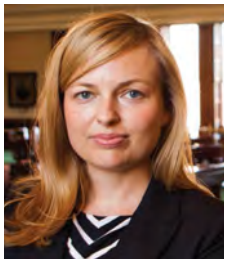
TAHP

The Texas Association of Health Plans

84th Texas Legislative Session

AFFORDABILITY ACCESSIBILITY ACCOUNTABILITY

Health Plan Highlights from the 84th Texas Legislature



Dear TAHP Member,

The 84th Legislative Session has come to a close, and the Texas Association of Health Plans is pleased to report on a number of important achievements made possible through a comprehensive communications, education and lobbying strategy carried out in coordination and collaboration with each of you.

By actively monitoring the progress of several hundred bills and staying in close contact with legislators and their staffs throughout the session, TAHP and its members secured a number of key legislative victories that support our overall goals of ensuring an affordable and stable health insurance market. These included successfully preventing many measures from advancing that would have resulted in onerous and costly new payment, contracting and benefit mandates for the industry, and in turn, increased health care costs for Texas consumers.

Specifically, TAHP worked to educate legislators and staff on the importance of boosting transparency to better protect consumers against surprise charges that result from the unfair practice of balance billing or from visits to freestanding emergency room facilities. Through opinion editorials in Texas newspapers, social media promotion, media outreach, educational materials for legislators and staff, testimonies, and targeted Capitol meetings, TAHP helped push both SB 481, which addresses the practice of balance billing, and SB 425, which boosts transparency at freestanding ERs, through both chambers and to the Governor's desk.

TAHP also made significant strides in educating legislators, staff and the public about the benefits and savings of Medicaid managed care in Texas. Research commissioned by TAHP and carried out by national research firms Milliman and Sellers Dorsey found that managed care has saved the state nearly $4 billion over a six-year period, compared to the fee-for-service model it replaced. Over the next three years, the approach is expected to save an additional $3.3 billion. Just as important, lives are being saved and improved, with hospital admissions down anywhere from 20 to nearly 40 percent for some of the most common—and costly—conditions like asthma and diabetes. TAHP produced a number of educational materials outlining these savings and benefits, and carried the message throughout the Capitol that the managed care approach is working in Texas. Through these efforts, the Legislature recognized the value of Medicaid managed care for Medicaid consumers and Texas taxpayers in their final budget and policy decisions. This included protecting the success of Medicaid managed care in the rate setting process by fully covering the cost of the Health Insurance Provider Fee and not arbitrarily cutting the risk margin, while protecting and expanding the Medicaid managed care solution to more Medicaid consumers. Rather than cuts to health plans that would have reduced services and quality, the state protected the Medicaid managed care system that is already creating budget savings and improving lives through better care management and coordination.

In this report you will find a detailed update on these and other efforts, including where TAHP's priority legislation stands, as well as an outlook for the 85th Legislative Session.

Thank you to all our members for your support and help throughout the session, and thank you as always for your valuable insight and feedback. Please continue to stay in close contact with us, and never hesitate to suggest ideas for how we can better represent the health insurance industry and make a positive difference for the millions of Texas consumers who depend on you for quality and affordable health care.

Sincerely,
Jamie Dudensing

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Texas Association of Health Plans

Improving Affordability, Accessibility and Accountability

Commercial Health Insurance Market

TAHP and its members are committed partners in maintaining a competitive health insurance market in Texas as part of an overall effort to increase access to health care coverage.

During the 84th Legislature, TAHP advocated to protect and strengthen the health insurance market to ensure it is both accountable and affordable. Together with our members, TAHP promoted the importance of securing a sound and efficient market that maximizes consumer choice and affordability.

TAHP believes increased transparency and shared accountability by all providers is essential for achieving affordable and accessible health care. TAHP worked this session to ensure health plans can continue to build on these efforts to empower consumers with more information and options for affordable coverage.

Sensible regulations play an important role in protecting consumers and providers. Just as important, TAHP has worked to educate legislators and their staffs on the negative consequences of overly prescriptive regulations or burdensome government mandates that harm efforts to develop affordable care options. During the session, TAHP and its members were instrumental in preventing onerous new mandates and regulations from advancing that would have raised costs on coverage for Texas consumers and businesses.

Overall, the 84th Legislature produced positive results for the health insurance industry that will enable health plans to continue to provide affordable health coverage and increased price transparency to consumers. This included the adoption of new transparency and mediation protections for consumers for out-of-network billing disputes and the defeat of costly new regulations that would have mandated out-of-network reimbursement rates based on inflated billed charges and would have increased the costs of premiums.

TAHP Priority Legislation

Passed:

Freestanding ER Transparency Reform

SB 425 (Schwertner/G. Bonnen)

This TAHP-supported bill requires freestanding emergency rooms to be forthcoming regarding the fees and other charges patients might incur. The bill seeks to protect Texas consumers from the often unknown expenses associated with seeking care at freestanding emergency rooms. While freestanding ERs appear and act much like urgent care centers, what many consumers do not know is that freestanding ERs may charge up to four-to-five times more than urgent care centers for the same services.

TAHP worked with Sen. Schwertner and his staff to educate other members of the legislature and the public about the issues Texans are experiencing at freestanding ERs and the need for increased transparency.

SB 425 requires freestanding ERs to post a prominent notice—and also include this notice on their web site—that clearly includes the following information:

- **The facility is an emergency room.**
- **The facility charges rates comparable to a hospital emergency department, including a possible facility fee.**
- **The physician may bill separately from the facility.**
- **The facility and facility-based physicians may not be participating providers in an individual's health plan network.**

Continued on Page 9

SB 425 takes effect September 1, 2015. The new transparency requirements apply beginning January 1, 2016.

Through committee testimonies, educational materials, media outreach, social media promotion, collaboration with organizations like the Texas Association of Business and consumer groups, and targeted meetings at the Capitol, TAHP played a significant role in moving SB 425 across the finish line.

TAHP issued the following statement to the media upon passage of SB 425:
"While freestanding ERs may be the right choice for certain medical situations, many Texans are unaware that these facilities can charge four-to-five times more than their look-alike, urgent care centers. SB 425 would help Texas consumers make more informed decisions about where to seek care for various medical situations and know up front that if they visit a freestanding ER, they will be charged the same amount they would pay to visit a traditional ER. It's essential that Texas consumers have access to critical information to help them navigate what can be a costly and confusing system," said Jamie Dudensing, CEO of TAHP.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Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.
Texas Association of Health Plans
TAHP Supports SB 425:
Increased Transparency from Freestanding ERs
Deciding where to go for health care
Doctor's Office
Retail Health Clinic
Urgent Care Center
Free Standing ER
Hospital Emergency Room


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Texas Association of Health Plans
Where to go for health care
Freestanding ERs vs Urgent Care Centers
EMERGENCY


VALLEY STAR
Health care consumer protection bill sits on governor's desk
Health CARE


GALVESTON COUNTY
THE DAILY NEWS
Transparency can reduce 'bill shock' for patients with emergency care charges

Passed:

Balance Billing Protections

SB 481 (Hancock/Smithee)

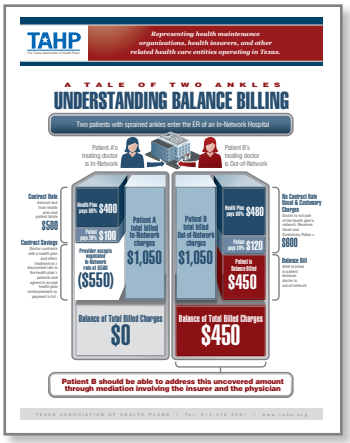
This TAHP-supported bill expands options for consumers to go to mediation when they are balance billed by a facility-based physician for any amount above $500, instead of the current limit, which requires bills above $1,000. The bill strengthens the requirements notifications to consumers that mediation is an available option to resolve a balance billing dispute, and adds assistant surgeons to the list of providers subject to mediation and requirements to notify consumers about the option of mediation. *SB 481 takes effect September 1, 2015 (Note: HB 1638, a similar balance billing bill, would have allowed for arbitration and prohibited balance billing for all emergency out-of-network billing disputes but did not pass).*

SB 481 addresses the growing practice of balance billing occurring across Texas that is surprising individuals and their families with unexpected medical charges, often when they have received emergency medical care. Balance billing occurs when consumers seek care at in-network facilities but are in fact treated by out-of-network physicians at those facilities and later receive separate bills for charges not covered by their insurance.

SB 481 is a common-sense approach to empowering consumers and boosting transparency in the balance billing process.

TAHP worked with Sen. Hancock and his staff to promote SB 481 and move it along in the Senate and the House. TAHP produced a variety of educational and press materials, including an opinion piece by Jamie Dudensing published in the Fort Worth Star-Telegram, Sen. Hancock's hometown paper.

TAHP issued the following statement to the media:
"For too many Texans, trips to the emergency room and other medical facilities are resulting in unexpected medical charges that can take a serious toll on family budgets. As the unfair practice of balance billing continues to grow across Texas, TAHP applauds passage of SB 481, which would expand the use of mediation to bring a higher degree of fairness to the situation and, ultimately, better protect Texans from surprise debt," said Jamie Dudensing, CEO of Texas Association of Health Plans.



Passed:

Own Risk Solvency Assessment Model Act (ORSA)

SB 655 (Eltife/Smithee)

This bill adopts the NAIC Own Risk Solvency Assessment Model Act (ORSA Model) providing the requirements for maintaining a risk management framework, completing an own risk and solvency assessment, and filing a summary report with TDI. The bill provides that the summary report will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if made public. The bill follows NAIC Model provisions and confidentiality provisions. *The bill is effective immediately.*

Did Not Pass:

Provider Consolidation and Transparency

SB 1445 (Estes)

The bill would have increased transparency of provider rates and facility fees to help empower consumers and promote competition. SB 1445 would also have required trends in the health care market to be studied, including the impact of consolidation on the market and patient access, quality and care coordination. TAHP supported SB 1445 as a means of reducing anti-competitive consolidation that can send health care prices up by as much as 40% or more. TAHP supports improving care through integrating services, but not if the result is merely higher prices for the same services. As it does in any other business, competition in health care lowers costs, improves quality, increases investments, and promotes innovation. *SB 1445 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Prompt Pay Reform

HB 1433 (Smithee)/SB 843 (Taylor)

Aimed at the increasing litigation involving prompt payment claims, this bill was negotiated between TAHP and the Texas Medical Association (TMA). It would have created a two-year statute of limitations for private causes of action for violations of the prompt payment law and reduced the maximum penalty amounts available. Specifically, it would have reduced the maximum penalties (prior to the addition of additional interest, if applicable) from $100,000 to $5,000 for claims paid up to 45 days after the date the claim is due, and from $200,000 to $10,000 for claims paid on or after the 46th day after the date the claim is due. The bill also would have restored the 50% of facility penalty payment amounts made to the Texas Health Insurance Pool to the billing hospitals.

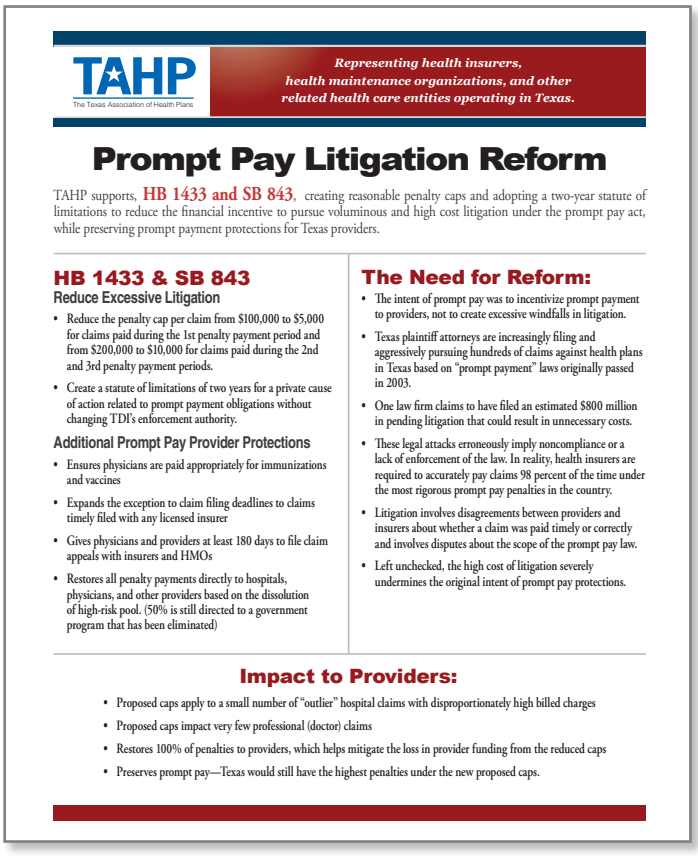
While there were concerns about penalties based on self-determined, unlimited and unregulated billed charges, the bill failed to pass out of committee due to concerns about financial losses to hospitals. However, TAHP and its members made important strides in educating legislators about the need for prompt pay reform, and TAHP plans to continue its efforts throughout the interim and next session. *HB 1433 was introduced and referred to the House Committee on Judiciary and Civil Jurisprudence. SB 843 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Prompt Pay Hospital Funding

HB 3006 (Coleman)

The bill would have returned 100% of prompt pay penalties back to hospitals by repealing the provisions of the prompt pay law that require 50% of facility penalty payments to be used to fund the Texas Health Insurance Pool (the Pool). It did not address the additional 18% interest on penalty amounts for physician claims that are remitted to the Pool. As a result of HB 3006 not passing, the current provisions requiring the funds to be remitted to the Pool remain in the Insurance Code. SB 1367 from the 2013 legislative session provided for dissolution of the Pool and transfer of Pool funds to TDI; it provided that beginning in 2014, the penalty funds could be used "for any other purpose authorized by the commissioner by rule to improve access to health benefit coverage for individuals without coverage." However, those funds were not specifically allocated to TDI through the budgeting process and so, effectively, are part of the state general revenue funds. **No legislation passed this session that changed prompt pay penalty funding to hospitals or physicians.** *HB 3006 was passed out of the House Insurance Committee and failed to pass out of the House due to end-of-session procedural deadlines.*



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The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Prompt Pay Litigation Reform

TAHP supports, **HB 1433 and SB 843**, creating reasonable penalty caps and adopting a two-year statute of limitations to reduce the financial incentive to pursue voluminous and high cost litigation under the prompt pay act, while preserving prompt payment protections for Texas providers.

HB 1433 & SB 843

Reduce Excessive Litigation

- Reduce the penalty cap per claim from $100,000 to $5,000 for claims paid during the 1st penalty payment period and from $200,000 to $10,000 for claims paid during the 2nd and 3rd penalty payment periods.
- Create a statute of limitations of two years for a private cause of action related to prompt payment obligations without changing TDI's enforcement authority.

Additional Prompt Pay Provider Protections

- Ensures physicians are paid appropriately for immunizations and vaccines
- Expands the exception to claim filing deadlines to claims timely filed with any licensed insurer
- Gives physicians and providers at least 180 days to file claim appeals with insurers and HMOs
- Restores all penalty payments directly to hospitals, physicians, and other providers based on the dissolution of high-risk pool. (50% is still directed to a government program that has been eliminated)

The Need for Reform:

- The intent of prompt pay was to incentivize prompt payment to providers, not to create excessive windfalls in litigation.
- Texas plaintiff attorneys are increasingly filing and aggressively pursuing hundreds of claims against health plans in Texas based on "prompt payment" laws originally passed in 2003.
- One law firm claims to have filed an estimated $800 million in pending litigation that could result in unnecessary costs.
- These legal attacks erroneously imply noncompliance or a lack of enforcement of the law. In reality, health insurers are required to accurately pay claims 98 percent of the time under the most rigorous prompt pay penalties in the country.
- Litigation involves disagreements between providers and insurers about whether a claim was paid timely or correctly and involves disputes about the scope of the prompt pay law.
- Left unchecked, the high cost of litigation severely undermines the original intent of prompt pay protections.

Impact to Providers:

- Proposed caps apply to a small number of "outlier" hospital claims with disproportionately high billed charges
- Proposed caps impact very few professional (doctor) claims
- Restores 100% of penalties to providers, which helps mitigate the loss in provider funding from the reduced caps
- Preserves prompt pay—Texas would still have the highest penalties under the new proposed caps.

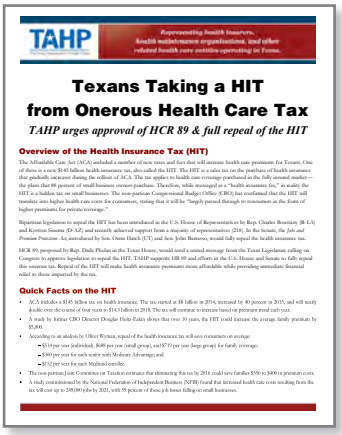
Did Not Pass:

Health Insurance Tax Repeal Resolution

HCR 89 (Phelan)

The resolution urged the U.S. Congress to approve legislation fully repealing the health insurance fee (HIT) included in the Affordable Care Act. The HIT is a $145 billion tax on health insurance that started at $8 billion in 2014, increased by 40% in 2015, and will nearly double over the course of four years to $14.3 billion in 2018. The non-partisan Congressional Budget Office has confirmed that the HIT will translate into higher health care costs for consumers, stating that it will be "largely passed through to consumers in the form of higher premiums for private coverage."

TAHP worked to build support for HCR 89 both at the Capitol and in the news media, releasing the following statement: *"As health care costs continue to climb, the last thing Texans need is a $145 billion health care tax that translates into higher premiums for themselves and their families. The effort to win full repeal of this onerous tax is gaining steam in Congress as more and more leaders on both sides of the aisle realize its harmful impact on families across the country, on small businesses, job creation and our economy,"* said TAHP CEO Jamie Dudensing. *"TAHP supports Rep. Phelan's HCR 89, which sends a united message from the Texas Legislature to the U.S. Congress to swiftly approve full repeal of the HIT."*



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Texans Taking a HIT from Onerous Health Care Tax

TAHP urges approval of HCR 89 & full repeal of the HIT

Overview of the Health Insurance Tax (HIT)

Quick Facts on the HIT

Texas lawmaker gathers support to repeal health insurance fee

HCR 89 passed out of the House Committee on State & Federal Power & Responsibility, but did not pass out of the House due to end-of-session procedural deadlines.

TAHP will continue to work with national organizations to advocate for federal repeal of the ACA health insurance tax.

Key Legislation Affecting the Health Insurance Industry

TAHP and its member plans worked throughout session to ensure that bills adopted by the legislature did not adversely impact the health insurance market. TAHP worked with legislators and stakeholder groups on a number of bills throughout session and negotiated key amendments to see that any new protections and regulations.

Passed:

"Right to Try Act"

HB 21 (Kacal/Bettencourt)

Known as the "Right to Try Act," this bill amends the Health & Safety Code to allow a patient who has a terminal illness and provides informed consent to use an investigational drug, biological product, or device if certain conditions are met. It does not affect the coverage of enrollees in clinical trials under Insurance Code Chapter 1379. The bill does not otherwise address insurance coverage and is not a benefit mandate. A patient is eligible to access and use an investigational drug, biological product, or device under this chapter if:

- **the patient has a terminal illness, attested to by the patient's treating physician; and**
- **the patient's physician:**
  - **in consultation with the patient, has considered all other treatment options currently approved by the FDA and determined that those treatment options are unavailable or unlikely to prolong the patient's life; and**
  - **has recommended or prescribed in writing that the patient use a specific class of investigational drug, biological product, or device.**

The bill is effective immediately.

