TAHP

Texas Association of Health Plans

83rd Texas Legislature

HEALTH PLAN HIGHLIGHTS

2013

Dear TAHP Member:

The Texas Legislature's 83rd Regular Session has concluded. For TAHP and its members, the session will likely be remembered as one of the most challenging for health plans in many years.

A new executive director and legislative team at TAHP; new legislators, many with preconceived notions about the role of insurance in health care; an almost entirely new House Insurance Committee; a legislature divided on the appropriate approach to Medicaid expansion; and resistance to the impending implementation of the Affordable Care Act converged to present what seemed to be a daunting session headed for disaster.

I am happy to report the worst has been avoided. Despite the filing of more than 300 bills, our organization succeeded in mitigating the consequences of proposals that would have undermined health plans' ability to promote affordability and access to quality health care.

After hundreds of hours of work at the Capitol by your TAHP team and leadership, combined with my more than 50 appearances before committees to testify, we succeeded in ensuring the industry's voice was heard and the full impact of the many misguided proposals were understood.

We know that the session's end marks the beginning of the next phase of change for health care in Texas and across our country. There are indeed more challenges ahead, but I am confident that our same formula of hard work, education and preparation will place our industry in the strongest possible position to navigate these uncertain times.

Thank you to the TAHP leadership, health plan members, staff and legislative allies that contributed to the results of the session. Our association stood strong and health plans in Texas are in a better place because of our work together.

Following is a summary of the health plan highlights from the Legislature's 2013 regular session. I hope you find this information useful and I look forward to working with you to pursue our common goal of continuing to offer access to affordable health care for all Texans.

Warmest regards,

David Gonzales
CEO/Executive Director

TAHP

Table of Contents

New Texas Insurance Commissioner Appointed

The Texas Senate's failure to confirm Eleanor Kitzman as the Texas Insurance Commissioner during the state's 83rd Regular Session effectively ended her tenure in the role she had occupied since 2011. In response, Gov. Rick Perry appointed Julia Rathgeber of Austin to the position on May 27 for a term to expire on February 1, 2015.

Rathgeber's career includes service as the deputy chief of staff for Lt. Gov. David Dewhurst as well as tenures at the state's General Land Office and the Texas Commission on Environmental Quality.

Dewhurst praised Rathgeber's appointment, touting her "sharp intellect, proven leadership ability and thorough knowledge of the ins and outs of state government."

During the 83rd 1st called special session, the Senate Nominations Committee voted unanimously (6-0), approving of Commissioner Rathgeber's appointment. The committee's recommendation was later confirmed by the Senate.

Texas to Have Federal Exchange

The Affordable Care Act (ACA) provides that an online insurance market to be known as a Health Insurance Exchange is to open in every state October 1, 2013. The ACA provides states the option of managing their own Exchanges, create a state-federal partnership for their Exhanges or default to a federally managed Exchange. The 83rd Texas Legislature adjourned its Regular Session without adopting a Texas Health Exchange meaning the state's Exchange will be managed by the federal government.

The Exchange will offer standardized benefit plans and varying levels of coverage based on the actuarial value of the benefits offered. Insurers wishing to sell plans on the Exchange are required to undergo a certification process with the Centers for Medicare and Medicaid Services to become a qualified health plan. To date, there has been no announcement of the insurers that are seeking to become qualified health plans in Texas or the cost of the benefit plans that will be offered.

Seventeen states elected to create their own Exchange, seven opted for a state-federal partnership Exchange, and 27 states chose to allow the federal government to run their Exchange. The Congressional Budget Office has estimated that approximately 24 million people will purchase coverage through Exchanges by 2019.

No Medicaid Expansion in Texas

The Texas Legislature declined to expand Medicaid this session and instead took steps to make it more difficult to do so in the future. Lawmakers approved a bill that would prevent the state from expanding Medicaid in the future without legislative approval.

An attempt to create a "Texas solution" was advanced as legislation and floor amendments but failed. The measures proposed to use federal Medicaid expansion funding to allow qualified individuals to purchase coverage in the private market. The concept would have required federal approval.

The U.S. Supreme Court ruled last year that states cannot be forced to expand Medicaid eligibility.

During the session, TAHP sought to balance health plan interests relative to competing state and federal visions for health care reform. In the end, the Legislature's overwhelming opposition to federal expansion of Medicaid or to exploring a Texas alternative to Medicaid expansion prevailed.

COMMERCIAL HIGHLIGHTS

Transparency legislation addressing uncertain and arbitrary pricing of medical products and services dominated the 83rd Regular Legislative Session. Consumer concerns, specifically "balanced billing" practices served as the basis for many bills seeking disclosure of true costs, billed charges and paid claims in the commercial health insurance market. Strict disclosure requirements of hospitals, health care practitioners and health plans failed.

Many other bills intended to regulate provider contracting arrangements for in-network and out-of-network providers were filed this session, including the following issues; contracting terms and conditions, reimbursement, expedited credentialing, and restrictions in terminating provider contracts - many of those bills failed as well.

The combined efforts of our internal staff, member companies' government relations teams, and external lobby consultants helped ensure the industry's voice was heard and succeeded in avoiding the full impact of many misguided proposals during the session. Hundreds of hours went into representing our perspectives on more than 100 bills heard before Senate and House Committees. This report provides the highlights of bills that passed, some with our support and some with our opposition.

