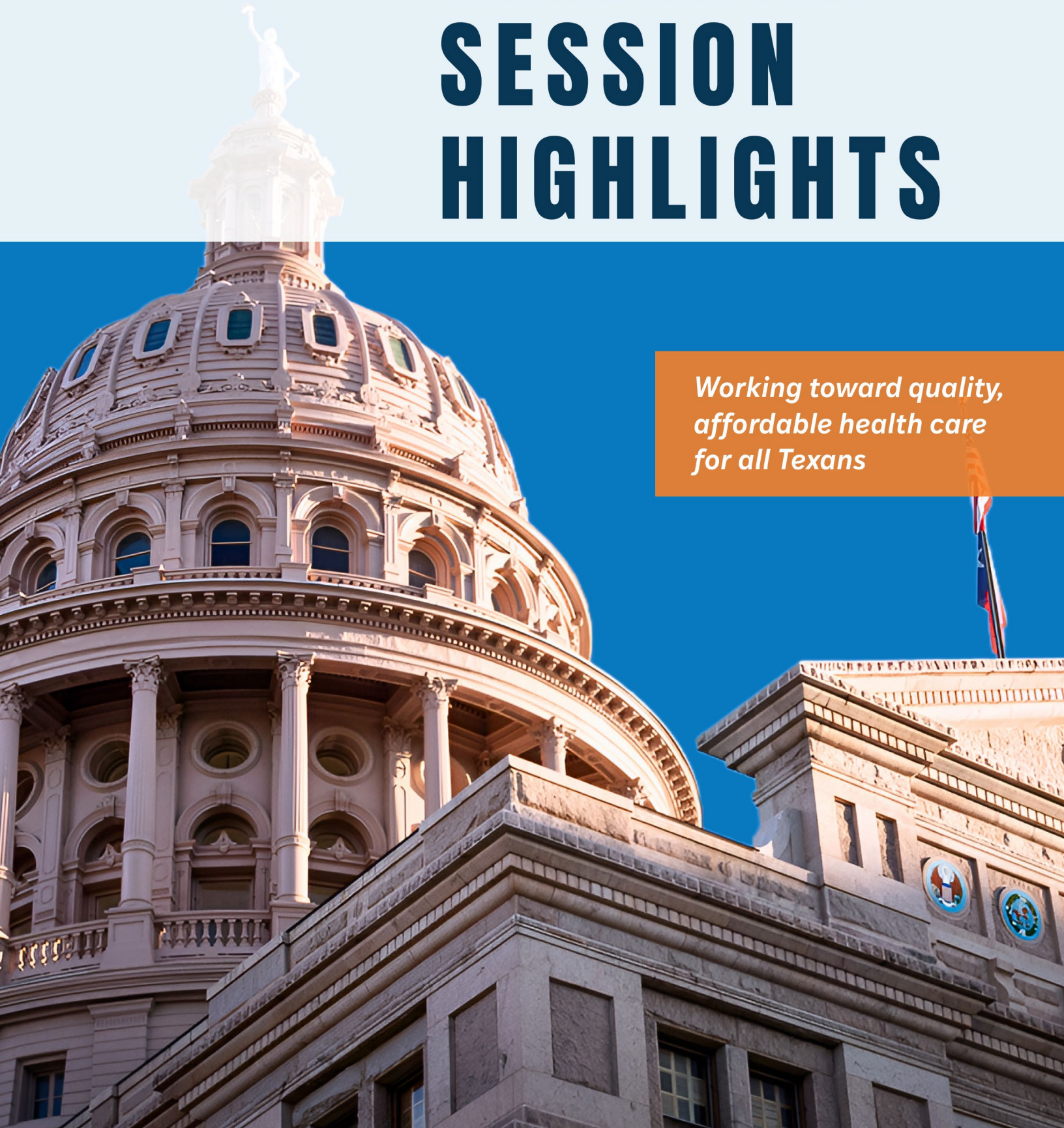
TAHP

The Texas Association of Health Plans

89TH TEXAS LEGISLATURE

SESSION HIGHLIGHTS



Working toward quality, affordable health care for all Texans

About TAHP

Led by an experienced team of health care policy experts, the Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, Medicaid plans, Medicare Advantage plans, and related health care entities operating in Texas. For more than three decades, TAHP has been dedicated to promoting affordable, high-quality health care for all Texans through advocacy and education.

Our mission is to increase awareness about our members' services, highlight their contributions to local communities, and demonstrate their role in improving health care access and delivery across Texas. TAHP works closely with our members, community partners, and key stakeholders, including the Texas Legislature and state agencies, to strengthen health care policy for the benefit of all Texans.

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This session, TAHP

...monitored **561 bills,** of which
293 received a hearing

...actively supported
76 bills

...actively opposed
25 bills

...testified
43 times

...submitted
36 written testimonies

...submitted
69 position cards

...testified
34 bills

...advocated for **14 priority bills** and **10 became law**

Over 130 health plan mandate bills were filed

...**52 received a hearing**

...**40 passed out of a committee**

...and **12 passed both chambers**

Takeaways From Your TAHP Team

This guide offers a comprehensive summary of the health care legislation passed in the 89th Texas Legislature. As we reflect on this session, key themes included improving health care affordability, protecting Medicaid managed care, limiting costly mandates, and increasing access to care.

Our most significant win this session—after years of advocacy—was establishing a new review process to evaluate health insurance mandates before they are enacted. Lawmakers will now have upfront, independent, data-driven estimates to clearly understand the costs and impacts of mandates on Texas families and businesses.

We successfully worked to prevent numerous costly health insurance mandates, particularly those targeting self-funded employer (ERISA) plans. Legislation was passed to modernize outdated insurance regulations, streamline processes, and enhance transparency for employers, insurers, and providers. Lawmakers also approved important reforms to simplify billing practices, reduce surprise medical bills, and expand price transparency in health care.

Prescription drug affordability remained a major focus. TAHP played a critical role in educating legislators about the cost impacts of various drug pricing proposals, and we successfully prevented many costly new requirements. The Texas Pharmaceutical Initiative was extended, providing an important opportunity to continue advocating for effective solutions to lower drug prices and eliminate excessive markups.

Medicaid managed care emerged from the session strong, with no legislation passed that would undermine its proven effectiveness and innovation. Lawmakers strengthened protections against Medicaid fraud, simplified provider enrollment, and added targeted new benefits like lactation support for new mothers. We look forward to continued engagement during the upcoming Sunset review process to further strengthen Texas Medicaid.

Legislators also prioritized solutions to improve access to health care across the state. Recognizing Texas' growing workforce shortages—especially in rural and underserved communities—lawmakers simplified licensure for health professionals, supported mental health initiatives, and enhanced resources for crisis response and chronic disease prevention.

We deeply appreciate the opportunity to serve as the voice of Texas' health coverage industry. As we move into the interim, we remain committed to working closely with lawmakers, stakeholders, and our members to build upon this session's successes and continue advocating for accessible, affordable, and innovative health care solutions for all Texans.

Jamie Dudensing
Chief Executive Officer

Jason Baxter
Director of Government Relations

Blake Hutson
Director of Public Affairs

Madison Kieschnick
Director of Policy & Government Affairs

Key Highlights from

1

Goldcarding Expanded (HB 3812)

Lawmakers expanded the state's goldcarding program, making it easier for physicians to qualify for a gold card by extending the evaluation period to 12 months and allowing Medicare, Medicaid, and ERISA claims to count toward eligibility.

2

Mandate Fiscal Review Established (HB 138) & APCD Funded

Lawmakers created a new fiscal review process to provide upfront, data-driven cost estimates of proposed health insurance mandates. Separately, the Legislature also fully funded the All-Payor Claims Database (APCD), which will allow Texas to study overall health care costs and identify potential savings.

3

ERISA Preemption Protected

For the second consecutive session, major legislation (SB 1122) aimed at imposing costly state mandates on self-funded ERISA health plans failed, preserving coverage flexibility for the state's largest employers.

4

Insurance Code Modernized—Shopping Incentives & Value-Based Payments (SB 926 & HB 2254)

Legislators updated outdated insurance rules to clearly allow insurers to reward patients who choose higher-quality, lower-cost providers (SB 926) and permit value-based payment agreements between primary care providers and insurers (HB 2254). These changes support more affordable, patient-centered care.

5

New Medicaid Benefits Added

Medicaid added new coverage for lactation consultation services (HB 136) and nutrition programs (HB 26), strengthening maternal and child health and improving outcomes.

6

Stronger Medicaid Fraud Protections (HB 142 & SB 1038)

New legislation significantly strengthened fraud prevention and oversight within Medicaid. HB 142 expanded the role of the Recovery Audit Contractor (RAC) program, while SB 1038 clarified definitions and substantially increased penalties for Medicaid fraud and abuse, protecting taxpayer dollars and patient care.

the 89th Legislature

HHSC Scheduled for Sunset

HHSC remains scheduled for Sunset review next session, creating an opportunity for Medicaid improvements. TDI was initially considered but ultimately not included (HB 1545).

Medigap Coverage Expanded for Under 65 (HB 2516)

Texans under age 65 who qualify for Medicare due to ALS or End-Stage Renal Disease (ESRD) now have expanded, equal access to Medigap coverage options.

Surprise Billing Protections Improved (SB 2544, SB 916)

Legislators established reasonable deadlines for hospitals and emergency rooms to file billing mediation requests, while also extending key protections against ambulance surprise billing.

AI Regulations and Insurance (HB 149, SB 815)

While lawmakers extensively debated new artificial intelligence regulations, the final legislation (HB 149) did not include new AI rules affecting health insurance. A separate bill (SB 815) simply reinforced existing requirements that a licensed physician—not AI alone—must make adverse prior authorization determinations.

Prescription Drug Reforms & TPI Extended (SB 1236, HB 4638)

New legislation increased transparency and oversight between pharmacies and PBMs, while lawmakers extended the Texas Pharmaceutical Initiative (TPI) for two years to continue addressing prescription drug affordability.

New Vision Plan Contracting Requirements (HB 3211)

Lawmakers passed new requirements that vision plans must allow optometrists and therapeutic optometrists to join their networks if they meet credentialing criteria.

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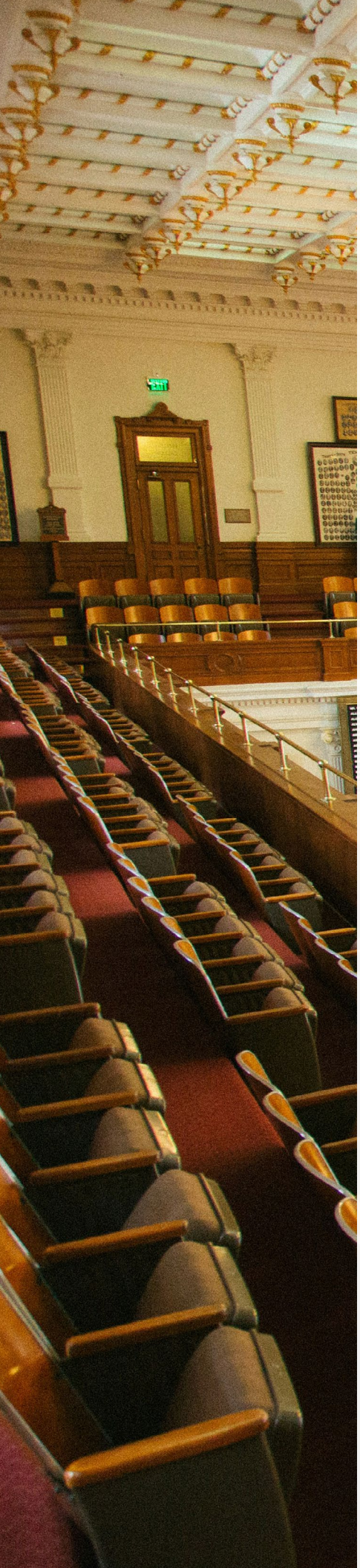
Key Legislation Affecting the Health Coverage Industry 11



Key Health Care Legislation

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Key Legislation Affecting the Health Coverage Industry

Texas lawmakers passed significant legislation this session to modernize insurance regulations, streamline administrative processes, and reduce unnecessary burdens. These reforms are important because the high cost of health coverage remains a major challenge, especially for Texas employers who continue struggling to offer affordable health plans to their employees.

Typically, each legislative session sees many proposals for costly new health insurance mandates. This year alone, more than 130 mandate bills were filed. However, legislators took a different approach this session, shifting their focus toward affordability, innovation, and flexibility rather than simply adding more mandates. To help achieve this, lawmakers created a new upfront review process designed to determine how proposed mandates would affect employer costs before they are passed into law.

