85th Texas Legislative Session

TAHP
The Texas Association of Health Plans

SESSION HIGHLIGHTS

HEALTH PLAN HIGHLIGHTS *from the* 85th LEGISLATIVE SESSION

TAHP 2017 Legislative Session Statistics

- TAHP monitored 411 pieces of legislation. Of these filed bills, TAHP actively supported 66 bills and opposed 119 bills.
- Out of these bills, 212 received a committee hearing in the House or Senate. TAHP provided testimony 35 times, 17 times in opposition and 12 times in support. TAHP registered a position without testimony or "submitted a card" 45 times, 18 times in opposition and 27 times in support.
- TAHP actively worked the House Calendars committee to prevent TAHP-opposed bills from reaching the House floor for a vote. TAHP effectively opposed and killed 14 bills through the calendars process.
- TAHP successfully advocated for 9 priority pieces of legislation that have been signed by the governor.

Texas Association of Health Plans

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Did Not Pass

Did Not Pass

Did Not Pass

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Dear TAHP Member,

The 85th 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 comprehensive communications, education, and advocacy strategy carried out in coordination and collaboration with each of our members.

The legislative session yielded a number of important patient protections that were a top TAHP member priority, including expanding surprise billing protections to all emergency room and freestanding ER visits and expanding network transparency requirements for freestanding ERs .

Specifically, TAHP worked to educate legislators and their staffs 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 SB 507, which expands mediation protections and HB 3276, which increases transparency from freestanding emergency rooms, through both chambers and to the Governor's desk.

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 several key legislative victories that support our overall goals of ensuring an affordable and stable health insurance market and Medicaid managed care system. 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, would have increased health care costs for Texas consumers and Texas taxpayers.

In this report, you will find a detailed update on the 85th Legislative Session. Thank you to all of 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 affordable health coverage.

Sincerely,
Jamie Dudensing

Texas Association of Health Plans

Health Plan Highlights from the 85th Texas Legislature

During the 85th Legislature, the Texas Association of Health Plans advocated to maintain a competitive health insurance market in Texas. By actively monitoring the progress of several hundred bills and staying in close contact with legislators and their staffs throughout session, TAHP and its members secured a number of key legislative victories that support our overall goals of ensuring an affordable and stable health insurance market. TAHP also worked to educate legislators and their staffs on the negative consequences of overly prescriptive regulations or burdensome government mandates that drive up the cost of health coverage. During session, TAHP and its member plans were instrumental in preventing many measures from advancing that would have restricted private market negotiations, reduced competition, increased cost for Texas consumers and businesses, and limited affordable health plan coverage options.

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Overall, the 85th Legislature produced positive results for the health insurance industry that will enable health plans to continue to provide affordable health coverage and protect consumers from exorbitant surprise billing and misleading network participation information. These positive changes to Texas law include the adoption of additional surprise billing protections, new transparency requirements for freestanding ERs, expanded access to telemedicine services, and the defeat of several costly measures that would have mandated out-of-network reimbursement rates based on inflated billed charges. Thank you to all of our members for your help and support throughout session, in addition to your valuable insights and feedback.


85th Legislature

TAHP

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

Texas Medicaid Managed Care: Saving Lives & Saving Dollars

Texas is a national leader in the use of managed care. Medicaid managed care has dramatically improved the lives, outcomes, and quality of care for Medicaid patients. Hospital admissions are down 20 to 40% for some of the most common and treatable conditions, including asthma, diabetes, pneumonia, and infections. A new study has also found that access and quality for Medicaid health plan enrollees is better than Medicaid fee for service and comparable to private health coverage.[1]

Taxpayer dollars are being saved through better care coordination, private market competition and negotiations, and reductions in fraud, waste and abuse. The managed care approach, which replaced the less efficient fee-for-service model, has saved the state billions. As a result, Texas has some of the lowest per capita Medicaid costs in the country.

"Texas has been very innovative in our policies to ensure Medicaid services are provided in a cost-effective manner through managed care."

Governor Greg Abbott, September 29, 2015 letter to the federal Centers for Medicare and Medicaid Services

Benefits of Managed Care

- Provides the state **budget certainty** – Fixed monthly premiums
- **Saves the state money** while delivering quality of care
- **Promotes preventive care and continuity of care** through medical homes
- **Guaranteed access** to a network of providers
- **Promotes innovative solutions** such as value-based purchasing to improve health care access
- **Provides integration of services** through the coordination of patient care

Texas Medicaid Health Plans by the Numbers

$3.8B Total Est. Taxpayer Savings Achieved from SFY 2010 - SFY 2015

$3.3B Total Est. Taxpayer Savings to be Achieved from SFY 2015 - SFY 2018

$7.1B Total Est. Taxpayer Savings to be Achieved from Under the Managed Care Model, Compared to FFS

[1] Texas Medicaid Performance Study, The University of Texas Health Science Center at Houston, December 2016

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Solutions for Affordable, Quality Health Care for Texans

Now more than ever, it is critical that we work together to find meaningful solutions that ensure affordable health coverage and care for all Texans. Health plans play an important role in lowering health care cost through private market competition and negotiation. Despite efforts to hold down premiums, research shows that premiums track directly with underlying health care costs and utilization of services, which have been consistently trending upwards. Soaring drug prices and medical care costs must be addressed. In August 2016, health care costs in the U.S.—from the price of prescription drugs to physician appointments—rose more than any other time since 1984.[1]

TAHP advocates for a sound and competitive health insurance market that maximizes private market competition, consumer choice, and affordable coverage options.

Health Coverage in Texas

Health coverage plays an essential role in ensuring healthy families and healthy communities. As of 2014, 83% of Texans (more than 22 million) had some form of coverage, while 17% (or nearly 5 million) did not have health benefits.

Texas Health Coverage and the Uninsured in 2014

People with health coverage are generally healthier individuals who have regular doctors and take advantage of key preventive health care services. Insured individuals are also better insulated from financial hardship and medical debt because their coverage protects them in the event of a serious illness or injury.

9 out of 10 Insured Adults are Satisfied with Health Plan Networks

Efforts by health plans to achieve high quality coverage and provider networks are making a positive difference. The Kaiser Family Foundation found that 9 out of 10 insured Americans are satisfied with their choices of doctors and the value of their health plans.

[1] U.S. Labor Department, September 2016

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TAHP Priority Legislation

Passed:

Expanded Mediation for Balance Billing

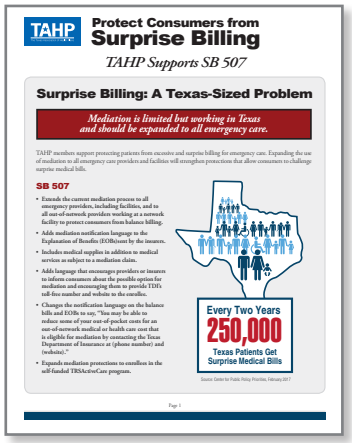
SB 507 by Sen. Hancock & Rep. Frullo

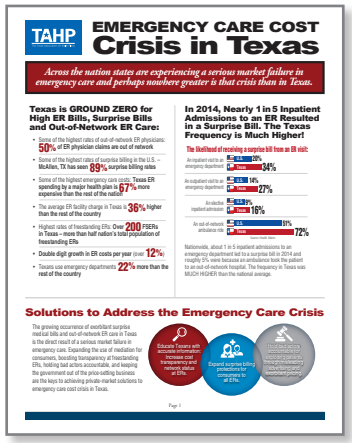
TAHP worked very closely with legislators on SB 507, one of the top priorities of the legislative session. The bill significantly expands protections for Texas consumers against the growing practice of surprise medical billing. The bill expands mediation protections, already successfully used on a limited basis by consumers in Texas, for insured consumers with PPO plans to all out-of-network emergency providers, including freestanding emergency rooms, and to all out-of-network providers working at a network facility. The bill also expands the mediation law to apply to enrollees of the Teachers Retirement System. Mediation is a process by which consumers can challenge surprise medical bills and leave the dispute to the insurer and provider. This legislation builds on a law written by Sen. Hancock in the 81st Legislature that made mediation available to consumers who were balanced billed by six specific types of facility-based physicians.

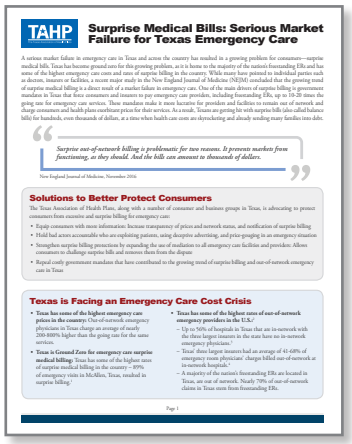
The new law also expands disclosure requirements regarding network status and balance billing by insurers, facilities and other health care providers, including the requirement that a statement substantially similar to the following be provided on bills and EOBs: "You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at (website) and (phone number)."

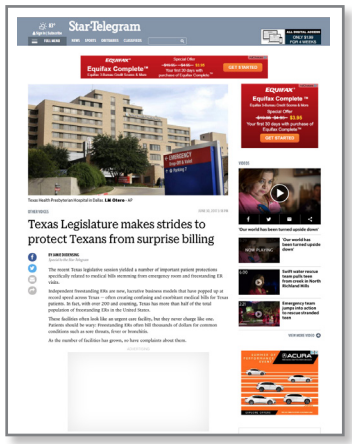
Signed by the Governor.

The bill is effective September 1, 2017, and applies to claims for services or supplies provided on or after January 1, 2018.









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Passed:

Additional Freestanding ER Disclosures

HB 3276 by Rep. Oliverson & Sen. L. Taylor

Freestanding ERs (FSERs) have become a major concern for consumers in Texas due to their confusing advertising and exorbitant pricing. HB 3276 requires greater transparency from independent and affiliated FSERs by requiring them to disclose their network status to patients. HB 3276 builds on legislation adopted last session by adding a requirement that a FSER must post a notice that either lists the health plans for which it is in-network or inform consumers that the facility does not participate in their health plan. (A facility that is in at least one network may comply with this requirement if it lists the network(s) on its website and provides written confirmation to the patient of whether it is in the patient's network to the patient.) The requirements apply to both independent and hospital-affiliated FSERs. By holding FSERs more accountable, consumers will be better equipped to make informed decisions and protect themselves against surprise medical bills.

Signed by the Governor.

The bill is effective September 1, 2017.


85th Legislature | TAHP

TAHP Supports Pro-Consumer HB 3276 to Require Greater Transparency from Independent Freestanding ERs

Nearly 70 Percent of Out-of-Network Emergency Claims for Texas ER Facilities Occur at Freestanding ERs.


TAHP

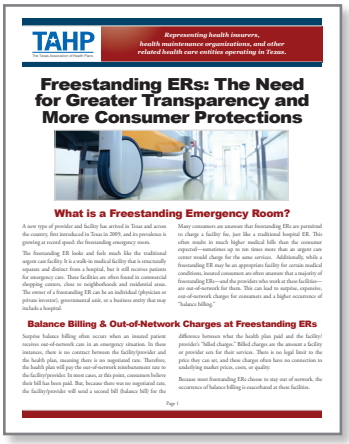
Legislative Solutions to Better Protect Texans in Emergency Medical Situations

SB 2064 & HB 3867

SB 507 & HB 1566

SB 1592

SB 2240, HB 3099, HB 3276 & HB 3122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Freestanding ERs: The Need for Greater Transparency and More Consumer Protections

What is a Freestanding Emergency Room?

Balance Billing & Out-of-Network Charges at Freestanding ERs


TAHP

Reining In Freestanding ERs: Unsustainable Costs, Consumer Confusion, and Surprise Billing

Solutions To Better Protect Consumers

Freestanding ERs Create Confusion & Excessive Costs for Texas Consumers & Employers

Passed:

HMO Network Contracting (including PBMs)

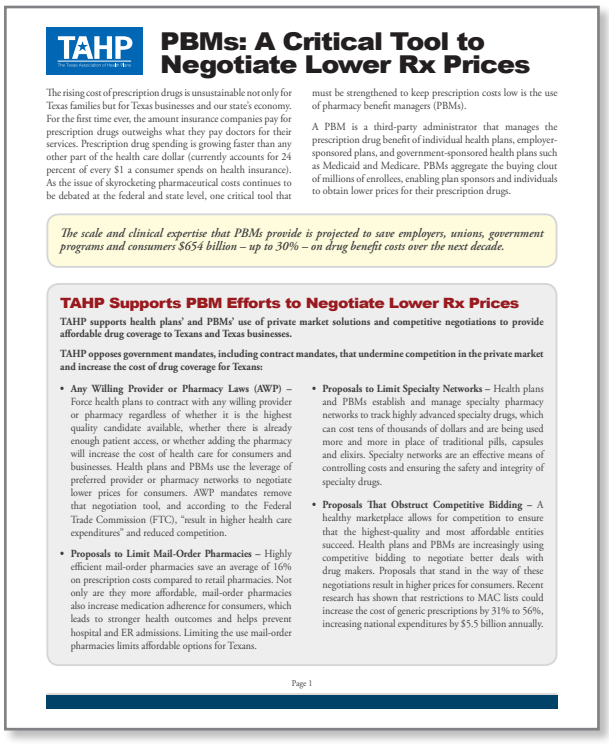
HB 3218 by Rep. Phillips & Sen. Schwertner

This bill allows HMOs to continue accessing PBM pharmacy networks, rather than requiring HMOs to contract directly with each network pharmacy. One of TAHP's top priorities this session, this bill addressed the Department of Insurance's (TDI's) recent position that current provisions of the Insurance Code prohibit HMOs, including Medicaid MCOs, from using PBMs to contract with pharmacies for network participation. TDI agreed that it would delay enforcement of its position until after the legislative session so that TAHP would have an opportunity to address it through a legislative solution. TAHP worked with other stakeholders, including pharmacy trade associations, to pass the bill with no opposition.

HB 3218 amends the HMO Act to specifically allow an HMO to contract with network providers through other entities (such as PBMs) that contract directly with the providers. The HMO's agreement with the entity must state that it does not limit the HMO's authority or responsibility to comply, and that the entity must comply, with applicable regulatory requirements; the agreement must also comply with most of the provisions and requirements of Insurance Code chapter 1272 as if the entity were a "Delegated Entity."

Signed by the Governor.

The bill is effective September 1, 2017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PBMs: A Critical Tool to Negotiate Lower Rx Prices

The scale and clinical expertise that PBMs provide is projected to save employers, unions, government programs and consumers $654 billion – up to 30% – on drug benefit costs over the next decade.

TAHP Supports PBM Efforts to Negotiate Lower Rx Prices

TAHP supports health plans' and PBMs' use of private market solutions and competitive negotiations to provide affordable drug coverage to Texans and Texas businesses.

TAHP opposes government mandates, including contract mandates, that undermine competition in the private market and increase the cost of drug coverage for Texans:

- **Any Willing Provider or Pharmacy Laws (AWP) –** Force health plans to contract with any willing provider or pharmacy regardless of whether it is the highest quality candidate available, whether there is already enough patient access, or whether adding the pharmacy will increase the cost of health care for consumers and businesses. Health plans and PBMs use the leverage of preferred provider or pharmacy networks to negotiate lower prices for consumers. AWP mandates remove that negotiation tool, and according to the Federal Trade Commission (FTC), "result in higher health care expenditures" and reduced competition.
- **Proposals to Limit Mail-Order Pharmacies –** Highly efficient mail-order pharmacies save an average of 16% on prescription costs compared to retail pharmacies. Not only are they more affordable, mail-order pharmacies also increase medication adherence for consumers, which leads to stronger health outcomes and helps prevent hospital and ER admissions. Limiting the use mail-order pharmacies limits affordable options for Texans.
- **Proposals to Limit Specialty Networks –** Health plans and PBMs establish and manage specialty pharmacy networks to track highly advanced specialty drugs, which can cost tens of thousands of dollars and are being used more and more in place of traditional pills, capsules and elixirs. Specialty networks are an effective means of controlling costs and ensuring the safety and integrity of specialty drugs.
- **Proposals That Obstruct Competitive Bidding –** A healthy marketplace allows for competition to ensure that the highest-quality and most affordable entities succeed. Health plans and PBMs are increasingly using competitive bidding to negotiate better deals with drug makers. Proposals that stand in the way of these negotiations result in higher prices for consumers. Recent research has shown that restrictions to MAC lists could increase the cost of generic prescriptions by 31% to 56%, increasing national expenditures by $5.5 billion annually.

Texas Association of Health Plans

Passed:

Increased Access to Telemedicine

SB 1107 by Sen. Schwertner & Rep. F. Price

This bill significantly expands Texans' access to telemedicine and telehealth services. SB 1107 amends the definitions of "telemedicine" and "telehealth" services and changes the standards for when a physician or practitioner can provide these services, no longer requiring direct face-to-face contact. It provides standards for establishing a valid physician-patient relationship, required for prescribing drugs, through a telemedicine service. It also sets the standard of care for telemedicine and telehealth services to be the same as applies in an in-person setting.

The legislation also amends the Insurance Code telemedicine benefit coverage provisions in chapter 1455 to incorporate the bill's revised definitions of telemedicine and telehealth services. Plans may not exclude a covered health care service or procedure delivered by a network professional as a telemedicine or a telehealth service solely because it is not provided through an in-person consultation. As with the current section, applicable copayment, coinsurance, and deductible amounts may not exceed those for the same covered service if provided in-person.