Health Plan Contracting

Thirteen bills were introduced that proposed to dictate contracting arrangements with network and non-network providers, mandate credentialing procedures, fix provider rates and require disclosure of provider fee schedules and actual payments. Two bills passed as follows:

Silent PPO

SB 822 (Sen. Schwertner/ Rep. Eiland)

Requires that a health plan or third party administrator not sell, lease, or otherwise transfer information regarding the reimbursement terms of a provider network contract without the provider's consent, obtained through a separate signature line for each line of business.

Provider Fee Schedules

SB 1221 (Sen. Paxton/Rep. Smithee)

Prohibits a health plan that contracts with a Medicaid/CHIP provider from requiring the health care provider to contract for discounted fees and rates for use with health benefit plans issued to individuals and groups in the commercial market, without proper written notice.

Benefit Mandates

There were numerous bills that proposed mandated benefits, three bills passed. Qualified health plans participating in the Exchange are exempt from these mandates if they exceed the specified essential health benefits required by federal law. The bills that passed were as follows:

Congenital Heart Disease

HB 740 (Rep. Crownover/ Sen. Deuell)

Requires newborn screenings for Critical Congenital Heart Disease CCHD, updates the guidelines for required newborn screenings, authorizes physicians to delegate the responsibility for screening tests, and modifies the Newborn Screening Advisory Committee at the Department of State Health Services.

Acquired Brain Injury

HB 2929 (Rep. Sheets/ Sen. Deuell)

Amends current statutory requirements of health benefit plan coverage for brain injury, prohibiting a health benefit plan from limiting the number of days of treatment without regard to therapy, treatment, testing, remediation, or other service. The bill establishes medical necessity with the treating physician for determining the number of days covered for post-acute care.

Screening and Treatment of Autism Spectrum Disorder

HB 3276 (Rep. Simmons/ Davis)

Requires health plans to provide coverage for screening a child for autism spectrum disorder at 18 and 24 months of age and treatment by a health care practitioner or an individual acting under the supervision of a health care practitioner.

Autism Spectrum Disorder

SB 1484 (Sen. Watson/L. Gonzales, Simmons and S. Thompson)

Requires that if a health benefit plan enrollee was diagnosed with autism spectrum disorder before the child's 10th birthday, the plan would provide coverage of generally recognized services without consideration of the enrollee's age.

Management of Prescription Drug Benefits

A number of bills were filed that set minimum standards for the contracting and management of prescription drug benefits by managed care plans. TAHP was successful in opposing all but one bill regarding audit processes with contracted pharmacies, as follows;

Pharmacy Audits

HB 1358 (Rep. Hunter/ Sen. Van de Putte)

Implements procedures and policies for audits of pharmacists and pharmacies.Requires that health plans and PBMs provide at least 14 days written notice of the audit and include in the notice the range of claims subject to the audit. Exceptions for providing notice include a reason to suspect a pharmacy of fraud or intentional misrepresentation. Specific requirements include the following:

- Requires that an audit report, including the amount of recoupment must be provided within 120 days of a preliminary report. The bill provides for pharmacy response and challenge to the audit findings.
- Auditing entities are prohibited from using "extrapolation" of a sample of audited claims to estimate results for a larger batch of claims.

Subrogation

One bill was adopted that placed limits on the contractual subrogation rights of certain health benefit plans and authorizes the courts to award attorney's fees in certain situations.

Limiting on the Subrogation Rights of Health Plans

HB 1869 (Rep. Price/ Sen. Duncan)

The bill exempts a worker's compensation insurance policy, Medicare, Medicaid medical assistance program or a Medicaid managed care program, CHIP, and self-funded ERISA Plans. The bill does entitle the payor to recover payments made and benefits provided to an individual covered by a plan who was injured by a third-party tortfeasor. The bill further specifies that all payors would be entitled to a portion of the recovery.

With respect to attorney's fees; If a covered individual was not represented by an attorney when seeking recovery, a payor's portion of the recovery would be limited to the lesser of:

- One-half of the covered individual's gross recovery; or
- the total cost of the benefits paid, provided, or assumed by the payor as a direct result of the third party's tortious conduct.
- When a plaintiff is represented by counsel, payors may share in 50% of plaintiff's recovery less attorney fees and procurement costs or actual costs, whichever is less. The attorney's fees for a payor who is relying on the plaintiff's attorney for recovery may agree to a fee structure - without an agreement, courts may award reasonable fees capped at 1/3 of payor's recovery.
- Subrogation against first party UM/UIM and medical payment is allowed unless it was paid for directly by the plaintiff or the plaintiff's immediate family.

Texas Department of Insurance Regulatory Oversight

14 bills were introduced that set stricter standards at TDI for the approval and review of rates and forms, initiate rate review, arbitration, and other regulatory oversight. None of these measures were adopted (See TAHP "Failed Bills" chart).