Alongside this new approach, important legislation was enacted to simplify outdated regulations, improve transparency in health care contracts, and reduce administrative burdens that drive up costs. TAHP actively supported these measures while successfully negotiating or preventing many problematic mandate proposals, including protecting employers from attempts to extend mandates to ERISA plans.

Together, these actions create a solid foundation for more affordable health insurance options, directly benefiting Texas employers and families.

Creates a Legislative Mandate Fiscal Review

HB 138 by Rep. Dean & Sen. Bettencourt

Legislators are often unaware of the full impact health insurance mandates have on Texas families and businesses. While 29 other states provide lawmakers with cost estimates of private health coverage mandates, Texas has lacked this critical information. HB 138 addresses this gap by creating an independent, upfront estimate of how proposed health insurance mandates affect coverage costs and accessibility in Texas.

What HB 138 Does:

This bill establishes the Health Impact, Cost, and Coverage Analysis Program (HICCAP) at UTHealth Houston's Center for Healthcare Data. The program will use the All-Payor Claims Database (APCD) to provide lawmakers with clear, data-driven estimates that show how proposed health insurance mandates will affect costs, coverage, and overall health outcomes in Texas.

The Lt. Governor, the Speaker, committee chair or vice chair can request this analysis at any time, whether the legislature is meeting or not. Once

requested, the Center has 30 days during the legislative session or 60 days outside of session to complete the analysis.

Each analysis will carefully evaluate whether the proposed mandate would increase or decrease insurance costs, impact public health outcomes, affect utilization of health services, increase administrative expenses, or lead to more spending by businesses, governments, and individuals. The analysis will also review existing medical and scientific research and consider current availability and use of the proposed health services in Texas. The goal is to give lawmakers a clear and complete understanding of how each proposed mandate could impact Texas families and employers before voting.

HICCAP will analyze any proposal that requires an insurer to:

- Cover additional health care services or treatments
- Increase or decrease reimbursement rates to health care providers
- Implement new administrative or contractual obligations

Each analysis will provide lawmakers how the proposed mandate will impact:

- How the proposal would improve or affect Texans' health
- Projected increases or decreases in premium costs for families, employers, and individuals
- Expected changes in how often the mandated service is used
- Costs incurred by insurers, employers, and policyholders to manage the mandate
- Increased costs for private employers, retirement systems, local governments, and individuals
- Whether the mandate would help reduce premature deaths

Each analysis will also include:

- Whether the mandated service is already widely available and used
- Whether insurers currently restrict access to the proposed service
- The strength and quality of evidence supporting the mandated service, based on peer-reviewed scientific studies and academic research

Data Calls: In addition to analyzing provider claims in the APCD, the Texas Department of Insurance (TDI) may issue specific data calls to insurers requesting detailed estimates of administrative costs.

Funding: Program costs will be funded through annual fees assessed on health benefit plans and collected by the Comptroller. These fees will be based on the number of covered lives in state-regulated plans.

Effective Immediately.

Texas Responsible Artificial Intelligence Governance Act

HB 149 by Rep. Capriglione & Sen. Schwertner

This legislation is the product of extensive work throughout the interim and session to establish regulations for artificial intelligence (AI) in the state. Importantly, the law ensures deference to the Texas Department of Insurance (TDI) and existing laws regulating insurance that already account for AI uses. Nothing in the new chapter related to AI authorizes any agency besides TDI to regulate the business of insurance.

The bill establishes prohibited uses for AI, including unlawful discrimination, but again clarifies that the section is not applicable to an insurance entity that is subject to insurance laws related to unfair discrimination.

The Attorney General will have enforcement authority over the chapter, and it requires the creation of a website for consumers to submit complaints. The bill also creates the Texas Artificial Intelligence Council, which will identify laws that impede innovation, analyze opportunities to improve government efficiency, and offer guidance.

Effective January 1, 2026.

Standardizes Coordination of Benefits Forms

HB 388 by Rep. Harris Davila & Sen. Hughes

HB 388 establishes a uniform questionnaire to simplify and streamline the coordination of benefits process, which is how insurers determine which plan pays first when a patient has coverage from multiple sources. Currently, these questionnaires vary across plans, creating administrative complexity. The bill directs the Texas Department of Insurance (TDI) to collaborate with stakeholders to develop this standard questionnaire. Insurers offering plans with coordination of benefits must use this standardized form and make it available to health care providers by February 1, 2026.

Requires TDI to adopt rules by January 1, 2026. Insurers must begin using the questionnaire by February 1, 2026. Applies to EPO/PPO, HMO, MEWA, Small Employer, CC, TRS/ERS/University, and Medicaid/CHIP plans.

Transparency Exemption for Three-Share Plans

HB 721 by Rep. Leo Wilson & Sen. Middleton

In 2007, Texas established "three-share" health plans where state funds are used to subsidize premiums for low-income employees of small businesses. This bill removes these regional and local health care programs from health care price transparency laws established by the legislature in 2021. This includes requirements for enrollee disclosures and requirements to disclose all pricing and reimbursement information in machine-readable files.

Effective September 1, 2025 for "three-share" regional and local health care programs.

Out of State Telemedicine Coverage

HB 1052 by Rep. Bhojani & Sen. Blanco

This bill requires insurers to provide coverage for telemedicine medical services, teledentistry dental services, or telehealth services provided out of state if the patient primarily resides in Texas and the health care provider providing the service is licensed in Texas. Essentially, the bill clarifies that the current coverage requirement for telehealth services extends to a patient/provider that is temporarily out-of-the state when receiving/providing the service. Coverage must be provided on the same basis as if the procedure were provided in the state.

Effective for health plans issued or renewed on or after January 1, 2026.

Allows Insurers to Offer Value-Added Services

HB 2221 by Rep. Hull & Sen. Hancock

HB 2221 aligns Texas insurance law with model legislation from the National Association of Insurance Commissioners (NAIC), clearly allowing insurers, health plans, and agents to provide certain "value-added services" to consumers without violating state anti-rebate laws. Currently, providing additional services not explicitly listed in a policy could be considered illegal rebating under Texas law. This bill removes that uncertainty.

These value-added services must relate directly to the insurance coverage and must primarily help manage risk, improve health outcomes, lower claims costs, or provide health and financial wellness benefits. Examples include wellness and prevention programs, financial education, post-loss support services, or incentives promoting healthier behaviors. If a health tracking device is provided as a value-added service, its purpose must be disclosed to the consumer and the consumer must affirmatively consent to its use. HB 2221 clearly states that these services can be offered at no additional cost beyond premiums paid by the consumer and are not required to be explicitly listed in the policy documents.

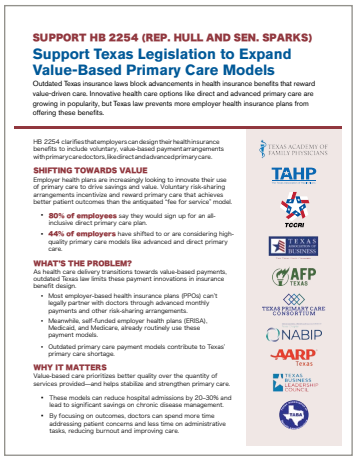
The bill also clarifies that enforcement of anti-rebating rules is handled exclusively by the Texas Department of Insurance, instead of allowing private lawsuits. This change ensures consistency in enforcement across different types of insurance, including life, accident, health, and property and casualty policies.

HB 2221 provides insurers greater flexibility to offer beneficial, cost-saving programs, helping improve consumer health and potentially lowering health care costs.

Effective September 1, 2025. Applies to all commercial health plans.

Removes Barriers to Value-Based Care: EPO & PPO

HB 2254 by Rep. Hull & Sen. Sparks


SUPPORT HB 2254 (REP. HULL AND SEN. SPARKS)

Support Texas Legislation to Expand Value-Based Primary Care Models

Outdated Texas insurance laws block advancements in health insurance benefits that reward value-driven care. Innovative health care options like direct and advanced primary care are growing in popularity, but Texas law prevents more employer health insurance plans from offering these benefits.

HB 2254 clarifies that employers can design their health insurance benefits to include voluntary, value-based payment arrangements with primary care doctors, like direct and advanced primary care.

SHIFTING TOWARDS VALUE

Employer health plans are increasingly looking to innovate their use of primary care to drive savings and value. Voluntary risk-sharing arrangements incentivize and reward primary care that achieves better patient outcomes than the antiquated "fee for service" model.

- **80% of employees** say they would sign up for an all-inclusive direct primary care plan.
- **44% of employers** have shifted to or are considering high-quality primary care models like advanced and direct primary care.

WHAT'S THE PROBLEM?

As health care delivery transitions towards value-based payments, outdated Texas law limits these payment innovations in insurance benefit design.

- Most employer-based health insurance plans (PPOs) can't legally partner with doctors through advanced monthly payments and other risk-sharing arrangements.
- Meanwhile, self-funded employer health plans (ERISA), Medicaid, and Medicare, already routinely use these payment models.
- Outdated primary care payment models contribute to Texas' primary care shortage.

WHY IT MATTERS

Value-based care prioritizes better quality over the quantity of services provided—and helps stabilize and strengthen primary care.

- These models can reduce hospital admissions by 20–30% and lead to significant savings on chronic disease management.
- By focusing on outcomes, doctors can spend more time addressing patient concerns and less time on administrative tasks, reducing burnout and improving care.

Texas Academy of Family Physicians · TAHP · TCCRI · Texas Business Group on Health · AFP Texas · Texas Primary Care Consortium · NABIP · AARP Texas · Texas Business Leadership Council

Health care payment models are shifting away from fee-for-service payments toward value-based arrangements that reward quality and patient outcomes. Texas Medicaid, Medicare, and self-funded employer plans already utilize these innovative payment models. However, current state laws create barriers preventing state-regulated insurers from adopting similar arrangements.

HB 2254 removes these barriers by clearly allowing PPO and EPO health plans to contract with primary care providers under certain value-based payment agreements, such as risk-sharing or capitation (a fixed payment per patient). It explicitly does not allow global capitation contracts, which include all health services. Under this bill, primary care providers who enter these arrangements are not considered to be engaging in the business of insurance.

Participation Requirements & Safeguards:

- Limited specifically to primary care providers only.
- Contracts cannot discourage physicians from providing medically necessary health care services.
- Contracts must clearly define performance measures, patient attribution methods, bridge rates, stop-loss thresholds, and shared savings procedures.
- Providers must have opportunities to renegotiate capitation rates.
- Contracts must clearly indicate whether catastrophic events are included or excluded in cost calculations.
- Providers cannot subcontract these agreements.
- Providers are not required to participate in these arrangements, and insurers are prohibited from discriminating against physicians who choose not to participate. Providers can file complaints of discrimination with the Texas Department of Insurance.

HB 2254 aligns Texas state-regulated insurers with broader market trends toward value-based care, supports innovative payment models, and ensures critical patient and physician protections.

Effective Immediately, Applies to EPO & PPO health plans.

Expands Medigap Coverage for Texans Under 65

HB 2516 by Rep. Guillen & Sen. Schwertner

This bill requires issuers of Medicare supplemental plans to persons 65 years or older to offer the same coverage to individuals younger than 65 years of age who are eligible by reason of amyotrophic lateral sclerosis (ALS) or end-stage renal disease (ESRD). Any benefit, protection, policy, or procedure applicable to coverage under a plan for an individual 65 years of age or older must apply to coverage offered to persons under 65. If the plan is a standardized Plan A, Plan B, or Plan D Medicare supplement plan, it must be offered at the same premium rate. If it is not one of those standardized plans, the premium rate must not exceed 200% of the premium rate charged for the same plan to an individual 65 years of age.

The bill also establishes enrollment periods for plans issued to persons under 65 years of age. It allows an individual to enroll any time during the six-month period beginning the first day of the first month the individual becomes enrolled for benefits under Medicare Part B. During an enrollment period, an insurer may not:

- Deny or condition the issuance of a Medicare supplement plan
- Subject the applicant to medical underwriting or discriminate in the price of a Medicare supplement plan because of the applicant's health status, claims experience, receipt of health care, or medical condition
- Impose a waiting period
- Impose a limitation or exclusion of benefits based on the applicant's preexisting condition.

The bill requires the Texas Department of Insurance to adopt rules implementing the bill, including rules designating enrollment periods. In addition to the

enrollment periods provided by law, an individual younger than 65 years of age and enrolled in Medicare Part B based on a diagnosis of ESRD or ALS, may apply for coverage during a one-time open enrollment period beginning December 1, 2025 and ending June 1, 2026. In the event that the individual requests an application after December 1, 2025 and the application is unavailable, the six-month period begins on the date the application initially becomes available.

Effective immediately and applies to Medigap plans issued on or after September 1, 2025.