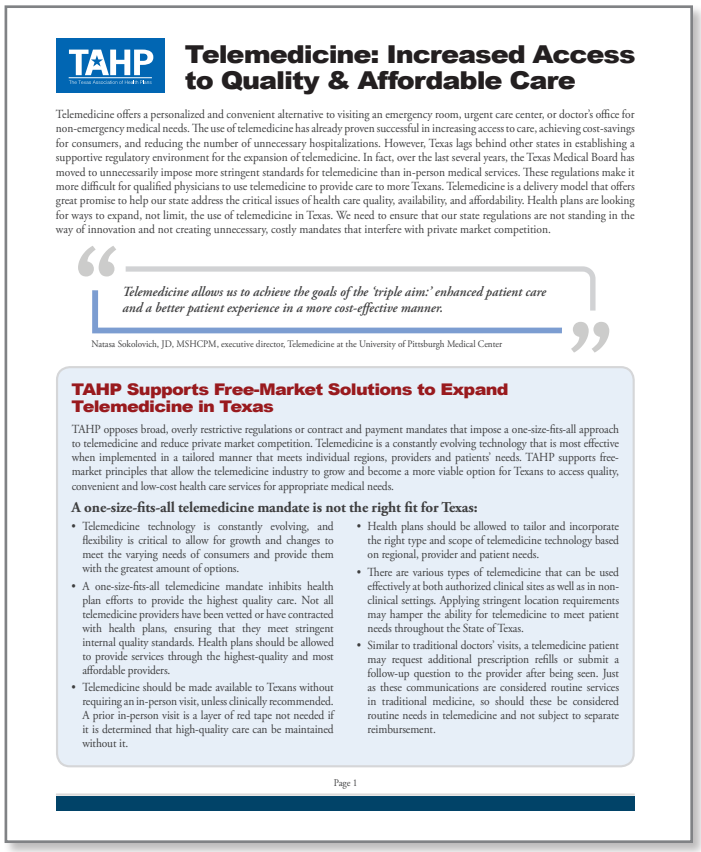
A negotiated provision in the bill states that, notwithstanding the "mandate" language, health plans are not required to provide coverage for a telemedicine or a telehealth service provided by only synchronous or asynchronous audio interaction, including an audio-only telephone consultation, a text-only e-mail message, or a facsimile transmission.

TAHP and its member plans were able to prevent inclusion of a proposed payment "parity" mandate that would have required health plans to pay for telemedicine services at the same rate as if the services were provided face-to-face. Significantly, TAHP was also successful in limiting application of the benefit mandate to telemedicine/telehealth services provided only by in-network physicians and practitioners.

The legislation requires plan issuers to adopt and display "in a conspicuous manner" on its website its policies and payment practices for telemedicine and telehealth services. TAHP and member plans successfully negotiated an additional provision clarifying that this "does not require an issuer to display negotiated contract payment rates…."

Signed by the Governor.

The bill is effective immediately, except that the Insurance Code provisions are effective on January 1, 2018.



TAHP

Telemedicine: Increased Access to Quality & Affordable Care

Telemedicine offers a personalized and convenient alternative to visiting an emergency room, urgent care center, or doctor's office for non-emergency medical needs. The use of telemedicine has already proven successful in increasing access to care, achieving cost-savings for consumers, and reducing the number of unnecessary hospitalizations. However, Texas lags behind other states in establishing a supportive regulatory environment for the expansion of telemedicine. In fact, over the last several years, the Texas Medical Board has moved to unnecessarily impose more stringent standards for telemedicine than in-person medical services. These regulations make it more difficult for qualified physicians to use telemedicine to provide care to more Texans. Telemedicine is a delivery model that offers great promise to help our state address the critical issues of health care quality, availability, and affordability. Health plans are looking for ways to expand, not limit, the use of telemedicine in Texas. We need to ensure that our state regulations are not standing in the way of innovation and not creating unnecessary, costly mandates that interfere with private market competition.

Telemedicine allows us to achieve the goals of the 'triple aim:' enhanced patient care and a better patient experience in a more cost-effective manner.

Natasa Sokolovich, JD, MSHCPM, executive director, Telemedicine at the University of Pittsburgh Medical Center

TAHP Supports Free-Market Solutions to Expand Telemedicine in Texas

TAHP opposes broad, overly restrictive regulations or contract and payment mandates that impose a one-size-fits-all approach to telemedicine and reduce private market competition. Telemedicine is a constantly evolving technology that is most effective when implemented in a tailored manner that meets individual regions, providers and patients' needs. TAHP supports free-market principles that allow the telemedicine industry to grow and become a more viable option for Texans to access quality, convenient and low-cost health care services for appropriate medical needs.

A one-size-fits-all telemedicine mandate is not the right fit for Texas:

- Telemedicine technology is constantly evolving, and flexibility is critical to allow for growth and changes to meet the varying needs of consumers and provide them with the greatest amount of options.
- A one-size-fits-all telemedicine mandate inhibits health plan efforts to provide the highest quality care. Not all telemedicine providers have been vetted or have contracted with health plans, ensuring that they meet stringent internal quality standards. Health plans should be allowed to provide services through the highest-quality and most affordable providers.
- Telemedicine should be made available to Texans without requiring an in-person visit, unless clinically recommended. A prior in-person visit is a layer of red tape not needed if it is determined that high-quality care can be maintained without it.
- Health plans should be allowed to tailor and incorporate the right type and scope of telemedicine technology based on regional, provider and patient needs.
- There are various types of telemedicine that can be used effectively at both authorized clinical sites as well as in non-clinical settings. Applying stringent location requirements may hamper the ability for telemedicine to meet patient needs throughout the State of Texas.
- Similar to traditional doctors' visits, a telemedicine patient may request additional prescription refills or submit a follow-up question to the provider after being seen. Just as these communications are considered routine services in traditional medicine, so should these be considered routine needs in telemedicine and not subject to separate reimbursement.

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Passed:

Formulary Disclosure "Clean-Up"

HB 1227 by Rep. Smithee & Sen. Seliger

This TAHP-supported bill is a clean-up of HB 1624 from the previous session, which adopted extensive formulary disclosure requirements within a chapter that applies to employer group as well as Individual plans. Because the law was intended to provide additional information to consumers shopping for coverage, TAHP successfully advocated that the requirements should not apply to employer group plans. HB 1227 moves the formulary disclosure requirements to a new subchapter of the Insurance Code (B-1 of Ch. 1369) that is applicable to individual plans only.

Signed by the Governor.

The bill is effective September 1, 2017 and applies to health benefit plans issued or renewed on or after that date.

Texas Association of Health Plans

Passed:

Temporary "Risk Pool" Authorized

SB 2087 by Sen. Hancock & Rep. Phillips

SB 2087 authorizes a temporary health insurance risk pool and allows the Commissioner of Insurance to apply for a federal state innovation waiver. This is important legislation, especially considering the current state of uncertainty regarding the Affordable Care Act.

The bill authorizes TDI to apply for federal funds (to the extent they become available) to establish and administer a temporary health insurance risk pool, whose exclusive purpose may be to provide a temporary mechanism for maximizing available federal funding, in order to assist residents of this state in obtaining access to quality health care at minimum cost to the public. The funds may be used for any of the following purposes (subject to any requirements for obtaining federal funds):

- to provide alternative individual health insurance coverage to eligible individuals that does not diminish the availability of traditional commercial health care coverage;
- to provide funding to individual health benefit plan issuers that cover individuals with certain health or cost characteristics in exchange for lower enrollee premium rates; or
- to provide a reinsurance program for health benefit plan issuers in the individual market in exchange for lower enrollee premium rates.

However, the funds may not be used to expand the state's Medicaid program, including Medicaid managed care.

The bill also allows the commissioner to apply to the U.S. Secretary of Health and Human Services for a state innovation waiver of applicable provisions of the Affordable Care Act and any applicable regulations or guidance with respect to health insurance coverage in Texas for a plan year beginning on or after January 1, 2017, or under any applicable federal law adopted after May 1, 2017, for a waiver of applicable federal law or regulations with respect to health insurance.

Signed by the Governor.

The bill is effective immediately.

Passed:

Waiver of Federal Small Employer Requirements

SB 1406 by Sen. Creighton & Rep. Smithee

This bill authorizes the Texas insurance commissioner to apply to and negotiate with the U.S. Secretary of Health and Human Services to obtain a state innovation waiver that waives some of the actuarial value requirements and related levels of health plan coverage requirements imposed under the Affordable Care Act for small employer benefit plans.

Signed by the Governor.

The bill is effective immediately.

Passed:

Credit for Reinsurance

SB 1070 by Sen. Hancock & Rep. Frullo

This TAHP-supported bill adopts TDI's recommendation regarding reinsurance credit. SB 1070 authorizes health insurers and HMOs to provide reinsurance and allows an authorized insurer to provide reinsurance on any line of insurance for which it is authorized in the state. It also provides standards for credit for reinsurance and certification of reinsurers.

Signed by the Governor.

The bill is effective September 1, 2017 and applies to reinsurance contracts entered into or renewed on or after January 1, 2018.

Passed:

Mediation Available for TRS Enrollees

HB 1428 by Rep. Smithee & Sen. Huffman

This TAHP-supported bill allows enrollees in Teachers Retirement System health benefit plans who are balance billed more than $500 by certain non-network providers to access the mediation process administered by TDI.

Signed by the Governor.

The bill is effective September 1, 2017 and applies to a health benefit claim for a medical service or supply provided on or after January 1, 2018.

Texas Association of Health Plans

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 affect the health insurance market. TAHP worked with legislators and stakeholder groups on a number of bills throughout session and negotiated key amendments to ensure that any new protections and regulations did not negatively impact the health insurance market.

Passed:

Mental Health Parity

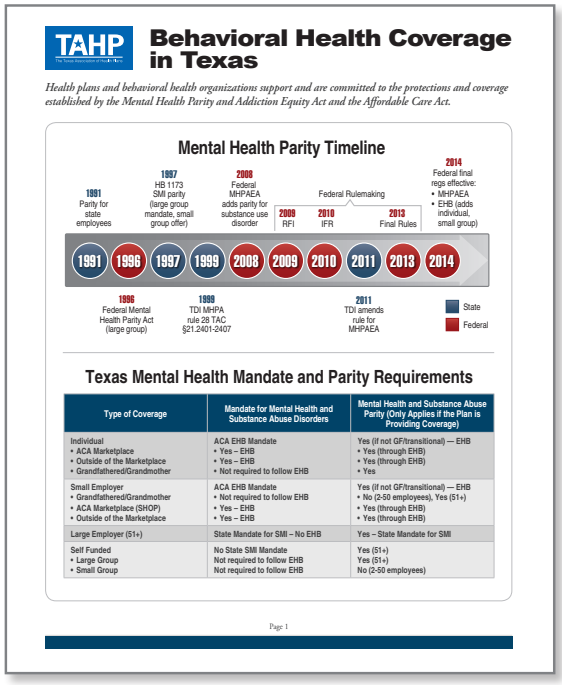
HB 10 by Rep. Price & Sen. Zaffirini

The bill, as filed, required an expansion of mandated coverage, but the final version calls for parity of coverage for mental health and substance abuse disorders on the same basis as medical/surgical services, prohibiting quantitative or non-quantitative limits that are more restrictive. These requirements apply to individual, small employer group and large employer group plans that cover physical and mental health services.

HB 10 also creates an ombudsman, a government official appointed to represent the interests of the public, regarding access to behavioral and mental health care, and a substance use disorder parity work group at the office of mental health coordination. It also requires TDI to conduct a study and report regarding coverage for mental and physical health.

Signed by the Governor.

The bill is effective September 1, 2017; the coverage parity requirements apply to plans issued or renewed on or after January 1, 2018.



TAHP

Behavioral Health Coverage in Texas

Health plans and behavioral health organizations support and are committed to the protections and coverage established by the Mental Health Parity and Addiction Equity Act and the Affordable Care Act.

Mental Health Parity Timeline

1991 Parity for state employees
1996 Federal Mental Health Parity Act (large group)
1997 HB 1173 SMI parity (large group mandate, small group offer)
1999 TDI MHPA rule 28 TAC §21.2401-2407
2008 Federal MHPAEA adds parity for substance use disorder
2009 RFI
2010 IFR
2011 TDI amends rule for MHPAEA
2013 Final Rules
2014 Federal final regs effective: • MHPAEA • EHB (adds individual, small group)
Federal Rulemaking
State
Federal

Texas Mental Health Mandate and Parity Requirements

Type of Coverage	Mandate for Mental Health and Substance Abuse Disorders	Mental Health and Substance Abuse Parity (Only Applies if the Plan is Providing Coverage)
Individual • ACA Marketplace • Outside of the Marketplace • Grandfathered/Grandmother	ACA EHB Mandate • Yes – EHB • Yes – EHB • Not required to follow EHB	Yes (if not GF/transitional) — EHB • Yes (through EHB) • Yes (through EHB) • Yes
Small Employer • Grandfathered/Grandmother • ACA Marketplace (SHOP) • Outside of the Marketplace	ACA EHB Mandate • Not required to follow EHB • Yes – EHB • Yes – EHB	Yes (if not GF/transitional) — EHB • No (2-50 employees), Yes (51+) • Yes (through EHB) • Yes (through EHB)
Large Employer (51+)	State Mandate for SMI – No EHB	Yes – State Mandate for SMI
Self Funded • Large Group • Small Group	No State SMI Mandate Not required to follow EHB Not required to follow EHB	Yes (51+) Yes (51+) No (2-50 employees)

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Passed:

Coverage Mandate for Hearing Aids and Cochlear Implants

HB 490 by Rep. R. Anderson & Sen. Kolkhorst

This bill requires coverage for medically necessary hearing aids and cochlear implants (and related services and supplies) for enrollees who are 18 or younger. The coverage is limited to one hearing aid for each ear every three years and must include fitting and dispensing services. The coverage also includes the provision of ear molds as necessary to maintain optimal fit of hearing aids; related treatments including habilitation and rehabilitation necessary for educational gain; and, for a cochlear implant, an external speech processor and controller with necessary component replacement every three years. The coverage must have no less favorable limits and factors than those for physical illnesses generally have. Furthermore, it is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under the plan, including a provision relating to deductibles, coinsurance, or prior authorization. The bill applies to ERS and TRS plans in addition to commercial plans, including consumer choice plans.

The bill, as filed, prohibited application of deductibles to the coverage, but TAHP worked with the bill author to have that provision removed.

Signed by the Governor.

The bill is effective September 1, 2017 and applies to plans issued or renewed on or after January 1, 2018.

Texas Association of Health Plans

Passed:

Eligibility for Investigational Stem Cell Treatments

HB 810 by Rep. Parker & Sen. Bettencourt

This bill will allow terminally ill patients to use an "investigational stem cell treatment" (an adult stem cell treatment that is under investigation in and being administered in a clinical trial, and has not yet been approved for general use by the FDA), if certain conditions are met. The treatment must be administered directly by a physician certified under the new law, overseen by an institutional review board (IRB), and provided at a licensed hospital, ambulatory surgical center, or medical school. The Medical Board will adopt rules for an IRB affiliated with a medical school or large hospital that can certify physicians to provide the treatments.

The bill does not affect coverage of enrollees in clinical trial under the Insurance Code (Ch. 1379).

Signed by the Governor.

The bill is effective September 1, 2017.

Passed:

Coverage Mandate for Digital Mammography

HB 1036 Rep. Thompson & Sen. Whitmire

This bill expands the current low-dose mammography mandate to include "all forms of" low-dose mammography. The bill requires coverage of digital mammography including breast tomosynthesis (a radiologic procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast). The bill applies to ERS and commercial plans, including consumer choice plans.

Signed by the Governor.

The bill is effective September 1, 2017, and applies to plans issued or renewed on or after January 1, 2018.

Passed:

Coverage Mandate for Prescription Drug Synchronization

HB 1296 Rep. Frullo & Sen. Buckingham

This bill requires health plans covering prescription drugs to establish a process for medication synchronization. The plan must prorate the enrollee's cost-sharing, but may not prorate the pharmacist dispensing fee. It requires a health benefit plan to prorate the cost-sharing for a prescription drug dispensed in a quantity of less than a 30-day supply if the enrollee agrees and the pharmacy or prescribing physician notifies the plan that the quantity dispensed is based on synchronization and is in the enrollee's best interest.

These requirements apply only with respect to only a medication that:

- is covered by the enrollee's health benefit plan;
- meets the prior authorization criteria specifically applicable to the medication under the health benefit plan on the date the request for synchronization is made;
- is used for treatment and management of a chronic illness;
- may be prescribed with refills;
- is a formulation that can be effectively dispensed in accordance with the medication synchronization plan; and
- is not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

Health plans must establish a process for the plan, enrollee, prescriber and pharmacist to jointly approve a medication synchronization plan to treat an enrollee's chronic condition. The health plan must cover medication dispensed in accordance with the dates in the synchronization plan, and must establish a process allowing a pharmacy or pharmacist to "override" a plan's denial for coverage based on the refill being early if the drug is being refilled in accordance with the synchronization plan. The bill applies to commercial plans, including consumer choice plans; ERS and TRS plans; and Medicaid and CHIP plans to the extent allowed by law.

Signed by the Governor.

The bill is effective September 1, 2017 and applies to plans issued or renewed on or after January 1, 2018.

Texas Association of Health Plans

Passed:

Confidentiality of Solvency Exam Reports

HB 2437 by Rep. Phillips & Sen. Hancock

This bill expands the confidentiality of TDI examination reports for carriers under supervision or conservatorship so that the reports are not subject to discovery or admissibility in a civil action or a subpoena (other than by a grand jury). The new law does not limit TDI's authority to use a final or preliminary report, and any information obtained during an exam, in the furtherance of any legal or regulatory action relating to the administration of the Insurance Code that the commissioner, in his or her sole discretion, considers appropriate.