The following two bills were adopted:

Dissolution of the Texas Health Insurance Pool
SB 1367 (Sen. Duncan/ Smithee)

SB 1367 requires the Texas Health Insurance Pool board of directors to develop a plan for the orderly dissolution of the Pool, to be submitted to the Commissioner of Insurance for approval. The legislation requires that coverage will cease on the later of December 31, 2013 or the earliest date new guaranteed issue coverage is available, determined by the commissioner.

The bill would extend the Pool's authority to collect premium assessments until the insurance commissioner determined all of the Pool's financial obligations had been met. After making this determination, the Commissioner would issue a final assessment or refund any assessment surplus on a pro rata or otherwise equitable basis to health benefit plan issuers.

SB 1367 would also distribute $5 million from any surplus premium assistance funding provided by prompt payment penalties to the Texas Health Services Authority (THSA). Remaining premium assistance fund would support the Healthy Texas program until January 1, 2014, after which they would be used for any commissioner-authorized purpose to improve uninsured Texans' health insurance access.

Small Group Employer
SB 1332 (Sen. Duncan/ Smithee)

SB 1332 redefines "large employer" and "small employer" to base those definitions on the number of employees, rather than "eligible" employees the employer employs, changing the methodology for determining the number of employees consistent with federal criteria.

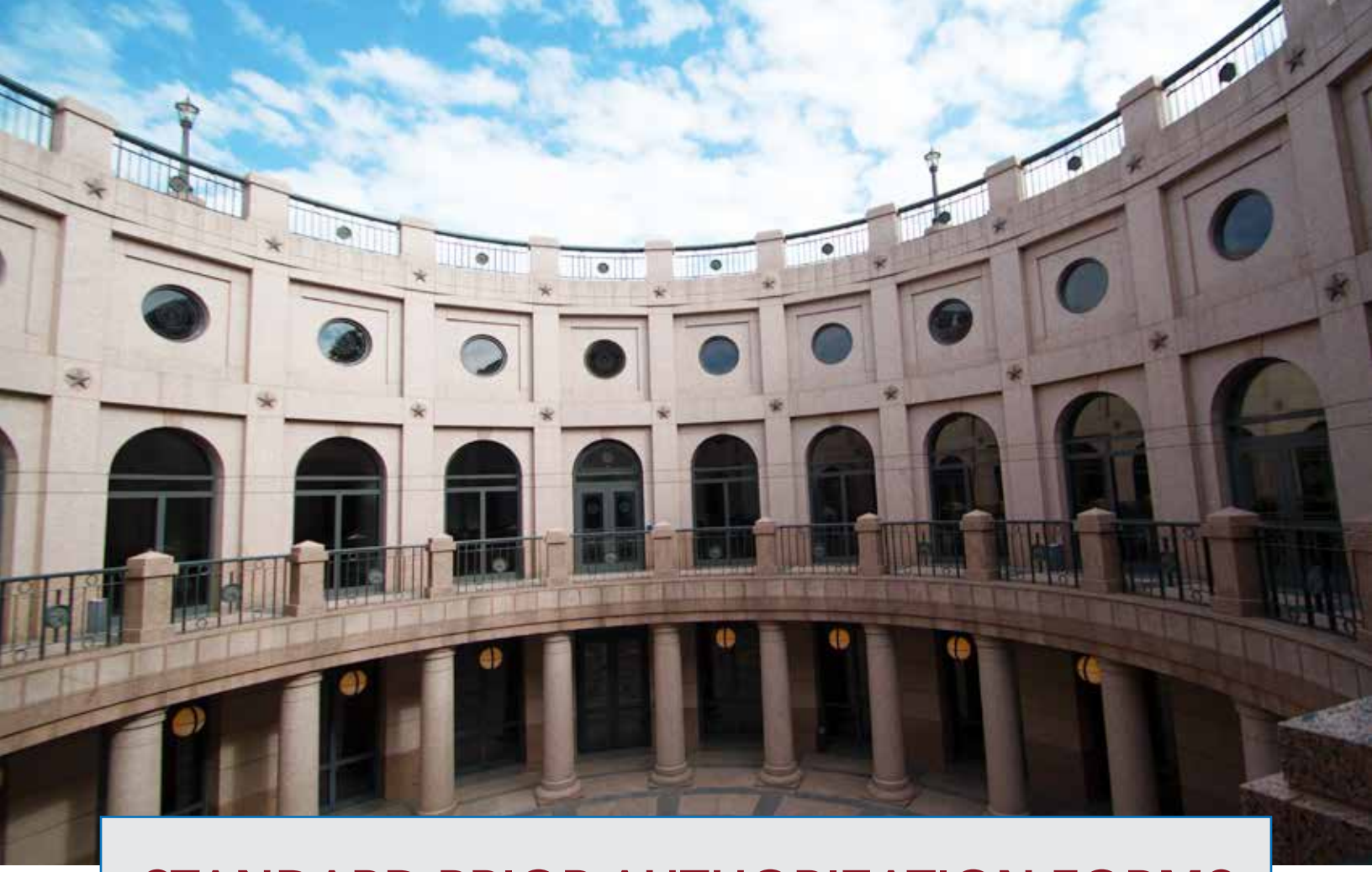
Current law defines a small employer as an entity that employs two to 50 employees. Federal law defines employer size based on the total number of employees. SB 1332 changes the state's method of determining employer classification in response to federal health insurance regulations that allow states to determine small group employers through 2016.