Nonprofit Regional Healthcare Programs

HB 2655 by Rep. Oliverson & Sen. Hinojosa

In 2007, the 80th Texas Legislature enacted legislation that allowed local entities to establish health care programs for small employers, known as three-share premium assistance programs. Three-share programs are not regulated as insurance companies, and county commissioners courts are authorized to establish, participate in, and directly govern these programs. This bill would authorize community-based nonprofit organizations to establish or participate in these regional health care programs without the participation of the commissioners court of a county if the program is a premium assistance program not offering health care services or health care benefits.

Effective September 1, 2025.

CAR-T Provider & Coverage Requirements

HB 3057 by Rep. Landgraf & Sen. Sparks

HB 3057 ensures broader patient access to chimeric antigen receptor T-cell (CAR-T) therapy by requiring health plans to cover medically necessary CAR-T services provided by any qualified provider in their existing network. Specifically, if a health care provider already participates in a health plan's network for other services and meets the FDA's certification requirements for administering CAR-T therapy, the plan must cover CAR-T therapy from that provider. Plans are prohibited from imposing additional provider-based restrictions or limitations beyond these qualifications. The Texas Department of Insurance is required to adopt rules to implement these coverage requirements.

Effective for health plans issued or renewed on or after January 1, 2026. Applies to EPO/PPO, HMO, MEWA, Small Group, CC, and ERS/TRS/University plans.

Vision Network Participation Requirements

HB 3211 by Rep. Dean & Sen. Middleton

This bill requires vision care plans (not major medical plans) to include on their website a method for optometrists to submit an application for network participation. A vision plan may only require an applicant to provide standardized information and information specified on the Council for Affordable Quality Healthcare (CAQH) credentialing application. Not later than the 10th business day after receiving an application, the plan must make a contract and fee schedule available to the provider, and not later than 30 days after receipt of the application, approve or deny it.

A vision plan is prohibited from excluding optometrists as participating providers if they meet credentialing requirements, including based on the number of optometrists in a geographic area or the time, distance, or appointment availability of an optometrist. Additionally, the insurer is required to allow an optometrist to participate in all the insurer's vision care plans and vision panels.

The bill also requires all health plans, vision plans, and managed care plans to include a fee schedule and standardized codes in their contracts with optometrists.

Effective immediately.

SBOE Health Plan Access

HB 3254 by Rep. Leo Wilson & Sen. Zaffirini

The bill makes members of the State Board of Education (SBOE) and their dependents eligible for participation in health benefits offered to state employees through the Texas Group Health Benefits Act administered by the Employee Retirement System of Texas (ERS).

Effective September 1, 2025 for ERS health plans.

Expands Goldcarding & MD Licensure Requirements for UR

HB 3812 by Rep. Bonnen & Sen. Hancock

Many health plans offer "goldcarding" programs, allowing doctors with consistently high prior-authorization approval rates to be exempt from certain future preauthorization requirements. In a previous session, Texas lawmakers mandated a state goldcarding program. HB 3812 expands that program, making it easier for physicians to qualify for a gold card.

Preauthorization Exemptions

Currently, physicians must achieve a 90% approval rate on preauthorization requests to earn a gold card exemption. HB 3812 maintains the existing 90% requirement but expands the claims data used to determine a physician's eligibility. The bill extends the timeframe for evaluating approval rates from six months to one year, starting each January. It also expands the pool of claims insurers must consider when determining a physician's approval rate. Insurers now must count all claims submitted by a provider, including claims from self-funded (ERISA) plans, Medicaid, and Medicare. However, the state-mandated goldcard exemptions continue to apply only to state-regulated insurance plans, ERS, and TRS.

The bill also introduces new protections when an insurer considers revoking a gold card. If a provider submits fewer than five claims during a review, the insurer must review all submitted claims rather than just a sample. Additionally, providers now have the right to appeal gold card revocation decisions through an independent review organization (IRO).

Administrative Licenses

Currently, the Texas Medical Board issues administrative medical licenses to physicians in non-clinical roles. HB 3812 prohibits doctors who direct utilization review from holding only an administrative license and requires them to have a full medical license. The bill also ensures that decisions to revoke a gold card are made by fully licensed physicians, rather than by those holding only administrative licenses.

Annual Report

The bill requires an insurer to submit to the Texas Department of Insurance (TDI) an annual report for each health care service subject to an exemption from preauthorization requirements. The report must include:

- Exemptions granted by the insurer
- Rescissions and denials by the insurer
- IRO determinations requested by providers for exemption reviews, including the outcome of each review

The bill establishes that such a report is public information, but the bill requires TDI to ensure that the report does not contain any identifying information before disclosing the report.

Effective September 1, 2025 for EPO/PPO, HMO, ERS/TRS/ University health plans. Full licensure requirement for medical directors will apply to Medicaid/CHIP MCOs.

Texas Regulatory Efficiency Office

SB 14 by Sen. King & Rep. Capriglione

SB 14, the Regulatory Reform and Efficiency Act, creates a new office within the Governor's office—the Texas Regulatory Efficiency Office—to help streamline and simplify the state's regulatory processes. The goal is to identify unnecessary and outdated rules, improve transparency and public access to regulatory information, and help agencies reduce administrative burdens and costs.

What the Texas Regulatory Efficiency Office Will Do:

- Help state agencies identify unnecessary or ineffective rules and assess the costs these rules place on businesses and individuals.
- Work with agencies to simplify the rulemaking process and expand efficiencies.
- Improve public access by creating a user-friendly, interactive website where Texans can easily find information about agency rules, required forms, and filings.
- Develop a clear regulatory economic analysis manual outlining best practices for how agencies should prepare cost-benefit analyses and impact statements.
- Publish a regulatory reduction guide to assist agencies in streamlining their regulations, and require agencies to document their results.

Advisory Panel: The bill authorizes creation of a Regulatory Efficiency Advisory Panel, appointed by the Governor. This panel will provide expertise and recommendations on ways to improve rulemaking processes, identify unnecessary regulations, and propose opportunities for reducing regulatory burdens on businesses and individuals.

Statutory Interpretation and Judicial Review: SB 14 clarifies how courts should interpret agency rules and laws. It establishes that courts are not required to defer to a state agency's interpretation of laws or rules during legal proceedings. Courts must independently review legal questions without automatically favoring the agency's interpretation.

Effective immediately.

Dental Anesthesia Coverage for Kids

SB 527 by Sen. Schwertner & Rep. Oliverson

This bill requires insurers to cover medically necessary general anesthesia in connection with dental services provided to individuals under 13 years old if the patient is unable to undergo dental treatment without it. The bill would not require coverage of dental care or procedures.

Applies to all health plans issued or renewed on or after January 1, 2026 including EPO/PPO, HMO, MEWA, small group, consumer choice, and ERS/TRS/University plans.

Prohibits AI-Only Utilization Review Denials

SB 815 by Sen. Schwertner & Rep. Spiller

This bill prohibits a utilization review agent from using an "automated decision system" to make, wholly or partly, an adverse determination. The bill defines "automated decision system" as an algorithm, including an algorithm incorporating an artificial intelligence system, that uses data-based analytics to make, suggest, or recommend certain determinations, decisions, judgments, or conclusions. However, the bill expressly does not prohibit the use of an algorithm, artificial intelligence system, or automated decision system for administrative support or fraud-detection functions. The bill authorizes the Texas Department of Insurance to audit and inspect at any time a utilization review agent's use of an automated decision system for utilization review.

Additionally, the bill makes certain changes to the existing law relating to adverse determination notices. The notice will now need to include a description of and the source of the screening criteria and the review procedures used in making the adverse determination.

Applies to all EPO/PPO, HMO, consumer choice, Medicaid and CHIP plans issued or renewed on or after January 1, 2026.

Extends Enrollment & Automatic Coverage for Newborns

SB 896 by Sen. Blanco & Rep. Cole

SB 896 gives parents more time and flexibility to enroll their newborns in existing health plans and extends the automatic initial coverage period for newborns. Currently, employer-based health plans in Texas automatically cover newborns for about 31 days after birth—even before parents formally enroll their child or pay premiums. After these initial 31 days, parents must enroll the newborn to continue coverage. Federal law (HIPAA) requires employer plans to provide automatic coverage for at least 30 days. The Affordable Care Act (ACA) allows parents 60 days after birth (a special enrollment period) to enroll newborns in individual Marketplace plans. However, individual ACA plans typically do not offer automatic coverage before enrollment.

Specifically, SB 896:

- **Two-Month Automatic Coverage:** Extends automatic initial newborn coverage from 31 days to 61 days for employer-based group plans, and requires individual plans offering newborn coverage to provide at least 61 days of initial coverage.
- **Extends Notification Deadline:** Gives parents 60 days (instead of 31 days) after birth to notify their insurer and enroll their newborn, ensuring continuous coverage.

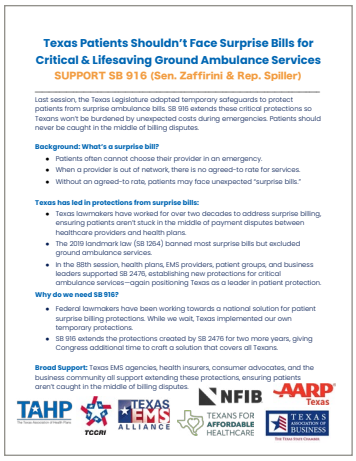
These changes align Texas law more closely with federal ACA enrollment timelines and help parents avoid coverage gaps during the critical first weeks after childbirth.

Effective September 1, 2025 for all health plans, including small and large group, MEWAs, and individual plans, issued or renewed starting January 1, 2026.

Extends Ban on Ambulance Surprise Bills

SB 916 by Sen. Zaffirini & Rep. Spiller

SB 916 extends Texas's existing ambulance surprise billing protections through September 1, 2027. Texas first passed surprise billing protections (SB 1264) in 2019 to stop unexpected medical bills from out-of-network providers. However, ambulance services were not included, leaving patients exposed to surprise bills from ambulance providers. In 2023, lawmakers



temporarily added ambulance billing protections, but those were scheduled to expire in 2025.

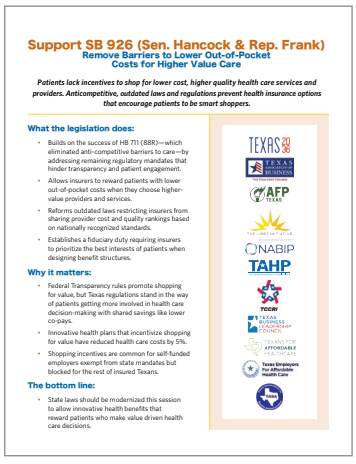
SB 916 continues these protections for two more years. Ambulance providers are required to accept reimbursement rates set by local governments and publicly available online. If no local rate is set, providers will be reimbursed at 325% of the Medicare rate. Local governments can adjust their rates annually, but increases must be modest, capped by inflation guidelines. To ensure compliance, the bill allows penalties against ambulance providers who repeatedly submit inaccurate bills or intentionally violate these rules.

This two-year extension gives Texans continued protection from surprise ambulance bills while lawmakers await a potential nationwide solution.

Effective September 1, 2025. Applies to EPO/PPO, HMO, ERS/TRS/University plans.

Allows Shopping Incentives: Tiering & Stiering

SB 926 by Sen. Hancock & Rep. Frank



Texas has outdated regulations that restrict health plans from rewarding patients who choose higher-quality, lower-cost providers. SB 926 updates state law by clearly allowing insurers to offer patients incentives, such as lower copays, deductibles, and other reduced cost-sharing, when they select certain in-network providers. Encouraging patients to choose affordable, high-quality care has been shown to significantly reduce overall health care spending.

Shopping Incentives: The bill allows insurers to offer these patient incentives but establishes a clear fiduciary responsibility, requiring insurers to act primarily for the benefit of patients or group plan holders. Insurers specifically:

- Cannot offer incentives solely because a provider is affiliated or controlled by the insurer.
- Must not encourage patients to limit medically necessary care or select lower-quality services.
- Must use objective, verifiable, and accurate data when determining eligible providers.
- Cannot base incentives solely on cost.
- Must ensure out-of-network emergency care cost-sharing is not higher than in-network emergency care cost-sharing.

Physician Quality and Cost Ranking: SB 926 also modernizes how insurers can publicly rank providers based on quality or cost. Insurers using provider rankings must:

- Adopt standards developed by an independent organization designated by the Texas Department of Insurance (TDI). This organization must be unbiased, nationally recognized, and have a transparent, risk-adjusted methodology.
- The ranking standards used must emphasize quality of care, be nationally recognized and based on peer-reviewed medical literature, have a transparent methodology, include risk adjustment if based on clinical outcomes, and support a simple process for providers to request corrections.
- Clearly disclose ranking methodologies to providers at least 45 days before publication, indicating which products or networks the rankings will impact.
- Provide a simple, clear process for providers to identify and correct ranking discrepancies both before and after publication.
- Promptly correct verified discrepancies by the publication date or within 30 days of notification.