Signed by the Governor. The bill is effective immediately.

Passed:

Marriage and Family Therapists' Use of DSM

HB 2818 by Rep. Romero & Sen. V. Taylor

This bill amends the statutory definition of "Marriage and Family Therapy" to include "diagnostic assessment" and remediation of mental, cognitive, affective, behavioral, or relational dysfunction, disease, or disorder in the context of marriage or family systems. Importantly, the definition provides that it may include the use of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases.

Signed by the Governor. This bill is effective immediately.

Passed:

Opioid Antagonist Prescription Guidelines

SB 584 by Sen. West & Rep. Rose

This bill requires the Medical Board to adopt guidelines for prescription of opioid antagonists.

The guidelines must address prescribing an opioid antagonist to a patient to whom an opioid medication is prescribed, in addition to identifying patients at risk of an opioid-related drug overdose and prescribing an opioid antagonist to that patient or to a person in a position to administer the opioid antagonist to that patient. In adopting the guidelines, the board must consult with the Board of Pharmacy and materials published by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, and may consult other appropriate materials.

Signed by the Governor. The bill is effective September 1, 2017

Passed:

Step Therapy Protocols

SB 680 by Sen. Hancock & Rep. G. Bonnen

This bill adopts consumer protections and guidelines for step therapy protocols. While the final legislation places limits on step therapy protocols, TAHP, PCMA, and other stakeholders negotiated several significant improvements to the filed bill to ensure that health plans and PBMs can continue to use step therapy to encourage safe and cost-effective medication use.

The bill includes criteria for developing clinical practice guidelines, including an opportunity for public input. TAHP and other stakeholders negotiated additional language clarifying that such criteria does not apply to a pharmacy and therapeutics committee established by a health benefit plan issuer or a PBM that advises the health benefit plan issuer or PBM regarding drugs or formularies.

The bill requires each health benefit plan issuer to establish an exception process in a user-friendly format and exception requests to be submitted on a form prescribed by TDI. The final bill allows health plans to require supporting documentation. Legislative intent was established on the House floor confirming that health plans can require clinically appropriate supporting documentation to be submitted with the form.

Exception Criteria includes:

- Contraindication;
- Likely adverse reaction not in the best interest of the patient based on certain conditions
- Previous ineffectiveness or adverse event
- Continuity of care; and
- Expected to be ineffective or cause harm.

The timelines for responding to exception requests are 72 hours after receiving the request or 24 hours if death of or serious harm to the patient is probable; failure to meet these deadlines results in the exception requests being considered granted. Denial of a step therapy exception request is an "adverse determination" subject to an expedited appeal under the current utilization review laws.

Signed by the Governor.

The bill is effective September 1, 2017 and applies to plans issued or renewed on or after January 1, 2018.

Texas Association of Health Plans

Passed:

Holding Company Registration Statements

SB 1073 by Sen. Hancock & Rep. Smithee

Based on a recommendation in TDI's Report to the Legislature, this bill increases disclosure requirements and repeals some exceptions to enterprise risk report requirements. Since Texas law is not consistent with other states, a Texas-based insurer licensed in other states may be required to file an enterprise risk report in each of those states and is subject to additional regulatory scrutiny by each of those states. This multi-state burden is eliminated by removing the current Texas exemptions so that Texas law will align with other states' nationally recognized standards for enterprise risk reports and financial solvency regulation.

Signed by the Governor.

The bill is effective immediately.

Passed:

Pharmacy Cost-sharing Provisions

SB 1076 by Sen. Schwertner & Rep. G. Bonnen

This bill prohibits a health benefit plan that covers prescription drugs from requiring an enrollee to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of:

- the applicable copayment;
- the allowable claim amount for the prescription drug; or
- the amount an individual would pay for the drug if the individual purchased the drug without using a health benefit plan or any other source of drug benefits or discounts.

The bill was amended on the House floor to include provisions from HB 2262/SB 1040, requiring coverage for accelerated refills of prescription eye drops in certain conditions.

Signed by the Governor.

The bill is effective September 1, 2017 and applies to plans issued or renewed on or after January 1, 2018.

Passed:

Differentiation Based on Physician Certification

SB 1148 by Sen. Buckingham & Rep. G. Bonnen

The bill would amend the Occupations Code and the Insurance Code relating to maintenance of certification by a physician or an applicant for a license to practice medicine in this state. The bill would prohibit certain hospitals, institutions, programs, or managed care plan issuer from differentiating between physicians based solely on a physician's maintenance of certificate. The bill would prohibit the Texas Medical Board (TMB) from requiring maintenance of certificate or adopting a rule that would require maintenance of certificate.

Signed by the Governor.

The bill is effective January 1, 2018.

Passed:

Suspension of the Texas Health Reinsurance System

SB 1171 by Sen. Estes & Rep. Paul

This TAHP-supported bill suspends the Texas Health Reinsurance System (the system) and provides that it may operate only during the period that a TDI order authorizing operation is in effect.

TDI must hold a hearing regarding reauthorization of the system if it believes small employer group plans are threatened with the inability to secure reinsurance coverage in the open market, or if it receives a petition requesting the hearing from an association of health benefit plan issuers in this state or a group of at least 15 small employer health benefit plan issuers operating in this state. TDI may reauthorize the system if it finds that its operation would be in the public interest.

The board may make a final assessment of the small employer health benefit plan issuers that, for any portion of the last year in which the system operated, were reinsured in the system. After the effective date of the suspension of the operation of the system, the commissioner shall take any action necessary to distribute the surplus assets of the system until all remaining assets are distributed.

Signed by the Governor.

The bill is effective immediately.

Texas Association of Health Plans

Key Legislation Affecting Medicaid

During the 85th 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.

Passed:

Peer Support Services

HB 1486 by Rep. Price & Sen. Schwertner

HB 1486 directs HHSC to develop and adopt standards and rules establishing certification, training requirements and scope of practice for peer specialists and peer services for mental health and substance use disorders, no later than September 1, 2018. The agency is directed to create a workgroup consisting of various stakeholders to help inform the standards. The bill further directs HHSC to include peer support services in the Medicaid program.

Signed by the Governor.

The bill is effective immediately.

Passed:

Texas Health Steps Mental Health Screenings

HB 1600 by Rep. Thompson & Sen. Watson

HB 1600 allows a Medicaid provider to receive reimbursement for a mental health screening conducted during an annual medical exam for a child between the ages of 12 and 19 through the Texas Health Steps program. The bill specifies that the provider can conduct a mental health screening using one or more validated, standardized mental health screening tools.

Signed by the Governor.

The bill is effective September 1, 2017.

Passed:

Medicaid HIV Outcome Measure

HB 1629 by Rep. Coleman & Sen. Zaffirini

The bill directs HHSC and the Department of State Health Services (DSHS) to develop and implement an outcome measure for Medicaid and CHIP, in order to measure the percentage of clients with HIV infection. TAHP worked with Rep. Coleman and Sen. Zaffirini's offices to ensure the final bill does not require HHSC to include the measure in the P4Q program, but rather, as intended by the authors, only requires an MCO to measure and report on the metric.

Signed by the Governor.

The bill is effective immediately.

Passed:

Extension of State Run Medicaid Prescription Drug Formulary

HB 1917 by Rep. Raymond & Sen. Schwertner

This bill extends the current sunset date of the state-run Medicaid prescription drug formulary from September 2018 to September 2023. This prohibits the plans from managing their own formularies for another 5 years.

Signed by the Governor.

The bill is effective immediately.

Texas Association of Health Plans

Passed:

Maternal Depression Screening in Medicaid and CHIP

HB 2466 by Rep. Davis & Sen. Huffman

This TAHP-supported bill allows HHSC to provide a maternal depression screening for the mother of a child enrolled in the CHIP or Medicaid program, regardless if the mother is enrolled in the program. The Centers for Medicare and Medicaid Services (CMS) recently released guidance allowing states to apply for matching federal funds for this purpose.

The bill was amended on the Senate floor to include provisions from HB 1158, which died on the House Local and Uncontested calendar late in the session. In addition to permitting HHSC to seek federal funding for maternal depression screenings, the final version includes a provision to allow a Medicaid recipient to indicate at the time of application that they would like their MCO or provider to contact them via telephone, text message, or email, and to indicate their preference. Furthermore, the bill includes a provision allowing pregnant women to indicate if they are in their first pregnancy – this information will allow the agency to connect a first-time mother with the Nurse Family Partnership program. The bill directs HHSC to implement changes to the Medicaid application, no later than January 1, 2018.

Signed by the Governor.

The bill is effective January 1, 2017.

Passed:

Medicaid MCO Nonemergency Medical Transportation

HB 2501 by Rep. Phillips & Sen. Creighton

This bill applies the current auto and liability insurance coverage requirements for a transportation network company to Medicaid MCO contracts for nonemergency medical transportation in certain circumstances. The provisions apply to an entity arranging nonemergency medical transportation services under a contract with the state or a managed care organization for individuals qualifying for Medicaid or Medicare only if the entity:

- provides the transportation services through a digital network that connects transportation network company drivers to transportation network company riders for prearranged rides;
- contracts individually with each transportation network company driver who is connected to transportation network company riders for the prearranged rides through the entity's digital network; and
- otherwise, meets all requirements under the Medicaid or Medicare program for delivery of nonemergency medical transportation services.

Signed by the Governor.

The bill is effective September 1, 2017.

Passed:

Medicaid "Any Willing Provider"

HB 3675 by Rep. Paddie & Senator Hinojosa

HB 3675 requires HHSC to allow licensed optometrists, therapeutic optometrists, ophthalmologists, and institutions of higher education that provide accreditation programs for these providers to enroll in Medicaid, and requires MCO's to offer all enrolled providers of these type a contract and include them in their networks.

Signed by the Governor.

This bill is effective September 1, 2017.

Texas Association of Health Plans

Passed:

Mental Health Services in the Medicaid Program

SB 74 by Sen. Nelson & Rep. Price

SB 74 clarifies the intent of SB 58, from the 83rd Legislative Session, regarding requirements for targeted case management and mental health rehabilitation contracts with private providers. The bill prohibits HHSC from requiring private providers to provide the non-covered Medicaid services currently provided by Local Mental Health Authorities. The intent of this bill is to allow MCOs more flexibility in contracting with private providers.

The bill was amended on the House floor to include language that was originally in HB 3541, by Price, relating to MCO contracts with behavioral health organizations (BHOs). The language that was added and passed requires HHSC, to the extent feasible, to ensure coordination between MCOs and BHOs in the following ways:

- require the sharing and integration of care coordination, service authorization and utilization management data;
- encourage the co-location of physical and behavioral health care coordination staff;
- require warm call transfers between care coordination staff;
- require joint rounds for network providers; and
- ensures that MCOs have a seamless provider portal for both physical and behavioral health providers.

Signed by the Governor.

The bill is effective immediately and HHSC is directed to adopt rules no later than January 1, 2018.

Passed:

State Agency Contracting Reform

SB 533 by Sen. Nelson & Rep. Geren

The bill amends current law relating to state agency contracting including: 1) giving the Department of Information Resources (DIR) additional oversight authority of information resources projects; 2) requiring the comptroller to update a contract management guide to include policies on the interactions and communication between state agency employees and vendors; and 3) requiring a state agency employee to disclose any potential conflict of interests.

The bill was amended in the House to add new contracting requirements from HB 18 and HB 20, both by Capriglione. HB 20 would have given the Legislative Budget Board (LBB) staff significant authority over contracts, including the ability to recommend and monitor corrective action plans. The final bill that passed does not include any requirements from HB 18 or HB 20.

Signed by the Governor.

The bill is effective September 1, 2018.

Passed:

Advanced Practice Registered Nurse as PCP in Medicaid or CHIP Networks

SB 654 by Sen. Seliger & Rep. Smithee

This bill allows an advance practice registered nurse (APRN) to be included as a primary care provider in a Medicaid or CHIP MCO's network, regardless of whether the supervising physician is in-network. The bill is permissive and does not require a health plan to adopt this provision. As filed, the bill would have applied to commercial HMO and PPO plans as well.

Signed by the Governor.

The bill is effective September 1, 2017.

Passed:

HHSC Audits of MCOs

SB 894 by Sen. Buckingham & Rep. Muñoz

This bill directs HHSC to develop an overall strategy for planning, managing, and coordinating audit resources related to MCOs, particularly for auditing and collecting payments to Medicaid MCOs.

The bill was amended in the House to include electronic visit verification (EVV) requirements for MCOs. The final bill directs HHSC to conduct a review of the EVV program and evaluate strategies to streamline administrative requirements. HHSC is only required to implement the EVV provisions in the bill if they are found to be necessary following the review of the program.

Signed by the Governor.

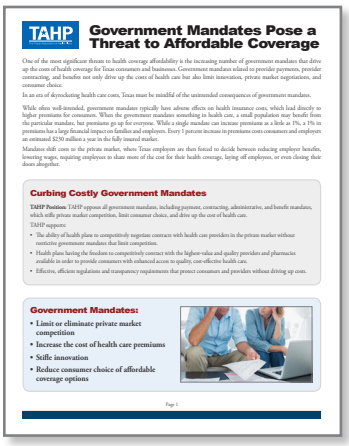
The bill is effective September 1, 2017.

Texas Association of Health Plans

Preventing Costly New Government Mandates

Commercial Health Plan Regulatory and Contractual 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 benefits 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.


TAHP

Government Mandates Pose a Threat to Affordable Coverage

One of the most significant threats to health coverage affordability is the increasing number of government mandates that drive up the costs of health coverage for Texas consumers and businesses. Government mandates related to provider payments, provider contracting, and benefits not only drive up the costs of health care but also limit innovation, private market negotiations, and consumer choice.

In an era of skyrocketing health care costs, Texas must be mindful of the unintended consequences of government mandates.

While often well-intended, government mandates typically have adverse effects on health insurance costs, which lead directly to higher premiums for consumers. When the government mandates something in health care, a small population may benefit from the particular mandate, but premiums go up for everyone. While a single mandate can increase premiums as a little as 1%, a 1% in premiums has a large financial impact on families and employers. Every 1 percent increase in premiums costs consumers and employers an estimated $230 million a year in the fully insured market.

Mandates shift costs to the private market, where Texas employers are then forced to decide between reducing employer benefits, lowering wages, requiring employees to share more of the cost for their health coverage, laying off employees, or even closing their doors altogether.

Curbing Costly Government Mandates

TAHP Position: TAHP opposes all government mandates, including payment, contracting, administrative, and benefit mandates, which stifle private market competition, limit consumer choice, and drive up the cost of health care.

TAHP supports:

- The ability of health plans to competitively negotiate contracts with health care providers in the private market without restrictive government mandates that limit competition.
- Health plans having the freedom to competitively contract with the highest-value and quality providers and pharmacies available in order to provide consumers with enhanced access to quality, cost-effective health care.
- Effective, efficient regulations and transparency requirements that protect consumers and providers without driving up costs.

Government Mandates:

- Limit or eliminate private market competition
- Increase the cost of health care premiums
- Stifle innovation
- Reduce consumer choice of affordable coverage options

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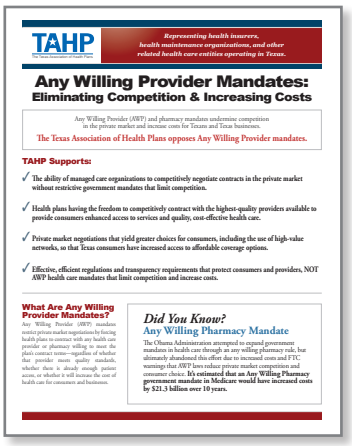

TAHP

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

Any Willing Provider Mandates: Eliminating Competition & Increasing Costs

Any Willing Provider (AWP) and pharmacy mandates undermine competition in the private market and increase costs for Texans and Texas businesses.

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 regulations 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?

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

Did You Know?
Any Willing Pharmacy Mandate

The Obama Administration attempted to expand government mandates in health care through an any willing pharmacy rule, but ultimately abandoned this effort due to increased costs and FTC warnings that AWP laws reduce private market competition and consumer choice. It's estimated that an Any Willing Pharmacy government mandate in Medicare would have increased costs by $21.3 billion over 10 years.

Did Not Pass:

Required "Shared Savings"

HB 307 by Rep. Burrows

This bill would have required increased price transparency from providers and required both commercial and Medicaid health plans to share "savings" with enrollees who obtain a service for less than the average network cost for the service.

The bill was heard and left pending in the House Insurance committee.

Did Not Pass:

PBMs Regulated as "Contracting Entities"

HB 1881 by Rep. Muñoz/SB 1564 by Sen. Kolkhorst

These bills would have applied all of the "contracting entity" requirements of Insurance Code Chapter 1458 to PBMs and pharmacy networks.

The bills were not heard in committee.

Did Not Pass:

Out-of-Network Payment Reporting to TDI

HB 2077 by Rep. Bonnen

This bill would have required PPO and HMO plans to report biennially to TDI information required, by rule, relating to payment methodologies and formulas used to calculate rates for out-of-network physicians and health care providers.

The bill was heard in the House Insurance committee and left pending.

Did Not Pass:

Health Plan Self-Referral Prohibition

HB 2257 by Rep. Muñoz

This bill would have prohibited an insurer from directing a policyholder to a physician or healthcare provider working for, or under contract with, an entity affiliated with the insurer for specified health care services or supplies; a violation would be an unfair method of competition or an unfair, deceptive act or practice in the business of insurance.

The bill was not heard in committee.

