2 million in **additional reimbursement for rural hospitals**, including a new rural hospital grant program

Additional Medicaid Funding

- $302 million for **mental health** community hospitals, $199.4 million for mental health state hospital operations, and $83 million for community mental health grant programs
- Funding for the ongoing costs for improvements to the Medicaid and CHIP Provider Enrollment and Credentialing Portal (**PEMS+**) (see Rider 36)
- $50 million in additional in General Revenue to **increase waiver slots** (roughly 1,800 new slots)

Questions?