Passed:

Prohibition Against "De-Listing" Network Providers for Out-of-Network Referrals

HB 574 (G. Bonnen/Campbell)

The bill prohibits an HMO or insurer from terminating a physician or provider from its network solely because the physician or provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers. The bill prohibits an insurer or HMO from requiring an out-of-network provider to use a disclosure form intended to intimidate an enrollee. The bill was amended in the House on second reading to apply prompt payment laws to non-network providers for claims submitted for any member with out-of-network benefits. TAHP successfully advocated to remove this amendment on third reading and to avoid it in the Senate. *The bill takes effect September 1, 2015.*

Passed:

Biosimilar Substitution

HB 751 (Zerwas/Kolkhorst)

The bill allows the substitution of lower-priced, generically equivalent drug products for certain brand name drug products and the substitution of interchangeable biological products for certain biological products. The bill requires the dispensing pharmacist to communicate to the prescribing practitioner the specific product provided to the patient within 3 business days. The communication shall be sent electronically through medical records, electronic prescribing or an electronic pharmacy record. If these are not available, the pharmacist shall communicate through facsimile, telephone, electronic transmission, or other prevailing means. TAHP negotiated a Sunset provision for the communication requirement to expire September 1, 2019. *The bill takes effect September 1, 2015.*

Passed:

ERS High-Deductible Health Plan

HB 966 (Crownover/Campbell)

The bill establishes a state consumer-directed health plan option for state employees and their eligible dependents. It directs the board of trustees of the Employee Retirement System of Texas to establish health savings accounts and finance a self-funded high-deductible plan. TAHP and its members supported HB 966's passage. *The bill would take effect September 1, 2015, with coverage beginning September 1, 2016.*

Passed:

Hemophilia Assistance Program

HB 1038 (Sheffield/Watson)

The bill authorizes DSHS to provide insurance premium payment assistance to eligible persons with hemophilia. The Hemophilia Assistance Program helps Texas residents over 21 years old with hemophilia who have an income level at or below 200% of the poverty level pay for their blood factor products. The premium payments would be in addition to an existing DSHS program that provides financial assistance for eligible persons to obtain blood, blood derivatives and concentrates, and other substances for use in medical or dental facilities or in the home. *The bill is effective immediately.*

Passed:

Qualified Health Plan ID Cards

HB 1514 (Sheffield/Creighton)

The bill mandates health plans to include identifying information on health plan identification cards that would notify a provider that the consumer purchased a qualified health plan through the federally facilitated marketplace and received a subsidy. After concerns were expressed by TAHP and other consumer groups about potential discrimination against consumers identified as receiving an ACA premium subsidy, reported by the Texas Tribune and Houston Chronicle, the bill was amended to require only that the ID card identify the coverage as a QHP plan, and not the 'S' designation of the subsidy. TAHP submitted an official veto request to the governor due to concerns about discrimination and access to care for consumers. *The bill takes effect September 1, 2015.*

Passed:

Utilization Review for Prescription Drugs and Infusion Therapy

HB 1621 (G. Bonnen/Seliger)

The bill requires a utilization review agent to provide notice of an adverse determination for a concurrent review of prescription drugs or intravenous infusions not later than the 30th day before the provision of the drugs or infusions will be discontinued, and provides for expedited appeals. Several amendments to the bill were made to address TAHP concerns, including limiting applicability to drugs and infusion therapy for which the enrollee is already receiving benefits and providing for expedited appeals and direct access to an IRO rather than requiring coverage during the appeals process (even if the denial was upheld). A TAHP-requested amendment was also added exempting Medicaid and CHIP plans. *The bill takes effect September 1, 2015. The provisions of the bill apply only to an adverse determination made in relation to coverage or benefits under a health insurance policy issued or renewed on or after January 1, 2016.*

Passed:

Health Plan Formulary Transparency

HB 1624 (Smithee/Seliger)

The bill requires health benefit plan issuers to display electronically searchable formulary information on their web sites with a link to the information included in the electronic summary of benefits. The bill provides for TDI rulemaking, but a TAHP-requested amendment removed the requirement for TDI to prescribe a standard disclosure template, so that it will not conflict with new federal requirements. TAHP also advocated for another amendment that was adopted removing the requirement to include specific copayments for each tier as set out in the coverage document and to allow required cost-sharing information to be provided in a web-based tool. The bill includes specific transparency standards for formulary requirements including:

- **Cost-sharing amounts;**
- **Prior authorization;**
- **How prescription drugs will be applied to the deductible;**
- **Identification of preferred formulary drugs; and**
- **An explanation of coverage of each formulary drug.**

The bill also increases standards for provider directories, including the requirement to be electronically searchable with a direct link in a conspicuous manner on the web site home page. Corrections and updates must be made each month.

The bill takes effect September 1, 2015. The bill applies only to a health plan issued or renewed on or after January 1, 2016.

Passed:

Patient Confidentiality

HB 1779 (Murr/Uresti)

The bill aligns the Texas Occupations Code provisions governing physicians with the Health and Safety Code provisions governing hospitals regarding when confidential patient records may be released in response to subpoenas. The bill clarifies what constitutes a valid subpoena under the Texas Medical Practice Act. This ensures patient confidentiality and alleviates administrative burdens on health care systems responding to third-party subpoenas. *The bill takes effect September 1, 2015.*

Passed:

Direct Primary Care

HB 1945 (G. Bonnen/Hancock)

The bill protects a physician providing "direct primary care," by clarifying that a "direct primary care" contract is not insurance or an HMO subject to TDI regulation. TAHP advocated for changes to the original bill regarding billing of insurance plans and increased transparency and disclosure to protect consumers. The bill as passed requires that a physician providing direct primary care must give prior written or electronic notice to the patient that direct primary care is not insurance and prohibits a physician from billing an insurer or HMO for direct primary care that is paid under a medical service agreement. *The bill is effective immediately.*

Passed:

Provisional Agent Permit

HB 2145 (Smithee/Creighton)

The bill allows TDI to issue a provisional permit to an applicant who is being considered for appointment as an agent by another agent, an insurer, or an HMO if certain conditions are met. *The bill takes effect and applies to applications filed on or after September 1, 2015.*

Passed:

Ovarian Cancer Screening Mandate

HB 2813 (K. King/Eltife)

The bill adds ovarian cancer screening, including a CA125 blood test, to the diagnostic medical procedures coverage mandate for health benefit plans. An amendment was added providing that if the mandate would require the state to make offset payments under the ACA, a qualified health plan is not required to provide screening that exceeds the required essential health benefits. *Applies to plans issued after September 1, 2015.*

Passed:

Coordination of Secondary Dental Coverage

HB 3024 (Guerra/Hinojosa)

The bill creates new requirements for the coordination of benefits between two plans with dental coverage. The secondary insurer is responsible only for dental expenses covered under its insurance policy that are not covered under the primary policy. TAHP requested clarifying language, which is included in the final version, that the secondary insurer's responsibility for dental expenses would not exceed its policy limits. *The bill takes effect September 1, 2015 and applies only to a policy issued or renewed on or after January 1, 2016.*

Passed:

Discount Health Care Program

HB 3028 (Frullo/Watson)

The bill amends current law relating to regulation of certain conduct by discount health care program operators, or concerning discount health care programs, that relates to prescription drugs or prescription drug benefits and authorizes administrative and civil penalties. The bill establishes that discount health care programs are an unfair method of competition or an unfair or deceptive act if they require a pharmacy or pharmacist to:

- **participate in a specified provider network as a condition of processing a claim for prescription drugs under the discount health care program; or**
- **participate in, or process claims under, a discount health care program as a condition of participation in a provider network.**

The bill also prohibits a pharmacy benefit manager (PBM) from requiring a pharmacist or pharmacy to:

- **accept or process a claim for prescription drugs under a discount health care program unless the pharmacist or pharmacy agrees in writing to accept or process the claim;**
- **participate in a specified provider network as a condition of processing a claim for prescription drugs under a discount health care program; or**
- **participate in, or process claims under, a discount health care program as a condition of participation in a provider network.**

The bill takes effect September 1, 2015.

Passed:

Pharmacy Benefit Manager – Transaction Fee Prohibition

SB 94 (Hinojosa/Guerra)

The bill prohibits a health benefit plan issuer or a PBM from directly or indirectly charging or holding a pharmacist or pharmacy responsible for a fee for any step of, or component, or mechanism related to the claim adjudication process. *The bill takes effect September 1, 2015.*

Passed:

MAC Pricing Transparency

SB 332 (Schwertner/Hunter)

The bill establishes criteria and disclosure requirements for maximum allowable cost (MAC) drug lists. The bill was negotiated and agreed upon by PBMs and independent pharmacy groups. TAHP successfully advocated for keeping all amendments off of this bill that would have created new costly mandates on PBMs. A health benefit plan issuer or PBM may not include a drug on a MAC list unless the drug: (1) is listed as "A" or "B" rated in the most recent "Orange Book;" is rated "NR" or "NA" by Medi-Span; or has a similar rating by a nationally recognized reference; and (2) the drug is generally available for purchase by pharmacists and pharmacies in this state from a national or regional wholesaler and is not obsolete.

In formulating the MAC price for a drug, a plan issuer or PBM may only use the price of that drug and any drug listed as therapeutically equivalent in the Orange Book, with limited exception. A plan issuer or PBM must disclose the sources of the pricing data used; the information must be disclosed on the date the plan issuer or PBM enters into the contract with the pharmacist or pharmacy and later upon request. Although MAC lists are confidential, plan issuers or PBMs must provide to each pharmacist or pharmacy under contract convenient access to the applicable MAC list.

A plan issuer or PBM contract must include a procedure for the appeal of a MAC price within 10 days. If the appeal is successful, the plan issuer or PBM must adjust the MAC price on the date the appeal is decided, apply the adjusted MAC price to all similarly situated pharmacists and pharmacies as determined by the plan issuer or PBM, and allow the pharmacist or pharmacy to reverse and rebill the pharmacy benefit claim giving rise to the appeal and any other claim based on the MAC price made after the date of the appealed claim.

An amendment was added clarifying that this bill does not apply to Medicaid, CHIP, Texas Employees plans, or the worker's compensation insurance. *The bill takes effect September 1, 2015. Applies only to contracts entered into or renewed on or after January 1, 2016.*

Passed:

Vision Plan Preferred Provider Designation and Optometrist Protections

SB 684 (Taylor/G. Bonnen)

The bill prohibits an insurer from withholding a preferred provider designation to an optometrist or therapeutic optometrist licensed by the Texas Optometry Board or an ophthalmologist licensed by the Texas Medical Board who:

- **joins the professional practice of a preferred provider;**
- **applies to the insurer for designation as a preferred provider; and**
- **complies with the terms and conditions of eligibility to be a preferred provider.**

The physician or provider must comply with the terms of the preferred provider contract.

The bill was amended on the House floor to add provisions of HB 3550 (Munoz), including that a managed care plan may not directly or indirectly:

- **control or attempt to control the professional judgment, manner of practice, or practice of an optometrist or therapeutic optometrist;**
- **employ or contract for the services of an optometrist or therapeutic optometrist if part of the optometrist's or therapeutic optometrist's duties involves the practice of optometry or therapeutic optometry;**
- **pay an optometrist or therapeutic optometrist for a service not provided;**
- **restrict or limit an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials, including optical laboratories to provide services or materials to a patient; or**
- **require an optometrist or therapeutic optometrist to disclose a patient's confidential or protected health information unless the disclosure is directly related to payment.**

After concerns were expressed by TAHP, these provisions were changed to clarify that capitation is not prohibited and that the bill does not restrict or limit a managed care plan's determination of specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories. The privacy provision was amended to allow disclosure as authorized by the patient or allowed without authorization by HIPAA or state law. The bill was also amended to require optometrists or therapeutic optometrists to disclose to patients any business interest they have with an out-of-network supplier or manufacturer that they are referring to the patient. *The bill takes effect September 1, 2015.*

Passed:

Reducing TDI Reporting Requirements

SB 784 (Eltife/Frullo)

Requires annual rather than quarterly reports to TDI relating to changes in losses, premiums, and market share and quarterly reports by TDI to the governor, lieutenant governor, speaker of the House of Representatives, the legislature, and the public regarding the information (other than information made confidential by law) in the insurers' reports and market conduct, especially rates and consumer complaints. *The bill takes effect on September 1, 2015, and applies to claims closed on or after January 1, 2016.*

Passed:

Insurance Agent Temporary License Appointments

SB 876 (Eltife/Frullo)

The bill makes changes recommended by TDI for improving the licensing process for insurance agents and adjusters. The changes relate to temporary licenses, license expiration, continuing educations, and non-resident licenses. The bill was amended to include a provision from HB 3911 allowing an exception to the provision that an agent, insurer, or HMO may not appoint more than 500 temporary license holders during a calendar year, requiring TDI to adopt reasonable rules setting standards for appointment of more than 500 temporary license holders, considering the ability to monitor appointed temporary agents. ***The bill takes effect September 1, 2015.***

Passed:

Hospital Indemnity

SB 979 (Creighton/Meyer)

The bill updates the hospital indemnity definition by replacing "hospital confinement indemnity" with "hospital indemnity or other fixed indemnity" as a type of individual A&H coverage for which TDI should adopt minimum standards. ***The bill is effective immediately.***

Passed:

Insurance Policy Reserves

SB 1654 (Hancock/Sheets)

The bill amends the Insurance Code provisions regarding TDI's annual valuation of reserves for all outstanding life insurance policies and annuity and pure endowment contracts of life insurance companies, now applying to those "issued before the operative date of the valuation manual," rather than stating that TDI may certify the amount of those reserves. ***The bill takes effect September 1, 2015.***

Passed:

Pharmacist-Administered Epinephrine

HB 1550 (Zerwas/Kolkhorst)

Allows a pharmacist to administer epinephrine through an auto-injector device in an emergency situation, in accordance with rules to be adopted by the pharmacy board to protect the public health and safety. A pharmacist may not receive remuneration for the administration of epinephrine through an auto-injector device but may seek reimbursement for the cost of the epinephrine auto-injector device. ***Effective September 1st for the purpose of allowing the Texas State Board of Pharmacy to adopt rules that may take effect January 1, 2016. Before January 1, 2016, pharmacists may administer epinephrine through an auto-injector device to the extent allowed under the law that exists before September 1, 2015.***

Passed:

TDI Fraud Investigations

SB 782 (Eltife/Smithee)

Makes technical changes to the Insurance Code provisions relating to TDI fraud investigations and clarifies that TDI can provide technical or litigation assistance to other governmental agencies enforcing laws relating to fraudulent insurance acts. ***The bill takes effect September 1, 2015.***

Passed:

TDI Anti-fraud Education Programs

SB 783 (Eltife/Frullo)

Requires TDI's fraud unit to develop fraud educational programs and disseminate materials necessary to educate the public effectively regarding antifraud programs. The insurance fraud unit may accept gifts, grants and donations for these purposes. ***The bill takes effect September 1, 2015.***

Passed:

Prescription for Opioid Antagonist

SB 1462 (West/Johnson)

Allows a prescriber to prescribe, directly or by standing order, and allows a pharmacist to dispense under a valid prescription, an opioid antagonist to a person at risk of experiencing an opioid-related drug overdose or a family member, friend, or someone else in a position to assist that person. A prescription issued or filled under this section is considered as issued for a legitimate medical purpose in the usual course of professional practice. Authorizes emergency services personnel are to administer an opioid antagonist to a person who appears to be suffering an opioid-related drug overdose, as clinically indicated. ***The bill takes effect September 1, 2015.***

Preventing Costly New Government Mandates

Working together with our members, TAHP was instrumental in preventing a number of new and burdensome government mandates from advancing. Health insurance regulatory and contract mandates drive up the cost of insurance coverage for employers and consumers, often without any corresponding benefit for consumers. Many of these bills would have restricted private market negotiations—reducing competition, increasing cost for Texas consumers and businesses, and limiting affordable health plan coverage options.

Commercial Health Plan Regulatory and Contractual Mandates

Did Not Pass:

Utilization Review

HB 180 (Zedler)

The bill would have required that UR agents and IROs provide the name and qualification of the physician who made the utilization review determination, upon request. TAHP expressed opposition to being required to disclose this information, which is currently confidential under state law, because it provides a disincentive for physicians to assist in utilization and external review activities. ***HB 180 was introduced, referred to the House Business and Industry Committee, and received a hearing.***

Did Not Pass:

Out-of-Network Government Rate Setting

HB 616 (G. Bonnen)/SB 1097 (Campbell)

The bill would have mandated that health plans pay usual and customary charges for out-of-network claims. The "usual and customary (U&C) charge" was defined as being in the 90th percentile of reported billed charges for the service and would have required non-network provider reimbursement to be the lesser of the billed charge or the U&C charge (unless the billed charge is "justifiable," in which case billed charges are to be paid). It provided that if an out-of-network provider submits a clean claim for payment of a charge that includes a statement indicating that the provider is willing to accept a payment for the service in the 85th percentile of reported billed charges, prompt pay requirements would apply. It would have further required an annual certification to TDI (available to the public) of the difference in value for a purchaser between the coverage with and without the out-of-network provider benefits and that the difference between the amounts reflects the difference in value.

TAHP testified in opposition to HB 616. The bill would have required health plans to pay out-of-network providers for the services they provide based on inflated billed charges. This would require private health insurance to pay government mandated rates without a contractual relationship, instead of allowing private market negotiations. Doing so interferes with private market innovations that foster consumer choice of affordable health coverage options. This bill would have had a significant impact on the cost of health coverage for Texas consumers and businesses. Based on fiscal note projections to the Texas Employee Plans, the bill easily could have increased Texas health insurance premiums by more than 10% at a cost of over $2.5 billion a year. The bill would have also extended prompt pay requirements (a statutory protection reserved for contracted parties) to out-of-network, non-contracted providers. ***HB 616 was introduced, referred to the House Insurance Committee, and received a hearing. SB 1097 was introduced and referred to the Senate Committee on Business & Commerce.***

Did Not Pass:

Prohibition Against Reimbursement Discrimination

HB 761 (Zedler)

The bill would have prohibited managed care plans from differentiating among types of practitioners in the amount paid, or the method used to compute the amount to be paid, for the performance of a covered physical modality or procedure that is within the scope of the license of more than one of those types of practitioners. TAHP opposed this contract and reimbursement mandate. The Affordable Care Act already prohibits payment discrimination but still allows health plans to competitively negotiate rates. ***HB 761 was introduced and referred to the House Insurance Committee.***

Did Not Pass:

Health Plan Form Approval

HB 773 (Gutierrez)

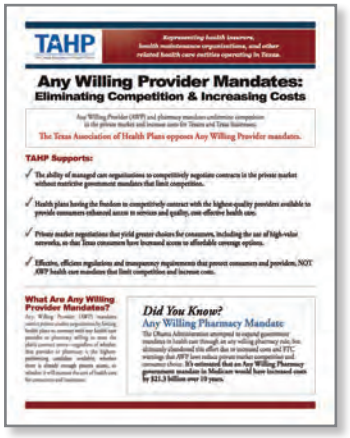
The bill would have prohibited an insurer from using a form, and to immediately stop using any forms, if not approved or disapproved by TDI. TAHP opposed this increase in government regulation. *HB 773 was introduced and referred to the House Insurance Committee.*

Did Not Pass:

Any Willing Pharmacist

HB 778 (Bell)/HB 1770 (Hunter)/SB 322 (Schwertner)

The bill would have created an "any willing pharmacy" law requiring a health benefit plan issuer or PBM to accept a pharmacist or pharmacy as a network provider if the pharmacist or pharmacy agrees to provide prescription drugs and pharmaceutical care in accordance with the terms of the health benefit plan and to accept applicable conditions. It would not have allowed a health benefit plan issuer or a PBM to limit an enrollee from selecting a pharmacist or pharmacy and from interfering with such a selection. It would have further prohibited a health benefit plan issuer or PBM from requiring a pharmacist or pharmacy to participate as a provider or preferred provider as a condition of participating as a provider or preferred provider under another health benefit plan. TAHP testified in opposition to this bill. It would have reduced competition, eliminated choice, and increased costs by restricting private market negations and requiring health plans to contract with any pharmacy regardless of whether it is the highest-performing pharmacy available, whether there is already enough patient access, or whether it will increase the cost of health care for consumers and businesses. AWP laws prohibit health plans from selective and exclusive network contracting, reducing both the incentive and the ability of health care providers to vigorously compete with each other to provide the highest-quality, lowest-cost goods and services for consumers and employers. *HB 778 was introduced, referred to the House Insurance Committee, and received a hearing. HB 1770 was referred to the House Insurance Committee. SB 322 was introduced and referred to the Senate Business & Commerce Committee.*


TAHP

Any Willing Provider Mandates:
Eliminating Competition & Increasing Costs

TAHP Supports:

What Are Any Willing Provider Mandates?