Did Not Pass:

Texas-License Requirement for UR Reviewers

HB 2345 by Rep. Workman/SB 2030 by Sen. Buckingham

This bill would have amended the Utilization Review Act in the Insurance Code to require physician reviewers to be licensed in Texas (the current requirement is a license issued by any state in the U.S.).

The bill was voted out of the House Insurance committee but died in Calendars.

Texas Association of Health Plans

Did Not Pass:

Prohibition Against Health Plan Provider Networks

HB 2350 by Rep. Muñoz

The stated purpose of HB 2350 was to, "prohibit the provision of health care benefits by entities such as insurers and HMOs through provider networks, preferred providers, or similar arrangements."

The bill was not heard in committee.

Did Not Pass:

Automatic Additional Exemplary Damages

HB 2394 by Rep. Davis

This bill would have required courts to award, in addition to any other damages, exemplary damages equal to the total amount of premiums paid in the previous five years to a claimant who prevails in a civil action against any TDI-licensed entity arising from a claim for coverage or benefits under an insurance policy or health benefit plan.

The bill was not heard in committee.

Did Not Pass:

Assignment of Civil Causes of Action to Providers

HB 2449 by Rep. Muñoz/SB 1613 by Sen. Campbell

This bill provided that an enrollee's assignment of benefits to a physician or other health care provider authorizes the physician or provider to take any action the enrollee is authorized to take to recover reimbursement from the insurer for benefits under the insurance policy or any law or rule applicable to the policy, including an action under the laws governing unfair and deceptive acts or practices.

The bills were not heard in committee in either house.

Did Not Pass:

$10,000 Minimum Damages

HB 2620 by Rep. Muñoz

This bill would have increased the amount that any plaintiff who prevails in an action relating to health benefits under the Insurance Code for an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to a minimum of $10,000 (i.e., the greater of the amount of actual damages, plus court costs and reasonable and necessary attorney's fees (current law) or $10,000, plus court costs and reasonable and necessary attorney's fees).

The bill was heard and left pending in the House Insurance committee. TAHP submitted a card in opposition.

Did Not Pass:

Reporting All Claim Denials to TDI

HB 2630 by Rep. Muñoz

This bill would have required insurers and health benefit plan issuers (including Medicaid and CHIP plans) to report all claim denials, including reasons for denial, to TDI on a quarterly basis.

The bill was not heard in committee.

Did Not Pass:

"Any Willing Lab"

HB 2711 by Rep. Muñoz

This bill would have created an "Any Willing Lab" mandate for commercial plans (including consumer choice), ERS and TRS plans, and Medicaid and CHIP plans.

Jamie Dudensing testified for TAHP against the bill, saying it was a "right-to-hire mandate" for laboratories, it increased healthcare premiums, and contrary to testimony by lab owners, would not create more consumer options.

The bill was heard and left pending in the House Insurance committee.

Texas Association of Health Plans

Did Not Pass:

Provider Directory Updates

HB 2760 by Rep. G. Bonnen

Many of the provisions of HB 2760 were unreasonable. This bill, as filed, would have reduced the general timeframe for updating provider directories from monthly to daily. TAHP negotiated a change to every 5 days in the committee substitute, but still opposed the bill. It would have required health plans to investigate and correct error reports within only two business days.

HB 2760 would have also created an unnecessary administrative and regulatory burdens in requiring health plans to create and submit to TDI a log of all reports regarding inaccurate network directories and requiring TDI to investigate if three errors occurred within a month. It also required TDI to annually, publicly identify and examine for network adequacy the two insurers with the most mediation requests during the prior year. TAHP also negotiated deletion of this provision. Jamie Dudensing testified against the bill.

The bill was voted out of the House Insurance committee but died in Calendars.

Did Not Pass:

Frozen Formulary

HB 2882 by Rep. Oliverson/SB 1967 by Sen. Creighton

This bill would have severely restricted health plans' ability to make changes to drug benefits, including prohibiting certain modifications even at annual plan renewals (i.e., indefinitely "freezing" formularies and benefits). The bill would have prohibited a health plan from modifying an enrollee's contracted benefit level for most prescription drugs covered during the prior plan, even at renewal; the prohibited modifications included removing a drug from a formulary, adding a prior authorization requirement, imposing or altering a quantity limit, imposing a step-therapy restriction, and moving a drug to a higher cost-sharing tier.

Jamie Dudensing testified against the bill and TAHP also submitted written testimony.

The bill was heard and left pending in the House Insurance committee.

Did Not Pass:

Prohibition on Prior Authorization Requirements

HB 3412 by Rep. Shaheen

This bill would have required TDI to adopt rules prohibiting prior authorization for certain covered benefits.

The bill was scheduled for hearing in the House Insurance committee, but was not heard.

Did Not Pass:

ACA Provisions

HB 4218 by Rep. Coleman/SB 2224 by Sen. Rodriguez

This bill would have mandated coverage of preventive care, mental health and substance abuse disorders, essential health benefits, and would have adopted other provisions of the ACA.

The bills were not heard in committee in either house.

Did Not Pass:

Misrepresentation in EOB

SB 1614 by Sen. Campbell

This bill would have added making a misleading representation or a misrepresentation in an EOB to the Insurance Code's list of actions that are "an unfair method of competition or an unfair or deceptive act or practice in the business of insurance."

The bill was not heard in committee.

Did Not Pass:

"Balance Billing" Definition

SB 1615 by Sen. Campbell

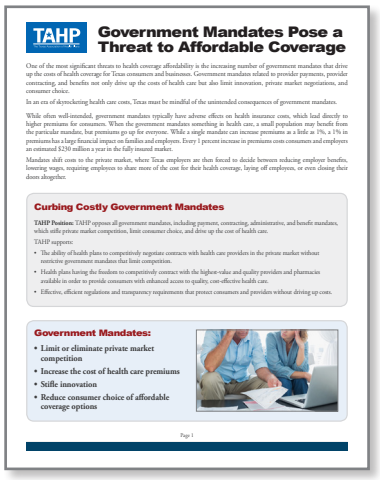
This bill would have amended the mediation statutes to provide that the term "balance billing" does not include any amount the health plan "is obligated to reimburse the enrollee or to pay on behalf of the enrollee for service received by the enrollee from the health care provider."

The bill was not heard in committee.

Texas Association of Health Plans

Out-of-Network Payment Mandates:

Instead of allowing for private-market negotiations, government payment mandates require private health plans to pay providers at a government-determined rate. When the government sets privately negotiated rates at "billed charges" or "usual and customary charges," it creates perverse incentives in the market and often results in negative consequences. In Texas, there is no legal limit to the amounts that providers can bill. Billed charges (or provider "sticker prices") often have little or no connection to underlying market prices, quality, or actual health care costs, and these amounts are usually not what is accepted and negotiated in the market. These billed charges are often 10 to 20—even 100—times what Medicare pays for the same services. These mandates incentivize providers to remain out-of-network, significantly increase health care costs, increase consumer out-of-pocket costs, and lead to more expensive health insurance premiums for employers and consumers. Several such mandate bills were filed during the 85th session, none of which passed.


TAHP

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Mandates shift costs to the private market, where Texas employers are then forced to decide between reducing employer benefits, lowering wages, requiring employees to share more of the cost for their health coverage, laying off employees, or even closing their doors altogether.

Curbing Costly Government Mandates

TAHP Position: TAHP opposes all government mandates, including payment, contracting, administrative, and benefit mandates, which stifle private market competition, limit consumer choice, and drive up the cost of health care.

TAHP supports:

- The ability of health plans to competitively negotiate contracts with health care providers in the private market without restrictive government mandates that limit competition.
- Health plans having the freedom to competitively contract with the highest-value and quality providers and pharmacies available in order to provide consumers with enhanced access to quality, cost-effective health care.
- Effective, efficient regulations and transparency requirements that protect consumers and providers without driving up costs.

Government Mandates:

- Limit or eliminate private market competition
- Increase the cost of health care premiums
- Stifle innovation
- Reduce consumer choice of affordable coverage options

Page 1

Did Not Pass:

Average Charges Mandate

HB 2945 by Muñoz/SB 1485 by Sen. Campbell

This bill would have required payment by preferred provider benefit (PPO) plans of all out-of-network claims for covered services in an amount of at least the average charge for the service in the area.

The bills were not heard in committee in either house.

Did Not Pass:

Usual and Customary Charges Mandate

HB 3753 by Rep. G. Bonnen

This bill is very similar, requiring a PPO plan issuer to pay all out-of-network claims for covered services in an amount of at least the "usual and customary charge" for the service, defined as the average allowed charge by a physician or healthcare provider with the same type of license in the area.

The bill was not heard in committee.

Did Not Pass:

Average Charges Mandate

HB 3755 by Rep. R. Anderson/SB 1486 by Sen. Campbell

These bills are also similar, requiring a PPO plan issuer to pay all out-of-network claims for covered services in an amount of at least the average charge for the service by in-network providers in the area.

Jamie Dudensing, representing TAHP, testified in opposition to the bill, expressing to the committee that basing a payable amount on the "sticker price" isn't actually a free market price, as the high threshold charge is artificially inflated. She relayed concern that this measure would ultimately result in a cost increase for consumers and employers (as providers of health insurance coverage to employees).

The bill was heard and left pending in the House Insurance committee.

Did Not Pass:

Usual and Customary Charges

HB 3814 by Rep. G. Bonnen

This bill would have created a payment mandate for PPO plans to pay a usual and customary charge for out-of-network services, defined as 135% of the, "average maximum allowed charge."

The bill was not heard in committee.

Did Not Pass:

135% of Highest Charge Mandate

HB 4016 by Rep. G. Bonnen

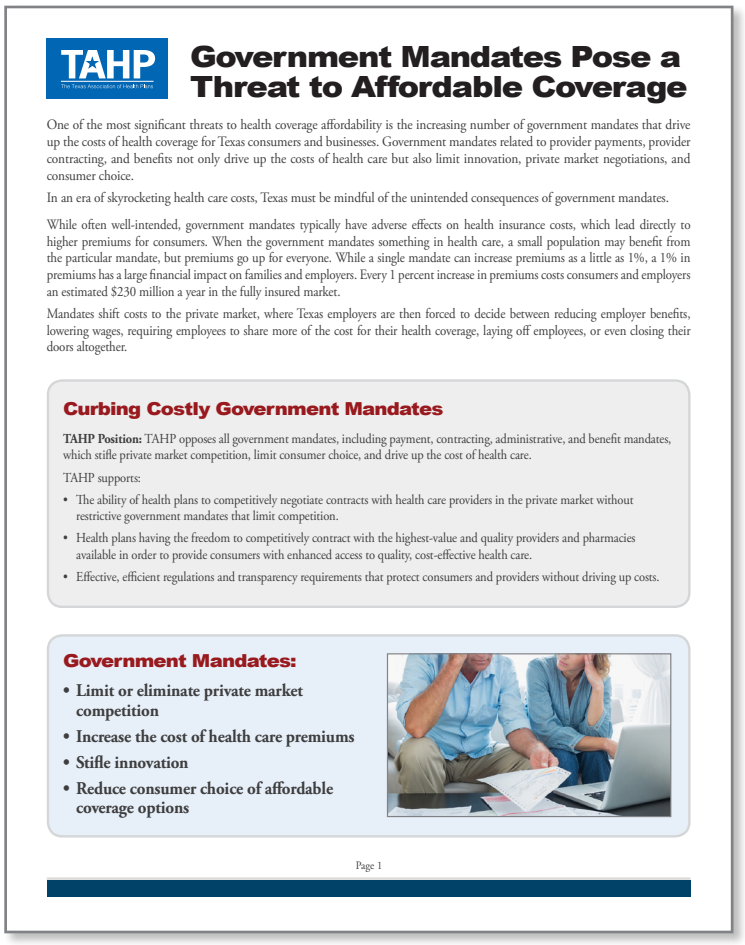
This bill would have adopted a "135% of highest charge" usual and customary payment mandate (providers choosing to participate in the chapter must accept that amount as payment in full) and prompt payment requirements for out-of-network providers.

The bill was not heard in committee.

Texas Association of Health Plans

Health Coverage Benefit Mandates

A health benefit mandate requires carriers to offer additional benefit coverage for specific health care services, types of providers and types of enrollees and dependents. Nationally, there are an estimated 2,200 or more state mandates requiring insurance companies to cover, for example, the cost of treatments such as acupuncture, fertility treatment, or substance abuse programs. These mandates can increase the cost of health care anywhere from 10 to 50 percent. Texas ranks 6th in the nation for the highest number of mandates. New health benefit mandates were responsible for as much as 23 percent of all premiums from 1996-2011. The Affordable Care Act further increased benefit mandates by requiring health plans to cover the "essential health benefits" package for health insurance coverage starting on or after January 1, 2014, including benefits such as ambulatory patient services, emergency services, hospitalization, and more.



TAHP
The Texas Association of Health Plans

Government Mandates Pose a Threat to Affordable Coverage

One of the most significant threats to health coverage affordability is the increasing number of government mandates that drive up the costs of health coverage for Texas consumers and businesses. Government mandates related to provider payments, provider contracting, and benefits not only drive up the costs of health care but also limit innovation, private market negotiations, and consumer choice.

In an era of skyrocketing health care costs, Texas must be mindful of the unintended consequences of government mandates.

While often well-intended, government mandates typically have adverse effects on health insurance costs, which lead directly to higher premiums for consumers. When the government mandates something in health care, a small population may benefit from the particular mandate, but premiums go up for everyone. While a single mandate can increase premiums as a little as 1%, a 1% in premiums has a large financial impact on families and employers. Every 1 percent increase in premiums costs consumers and employers an estimated $230 million a year in the fully insured market.

Mandates shift costs to the private market, where Texas employers are then forced to decide between reducing employer benefits, lowering wages, requiring employees to share more of the cost for their health coverage, laying off employees, or even closing their doors altogether.

Curbing Costly Government Mandates

TAHP Position: TAHP opposes all government mandates, including payment, contracting, administrative, and benefit mandates, which stifle private market competition, limit consumer choice, and drive up the cost of health care.

TAHP supports:

- The ability of health plans to competitively negotiate contracts with health care providers in the private market without restrictive government mandates that limit competition.
- Health plans having the freedom to competitively contract with the highest-value and quality providers and pharmacies available in order to provide consumers with enhanced access to quality, cost-effective health care.
- Effective, efficient regulations and transparency requirements that protect consumers and providers without driving up costs.

Government Mandates:

- **Limit or eliminate private market competition**
- **Increase the cost of health care premiums**
- **Stifle innovation**
- **Reduce consumer choice of affordable coverage options**

Page 1

Did Not Pass:

Diabetes Supplies Mandate

HB 165 by Rep. Raymond

Expansion of the diabetes services and supplies mandate to include coverage for an "artificial pancreas device system."

The bill was not heard in committee. (Refile from 84th Legislature).

Did Not Pass:

Mammography Mandate

HB 195 by Rep. Bernal

Expansion of the low-dose mammography mandate to include coverage for diagnostic mammograms that is no less favorable than for a screening mammogram.

The bill was heard and left pending in the House Insurance committee.

Texas Association of Health Plans

Did Not Pass:

Pre-Existing Conditions Mandate

HB 224 by Rep. Rodriguez

State mandate to cover treatment of pre-existing conditions.

The bill was not heard in committee.

Did Not Pass:

Mammography Mandate

HB 583 by Rep. Collier

Expansion of the low-dose mammography mandate to require an offer of coverage for supplemental screening in certain cases.

The bill was not heard in committee.

Did Not Pass:

HIV Testing Mandate

HB 717 by Rep. Wu/SB 1265 by Sen. Miles

Requirement for a health care provider that takes a blood sample for routine testing to submit it for HIV testing unless the patient opts out, regardless of whether an HIV test is part of a primary diagnosis; mandate for coverage of the tests.

HB 717 was heard and left pending in the House Insurance committee.

Did Not Pass:

Craniofacial Mandate

HB 831 by Rep. Anderson

Expansion of the mandate for coverage of services to treat craniofacial abnormalities to include services in addition to surgery.

The bill was voted out of the House Insurance committee but died in Calendars.

Did Not Pass:

12 Month Supply of Contraceptives

HB 940 by Rep. Howard/HB 1161 by Rep. Davis

Mandate to cover up to a 12-month supply of prescription contraceptive drugs at one time.

Applicable to ERS, TRS, Medicaid, and CHIP plans. HB 1611 was voted out of the House Insurance committee but died in Calendars.

Did Not Pass:

Newborn Screening Mandate

HB 1067 by Rep. Meyer/HB 1937 by Rep. Villalba

Newborn screening requirement for adrenoleukodystrophy and adds the condition to the mandate to cover formulas used to treat certain conditions.

HB 1937 was heard and left pending in the House Public Health committee; Jamie Dudensing testified against the bill.

Did Not Pass:

Prescription Drugs for Stage IV Cancer Mandate

HB 1539 by Rep. Thompson

Prohibition against step therapy for prescription drugs for treatment of stage IV cancer.

The bill was heard and left pending in the House Insurance committee.

Did Not Pass:

Serious Emotional Disturbance of a Child Treatment Mandate

HB 1599 by Rep. Thompson

Mandate for large employer group health benefit plans (mandated offer for small employer groups) to provide coverage for treatment of serious emotional disturbance of a child.

The bill was voted out of the House Public Health Committee and died in Calendars.

Did Not Pass:

PTSD/Eating Disorders/Serious Emotional Disturbance of a Child Treatment Mandates

HB 2094 by Rep. Price/SB 861 by Sen. Zaffirini

Mandates for coverage of treatment for PTSD, eating disorders, and serious emotional disturbance of a child.

The bills were not heard in committee in either house.