If insurers repeatedly violate these requirements, TDI can prohibit them from using provider rankings for at least 12 months.

Effective September 1, 2025. Applies to EPO/PPO and HMO plans.

Newborn Duchenne Muscular Dystrophy Screening

SB 1044 by Sen. Parker & Rep. Capriglione

Texas currently maintains a newborn screening program operated by the Department of State Health Services (DSHS) to identify, prevent, and treat certain serious health conditions in infants. SB 1044 adds Duchenne muscular dystrophy to the state's official newborn screening panel, making it eligible for early detection, prevention, and treatment services.

When the state adds a new condition like Duchenne muscular dystrophy to the newborn screening panel, health plans, including Medicaid and private insurance, are required by Texas law to cover the screening, diagnosis, and any necessary follow-up care related to that condition.

The bill directs DSHS to implement Duchenne muscular dystrophy screening once the department has completed necessary laboratory preparations. The Legislature specifically appropriated funding for this purpose in the state budget, ensuring the screening program will move forward.

Effective September 1, 2025.

Removes On-Site Audit Requirements

SB 1151 by Sen. Blanco & Rep. Wharton

Currently, if a third-party administrator (TPA) manages health benefits for more than 100 enrollees on behalf of an insurer, Texas law requires the insurer to conduct an audit in person (on-site) once every two years. SB 1151 removes the requirement that these audits must occur on-site, giving insurers greater flexibility to conduct audits remotely or through other appropriate methods. Removing the on-site requirement reduces administrative costs for insurers, potentially leading to lower premiums for employers and consumers.

Effective September 1, 2025 for EPO, PPO, HMO & Medicaid Plans.

Prohibits EHR Offshoring

SB 1188 by Sen. Kolkhorst & Rep. Harless

This bill requires a covered entity, including payors and their subcontractors, to ensure that electronic health records under the control of the entity are physically maintained in the United States. A covered entity shall ensure that the electronic health record information of this state's residents is accessible only to individuals who require the information for the purposes of treatment, payment, or other health care operations. Entities must also ensure that electronic health records of minors are available to parents or guardians immediately. The bill requires HHSC, the Texas Medical Board, and the Texas Department of Insurance to jointly ensure that each electronic health record in this state document an individual's biological sex at birth and information on any sexual development disorder of the individual. It prohibits amending the biological sex only to correct a clerical error or based on a diagnosis of a sexual development disorder that changes the individual's biological sex. If there is a credible allegation of a violation of the bill's provisions, an appropriate regulatory agency must conduct an investigation and impose disciplinary action. The bill also allows the Attorney General to enforce the bill through injunctive relief and civil penalties.

Effective September 1, 2025 for all health insurance coverage.

Gender Transition Coverage Requirements

SB 1257 by Sen. Hughes & Rep. Leach

This bill requires a health benefit plan that provides or has ever provided coverage for an enrollee's gender transition procedure or treatment to provide coverage for:

- All possible adverse consequences related to the enrollee's gender transition procedure or treatment.
- Any baseline and follow-up testing or screening necessary to monitor the mental and physical health of the enrollee on at least an annual basis.
- Any procedure, treatment, or therapy necessary to manage, reverse, reconstruct from, or recover from the gender transition procedure or treatment.

The bill also requires health plans that currently cover gender transition procedures or treatment to also provide the above coverage to any enrollee regardless of whether the enrollee was enrolled in the plan at the time of the initial gender transition procedure or treatment.

The bill defines "gender transition" as a medical process by which an individual's anatomy, physiology, or mental state is treated or altered, including by the removal of otherwise healthy organs or tissue, the introduction of implants or performance of other plastic surgery, hormone treatment, or the use of drugs, counseling, or therapy, for the purpose of furthering or assisting the individual's identification as a member of the opposite biological sex. The bill defines "gender transition procedure or treatment" as a medical procedure or treatment performed or provided for the purpose of assisting an individual with a gender transition.

Effective September 1, 2025 for Medicaid/CHIP plans, and applies to EPO/PPO, HMO, MEWA, Small Group, ERS/TRS/ University plans delivered, issued for delivery, or renewed on or after January 1, 2026.

Prohibits Medicare & Medigap DME Balance Billing

SB 1330 by Sen. Hancock & Rep. Paul

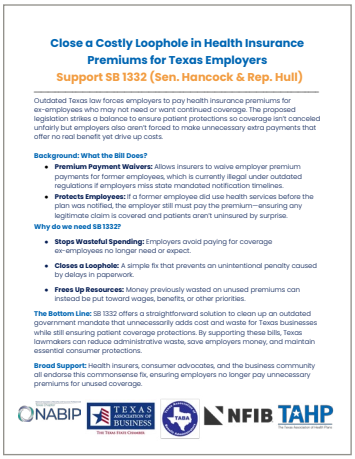
This bill prohibits durable medical equipment (DME) suppliers that do not participate in Medicare from charging Medicare enrollees more than 115% of the Medicare-approved amount for durable medical equipment, orthotic devices or supplies, or prosthetic devices or supplies covered under Medicare unless the enrollee agrees in writing and either enters a rental plan or pays in full. The bill clarifies that Medicare will reimburse 80% of the Medicare-allowed amount, and a Medicare supplement benefit plan is not required to reimburse in excess of 115% of the Medicare-allowed amount. A violation of the chapter would be considered a deceptive act for the purpose of the Texas Deceptive Trade Practices Act.

Effective September 1, 2025.

Allows Waiving of Ex-Employee Premiums

SB 1332 by Sen. Hancock & Rep. Hull

Currently, when an employee leaves or is terminated, Texas employers must pay the employee's health insurance premium through the end of the month the insurer is notified. If the insurer doesn't receive the notification promptly, the employer could owe an extra month's premium—even if the former employee didn't receive any health care services.



Close a Costly Loophole in Health Insurance Premiums for Texas Employers

Support SB 1332 (Sen. Hancock & Rep. Hull)

Outdated Texas law forces employers to pay health insurance premiums for ex-employees who may not need or want continued coverage. The proposed legislation strikes a balance to ensure patient protections so coverage isn't canceled unfairly but employers also aren't forced to make unnecessary extra payments that offer no real benefit yet drive up costs.

Background: What the Bill Does?

- **Premium Payment Waivers:** Allows insurers to waive employer premium payments for former employees, which is currently illegal under outdated regulations if employers miss state mandated notification timelines.
- **Protects Employees:** If a former employee did use health services before the plan was notified, the employer still must pay the premium—ensuring any legitimate claim is covered and patients aren't uninsured by surprise.

Why do we need SB 1332?

- **Stops Wasteful Spending:** Employers avoid paying for coverage ex-employees no longer need or expect.
- **Closes a Loophole:** A simple fix that prevents an unintentional penalty caused by delays in paperwork.
- **Frees Up Resources:** Money previously wasted on unused premiums can instead be put toward wages, benefits, or other priorities.

The Bottom Line: SB 1332 offers a straightforward solution to clean up an outdated government mandate that unnecessarily adds cost and waste for Texas businesses while still ensuring patient coverage protections. By supporting these bills, Texas lawmakers can reduce administrative waste, save employers money, and maintain essential consumer protections.

Broad Support: Health insurers, consumer advocates, and the business community all endorse this commonsense fix, ensuring employers no longer pay unnecessary premiums for unused coverage.

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SB 1332 allows insurers to waive this extra premium if the terminated employee didn't use covered health care services after their eligibility ended. This protects employers from paying unnecessary premiums, reducing health care costs for employers.

Effective immediately. Applies to EPO/PPO and HMO health plans.

Allows Mandate Lite University Student Coverage

SB 1409 by Sen. Parker & Rep. Johnson

This bill allows higher education institutions to offer "higher education health benefits." This legislation is similar to authorization passed in the 87th session to allow "Farm Bureau" health plans, which also do not have to meet state insurance requirements.

The bill clarifies that colleges and universities offering these plans are not considered health insurers and are not engaged in the business of insurance. However, institutions must register with the Texas Department of Insurance. Institutions are required to clearly notify students that these health benefits are not provided through state-regulated insurance plans. Students must sign this notification, and the institution must retain signed copies.

Institutions offering these plans can partner with licensed insurance companies to manage risk or provide insurance coverage related to the health benefits. Plans must be actuarially sound, meaning the institution must obtain an actuary's opinion recommending appropriate financial reserves and stop-loss coverage to responsibly manage the health benefits offered.

Additionally, these plans cannot impose waiting periods of more than six months for preexisting conditions covered under the plan. The bill also requires these plans to comply with Texas surprise billing protections.

Effective immediately.

Limits IDR Mediation Claims Deadline to 180 days

SB 2544 by Sen. Hancock & Rep. Morgan

Currently, Texas law requires out-of-network providers to request arbitration under the surprise billing law within 90 days of receiving initial payment, but it does not include a similar deadline for mediation. Without this deadline, outdated mediation claims can be submitted months or even years later, causing unnecessary costs that can drive up premiums for employers and consumers.

SB 2544 closes this loophole by requiring out-of-network providers (hospitals and FSERs) to request mediation no later than 180 days after receiving initial payment. This change creates predictability in the dispute resolution process.

Grace Period for Older Claims: To prevent confusion or disruption, the bill provides a one-time grace period for older claims paid before the bill takes effect. For claims paid on or before the bill's effective date, providers have 120 days after enactment to request mediation. After this grace period, older claims will no longer be eligible for mediation.

These changes reduce administrative costs and help protect employers and consumers from unnecessary premium increases.

Effective immediately for EPO/PPO, HMO, ERS/TRS/ University health plans.

Criminal Background Checks for TDI Licenses

SB 2587 by Sen. Zaffirini & Rep. Guillen

This bill expands state criminal history requirements across all state agencies, including by allowing the Texas Department of Insurance (TDI) to obtain criminal history record information for applicants for a license issued by TDI, as well as corporate officers or directors of an insurance company regulated by TDI.

Effective September 1, 2025 for all health insurance coverage.

Key Legislation Affecting Medicaid, CHIP, & Managed Care

Medicaid managed care delivers high-quality health coverage to millions of Texans, controlling costs while ensuring comprehensive care coordination. Lawmakers maintained strong support for managed care this session and legislation failed to pass that would have undermined the innovation and affordability at the core of the Medicaid program. Instead, bills passed streamlined unnecessary administrative requirements, enhanced transparency, strengthened protections against fraud and waste, and prioritized meaningful improvements in patient care.

Legislators added a limited set of new Medicaid benefits, including lactation services to support new mothers and nutrition initiatives. Several other bills enacted this session strengthened oversight and safeguards against fraud, waste, and abuse. TAHP successfully advocated against proposals that would have weakened Medicaid's competitive, market-based approach. Looking ahead, TAHP will focus on implementing these new measures and identifying additional opportunities during the upcoming Sunset review process to further improve the Medicaid managed care program.

Expands Funding & Support for Rural Hospitals

HB 18 by Rep. VanDeaver & Sen. Perry

Texas leads the nation in rural hospital closures, threatening access for Texas families. This bill establishes a State Office of Rural Hospital Finance to provide technical assistance to rural hospitals and health systems. It would also create a Texas Rural Hospital Officers Academy to deliver professional development and continuing education programs for rural hospital officers.

The bill establishes grant programs to support rural hospitals at risk of financial instability, drive innovation, and respond to disasters. It also creates an add-on reimbursement rate for rural hospitals with a department of obstetrics and gynecology, which HHSC would be tasked with administering. The bill removes existing criteria for the state's rural pediatric telemedicine grant programs related to quality assurance programs, staffing, and emergency facilities, while retaining a requirement for rural hospitals to maintain records and produce reports measuring grant effectiveness. The budget funds these initiatives at $51 million over the next biennium.

Finally, the bill creates a Rural Pediatric Mental Health Care Access Program to expand telemedicine and telehealth programs to assist in identifying and assessing behavioral health needs and providing access to mental health care services for pediatric patients at rural hospitals.

Effective immediately.

Medicaid Nutrition Counseling ILOS Benefit

HB 26 by Rep. Hull & Sen. Kolkhorst

Nutrition counseling helps people adopt healthy eating habits, manage conditions like diabetes and obesity, and potentially reduce health care costs in the long run. This bill requires HHSC to allow Medicaid managed care organizations to offer medically necessary, cost-effective nutrition counseling and instruction services in lieu of another service (ILOS) specified in the state Medicaid plan. However, the list of nutrition counseling and instruction services that are permitted may not include home-delivered meals, food prescriptions, or grocery support.