Professional Employer Organizations

Welfare Benefit Plans of Employer Organizations
SB 1286 (Sen. Williams/ Rep. Hunter)

Establishes that a client and holder of a professional employer organization license may sponsor retirement and welfare benefit plans for covered employees. The bill authorizes a licensed organization to sponsor a single welfare benefit plan under which eligible covered employees of one or more clients may elect to participate. The bill requires a fully insured welfare benefit plan offered to the covered employees provided by an authorized insurance company or a self-funded health benefit plan to be treated for purposes of state law as a single employer welfare benefit plan.

SB 1286 authorizes a licensed organization to sponsor a benefit plan that is not fully insured, if the organization meets certain requirements and is approved to sponsor the plan by the Commissioner of Insurance. The measure prohibits the commissioner from adopting a rule that requires clients or covered employees to be members of an association or group in the same trade or industry in order to be covered by such a plan. The bill requires the rules to include all requirements to be met by the licensed organization and the plan and sets out those requirements.



STANDARD PRIOR AUTHORIZATION FORMS

Standard Prior Authorization Form for Prescription Drug Benefits

SB 644 (Sen. Huffman/ Rep. Zerwas)

Standard Prior Authorization Form for Health Care Services

SB 1216 (Sen. Eltife/ Rep. Davis)

Two bills (SB 644 and SB 1216) were adopted directing the Texas Department of Insurance to appoint separate advisory councils to create standard prior authorization forms and procedures for pharmacy and medical benefits.

Both bills require the TDI Commissioner, not later than January 1, 2015, to create a single standard form for requesting prior authorization of prescription drug benefits and medical services as follows:

- The form is to be developed with input from an advisory committee appointed by the TDI Commissioner. The committee is to take into consideration national standards based on common criteria, specifications and electronic transmission of forms, including, technical, operational, and practical aspects, the length of the form, and the length of time allowed for acknowledgement of receipt of the form.
- Provides health plans two years from the date national standards for electronic prior authorization of benefits are adopted to implement prior authorization requests electronically with a prescribing provider who has e-prescribing capability and who initiates a request electronically.
- Provisions apply only to a request for prior authorization of prescription drug benefits and medical benefits made on or after September 1, 2015.

MEDICAID/CHIP HIGHLIGHTS

The 2013 Regular Session included a number of bills that challenged the role, value, and authority of health plans within the Medicaid and CHIP programs. Many of these measures included additional cost and administrative complexity for the state's Medicaid and CHIP programs with many being filed in response to the 2012 managed care expansion into new service areas.

Budget constraints, historically central to Medicaid and CHIP programs funding discussions, were less of a factor during the session due to a state budget surplus and positive economic outlook in the state. Without the pressure to cut billions of dollars out of the Medicaid program, legislators had relatively little interest in adopting a full pharmacy carve-in benefit despite the $74 million in potential savings to the state it would have provided.

In the end, TAHP Medicaid and CHIP health plans worked diligently to address a wide range of policies on the following issues:

Improved Efficiencies and Outcomes

Medicaid LTSS, IDD integration and Medicaid Outcomes Improvement
SB 7 (Sen. Nelson/ Rep. Raymond)

Medicaid FWA, and MTP Bill
SB 8 (Sen. Nelson/ Rep. Kolkhorst)

Among this session's key health care bills was SB 7 that provides for a redesigning of the delivery system for individuals with intellectual and developmental disabilities (IDD) in need of both acute care and long-term services and supports. The bill also expands and reforms Medicaid's STAR+PLUS (and STARKids) managed care program to provide basic attendant and habilitation services to individuals with IDD currently on waiting lists for services, further expands STAR+PLUS to the Medicaid Rural Service Area and carves nursing facility services into STAR+PLUS.

Senate Bill 8, another key reform bill focuses on Medicaid fraud detection measures, details provider marketing limitations, and proposes a new capitated transportation delivery model for Medicaid. TAHP was successful in clarifying that transportation benefits would occur outside of the MCO model.

SB 7 would expand the STAR+PLUS Medicaid managed care program to all areas of the state to serve individuals eligible for acute-care services and long-term services and supports. STAR+PLUS would also provide benefits to eligible recipients residing in nursing facilities. The bill establishes requirements for MCOs providing coverage in nursing facilities, including requirements related to reducing potentially preventable events, and unnecessary hospitalizations as well as mandatory 10-day turnaround time for processing clean claims for nursing homes, intermediate care facilities and group homes. It also requires HHSC approval for MCO across-the-board, unilateral reductions in provider rates, with a proposed 2015 sunset date on this requirement.

Administrative Simplification for Providers

Medicaid LTSS, IDD Integration and Medicaid Outcomes Improvement
SB 7 (Sen. Nelson/ Rep. Raymond)

Provider Protection Plan
SB 1150 (Sen. Hinojosa/ Rep. Guerra)

Standardization of prior authorization and credentialing processes

There were four bills filed mandating uniform standardized processes for prior authorization and credentialing within the Medicaid and CHIP programs - none passed. TAHP instead focused legislator's attention on SB 1150 that was directed at enhanced "provider protections." The final substitute for SB 1150 requires an HHSC-led workgroup to review and recommend reductions in claims processing times and other administrative simplification options, if feasible and appropriate. Numerous other related and more aggressive bills and/or amendments were not passed.