Texas Association of Health Plans

Did Not Pass:

PTSD/Eating Disorders/Serious Emotional Disturbance of a Child Treatment Mandates

HB 2096 by Rep. Price

Mandates for coverage of treatment for PTSD, eating disorders, and serious emotional disturbance of a child; expansion of serious mental illness mandate to apply to Individual and small employer group plans.

The bill was not heard in committee.

Did Not Pass:

PTSD Treatment Mandate

HB 2603 by Rep. Farrar/SB 1154 by Sen. Menéndez

Mandate for coverage of treatment for PTSD.

HB 2603 was voted out of the House Public Health committee but died in Calendars.

Did Not Pass:

Substance Abuse Disorder Treatment Mandate

HB 2605 by Rep. Muñoz

Mandate for coverage of (and parity for) mental health conditions and substance abuse disorders.

The bill was not heard in committee.

Did Not Pass:

Ovarian Cancer Treatment Mandate

HB 3304 by Rep. King

Mandate for ovarian cancer testing and screening to include "any other test or screening approved by the FDA for the detection of ovarian cancer."

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

Did Not Pass:

Hair Prosthesis Mandate

HB 3523 by Rep. Gervin-Hawkins

Mandate for coverage of a hair prosthesis (eligibility limited in House Committee Substitute to a patient who is undergoing or has undergone medical treatment for cancer).

The bill was voted out of the House Insurance committee, as substituted, but died in Calendars.

Did Not Pass:

Obesity Treatment Mandate

HB 3560 by Rep. Oliverson/SB 756 by Sen. Menéndez

Mandate for coverage of medically necessary services to treat obesity, including bariatric surgery; the House Committee Substitute did not include the mandated benefits but would have created a joint interim legislative committee to study health benefit coverage for the diagnosis and treatment of obesity.

HB 3560 was voted out of the House as substituted but was not heard in a Senate committee.

Did Not Pass:

Abuse-Deterrent Opioid Mandate

HB 3864 by Rep. Rodriguez/SB 270 by Sen. Creighton

Mandate to cover abuse-deterrent opioid analgesic drugs.

The bills were not heard in committee in either house.

Did Not Pass:

Eating Disorders Treatment Mandate

HB 3891 by Rep. Coleman

Mandate to cover treatment for eating disorders.

The bill was voted out of the House Public Health committee and was set on the House calendar but not heard.

Did Not Pass:

Early Childhood Intervention Treatment Mandate

HB 3930 by Rep. Miller

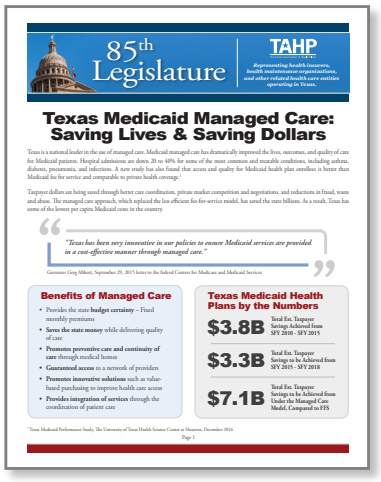
Expansion of the mandate to cover treatment of developmental delays mandate to include "early childhood intervention services."

The bill was heard and left pending in the House Insurance committee.

Texas Association of Health Plans

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 eliminating the private-market competitive negotiations that have allowed MCOs 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 flexibility in order to innovate and 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 cost of the Medicaid program for taxpayers. In the 85th 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:

State Agency Contracts

HB 20 by Rep. Capriglione

The bill would have given the Legislative Budget Board (LBB) broad authority over state contracts, including the authority to review for compliance, recommend corrective action and monitor corrective action plans, and the ability to recommend cancellation of a contract.

The bill passed the House but did not receive a committee hearing in the Senate.

Did Not Pass:

Telemonitoring

HB 727 by Rep. Guerra

The bill would allow HHSC to add any diagnosis to allowable conditions for home telemonitoring benefits, if there is evidence of effectiveness. The bill would also require reimbursement for a daily telemonitoring service, even if a transmission fails, as long as the provider makes contact with the client to resolve transmission issues.

The bill passed the House but did not receive a committee hearing in the Senate.

Did Not Pass:

Medicaid Pharmacy Reimbursement Mandate

HB 1133 by Rep. Sheffield

This bill would have mandated the methodology by which Medicaid MCOs reimburse pharmacies. The bill would have required the MCO to pay a dispensing fee established by HHSC plus the actual acquisition cost using the National Average Drug Acquisition Cost (NADAC).

The bill easily passed the House, but TAHP worked to ensure that the bill did not receive a hearing in the Senate.

Did Not Pass:

MCO Reimbursement Timeframes

HB 1398 by Rep. Muñoz

This bill would have changed the payment timeline for MCOs to pay claims for services from 30 to 15 days. The bill was voted favorably from Public Health, but TAHP was able to keep the bill from moving any further and it eventually died in Calendars Committee. There were attempts, but TAHP was able to stop this language from being added to several other bills.

The bill died in Calendars Committee.

Did Not Pass:

Medicaid Prompt Pay Penalty

HB 1420 by Rep. Martinez

This bill would have allowed HHSC the ability to assess an additional prompt pay penalty on Medicaid MCOs in the amount of 20% of the entire claim in addition to the current penalty (18% interest) for untimely payment of claims. TAHP worked with the author, following the hearing in the House Human Services Committee, to resolve the provider complaint that prompted him to file the bill, resulting in the author not moving the bill out of committee.

The bill was not moved out of committee.

Texas Association of Health Plans

Did Not Pass:

Personal Needs Allowance Increase

HB 1622 by Rep. Senfronia Thompson

The bill would have increased the Medicaid personal needs allowance for individuals in a nursing facility, assisted living facility, or an ICF-IDD from $60 to $75/month.

The bill passed the House but was never heard in the Senate.

Did Not Pass:

Extrapolation

HB 1649 by Rep. Muñoz

The bill would have prohibited HMOs and insurers from using "extrapolation" to complete an audit of a participating (network) physician or provider. The bill also applied to Medicaid health plans, as filed, but the version that passed the House exempted Medicaid MCOs.

The bill did not receive a hearing in the Senate.

Did Not Pass:

Medicaid Service Coordination Bills

HB 1768, 1769, 1770 by Rep. Muñoz, HB 3520 by Rep. Davis, and HB 3850 by Rep. Zerwas

There were multiple bills filed this session that related to service coordination, mainly due to a LBB staff report. While none of these bills passed, a HHSC budget rider was adopted that directs HHSC (in collaboration with other agencies and the MCOs) to evaluate opportunities to streamline case management services across programs. The rider further directs HHSC to evaluate whether reductions to capitation rates are necessary for Medicaid members receiving duplicative case management services and identify opportunities to ensure that a single entity is designated as the primary case manager. A report of the agency's findings and recommendations is due to the Legislature by May 1, 2018.

Did Not Pass:

Services Coordination Caseload Standards

HB 1770 by Rep. Muñoz, HB 3520 by Rep. Davis, and HB 3850 by Rep. Zerwas

These bills would have required HHSC to establish caseload standards for care coordination in the STAR+PLUS Medicaid program.

Did Not Pass:

LMHA Care Coordination

HB 1768 by Rep. Muñoz, HB 3520 by Rep. Davis, and HB 3850 by Rep. Zerwas

These bills would have required HHSC to ensure that the Local Mental Health Authority (LMHA) provider is responsible for care coordination for Medicaid clients receiving certain Medicaid services (targeted case management and mental health rehabilitation).

Did Not Pass:

MCO Service Coordination Information-Sharing

HB 1769 by Rep. Muñoz, HB 3520 by Rep. Davis, and HB 3850 by Rep. Zerwas

These bills would have directed HHSC to ensure that MCOs share information, including medical records, among care coordinators and providers.

HB 1768, HB 1769 and HB 1770 by Muñoz were all heard in House Human Services Committee but were never voted out of the Committee. HB 3520 and HB 3850 never received a hearing.

Did Not Pass:

Payment of Ancillary Claims

HB 2373 by Rep. Miller/SB 557 by Rep. Rodríguez

This bill would have extended the claims filing deadline for an ancillary service for a Medicaid recipient in a nursing facility who is receiving community based services, to 270 days from when the ancillary service is provided. The existing requirement is 95 days. The bill was filed because ancillary service providers are experiencing difficulties obtaining information from home health agencies and nursing facilities in a timely manner in order to meet the MCO claims filing deadlines.

The bill passed the House but did not receive a hearing in the Senate.

Texas Association of Health Plans

Did Not Pass:

Medicaid MCO Expenditures Report

HB 2375 by Rep. Muñoz

This bill would have required HHSC to submit a report to the legislature each even-numbered year that includes the amount of money appropriated to the MCO that was not spent, the amount of profit sharing received, the estimated savings resulting from access to preventive care and improved quality, and total cost of the program for the year compared to the previous year and adjusted to eliminate program enrollment growth.

The bill had a hearing in House Human Services but was not voted out of committee.

Did Not Pass:

Nursing Facility Quality Based Payment Incentive Program

HB 2454 by Rep. Klick/SB 1819 by Sen. Burton

This bill would have required HHSC to ensure rates for nursing facilities include a NF quality-based payment incentive program. The current statute allows incentives to the extent that appropriated funds are available.

The house bill had a hearing and was passed out of committee, but never made it to the House floor. The senate bill did not receive a hearing.

Did Not Pass:

Prohibition on Medicaid Managed Care

HB 2500 by Rep. Muñoz

This bill would have required the state to provide Medicaid solely through the traditional fee-for-service (FFS) delivery model and to complete the transition from managed care to FFS by September 1, 2019.

The bill did not receive a hearing.

Did Not Pass:

Medicaid Capitation Payments and Reporting

HB 2626 by Rep. Muñoz

This bill would have given the legislature the ability to set an upper limit on the percentage of Medicaid capitated or other premium payment amounts that an MCO may spend on administration, overhead, and marketing costs each year of the biennium. The bill also requires MCOs to report on: 1) the percentage of MCOs budget that was spent during the year on administration, overhead, and marketing costs; and 2) reimbursement for clinical services provided to enrollees and activities that improve healthcare quality for enrollees.

The bill had a hearing in House Human Services but did not receive a vote to move out of committee.

Did Not Pass:

Integrated Behavioral Health and Physical Health Contracts

HB 2801 by Rep. Price

The bill would have required a MCO to allow an integrated provider of both behavioral and physical health services the option of entering into a single contract, regardless if the MCO subcontracts with a BHO.

This bill did not receive a hearing.

Did Not Pass:

Medicaid Therapy Rates

HB 2905 by Rep. Muñoz

This bill would have required HHSC to ensure that reimbursement for therapies (occupational, physical and speech) in Medicaid are at least equal to reimbursement rates in place on August 31, 2015, regardless if the individual is enrolled in FFS or managed care.

The bill did not receive a hearing.

Did Not Pass:

OIG Clarification

HB 2969 by Rep. Raymond

The bill was filed to help provide clarification related to technology HHSC can use in detecting and deterring fraud in the Medicaid program. The bill was amended in the House Human Services committee to include a provision that would have required MCOs and OIG to split recoveries. Each entity would retain 50% of monies recovered, regardless of who discovered or recouped the funds.

The bill passed out of committee and was set on the House calendar, but not in time to receive a final House vote.

Texas Association of Health Plans

Did Not Pass:
BHO and MCO Coordination
HB 3541 by Rep. Price

This bill would have established coordination requirements for MCOs that provide behavioral health through a third party or subsidiary.

The bill was set on the House calendar but was not heard before the deadline. Provisions from the bill were added to SB 74 which passed.

Did Not Pass:
1115 Medicaid Waiver
HB 3634 by Rep. Gregg Bonnen

The bill would have required HHSC to seek the following amendments to the 1115 Medicaid waiver and operate Medicaid under a block grant funding system based on population and cost growth trends: 1) reinstate eligibility criteria for Medicaid and CHIP that existed on December 31, 2013 and discontinue use of MAGI; 2) implement, at least, a 6 month Medicaid managed care lock-in as allowable under federal law; 3) ensure that eligibility periods are for only 6 months; 4) require Medicaid recipients to pay copayments; 5) require Medicaid and CHIP recipients to participate in a HIPP reimbursement program, if available to the child; 6) assess fees for missed health care appointments; 7) require adults to sign a personal responsibility agreement; and 8) ensure that HHSC has authority to evaluate new payment models without the need to seek additional waivers or authorizations.

The bill had a hearing in House Public Health but no action was taken to move the bill.

Did Not Pass:
Vendor Drug Program Reform
HB 3732 by Rep. Raymond

This bill would have extended the state-run Medicaid formulary through 2030 and would have put in requirements to reform the current program based on the provider, MCO, and client concerns with the current program.

The bill was set for a hearing in the House Human Services Committee but was pulled at the last minute because of a large fiscal note associated with the bill.

Did Not Pass:
Medicaid MCO Fee Schedule
HB 3884 by Rep. Muñoz

This bill would have required Medicaid MCOs to establish a schedule for payment of reimbursable claims and include the fee schedule in provider contracts.

This bill never received a hearing.

Did Not Pass:
Medicaid Omnibus Bill
HB 3982 by Rep. Raymond/SB 1776 by Sen. Hinojosa

This bill would have made significant prescriptive changes to the administration and operation of the Medicaid program in a managed care model.

Changes included:

- limiting an MCOs ability to reduce provider rates;
- dictating specific requirements related to prior authorization processes;
- establishing a minimum standard of medical necessity for MCOs;
- making changes to appeals processes; and
- directing HHSC to develop rules related to observation stays in an inpatient facility.

The bill was voted out of the House Human Services Committee with 4 "no" votes and was finally set on the House Calendar, but was not heard.

Did Not Pass:
Coverage of Prosthetic Devices in Medicaid
SB 1174 by Sen. Hinojosa

This bill would have required HHSC to provide a prosthetic device to a Medicaid recipient, regardless of age, who is in need of the device because of: 1) a congenital absence, 2) a surgical revision, or 3) a traumatic amputation of an extremity, hip, or shoulder.

The bill was heard in Senate Health and Human Services Committee but no action was taken on the bill.

Texas Association of Health Plans

Did Not Pass:

Medicaid Pharmacy Reimbursement

SB 1567 by Sen. Kolkhorst/HB 3388 by Rep. Klick

These bills would have required that a contract between the MCO (and any subcontracted PBM) and a pharmacist or pharmacy provider, include the reimbursement methodology used, at a minimum, indicate: 1) the amount to be paid for each claim or ingredient cost as a percentage of the amount that would be paid under FFS; and 2) the amount to be paid for each claim for the dispensing fee as a percentage of the amount that would be paid under FFS.

TAHP worked with providers and the authors, and neither bill received a hearing.

Did Not Pass:

OIG Recoveries

SB 1787 by Sen. Hinojosa

This bill would have clarified OIG requirements and required a MCO to submit written notice to the OIG of suspected fraud, in a form prescribed by the OIG. The committee substitute was amended to require that a MCO notifies OIG of recoveries that exceed $100,000 and would have required the OIG and the MCO to share recoveries by 50%, regardless of who discovers or recoups.

The bill passed the Senate but did not receive a hearing in the House.

Did Not Pass:

Cost Effectiveness Studies for Medicaid Program

SB 1927 by Sen. Kolkhorst

SB 1927 would have required HHSC to conduct several studies including:

- A study of the cost-effectiveness and feasibility of MCO procurement changes, including moving to a price bidding model and procuring contracts statewide versus on a regional basis.
- A study to identify and evaluate barriers preventing Medicaid recipients from choosing consumer directed services options.
- A study on the feasibility of establishing a community attendant registry.
- A study on dental services for adults with disabilities.
- A study on alternative delivery models for Medicaid programs to include efforts taken to ensure current delivery models are effective, and an assessment of cost savings achieved from the current delivery model.

The bill, as amended in committee, also included a provision requiring OIG and MCOs to split all fraud, waste and abuse recoveries by 50% regardless of who discovered or recouped.

The bill passed the Senate and House Human Services Committee but was not set on a House Calendar.

Texas Association of Health Plans

85th Legislature Medicaid Budget Highlights

The Texas Senate and House of Representatives passed a $217 billion 2018-2019 budget, officially named The General Appropriations Act or Senate Bill 1. Though the overall dollar amount is about the same as the 2016-2017 level of support for public and higher education, health care, public safety, and other services, the budget is actually a decrease of about 8 percent in "real" terms, due to the rapid population growth and inflation forecast for the next two years.

LBB Summary of Conference Committee Report for Senate Bill 1: FY 18-19

SB1 - Conference Committee Report (2018 - 19 State Budget)

Medicaid Conference Committee Issue Docket

FY 17 Supplemental Appropriations Act: HB 2 (Zerwas/Nelson)

House Bill 2, the supplemental appropriations bill, adjusts the Fiscal Year (FY) 2017 budget for additional funding needs. Typically, the legislature must adjust the current budget to help meet additional needs, including additional Medicaid costs. HB 2 includes $800 million in state funds, which comes with a matching $1.6 billion funds, to cover the Medicaid shortfall for FY 2017. Medicaid funds makes up, by far, the largest amount of the $2.6 billion supplemental budget.