The bill also allows HHSC to establish a pilot program under which MCOs may offer nutrition support services to pregnant moms in lieu of state Medicaid plan services. These "medically tailored meals" would be designed by a registered dietitian as part of a treatment plan to improve health outcomes. To be eligible for the program, a recipient would have to be pregnant and diagnosed with a chronic health condition that could lead to a high-risk pregnancy or birth complications, such as gestational diabetes, hypertension, and obesity. Finally, the bill would require HHSC to collect and analyze data on the impact to maternal and infant health outcomes that nutrition support services have on pilot program participants and submit a report to the legislature. The pilot program expires August 31, 2030.

Effective September 1, 2025, for Medicaid and CHIP but only applies to contracts entered into after the effective date of the Act.

Medicaid Lactation Consultation Benefit

HB 136 by Rep. Hull & Sen. Alvarado

Recent sessions have brought an increased focus on Medicaid support for moms. HB 136 continues that effort by adding coverage for lactation consultation services in Medicaid. Specifically, the bill requires HHSC to allow lactation consultants to enroll in Medicaid as a separate provider type, ensuring they can directly receive reimbursement for lactation services provided to Medicaid recipients.

Effective September 1, 2025 for Medicaid.

Strengthens OIG Oversight & Allows RAC MCO Audits

HB 142 by Rep. Noble & Sen. Perry

Texas currently uses Recovery Audit Contractors (RACs) to identify Medicaid overpayments and underpayments in fee-for-service programs. HB 142 expands RAC authority, allowing them to also audit claims in Medicaid managed care. Under this bill, RACs can identify and recover managed care overpayments from either managed care organizations (MCOs) or providers.

The RAC audits must meet specific conditions:

- RAC audits are only permitted if the Office of Inspector General (OIG) determines they are cost-effective and explicitly approves the review.
- RAC audits can only be initiated after at least one year has passed from the date the claim was received.
- RACs cannot initiate recovery if the MCO has already notified the OIG that they are auditing the claim.

Currently, MCOs have a two-year window to recover non-fraudulent claims. Under this bill, during the first year after payment, only the MCO may audit and recover claims. In the second year, both the MCO and the RAC can perform audits and recover overpayments.

The bill also removes two existing requirements:

- An annual, random statistical audit by HHSC of Medicaid claims for fraud, waste, and abuse.
- Mandatory preliminary investigations by OIG for every fraud or abuse allegation, to determine if a full investigation is warranted.

Effective September 1, 2025, for Medicaid and CHIP, but only requires HHSC to implement the bill if funds are specifically allocated for that purpose.

Medicaid Cranial Remolding Orthosis Coverage

HB 426 by Rep. Bernal & Sen. West

This bill requires Medicaid and CHIP to cover the full cost of a "cranial remolding orthosis" for a child diagnosed with craniostenosis, plagiocephaly, or brachycephaly if the child is between 3–18 months, has failed to respond to conservative therapy for at least 2 months, and meets additional indications. The bill defines "cranial remolding orthosis" as a custom-fitted or custom-fabricated medical device that is applied to the head to correct a deformity, improve function, or relieve symptoms of a structural cranial disease.

Effective September 1, 2025 for Medicaid & CHIP.

Exempts Discount Cards From Medicaid U&C

HB 2402 by Rep. Rose & Sen. Kolkhorst

Texas Medicaid sets payment rates based on the "usual and customary" (U&C) charges, which are the typical amounts providers routinely bill patients in their community. HB 2402 clarifies that monthly fee-based membership discount programs offering reduced rates or special pricing are excluded when calculating Medicaid's usual and customary rates. This clarification ensures discounted membership fees do not affect the calculation of Medicaid payment rates, helping Medicaid reimbursement accurately reflect typical local provider charges.

Effective September 1, 2025.

Requires FQHC Expedited Credentialing

HB 3151 by Rep. Hull & Sen. Cook

Medicaid MCOs are required by state and federal law to ensure that providers meet credentialing requirements. Currently, MCOs must conduct expedited credentialing in the Medicaid program for physicians that join a provider group that has an existing contract with an MCO and agree to the terms of that contract. This bill clarifies that providers that join an FQHC with an existing contract are also eligible. The bill also clarifies that FQHCs are considered "providers," and if an FQHC has a contract with an MCO, a new location will get expedited credentialing if they agree to the existing terms.

Effective September 1, 2025 for Medicaid and CHIP.

Medicaid Newborn Coverage Education

HB 3940 by Rep. Johnson & Sen. Kolkhorst

Federal Medicaid laws mandate that states automatically cover newborns when their mother is eligible for Medicaid. This bill requires HHSC to annually provide written notice to each MCO and health care provider, including hospitals and other health care facilities participating in Medicaid, reminding the organizations and providers that when a newborn child of a recipient has not been assigned a Medicaid identification number, the provider may accept or use the mother's Medicaid identification number on any claim for reimbursement under Medicaid. The notice also encourages organizations and providers to educate mothers that they may use the Medicaid identification number until the recipient's newborn child is enrolled in Medicaid. Finally, it requires facilities to provide new mothers information on enrolling in Medicaid upon delivery of an infant.

Effective September 1, 2025. HHSC will develop the notice required by the bill by December 1, 2025, and facilities will be required to provide information to new mothers starting January 1, 2026.

Expands Medicaid Provider Background Checks

HB 4643 by Rep. Dorazio & Sen. Hagenbuch

HHSC is currently allowed to conduct criminal background checks of a person enrolled as or applying to be a provider in the Medicaid program. This bill expands that authority to include persons with 5% or greater ownership in a provider, a person who owns 5% or more of a mortgage or other obligation secured by the provider, an officer or director of a provider, or a partner or managing employee of a provider.

Effective Immediately for the Medicaid program.

Consolidating HHSC Reporting Requirements

HB 4666 by Rep. Manuel & Sen. Blanco

This bill modifies many of HHSC's current reporting requirements:

- The data analysis unit would be required to provide a report annually instead of quarterly;
- The report on interventions and best practices by providers would be required biennially instead of annually;
- The report on the system redesign for services to IDD populations would be biennial instead of annual; and
- The quality-based outcomes measures report would be biennial instead of annual.

Finally, the bill clarifies that every report HHSC is required to provide to the governor or members of the legislature must be submitted not later than December 1 of the year the report is due.

Effective Immediately.

Prohibits Surveillance By State Contractors

HB 5061 by Rep. Leach & Sen. Schwertner

This bill prohibits a contractor or subcontractor of a state agency from engaging in surveillance targeting a member of the state legislature or a person employed to support the state legislature, any of their family members, a state agency employee, or a complainant. It also prohibits engaging in acts of intimidation or coercion against any of those persons, or using private or confidential information to influence a state contracting decision or proceeding.

The bill establishes oversight by the state auditor's office (SAO), as well as a complaint process, allowing persons to file a complaint with the SAO through an online portal. The SAO would be required to investigate submitted complaints, and if the SAO determines that there was a violation, the contractor could be subject to immediate termination of any contracts, administrative penalties, and being barred from future awards. The SAO is also required to submit an annual report of complaints as well as the outcome of those complaints.

Effective September 1, 2025.

Extends Medicaid Maternal Opioid Care Model

HB 5155 by Rep. Rose & Sen. Kolkhorst

There is currently a program for maternal opioid misuse that is funded by the federal government. The funds are used for improving quality and accessibility of care for pregnant women with opioid use disorder and their children after birth. This bill extends that program until September 1, 2029, or until federal funds are no longer available.

Effective immediately.

Nursing Facility Owner Disclosure & Patient Care Ratio

SB 457 by Sen. Kolkhorst & Rep. Frank

SB 457 makes important changes to Medicaid requirements for nursing facilities, including ownership disclosures and reimbursement rules, to enhance transparency and accountability.

Ownership Changes: When a nursing facility has a pending change of ownership (CHOW), this bill ensures Medicaid payments continue uninterrupted. To keep receiving payments during an ownership transition, the new owner must:

- Take over the previous owner's Medicaid provider agreement.
- Meet all licensing requirements.
- Agree to pay any outstanding liabilities from the previous owner through a successor liability agreement approved by HHSC.

The bill also strengthens transparency in ownership disclosures. New owners must clearly identify anyone holding at least a 5% ownership interest in the nursing facility and describe their ownership stake. Facilities must promptly inform HHSC if any ownership details change.

Patient Care Expense Ratio: SB 457 requires nursing facilities to spend at least 80% of their Medicaid reimbursement directly on patient care, and requires MCOs to include a provision requiring compliance with this law in their provider agreements. This includes costs like staff compensation, supplies, and facility assets. HHSC may recover Medicaid funds from facilities that fail to meet this 80% requirement, except if the facility:

- Has at least a four-star quality rating from the Centers for Medicare & Medicaid Services (CMS),
- Has occupancy rates at or below 75%, or
- Experienced expenses due to a natural disaster.

Facilities will be required to comply with expense ratio requirements by September 1, 2025. Requires HHSC to report on ratio compliance by November 1, 2027.

Allows Foster Parents to Pay Out-of-Network Costs

SB 855 by Sen. Sparks & Rep. Frank

Currently, children in foster care receive health coverage through the Medicaid STAR Health managed care program. SB 855 allows foster parents (or other caregivers authorized to consent to medical treatment) to seek and pay for medical care from providers who are out-of-network.

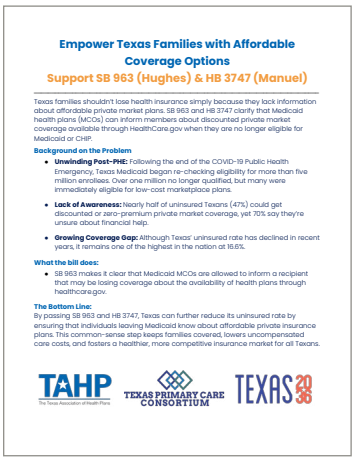
Under this bill, foster parents can choose and pay for out-of-network care directly, but the Department of Family and Protective Services (DFPS) will not be financially responsible for these costs. Foster parents must notify DFPS within 10 business days after the out-of-network treatment. DFPS is then required to document this care in the child's "health passport," a comprehensive medical record maintained throughout their time in foster care.

Medicaid Managed Care Organizations (MCOs), including STAR Health plans, cannot discourage or prevent foster parents from accessing this authorized out-of-network care.

Effective September 1, 2025 for the Medicaid program.

Allows MCOs to Share Private Coverage Options

SB 963 by Sen. Hughes & Rep. Manuel



Empower Texas Families with Affordable Coverage Options

Support SB 963 (Hughes) & HB 3747 (Manuel)

Texas families shouldn't lose health insurance simply because they lack information about affordable private market plans. SB 963 and HB 3747 clarify that Medicaid health plans (MCOs) can inform members about discounted private market coverage available through HealthCare.gov when they are no longer eligible for Medicaid or CHIP.

Background on the Problem

- **Unwinding Post-PHE:** Following the end of the COVID-19 Public Health Emergency, Texas Medicaid began re-checking eligibility for more than five million enrollees. Over one million no longer qualified, but many were immediately eligible for low-cost marketplace plans.
- **Lack of Awareness:** Nearly half of uninsured Texans (47%) could get discounted or zero-premium private market coverage, yet 70% say they're unsure about financial help.
- **Growing Coverage Gap:** Although Texas' uninsured rate has declined in recent years, it remains one of the highest in the nation at 16.6%.

What the bill does:

- SB 963 makes it clear that Medicaid MCOs are allowed to inform a recipient that may be losing coverage about the availability of health plans through healthcare.gov.

The Bottom Line:

By passing SB 963 and HB 3747, Texas can further reduce its uninsured rate by ensuring that individuals leaving Medicaid know about affordable private insurance plans. This common-sense step keeps families covered, lowers uncompensated care costs, and fosters a healthier, more competitive insurance market for all Texans.

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Nearly half of uninsured Texans could access low-cost or zero-premium private health coverage through HealthCare.gov, yet many Texans remain uninsured simply due to a lack of information about available options. SB 963 clarifies that Medicaid Managed Care Organizations (MCOs) can inform current and former Medicaid members about affordable private health plans, including qualified health plans through the federal marketplace (HealthCare.gov).

The bill specifically prohibits HHSC from adopting marketing rules that would restrict MCOs from:

- Informing individuals about qualified health plans available on HealthCare.gov.
- Advertising Medicare Advantage plans at community enrollment or other outreach events.

SB 963 requires that when MCOs provide information about private market plans, they clearly communicate potential out-of-pocket costs, including deductibles, copayments, and other cost-sharing requirements. The bill also prohibits MCOs from offering financial incentives or material gains to individuals as inducements to enroll in these private plans.

Effective September 1, 2025 for Medicaid and CHIP.

Strengthens Medicaid Fraud Definitions and Penalties

SB 1038 by Sen. Sparks & Rep. Noble

The Texas Office of Inspector General (OIG) estimates that approximately 10% of health care spending is lost to fraud, waste, and abuse. SB 1038 strengthens Medicaid protections by clearly defining additional actions that constitute fraud or abuse and increasing penalties for violations.