Did You Know?
Any Willing Pharmacy Mandate:

Did Not Pass:

Prohibition Against Reimbursement Discrimination

HB 1105 (Thompson)/SB 410 (Ellis)

The bill would have required that the methodology used to compute the amount of payment or reimbursement for podiatry services or procedures be the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician, including an osteopathic physician. TAHP opposed this contract and reimbursement mandate. The Affordable Care Act already prohibits payment discrimination but still allows health plans to competitively negotiate rates. *HB 1105 was introduced, referred to the House Insurance Committee, and received a hearing. SB 410 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Network Physician Designation

HB 1667 (G. Bonnen)

The bill would have required that an insurer not withhold a network designation to a physician who joins the professional practice of a contracted preferred provider, applies to the insurer for designation as a preferred provider, and complies with the terms and conditions of eligibility to be a preferred provider. TAHP opposed this contract mandate as unnecessary based on the current "expedited credentialing" laws, which provide additional protections to health plans. *HB 1667 was introduced and referred to the House Insurance Committee.*

Did Not Pass:

Out-of-Network Prompt Pay

HB 1691 (G. Bonnen)

The bill would have applied prompt pay and verification requirements to a non-network physician or provider who provides services to any member with non-network benefits. TAHP opposes extending prompt pay requirements (a protection reserved for contracted parties) to out-of-network, non-contracted providers. *HB 1691 was introduced and referred to the House Insurance Committee.*

Did Not Pass:

Prohibition Against Telemedicine Reimbursement Discrimination

HB 2348 (Price)

The bill would have required a health plan to pay all physicians for telemedicine services if it provides coverage for another person to provide telemedicine services (such as through a specific telemedicine provider or for mental health providers). *HB 2348 placed out of the House Insurance Committee but did not meet procedural deadlines to be passed on the House Calendar.*

Did Not Pass:

PBM/PSAO Negotiations

HB 2479 (Guerra)/SB 1176 (Eltife)

The bill would have required a PBM to conduct business with a pharmacy services administrative organization (PSAO) designated and authorized by a pharmacy as its agent, and prohibited a PBM from refusing to deal with the PSAO with regard to contracting and other matters. TAHP raised anti-trust concerns with the legislation in testimony before the committee. *HB 2479 was introduced and referred to the House Insurance Committee. SB 1176 was left pending in the Senate Committee on Business & Commerce.*

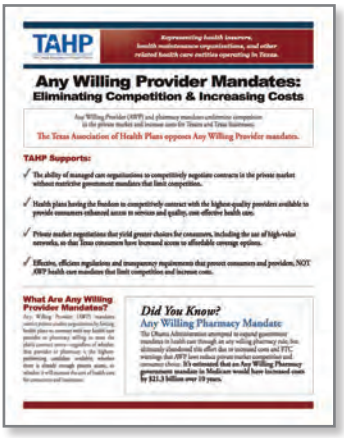
Did Not Pass:

Any Willing Pharmacist

HB 2618 (Munoz)

This bill would have created an "any willing pharmacy" law requiring a health benefit plan issuer or PBM to accept a pharmacist or pharmacy as a preferred provider if the pharmacist or pharmacy agrees to provide prescription drugs and pharmaceutical care in accordance with the terms of the health benefit plan and to accept other applicable conditions. It would have created new mileage requirements for pharmacy networks, prohibited termination of a pharmacy from a network (for any reason), prohibited requiring or even incentivizing the use of mail order if the mail order pharmacy is affiliated with a PBM, and imposed overly restrictive limitations on data transmission.

TAHP testified in opposition to this bill. This bill would have reduced competition, eliminated choice, and increased costs by restricting private market negations and requiring health plans to contract with any pharmacy regardless of whether it is the highest-performing pharmacy available, whether there is already enough patient access, or whether it will increase the cost of health care for consumers and businesses. AWP laws prohibit health plans from selective and exclusive network contracting, reducing both the incentive and the ability of health care providers to vigorously compete with each other to provide the highest-quality, lowest-cost goods and services for consumers and employers. *The bill was introduced, referred to the House Insurance Committee, and received a hearing.*


TAHP

Any Willing Provider Mandates:
Eliminating Competition & Increasing Costs

The Texas Association of Health Plans opposes Any Willing Provider mandates.

TAHP Supports:

- The ability of managed care organizations to competitively negotiate contracts in the private market without restrictive government mandates that limit competition.
- Health plans having the freedom to competitively contract with the highest-quality providers available to provide consumers enhanced access to services and quality, cost-effective health care.
- Private market negotiations that yield greater choices for consumers, including the use of high-value networks, so that Texas consumers have increased access to affordable coverage options.
- Effective, efficient regulation and transparency requirements that protect consumers and providers, NOT AWP health care mandates that limit competition and increase costs.

What Are Any Willing Provider Mandates?

Did You Know?
Any Willing Pharmacy Mandate

Did Not Pass:

ERISA Prompt Pay Requirements

HB 2757 (G. Bonnen)

The bill would have applied prompt payment laws, including penalty provisions, to self-funded health benefit plans administered by insurers acting as third-party administrators. *TAHP opposed this bill. HB 2757 was introduced and referred to the House Insurance Committee.*

Did Not Pass:

OPIC Network Adequacy Reviews

HB 3085 (Collier)/SB 1649 (Eltife)

The bill would have allowed the Office of Public Insurance Council (OPIC) to participate in TDI network adequacy reviews. The bill would have required OPIC to develop and implement a system to compare and evaluate, on an objective basis, the adequacy of networks offered by health plans and authorized OPIC to intervene in proceedings related to network adequacy of health plans. TAHP was opposed to the provisions allowing OPIC to intervene and request hearings regarding network adequacy filings. *HB 3085 was introduced and referred to the House Insurance Committee. SB 1649 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Prior Authorization Prohibition

HB 3919 (Klick)

The bill would have prohibited an HMO or insurer from requiring prior authorization for payment of a covered benefit and also required a TDI study of the use and effect of prior authorization for covered benefits and the circumstances that give rise to prior authorization, with TDI implementing the results of the study by adopting rules regulating, limiting, or prohibiting prior authorization practices. TAHP opposed this contract mandate interfering with health plan operations and administration of plan benefits. ***HB 3919 was introduced and referred to the House Insurance Committee.***

Did Not Pass:

Coordination of Benefits

HB 4016 (Herrero)

The bill would have mandated coordination of health benefits, requiring the primary health benefit plan issuer to be responsible for expenses covered under its policy, up to the full amount of the applicable policy or document limit. Before the primary policy limit is reached, the secondary health benefit plan issuer would have been responsible only for the expenses covered under its policy that are not covered under the primary policy or document. After the limit is reached, the secondary health benefit plan issuer would have been responsible for any expenses covered by both policies or documents that exceed the limit, up to the full amount of the applicable limit of the secondary policy or other coverage. This would have applied to health benefit plans and excludes HIPAA-excepted benefits. ***HB 4016 was introduced and referred to the House Insurance Committee.***

Did Not Pass:

Health Plan Rate Approval

SB 90 (Ellis)

The bill would have required filing and approval of rates for a health benefit plan issuer prior to use. It would have also authorized the Commissioner to disapprove a rate that is already in effect, only after a hearing. The bill applied to individual, group, and small group health benefit plans, and did not apply to disability income, supplemental liability, credit insurance, dental- or vision-only, hospital indemnity, Medicare supplemental, or workers' compensation coverage. ***TAHP opposed this bill. SB 90 was introduced and referred to the Senate Committee on Business and Commerce.***

Did Not Pass:

Credit Card Payment Prohibition

SB 1229 (Seliger)

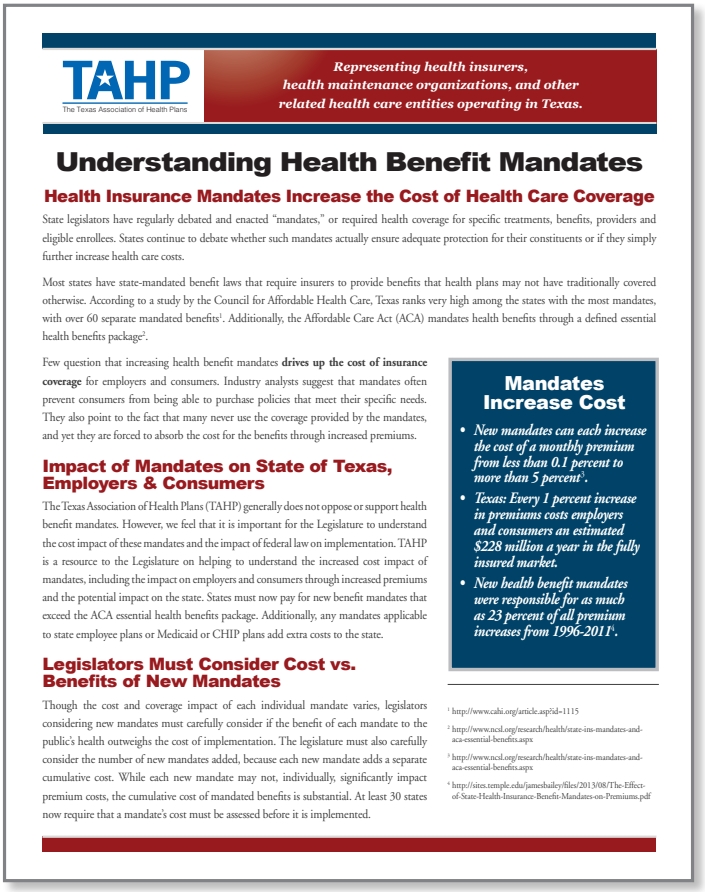
The bill would have prohibited a health plan or third party administrator from using a credit card payment (including virtual) to settle a claim for health care services with a health care provider, even for providers requesting such payments or who have not signed up for payments through automated clearinghouse electronic funds transfers. TAHP testified in opposition to this contract mandate. ***SB 1229 passed the Senate and was left pending in the House Committee on Investments and Financial Services.***

Health Coverage Benefit Mandates

TAHP generally does not oppose or support health benefit mandates. TAHP is a resource to the legislature in understanding the increased cost impact of mandates, including increased premium costs. Through meetings and briefing materials, TAHP educated legislators that although the cost and coverage impact of each individual mandate varies, policy-makers evaluating new mandates should carefully consider if the benefit of each mandate outweighs the cost of implementation. Employers and consumer industry analysts suggest that mandates often prevent consumers from being able to purchase policies that meet their specific needs. They also point to the fact that many consumers never use the coverage provided by mandates, and yet they are forced to absorb the cost for the benefits through increased premiums.

Under the ACA, states must pay for new benefit mandates that exceed the ACA essential health benefits package. Additionally, any mandates applicable to state employee plans, or Medicaid or CHIP plans, add extra costs to the state. TAHP provided informational materials on understanding health benefit mandates and was a resource to legislators on the potential cost impact of adding new health benefit mandates.

This session, the legislature considered more than 15 new health benefit mandates, and only one, HB 2813, passed. HB 2813 by Representative Ken King expands the benefit mandate for cervical cancer screenings to also apply to ovarian cancer. The remaining benefit mandates failed to pass.



TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Understanding Health Benefit Mandates

Health Insurance Mandates Increase the Cost of Health Care Coverage

State legislators have regularly debated and enacted "mandates," or required health coverage for specific treatments, benefits, providers and eligible enrollees. States continue to debate whether such mandates actually ensure adequate protection for their constituents or if they simply further increase health care costs.

Most states have state-mandated benefit laws that require insurers to provide benefits that health plans may not have traditionally covered otherwise. According to a study by the Council for Affordable Health Care, Texas ranks very high among the states with the most mandates, with over 60 separate mandated benefits[1]. Additionally, the Affordable Care Act (ACA) mandates health benefits through a defined essential health benefits package[2].

Few question that increasing health benefit mandates **drives up the cost of insurance coverage** for employers and consumers. Industry analysts suggest that mandates often prevent consumers from being able to purchase policies that meet their specific needs. They also point to the fact that many never use the coverage provided by the mandates, and yet they are forced to absorb the cost for the benefits through increased premiums.

Impact of Mandates on State of Texas, Employers & Consumers

The Texas Association of Health Plans (TAHP) generally does not oppose or support health benefit mandates. However, we feel that it is important for the Legislature to understand the cost impact of these mandates and the impact of federal law on implementation. TAHP is a resource to the Legislature on helping to understand the increased cost impact of mandates, including the impact on employers and consumers through increased premiums and the potential impact on the state. States must now pay for new benefit mandates that exceed the ACA essential health benefits package. Additionally, any mandates applicable to state employee plans or Medicaid or CHIP plans add extra costs to the state.

Legislators Must Consider Cost vs. Benefits of New Mandates

Though the cost and coverage impact of each individual mandate varies, legislators considering new mandates must carefully consider if the benefit of each mandate to the public's health outweighs the cost of implementation. The legislature must also carefully consider the number of new mandates added, because each new mandate adds a separate cumulative cost. While each new mandate may not, individually, significantly impact premium costs, the cumulative cost of mandated benefits is substantial. At least 30 states now require that a mandate's cost must be assessed before it is implemented.

Mandates Increase Cost

- *New mandates can each increase the cost of a monthly premium from less than 0.1 percent to more than 5 percent[3].*
- *Texas: Every 1 percent increase in premiums costs employers and consumers an estimated $228 million a year in the fully insured market.*
- *New health benefit mandates were responsible for as much as 23 percent of all premium increases from 1996-2011[4].*

[1] http://www.cahi.org/article.asp?id=1115

[2] http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx

[3] http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx

[4] http://sites.temple.edu/jameshailey/files/2013/08/The-Effect-of-State-Health-Insurance-Benefit-Mandates-on-Premiums.pdf

Did Not Pass:

Early Prescription Drug Refill Mandate

HB 185 (Zedler)

The bill would have prohibited a plan issuer from denying benefits for a refill, regardless of whether the refill is early, of a prescription drug covered under the plan if benefits for that drug have previously been paid under the plan unless the refill would cause an applicable quantity limit to be exceeded. *HB 185 was left pending in the House Insurance Committee.*

Did Not Pass:

HMO Mammogram Mandate

HB 449 (Alonzo)

The bill would have amended the current "low-dose mammography" benefit mandate to apply to HMOs and to provide that a health benefit plan may allow an enrollee to have a covered mammogram performed by a provider other than the enrollee's PCP. *HB 449 was left pending in the House Insurance Committee.*

Did Not Pass:

Mammogram Mandate

HB 694 (Hernandez)

The bill would have required that an issuer of a health benefit plan with mammography coverage must also offer coverage for supplemental breast cancer screening as part of an annual well-woman examination if the enrollee has dense breast tissue and additional risk factors for breast cancer (as determined by TDI rule) that warrant supplemental breast cancer screening beyond mammography. *HB 694 was passed out of the House Insurance Committee but did not meet procedural deadlines required to pass out of the House Calendars Committee.*

Did Not Pass:

PTSD Mental Health Mandate

HB 838 (Naishtat)/SB 1774 (Menendez)

The bill would have amended the definition of serious mental illness to include posttraumatic stress disorder (PTSD). *HB 838 passed out of the House and was referred to the Senate Committee on Business & Commerce. SB 1774 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Diabetes Equipment Mandate

HB 2133 (Raymond)/SB 1558 (Campbell)

The bill would have expanded the diabetes services and supplies mandate to include insulin pumps that work in conjunction with other medical devices to provide automated or predictive insulin infusion suspend or control functionality as part of a system classified as an artificial pancreas device system. *HB 2133 passed the House but failed to receive an affirmative vote in the Senate Committee on Business & Commerce. SB 1558 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Self-Inflicted Injury Mandate

HB 2219 (Coleman)

The bill would have prohibited a coverage exclusion for expenses incurred by a covered individual as a result of and related to an injury that is self-inflicted or caused in an attempt to commit suicide, regardless of the individual's state of mental health or whether the injury results in the individual's death. *HB 2219 passed the House and was referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Opioid Deterrent Mandate

HB 2505 (Clardy)/SB 1094 (Creighton)

The bill would have created a coverage mandate for abuse-deterrent opioid analgesic drugs and prohibited prior authorization except as required for opioid analgesic drugs that do not have abuse-deterrent properties. *HB 2505 passed out of the House and was referred to the Senate Committee on Business & Commerce. SB 1094 was referred to the Senate Committee on Business & Commerce and received a hearing.*

Did Not Pass:

Expansion of Terminal Illness Mandate

HB 2541 (Zerwas)

The bill would have prohibited a health benefit plan from reducing or denying coverage for a treatment based solely on the enrollee's diagnosis with a terminal illness. TAHP opposed the provision in the bill that would have established that a violation would be an unfair or deceptive act or practice and an unfair claim settlement practice. *HB 2541 passed the House and was referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Serious Mental Illness Mandate

HB 2749 (Coleman)/SB 1478 (Garcia)

The bill would have included anorexia nervosa, bulimia nervosa, and eating disorders as serious mental illnesses. *HB 2749 was introduced and referred to the House Insurance Committee. SB 1478 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

Hearing Aid Mandate

HB 2979 (Anderson)

The bill would have created a mandate for coverage of hearing aids for certain individuals and prohibited application of a deductible to the benefit. *HB 2979 passed out the House Insurance Committee but failed to pass out of the House Calendars Committee due to a procedural deadline.*

Did Not Pass:

Drug Synchronization Mandate

HB 3025 (Farney)

The bill would have required a health benefit plan with prescription drug benefits to pro-rate any cost-sharing amount charged for a prescription drug dispensed in a quantity less than a 30 days' supply if the pharmacy or prescribing provider notifies the health benefit plan that the quantity dispensed is to synchronize the dispensing dates of the covered person's prescription drugs and the synchronization of the dates is in the best interest of the covered person. It would have prohibited pro-rating of the dispensing fee and required plans to allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of medication synchronization. TAHP testified in opposition to this mandate. *HB 3025 passed out the House Insurance Committee but died on a House Calendar.*

Did Not Pass:

Mammogram Mandate

HB 3194 (Bernal)

The bill would have expanded the mammography mandate to require coverage for a diagnostic mammogram as part of an annual well-woman examination if ordered by a licensed health care professional treating the enrollee. *HB 3194 passed out the House Insurance Committee but failed to pass out of the House Calendars Committee due to a procedural deadline.*

Did Not Pass:

Autism Recreational Therapy Mandate

HB 3986 (Simmons)

The bill would have added "recreational therapy" to the generally recognized services in the autism mandate. TAHP was opposed to the lack of definition and standards. *HB 3986 passed out the House Insurance Committee but failed to pass out of the House Calendars Committee due to a procedural deadline.*

Did Not Pass:

HIV Testing Mandate

SB 194 (Ellis)

The bill would have required a health care provider who takes a sample of a person's blood as part of a routine medical screening to submit the sample for an HIV diagnostic test, regardless of whether it was part of a primary diagnosis, unless the person opts out of the HIV test. *SB 194 was introduced and referred to the Senate Health and Human Services Committee.*

Other Key Bills

Did Not Pass:

State-Based Exchange

HB 817 and HB 818 (C. Turner)

These bills would have provided for the establishment of a state-based exchange; HB 817 was contingent upon elimination of federal subsidies as a result of pending litigation (King v. Burwell). *HB 817 and HB 818 were referred to the House Insurance Committee.*

Did Not Pass:

Repealing Physical Therapy Referral Requirement

HB 1263 (Raymond)

The bill would have repealed the current prohibition against a physical therapist (PT) treating a patient without a prior referral if the treatment is within the PT's scope of practice and the therapist meets certain standards. TAHP testified this repeal could have unintended consequences for physical therapy coverage because PPO plans are prohibited from requiring referrals. *HB 1263 passed out of the House Public Health Committee but did not pass out of the House due to end-of-session procedural deadlines.*

Did Not Pass:

Out-of-Network Emergency Care Billing Disputes

HB 1638 (Smithee)/SB 1562 (Taylor)