FY 18-19 General Appropriations Act (GAA): SB 1 (Nelson/Zerwas)

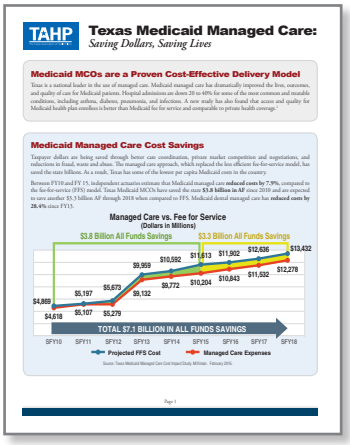
Appropriations for Health and Human Services encompass many different programs, but spending is driven primarily by Medicaid, the Children's Health Insurance Program (CHIP), and foster care. The 2018 and 2019 GAA Medicaid appropriation totals $62.4 billion in All Funds. This amount equates to a biennial reduction of $1.9 billion in All Funds. The reduction in Medicaid funding is due to decreases of $1.3 billion in All Funds in Medicaid client services, $0.6 billion in All Funds in administrative funding, and $0.1 billion in All Funds for other programs supported by Medicaid funding.

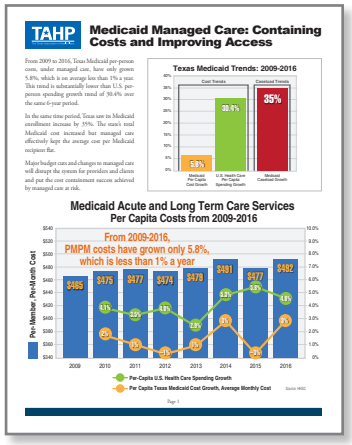
The budget uses caseload projections from the Legislative Budget Board (LBB), but does not include any funds for cost growth over the biennium, which means, more than likely, the 86th Legislature will have to pass a supplemental bill in 2019 to make up for a potential Medicaid shortfall. Lawmakers should expect to fill at least a $1 billion General Revenue Medicaid hole in the next regular session, before the state fiscal year 2019 ends. The shortfall could be closer to $2 billion if the costs run high and cost-containment cannot yield the required savings.

The appropriated funds include financing to restore approximately 25 percent of reductions made to therapy reimbursement rates in the 2016–17 biennium, $1 billion in All Funds in cost containment, including amounts related to reducing risk margin for Medicaid managed care, and specific direction to the Health and Human Services Commission (HHSC) to contain costs and execute savings.

Texas Association of Health Plans

Budget Cost Containment and Contracting Provisions





Each session the legislature typically adopts cost containment provisions in the budget, which direct HHSC to explore specific strategies to contain costs in Medicaid and CHIP to make the programs more efficient. As originally proposed, the House and Senate cost containment riders included many provisions that would have drastically impacted MCOs – including changes to contracting processes and alterations that would have resulted in around $1 billion in general revenue cuts to MCO premiums. Throughout the conference committee process, TAHP advocated to protect the Medicaid managed care system and to not adopt measures that disrupt the Medicaid managed care system. While the conference committee did not end up adopting major procurement changes and dramatic contract reductions that would have disrupted the Medicaid managed care system, the provisions that were adopted by the conference committee included reductions to MCO at-risk margins. The final adopted provisions are outlined below.

Cost Containment Rider 34. Directs HHSC to achieve savings of at least $350,000,000 in general revenue funds ($480,000,000 in federal funds) in the Medicaid program for the 2018-19 biennium through exploring the cost effectiveness and feasibility of 18 different initiatives, including:

- Increasing fraud, waste, and abuse prevention, detection, and collections.
- Seeking flexibility from the federal government to improve the efficiency of the Medicaid programs.
- Creating incentives for the completion of health risk screenings and engagement in healthy behaviors.
- Enforcing the limitations on recipient disenrollment from managed care plans.

The original House and Senate budgets included several additional strategies to achieve savings that TAHP was successful in removing, including provisions directing HHSC:

- to make changes to the MCO experience rebate;
- to pursue a price bidding process for managed care contracts;
- to reduce dependency on independent actuaries at HHSC; and,
- to simultaneously procure for multiple managed care programs and enhance the methodology for scoring managed care organization responses to requests for proposals.

The contracting and other cost containment provisions that the Legislature kept in the budget were consolidated into Rider 34. Included in the 18 cost containment initiatives is a provision directing HHSC to identify and execute savings regarding Medicaid managed care through the following:

- Conduct an independent audit of Medicaid managed care premiums using a separate external actuarial firm every two years to begin with the Medicaid managed care premiums for fiscal year 2018;
- Ensure collaboration between the Medicaid and CHIP data analytics unit and the HHSC actuarial staff to investigate and analyze any anomalies in the expenditure data used to set rates, and to ensure the expenditure data being used to set rates is sound;
- Evaluate the methodology used to develop trend factors and other growth assumptions, including ensuring the methodology properly accounts for growth that could be considered one-time rather than ongoing;
- Use a competitive procurement process with price as one component of the procurement evaluation.

Texas Association of Health Plans

Cost Containment Rider 34 (cont.)

HHSC is only required to move forward with these provisions if found to be cost effective and feasible.

TAHP was also successful in eliminating a contracting cost containment rider that directed HHSC to implement a 1%, across-the-board, reduction to all contracts, including MCO contracts. However, there is still an expectation of $350 million in general revenue savings.

Finally, the budget includes Rider 220, with proposed language by TAHP, which requires HHSC to contract with an independent organization to conduct a comprehensive review of managed care in Texas. The evaluation must include a review of the current delivery system and an assessment of the performance of managed care. The rider also directs HHSC to conduct a review of HHSC's contract management and oversight, to study the managed care rate setting processes, and to audit managed care administrative expenditures. HHSC's findings from the studies and evaluations required in Rider 220 are due to the Legislature by September 1, 2018.

Medicaid and CHIP MCO Risk Margin: HHSC Rider 158

Medicaid:

The Senate and House had conflicting provisions in their original budgets that included reductions to risk margins for all Medicaid programs up to 1.5%, which would have resulted in an overall reduction of $105,305,160 in general revenue funds ($106,251,822 in federal funds). TAHP exhausted many resources to help educate the Legislature about the impact of risk margin reductions. The final budget reduced the required savings amounts to $76,311,448 in general revenue ($106,251,822 in federal funds). **HHSC Rider 158** directs HHSC to achieve these savings by changing Medicaid risk margins as follows:

- Reduce the MCO risk margin from 2.0 to 1.5 percent for STAR and STAR Health; and,
- Reduce the MCO risk margin from 2.0 to 1.75 percent for STAR+PLUS and STAR Kids.

CHIP:

The final budget also directs HHSC to achieve savings by reducing the CHIP risk margin from 2.0 to 1.5 percent.

Other Major Health and Human Services Budget Highlights

HHSC Rider 19: Network Access Improvement Program Report. Requires HHSC to submit a report to the Legislature 45 days prior to the contract effective date of any new Network Access Improvement Program (NAIP) proposal.

HHSC Rider 21: Report on Pay for Quality Measures. Directs HHSC to evaluate how HHSC and providers use existing pay-for-quality measures to improve health care outcomes. A report is due to the Legislature by October 1, 2018 and should include recommendations on ways to improve the current program.

HHSC Rider 24: Report on the Vendor Drug Program. Directs HHSC to submit a report to the Legislature by December 1, 2018. The report should include the cost effectiveness of delivery models and steps taken to improve the current model.

HHSC Rider 27: Evaluation of Medicaid Data. Requires HHSC to evaluate data submitted by MCOs to determine what is useful and what is needed to oversee MCO contracts.

HHSC Rider 28: NAIP, MPAP and QIPP Payment Reporting. Pending CMS approval of these programs, HHSC is directed to submit a report outlining the estimated funds that will be available and the estimated amount of non-funds used as intergovernmental transfers. The report is due 90 days after receiving CMS approval.

HHSC Rider 30: Monitor the Integration of Behavioral Health Services. Requires HHSC to monitor MCO implementation of behavioral health integration and prioritize monitoring MCOs that provide behavioral health services through a contract with a third party.

HHSC Rider 156: Quality Based Payments and Delivery Reforms in Medicaid and CHIP. Directs HHSC to develop and implement quality based payments.

Texas Association of Health Plans

HHSC Rider 159: Data Analysis Unit Reporting. Directs HHSC to report to the Legislative Budget Board on a quarterly basis findings related to service utilization, providers, payment methodologies and compliance.

HHSC Rider 160. Lock-In for Controlled Substances. Directs OIG to coordinate with MCOs to expand appropriate use of a lock in program related to controlled substances.

HHSC Rider 165: Coordination of Medicaid Dental and Medicaid Services. Directs HHSC to review policies related to coordination of services between DMOs and MCOs. HHSC is further directed to ensure services are delivered in the most appropriate and cost-effective setting and that the role of DMOs and MCOs in the delivery of services is clearly defined.

HHSC Rider 166: Coordination of Services. Directs HHSC to conduct a study on ways to improve the coordination of therapy services that are billable to Medicaid and provided by school districts.

HHSC Rider 167: MCO Performance, Reporting Requirement. Directs the OIG to collaborate with MCOs to conduct a review of cost avoidance and waste prevention activities employed by MCOs.

HHSC Rider 168: Special Investigation Unit Guidance, Reporting Requirement. Directs OIG, in collaboration with MCOs and HHSC, to develop recommendations for the activities of Special Investigation Units. A report is due by March 31, 2018 outlining the recommendations.

HHSC Rider 175: Services for Individuals with Serious Mental Illness. Allows HHSC to develop and procure a managed care program in at least one area of the state to serve individuals with a serious mental illness in Medicaid and CHIP if determined to be cost effective.

HHSC Rider 187: Increase Consumer Directed Services (CDS). HHSC is directed to educate STAR+PLUS consumers about CDS options and seek to increase the percentage of clients who choose CDS. HHSC is further directed to collect information annually from MCOs based on the percentage of clients enrolled in CDS and develop incremental benchmarks for improvement.

HHSC Rider 204: Clear Process for Including Prescription Drugs on the Texas Drug Code Index. Directs HHSC to streamline the process for the inclusion of prescription drugs in the Medicaid and CHIP programs and submit a report on steps taken by December 1, 2017.

HHSC Rider 205: Electronic Visit Verification Administrative Simplification. Directs HHSC to conduct a review of the EVV program and evaluate strategies to streamline the administrative requirements. HHSC is directed to submit a report to the Legislature by March 31, 2018.

HHSC Rider 215: Medicaid Therapy Reporting. Requires HHSC to provide a quarterly report to the legislature on Medicaid pediatric acute care therapy services, including: the number of members on a waiting list and the number of therapy providers no longer accepting new clients.

HHSC Rider 218: Therapy Rates. Provides $21.5 million to restore 25% of the therapy services rate reductions previously directed by the legislature in the 2016-2017 budget. The Rider assumes rate reductions for therapy assistants to 85% of therapy rate to be implemented no earlier than December 1, 2017, and a further reduction to 70% of the therapy rate on September 1, 2018.

HHSC Rider 219: Prescription Drug Benefit. Directs HHSC to study potential cost savings in the administration of prescription drug benefits. The rider permits HHSC to consider in the study: a single state-wide claims processor and transitioning MCO pricing for pharmacies to the National Average Drug Acquisition Cost (NADAC) methodology, plus a dispensing fee set by HHSC.

Article IX, Section 10.07: Cross-Agency Collaboration on Value Based Payment Strategies. Directs HHSC, ERS, and TRS to collaborate on the development of potential value-based purchasing strategies and to the extent possible work toward similar outcome measures.

Article IX, Section 25: Health and Human Services System and Managed Care. Directs HHSC (in collaboration with other agencies and the MCOs) to evaluate opportunities to streamline case management services across programs. HHSC is further directed to evaluate whether reductions to capitation rates are necessary for Medicaid members receiving duplicative case management services and identify opportunities to ensure that a single entity is designated as the primary case manager. A report of the agency's findings and recommendations is due to the Legislature by May 1, 2018.

Texas Association of Health Plans

TAHP In The News 2017

During the 85th 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, and extensive social media promotion.

TAHP In The News

May 24, 2017 – HealthTech: Telemedicine Barriers Fall as Regulations Advance

"To date Texas has lagged behind the rest of the country in establishing a supportive regulatory environment for the expansion of telemedicine, a proven delivery model for increasing access to care—especially for rural Texas—and providing a less costly alternative to visiting emergency rooms for non-emergency conditions," said Jamie Dudensing, CEO of Texas Association of Health Plans, Forbes reports. "We're one step closer to removing barriers to this important technology."

May 24, 2017 – Dallas Morning News: For Texans with Shocking Medical Charges, Bill that Governor Signed Can't Come Soon Enough

"It was a brand-new concept, and it only applied in very limited situations," explained Jamie Dudensing, CEO of the Texas Association of Health Plans. "You can always do more," Dudensing said. "But this is really about ensuring that a base level protection is there. It's a big deal."

May 16, 2017 – Forbes: Texas, the Last Frontier for Telehealth, Opens for Business

"To date Texas has lagged behind the rest of the country in establishing a supportive regulatory environment for the expansion of telemedicine, a proven delivery model for increasing access to care—especially for rural Texas—and providing a less costly alternative to visiting emergency rooms for non-emergency conditions," said Jamie Dudensing, CEO of Texas Association of Health Plans. "We're one step closer to removing barriers to this important technology."

May 15, 2017 – Texas Insider: Texas Consumer & Business Groups Applaud Passage of SB 507

Texans for Affordable Healthcare coalition members today issued a series of statements after Senate Bill 507 by Senator Kelly Hancock and Representative John Frullo this week passed through both bodies of the Texas Legislature and is now on its way to the Governor's desk for consideration. SB 507 would significantly expand protections for Texas consumers against the growing practice of surprise medical billing, which occurs when insured patients receive out-of-network care unknowingly and are billed by a provider—often a freestanding emergency room—for fees that exceed the amount paid by the insurance, which are often 10-20 times the going rate.

May 7, 2017 – Washington Post: Free-standing ERs Offer Care without the Wait. But Patients Can Still Pay $6,800 to Treat a Cut

"Free-standing ERs, stand-alone facilities where people can receive acute care any time of day, have increased in Texas in recent years as a result of a 2009 law that permitted the establishment of emergency rooms independent of hospitals. They join a host of other on-demand facilities—including hospital ERs, hospital-owned satellite ERs, 'microhospitals' and urgent-care facilities—where people can receive care, especially if they have robust health insurance."

"There's this misleading factor, or I'd go so far as to say deception," said Shara McClure, a vice president at Blue Cross Blue Shield of Texas. "A member who's having an incident, having an acute condition, they go into these free-standing ERs thinking they're a cost-effective solution."

May 3, 2017 – Houston Chronicle: Lawmakers Hit Freestanding Emergency Rooms with Mediation and Disclosure Requirements

"The House voted 129-11 on Wednesday in favor of the Senate's version of a bill that will force freestanding emergency rooms and other out-of-network providers into mediation with customers who dispute surprise bills under a state program launched in 2009.

Senate Bill 507 also requires that bills sent to patients include a prominent explanation of the mediation process. The legislation was passed in the Senate in late March and approved by the House Insurance Committee on Tuesday.

Surprise medical bills, also known as balance bills, typically arise when patients seek care at an in-network facility, such as a hospital, but are treated by an out-of-network provider. A recent study by the Center for Public Policy Priorities found that more than 300 hospital emergency rooms in Texas do not have a single ER doctor covered by the state's three largest insurance plans."

Texas Association of Health Plans

April 28, 2017 – Texas Tribune's TribTalk: Outsized Freestanding ER Costs Tying the Hands of Texas Employers

"Texans often confuse freestanding ERs for urgent care centers, which are typically in-network, meaning they're covered by most employee insurance policies. Some are told by freestanding ERs that their insurance is accepted—but find out later that they are not in their health plan's network. That can mean thousands of dollars in surprise medical bills."

"For the majority of insured Texans, it's critical the Legislature take additional steps to restrict the misleading practices of freestanding ERs. Another Hancock proposal, Senate Bill 2064 (a companion, House Bill 3867, was introduced by State Rep. John Smithee, R-Amarillo), would ensure that Texans have the protections against price-gouging in emergency medical situations they now have in natural disasters and other emergencies—giving the state authority to intervene when a freestanding ER bills a patient for unconscionable charges.

Just as important, Sen. Larry Taylor, R-Pasadena, and Rep. Tom Oliverson, R-Cypress, have introduced pro-consumer bills (SB 2240 and HB 3276) that would significantly increase transparency. These proposals would require freestanding ERs to provide clear and easily understood information to patients upfront about their network status and not mislead patients."

April 25, 2017 – NBC News National: You Thought It Was An Urgent Care Center, Until You Got the Bill

"While often visually similar to urgent care centers—the walk-in doctor's offices cropping up across the country—freestanding emergency centers are emergency rooms located outside of hospitals, with prices similar to hospital ERs."

"In Texas, where Ginger Pine lives, freestanding emergency rooms are required by law to include "emergency" or "ER" in their signage, which helps to reduce some confusion, but simple Google Maps searches often bring up both urgent care centers and freestanding ERs synonymously. Not knowing the difference can have significant financial consequences."

April 21, 2017 – Texas Insider: Texas Health Plans Applaud Texas Health Plans Applaud Senate Passage of Schwertner Bill to Hold Freestanding ERs Accountable for Consumers

"Time and again, Texans meet confusion and frustration with misleading advertising and exorbitant prices when they seek care from independent freestanding ERs. These facilities have demonstrated a pattern of withholding important information from patients regarding their network status or the fees they will charge for their services," said Jamie Dudensing, TAHP CEO and a former practicing nurse. "Because freestanding ERs continue to ask to be compared not to walk-in urgent care centers, which consumers often confuse them for, but to hospital-based ERs, it's important that they are also held to the same standards as traditional ERs. Sen. Schwertner's legislation would ensure just that and hold freestanding ERs more accountable for following important licensing rules that protect Texas patients."

March 30, 2017 – Texas Dentists for Medicaid Reform: Credentialing for Medicaid Providers to Become Faster?