Reductions in claims turnaround time

SB 7 was the only bill with a specific reduction in claims turnaround time that passed, requiring:

- 10 day turnaround time for nursing homes, ICF and group homes,
- 30 days for LTSS and proof that these LTSS claims are paid on an average of 21 days, and
- 45 day turnaround for all other claims.

Pharmacy Benefits

Medicaid/CHIP pharmacy Carve-In Single Statewide Formulary
HB 595 (Rep. Kolkhorst/Sen. Nelson)

Pharmacy Audit Bill
HB 1358 (Rep. Hunter/ Sen. Van de Putte)

Medicaid MAC bill
SB 1106 (Sen. Schwertner/ Rep. Davis)

Medicaid/CHIP Single State Formulary

In spite of significant savings and MCOs' proven track record for improved quality, pharmaceutical interests worked to block efforts to create a single state formulary. As a result of their opposition, HB 595 and SB 7 were adopted

continuing the state's current Prescription Drug List (PDL). Interest in a rebate-driven state prescription drug formulary derailed the policy and political will to move toward a more sustainable, clinically sound Medicaid and CHIP drug benefit. As a result of HB 595 and SB 7, a single statewide formulary, managed by HHSC will continue through 2018.

Audits of Pharmacists and Pharmacies

TAHP participated with stakeholders in the development of HB 1358 regarding processes and procedures of pharmacy audits. HB 1358 requires that health plans and PBMs provide at least 14 days written notice of an audit and include in the notice the range of claims subject to the audit except for requests or inquiries into suspicion of fraud or intentional misrepresentation on submitted claims.

Maximum Allowable Cost (MAC) Rate Transparency and Disclosure

Significant debate on MAC transparency, public disclosure, and various proposed proscriptive formulas for determining MAC lists continued throughout session. SB 1106 passed as a result of significant collaboration and negotiations between all stakeholders interested in a bill reflecting a reasoned and improved process for determining adequate generic pricing for reimbursement. SB 1106 offers provider protections related to how frequently MAC lists are updated and identifies how MAC challenges will be managed.

MCO Network Adequacy, Rate Negotiation, & Contracting Measures

Medicaid LTSS, IDD integration and Medicaid Outcomes Improvement
SB 7 (Sen. Nelson/ Rep. Raymond)

Stakeholder Input Related to Medicaid MCO Quality Improvement
SB 1542 (Sen. Van de Putte/ Rep. Zerwas)

Integration of Medicaid Behavioral and Physical Health Services
SB 58 (Sen. Nelson/ Rep. Zerwas)

Utilization Review Process for STAR + PLUS MCOs
SB 348 (Sen. Schwertner/ Rep. Kolkhorst)

Provider Protection Plan
SB 1150 (Sen. Hinojosa/ Rep. Guerra)

Provider Due Process Related to OIG Payment Holds
SB 1803 (Sen. Huffman/ Rep. Kolkhorst)

Network Adequacy

SB 7 enhances network adequacy specific to Long Term Care Services and Supports (LTSS) providers and local mental health providers, in anticipation of the integration of individuals with intellectual and developmental disabilities (IDD) into managed care.

Enhanced Contract Management

SB 7 also focuses on the enhanced integration and improved outcomes of Medicaid and CHIP via a managed care model, including specific requirements for enhanced provider network reporting and new restrictions on the ability of MCOs to make unilateral, across-the-board rate reductions. TAHP worked closely with legislators and stakeholders

to improve the outcome of these requirements. In addition to SB 7, there were a number of other bills that passed adding oversight, reporting, and stakeholder input into MCO performance requirements including:

- SB 1542 (Van de Putte/Zerwas), with a new public process for stakeholder input related to MCO performance requirements;
- SB 58 (Nelson/Zerwas) and SB 126 (Schwertner/Davis) with provisions related to behavioral health comparative reporting;
- SB 348 (Schwertner/Kolkhorst) the substitute STAR+PLUS utilization review bill;
- SB 1150 (Hinojosa/Guerra), the provider protection bills; and
- SB 1803 (Zaffirini/Isaac) relating to provider protections for OIG payment holds.

The Season of Change

The season of change for health care in America is well under way. Here in Texas, we face not only the transformational changes mandated by the Affordable Care Act, but also the implementation of new state laws and regulations affecting EPOs, PPOs and other aspects of our operations. We face a time of significant adjustment not only in how we do business, but also how we strive to serve our customers.

It is imperative, perhaps now more than ever, that we step forward to advocate for legislative and regulatory measures that will strengthen health plans' ability to improve access, value and quality of care in our state.

Thank you for standing with TAHP.

TAHP will continue to provide leadership on your behalf in the days ahead.