Current law prohibits submitting claims to HHSC containing false statements. This bill

expands violations to include knowingly making misrepresentations or failing to disclose necessary information when applying for Medicaid benefits, seeking certification or recertification (including facilities), or submitting claims for payment. The bill clarifies that violations include:

- Seeking benefits that are not authorized, or exceeding the authorized amount.
- Submitting claims for services provided by unlicensed individuals.
- Billing for services or products without approval by a treating provider, for inadequate or inappropriate services, or failing to identify the actual provider's license type or identification number.

The bill also clarifies violations for Medicaid Managed Care Organizations (MCOs), specifically if they fail to provide required information to HHSC or other appropriate state agencies. Additionally, it specifies that each day a person obstructs the OIG from performing its duties counts as a separate violation, potentially increasing penalties.

SB 1038 enhances due process by requiring HHSC to clearly inform individuals about their appeal rights and extends the appeal deadline from 10 days to 30 days after receiving a preliminary report.

Finally, the bill increases the potential award given to individuals who report Medicaid fraud. Currently capped at 5% of administrative penalties, the bill expands this reward to 5% of the combined total of administrative penalties and damages imposed on violators.

Effective September 1, 2025.

Medicaid Provider Enrollment & Credentialing Support

SB 1266 by Sen. Alvarado & Rep. Button

Medicaid providers have reported difficulty navigating HHSC's enrollment and credentialing processes through the Provider Enrollment Management System (PEMS) website. SB 1266 addresses these concerns by requiring HHSC to establish a dedicated support team to help providers complete these processes.

The bill also requires HHSC to:

- Annually evaluate the performance and timeliness of the support team.
- Publish an annual evaluation summary on the HHSC website.
- Create a clear process for providers to submit complaints and feedback about the support team, and prominently post this process on the PEMS website.

SB 1266 also establishes new provider disenrollment procedures. HHSC must now notify providers electronically and by mail at least 30 days prior to disenrollment and allow providers an opportunity to correct any issues before disenrollment takes effect.

Effective September 1, 2025 for Medicaid. HHSC will conduct the initial evaluation and post the report not later than September 1, 2026.

SHARS Medicaid Program

SB 1952 by Sen. Paxton & Rep. Hull

The School Health and Related Services (SHARS) program allows local school districts to receive Medicaid reimbursement for certain health services provided to eligible students. SB 1952 formally codifies requirements for the SHARS program, clarifying roles and responsibilities to improve its administration.

The bill designates HHSC as the sole agency responsible for administering the SHARS program. HHSC must oversee the participation of local education agencies (LEAs) as providers, including conducting provider training and providing clear guidance and information about the program.

SB 1952 also requires HHSC to collaborate with regional education service centers to deliver resources, information, and assistance to LEAs. Additionally, HHSC and the Texas Education Agency (TEA) must enter into a memorandum of understanding clearly defining each agency's responsibilities for operating the SHARS program.

Effective immediately.

Key Legislation Affecting Drug Coverage

Prescription drug costs remain a significant driver of rising health care expenses, making pharmacy affordability a top priority for Texas families, employers, and lawmakers. This session, pharmaceutical spending and the role of pharmacy benefit managers (PBMs) continued to receive extensive legislative attention. TAHP worked to educate legislators on how certain proposed drug benefit reforms could unintentionally increase costs for employers and families, particularly proposals aimed at imposing pharmacy mandates on self-funded employer health plans.

Lawmakers passed important bills focused on increasing prescription drug transparency, improving fairness between pharmacies and insurers, and strengthening oversight of PBMs. Notably, the Texas Pharmaceutical Initiative (TPI) was extended for an additional two years and will continue exploring reforms to state-funded prescription drug coverage. As we move forward, TAHP will actively engage with TPI to advocate for solutions that lower prescription drug prices by addressing excessive markups and removing barriers to competition.

Prohibits PBM Data Offshoring

HB 3233 by Rep. Harris & Sen. Kolkhorst

This bill prohibits a pharmacy benefit manager (PBM) from storing or processing patient data for a resident of the state at a location outside of the United States or its territories.

Effective September 1, 2025 for EPO/PPO, HMO, and Medicaid/CHIP, but applies only to a contract entered into or renewed on or after the effective date.

Extends Texas Pharmaceutical Initiative

HB 4638 by Rep. Bonnen & Sen. Kolkhorst

HB 4638 extends the Texas Pharmaceutical Initiative (TPI), originally set to expire in 2025, through 2027. The TPI, established to identify opportunities for pharmacy cost savings and best practices, receives several updates under this bill.

The bill expands the TPI board from three to five members, creating staggered six-year terms. Approximately one-third of the members' terms will expire on February 1 of each odd-numbered year. Vacancies on the board will be filled in the same manner as the original appointments, covering only the remainder of the unexpired term.

Additionally, HB 4638 updates the schedule for TPI's required business plan. Instead of submitting a single business plan in 2024, TPI must now submit the plan every two years, starting June 1, 2026. These business plans must include clear recommendations on best practices and strategies for achieving pharmacy-related cost savings based on program utilization.

Prohibits Prescription Drug Gag Clauses

SB 493 by Sen. Kolkhorst & Rep. Wharton

This bill prohibits a PBM from prohibiting or restricting a pharmacist from informing a patient that their out-of-pocket cost for a prescription drug may be lower if they forgo submitting a claim under the patient's prescription drug coverage. These types of gag clauses are already prohibited by federal and state law for most types of plans. The bill also makes a pharmacy network contract unenforceable if it restricts a pharmacy or pharmacist from communicating with plan sponsors or administrators regarding prescription drug benefits, network access and adequacy, partnership opportunities, or prescription claim reimbursement.

Effective September 1, 2025 for commercial plans, but applies only to a contract entered into, amended, or renewed on or after the effective date.

Pharmacists & Insurer Contract Requirements

SB 1236 by Sen. Hughes & Rep. Hefner

Pharmacists have raised concerns related to health plans and pharmacy benefit managers (PBM) processes for contract modifications, recoupments, and transparency. This legislation is a multi-pronged approach addressing many of those concerns through limitations on how a PBM can recoup overpayments to pharmacies, make changes to a contract, and provide access to contract information.

Identification Card Requirements: Health plan identification cards must not assign the same group number to both state-regulated and self-funded (ERISA) enrollees, clearly distinguishing between plan types.

Audits and Recoupments: SB 1236 prohibits insurers and PBMs from retroactively denying or reducing pharmacy claims after the claims have been approved (adjudicated), except in limited cases, including if:

- The original claim was fraudulent.
- The pharmacy was already paid for the claim.
- The pharmacy made a significant error resulting in the patient receiving the wrong medication or incorrect dosage.

In cases of minor clerical errors, insurers or PBMs can only recoup the dispensing fee, not the full claim amount.

Network Contracts: Contracts between pharmacies and PBMs must clearly detail all financial terms, including reimbursement rates and methods, directly within the contract itself. Contracts cannot incorporate terms by referencing external documents, such as provider manuals, unless included as part of the contract.

Additionally, insurers and PBMs cannot:

- Require pharmacies to join specific networks or penalize them for choosing not to participate.
- Charge pharmacies application or participation fees before providing a full copy of the proposed contract.
- Condition participation in one pharmacy benefit network on participation in another.

Online Portal: PBMs and insurers must provide an online portal allowing pharmacies to easily access all relevant network contracts and contract addendums.

Contract Change Limitations and Notifications: SB 1236 establishes guidelines limiting how insurers or PBMs can modify pharmacy contracts, protecting pharmacies from unexpected changes.

Adverse Material Changes: Insurers and PBMs cannot impose an "adverse material change" to a pharmacy benefit network contract during the contract term unless pharmacies explicitly agree. An adverse material change includes reducing pharmacy reimbursement, placing pharmacies in a less favorable tier, or adding new administrative procedures that substantially increase pharmacy costs or reduce payments.

Certain changes are explicitly **not** considered adverse material changes:

- Payment decreases due solely to published government fee schedule updates.
- Changes already anticipated under the original contract terms.
- Administrative updates already anticipated by the contract.
- Changes mandated by federal or state law.
- Contract termination (with or without cause) at the end of the contract.

If insurers or PBMs propose an adverse material change, they must notify pharmacies clearly and prominently that pharmacies are not required to agree, and refusal will not impact their participation in other networks or contracts. Any adverse material change agreed to cannot take effect until 120 days after pharmacies formally consent.

Exemptions: These modification rules do not apply to "evergreen contracts," which are contracts with no specific end date or automatic renewal period and can only end upon notice from one party. They also do not apply to changes specifically required by federal or state law.

Other Contract Modifications: For modifications that are not adverse material changes, insurers and PBMs must notify pharmacies at least 90 days before the proposed changes take effect. Notifications must be sent by email, clearly describing the modification, identifying affected drugs, and linking directly to the

online contract portal. If a pharmacy does not respond within 30 days of receiving notice, the proposed modification is automatically considered approved.

Applicable to EPO/PPO, HMO, MEWA, Small Group, ERS/TRS/University.

Effective September 1, 2025 for all health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2026. Provisions relating to contracting apply only to contracts entered into after the effective date.

Key Legislation Reducing Health Care Costs

Texas faces major challenges from rising health care costs, ranking fifth highest in health care spending nationwide. Employer-sponsored health plan costs have risen 16% in just the past three years, making coverage increasingly unaffordable, particularly for small businesses. As a result, only 27% of Texas small employers currently offer health insurance to their employees.

Recognizing this critical issue, TAHP actively collaborated with stakeholders committed to lowering health care spending. This session, we advocated for a broad set of reforms to protect consumers from unfair and unexpected medical expenses and to address the root causes of Texas' high health care costs. Lawmakers responded by advancing several important bills aimed at increasing price transparency, reducing surprise billing, simplifying medical billing practices, and encouraging competition.

Collectively, these legislative actions represent important progress toward making health care more affordable and transparent for Texas employers, families, and taxpayers.

Ensures Paper Access to Itemized Medical Bills

HB 216 by Rep. Harris Davila & Sen. Hughes

Last session, lawmakers created new patient protections to require hospitals to provide itemized bills before sending a patient to debt collection. This new law allows the facility to provide the itemized bill electronically through a patient portal or via hard copies through mail or in person. The bill adds that if an itemized bill is provided electronically through a portal, the facility must determine whether the patient has an active patient profile on the portal, and if not, provide the physical copy to the patient. A patient, by request, may receive a copy of the itemized bill through the patient's chosen method of issuance. If a bill is mailed and it is returned as undeliverable or the patient's address was not current, the provider will not be subject to disciplinary action. Finally, the bill clarifies that providers are only required to keep itemized bills for as long as required under record retention laws.

Effective September 1, 2025.

Upfront Price Estimate for Elective Procedures

HB 1314 by Rep. Hickland & Sen. Hughes

Recent Texas laws have focused on engaging patients to be smart shoppers of health care services. This bill continues those efforts, shortening timelines for providing patients with an upfront estimate of charges. This bill revises provisions governing the billing policies of an ambulatory surgical center, birthing center, hospital, or freestanding emergency medical care facility. Currently, these facilities are required to provide an estimate not later than the 10th business day after the date on which it is requested. Instead, this bill requires the estimate to be emailed to the patient within five business days.

Current federal rules also allow consumers to dispute final billed charges if they exceed the estimate by $400 or more. This bill requires estimates to include information on how to dispute charges pursuant to those federal rules. If a facility fails to comply with the bill's provisions, the facility would be prohibited from taking any third-party collection action against a

consumer, reporting the consumer to a credit bureau, or pursuing an action against the consumer. Finally, the bill repeals a provision requiring DSHS to develop a consumer guide to health care.

Effective September 1, 2025.

Caps Uninsured Hospital Cash Pay Prices

HB 1612 by Rep. Frank & Sen. Kolkhorst

Uninsured patients frequently face higher hospital bills than insured patients, with no protection from a hospital's unilaterally set "billed charges". HB 1612 addresses this by setting clear limits on what hospitals can charge uninsured patients who choose to pay directly.

Under the bill, an uninsured patient may request to make a direct payment within 60 days of receiving hospital services. If the patient requests this direct payment option, the hospital's charges are limited to an amount that is no greater than:

- 25% above the hospital's "amounts generally billed," as defined by federal rules, or
- 50% above the hospital's lowest contracted rate with any health insurance provider (excluding rates from Medicaid, CHIP, or Medicare).

Effective September 1, 2025.