"To date, managed care health plans have made significant strides in transforming the Texas Medicaid program to deliver dramatically improved care and outcomes for patients and reduce costs for the State and taxpayers," said Jamie Dudensing, TAHP CEO and a former practicing nurse. "Today's announced CVO marks a significant step forward in streamlining credentialing and making it much easier for providers to participate in the program and see Texans on Medicaid. Medicaid health plans are proud to have initiated this effort, and we look forward to continuing to work with TMA to establish a one-stop-shop for providers that greatly reduces their paperwork burden, ensures a more seamless process, and boosts access to safe, quality care for Texans who rely on Medicaid program for their health care needs."

March 29, 2017 – Texas Tribune's TribTalk: Blue Cross and Blue Shield of Texas: Legislation to Protect Texans from "Surprise Bills" at Freestanding Emergency Rooms

"Unfortunately, patients are responsible for the difference between freestanding emergency rooms exorbitant charges and the payment by their insurance or employer. That is what is called a "surprise bill" or "balance bill" and those bills can be in the thousands of dollars. Also, the impact falls heaviest on Texans without insurance; exorbitant charges can be devastating to their personal finances and credit.

Most freestanding emergency rooms in Texas choose not to have contracts with insurance companies. In 2016, Blue Cross and Blue Shield of Texas contacted all known out-of-network freestanding emergency rooms in Texas, hoping to bring them into our network and protect our members from surprise bills. Not one out-of-network freestanding emergency room chose to contract with us. Many declined to even look at our contracted rates, preferring to remain out of network."

Texas Association of Health Plans

March 27, 2017 – Dallas Morning News: Texans Overpaid for Some Medical Services by Thousands, Study Says

Overall, Texans were more likely to use a hospital-based emergency room or urgent care. But, use of freestanding facilities jumped 236 percent over the dates studied. The cost of services and the amount insured patients ultimately paid out-of-pocket also increased over time.

March 24, 2017 – Business Wire: Rice University Study: Freestanding ERs Costly for Texans, Yield Exorbitant 'Sticker Shock'

"Rice University's comprehensive study confirms what we know to be true – that freestanding emergency rooms are costly to Texas patients, who often visit these facilities for common conditions that could be treated for much less at an urgent care center," said Jamie Dudensing of Texans for Affordable Healthcare. "Consumers should be able to focus on getting the immediate care they need without having to worry about the exorbitant fees a freestanding ER is going to charge. We support every effort to crack down on the confusing advertising and skyrocketing billing practices of these facilities, and encourage all Texans to heed the advice of this important study – think twice about visiting a freestanding ER."

March 14, 2017 – State of Reform: Hancock, Smithee Legislation Would Grant State Authority To Protect Texans Against Price-Gouging in Emergency Medical Situations

"An emergency medical situation presents enough stress without the addition of a surprise medical bill for thousands of dollars," said Jamie Dudensing, TAHP CEO and a former practicing nurse. "Freestanding ERs are confusing Texans across the state with misleading advertising convincing them they are in their insurance networks, but surprising them later with exorbitant, out-of-network bills and no recourse to challenge them. Costs for emergency care at traditional hospital ERs are also on the rise and sending Texans into medical debt.

March 13, 2017 – Texas Insider: Hancock, Smithee Legislation Would Grand State Authority to Protect Texans Against Price-Gouging in Emergency Medical Situations

"An emergency medical situation presents enough stress without the addition of a surprise medical bill for thousands of dollars," said Jamie Dudensing, TAHP CEO and a former practicing nurse. "Freestanding ERs are confusing Texans across the state with misleading advertising convincing them they are in their insurance networks, but surprising them later with exorbitant, out-of-network bills and no recourse to challenge them. Costs for emergency care at traditional hospital ERs are also on the rise and sending Texans into medical debt.

"Just as Texans are protected from price-gouging during natural disasters like a hurricane, so they should be protected from price-gouging in an emergency care situation. Sen. Hancock and Rep. Smithee's proposals take important steps to better protect consumers in medical emergencies. Responsibly seeking care for chest pains or the like shouldn't mean incurring thousands in debt."

March 8, 2017 – Texas Tribune's TribTalk: Blue Cross and Blue Shield of Texas: Freestanding ERs: Astronomical Costs and Statistics Tell the Real Story

"It is important to understand that freestanding ERs can charge up to 10 times more than urgent care centers charge for the same services. Adding to the confusion, freestanding ERs may use potentially misleading marketing materials and website language that can be confusing to patients. Many advertise that they accept all insurance plans. However, this is not the same as being "in-network," and often leaves consumers responsible for large portions of their bills.

Today, more than half of all freestanding ERs in the United States are located in Texas. There is a common—and false—idea that freestanding ERs primarily provide care to Texans in underserved areas who currently lack access to proper emergency care. Research shows that the owners of these types of ER facilities prefer to build in affluent neighborhoods where there is already a wide selection of health care options such as hospital-based emergency departments and physician offices."

"This is also a critical time to request support from your Texas legislators and push for more accountability from freestanding ERs that will strengthen protections for consumers and employers. Texas Senate Bill 507, and its companion, House Bill 1566, were both recently filed in the Texas Legislature. If passed into law, they would provide patients more protection regarding balance billing, which occurs when a health care provider bills a patient for the fees that exceed the amount covered by their insurance. The Texas Association of Health Plans supports expanding the use of mediation for patients to challenge balance bills, including those issued by freestanding ERs."

Texas Association of Health Plans

February 27, 2017 – Dallas Morning News: Editorial: Billing Abuses at Standalone Emergency Care Centers are Costing Texans a Hefty Chunk of Change

"We see promise in Senate Bill 507, which would give Texans recourse when they receive unexpected medical bills. The bill, authored by state Sen. Kelly Hancock, R-North Richland Hills, would expand the Texas Department of Insurance's mediation system to include all types of out-of-network providers treating patients at in-network hospitals and other facilities—including freestanding emergency departments. The bill, which has support from consumer groups, health plans and business associations, also would allow mediation for emergency care balance bills over $500 at any healthcare facility, whether in or out of network."

February 24, 2017 – Dallas News: As Free-standing ERs and Insurers Fight, Patients Get Stuck with the Bill

"And there's little incentive for the facilities to negotiate to be in-network," argued Jamie Dudensing, CEO of the Texas Association of Health Plans. "They get paid more out of network, and there's no limit to what their prices can be," she said.

"It's taken us more than one hundred years to get 600 hospitals [in Texas] that have an ER but only five years to get 200 free-standing ones," Dudensing said. "There is no market for that. The emergency room should not be your first choice, ever."

A recently formed coalition called Texans for Affordable Healthcare—made up of insurers, community hospitals and health underwriters—aims to expose what they call "non-transparent, anti-consumer tactics" and advocate for legislative solutions.

The goals are to increase price transparency and share the network status of free-standing ERs, as well as to expand surprise billing protections and remove misleading advertisements.

TAFEC is also pushing for legislation to make the usual and customary rates that insurance companies pay more transparent, and that would give the department of insurance the ability to penalize insurers that underpay claims. The providers would also like to be able to advocate on behalf of the patient in order to seek higher reimbursement.

February 22, 2017 – State of Reform: Unique Coalition Drives Balance Billing Legislation

"Home to the majority of the nation's freestanding ERs, Texas has become ground zero for the explosive growth of emergency care costs and rates of surprise medical billing," said Jamie Dudensing, TAHP CEO and a former practicing nurse. "TAHP applauds Sen. Hancock's efforts to better protect consumers against this growing trend, to require greater protections for consumers against surprise billing by freestanding ERs and other emergency care providers, and to ensure consumers have more options to challenge exorbitant, surprise medical bills often waiting for them in the mailbox after they've been treated in an emergency situation."

January 20, 2017 – Dallas News: Medical Billing is a National Problem That's Even a Bigger Headache in Texas

There's a "serious market problem in emergency care" that needs to be addressed," said Jamie Dudensing chief executive officer of the Texas Association of Health Plans. The TAHP is one of several groups that wants to expand available mediation options for consumers during the 2017 legislative session.

January 20, 2017 – Dallas News: Dallas Man Stuck in Battle Over a $128,000 Hospital Bill

"No amount of personal responsibility is going to matter when you're having a heart attack," added Jamie Dudensing, chief executive officer of the Texas Association of Health Plans. Patients have little choice, especially during emergency care.

January 19, 2017 – DMagazine Healthcare: TAHP Supports Legislation Against Surprise Medical Billing

"A statement from TAHP, the statewide association representing commercial and public health plans, said Sen. Hancock's legislation, SB 507, "would expand mediation protections," as it's currently being used on a limited basis by consumers in Texas, for insured consumers.

Moreover, TAHP studies found up to 56 percent of hospitals in Texas that are in-network with the three largest insurers in the state have no in-network emergency physicians, and nearly 70 percent of out-of-network claims in Texas stem from freestanding ERs.

Texas Association of Health Plans

January 19, 2017 – DMagazine Healthcare: TAHP Supports Legislation Against Surprise Medical Billing (cont.)

With the majority of the nation's freestanding ERs located in Texas, TAHP CEO Jamie Dudensing said the organization "applauds Sen. Hancock's efforts to better protect consumers against this growing trend."

"[We support his effort] to require greater protections for consumers against surprise billing by free-standing ERs and other emergency care providers, and to ensure consumers have more options to challenge exorbitant, surprise medical bills often waiting for them in the mailbox after they've been treated in an emergency situation," Dudensing said.

January 18, 2017 – Texas Insider: Texas Assoc. of Health Plans Applauds Sen. Hancock Bill to Protect Consumers Against Surprise Medical Bills

"Home to the majority of the nation's freestanding ERs, Texas has become ground zero for the explosive growth of emergency care costs and rates of surprise medical billing," said Jamie Dudensing, TAHP CEO and a former practicing nurse. "TAHP applauds Sen. Hancock's efforts to better protect consumers against this growing trend, to require greater protections for consumers against surprise billing by freestanding ERs and other emergency care providers, and to ensure consumers have more options to challenge exorbitant, surprise medical bills often waiting for them in the mailbox after they've been treated in an emergency situation."

January 5, 2017 – Austin American-Statesman: Amanda Martin Commentary: Freestanding Emergency Rooms, Medical Costs Threaten Texas

"Freestanding ERs and their skyrocketing medical costs are pinching not only their patients but also Texas businesses and the state's economic growth. Texas businesses, health care consumers, insurers, policymakers and regulators should unite now to address this urgent concern."

January 3, 2017 – KEYE TV (CBS Austin): Freestanding ERs Under Scrutiny by State Trade Groups [Also a TV Interview]

Dudensing says emergency centers charge hospital emergency room prices for what amounts to urgent care-type services.

"70 percent of the services they are providing are [for] very basic services like a common cold," said Dudensing, citing health plan information.

Dudensing says the cost and confusion created make it a priority for TAHP this legislative session.

"This is not the consumer's fault what's going on here and they need to be protected," said Dudensing.

She wants consumers to be able to challenge a surprise medical bill and more transparency on prices.

"The question is 'are they misleading consumers? Are consumers protected from them? Do they know that they're out of network? Do they know what they'll get charged?' Consumers need to know that information and be protected from providers that exploit that," said Dudensing.

December 30, 2016 – Houston Chronicle: Surprise Medical Bills Piling Up for Patients

Jamie Dudensing, CEO of the Texas Association of Health Plans, acknowledged that surprise billing - known in the industry as "balance billing" - is a growing problem. But she said Mastriani's case is an outlier: The vast majority of surprise bills are the result of emergency room visits and are not the fault of insurance companies, but rather a market failure that must be addressed by lawmakers.

In short, Dudensing said, there's no incentive for physicians to negotiate to ensure they're covered by the same plans that cover emergency rooms where they practice. In Texas, providers actually are paid more if they're out of network, she said.

"I truly believe this is not helping anyone for us to go around blaming each other," she said. "I believe that most doctors are working very hard and doing the right thing and want to be in-network. Instead of going around blaming people, I'd rather have protections to ensure those outlying situations don't happen to a consumer."

Texas Association of Health Plans

November 23, 2016 – R. Cain Law: Under Trump, New Questions About Mental Health Benefits in Texas

Jamie Dudensing, CEO of the Texas Association of Health Plans, said in an email statement that the organization "will be paying close attention" to the Trump administration's plans for the 2010 federal health law and said health care plans are prepared to adapt.

"Texas health plans have demonstrated a long-standing commitment to pioneering innovative programs to meet the health care needs of patients with mental health and substance abuse disorders and that commitment will be unwavering," Dudensing said.

November 17, 2016 – KGBT-TV (The Texas Tribune): Under Trump, New Questions About Mental Health Benefits in Texas

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"Texas health plans have demonstrated a long-standing commitment to pioneering innovative programs to meet the health care needs of patients with mental health and substance abuse disorders and that commitment will be unwavering," Dudensing said.

November 1, 2016 – Rivard Report: Texas Residents Could Receive More Federal Aid to Pay for Costly Health Plans

Jamie Dudensing, CEO for the Texas Association of Health Plans, said the reason "health insurance premiums are expensive is because health care is expensive." She said medical care from, drug prices to freestanding emergency rooms, is becoming more costly and consumers are feeling the brunt. Insurance companies have built pricing tools to help people understand what they are paying for.

"We are concerned about prices, but we're not panicked about what's happening because health insurance is available and it's good coverage," Dudensing said.

For insurers, a big concern is how people hop on and off plans throughout the year. Dudensing said uninsured people will sometimes become sick, get health insurance and cancel once they feel better. She said those tactics "completely negate" the point of health insurance and can affect prices.

November 1, 2016 – El Paso Proud: Texas Residents Could Receive More Federal Aid to Pay for Costly Health Plans

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October 31, 2016 – Texas Tribune: Open Enrollment for Health Insurance Begins Today in Texas

Jamie Dudensing, CEO for the Texas Association of Health Plans, said the reason "health insurance premiums are expensive is because health care is expensive." She said medical care, from drug prices to freestanding emergency rooms, is becoming more costly and consumers are feeling the brunt. Insurance companies have built pricing tools to help people understand what they are paying for.

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Dudensing said uninsured people will sometimes become sick, get health insurance and cancel once they feel better. She said those tactics "completely negate" the point of health insurance and can affect prices.

Texas Association of Health Plans

October 30, 2016 – Family eGuide: When to Choose Urgent Care Versus Emergency Room

As stated by Jamie Dudensing, CEO of Texas Association of Health Plans, "…SB 425 will give Texans a better idea of what to expect when they visit freestanding emergency rooms, which may look and feel like urgent care centers, but charge the same as traditional emergency rooms. When consumers are empowered with information, they are better able to care for themselves and their families without breaking their bank accounts."

August 7, 2016 – Texas Tribune: In Fight over Surprise Medical Bills, Some Lawmakers Target Insurance Regulators

Health insurers call this "network adequacy" claim a red herring. Jamie Dudensing, chief executive of the Texas Association of Health Plans, said the state's requirements for physician access are "among some of the most stringent in the nation" and that surprise medical bills are "rarely tied to issues with network adequacy."

August 2, 2016 – KUT: Why Medicaid Recipients May See More Generic Drugs in their Cabinets

Jamie Dudensing with the Texas Association of Health Plans represents both private insurance and managed care providers. The association ran a study to see if managed care organizations could do a better job with picking drugs than the state – and it came out with some interesting findings.

"So there's two things: The study found the strategy of choosing price with drug mix and generics first is a better strategy over rebates, and that health plans more effectively do that strategy," Dudensing says. "That would basically create $100 million in savings in state tax dollars per year."

July 12, 2016 – Governing: Surprise! Freestanding ERs Aren't Always What They Seem

"They can be tricky. Many of them will tell a patient when they're getting treatment that they accept insurance, but the patient gets a surprise bill down the line because they are out-of-network," said Jamie Dudensing, executive director of Texas Association of Health Plans. "They are also typically nicer than your average ER, and it's easier to get the care you want. They tend to cater to the consumer."

Texas, however, is cracking down on the increasingly for-profit industry. The state passed a law last year that requires freestanding ERs to make patients aware that physicians might not be in their health insurance network. And according to Dudensing, the state legislature is expected to take up more patient protection measures in its next session. The aim of future legislation, said Dudensing, is to increase transparency. She's confident that will happen.

"Consumers want easier access, and they want to be seen that day. It just so happens that the people who can do that are also the most expensive right now. It's all very confusing for consumers, but with time and more laws, it'll work itself out."

June 1, 2016 – Dallas Morning News: Surprise medical bills: A Problem Not Just for the Unsuspecting but the Wary, Consumers Say

Top health insurer lobbyist Jamie Dudensing, who heads the Texas Association of Health Plans, said emergency care "is the big driver" of balance bills.

She called for expanding mediation protection for patients receiving any kind of out of network service at an in-network hospital. Lawmakers also should drop the $500 minimum for bills qualifying for mediation, she said.

May 18, 2016 – D Healthcare: Are Freestanding Emergency Rooms Driving Up Costs?

"If you have a deductible in your plan, there are a lot of surprises for consumers around freestanding ERs," says Jamie Dudensing, the executive director of the Texas Association of Health Plans, a trade group representing the state's insurance companies. "But there's a reason why there are so many of them. They are convenient."

May 4, 2016 – Dallas Morning News: Texas Should Do More to Discourage Surprise Medical Bills, Consumer Groups Say

Top health insurer lobbyist Jamie Dudensing, who heads the Texas Association of Health Plans, said it could live with a ban on surprise bills for emergency care.

"We don't oppose it. We support getting the consumer out of it," she said in an email.