OPERATIONAL MEMBERS

Aetna
Amerigroup Texas
AmeriHealth Mercy
BlueCross BlueShield of Texas
Christus Health Plan
CIGNA
Community First Health Plan
Community Health Choice
Cook Children's Health Plan
Driscoll Children's Health Plan
El Paso First Health Plan
FIRSTCARE
CIGNA-HealthSpring
Humana
KS Plan Administrators, LLC
Memorial Hermann Health Solutions, Inc.
Molina Healthcare of Texas
Parkland Community Health Plan
Scott & White Health Plan
Sendero Health Plans
Seton Health Plan
Superior Health Plan/Centene
Texas Children's Health Plan
UnitedHealth Group
WellCare of Texas
WellPoint

ASSOCIATE & AFFILIATE MEMBERS

AbbVie
Access2Care
AECC Total Vision Health Plan
Beacon Health Strategies, LLC
Biogen Idec, Inc
Block Vision of Texas, Inc.
Daiichi Sankyo
Eli Lilly
Endo Pharmaceuticals
Genentech
Gilead
HMS
LeFleur Transportation Texas
LogistiCare
Magellan
Medco Medical Supply
McGinnis, Lochridge, Kilgore, LLP
Merck
Navitus Health Solutions
Novo Nordisk
Sanofi
Sedgwick LLP
Sunovion Pharmaceutical
Vertex
Watson

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THE FOLLOWING LEGISLATION PASSED

HB 740 (Crownover/Deuell)	Newborn screening for congenital heart disease mandate
HB 1358 (Hunter/Van de Putte)	Audits of pharmacists and pharmacies
HB 1869 (Price/Duncan)	Contractual subrogation rights of benefit plan issuers
HB 2163 (Eiland)	Assessment on out-of-state insurers for the examination of insurers
HB 2645 (C. Turner/Ellis)	Certification and operation of Independent Review Organizations
HB 2929 (Sheets/Deuell)	Acquired brain injury mandate
HB 3105 (Morrison/Deuell)	Removing intoxication exclusions in accident and health insurance policies
HB 3276 (Simmons/Davis)	Screening and treatment of autism spectrum disorder
SB 365 (Carona/Parker)	Expedited credentialing for podiatrists providing services under a managed care plan
SB 411 (Carona/Eiland)	Insurers' duty to provide information (10-15 days) in a fraud investigation
SB 632 (Carona/Lozano)	Discounts of non-covered optometric products & services in health plan contracts
SB 644 (Huffman/Zerwas)	Standard request form for prior authorization of prescription drug benefits.
SB 822 (Schwertner/Eiland)	Silent PPO, regulation of health care provider network contract arrangements
SB 874 (Hegar/Sanford)	Health care sharing ministries
SB 1221 (Paxton/Smithee)	Notification of Medicaid fee schedule in commercial markets
SB 1216 (Eltife/S. Davis)	Standard request form for prior authorization of health care services.
SB 1286 (Williams/Hunter)	Professional employer organizations
SB 1332 (Smithee/Duncan)	Definition of an employee and a small group employer
SB 1367 (Duncan/Smithee)	Dissolution of the Texas Health Insurance Pool
SB 1484 (Watson/L. Gonzales)	Autism spectrum disorder mandate past the age of nine years
SB 1795 (Carona/Guillen)	Regulation of navigators for health Exchanges

THE FOLLOWING LEGISLATION FAILED PASSAGE

Health Plan and Provider Contracting Arrangements

HB 522 (Kuempel)	Health plan payment for medical transportation services
HB 979 (S. Thompson) & SB 470 (Ellis)	Similar reimbursement requirement for same services provided by podiatrists and physicians
HB 1901 (Eiland)	Health plan payment of out-of-network ambulatory surgery benefits
HB 2162 (Eiland)	Restricting health plans from contracting nonemergency ambulance transportation services
HB 2299 (Munoz) & SB 1242 (Hegar)	Optometrists, therapeutic optometrists, or ophthalmologist contracts under a health plan
HB 2359 (G. Bonnen)	Limiting the range of compensation to health care providers performing the same service
HB 2657 (Zerwas) & SB 1347 (Lucio)	Prohibiting the termination of provider contracts for out-of-network referrals
HB 3269 (Smithee) & SB 1544 (Van de Putte)	Health plan payment of usual and customary ambulatory surgical center billed charges
HB 3270 (Smithee)	Preferred provider and exclusive provider network regulations
HB 3329 (Herrero)	Reimbursement rates offered by health benefit plans
SB 257 (Deuell)	Inaccurate payment of claims by certain health benefit plans subject to prompt pay penalty
SB 413 (Deuell)	Health plan payment for services in a freestanding emergency medical care facility
SB 1197 (Taylor)	Requirements of exclusive provider and preferred provider benefit plans.