The bill would have required an insurer to pay an out-of-network provider a reasonable amount for emergency care. In return, the out-of-network provider could not bill a consumer a balance bill or the difference of their billed charges and what the consumer's health plan paid. If there was a billing dispute, the provider or the insurer could request arbitration. HB 1638 was introduced and referred to the House Insurance Committee. *SB 1562 was introduced and referred to the Senate Committee on Business & Commerce.*

Did Not Pass:

HIT Exemption for Premium Tax

HB 2467 (P. King)

The bill would exclude additional premiums, revenues, or other fees, whether separately stated or built into the rates charged for coverage, under the ACA, and specific to the recoupment of Health Insurance Provider fees, from being included in determining an insurer's taxable gross premiums or a HMO's taxable gross revenues. *HB 2467 was introduced and referred to the House Insurance Committee.*

Did Not Pass:

Including APRNs in Provider Networks

HB 3398 (Paddie)/SB 1980 (Garcia)

The bill would have made changes to the way both Medicaid and commercial health plans contract with advanced practice registered nurses (APRNs) by allowing APRNs to be included in a health plan's network regardless of whether the APRN's supervising physician is in the network. Under HB 3398, if a health plan included an APRN in the plan's provider network as a primary care provider, the APRN's delegating physician would be included in the plan's network for purposes of supervision. HB 3398 was introduced and referred to the House Insurance Committee. *SB 1980 was introduced and referred to the Senate Health and Human Services Committee.*

Did Not Pass:

Prescription Drug Price Study

HB 4002 (Burrows)

The bill would have established the joint interim committee on pharmaceutical pricing to study and review the impacts of international pharmaceutical price discrimination on the people of Texas as well as on the state government. The study would have included: (1) the reasoning behind pharmaceutical companies pricing on the international market; (2) any changes in the cost of pharmaceuticals under the ACA; (3) the amount to which the American public subsidizes the international pharmaceutical market, research and development, and other costs; and (4) the impacts of price discrimination on individual citizens and the budget of Texas. TAHP supported the legislation. *HB 4002 was introduced and referred to the House Committee on International Trade and Intergovernmental Affairs.*

Did Not Pass:

Prohibition on Abortion Coverage

SB 575 (Taylor)/HB 1435 (Smithee)

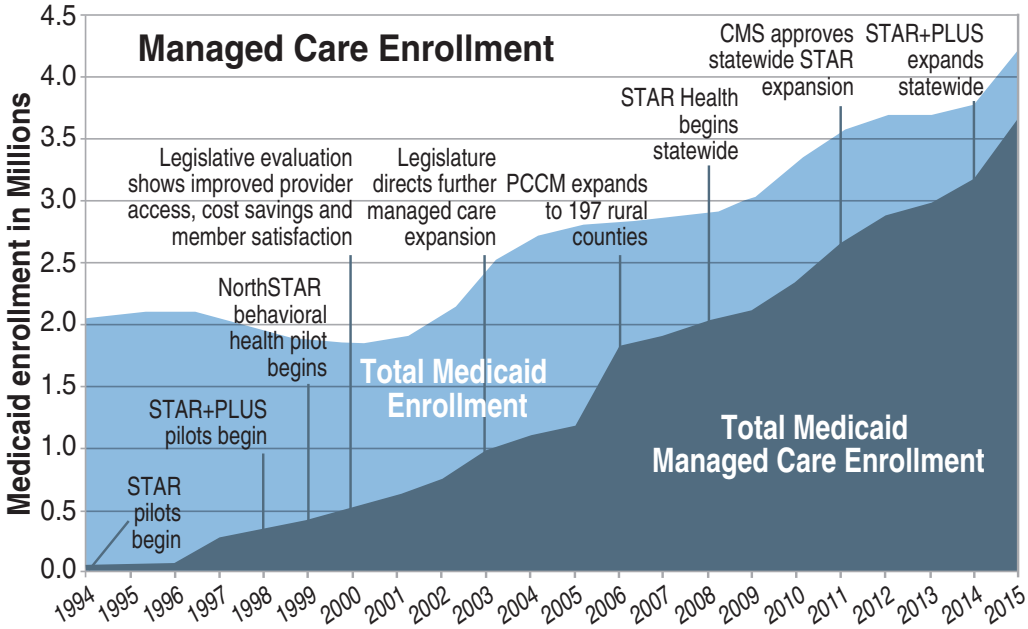
The bill would have prohibited a qualified health plan (QHP) offered through a health benefit exchange from providing coverage for an abortion except in very limited circumstances. It would have allowed a (non-exchange) health benefit plan to provide coverage for abortion, except in very limited circumstances, only if (1) the coverage is provided to an enrollee separately from other health benefit plan coverage offered by the health benefit plan issuer; (2) an enrollee pays separately from, and in addition to, the premium for other health benefit plan coverage a premium for coverage for abortion; and (3) an enrollee provides a signature for coverage for abortion, separately and distinct from the signature required for other health benefit plan coverage offered by the health benefit plan issuer. ***SB 575 passed the Senate and was placed on the House Major State Calendar but died under end-of-session procedural deadlines. HB 1435 was introduced and referred to the House Committee on State Affairs.***

Texas Association of Health Plans

Improving Affordability, Accessibility and Accountability

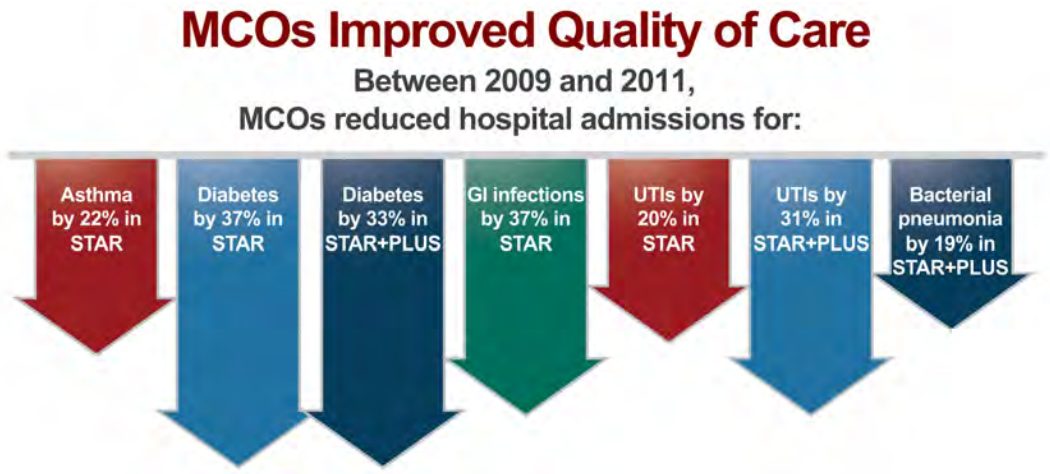
Medicaid and Public Health

Texas is a national leader in the use of managed care to increase access to care, manage costs, and improve health care quality in the Medicaid and CHIP programs. The managed care private-market approach drives innovation through flexibility and increases competition, which brings down health care costs and holds managed care organizations (MCOs) accountable for providing access to quality care. More than 3 million Texas Medicaid enrollees (approximately 85% of total enrollment) are served by a private health insurer through the Medicaid managed care program. Since the inception of Medicaid managed care in Texas, health plans have reduced costs and increased access to care.



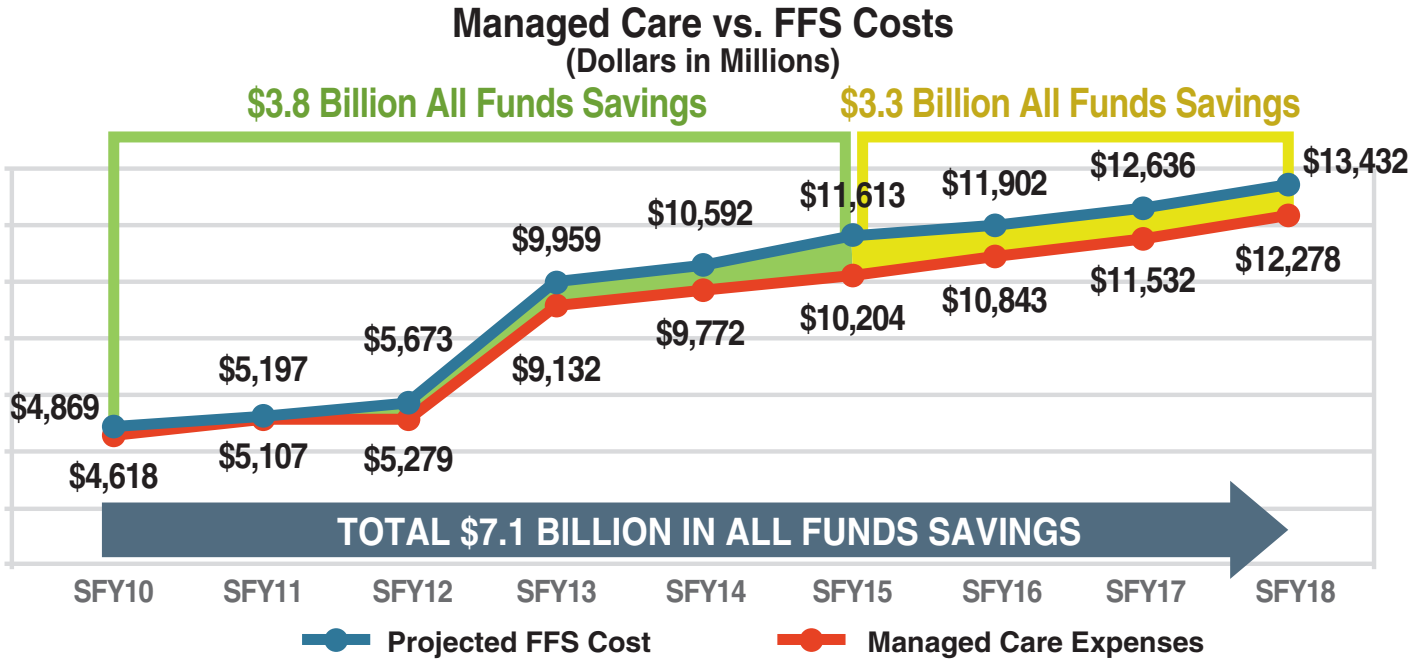
Improved Quality and Access

Medicaid MCOs have dramatically improved the lives, outcomes and quality of care for Medicaid consumers.



Medicaid Managed Care Cost Savings

Independent actuaries estimate that Medicaid managed care has reduced costs by 7.9% and saved the state $3.8 billion All Funds (AF) since 2010, and is expected to save another $3.3 billion AF through 2018 when compared to the fee-for-service (FFS) model. Medicaid dental managed care has reduced costs by 28.4% since FY13.



Source: Texas Medicaid Managed Care Cost Impact Study. Milliman. February 2015.

During the 84th Legislature, TAHP and its members advocated for fostering and expanding the success of Medicaid managed care for consumers and taxpayers. The continued success of managed care in Texas relies on maintaining a regulatory environment that fosters innovation, allows full integration of services, ensures a collaborative and transparent rate development process, and reduces administrative complexity wherever and whenever possible.

Members of the legislature recognized the value of Medicaid managed care for Medicaid consumers and Texas taxpayers in their final budget and policy decisions. This included protecting the success of Medicaid managed care in the rate setting process by fully covering the cost of the Health Insurance Provider Fee and not arbitrarily cutting the MCO risk margin, while protecting and expanding the Medicaid managed care solution to more consumers. Rather than cuts to health plans and new costly regulations that would have increased costs for taxpayers and reduced services and quality of care for consumers, the state invested in budget decisions and adopted new policies that protect the Medicaid managed care system, which is already achieving budget savings and improving lives through innovation and better care management and coordination.

TAHP Priority Legislation

House Bill 1 and House Bill 2—General Appropriations Act and Supplemental Appropriations Bill

Passed:

FY 15 Supplemental Appropriations Act

HB 2 (Otto/Nelson)

HB 2, the supplemental appropriations bill, adjusts the Fiscal Year (FY) 2015 budget for additional funding needs. Typically, the legislature must adjust the current budget to help meet additional funding needs, including additional Medicaid costs. By the end of the previous session, the Medicaid shortfall or supplemental need expected for FY 2015 was estimated to be more that $1 billion in state general revenue (GR) costs. The final FY 15 supplemental appropriation for Medicaid was $75.5 million GR ($180 million AF), for additional costs and caseload growth. The state appropriated another $80 million GR ($193.5 million AF) to fully cover the cost of the Health Insurance Provider fee and the associated federal income tax impact for Medicaid health plans. Before making any capitation payments to MCOs that are adjusted using this appropriation, HB 2 requires HHSC to submit a report to the Legislative Budget Board (LBB) on the full impact of the Health Insurance Provider Fee and other mid-year capitation adjustments. The total supplemental appropriation for FY 2015 is $290.0 million GR. ***The bill takes effect immediately.***

Passed:

FY 16-17 General Appropriations Act

HB 1 (Otto/Nelson)

Appropriations for Health and Human Services encompass many different programs, but spending is driven primarily by forecasted caseloads for entitlement programs, such as Medicaid, the Children's Health Insurance Program (CHIP), and foster care and related programs.

Medicaid appropriations for FY 16-17 total $61.2 billion AF, a $2.1 billion increase over FY 14-15. The budget assumes growth for caseloads. The budget also assumes the full cost of the Health Insurance Provider Fee for Medicaid health plans and it does not assume a reduction in the Medicaid managed care risk margin. It also includes full funding for the Community First Choice program.

FY 16-17 Medicaid appropriations do not include anticipated increases in cost growth. Budget writers acknowledged that a lack of funding for these costs will likely lead to a need for increased funding before the end of the biennium. Those additional costs are typically dealt with as an emergency supplemental appropriation when the legislature reconvenes, which will be in January 2017. Additionally, the legislature did not fund the primary care provider (PCP) payment increase, which would have continued the increase of Medicaid PCP rates to the Medicare rates.

FY 16-17 Budget Summary

Total Budget:
- $209.4 billion AF
- $106.6 billion GR
- 3.6% AF increase over FY 14-15

Total Article II – HHS Budget:
- $77.2 billion AF
- $2.7 billion AF increase over FY 14-15
- $33.4 billion GR

Tax Cuts:
- $3.8 billion in tax cuts
- Property tax reduction
- 25% Franchise Tax reduction

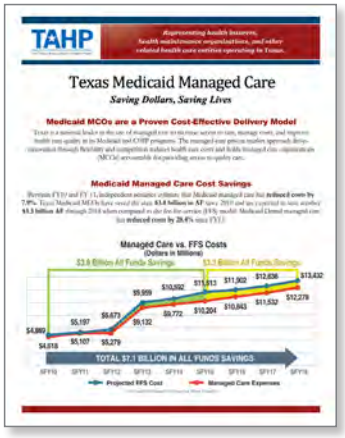
The Health and Human Services (HHS) agencies experienced some significant changes, largely due to the Sunset process and contracting concerns. Many of the HHS budget decisions reflect these changes. HB 1 also includes more than 100 legislative provisions, referred to as budget riders, related to HHS funding. Among the riders is an HHSC "cost containment rider," which lists ways to achieve mandated savings for Medicaid and several riders related to quality improvement programs and new reporting requirements for MCOs.

The summary of conference committee decisions can be found **here**. ***The bill takes effect September 1, 2015.***

Major Medicaid MCO Budget Decisions

Cost Containment Provisions and the Medicaid MCO Risk Margin

The final budget includes a reduction of $869.6 million AF, including $373.0 million GR, for cost-containment initiatives (HHSC Rider 50. Medicaid Funding Reduction and Cost Containment). **While the Senate version of the budget cut MCO premiums through a reduction in the premium risk margin, the final passed budget does not include that assumption.**



The Senate version of the budget included an assumption in the cost containment rider that would have cut more than $80 million GR (approximately $200 million AF) to health plans through a 25% rate reduction in the MCOs' capitation risk margin (2% to 1.5%). This proposed reduction would have put the stability and success of the Texas Medicaid managed care market at risk.

TAHP advocated that Medicaid managed care is already one of the most effective cost containment polices for the state—saving the state billions of dollars. Under managed care, premiums have stayed relatively flat, only growing 2.2% for STAR from 2009-2013.

The final adopted budget still contains the cost containment rider, but there is no longer an assumption that the risk margin will be cut to achieve these savings. The cost containment provision still assumes $100 million in savings through a reduction in utilization and reimbursement rates for therapy services in Medicaid.

Health Insurance Provider Fee

Throughout the legislative session, TAHP advocated for the inclusion of the cost of the ACA health insurance provider fee in the Medicaid managed care premiums to ensure adequate rates and maintain the success of Medicaid managed care. This funding is a strict pass-through and is necessary to maintain actuarially sound rates.

For FY 2015, 2016 and 2017, the budget committees appropriated $321.7 million in state funding and $459.5 million in federal Medicaid matching funds to fully cover the cost of the ACA health insurance provider fee.

HB 1 also includes a rider that would return the appropriation back to the state if the health insurance provider fee were to be federally repealed.

Other Major Health and Human Services Budget Increases

- $712.6 million AF: **Supplemental hospital financing** and 1115 waiver adjustment
- $327.6 million AF, including $125.7 million GR: Increase for **community care waiting list reductions** to serve an additional 5,601 long-term care waiver clients
- $31.5 million AF, including $12.3 million GR: New STAR+PLUS services for individuals with intellectual and developmental disabilities (IDD) (respite care and non-emergency transportation)
- $32.5 million GR: **Increase for attendant wages** ($8.00 base per hour)
- $50 million GR for a total $257.1 million AF: **Increase for women's health services**
- $150 million GR: **Increase in behavioral health and substance abuse** (total behavioral health/substance abuse funding: $3.6 billion AF, including $2.8 billion GR)
- $60 million GR: **Increase in graduate medical education** (ensures a residency spot for every Texas medical school graduate)

Major Budget Provisions (Riders) Adopted that Impact Medicaid Managed Care

HHSC Rider 66. Network Access Improvement Program

Requires HHSC to report on the Network Access Improvement Program (NAIP) including programs, targets and goals, list of participants, and funding amounts.

HHSC Rider 67. Report on Pay for Quality Measures

Requires HHSC to report and evaluate how Medicaid providers and MCOs are using the Pay for Quality program to improve health care delivery, how to make the program more effective, and recommendations for expansion.

HHSC Rider 81. Medicaid Managed Care Organization Network Adequacy Action Report

Requires HHSC to report to the legislature and the public the number of final disciplinary orders or corrective action plans imposed by HHSC over the last five years based upon violations of HHSC's Medicaid managed care program network adequacy requirements.

HHSC Rider 82. Assessment of Single Case Agreements

Requires HHSC to report the number and types of single case agreements between any Medicaid or CHIP MCO and a provider over the last five years.

HHSC Rider 83. Report on the Vendor Drug Program

Requires HHSC to evaluate new delivery models for cost-effectiveness, increased competition, and improved health outcomes for the vendor drug program.

HHSC Rider 94. Evaluation of Medicaid Data

Requires HHSC to evaluate data submitted by MCOs to determine whether the data continues to be useful or if additional data, such as measurements of recipient services, is needed to oversee contracts or evaluate the effectiveness of Medicaid.

HHSC Rider 95. Provider Enrollment Portal

Allows HHSC to establish a centralized Internet portal through which providers may enroll in Medicaid and share information with a centralized credentialing entity and coordinate with the MCOs to use the centralized credentialing entity to collect and share information. It also allows HHSC to consolidate the provider enrollment and the credentialing entity within the centralized Internet portal.

HHSC Rider 97. Nursing Facility Minimum Payment Amounts Program

Requires HHSC to fully transition the Nursing Facility Minimum Payment Amount Program (MPAP) from a program solely based on enhanced payment rates to publically-owned nursing facilities to a Quality Incentive Payment Program (QIPP) for all nursing facilities.

Article IX Rider 7.12. Notification of Certain Purchases or Contract Awards, Amendments, and Extensions

Requires all agencies to satisfy a number of new reporting requirements to the LBB before they are allowed to award contracts that exceed $10 million.