Texas Association of Health Plans

March 30, 2016 – Dallas Morning News: Health Insurers Fear Texas Trial Lawyers are Seeking Billions, but Attorneys Say That's Hype

The court's ruling means the 2003 law's sanctions against late payments apply only to "fully insured" health policies regulated by the Texas Department of Insurance, said insurance lobbyist Jamie Dudensing. The fully insured plans cover about 4.5 million of the state's 27 million people, said Dudensing, chief executive of the Texas Association of Health Plans.

Dudensing testified that the law's arcane penalty provisions perversely encourage hospitals to generate a new "revenue source" by increasing their billed charges – rates that only uninsured patients pay. People with insurance pay discounted or "contracted" rates, which insurers have negotiated with hospitals.

That's because the penalties are levied against the difference between billed and contracted charges – a procedure no other state uses, she said.

Next year, the insurers simply want lawmakers to remove billed charges from penalty calculations, Dudensing said. Instead, insurers will ask lawmakers to impose annual interest of 18 percent on unpaid amounts owed to providers, she said.

March 14, 2016 – Dallas Morning News: Mitchell Schnurman: If Employers and Patients Want Telemedicine, Why is Texas Blocking it?

"Employers want this and patients want it, too," said Jamie Dudensing, CEO of the Texas Association of Health Plans.

There's usually opposition to anything that cuts costs in health care, she said, because that's someone else's revenue. But telemedicine represents a novel opportunity.

"It's very rare to have something show up that increases access and lowers costs and manages to have high customer satisfaction," she said. "Consumers are ready for 21st century ideas."

March 9, 2016 – Texas Tribune: Insurers Want More Room for Generic Drugs in Texas Medicaid

A study commissioned by the Texas Association of Health Plans, an industry group, found that Texas pays about the national average cost per prescription but prescribes name-brand drugs at a higher rate than all but five other states.

"It's time to eliminate the barriers that are keeping Texas Medicaid health plans from ensuring Texans in Medicaid have access to the life-saving drugs they need, when they need them, and to do so in a way that brings down costs, saves taxpayer dollars and improves the quality of care," Jamie Dudensing, the association's chief executive, said in a prepared statement.

The Texas Association of Health Plans says insurers have done a good job negotiating higher rebates from drug companies but that doing so was equivalent to "playing the wrong game well." Giving managed care organizations the freedom to pick their own formularies would be a better avenue for cost savings, the industry group said.

December 18, 2015 – The Texas Tribune: More Have Health Insurance, But Texas Lags

That study, commissioned by the Texas Association of Health Plans, an industry group, found that the most dramatic gains in any market under federal health reform were in Texas' individual market, where people buy health insurance on their own without assistance from an employer. The number of Texans covered in the individual market has grown 115 percent under the Affordable Care Act—up to 1.5 million in 2015 from 695,000 two years before. The individual market now accounts for one-third of the total health insurance market in Texas, according to the report.

Texans are also giving up their coverage from before the Affordable Care Act, which required plans to cover a wider range of benefits, at a faster rate, according to the report. The number of people who chose to remain with their pre-Affordable Care Act plans has declined by more than half, with only 17 percent of individuals in Texas currently remaining enrolled in their old plans.

The impact of the Affordable Care Act on Texas health insurance landscape has been "significant, with a substantial increase in the number of Texans gaining health insurance in the traditional fully insured market and an explosive growth of the individual market," said Jamie Dudensing, chief executive of the Texas Association of Health Plans.

Texas Association of Health Plans

October 26, 2015 – San Antonio Express-News: 'Alphabet Soup' of Health Benefits Confusing to Many

"You're paying for the ability to go out of network and to not have to have a referral," said Texas Association of Health Plans CEO Jamie Dudensing. "So that increases the premium cost as compared to an HMO."

HMOs are less flexible and have lower monthly premiums. Coverage is limited strictly to doctors or hospitals in the network. Nothing will be covered outside of that network unless a patient needs emergency care. A patient who goes outside the network for something that is not an emergency likely will have to pay the entire bill.

"There's not really an out-of-network benefit, so that makes it cheaper for a consumer," Dudensing said of HMOs. "But that also means you have the responsibility of really trying to stay in network."

October 11, 2015 – Texas Public Radio: Texas Matters: How To Fight Surprise ER Bills

"A growing coalition of health plans, members of the business community and consumers worked closely with legislators in the 84th Legislature to address the practice of balance billing, boost transparency for consumers, and provide them with greater tools to address inflated medical charges," said Jamie Dudensing, CEO of TAHP and a former practicing nurse. "While important strides were made, there is more work to be done. A new national study underscores why that need is stronger than ever in Texas, where emergency care is resulting in exorbitant surprise medical bills for Texas consumers. We must do all we can to ensure Texans are better informed about the costs of care and have greater access to simple options like mediation to dispute unreasonable medical bills."

August 25, 2015 – Fort Worth Star-Telegram: In Wealthy ZIP Codes, Freestanding ERs Find a Home

"When consumers are empowered with information, they are better able to care for themselves and their families without breaking their bank accounts," Jamie Dudensing, chief executive of the Texas Association of Health Plans, said in a statement.

August 21, 2015 - Texas Tribune: Freestanding ERs Find A Home in Wealthy Areas

"When consumers are empowered with information, they are better able to care for themselves and their families without breaking their bank accounts," Jamie Dudensing, chief executive of the Texas Association of Health Plans, said in a statement.

May 19, 2015 – Lubbock Avalanche-Journal: Texas House Takes Aim at High Medical Bills, OKs Mediation Measure

"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," Jamie Dudensing, CEO of the Texas Association of Health Plans, said in a statement.

"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," Dudensing said.

May 12, 2015 – Talking Points Memo: TX House Passes Bill That Would Label Cards of Those with O-care Subsidies

Jamie Dudensing, chief executive of the Texas Association of Health Plans, said insurers are "very concerned" about the bill, according to the Texas Tribune. Dudensing said that the labels could result in doctors discriminating against patients who receive subsidies.

May 8, 2015 – Texas Tribune: Critics Question Whether Health Insurance Card Measure is a Remedy

Jamie Dudensing, chief executive of the Texas Association of Health Plans, which lobbies on behalf of several major insurers, said recently that she was similarly worried the bill could create a "scarlet letter" effect where some doctors could decide not to see a patient they learned to be on an "Obamacare" plan.

"Right now, providers are not really supposed to be discriminating against consumers if they have a contract with a health plan," Dudensing said this week at an event hosted by The Texas Tribune, adding that insurers were "very concerned" about the bill.

Doctors say the concerns are overblown, in part because the income information revealed by the "S" would be nonspecific—hardly different, Austin said, from the amount of information revealed by the knowledge that a person is enrolled in a Medicaid managed care plan.

"The only thing the 'S' indicator discloses is that the patient earns some amount less than $95,000 for a family of four and is eligible for a subsidy," she said in her testimony.

Texas Association of Health Plans

May 7, 2015 – Better Texas Blog: Scarlet Letters on Insurance ID Cards

Consumer and patient groups, community health centers, hospitals, and health plans have expressed concerns about the bill related to privacy and discrimination. Earlier this week at a Texas Tribune event, Jamie Dudensing, CEO of the Texas Association of Health Plans, said the bill would put a "scarlet letter" on the insurance ID cards of lower income people, even though they have the same private insurance as others.

November 11, 2014 – Kaiser Health News: Network Blues: Big Bills Surprise Some E.R. Patients

"Just get the consumer out of it," said Jamie Dudensing, the CEO of The Texas Association of Health Plans. "If you just leave it between the health plan and the physician, the consumer's not dealing with this issue. Let us work this out through the private market."

TAHP Op-Eds

April 28, 2017 – TribTalk: Outsized Freestanding ER costs tying the hands of Texas employers

April 4, 2017 – Waco Tribune-Herald: Jamie Dudensing, guest columnist: State legislators working to prevent emergency-care shock

December 6, 2015 – My San Antonio Express-News: Shopping for health care plans can save money

November 1, 2015 – Rio Grande Guardian: Dudensing: Window-shopping for health care could mean serious savings

May 14, 2015 – Waco Tribune-Herald: Jamie Dudensing, guest columnist: Embarrassing rate of maternal outcomes in US, Texas must be reversed

April 8, 2015 – Star-Telegram: Healthcare billing practice causes unpleasant surprises

February 20, 2015 – The Daily News (Galveston County): Transparency can reduce 'bill shock' for patients with emergency care charges

Magazine

August, 2016 – Austin Woman's Magazine: Making A Healthier Texas: From delivering babies to improving health care, Jamie Dudensing is committed to making lives better.

"I loved my time as a labor-and-delivery nurse. It's challenging but rewarding work," Dudensing says. "I do think back to my days as a practicing nurse and remember that I was always the person asking, 'Why do we do it this way?' "

"Here I was, in the Capitol, surrounded by all the policymakers and political leaders, and I realized my real passion was for public policy and making things better in health care from the inside out," she recalls.

"I'll admit I was a little intimidated at the prospect of making such a big career change so soon after earning my nursing degree, but I'm so glad I made the transition," she says. "I tell female friends all the time, 'If you're not sure you're doing what you're really passionate about, don't be afraid to think outside the box and explore what else is out there. The best career for you might be something you haven't even considered yet.' "

"Having known me as the Capitol nurse, some couldn't grasp the concept of crossing over from medicine into the legislative world," she says. "I walked the Capitol halls for days, going door to door with my resume until I found someone who believed my background was not a hindrance but actually an asset."

"Working those incredibly long hours on the budget was a great way to learn the real mechanism of how health policy is actually made," she says.

"I learned pretty quickly that the keys to success in this world are a mix of compromise, innovation and perseverance," Dudensing says. "When you feel strongly about something, you have to be willing to take risks. I have never shied away from a debate and still don't."

"I was so used to working behind the scenes that I had to learn an entirely new approach that included tackling one of my biggest fears, public speaking. Fortunately, we have a great team at TAHP that helps me prepare for the hearings, meetings and events in which we make our case for a health-care system that is more affordable, transparent and understandable," she says.

Texas Association of Health Plans

Magazine (cont.)

"I am so lucky to have worked with so many strong, capable women, building professional relationships that have turned into wonderful, lasting friendships. The political world is a tough one and it takes strong relationships to succeed," Dudensing says. "It can also still very much be a boys' club, and I am in debt to a number of strong female leaders and mentors who helped me along the way. Their example inspires me to share the lessons they taught me with young women who are just getting started at the Capitol. It's so important for women to help each other succeed, build each other up and encourage each other to find careers or passions in life that are truly fulfilling."

Radio Interview

October 11, 2015 – Texas Public Radio: Texas Matters: How To Fight Surprise ER Bills – Interviewed by David Martin Davies

Jamie Dudensing is the CEO of the Texas Association of Health Plans. "The most interesting thing that we found in the study was looking at ER claims or ER claims for life-threatening situations or high-duty claims, in that it was 650% of the rate that is paid in Medicare which that means that if a consumer goes to an in-network hospital but happens to see a physician that's out-of-network, their care will be covered through their insurance and insurance company will pay the amount for that out-of-network physician but that physician now can balance bills up or send them a second bill up to these very high rate. This study just really shows how high those rates can be and the variation in these rates."

Speaking Events

January 23, 2017 – State of Reform: Leading voices in Texas health care headline State of Reform

November 18, 2016 – Leverage PR: Health Tech Austin Presents – Telemedicine: Growing Pains in Texas and Beyond

Jamie Dudensing emphasized that different terms in virtual healthcare must be defined. She has found in Texas, telemedicine is when a medical doctor is providing care, telehealth is when a non-physician practitioner is providing assistance and telemonitoring is when someone is simply following medical information on a patient, like Diabetes. The defining difference is whether someone can provide prescription drugs.

Dudensing pointed out that employers are requesting telemedicine services for their employees. It's rare in healthcare to find something that reduces cost of care, improves access and patient satisfaction. It's no wonder how fast this trend is growing. And importantly, it also increases the availability of specialty care as physician supply issues are a growing concern right now.

Self-funded employers will contract with telemedicine providers, and many health insurance plans offer it this way as well often as something you can use as an extra benefit. Again, defining telemedicine is important because that impacts the legal side of it and how we develop contracts on it. How we pay for this is a big piece of the debate right now, said Dudensing.

It's difficult to predict what will happen, but they need to define telemedicine and offer clarity – no one wants to practice out of state laws and regulations. Now we have more need as well as doctors wanting to offer these services in competition with Teledoc, said Dudensing.

"One area that I find is always difficult to innovate in healthcare—as its consolidated and individual—is that large groups can figure out how to buy these huge technology platforms, yet small groups or individual physicians have much more trouble doing this on their own. It would be great if those physicians that practice individually could use the same technology products that are available to the larger groups," concluded Dudensing.

October 4, 2016 – Red State Women: A Conversation on the Upcoming November Election

February 9, 2015 – Trinity to Host "Health Care 2015 and Beyond" on Tues. February 17

Jamie Dudensing, CEO of Texas Association of Health Plans, the state's leading advocate for public and private health plans. Dudensing is an experienced policy professional with more than a dozen years in the Texas Capitol providing counsel on health care issues to senators and the lieutenant governor.

Texas Association of Health Plans

TV Interview

January 3, 2017 – KEYE TV (CBS Austin): Freestanding ERs under scrutiny by state trade groups – Interviewed by Lindsay Liepman

"Texas is ground zero for this problem."

She says emergency centers charge hospital ER prices to what amounts to Urgent Care type services.

"70% of the services they are providing are very basic services, like a common cold.

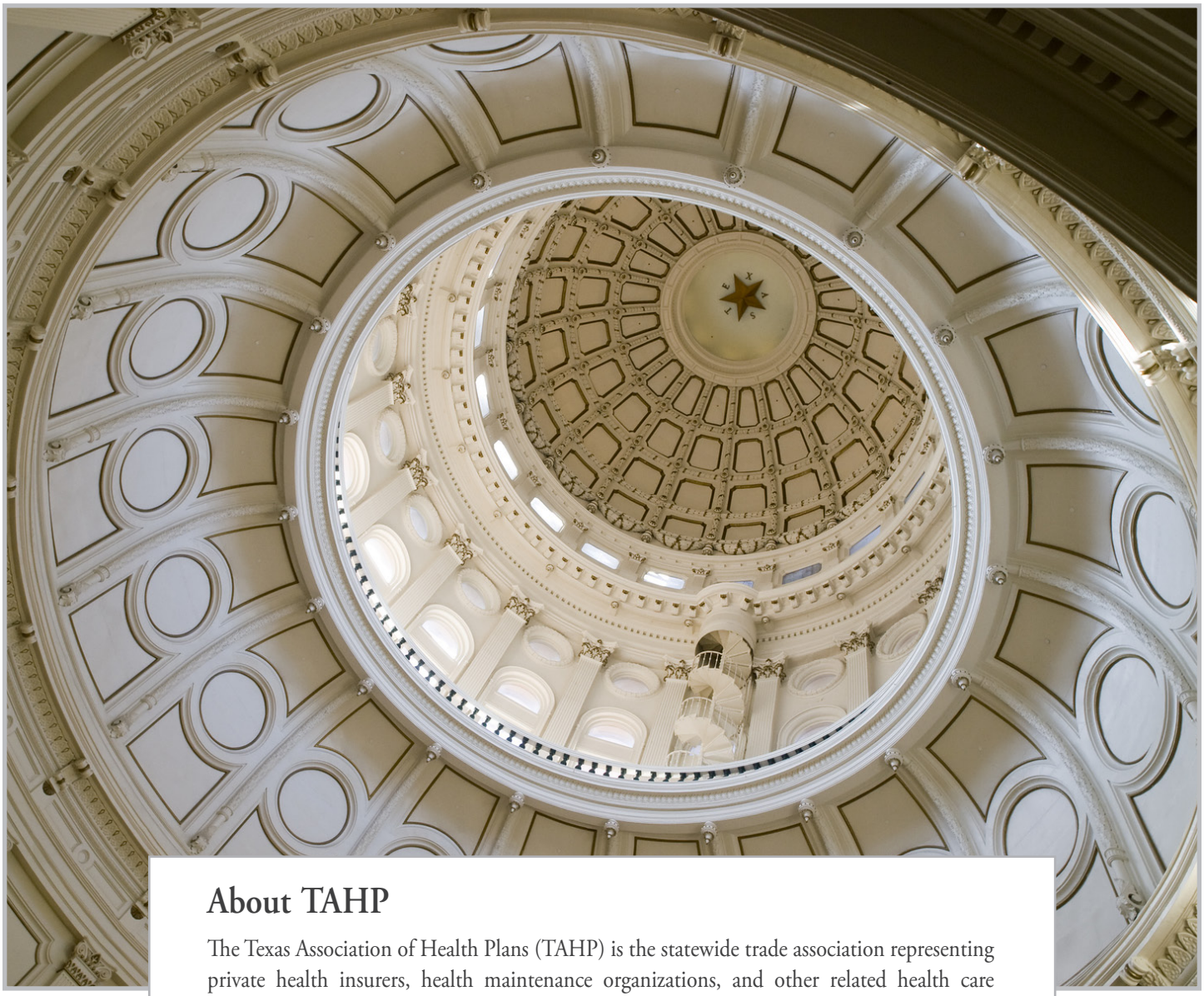
Dudensing says the cost and confusion created make it a priority this legislative session.

"This is not a consumer's fault, what's going on here, and they need to be protected."

She wants consumers to be able to challenge a surprise medical bill and more transparency on prices.

"The question is are they misleading consumers, are consumers protected from them, do they know that they are out-of-network, do they know what prices they're going to get charged? Consumers need to know that information and they need to be protected from providers that exploit that problem."

Texas Association of Health Plans



About TAHP

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

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