Disclosure and Transparency of Health Care Costs and Payment of Claims

HB 1406 (Smithee) & SB 800 (Van de Putte)	Disclosure of out-of-network payments by the health plans
HB 2360 (G. Bonnen)	Disclosure of health care costs by health plans
HB 2700 (G. Bonnen)	Disclosure of good faith estimates of the expected payment for health care services
HB 2838 (Smithee)	Disclosure of the price of certain health care services
HB 3020 (JD Sheffield)	Provider disclosure of the price charged for a health care services

Telemedicine

HB 1470 (Laubenberg)	The practice of telemedicine
HB 1806 (Smithee)	Coverage of telemedicine medical services under health benefit plans

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THE FOLLOWING LEGISLATION FAILED PASSAGE *(CONTINUED)*

HB 2017 (Price)	Payment for physician telephone consultation services
SB 830 (Schwertner)	Use of telemedicine in certain trauma facilities

Pharmacy Related Legislation

HB 542 (Zerwas) & SB 190 (Huffman)	Substitution of biological products
HB 1036 (Eiland)	Regulation of pharmacy benefit managers
HB 2530 (Guerra) & SB 1152 (Hinojosa)	Fees charged for adjudication of claims by health benefit plans
HB 3455 (Eiland)	Any willing pharmacy, patient choice and uniform contractual standards
HB 3456 (Eiland)	Calculation and reimbursement rates paid to pharmacies by health benefit plans
SB 478 (Hinojosa)	Prohibiting rebates and incentives for the purchase of certain drugs

Mandates

HB 170 (Alonzo)	Coverage of mammograms performed by health care providers
HB 495 (Hernandez Luna)	Coverage of supplemental breast cancer screening under health plans
HB 592 (Naishtat) & SB 1485 (Watson)	Expanding the definition of serious mental illness including Post Traumatic Stress Disorder
HB 997 (Smithee)	Requiring health plan coverage and supplemental coverage for abortions
HB 1119 (Y. Davis) & SB 469 (Ellis)	Requiring health plan coverage of HIV and AIDS tests
HB 3326 (Coleman)	Requiring health plan coverage for certain mental disorders

TDI Licensing and Regulatory Oversight

HB 1907 (Eiland)	Review by OPIC of rate filings by health benefit plan issuers
HB 2085 (McClendon)	Approval of forms and rates by the Texas Department of Insurance
HB 2086 (McClendon)	Limiting the period for bringing an action arising from insurance claims
HB 2558 (Sheets)	Confidentiality of information obtained by or disclosed to TDI
HB 2646 (C. Turner) & SB 1565 (Davis)	OPIC's ability to initiate a hearing on insurance rates or rate filings
HB 2717 (Eiland)	Authorizing a premium tax credit to an insurer that establishes or expands presence in state
HB 2782 (Smithee)	Authorization of the TDI Commissioner to disapprove health plan rate changes
HB 2853 (S. Turner)	Regulation of health benefit plan rates
HB 2956 (Smithee)	Binding arbitration provisions in insurance and health benefit plan coverage documents
HB 3451 (Eiland)	Licensing and ongoing requirements for insurance companies.
HB 3460 (Eiland)	Confidentiality of information reported to the Texas Department of Insurance
HB 3620 (Burnam)	Prior approval of rates and establishing gross premium taxes
SB 84 (Ellis)	Regulation of health benefit issuers in this state
SB 85 (Ellis)	Prior approval of health benefit plan issuer rates
SB 995 (Deuell)	Allowing employers to issue individual insurance plans

The Texas Health Insurance Pool

HB 2566 (Carter)	Requiring the electronic payment of premiums to the Texas Health Insurance Pool
HB 2957 (Smithee) & SB 1366 (Duncan)	Directing the use of funds of the Texas Health Insurance Pool
SB 1220 (Paxton)	Directing the use of funds of the Texas Health Insurance Pool

Other Legislation, Failed Passage

HB 1039 (Eiland) & SB 402 (Rodriguez)	Prohibiting a referral for practice of physical therapy
HB 3699 (Smithee) & SB 1614 (Duncan)	Amending timelines and eligibility requirements of the Healthy Texas Program
HB 3709 (Bell)	The Health Freedom Act giving individual freedom to choose not to have insurance

THE FOLLOWING LEGISLATION PASSED

HB 15 (Kolkhorst)	NICU Level of care designations for hospitals
HB 595 (Kolkhorst)	Repeals the 2013 of Medicaid/CHIP pharmacy carve-in
HB 1358 (Hunter) & SB 591 (Van de Putte)	Pharmacy audit bill (*Medicaid and CHIP MCOs are exempt)*
HB 1605 (S. Davis)	Harris County maternity care management pilot program
HB 1869 (Price)	Subrogation bill *(Medicaid and CHIP are exempted)*
SB 1 (Williams)	General Appropriations bill
SB 7 (Nelson)	Medicaid LTSS, IDD integration and Medicaid outcomes improvement; MCO contracts
SB 8 (Nelson)	Medicaid FWA, and MTP bill
SB 45 (Zaffirini)	Employment assistance for Medicaid waiver program participants
SB 58 (Nelson)	Integration of Medicaid behavioral and physical health services
SB 316 (Uresti)	Education related to substitution of opioid analgesic drugs
SB 348 (Schwertner)	Utilization review process for STAR + PLUS MCOs
SB 365 (Carona)	Expedited credentialing for podiatrists and optometrists
SB 406 (Nelson)	Delegation of prescriptive authority to PAs and RNPs
SB 421 (Zaffirini)	Enhanced local mental health systems of care for certain children
SB 492 (Lucio)	Licensing and regulation of prescribed pediatric extended care centers
SB 632 (Carona)	Prohibits MCO discounts on dentists, optometrists non-covered services
SB 644 (Huffman)	Standard prior authorization form for prescription drug benefits
SB 793 (Deuell)	Newborn hearing screening
SB 822 (Schwertner)	Regulation of silent PPO provider network contract arrangements
SB 874 (Hegar)	Health care sharing ministries
SB 1106 (Schwertner)	Medicaid MAC bill
SB 1150 (Hinojosa)	Provider protection plan
SB 1216 (Eltife)	Standard prior authorization for health care services
SB 1221 (Paxton)	Use of Medicaid fee schedules in provider contracting
SB 1542 (Van de Putte)	Stakeholder public input related to Medicaid MCO quality improvement
SB 1681(Zaffirini)	Relating to oversight and management of state contracts
SB 1803 (Huffman)	Provider due process related to OIG payment holds