Major Medicaid Managed Care Budget Provisions NOT Adopted

There were a number of budget provisions that were either adopted or considered in the House or Senate versions of the budget that would have had a negative impact on Medicaid managed care and on costs for the state of Texas. TAHP and its member plans voiced concerns about the negative impact these provisions could have on the success of Medicaid managed care, including the potential for increased costs to taxpayers. Fortunately, the following provisions were ultimately NOT included in the final budget:

Hospital Carve-Out

Would have carved hospitals out of the Medicaid managed care premium and transitioned them back to traditional FFS, if the Medicaid 1115 Transformation Waiver was not renewed. This provision would have cost the state $60 million for the biennium in premium tax revenue and increased costs for taxpayers.

Out-of-of Network Rate Increase

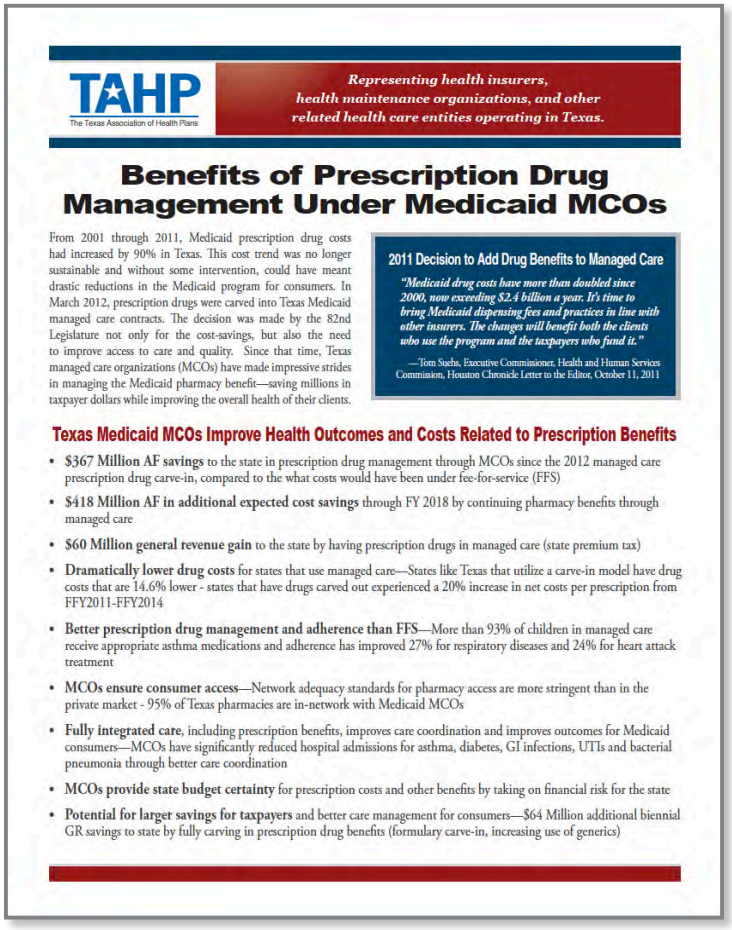
Would have required MCOs to pay out-of-network hospital reimbursement at 100% of the Medicaid FFS fee schedule versus the current 95% requirement.

Vendor Drug Carve-Out

Would have carved prescription drug benefits out of Medicaid managed care and transitioned them back to traditional FFS. This would have resulted in a loss of $64 million for the biennium in premium tax revenue for the state and risked the $418 million in savings managed care is anticipated to achieve in the current program through 2018.

Mandate for Three Dental MCOs

Would have required HHSC to contract with three dental managed care organizations (DMOs), instead of two. This provision would have forced HHSC to contract with at least three DMOs even if it was not in the best interest of clients and the state.



TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Benefits of Prescription Drug Management Under Medicaid MCOs

From 2001 through 2011, Medicaid prescription drug costs had increased by 90% in Texas. This cost trend was no longer sustainable and without some intervention, could have meant drastic reductions in the Medicaid program for consumers. In March 2012, prescription drugs were carved into Texas Medicaid managed care contracts. The decision was made by the 82nd Legislature not only for the cost-savings, but also the need to improve access to care and quality. Since that time, Texas managed care organizations (MCOs) have made impressive strides in managing the Medicaid pharmacy benefit—saving millions in taxpayer dollars while improving the overall health of their clients.

2011 Decision to Add Drug Benefits to Managed Care

"Medicaid drug costs have more than doubled since 2000, now exceeding $2.4 billion a year. It's time to bring Medicaid dispensing fees and practices in line with other insurers. The changes will benefit both the clients who use the program and the taxpayers who fund it."

—Tom Suehs, Executive Commissioner, Health and Human Services Commission, Houston Chronicle Letter to the Editor, October 11, 2011

Texas Medicaid MCOs Improve Health Outcomes and Costs Related to Prescription Benefits

- **$367 Million AF savings** to the state in prescription drug management through MCOs since the 2012 managed care prescription drug carve-in, compared to the what costs would have been under fee-for-service (FFS)
- **$418 Million AF in additional expected cost savings** through FY 2018 by continuing pharmacy benefits through managed care
- **$60 Million general revenue gain** to the state by having prescription drugs in managed care (state premium tax)
- **Dramatically lower drug costs** for states that use managed care—States like Texas that utilize a carve-in model have drug costs that are 14.6% lower - states that have drugs carved out experienced a 20% increase in net costs per prescription from FFY2011-FFY2014
- **Better prescription drug management and adherence than FFS**—More than 93% of children in managed care receive appropriate asthma medications and adherence has improved 27% for respiratory diseases and 24% for heart attack treatment
- **MCOs ensure consumer access**—Network adequacy standards for pharmacy access are more stringent than in the private market - 95% of Texas pharmacies are in-network with Medicaid MCOs
- **Fully integrated care**, including prescription benefits, improves care coordination and improves outcomes for Medicaid consumers—MCOs have significantly reduced hospital admissions for asthma, diabetes, GI infections, UTIs and bacterial pneumonia through better care coordination
- **MCOs provide state budget certainty** for prescription costs and other benefits by taking on financial risk for the state
- **Potential for larger savings for taxpayers** and better care management for consumers—$64 Million additional biennial GR savings to state by fully carving in prescription drug benefits (formulary carve-in, increasing use of generics)

Key Legislation Affecting Medicaid and Public Health

Passed:

HHS Sunset Review

In 2013, the Texas Sunset Commission began its review of the five Texas health and human services (HHS) agencies. This marked the first Sunset review of the state's HHS system since 1999 and the first comprehensive review since the 2003 consolidation resulting from HB 2292, which reduced the previous 12 legacy health agencies into the five we have today.

The Sunset staff reports, published in the fall of 2014, recommended major overhauls of the HHS agencies and system, including consolidation of the functions of all five agencies under the Health and Human Services Commission (HHSC). The Sunset reports can be found **here**.

Sunset staff recommendations were adopted (with modifications) by members of the Sunset Commission, chaired by Senator Jane Nelson, and subsequently filed as a package of bills. The Sunset bills continued to evolve throughout session, with one of the biggest changes being continuation of certain HHS functions as separate agencies rather than full consolidation under HHSC.

The 84th Legislature took the following actions on the HHS Sunset bills:

Key HHS Issues Identified by Sunset Commission

- Incomplete implementation of the HB 2292 vision of a consolidated HHS system
- Lack of clear lines of executive commissioner authority
- Fragmented Medicaid administration between agencies
- Failure to adapt agency processes to managed care
- Fragmented and burdensome Medicaid provider enrollment and credentialing processes
- Missed opportunities to promote quality of care improvements
- Lack of data management
- Outdated NorthSTAR approach
- Complications resulting from multiple women's health programs
- Poor management of the OIG
- Uncoordinated websites, hotlines, and complaints
- Duplicative advisory committees, task forces, and councils

Health and Human Services Commission Sunset

SB 200 (Nelson/Price)

The HHSC Sunset bill continues HHSC until September 1, 2027, and consolidates and reorganizes certain functions of the five HHS agencies in two phases:

Phase 1 (not later than September 1, 2016):

- **Transfers functions of Department of Assistive and Rehabilitative Services (DARS) [that are not transferred to Texas Workforce Commission (TWC) in SB 208 (Campbell/Burkett), TWC Sunset legislation] to HHSC and abolishes DARS; if federal approval is not received for the transition of DARS functions to TWC, then DARS functions transfer to HHSC by September 1, 2016;**
- **Transfers functions of HHSC Council, Department of Aging and Disability Services (DADS) Council, DARS Council, Department of Family and Protective Services (DFPS) Council, Department of State Health Services (DSHS) Council, and the Texas Council on Autism and Pervasive Developmental Disorders to HHSC and abolishes these entities; and**
- **Transfers all client services of the HHS system to HHSC, except for prevention and early intervention services (including Nurse-Family Partnership), which are transferred to DFPS.**

Phase 2 (not later than September 1, 2017):

- **Transfers functions of the Office for the Prevention of Developmental Disabilities and remaining DADS functions (e.g., State Supported Living Centers, regulatory) to HHSC and both entities are abolished; and**
- **Transfers DSHS regulatory and state hospital functions to HHSC.**

Continued on Page 33

SB 200 maintains DSHS as a separate agency with control over its public health functions, including the collection and maintenance of health care data. DFPS is also maintained as a separate agency for the statewide intake of reports and other information related to: Child Protective Services (CPS), Adult Protective Services (APS) (except investigations of abuse, neglect, and exploitation of the elderly and individuals with disabilities under certain circumstances), and prevention and early intervention services including the Nurse Family Partnership Program. Both DSHS and DFPS will sunset on September 1, 2023 unless continued.

The bill requires the executive commissioner to develop and submit a transition plan by March 1, 2016, and creates the Transition Legislative Oversight Committee to facilitate the transfers and report on the transfers and the need to continue DFPS and DSHS as separate agencies.

NorthSTAR

Removes references in statute to the NorthSTAR behavioral health program and requires HHSC to ensure that Medicaid MCOs fully integrate recipients' behavioral health services into their primary care coordination, giving particular attention to a MCO that contracts with a third party to provide behavioral health services.

Advisory Committees

Deletes nearly all HHS advisory committees, task forces and councils from statute and requires the HHSC executive commissioner to establish and maintain advisory committees across all major areas of the HHS system through rule. Entities deleted include: Behavioral Health Integration Advisory Committee, Texas Institute of Health Care Quality and Efficiency, STAR+PLUS Quality Council, STAR+PLUS Nursing Facility Advisory Committee, Regional Medicaid Managed Care Advisory Committee, and the State Managed Care Advisory Committee. The IDD System Redesign Advisory Committee and STAR Kids Advisory Committee are maintained until one year after implementation of those programs is complete. The Medical Care Advisory Committee is maintained and a MCO representation is added. Additional deletions and changes to HHS advisory committees were made in **SB 277 (Schwertner/Sheffield)**.

The bill also requires HHSC to create a master advisory committee calendar for all advisory committee meeting and post the master calendar on its web site and stream advisory committee meetings on its web site.

Drug Utilization Review Board

Abolishes the Pharmaceutical and Therapeutics Committee and transfers its functions to the Drug Utilization Review (DUR) Board. Responsibilities of the consolidated DUR Board will include: developing and submitting to HHSC recommendations on which drugs should be included or excluded from preferred drug lists (PDL), suggesting restrictions or clinical edits, recommending educational interventions for Medicaid providers, and reviewing Medicaid drug utilization. The DUR Board is required to hold quarterly public meetings and permit public comment before voting on PDL changes, adoption of or changes to drug use criteria, or adoption of prior authorization or DUR proposals.

SB 200 requires that two MCO representatives (physician and pharmacist) be included as non-voting members on the DUR Board. These MCO representatives may attend meetings but may not attend executive sessions or access confidential drug pricing information. The executive commissioner is required by February 1, 2016, to implement a process by rule for individuals to apply for DUR Board membership, including posting the application and information on HHSC's website.

Maintenance of Medicaid Eligibility

Requires HHSC to develop and implement a statewide effort to assist Medicaid recipients with maintaining their eligibility for Medicaid and avoiding lapses in coverage. As part of this effort, HHSC must require that MCOs help clients maintain eligibility, develop strategies to help Medicaid recipients receiving Supplemental Security Income (SSI) to maintain eligibility (if cost effective), and ensure that information relevant to a recipient's eligibility is provided to the recipient's MCO.

Incentive-Based Payments

Requires HHSC to develop a pilot project to increase the use and effectiveness of incentive-based provider payments by Medicaid MCOs. HHSC and the MCOs will be required to work with providers to develop common payment methodologies for the pilot that are structured to reward appropriate, quality care; align pilot outcomes with existing Medicaid managed care quality-based payment programs; encourage formal

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arrangements for providers to work together to provide better patient care; are adopted by all MCOs so that similar incentive methodologies apply to all participating providers under the same model; and are voluntarily agreed to by the participating providers. Based on results of the pilot, HHSC will identify incentive-based provider payment goals and outcome measures that can be implemented statewide and require MCOs to implement these goals and measures. TAHP was able to get language added in the Senate that ensures that the pilot does not supplant existing MCO provider incentive programs.

Coordination of Quality Initiatives

Requires HHSC to develop and implement a comprehensive, coordinated operational plan to ensure a consistent approach across major HHSC quality initiatives and revise quality initiatives accordingly.

Provider Enrollment and Credentialing

Requires HHSC to streamline the Medicaid provider enrollment and credentialing processes, including implementation of a centralized, online Medicaid provider enrollment portal. Allows HHSC to designate a centralized credentialing entity, share information in the Medicaid provider database with that entity, and require MCOs to use the entity to collect and share information. Also allows HHSC to create a single, consolidated enrollment and credentialing process and, if cost effective, contract with a third party to develop this process. If this single, consolidated enrollment and credentialing process is established, Medicaid MCOs would be required to formally re-credential Medicaid providers along the timeline established for the single, consolidated process, which may be less frequent than every three years.

TAHP CVO Project

TAHP has initiated the process of procuring a centralized Credentialing Verification Organization (CVO) for use by Medicaid/CHIP plans to reduce administrative burdens for providers participating in Medicaid managed care. TAHP posted a Request for Information (RFI) in April 2015. Responses to the RFI were due in May 2015. TAHP is currently reviewing RFI responses and plans to release a formal Request for Proposals in the fall of 2015.

Data

Requires HHSC to regularly evaluate whether data submitted by Medicaid MCOs continues to serve a useful purpose and whether additional data is needed to oversee the contracts or evaluate the effectiveness of Medicaid. The data is required to capture the quality of services received by Medicaid recipients and HHSC is charged with developing a dashboard by March 1, 2016, to assist agency leadership with overseeing the Medicaid program. The dashboard will compare the performance of Medicaid MCOs by identifying important Medicaid indicators.

OIG

Requires the Office of Inspector General (OIG) to consult with the executive commissioner on the adoption of rules defining OIG's role, jurisdiction, and frequency of audits of MCOs conducted by HHSC and OIG. OIG is required to coordinate with HHSC on all MCO audit and oversight activities, including seeking HHSC input and considering previous HHSC audits and onsite visits to determine whether to audit a MCO. Also requires the provider enrollment contractor (TMHP) and MCOs to defer to OIG regarding whether a person's criminal history record information precludes the person from participating as a Medicaid provider.

Organizational Divisions Required

Requires the executive commissioner to establish divisions within HHSC along functional lines and appoint a director for each (divisions will at a minimum include OIG, a medical and social services division, a regulatory division, an administrative division, and a facilities division for administering state facilities including state hospitals and state supported living centers).

Internal Audit

Requires HHSC to operate a consolidated internal audit program for HHSC and each HHS agency.

HHSC Executive Council

Establishes the HHSC Executive Council to receive public input and advise the executive commissioner on HHSC operations (includes TAHP-suggested language that encourages "broad and balanced" representation of industry and consumer interests on the Council).

Section 1115 Waiver and DSRIP Projects

Requires that HHSC, during the renewal of the 1115 Transformation Waiver, seeks to reduce the number of approved Delivery System Reform Incentive Payment (DSRIP) project options to include only projects that would be most critical to improving the quality of health care.

Women's Health Committee

Requires the executive commissioner to appoint a Women's Health Advisory Committee to provide recommendations on consolidation of the women's health programs.

Ombudsman Office

Requires HHSC to establish an Office of Ombudsman for the HHS system and abolishes other ombudsman offices except the Office of Independent Ombudsman for State-Supported Living Centers (SSLCs), the Office of the State Long-Term Care Ombudsman, and any other ombudsman office required by federal law.

Medicaid Dental Director

Requires the executive commissioner to appoint a Medicaid dental director who is a licensed dentist.

SB 200 also requires that HHSC undergo a limited-scope Sunset review during FY 2022-2023. ***The bill takes effect September 1, 2015, except as otherwise provided by this Act.***

Passed:

Department of State Health Services Sunset

SB 202 (Nelson/Price)

The bill transfers many of the DSHS regulatory programs to the Texas Department of Licensing and Regulation and the Texas Medical Board. Remaining DSHS regulatory functions and the agency's state hospital functions will be transferred to HHSC per SB 200, and DSHS will remain a separate state agency for public health functions. ***The bill takes effect September 1, 2015, except for Part 2 of Article 1 of this Act, which takes effect September 1, 2017.***

Passed:

Texas Health Services Authority Sunset

SB 203 (Nelson/Raymond)

The bill continues the Texas Health Services Authority (THSA) in statute as a quasi-governmental entity for six additional years until September 1, 2021, at which time the THSA will transition to a private nonprofit corporation. ***The bill takes effect September 1, 2015, except for Section 15(b), which takes effect September 1, 2021.***

Passed:

Department of Family and Protective Services Sunset

SB 206 (Schwertner/Burkett)

The bill streamlines agency requirements; requires CPS to implement an annual business planning process; requires the development of a foster care redesign implementation plan; requires a strategic plan for prevention and intervention services; implements a child care license and renewal process; modifies child care licensing and enforcement provisions; and allows home schooling for foster care children under certain circumstances. With the passage of SB 200, services provided by DFPS will transition to HHSC and DFPS will remain a separate agency for the purposes of CPS/APS. ***The bill takes effect September 1, 2015, except for Sections 42.050 (d) and 42.052 (f-1), Human Resources Code, as added by this Act, which take effect September 1, 2016.***

Passed:

Office of Inspector General Sunset

SB 207 (Hinojosa/L. Gonzales)

The bill addresses management, transparency, and due process issues identified by the Sunset Commission's review of OIG.

Role of the Executive Commissioner, OIG, and Governor: Requires OIG to work in consultation with the executive commissioner of HHSC to adopt rules necessary to implement a power or duty related to the operations of OIG. OIG is required to closely coordinate with the executive commissioner and the staff of programs under OIG's purview when performing functions related to the prevention of fraud, waste, and abuse in the HHS system and the enforcement of state law related to the provision of those services, including audits, utilization reviews, provider education, and data analysis.

Continued on Page 36

Definition of Fraud

Changes the definition of "fraud" to specify that the term does not include unintentional technical, clerical, or administrative errors.

Specific OIG MCO Provisions

Requires OIG to investigate fraud, waste, and abuse by MCOs. This includes establishing training and oversight requirements for MCO special investigative units (SIUs) or contracted entities and HHSC and OIG staff; establishing requirements for approving plans to prevent and reduce fraud and abuse adopted by MCOs; evaluating and communicating statewide fraud, waste, and abuse trends to SIUs and contracted entities; and assisting SIUs in discovering or investigating fraud, waste, and abuse as needed.

The bill also repeals the prohibition of Health Insurance Premium Payment (HIPP) reimbursement program in Medicaid managed care. It requires the MCOs to defer to OIG Medicaid provider enrollment decisions related to criminal background checks.

The bill also requires the executive commissioner to adopt rules, in consultation with OIG, defining OIG's role with respect to MCO SIUs and other contracted entities, including that OIG will review the findings of SIUs, investigate MCO overpayment cases over $100,000, and investigate providers enrolled in more than one MCO.

Criminal History Background Checks

Requires OIG to enter into a memorandum of understanding with each state licensing authority that requires a fingerprinted background check of a health care professional to ensure that only individuals who are licensed and in good standing as health care professionals are approved as Medicaid providers.