Expands MRF Price Transparency to ASCs, FSERs

SB 331 by Sen. Kolkhorst & Rep. Frank

This bill adds freestanding emergency medical care facilities, birthing centers, ambulatory surgical centers, and other facilities to the hospital cost disclosure law. This law requires facilities to provide machine-readable files that contain a list of standard charges, as well as a consumer-friendly list of shoppable services. However, the bill clarifies that the law does not apply to facilities that have a gross revenue of less than $10 million. The bill also applies existing administrative penalties to the new facility types, which include corrective action plans and then fees that accrue daily based on the facility's total gross revenue.

Effective immediately and facilities must begin disclosing prices by August 31, 2029.

Biennial Health Coverage Reference Guide

SB 1307 by Sen. Cook & Rep. Vo

This bill requires the Texas Department of Insurance (TDI) to develop and publish a biennial reference guide designed to educate the public about health coverage in the state. The guide will include a shopping guide, an explanation of out-of-pocket costs, an overview of programs that may assist consumers in obtaining coverage, resolving disputes with an insurer, information on filing complaints, and information on coverage regulated by the state.

Effective September 1, 2025, and TDI must publish the first guide no later than January 1, 2026.

Limits Health Provider Noncompete Agreements

SB 1318 by Sen. Schwertner & Rep. Bonnen

SB 1318 sets clear limits on noncompete clauses used in employment contracts for physicians, dentists, nurses, and physician assistants.

The bill specifically limits noncompete buyout amounts to no more than the provider's total annual salary and wages. Noncompete agreements cannot last longer than one year following termination of employment and cannot extend geographically beyond a five-mile radius.

Additionally, for physicians specifically, the bill prohibits enforcing a noncompete agreement if the physician's employment was involuntarily terminated without good cause.

Effective September 1, 2025.

Key Legislation Increasing Access to Health Care

Texas continues to face serious challenges in health care access, especially in rural and underserved communities. Texas is on track to meet just 59% of its primary-care physician needs and will be short roughly 56,000 registered nurses by 2036. Mental-health access is even worse: 246 of the state's 254 counties are federal shortage areas, and psychiatrist demand already exceeds supply by more than 50%. Nearly 80% of physicians practice in the five largest metro areas, leaving many rural communities without adequate care.

Lawmakers responded this session by passing legislation that expands Texans' ability to get timely, quality care. Key bills simplify licensing processes for doctors, nurses, and other providers, making it easier to practice in Texas. Other measures focus on supporting veterans' mental health services, expanding crisis-response resources, and improving early diagnosis and treatment for chronic conditions. Collectively, these laws take important steps toward ensuring more Texans receive the care they need when they need it.

Establishes Statewide Sickle Cell Disease Registry

HB 107 by Rep. Simmons & Sen. West

HB 107 establishes a statewide Sickle Cell Disease (SCD) Registry within the Texas Department of State Health Services (DSHS). The registry will provide a single, accurate source of information about sickle cell disease cases across Texas. Health care facilities must report data on SCD cases to DSHS, and all data collection must comply with HIPAA, the Occupations Code, and other applicable privacy laws.

The registry is intended to improve health care access, promote earlier diagnosis, guide health policy decisions, and ensure medical professionals have essential information to effectively treat sickle cell patients. DSHS will submit annual reports to the legislature summarizing information collected through the registry.

Effective September 1, 2025.

Expands Direct Primary Care

HB 541 by Rep. Shaheen & Sen. Zaffirini

This bill broadens the current "direct primary care" law by allowing any physician or health care practitioner to enter into a "direct patient care" agreement. A direct patient care agreement would be defined as a signed written agreement under which a physician or health care practitioner would agree to provide health care services to a patient in exchange for a direct fee for a period of time. These agreements are exempt from insurance regulation. The bill maintains the current prohibition on billing insurance for these "direct" services.

Effective immediately.

Simplifies Military Veteran MD Licensure

HB 879 by Rep. Frank & Sen. Blanco

This bill allows physicians, nurses, and physician assistants who are licensed in another state and who served in the armed forces in this state as a physician, nurse, or physician assistant to receive a license in this state. The provider would have to have been honorably discharged and they will be required to take state jurisprudence exams. The provider is also ineligible if they have a disciplinary action pending in another jurisdiction.

Effective September 1, 2025.

Telehealth Documentation & Consent

HB 1700 by Rep. Fairly & Sen. Sparks

This bill requires state agencies that regulate health professionals delivering telemedicine, teledentistry, or telehealth services to adopt standardized rules governing consent-related documentation. The rules must establish uniform formats and requirements

for how providers obtain and retain documentation of patient consent for treatment, data collection, and data sharing. Additionally, the bill requires agencies to address appropriate standards of care for documenting consent in audio-only telehealth interactions.

Effective September 1, 2025.

Study on Veterans' Mental Health Services

HB 1965 by Rep. Garcia & Sen. Menéndez

This bill requires the Texas Veterans Commission (TVC) to conduct a study to evaluate strategies to improve and expand mental health services provided through the commission's Military Veteran Peer Network. The bill requires the study to include recommendations on expanding the number of certified peer service coordinators who provide mental health services to service members, veterans, and their families. The study also will have to focus on the provision of certified peer service coordinators in rural communities. The commission is required to submit a report to the Legislature containing the study's results and recommendations for action by December 1, 2026.

Effective immediately.

Simplifies Foreign MD Licensure

HB 2038 by Rep. Oliverson & Sen. Kolkhorst

HB 2038 creates a simpler pathway for physicians licensed in other countries to practice medicine in Texas. Physicians who qualify under this bill can obtain a provisional license to practice initially within a residency program. After renewal, they may practice in rural or medically underserved areas. Following successful completion of required examinations, these physicians become eligible for full medical licensure. The bill excludes physicians from countries identified as posing a national security threat to the United States.

Additionally, HB 2038 establishes a physician graduate license, allowing physicians who have completed medical school but not residency to practice under supervision by a fully licensed physician.

Effective September 1, 2025.

Nursing Retaliation & Overtime Protections

HB 2187 by Rep. Howard & Sen. Hancock

This bill requires HHSC to establish a website for nurses to report violations of safe staffing or mandatory overtime laws. The bill then gives HHSC the authority to investigate violations. The bill also prohibits hospitals from retaliating against nurses who report violations of the staffing committee law.

Effective September 1, 2025.

Nursing School Consolidated Application

HB 2851 by Rep. Howard & Sen. Kolkhorst

This bill requires organizations that provide consolidated application services for medical or dental schools, including the application service operated through the UT System, to include applications for nursing schools. The bill also develops an advisory committee to develop recommendations and assist with implementing the law.

Effective September 1, 2025.

Forms Local Health Workforce Advisory Board

HB 3800 by Rep. Orr & Sen. Sparks

This bill requires HHSC to establish an advisory board to develop a resource guide that facilitates collaborations among health care providers and higher education institutions in addressing workforce needs. The board includes institutions, licensing boards, and members representing hospital and long-term care associations.

Effective September 1, 2025.

Health Professions Workforce Coordinating Council

HB 3801 by Rep. Orr & Sen. Cook

This bill creates the Health Professions Workforce Coordinating Council, which is attached to DSHS. The Council includes members from relevant state agencies, as well as four members appointed by the governor with relevant health care experience. The council biennially develops a strategic plan, defining targeted goals and objectives for the workforce, identifying immediate needs, and

proposing recommendations. The council also creates a workgroup, which would identify sources of information and build data analysis models to monitor historical growth of health professions.

Effective September 1, 2025.

Expands PT Direct Access

HB 4099 by Rep. Harris Davila & Sen. Perry

This bill changes the current licensing limitation that allow a physical therapist to treat a patient for only 15 days without a referral if they hold a doctoral degree and 10 days for a PT without a doctoral degree. Under the new law, PTs will be allowed to treat patients without a referral for 30 calendar days. As currently prescribed by law, PTs practicing under this exception are required to provide notice to a patient that their insurance may not cover the services.

Effective September 1, 2025.

Single License for a Hospital & Mobile Stroke Unit

HB 4743 by Rep. Bonnen & Sen. Campbell

This bill authorizes the Department of State Health Services to issue one license for a hospital and its mobile stroke unit if the mobile stroke unit is accredited by a health care accreditation organization approved by the Centers for Medicare and Medicaid Services. The bill exempts mobile stroke units licensed under the bill from the requirement to post a hospital license in a conspicuous place on the licensed premises and requires the executive commissioner of the Health and Human Services Commission to adopt rules necessary to implement this authorization as soon as practicable after the bill's effective date.

Effective September 1, 2025.

Report on Opioid Antagonist Programs

HB 4783 by Rep. VanDeaver & Sen. Hancock

This bill requires the Health and Human Services Commission (HHSC), no later than October 1 of each even-numbered year, to prepare a report evaluating the distribution of opioid antagonists in Texas to reverse and prevent opioid overdoses. The report will be submitted to the governor, the lieutenant governor, and the speaker of the House of Representatives. The bill defines "opioid antagonist" as any drug that binds to opioid receptors and blocks or otherwise inhibits the effects of opioids. The bill requires HHSC, in preparing the report, to coordinate and consult with each state agency and institution of higher education that receives funding or other resources for the distribution of opioid antagonists.

Effective September 1, 2025.

Supports 988 Crisis Line & BH Services

HB 5342 by Rep. Landgraf & Sen. Menéndez

This bill creates a 988 suicide and crisis lifeline trust fund, held by the comptroller. The fund consists of legislative appropriations, available federal funding, and grants and donations. The funds will be used to implement, maintain, and improve the lifeline, provide funding for crisis outreach, provide funding for uninsured individuals, and administer the trust. HHSC will be allowed to impose a service fee to supplement funding on local exchange access lines, wireless connections, and prepaid wireless services.

Effective September 1, 2025.

Dementia Prevention & Research Institute of Texas

SB 5 by Sen. Huffman & Rep. Craddick

This bill creates the Dementia Prevention and Research Institute of Texas. The Institute will create and expedite research on dementia, Alzheimer's, Parkinson's, and related disorders by awarding grants and collaborating with state agencies. The Institute will be responsible for monitoring progress of awardees and ensuring compliance with the terms of grants. The bill requires the passage of a constitutional amendment that transfers $3 billion from state general revenue to become effective.

Effective December 1, 2025 if the constitutional amendment authorizing funding is passed by voters.

Community Mental Health Grants for Veterans

SB 897 by Sen. Blanco & Rep. Lopez

This bill lowers the grant match requirement for mental health programs serving veterans and their families from 100% to 75% for counties with over 250,000 residents.

Effective September 1, 2025.

Expands Access to Investigational Treatments

SB 984 by Sen. Bettencourt & Rep. King

This bill allows health care facilities to provide investigational treatments to patients if the facility is operating under a federal assurance for the protection of human subjects. The patient is eligible to access the treatment if they have a life-threatening or debilitating illness, has considered all other treatment options, and consented to the treatment. A health benefit plan or governmental agency may, but is not required to, provide coverage for the investigational treatment.

Effective September 1, 2025.

Texas Mental Health Profession Pipeline Program

SB 1401 by Sen. West & Rep. Davis

This bill establishes the Texas Mental Health Profession Pipeline Program. Participating institutions of higher education are responsible for providing a clear, guided pathway for public junior college students to transfer into programs leading to a licensure in psychology, professional counseling, psychiatric advanced practice nursing, social work, or marriage and family therapy. The higher education institution is required to partner with one or more junior colleges to ensure that the student does not lose any credits earned before transferring, can earn a baccalaureate degree in less than two years, and is automatically admitted to a postbaccalaureate program if they meet minimum academic requirements. It also requires each participating institution to report to the Higher Education Coordinating Board statistics on the effectiveness of their program.

Effective September 1, 2025.

Diabetes-Related Amputations Prevention Study

SB 1677 by Sen. Menéndez & Rep. VanDeaver

The bill directs the Texas Higher Education Coordinating Board to designate a university to conduct a study on the prevention and reduction of diabetes-related amputation. In developing the study, the university must develop recommendations, best practices, and policy solutions including insurance coverage for therapies designed to treat diabetic foot ulcers. The university must consult with public health professionals, providers, patients, and other individuals they deem necessary. The university shall submit a report to the Department of State Health Services not later than September 1, 2026.

Effective September 1, 2025.

Budget Overview & Fiscal Outlook

The Texas Legislature approved a $338 billion two-year budget for fiscal years 2026-2027, an increase of approximately $17 billion (5%) from the previous biennium. General Revenue (GR) funding totals $149 billion, with the remaining funds sourced from federal dollars and dedicated state revenues.

Lawmakers entered the 89th Session with $194.6 billion available for general-purpose spending, marking a slight 1.1% decrease from the prior budget cycle. The Comptroller projected $176.4 billion in GR-related collections, supported by a $23.8 billion carryover, primarily from unspent education funds and agency savings.