THE FOLLOWING LEGISLATION FAILED PASSAGE

HB 161 (Raymond)	Drug testing of certain persons seeking financial assistance
HB 473 (S. Turner)	Provision of certain medications to children less than five years of age
HB 542 (Zerwas) & SB 190 (Huffman)	Substitution of biological products
HB 620 (Eiland)	Regulation of certain health plan provider contract arrangements
HB 624 (Zedler)	No rate differentiation between MD and other levels of providers
HB 914 (Kolkhorst)	Equalizing Medicaid therapy rates
HB 1002 (E. Johnson)	Relating to creation of the Texas Health Insurance Exchange
HB 1036 (Eiland)	Omnibus PBS/MAC bill
HB 1039 (Eiland) & SB 402 (Rodriguez)	Regulation of the practice of physical therapy w/o a gatekeeper
HB 1088 (Martinez)	MCO unilateral rate reductions
HB 1089 (Martinez)	Medicaid MCOs must cover prescriptions deemed medically necessary
HB 1137 (J. Davis)	Medicaid MAC lists
HB 1280 (Lozano)	Prohibits MCO discounts on dentists, optometrists non-covered services
HB 1381 (M. Martinez) & SB 450 (Hinojosa)	VDP carve out
HB 1536 (Guerra/Hinojosa)	Administrative due process hearings on OIG payment holds

THE FOLLOWING LEGISLATION FAILED PASSAGE *(CONTINUED)*

HB 1406 (Smithee) & SB 800 (Van de Putte)	Mandates OON Payment
HB 1647 (Raymond)	Comprehensive standards for Medicaid credentialing and PA processes
HB 1761 (Kolkhorst) & SB 1059 (Nelson)	HHSC strategies for appropriate use diagnostic ancillary services
HB 1901 (Eiland) & SB 1746 (Uresti)	Payment of out-of-network ASC benefits by certain health benefit plans
HB 1924 (Eiland)	Technology to assist HHSC with FWA claims scrutiny
HB 2017 (Price)	Payment of physicians for telephone consultation services
HB 2129 (Zerwas)	Health insurance information for DSHS services under the Exchange
HB 2162 (Eiland)	Health benefit plan coverage for certain NEMT services
HB 2217 (Bonnen) & SB 1764 (Deuell)	Medicaid/CHIP cranial molding orthosis bills
HB 2299 (Munoz) & SB 1242 (Hegar)	Any willing eye doctor bills
HB 2359 (Bonnen)	Disclosure of providers' health care costs
HB 2360 (Bonnen)	Disclosure of health care costs by health plans
HB 2530 (Guerra) & SB 1152 (Hinojosa)	Restricts the use of PBM (click) provider fees
HB 2647 (Martinez)	15 day claims processing, MCO electronic documentation
HB 2700 (Bonnen)	Good faith estimate of payments to providers
HB 2731 (Raymond)	MCO requirements for provider admin simplification
HB 2965 (Alonzo) & SB 1424 (Hinojosa)	Any willing eye doctor bills if network is not adequate
HB 3158 (Zerwas) & SB 1463 (West)	HCC - MCO pilot programs
HB 3262 (D. Miller) & SB 1431 (Hinojosa)	Single, public MAC
HB 3269 (Smithee) & SB 1544 (Van de Putte)	ASC payment of and disclosures
HB 3398 (Raymond)	Any willing enteral nutrition therapy provider
HB 3426 (Lavender)	No Medicaid reimbursement for nonemergency ER services
HB 3452 (Eiland)	Judicial review of Medicaid reimbursement disputes
HB 3455 (Eiland)	Any willing pharmacy bill
HB 3456 (Eiland)	Calculation of reimbursement rates paid to certain pharmacies
HB 3473 (Paddie)	Mandatory inclusion of certain hospital districts MCOs in Medicaid bids
HB 3712 (Guerra)	Provider protections bill
HB 3788 (C. Perry)	Medicaid review and reform
HB 3791 (Zerwas)	"Texas alternative solution" to improve Medicaid
SB 56 (Nelson)	Medicaid provider marketing, MTP program
SB 57 (Nelson)	Medicaid acute care services and LTSS delivery and quality
SB 253 (Deuell)	Newborn screening for congenital heart defects
SB 337 (J. Rodriguez)	Coordination of services provided by Medicaid MCOs and LMHAs
SB 413 (Deuell)	Free-standing ER bill
SB 1339 (Duncan)	Subrogation bill - Medicaid and CHIP MCOs were exempted
SB 1435 (Hinojosa)	Providers' rights to due process under Medicaid program