Investigations

Requires OIG to complete preliminary investigations of Medicaid fraud and abuse by the 45th day after the date HHSC received a complaint or allegation or has reason to believe that fraud or abuse has occurred. It requires OIG to complete a full investigation by the 180th day after the date the full investigation began, unless the office determines that more time is needed. If OIG determines that it needs more time, the office has to notify the provider subject to the investigation of the delay and has to specify why the office was unable to complete the investigation within the 180-day period.

Payment Holds and Provider Notice

Specifies that a payment hold is a serious enforcement tool that OIG imposes to mitigate ongoing financial risk to the state, and that a payment hold would take effect immediately. Requires OIG to consult with the state's Medicaid fraud control unit in establishing guidelines regarding the imposition of certain payment holds. Other provisions related to payment holds are outlined in the bill as well.

Administrative Hearings

Requires OIG to file a request with the State Office of Administrative Hearings (SOAH) for an expedited administrative hearing regarding a payment hold within three days after the date the office received a provider's request for such a hearing. The bill also would require a provider to request an expedited administrative hearing within 10 days after receiving notice from OIG regarding a payment hold. Under the bill, SOAH would have to hold the expedited administrative hearing within 45 days after receiving a hearing request. These changes apply only to a complaint or allegation received on or after September 1, 2015.

Informal Resolution Process

Allows OIG to decide whether to grant a provider's request for a first or second informal resolution meeting. Informal resolution meetings will be confidential and any information or materials obtained by OIG will be privileged and confidential and not subject to disclosure.

Recoupment of Overpayment or Debt

Requires HHSC or OIG to give a provider written notice of any proposed recoupment of an overpayment or debt related to Medicaid services and any damages or penalties related to a fraud or abuse investigation.

Rules on OIG Operation and Duties

Requires the executive commissioner of HHSC to set rules for opening and prioritizing cases. In addition, the executive commissioner, in consultation with OIG, is required to adopt rules detailing OIG investigation procedures and criteria for enforcement and punitive actions. Significant coordination between the commissioner and OIG is required.

Extrapolation Review

Requires OIG to review its investigative process, including its use of sampling and extrapolation to audit provider records. Also requires OIG to arrange for the Association of Inspectors General or a similar third party to conduct a peer review of the office's sampling and extrapolation techniques.

Continued on Page 37

Pharmacies Subject to Audits

Specifies that a pharmacy has a right to request an informal hearing before the HHSC's appeals division to contest an audit that did not find that the pharmacy engaged in Medicaid fraud. Requires HHSC appeals division staff, assisted by vendor drug program staff, to make the final decision on whether an audit's findings were accurate.

Federal Medical Coding Guidelines for Hospital Reviews

Requires OIG, including office staff and any third party, to comply with federal medical coding guidelines, including guidelines for diagnosis-related group validation and related audits.

Performance Audits and Audit Coordination

Authorizes OIG to conduct a performance audit of any program or project administered or agreement entered into by HHSC or a HHS agency, including an audit related to contracting procedures or the performance of HHSC or a HHS agency.

Coordination Requirements

Requires that in all aspects of OIG engagement, coordination with the executive commissioner will occur.

The Sunset Advisory Commission will conduct a special purpose review of the overall performance of OIG during its review of agencies for the 87th Legislature. The bill takes effect September 1, 2015.

Passed:

Health and Human Services Re-codification

SB 219 (Schwertner/Price)

This bill updated the various Texas statutes relating to the provision and administration of health and human services to reflect changes that resulted from HB 2292 in 2003. The bill corrects references to outdated or expired entities, updates statute to reflect the transfer of duties and responsibilities from the 12 legacy agencies to the five HHS agencies, and deletes terminology that has since been recognized as offensive or insensitive. In light of the major statutory changes resulting from the HHS Sunset review, the need to update these statutes became more urgent. All other bills amending these sections of statute were required to correspond with the statutory updates in SB 219. ***The bill takes effect immediately.***

Passed:

Department of Aging and Rehabilitation Services Sunset

HB 2463 (Raymond/Campbell)

The bill requires DARS to integrate independent living services for all individuals with disabilities into one program, including services for the blind, and requires that these services be provided at centers for independent living. The bill also requires DARS to operate a comprehensive rehabilitation program and a children's autism program. The bill also abolishes and transfers functions of DARS (that are not transferred to TWC under **SB 208**) to HHSC by September 1, 2016. If DARS/TWC are unable to obtain federal approval for the transfer of certain DARS functions to TWC, then those functions will also be transferred to HHSC no later than September 1, 2016. ***The bill takes effect September 1, 2015.***

Government Contracting Reforms

In the wake of investigations into the HHSC/OIG 21CT contract, reforming government contracting became one of the 84th Legislature's top priorities. One major contracting bill was passed, and a rider was adopted in the budget, making changes to the way state agencies report and monitor vendor contracts, including contracts with Medicaid and CHIP MCOs.

Passed:

State Contracting Reform

SB 20 (Nelson/Price)

The bill increases reporting and oversight related to agency contracts, with emphasis on high dollar contracts. For contracts over $100 million, the bill requires the State Auditor to consider adding these high dollar contracts to the annual audit plan. For contracts over $5 million, the agency's procurement officer is required to verify in writing that the solicitation and purchasing methods and contractor selection process comply with state law and agency policy. For any contract over $1 million, the bill requires an agency board to approve the contract, the agency head to sign it, and the agency to develop reporting requirements to provide information on compliance with financial provisions, corrective action plans, and any liquidated damages. The bill also requires agencies to develop risk-based analysis to identify potential waste, fraud, or abuse in contracting. The bill also:

- **Requires agencies to report to the comptroller's Centralized Accounting and Payment/Personnel System (CAPPS) the justification for each contract amendment or extension that increases a contract by $10 million or 20 percent;**
- **Increases the scrutiny on vendor performance and consequences for bad performance in vendor debarment considerations;**
- **Enhances the use of the comptroller's Vendor Performance Management System by requiring agencies to report contract performance to the system, the comptroller to grade the vendor's performance, and for agencies to reference the system before entering into contracts; and**
- **Requires the comptroller to study the feasibility and cost of centralizing contracting.**

The bill takes effect September 1, 2015.

Adopted:

Contracting Budget Rider

Article IX, Sec. 7.12. Notification of Certain Purchases or Contract Awards, Amendments, and Extensions

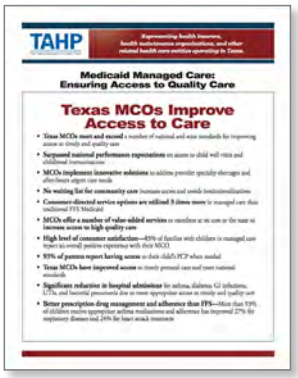
The budget rider requires state agencies and institutions of higher education to provide notice to the LBB before expending any funds on contracts that are greater than $10 million, or greater than $1 million and awarded as the result of an emergency or without going through a competitive bidding process. The notice must be made at least 10 business days before payment is made (within 48 hours for an emergency contract) and include specified information related to the contract. If an agency fails to meet the notification requirements, the Director of LBB is required to provide written notification to the comptroller, governor, and LBB detailing which notification requirements the agency did not meet and any recommendations on how to address identified risks related to the contract, which may include contract cancellation. *The rider takes effect September 1, 2015.*

New Medicaid Managed Care Requirements: Network Adequacy, Transparency, Rate Setting, and Service Delivery Reforms

Passed:

Medicaid Network Adequacy

SB 760 (Schwertner/Price)


TAHP

Medicaid Managed Care: Ensuring Access to Quality Care

Texas MCOs Improve Access to Care

The bill increases oversight and penalties for Medicaid MCOs' network adequacy. The bill requires Medicaid MCOs to make their provider directories available online and update them on at least a monthly basis. Paper copies are still required for STAR+PLUS and STAR Kids unless recipients opt out. For all of other Medicaid MCO programs, paper directories are only required if recipients request them.

The bill requires HHSC to establish minimum provider access standards. The bill also increases reporting requirements related to MCO network adequacy, including a biennial report to the legislature and public. It also requires MCOs to report the average time period between prior authorization requests and the date the MCO approves or denies the request, and the average time period between prior authorization approval and the date of care. The bill requires MCOs to establish an expedited credentialing process for provider types identified by HHSC (limited to providers joining a health care provider group already contracted with the MCO). If MCOS fail to comply with one or more provider access standards and do not make substantial efforts to mitigate the non-compliance, the bill allows HHSC to elect not to retain or renew a MCO's contract, or require the MCO to pay liquidated damages. If a MCO is non-compliant in the same services delivery area for two consecutive quarters and the MCO has not made substantial efforts to mitigate or remedy the non-compliance, the bill requires HHSC to suspend default enrollment.

TAHP testified on SB 760, expressing support for the overall goals of improving access to care and citing a few technical concerns with regard to its penalty structure and credentialing process. The bill as passed included several TAHP-suggested changes including:

- **Ensuring that MCOs are not penalized for not meeting access standards for circumstances that are outside the MCOs' control (e.g., no provider in the area, provider refusal to contract);**
- **Ensuring that MCOs can recoup the difference between the in-network and out-of-network reimbursement when a provider who received expedited credentialing does not end up meeting the MCO's credentialing requirements;**
- **Allowing MCOs to make initial and subsequent primary care provider assignments, reducing administrative burdens currently related to the enrollment broker making initial PCP assignments; and**
- **Eliminating a provision from the bill that would have placed a percentage of the MCOs' premiums at-risk for meeting provider access standards (this percentage would have been in addition to the 4% premiums already at-risk under the Pay-for-Quality program).**

TAHP stressed that Texas has strong network access standards in place, and that compared to the traditional FFS approach, Medicaid managed care in Texas has already made significant strides in improving access to care and quality of care for Medicaid beneficiaries – often doing so with the same amount of money or less than that used by FFS.

TAHP shared that MCOs in Texas have surpassed national performance standards on access to child well visits and immunizations, with 93 percent of parents in Medicaid reporting they encounter no problems in accessing a primary care physician for their children. TAHP highlighted improvements MCOs have made in boosting access to timely prenatal care for expectant mothers, reducing hospital admissions for asthma and diabetes, addressing doctor shortages through telemedicine, and improving drug management and access to medications for beneficiaries, particularly in the area of respiratory conditions and heart attacks.

The bill also passed with House amendments that added two standalone bills: SB 1880 by Senator Zaffirini and an abbreviated version of SB 1475 by Senator Garcia. SB 1880, which also passed as a standalone bill, ensures that the state is compliant with federal requirements related to investigations of abuse, neglect, and exploitation for the health and welfare of individuals receiving home and community-based services, including ensuring that DFPS has clear authority to investigate services delivered under managed care.

The abbreviated language added from SB 1475 requires HHSC to provide support and information services to Medicaid consumers through a network of entities coordinated by HHSC. The network

Continued on Page 40

of entities will include the HHSC Ombudsman's Office, the Office of the State Long-Term Care Ombudsman, Medicaid/CHIP Health Plan Management, area agencies on aging (AAAs), aging and disability resource centers (ADRCs), and any other entity determined appropriate, including non-profit organizations contracted with HHSC. ***The bill takes effect September 1, 2015.***

Passed:

CPS Comprehensive Needs Assessments

SB 125 (West/Naishtat)

The bill requires a child to receive a developmentally appropriate comprehensive assessment not later than the 45th day after the date the child enters DFPS conservatorship. The bill requires the assessment to include a screening for trauma and interviews with individuals who have knowledge of the child's needs, and requires DFPS to develop guidelines regarding the contents of an assessment report. ***The bill takes effect September 1, 2015.***

Passed:

"SB 7 Clean-Up"

HB 3523 (Raymond/Perry)

The bill is a follow-up to last session's SB 7 by Senator Nelson, which provided the framework and direction for an improved system of services for individuals with disabilities, including carving nursing facility services and IDD waiver benefits into managed care. HB 3523 delays the transition of IDD waiver benefits into managed care by only one year (TxHmL benefits will now transition on September 1, 2018 and HCS, CLASS, DBMD, and ICF/IID benefits will transition on September 1, 2021). HB 3523 will also allow MCOs to negotiate their own rates with nursing facility providers beginning September 1, 2021, while ensuring that nursing facilities continue to receive staff enhancement payments. TAHP expressed concerns with the earlier provisions in the bill that would have required that HHSC set the nursing facility minimum reimbursement rates permanently, and would have delayed the transition of IDD waiver benefits to managed care indefinitely. However, TAHP worked with IDD advocates and providers to address these concerns in the final bill. ***The bill takes effect immediately.***

Passed:

Substitute Dentists

HB 1661 (Guerra/Uresti)

The bill requires HHSC, to the extent allowed by federal law, to adopt rules ensuring that the same standards that apply to a physician who bills the Medicaid program for services provided by a substitute physician also apply to a dentist who bills Medicaid for services provided by a substitute dentist. ***The bill takes effect immediately.***

Passed:

PACE Rate-Setting and STAR+PLUS Comparison

HB 3823 (Price/Perry)

The bill requires HHSC to ensure that reimbursement rates for PACE providers are adequate to sustain the program and are cost-neutral or lower in cost when compared to STAR+PLUS. HB 3823 also requires HHSC and DADS to conduct an evaluation that compares the PACE and STAR+PLUS programs in regard to costs and outcomes. ***The bill takes effect immediately.***

Expanding Access to Services

Passed:

Improving Continuity of Medicaid Eligibility for Certain Youth

HB 839 (Naishtat/Rodriguez)

The bill improves continuity of Medicaid coverage for children who have been in a juvenile detention facility by requiring HHSC to suspend, rather than terminate, the child's benefits upon entering the facility and requiring HHSC to reinstate the child's eligibility within 48 hours of receiving notice of the child's release from the facility. ***The bill takes effect immediately.***

Passed:

ABLE Act

SB 1664 (Perry/Burkett)

The bill establishes the Texas Achieving a Better Life Experience (ABLE) Program which will allow individuals with disabilities and their families to create a tax-free ABLE savings account to cover qualified expenses. Through these accounts, eligible individuals with disabilities will be able to save earned income and plan for the future without the fear of losing eligibility for Medicaid. ***The bill takes effect immediately.***

Keeping Texans Safe

Passed:

"Three Strikes Bill"

SB 304 (Schwertner/Raymond)

The bill strengthens the state's regulatory oversight of nursing facilities. The bill's "three strikes" provision requires the executive commissioner of HHSC to revoke the license of a nursing facility that has committed three violations within a 24-month period that constitute an immediate threat to health and safety related to abuse or neglect of a resident. ***The bill takes effect immediately, except for Sections 242.061 (a-2) and (a-3), Health and Safety Code, as added by this Act, which take effect September 1, 2015.***

Passed:

APS Investigations in Managed Care

SB 1880 (Zaffirini/Raymond)

The bill ensures that the state is compliant with federal requirements related to investigations of abuse, neglect, and exploitation for the health and welfare of individuals receiving home and community-based services, including ensuring that DFPS has clear authority to investigate services delivered under managed care. ***The bill takes effect September 1, 2015.***

Passed:

Waiver Provider Regulation

SB 1385 (Schwertner/Price)

The bill strengthens DADS sanctions for providers in the TxHmL and HCS waiver programs. ***The bill takes effect September 1, 2015.***

Passed:

Habilitation Services

HB 4001 (Raymond/Schwertner)

The bill adds habilitation services to the services that are included under the home and community support services agency (HCSSA) licensure. The bill also passed with a Senate amendment that added SB 1385, which strengthens DADS sanctions for providers in the TxHmL and HCS waiver programs. ***The bill takes effect September 1, 2015.***

Passed:

Prescription Monitoring Program

SB 195 (Schwertner/Crownover)

The bill would transfer the Texas Prescription Monitoring Program (TPMP) and the Prescription Access in Texas (PAT) database from the Department of Public Safety to the Texas State Board of Pharmacy (TSBP). *The bill takes effect immediately.*

Passed:

Pharmacy Board Regulations

SB 460 (Schwertner/Crownover)

The bill updates the Texas Board of Pharmacy statute regarding the state's regulation of pharmacies and pharmacists by:

- **Authorizing pharmacists, in the event of a natural or manmade disaster, to dispense no more than a 30-day supply of a dangerous drug without the authorization of the prescribing practitioner if certain circumstances are met;**
- **Prohibiting the dispensing of a prescription without a valid practitioner-patient relationship for all prescriptions, regardless of whether the prescription was issued based on a face-to-face or Internet-based/telephonic consultation;**
- **Authorizing the Board to discipline an applicant or license holder for waiving, discounting, or reducing (or offering to waive, discount, or reduce) a patient copayment or deductible for a compounded drug without legitimate, documented financial hardship of the patient, or evidence of good faith effort to collect the copayment or deductible from the patient; and**
- **Repealing the requirement that a pharmacist display a specified sign regarding the availability of a less expensive, generically equivalent drug and the requirement that a pharmacist publicly display their license and license renewal certificate.**

The bill takes effect September 1, 2015.

Passed:

Dental Support Organizations

SB 519 (Schwertner/Crownover)

The bill requires dental support organizations (DSOs) to register annually with the Secretary of State and creates a civil penalty for a DSO that fails to register. ***The bill takes effect September 1, 2015.***

Passed:

Texas Health Care Information Council data

HB 764 (King/Rodriguez)

The bill relates to information collected by the Texas Health Care Information Council (THCIC) and requires DSHS to develop a notice (to be included on an existing form) to patients of the collection of the patient's data for health care purposes. Also requires DSHS to prepare an annual report to the commissioner describing the security measures taken to protect the data collected and any breaches, attempted cyber attacks, and security issues related to the data that are encountered during the calendar year. If a cyber attack occurs targeting data collected under THCIC, DSHS shall notify the Texas Department of Public Safety and the Federal Bureau of Investigation of the attack. *The bill takes effect September 1, 2015.*

Promoting Health Care Technology

Passed:

School-Based Telemedicine

HB 1878 (Laubenberg/V. Taylor)

The bill requires HHSC to ensure that Medicaid reimbursement is provided to a physician for a telemedicine service, even if the physician is not the patient's primary care physician, if the physician:

1. **is a Medicaid provider;**
2. **the service is provided a child in a primary or secondary school-based setting;**
3. **the child's parent or legal guardian provides consent before the service is provided; and**
4. **a health professional is present with the child during the treatment.**

Because telemedicine services provided in a school-based setting are already payable under Medicaid, and non-payment for these services under managed care is rare, HHSC estimated a minimal impact on the Medicaid program from this legislation. ***The bill takes effect September 1, 2015.***

Passed:

Home Telemonitoring

HB 3519 (Guerra/Watson)

The bill extends Medicaid reimbursement for home telemonitoring services to September 1, 2019. ***The bill takes effect September 1, 2015.***

Passed:

Health Information Exchange

HB 2641 (Zerwas/Schwertner)

The bill enhances the use of health information technology and exchange in the state by requiring that all HHS agency information systems are compliant with national data exchange standards, allowing Medicaid reimbursement for the use of electronic health information exchange, allowing providers to submit and receive data from state registries via health information exchanges, and extending the Medicaid home telemonitoring reimbursement until September 1, 2019. The bill also creates certain limitations on a health care provider's liability relating to health information exchanges. TAHP supported HB 2641. ***The bill takes effect September 1, 2015.***

Strengthening the Health Care Workforce–Increasing Access to Care

Passed:

Nursing Education

HB 495 (Howard/Hinojosa)

The bill extends the expiration date for the existing dedication of funds from the Permanent Fund for Higher Education Nursing, Allied Health, and Other Health Related Programs (established by the Texas Tobacco Lawsuit Settlement) to nursing education programs from August 31, 2015, to August 31, 2019. ***The bill takes effect immediately.***

Passed:

Graduate Medical Education

SB 18 (Nelson/Zerwas)

The bill enhances graduate medical education (GME) in Texas by amending existing GME programs administered by the Texas Higher Education Coordinating Board and establishing the Permanent Fund Supporting Graduate Medical Education outside of the GR Fund. SB 18 also requires the transfer of certain assets from the Texas Medical Liability Insurance Underwriting Association to the new fund. ***The bill takes effect September 1, 2015.***

Passed:

Loan Repayment for Mental Health Professionals

SB 239 (Schwertner/Zerwas)