Key Highlights:

- **Education & Property Tax Relief:** Major investments in public education, substantial teacher pay raises, and significant property tax reductions.
- **Health & Human Services:** Addresses potential shortfalls in federal funding for Medicaid and CHIP, allocating targeted investments in health programs and increased funding to meet caseload demands.
- **Supplemental Budget:** Additional supplemental spending for the current fiscal cycle (ending August) has also been approved. HB 500, the supplemental budget bill, appropriates $982.7 million in General Revenue Funds to the Health and Human Services Commission (HHSC), including $750.0 million for Medicaid. HHSC did not have a Medicaid shortfall for FY 2025.

SB 1 Budget

SB 1 Summary

HB 500 Supplemental Budget

Revenue & Reserves:

- **Total Revenue:** Projected at $362.2 billion, including $115 billion in federal funds and $70.7 billion in dedicated state revenues.
- **Economic Stabilization Fund:** Expected to reach its constitutional cap of $28.5 billion by the biennium's end.

Medicaid Funding— General Appropriations Act

General Appropriations Act for 2026–2027
SB 1 Sen. Huffman & Rep. Bonnen

Health & Human Services (HHS) For the 2026–27 biennium, the Legislature appropriated $105.7 billion in All Funds for HHS, an increase of $4.9 billion, including $45.7 billion in GR and GR-Dedicated Funds (up $1.9 billion). Key drivers included caseload growth in Medicaid ($5.9 billion) and CHIP ($1.4 billion), a contingency fund increase ($152.7 million), and reductions in behavioral health and expiring federal COVID-19 aid.

Medicaid Funding and Growth

For the 2026–27 biennium, the Texas Legislature allocated $82.6 billion in All Funds for Medicaid, a substantial increase of $6.2 billion over the previous biennium. General Revenue (GR) funding totals $32 billion, up $2.7 billion.

Caseload growth has stabilized, but a smaller portion of Medicaid is funded by Federal Funds due to less favorable federal matching rates (FMAP), increasing Texas's reliance on paying for Medicaid with state tax dollars. The budget fully funds caseload growth, but does not fully cover anticipated increases due to medical inflation, patient acuity, or higher utilization, potentially posing future budget challenges.

Medicaid Budget Breakdown

- **$75.9 billion**—direct client services.
- **$2.4 billion**—Medicaid-supported programs.
- **$4.3 billion**—Medicaid administration and related program support.

Key Drivers of Medicaid Growth

- **$5.9 billion** increase for client services (reflecting caseload demands).
- **$0.3 billion** increase for Medicaid-supported programs.
- Slight administrative cost reductions (**less than $0.1 billion**).

Key Funding Initiatives

Systems & Technology Investments

- **TIERS Upgrade:** $481.9 million to fully upgrade the Texas Integrated Eligibility Redesign System (TIERS).
- **Provider Enrollment System:** $23 million and 14.7 FTEs to enhance the Medicaid Provider Enrollment Management System (PEMS).

Rural Health Support

- **Innovation Grants:** $50 million allocated for rural hospital innovation grants.
- **Stabilization Grants:** $50 million to maintain existing rural hospital stabilization grants (contingent on HB 18).
- **Pediatric Teleconnectivity:** $20 million to improve pediatric teleconnectivity in rural hospitals.

Women's & Maternal Health

- **Mobile Health Units:** $20 million to expand mobile women's health units (an increase of $10 million).
- **Maternal Health Grants:** $5 million for community grants aimed at improving maternal health outcomes.
- **Quality & Safety Initiatives:** $10 million to support maternal health quality and safety improvements.

Transparency & Efficiency

- **All-Payor Claims Database (APCD):** $9 million to support the Texas APCD, ensuring statewide health care price and cost transparency **(Rider 12)**.
- **Cost Containment:** Requires HHSC to achieve at least $550 million in GR cost containment savings, an increase from $450 million **(Rider 33)**.

Medicaid Provider Rate Increases

- **Hospital Payments:** $360 million for trauma care, $300 million for safety-net hospitals, $63 million for rural inpatient/outpatient services, and $15.2 million for rural hospitals with OB-GYN departments **(Rider 8)**.
- **Attendant Wage Increase:** $2.4 billion to increase attendant base wage to $13/hr and raise payroll and administrative rates **(Rider 23)**.
- **Maternal Fetal Radiology:** $13.6 million for a 10% Medicaid rate increase **(Rider 24)**.
- **Nursing Facility Rates:** $533.8 million to increase dietary and administrative reimbursements (90% directed to specified costs, contingent on SB 457) **(Rider 25)**.
- **Applied Behavior Services:** $31.1 million to raise reimbursement rates to $14.50 per unit **(Rider 30)**.
- **IDD Nursing Facilities:** $4 million to align reimbursement rates with Medicare equivalents for specialized facilities **(Rider 31)**.
- **Medicaid Dental Rates:** Requires HHSC to revert most dental rates to 2/28/25 levels (excluding updated codes), then apply capped, uniform increases to keep spending in line with 3/1/25 policy **(Rider 39)**.

Health Care and Medicaid Budget Riders

Medicaid Enterprise Systems
Rider 6

Establishes an Executive Steering Committee to oversee Medicaid Enterprise System (MES) contracts and Medicaid Management Information System (MMIS) modernization projects. Requires timely reporting of project progress and potential delays or cost overruns to the Legislative Budget Board (LBB).

Hospital Payment
Rider 8

Allocates $1.1 billion (AF) in Medicaid hospital add-on payments:

- $360M for trauma care systems
- $300M for safety-net hospitals
- $132.8M for outpatient services
- $90.4M for rural hospital inflation adjustments
- $123.5M for maintaining rural hospital Medicaid reimbursement levels
- $63M for $1,500 Medicaid add-on payments for rural hospital labor and delivery services
- $63M for increasing Medicaid inpatient/outpatient rural hospital reimbursement
- $15.2M for rural hospitals with OB-GYN departments

HHSC must ensure managed care plans distribute funds as intended and develop methodologies to cap non-emergency outpatient ER services at 65% of cost.

Increase Consumer-Directed Services
Rider 9

Requires HHSC to educate STAR+PLUS clients about Consumer Directed Services (CDS), set incremental benchmarks for CDS enrollment, and collect annual MCO reports detailing CDS participation progress.

Medicaid Therapy Services Reporting
Rider 10

Requires HHSC to report annually (instead of biennially) on Medicaid therapy service accessibility and utilization.

Interest List Reporting
Rider 17

Directs HHSC to publish detailed monthly data online for HCBS, CLASS, DBMD, TxHmL, STAR+PLUS, and MDCP waiver programs, including counts, interest list release data, wait times, and eligibility outcomes.

Hospital Reimbursement
Rider 18

Directs HHSC to adopt a prospective Medicaid inpatient hospital payment system, pending federal approval, to reflect costs, reduce payment variation, and include adjustments for rural hospitals.

Temporary FTE Authority for Medicaid Unwinding
Rider 22

Provides 642 temporary FTEs each year to manage the workload associated with Medicaid continuous coverage unwinding.

Base Wage Increase for Personal Attendants
Rider 23

Allocates $2.4 billion (AF) to increase personal attendant base wages to $13/hour. Includes payroll taxes, benefits increases (15% residential, 14% non-residential), and administrative rate adjustments. HHSC must verify compliance via biennial cost reporting and annual reviews.

Maternal Fetal Radiology Rate Increase
Rider 24

Allocates $13.6 million (AF) to increase Medicaid reimbursement rates for maternal fetal medicine radiology by 10%. Requires managed care plans to pass increases directly to providers.

Nursing Facility Rate Increase
Rider 25

Provides $533.9 million (AF) to increase dietary and administrative reimbursement rates for nursing facilities. At least 90% of funds must directly support specified costs (contingent on SB 457).

Provider Enrollment and Management System (PEMS)
Rider 28

Provides $23 million (AF) and 29.7 FTEs to enhance the Provider Enrollment and Management System.

Electronic Visit Verification (EVV) Fraud Prevention
Rider 29

Requires HHSC to establish strict criteria for compliance grace periods in EVV, report frequency of exceptions, and implement these measures by February 1, 2026.

Applied Behavior Analysis Rate Increase
Rider 30

Provides $31.1 million to raise Medicaid reimbursement rates for applied behavior analysis services to $14.50 per unit. Requires reporting from MCOs on compliance and utilization.

IDD Nursing Facility Rate Increase Rider 31

Allocates $4 million (AF) to match Medicaid reimbursement rates for specialized IDD nursing facilities (≥90% IDD residents) with Medicare-equivalent rates, mandating annual HHSC rate review.

Cost Containment Initiatives Rider 33

Requires HHSC to achieve at least $550 million in General Revenue savings by reducing fraud, maximizing federal Medicaid flexibility, enhancing administrative efficiency, and utilizing telemedicine.

Credentialing for STAR Health Providers Rider 34

Directs HHSC to streamline provider credentialing for the STAR Health managed care program, especially for mental and behavioral health, to improve access to qualified providers.

Nutritional Support Services Rider 35

Allows HHSC to authorize managed care organizations to provide nutritional support services tailored to health outcomes as an alternative Medicaid benefit in lieu of a service or setting covered under the state plan. When determining nutritional support services to include in MCO contracts, HHSC must consider nutrition counseling and instruction services specifically tailored to individual health risks or those demonstrating proven health outcome improvements.

Pediatric Care Center Rate Review Rider 36

Requires HHSC to annually review Medicaid reimbursement rates for pediatric care center services.

Medicaid and CHIP Residency Verification Rider 37

Requires HHSC to verify the Texas residency of Medicaid and CHIP clients at least monthly to ensure only eligible Texas residents receive benefits. The rider authorizes HHSC to contract with third-party vendors to identify and recover improper capitation payments made for individuals determined not to be Texas residents.

Medicaid Dental Reimbursement Rate Adjustment Rider 39

Requires HHSC to revert most Medicaid dental reimbursement rates to the levels in effect on February 28, 2025, except for any procedure codes already adjusted during the March 1, 2025 biennial review—in which case those updated rates remain in effect. After adjusting to the baseline February rates, HHSC must apply a capped, uniform percentage increase to the specified list of dental procedure codes. The rider limits these new rate increases as necessary to ensure total expenditures for dental services align with projected spending under the policy established on March 1, 2025.

Community Mental Health Grants Rider 50

Allocates $235.5 million (GR) for community mental health grants, requiring detailed annual reporting on utilization and effectiveness.

Rural Hospital Telepsychiatry Rider 52

Provides $7.4 million for telepsychiatry consultations in rural hospitals through statewide telepsychiatry networks, staff training, and quality improvements.

Intermediate Care for Complex Patients Study Rider 56

Directs HHSC to study and propose a pilot for residential intermediate care for complex individuals with severe mental illness, traumatic brain injury, or IDD, submitting recommendations by October 15, 2026.

Women's Health Funding (Informational Listing) Rider 75

Specifies use of existing funds, including $98M (Healthy Texas Women), $147.1M (Family Planning), $6.9M (Breast/Cervical Cancer Services), and $20M to expand mobile health units, requiring advance notification of adjustments.

Maternal Health Outcomes Program Rider 77

Allocates $5 million for maternal health outcome grants focused on reducing obstetric complications, improving administrative and technical support, and increasing program participation.

Texas Colorectal Cancer Initiative
Rider 92

Allocates $10 million for colorectal cancer treatment for uninsured and underinsured Texans (≤200% FPL), requiring exploration of available federal matching funds.

Rural Hospital Grant Program
Rider 93

Provides $100 million for rural hospitals to recruit health professionals, stabilize finances, improve maternal care, fund innovative rural health models, and support essential access grants. HHSC must report detailed outcomes annually.

Office of Inspector General Quarterly Reports
Rider 120

Requires detailed quarterly reports on managed care fraud prevention challenges, strategies, referrals to the Attorney General's Medicaid Fraud Unit, lock-in program participation, potential recoveries, and related OIG training activities.

Texas Pharmaceutical Initiative (TPI)
Rider 124

Provides 25.6 FTEs annually and appropriates carried-forward funds. Requires quarterly reports on budget, FTE usage, significant adjustments, and active business plan progress to the LBB and Governor's Office.

Use of Trauma Fund Receipts
Article II Sec. 15

Mandates the transfer of $80.1 million from DSHS to HHSC from Trauma Facility/EMS Account No. 511 to fund Medicaid trauma care and safety-net hospitals.

Texas All-Payor Claims Database (APCD)
Article III Rider 12

Allocates $9 million to UTHealth's Center for Healthcare Data to enhance healthcare transparency statewide. Requires HHSC, ERS, TRS, and TDCJ to submit claims data. Database usage is free for state agencies and low-cost for others.

DSH Payments to State-Owned Hospitals
Article IX Sec. 10.02

Clarifies that Disproportionate Share Hospital payments made to state-owned hospitals are considered replacement funds and must follow Comptroller rules, returning funds to the original accounts from which transfers occurred.

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