The bill requires the Texas Higher Education Coordinating Board, if funds are appropriated, to establish a loan repayment program for mental health professionals (psychiatrists, psychologists, licensed professional counselors, advanced practice registered nurses who hold a nationally recognized board certification in psychiatric or mental health nursing, and licensed clinical social workers). ***The bill takes effect September 1, 2015.***

Passed:

Psychological Interns

HB 1924 (Coleman/Eltife)

The bill expands the authority of a licensed psychologist to delegate psychological tests or services (as determined appropriate by the Texas State Board of Examiners of Psychologists) to pre-doctoral interns, which will serve to increase internship opportunities and access to care. ***HB 1924 takes effect September 1, 2015.***

Improving Health Care in Texas

Passed:

Prenatal Surgical Procedures

HB 606 (S. Davis/Huffman)

The bill requires HHSC to conduct a study and submit a written report no later than December 1, 2016, to evaluate the benefits of prenatal surgical procedures to treat birth defects. The study must analyze the difference between prenatal surgical procedures and postnatal procedures with respect to average total cost to payers (including Medicaid), survival rates, long-term outcomes, and quality of life for children with birth defects. ***The bill takes effect immediately.***

Passed:

Perinatal Advisory Council

HB 3433 (Sheffield/Kolkhorst)

The bill requires additional rural representation on the Perinatal Advisory Council and extends the timeframe for establishing neonatal and maternal levels of care to August 31, 2018, and August 31, 2020 respectively. ***The bill takes effect immediately.***

Passed:

Centers of Excellence for Fetal Diagnosis and Therapy

HB 2131 (S. Davis/Huffman)

The bill requires DSHS to establish a subcommittee and criteria for the designation of Centers of Excellence for Fetal Diagnosis and Therapy. Entities receiving this designation must provide comprehensive maternal, fetal, and neonatal health care for pregnant women with high-risk pregnancies. ***The bill takes effect September 1, 2015.***

Passed:

Immunization Records

HB 2171 (Sheffield/Zaffirini)

The bill extends the age for which immunization records can be maintained in the state's Immunization Registry without requiring additional consent from 18 to 26. ***The bill takes effect September 1, 2015.***

Passed:

Texas Health Improvement Network

HB 3781 (Crownover/Watson)

The bill establishes the Texas Health Improvement Network with the purpose of reducing per capita costs of health care, improving the individual experience of health care, and improving the health of Texas residents. The Network will be administratively attached to the University of Texas System and consist of experts in areas such as public health, mental health, epidemiology, and health informatics. The Network will support local communities by offering leadership training, data analytics, community health assessments, and grant writing support. HB 3781 also establishes an advisory council, appointed by the UT System Chancellor, to advise the Network. The legislation requires the council membership to include leaders from a variety of fields, including insurance. ***The bill takes effect immediately.***

Ensuring Flexibility and Efficiency for Medicaid Managed Care

There were a number of Medicaid and CHIP bills filed that would have jeopardized the success of the Medicaid managed care model by mandating provider reimbursement rates and eliminating the private-market competitive negotiations that have allowed managed care to contain costs and improve quality in the Medicaid program. The ability to innovate is critical to being able to provide the highest quality services to Medicaid members. Continuing the success of Medicaid managed care requires a careful balance between accountability and the flexibility to innovate to improve the care delivery and cost-effectiveness of the Medicaid program. Other bills would have increased administrative burdens in the Medicaid program at a time when administrative simplification is sorely needed. The common thread among each of the bills below is that they would have increased the price tag of the Medicaid program for taxpayers.

In the 84th session, TAHP's primary goal was to continue to advocate for the flexibility and efficiency that has allowed Medicaid managed care to improve quality and access to care, while reducing costs for taxpayers.

Did Not Pass:

MCO Administrative Rate Hearings

HB 1041 (Collier)

The bill would have given every Medicaid provider the right to a contested case hearing and judicial review if the provider believed that their reimbursement rate under Medicaid FFS or managed care did not allow the provider to recover their "reasonable operating expenses and to realize a reasonable return on the provider's investments." TAHP opposed HB 1041 and the committee substitute, citing concerns that the bill would increase costs to taxpayers, circumvent the legislative appropriations process to force provider rate increases, increase administrative burdens, and disregard the voluntary nature of contracts between providers and MCOs. *HB 1041 passed the House Human Services Committee but failed to pass out of the House Calendars Committee due to a procedural deadline.*

Did Not Pass:

Pharmacy Rate Mandate

HB 3366 (Sheffield)/SB 1612 (Kolkhorst)


TAHP

Benefits of Prescription Drug Management Under Medicaid MCOs

Texas Medicaid MCOs Improve Health Outcomes and Costs Related to Prescription Benefits

The bill would have required HHSC to set the methodology and reimbursement rate Medicaid and CHIP health plans use to pay pharmacies. TAHP testified in opposition to HB 3366, outlining the negative impact the bill would have on pharmacy benefits. TAHP opposed HB 3366 because it would have set pharmacy reimbursement rates drastically higher than any other market, significantly increasing costs to Texas taxpayers, despite the fact that Texas MCOs already pay pharmacies rates that are comparable to commercial and Medicare plans. The bill would have also undone the pharmacy protections passed last legislative session related to price transparency and accountability. *HB 3366 passed out of the House Public Health Committee but failed to pass out of the House Calendars Committee due to a procedural deadline. SB 1612 was introduced and referred to the Senate Health and Human Services Committee.*

Did Not Pass:

Medicaid Claims Turnaround

HB 3464 (Munoz)

The bill would have drastically reduced the number of days Medicaid MCOs have to process most provider and pharmacy claims to 15 days, including claims for long-term services and supports providers. TAHP testified against HB 3464, outlining the negative consequences it would have on providers, MCOs, and the integrity of the Medicaid program. Medicaid MCOs are currently required to process most provider claims within 30 days, and electronic pharmacy claims within 18 days. Medicaid MCOs are required to meet these timeframes for 98 percent of clean claims or risk contractual remedies such as liquidated damages. These standards are in line with, or stronger than, industry standards for commercial plans. *HB 3464 passed the House Public Health Committee but failed to pass out of the House Calendars Committee due to a procedural deadline.*

Did Not Pass:

Cranial Molding Orthosis

HB 3473 (G. Bonnen)

The bill would have prescribed, in statute, the conditions under which a child would qualify for a cranial molding orthosis in the Medicaid and CHIP programs. TAHP sent a letter to the committee chairman and members outlying the association's opposition to the bill. While the use of cranial molding orthoses is generally accepted as effective and medically necessary under certain circumstances, HB 3473 would have expanded Medicaid/CHIP coverage of these costly devices to conditions for which there is a lack of clear evidence demonstrating any clinical benefit compared to no treatment. Additionally, TAHP

Continued on Page 46

had concerns with placing specific medical necessity criteria in statute, which would restrict the ability for the Medicaid/CHIP programs to react appropriately when new medical research emerges and acceptable medical standards are revised in the future. HB 3473 was also inconsistent with the American Academy of Pediatrics guidelines, which recommend that use of cranial molding orthoses be reserved for severe cases of deformity. ***HB 3473 was introduced, referred to the House Public Health Committee, and received a hearing.***

Did Not Pass:

MCO Recoupment

HB 3917 (Klick)

The bill would have prohibited HHSC/MCOs from recouping any part of an improper payment that was made to a provider even when errors were made as a result of fraud, waste or abuse, or if errors were made due to retroactive eligibility determinations that are outside of MCOs' control. It would have also disregarded errors made due to fee schedule changes or private contract decisions.

TAHP opposed HB 3917 and testified against it, outlining how it is inconsistent with federal regulations because it would prohibit HHSC from recouping improper payments made to a provider, even though Texas is required to pay back the federal government the federal portion of any overpayment regardless of the reason. This would have resulted in increased costs to taxpayers. ***HB 3917 passed the House Human Services Committee but failed to pass out of the House Calendars Committee due to a procedural deadline.***

Did Not Pass:

Nursing Facility Rate Increase Mandate

SB 1602 (Kolkhorst)

The bill would have required Medicaid MCOs to reimburse Medicaid nursing facility services for dual eligibles at the Medicare reimbursement rate or higher, at a price tag for the state of more than $1 billion. SB 1602 would also have extended the existing nursing facility "significant traditional provider" (STP) requirement by two years (through August 31, 2019) and extended the existing single statewide prescription formulary requirement by an additional year (through August 31, 2019).

TAHP testified in opposition to SB 1602 outlining concerns that the bill would have increased costs to taxpayers, limited MCOs' ability to contract with quality nursing facilities, and reduced MCOs' ability to effectively manage prescription drug benefits. Allowing MCOs to manage their own formulary, PDL, and prior authorization procedures would save the state an estimated $64 million GR biennially. ***SB 1602 was introduced, referred to the Senate Health and Human Services Committee, and received a hearing.***

Other Key Medicaid and Public Health Bills that Failed to Pass

Did Not Pass:

LBB Contract Management

HB 15 (Otto/Nelson)

The bill would have replaced the existing Interagency Contract Advisory Team with a Contract Management and Oversight Team at the LBB. ***HB 15 passed both the House and the Senate, a conference committee was appointed, a conference committee report was distributed, the House adopted the conference committee report, the Senate did not adopt the conference committee report.***

Did Not Pass:

Medicaid Expansion

HB 116 (Fischer)/SB 89 (Ellis)/HB 1138 (Israel)

The bill would have required HHSC to provide medical assistance to all persons who apply for that assistance and for whom federal matching funds are available under the ACA to provide that assistance. ***HB 116 and 1138 were introduced and referred to the House Appropriations Committee. SB 89 was introduced and referred to the Senate Health and Human Services Committee.***

Did Not Pass:

Medicaid Prohibition

HB 306 (J. White)

The bill would have prohibits providing education or health benefits, including Medicaid, to persons not lawfully in the United States. ***HB 306 was introduced and referred to the House State Affairs Committee.***

Did Not Pass:

CHIP Contraceptive Coverage

HB 466 (Howard)

The bill would have required CHIP MCOs to provide prescription contraceptive drugs or devices as a covered benefit. ***HB 466 was introduced and referred to the House Public Health Committee.***

Did Not Pass:

Chiropractor Reimbursement Mandate

HB 762 by Rep. Zedler

The bill would have required HHSC to provide Medicaid reimbursement to a chiropractor participating in Medicaid. ***HB 762 introduced and referred to the House Public Health Committee.***

Did Not Pass:

Medicaid Expansion

HB 977 (Collier)/SB 423 (West)

The bill would have provided for the expansion of Medicaid eligibility under the ACA. *HB 977 was introduced and referred to the House Appropriations Committee. SB 423 was introduced and referred to the Senate Health and Human Services Committee.*

Did Not Pass:

SSLC Fee Schedule

HB 1260 (S. King)

The bill would have required HHSC to establish, by rule, a list of services a SSLC may provide under a contract to individuals not residing in the SSLC and a schedule of fees the SSLC may charge for those services. *HB 1260 passed the House Human Services Committee, was placed on the House General State Calendar, but died due to end-of-session procedural deadlines.*

Did Not Pass:

Peer Specialists

HB 1541 (Burkett)

The bill would have required HHSC to establish a separate Medicaid provider type for peer specialists for purposes of enrollment as providers and reimbursement under Medicaid, and would have required HHSC to include peer services provided by peer specialists as a Medicaid allowable service. *HB 1541 was introduced, referred to the House Human Services Committee, and received a hearing.*

Did Not Pass:

Self-Directed Mental Health Services Pilot

HB 1873 (Naishtat)

The bill would have required HHSC and DSHS to jointly develop and implement a four-year pilot project for self-directed mental health services in Medicaid managed care to maximize patient choice and encourage personal responsibility for achieving recovery. *HB 1873 was introduced, referred to the House Human Services Committee, and received a hearing.*

Did Not Pass:

County Based Medicaid Expansion

HB 2270 ("Mando" Martinez)/HB 4000 (Blanco)

The bill would have provided for the expansion of eligibility for Medicaid in certain counties under the ACA. *HB 2270 was introduced and referred to the House Appropriations Committee. HB 4000 was introduced and referred to the House Appropriations Committee.*

Did Not Pass:

Dentist Contracting

HB 2330 (Zerwas)/SB 960 (Uresti)

The bill would have clarified the situations under which it would (and would not) be presumed that a dentist had allowed a non-dentist to control, influence, or otherwise interfere with the dentist's independent professional judgment. *SB 960 was introduced, referred to the Senate Health and Human Services Committee, and received a hearing. HB 2330 was introduced, referred to the House Public Health Committee, and received a hearing.*

Did Not Pass:

Complex Rehab Technology

HB 2638 (Raymond)

The bill would have required HHSC to create a separate Medicaid provider type for complex rehabilitation technology and prohibit HHSC from classifying this equipment as a type of durable medical equipment. *HB 2638 was introduced and referred to the House Human Services Committee.*

Did Not Pass:

Ambulance Rate Mandate

HB 2773 ("Mando" Martinez)/SB 702 (Hinojosa)

The bill would have required Medicaid MCOs to reimburse all ambulance services (including non-emergency services) at 100% of the Medicaid FFS reimbursement rate. *HB 2773 was introduced and referred to the House Public Health Committee. SB 702 was introduced and referred to the Senate Health and Human Services Committee.*

Did Not Pass:

Managed Care Study – Pharmacy Savings

HB 3035 ("Mando" Martinez)

The bill would have required HHSC to conduct a study on the accuracy of the LBB's estimate for Medicaid savings related to the 2011 decision to carve drugs into managed care. *HB 3035 passed the House Human Services Committee but failed to pass out of the House Calendars Committee due to a procedural deadline.*

Did Not Pass:

Managed Care Study – Persons Served and Services Provided

HB 3036 ("Mando" Martinez)

The bill would have required HHSC to conduct a study on the accuracy of the LBB's estimate of savings from the 2011 Medicaid managed care expansion. *HB 3036 was introduced and referred to the House Human Services Committee.*

Did Not Pass:

Evidence-Based Autism Services

HB 3282 (Simmons)

The bill would have increased coordination, communication, and collection of information pertaining to the provision of evidence-based behavioral services for students with autism in Texas. *HB 3282 passed out of the House Public Education Committee, was placed on the House General State Calendar, but died due to end-of-session procedural deadlines.*

Did Not Pass:

Postpartum Depression Coverage

HB 3372 (Coleman)

The bill would have required that women who receive Medicaid benefits during a pregnancy receive screening and treatment for postpartum depression for the eight-month period after giving birth. *HB 3372 was introduced and referred to the House Public Health Committee.*

Did Not Pass:

Cost-Sharing and Personal Responsibility

HB 3445 (Laubenberg)

The bill would have required HHSC to seek federal approval to adopt a cost-sharing provision that requires a Medicaid recipient who chooses to receive a nonemergency medical service through a hospital emergency room to pay a copayment or premium payment if certain conditions are met. *HB 3445 was introduced, referred to the House Public Health Committee, and received a hearing.*

Did Not Pass:

Pregnant Women's Medicaid

HB 3449 (Coleman)

The bill would have extended Medicaid coverage for new mothers by continuing Medicaid eligibility for a woman who was eligible for Medicaid as a pregnant woman for at least six months after giving birth. *HB 3449 was introduced and referred to the House Public Health Committee.*

Did Not Pass:

EVV Tax Exemption

HB 3542 (Raymond)

The bill would have provided a state sales tax exemption for Medicaid MCOs for electronic visit verification (EVV) services, which TAHP supported. *HB 3542 was passed out of the House Ways and Means Committee, but failed to pass out of the House Calendars Committee due to a procedural deadline.*

Did Not Pass:

Expedited Credentialing for Social Workers

HB 3672 (Naishtat)/SB 1402 (Rodriguez)

The bill would have required expedited credentialing for licensed clinical social workers who are part of a social work medical group that already has a contract in force with the Medicaid MCOs. HB 3672 passed the House and was referred to the Senate Health and Human Services Committee. *SB 1402 was introduced and referred to the Senate Health and Human Services Committee.*

Did Not Pass:

"Texas Way"/"Texas Solution"

HB 3845 (Coleman)/HB 4054 (Fischer)

These bills would have provided for a "Texas Way" or "Texas Solution" to reform and address issues related to the Medicaid program, including the creation of an alternative program designed to ensure health benefit plan coverage to certain low-income individuals through the private marketplace. Contingent on federal block grant funding, HHSC establish a state Medicaid program that provides benefits under a risk-based Medicaid managed care model. Eligible individuals may receive a Medicaid sliding scale subsidy to purchase a health benefit plan from an authorized health benefit plan issuer, as well as additional cost-sharing subsidies. *HB 3845 and HB 4054 were introduced and referred to the House Appropriations Committee.*

Did Not Pass:

Medicaid Block Grant

HB 3847 (Burns)

The bill would have authorized the executive commissioner of HHSC to seek a waiver or other authorization necessary to operate the Medicaid program under a block grant funding system. *HB 3847 was introduced and referred to the House Appropriations Committee.*

Did Not Pass:

Emergency Eye Care Reimbursement Mandate

HB 3921 (Klick)

The bill would have required Medicaid MCOs to reimburse an out-of-network eye care specialist at the same rate as an in-network specialist for providing emergency eye health care services. *HB 3921 was introduced and referred to the House Public Health Committee.*

Did Not Pass:

Optometrist Reimbursement Mandate

HB 3922 (Klick)

The bill would have required Medicaid MCOs to reimburse an optometrist or a therapeutic optometrist for services provided to a recipient enrolled in the MCO as long as the service was allowable under Medicaid and within the practitioner's scope of practice. *HB 3922 was introduced and referred to the House Public Health Committee.*

Did Not Pass:

Medicaid Enrollment for Eye Care Providers

HB 3924 (Klick)

The bill would have required HHSC to enroll an optometrist, therapeutic optometrist, or ophthalmologist as a Medicaid provider if certain conditions were met. *HB 3924 was introduced and referred to the House Public Health Committee.*

Did Not Pass:

Consumer Supports Services

SB 1475 (Garcia)

The bill would have required HHSC to establish an enhanced Medicaid managed care consumer support system. TAHP testified in favor of SB 1475 in the Senate Health and Human Services Committee, citing general support for efforts to improve consumer supports for Medicaid consumers, including better coordinating existing consumer supports and addressing Medicaid eligibility and enrollment issues. Although SB 1475 failed to pass, an abbreviated version of the bill passed as an amendment on SB 760 (Schwertner/Price). *SB 1475 was introduced, referred to the Senate Health and Human Services Committee, and received a hearing.*

Did Not Pass:

MCO Credentialing Committee

SB 1545 (Perry)

The bill would have established an advisory committee at HHSC on physician credentialing by Medicaid MCOs. *HB 1545 was introduced and referred to the Senate Health and Human Services Committee.*

Did Not Pass:

Cognitive Rehabilitation Therapy

SB 1884 (Zaffirini)

The bill would have required Medicaid coverage for cognitive rehabilitation therapy for a Medicaid recipient who suffers an acquired or traumatic brain injury, regardless of what age the injury occurred. *SB 1884 was introduced and referred to the Senate Health and Human Services Committee.*

Did Not Pass:

Department of Aging and Disability Services Sunset

SB 204 (Hinojosa/Raymond)

The bill would have strengthened the regulation of long-term care providers, including home health agencies, assisted living facilities, day habilitation providers, and nursing facilities. SB 204 also would have required closure of the Austin State Supported Living Center (SSLC) and established the SSLC Restructuring Commission to evaluate each SSLC and determine whether closure is recommended. The House also added 20 floor amendments, most of which were related to the SSLC Restructuring Commission and closure of SSLCs. *SB 204 passed the House and Senate and a conference committee was appointed, but the bill failed to pass because a conference committee report was not filed.*

Did Not Pass:

Transparency in MCO Premium Rate-Setting

HB 2084 (Munoz/Hinojosa)

The bill requires HHSC to ensure transparency of the premium rate-setting process, including requiring actuarially sound rates for the populations covered and the services provided. HB 2084 specifies that in publishing the actuarial reports, HHSC is not required to publish proprietary information. TAHP advocated for increased rate-setting transparency throughout the Sunset process and legislative session. To operate effectively and provide the state budget predictability, the MCOs and HHSC must establish a rate-setting process that is collaborative and transparent. There are many factors constantly evolving that influence the cost of providing health care and services to the Medicaid population, and this process will be more successful with increased transparency. *The bill was vetoed by the governor on June 20, 2015.*

Texas Association of Health Plans

Improving Affordability, Accessibility and Accountability

Public Outreach

During the 84th Legislative Session, TAHP planned and carried out a strategic public affairs campaign that, in addition to government relations, included targeted public relations, education, and public outreach efforts to boost the profile of TAHP and promote TAHP's core messages and legislative priorities.

These included regular press releases, published opinion pieces in Texas newspapers, letters to the editor, social media promotion, public speaking engagements, coalition-building with consumer groups, producing educational materials, and hosting legislative receptions and informative sessions for TAHP members as well as legislators and their staff.

Legislative Events

Legislative Day at the Capitol

On Tuesday, February 24, TAHP hosted its board meeting in Austin, with health plan representatives attending from across the state and country. Following the board meeting, plans attended a Legislative Day event hosted by TAHP at the Capitol, where they heard from a number of legislators and leadership staff members, including State Senator Kevin Eltife, R-Tyler, Chairman of the Senate Committee on Business and Commerce; Rep. John Frullo, R-Lubbock, Chairman of the House Insurance Committee; Rep. Four Price, R-Amarillo, Chairman of the House Appropriations Subcommittee on Article II; Rep. Myra Crownover, R-Denton, Chair of the House Public Health Committee; Rep. Richard Raymond, D-Laredo, Chairman of the House Human Services Committee; HHSC Deputy Commissioner Chris Traylor; Julia Rathgeber, Deputy Chief of Staff to Governor Abbott; Kara Crawford, Policy Advisor to Governor Abbott; and Meredyth Fowler, Counsel to the Speaker on General Government. Plans had the opportunity to discuss legislative priorities for the 2015 legislative session.

Legislative Reception at Parkside Restaurant

Capping off the board meeting and Legislative Day, TAHP hosted a reception with member plans, medical directors, legislators and Capitol staff at Parkside Restaurant in downtown Austin.

Lunch n' Learn

In February, TAHP partnered with the Texas Association of Business to host a "Lunch n' Learn" event for Capitol staff. More than 30 staffers and a number of TAHP members participated and heard presentations from Bill Hammond, CEO of the Texas Association of Business, and TAHP CEO, Jamie Dudensing, on our shared legislative priorities, such as promoting the benefits of Medicaid managed care, the importance of protecting consumers from excessive balance billing, and prompt pay litigation reform.

Legislative Events

Medical Directors' Forum

On Wednesday, February 25th, TAHP hosted its quarterly medical directors' forum, focused on behavioral health. Topics presented included local behavioral health innovations under the 1115 Transformation Waiver, behavioral health integration and alternative payment models, management of serious mental illness, and best practices in mental health service delivery. Presenters included Ardas Khalsa (Health and Human Services Commission), Daniel Deslatte (UT HSC Tyler), Carol Huber (University Health System), Dr. Shawn Boykin (Sunovion), Dr. Andrea Auxier (Beacon Health Options), Dr. Andrew Keller (Meadows Mental Health Policy Institute), and Lauren Lacefield Lewis (Department of State Health Services). The forum closed with a visit from Representative Zerwas, who shared his thoughts with the group on key health care legislative issues.

Franklin BBQ Receptions

In March, TAHP hosted two legislative health care nights at Franklin BBQ in East Austin. We were pleased to be joined by a number of senators, representatives, legislative staff, TAHP board members, and member health plans. It was a well-attended evening complete with some of Texas' tastiest brisket along with some of its most influential leaders.

Speaking Engagements

Healthcare Financial Management Association of Texas Conference

On March 30, TAHP CEO Jamie Dudensing participated as speaker on the Managed Care Perspectives Panel for the Healthcare Financial Management Association of Texas' annual conference. Dudensing spoke about current barriers to affordable health care and efforts being made to lower health care costs for Texans, including innovative steps being taken in Texas Medicaid through the managed care approach.

Leadership Austin Program

On April 24, TAHP's Dudensing participated in a speaking panel on "Improving and Innovating Health Care in Austin" as part of Leadership Austin's annual program. The audience consisted of business, non-profit and government leaders from Austin who were selected to participate in Leadership Austin's "Essential Class of 2015." Dudensing spoke on the important innovations health plans in Texas have and continue to make to adapt to major changes in health care policy and keep health care accessible and affordable.

Texas Tribune Health Care Symposium

On May 4, TAHP's Dudensing participated in a panel on the impact of the Affordable Care Act on Texas at the Texas Tribune's Symposium on Health Care. Dudensing discussed how the ACA has effectively changed the health care landscape in Texas and across the nation--increasing access to care and encouraging innovation but also raising costs. In response to audience questions about Medicaid expansion, Dudensing highlighted the impressive savings that the managed care approach has achieved in Texas, compared to the fee-for-service model it replaced, and how MCOs have reduced hospital admissions for some of the costliest and most common conditions such as diabetes and asthma.

Communications

TAHP Guest Column on Freestanding ERs in Galveston Daily News

In February, the Galveston Daily News ran a TAHP op-ed in support of SB 425 and the need for greater transparency with regard to freestanding ERs. In the opinion piece, TAHP CEO Jamie Dudensing wrote:

"Depending on the severity of the medical situation, a free-standing ER might be the right choice for a patient, but those facilities' high-level capabilities might be unnecessary for individuals with less urgent symptoms or those in search of routine care. When consumers are empowered with information, they are better able to care for themselves and their families without breaking their bank accounts."

TAB Column on Balance Billing Appears In Numerous Texas Papers

During the legislative session, a growing coalition including TAHP and the Texas Association of Business (TAB) worked to promote SB 481, which gives consumers greater access to mediation to address balance billing charges. An opinion piece by TAB President & CEO Bill Hammond appeared in several Texas daily newspapers in March, including the San Antonio Express-News, Waco Tribune-Herald, the Corpus Christi Caller-Times, and the Orange Leader. Hammond wrote:

"The Texas Association of Business hopes the Legislature will take additional steps this session to further protect consumers from "balance bill shock" by lowering the financial threshold required for mediation. Just as physicians should have recourse to pursue payments for their services, consumers should have access to mediation services to ensure their medical bills are fair and transparent. More expansive use of mediation will bring a higher degree of fairness to the situation and, ultimately, better protect Texans from surprise debt and lower health care costs for patients and businesses."

TAHP Weighs in on Medicaid Super-Utilizers in the Houston Chronicle

On March 27, the Houston Chronicle ran a Letter to the Editor from TAHP weighing in on a recent Chronicle editorial calling for a statewide strategy to address super-utilizers, or patients who are intensive users of the health care system. TAHP wrote, "New research commissioned by TAHP indicates that Texas' shift in recent years from the fee-for-service model to the managed-care approach in Medicaid is yielding positive results by doing precisely that: addressing super-utilizers as well as the most costly areas of Texas' health care system… TAHP is hopeful that during the 84th Legislature, state leaders will work to build on the Medicaid managed-care approach so we can continue to improve super-utilizers' health and in turn reduce costs for every Texas taxpayer."

TAHP Column on Balance Billing in the Fort Worth Star-Telegram

On April 8, the Fort Worth Star-Telegram included an op-ed by TAHP CEO Jamie Dudensing on current efforts in the 84th Legislature to address the practice of balance billing.

Dudensing wrote, *"Balance billing is just one symptom of the greater challenges posed by out-of-network care. But it's an issue that will only continue to grow until every involved party comes to the table and works together to find reasonable solutions.*

"Expanding mediation will bring a higher degree of fairness to the situation and, ultimately, better protect Texans from surprise debt."

TAHP Guest Column On Improving Maternal Health Care in the Waco Tribune-Herald

In observation of National Women's Health Week in April, the Waco Tribune-Herald published an op-ed by TAHP's Dudensing regarding disturbing new findings about the state of maternal health care in the U.S. According to Save the Children's 16th annual "State of the World's Mothers" report, the U.S. ranks 61st globally in maternal health, performing worse than any other developed country.

Dudensing wrote, *"Texas commercial health plans and Medicaid health plans recently created a coalition with the Department of State Health Services to identify several strategies to improve maternal health. These include developing wellness programs for women of reproductive age to educate on the best behaviors to ensure a healthy pregnancy; providing peer support services to expectant and new mothers to encourage breastfeeding; and providing a better continuum of care as mothers transition from prenatal to postpartum care.*

"This is especially important for expectant mothers on Medicaid. As it stands, pregnant women on Medicaid only have coverage until 60 days after the birth of their children. Several proposals currently under consideration in the Texas Legislature would extend their coverage for up to 12 months after birth.

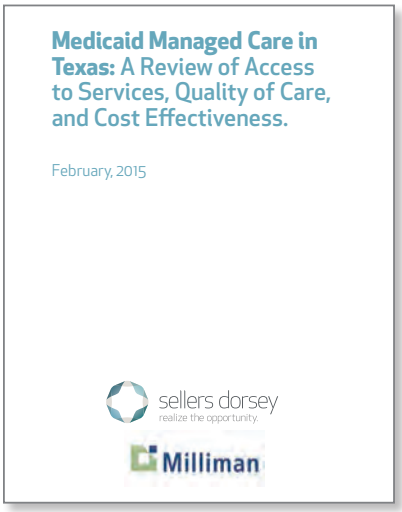
"We also must do more to incentivize and reward facilities, providers and consumers who follow best practices to lead to healthy pregnancies. And we must build on efforts to reduce the number of medically unnecessary inductions and c-sections, which are currently overused here in Texas and across the country and can pose serious risks to a mother's health.

"These efforts will require the coordination and commitment of every involved party — providers, health plans, medical facilities and government leaders. We each have a role to play in improving care, and we can and should do better by Texas women."

Education

Promoting the Savings & Benefits of Medicaid Managed Care

Over the past year, TAHP has made a continuous effort to educate both policymakers and the public on the remarkable strides that have been made in Texas Medicaid under the managed care model.



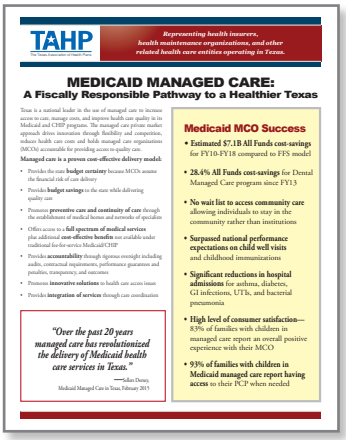
In February, we released studies commissioned by TAHP and carried out by national research firms Milliman and Sellers Dorsey that examined the impact of the managed care model in recent years on the state and on Texas Medicaid beneficiaries.

The studies concluded that 10 years after Texas embraced the managed care approach, flexibility has created a remarkably successful partnership between Texas and the health plans that manage Medicaid. Compared to the FFS model it replaced, the managed care approach has saved the state nearly $4 billion over a six-year period. Over the next three years, it is expected to save an additional $3.3 billion. For the STAR program–Texas Medicaid's largest managed care program, with 2.7 million consumers—costs grew only 2.2% from 2009 to 2013 while national health care costs grew nearly seven times as much, or 15%, over the same period of time.

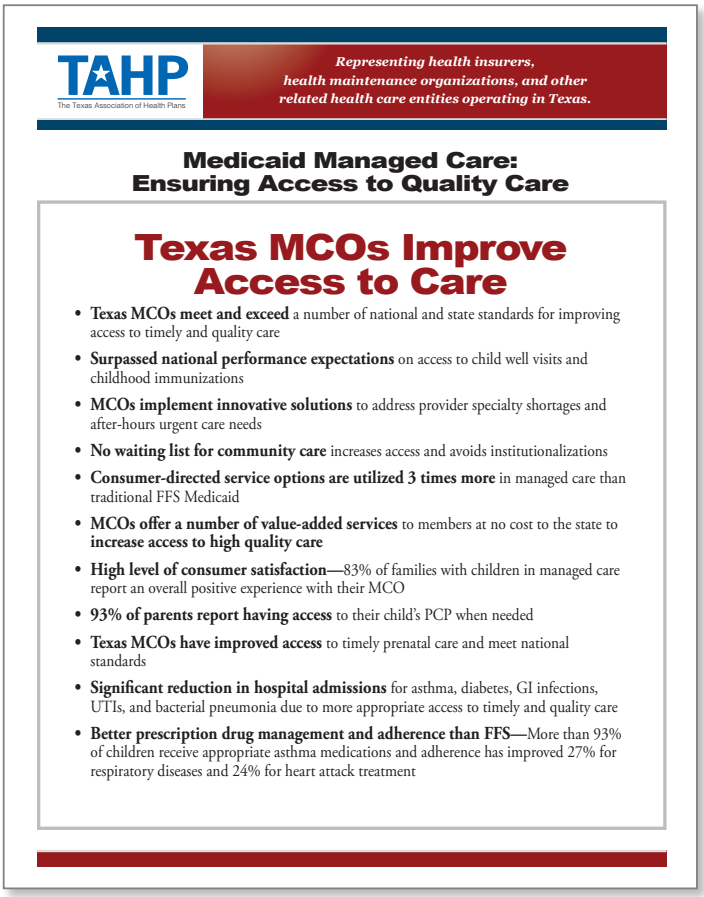
Just as important, the studies reported that lives are being saved and improved due to integrated and coordinated care. Hospital admissions are down anywhere from 20 to nearly 40 percent for some of the most common—and preventable—conditions: asthma, diabetes, GI infections and more. Child "well visits" and childhood immunizations are surpassing national standards. Beneficiaries are also feeling more confident about the quality of their coverage and access to care. More than 80 percent of Texas families with children in managed care report an overall positive experience with their health plan and more than 90 percent report having access to their primary care provider.

TAHP produced several educational materials highlighting these benefits and carried managed care's positive message throughout the halls of the Texas Capitol during the 84th Legislative Session.

As the debate over Medicaid's future ensues, TAHP will continue to educate policymakers and Texans on the benefits of managed care and specifically the need for greater flexibility from the federal government to build on the managed care approach and continue to innovate, find cost savings, and improve care for the millions of Texans who depend on Medicaid for their health and well-being.


TAHP
Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.
MEDICAID MANAGED CARE:
A Fiscally Responsible Pathway to a Healthier Texas
Medicaid MCO Success
• Estimated $7.1B All Funds cost-savings for FY10-FY18 compared to FFS model
• 28.4% All Funds cost-savings for Dental Managed Care program since FY13
• No wait list to access community care allowing individuals to stay in the community rather than institutions
• Surpassed national performance expectations on child well visits and childhood immunizations
• Significant reductions in hospital admissions for asthma, diabetes, GI infections, UTIs, and bacterial pneumonia
• High level of consumer satisfaction—83% of families with children in managed care report an overall positive experience with their MCO
• 93% of families with children in Medicaid managed care report having access to their PCP when needed
"Over the past 20 years managed care has revolutionized the delivery of Medicaid health care services in Texas."
—Sellers Dorsey,
Medicaid Managed Care in Texas, February 2015


TAHP
Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.
Benefits of Prescription Drug Management Under Medicaid MCOs
2011 Decision to Add Drug Benefits to Managed Care
"Medicaid drug costs have risen more than $4 billion since 2000, now exceeding $2.5 billion a year. It's time to bring Medicaid dispensing fee and practices in line with other payers. The changes will benefit both the elderly who use the program and the taxpayers who fund it."
Texas Medicaid MCOs Improve Health Outcomes and Costs Related to Prescription Benefits
• $367 Million AF savings in the state in prescription drug management through MCOs since the 2012 managed care prescription drug carve-in, compared to the what costs would have been under fee-for-service (FFS)
• $618 Million AF in additional expected cost savings through FY 2018 by continuing pharmacy benefits through managed care
• $60 Million general revenue gain to the state by having prescription drugs in managed care (since premium tax)
• Dramatically lower drug costs for seniors that use managed care—Seniors like Texas that utilize a carve in model have drug costs that are 14.6% lower—more than have drugs carved out, experienced a 20% increase in net costs per prescription from FY2011-FY2014
• Better prescription drug management and adherence than FFS—More than 93% of children in managed care receive appropriate asthma medications and adherence has improved 27% for respiratory diseases and 24% for heart attack treatment
• MCOs ensure consumer access—Network adequacy standards for pharmacy access are more stringent than in the private market—95% of Texas pharmacies are in-network with Medicaid MCOs
• Fully integrated care, including prescription benefits, improves care coordination and improves outcomes for Medicaid consumers—MCOs have significantly reduced hospital admissions for asthma, diabetes, GI infections, UTIs and bacterial pneumonia through better care coordination
• MCOs provide state budget certainty for prescription costs and other benefits by taking on financial risk for the state
• Potential for larger savings for taxpayers and better care management for consumers—$64 Million additional historical GR savings to state by fully carving in prescription drug benefits (formulary carve-in, increasing are of greatest


TAHP
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Medicaid Managed Care:
Ensuring Access to Quality Care
Texas MCOs Improve Access to Care
• **Texas MCOs meet and exceed** a number of national and state standards for improving access to timely and quality care
• **Surpassed national performance expectations** on access to child well visits and childhood immunizations
• **MCOs implement innovative solutions** to address provider specialty shortages and after-hours urgent care needs
• **No waiting list for community care** increases access and avoids institutionalizations
• **Consumer-directed service options are utilized 3 times more** in managed care than traditional FFS Medicaid
• **MCOs offer a number of value-added services** to members at no cost to the state to **increase access to high quality care**
• **High level of consumer satisfaction—**83% of families with children in managed care report an overall positive experience with their MCO
• **93% of parents report having access** to their child's PCP when needed
• **Texas MCOs have improved access** to timely prenatal care and meet national standards
• **Significant reduction in hospital admissions** for asthma, diabetes, GI infections, UTIs, and bacterial pneumonia due to more appropriate access to timely and quality care
• **Better prescription drug management and adherence than FFS—**More than 93% of children receive appropriate asthma medications and adherence has improved 27% for respiratory diseases and 24% for heart attack treatment

Education

Texas Association of Business Highlights Medicaid Managed Care Savings

In April, the Texas Association of Business (TAB) launched a two-day billboard campaign in Austin, using the "message of the day" billboard on Interstate 35, to highlight the findings of the TAHP-commissioned studies on the positive impact of Medicaid managed care. The billboards read: "MEDICAID MANAGED CARE HAS SAVED TEXAS TAXPAYERS OVER $10 BILLION, TEXAS ASSN. OF BUSINESS TXBIZ.ORG" and "MEDICAID MANAGED CARE, SAVING LIVES AND SAVING DOLLARS, TEXAS ASSN OF BUSINESS, TXBIZ.ORG."

TAB CEO Bill Hammond said, ***"Taxes have been on the mind of people this week. Not only has this program saved taxpayer dollars, it has improved both access to and quality of care."***

TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

MEMBER PLANS

Aetna
Allegian Health Plans
Amerigroup Texas
AmeriHealth Caritas
Blue Cross Blue Shield of TX
Children's Medical Center Health Plan
Christus Health
CIGNA/HealthSpring
Community First Health Plan
Community Health Choice
Cook Children's Health Plan
Driscoll Children's Health Plan
El Paso First Health Plan
FirstCare Health Plans
Humana
KS Plan Administrators, LLC
Memorial Hermann Health Solutions, Inc.
Molina Healthcare of Texas
Parkland Community Health Plan
Scott & White Health Plan
Sendero Health Plan
Seton Health Plan
Superior HealthPlan
Texas Children's Health Plan
UnitedHealthcare
WellCare of Texas

Who is TAHP?

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related health care entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. The association was founded in 1987, and represents the health care industry's commitment to improving health care for Texans.

TAHP is dedicated to advocating for public and private health care solutions that improve access, value and quality of care for many Texans. We bring together industry leadership to develop answers to the critical health care issues in Texas through continuous communication with its members, industry and community stakeholders, as well as with representatives of the Legislature and state agencies.

As the voice for health plans in Texas, TAHP strives to increase public awareness about our members' services, health care delivery benefits and contributions to communities throughout the state.

For more information, follow us on twitter @txhealthplans or visit www.tahp.org

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