

Vinson & Elkins

V&E Health Policy Group

80th Texas Legislature Executive Summary

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This Executive Summary contains summaries of certain key healthcare legislation grouped under the top five subjects listed on the next page, together with funding for cancer research, found on the extranet site for the Texas Legislative Compliance Group 2007 (TLCG). During the session, V&E tracked 677 health-related bills with 46 resulting in new legislation. This report does not cover all healthcare bills passed this session, or necessarily provide a complete summary of the subject matter addressed by the legislation.

The TLCG includes a members-only, password-protected Extranet site with subject-matter links to additional healthcare legislation that passed this session, as well as post-session compliance guidance. To join V&E’s Texas Legislative Compliance Group 2007, send the [Registration Form](http://www.velaw.com/mcso/shared/health/ParticipationForm_VETLTCG.pdf) (http://www.velaw.com/mcso/shared/health/ParticipationForm_VETLTCG.pdf) to Emily McCallum at emccallum@velaw.com (512.542.8449) or via telefax at 512.236.3266. You will not be officially enrolled, or obligated, until we send you an engagement letter that will let you know the cost. If you would like additional information, or a demonstration of the extranet site, please contact Elizabeth Rogers at 512.542.8548 or erogers@velaw.com.

2007 TEXAS LEGISLATIVE COMPLIANCE GROUP

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THE 80TH TEXAS LEGISLATURE

Faced with a healthcare system in crisis, the 80th Texas Legislature made some significant strides for statewide healthcare system reform. Ultimately, the Legislature passed a suite of healthcare legislation designed to increase the accessibility, efficiency, quality, and transparency of healthcare for all Texans.

As forecasted in *V&E's Top 5 Picks* issued prior to the session, the uninsured and Medicaid reform were the top legislative priority, followed by healthcare workforce shortages, HIT and quality issues, healthcare transparency, and managed care initiatives. In a productive session for healthcare legislation, each of these priorities resulted in legislative action.

The centerpiece of the new legislation is a comprehensive **Medicaid reform** bill designed to curtail rising Medicaid costs and increase healthcare access for low-income Texans. To address **workforce shortages**, the Legislature passed a number of bills to promote the recruitment and retention of nursing students and faculty alike. Leading the **HIT and quality initiatives** are bills that establish a mandatory healthcare-associated infection reporting system and the Texas Health Services Authority, a public-private collaborative charged with implementing a voluntary, electronic statewide health information exchange. The session also produced an extensive **transparency** bill to increase consumer access to healthcare cost data by imposing increased disclosure requirements on health plans and providers. Key **managed care** bills amend the prompt pay penalties for underpaid claims, establish disclosure requirements for out-of-network provider billing, expand the scope of the third party administrator statute, as well as increase regulatory authority over certain networks, claims processing entities, and non-insurance discount healthcare programs. Finally, legislation establishing \$3 billion in **funding for cancer research** will make grants and loans available to institutions of learning, advanced medical research facilities, and collaborations, subject to voter approval.

UNINSURED AND MEDICAID REFORM

The problems of the uninsured and Medicaid reform reinforce one another, with rising healthcare costs at the root of the problem. For this reason, many of the legislative steps taken this session complement one another: the reform measures are designed to create opportunities for more employers to offer coverage, reducing the strain on Medicaid, and to innovate with Medicaid to increase efficiency and reduce costs.

THE UNINSURED

The Issue. Currently, one out of every four Texans, or 5.6 million individuals, are uninsured, which is the highest percentage in the nation. The astounding number of uninsured Texans results from a number of factors, including the rising Medicaid budget and stringent eligibility cutoffs, unaffordability of insurance, restrictive or nonexistent employer health insurance coverage, unevenly distributed resources, and the overall poor health status of Texans. Healthcare providers bear a large part of the cost of the uninsured, but everyone pays for the uninsured through higher medical fees and insurance premiums, overburdened local trauma systems, and increased taxes.

New Legislation. SB 10 (Nelson), which originally focused on Medicaid reform, became the ultimate vehicle for programs to address the uninsured. Key provisions include:

- Establishment of the Texas Health Opportunity Pool Trust Fund (“Trust Fund”), a statewide trust fund designed to address issues related to the uninsured and uncompensated care.
 - The Trust Fund will be set up pursuant to a federal waiver from CMS. HHSC must maximize federal payments under DSH and UPL programs instead of intergovernmental transfers for use in the Trust Fund and must preserve existing resources funded by IGTs or certified public expenditures used to optimize Medicaid payments to safety net hospitals for uncompensated care, unless the need for resources is lessened. HHSC must also search for new sources of federal matching. HHSC is required to seek broad-based stakeholder input and the advice of the Legislative Budget Board before finalizing the terms of the Trust Fund waiver.
 - The Trust Fund may be used to increase access to healthcare coverage for low-income persons, including through premium payment assistance and contributions to health savings accounts, to reimburse providers for providing uncompensated care, reduce the uninsured, to reduce the need for uncompensated hospital care, or for any other purposes allowed by SB 10 and the federal waiver. To be eligible for money under the Trust Fund to offset uncompensated care, a hospital or political subdivision must use a portion of the money to implement strategies to reduce the need for uncompensated inpatient and outpatient care, including emergency room care. These strategies might include fostering improved access to primary care systems, regional or local healthcare programs, premium subsidies for health benefits coverage, and creating healthcare system efficiencies (such as through EHR systems).
- Joint development of a premium payment assistance program by HHSC and TDI. SB 10

also creates a committee on health and long-term care insurance incentives, which will make recommendations by September 1, 2008 on (1) how to reduce the cost of healthcare coverage; and (2) the availability of coverage and how to expand coverage. This information would be provided to HHSC and TDI to help with the development of the premium payment assistance program.

- Creation of regional healthcare programs, set up by commissioners courts of two or more counties, and local healthcare programs, set up by commissioners courts of single counties, to provide healthcare services or benefits to the employees (and possibly their dependents) of participating small employers. Participating employers and employees must pay a share of the premiums or other costs of the program. Regional and local healthcare programs may apply for Trust Fund monies under certain conditions.

HB 3154 (Laubenberg) creates a regional healthcare systems review committee comprised of the counties in DSHS public health region three (north central Texas) to conduct public hearings regarding, and study the implications of, implementing regional healthcare services.

What's to Come. SB 10 also creates a Health and Human Services Transition Legislative Oversight Committee, composed of four Senate and four House members, which will, among other things, look at the establishment of programs to address the uninsured and how to address uncompensated hospital care.

For the HHSC-TDI premium payment assistance program, HHSC must promulgate rules setting eligibility criteria, the amount of and process for assistance, and the mechanism for measuring and reporting the number of persons covered as a result of the program. These rules will likely follow the Trust Fund waiver process and the recommendations of the committee on health and long-term care insurance incentives.

MEDICAID REFORM AND CHIP

The Issue. Texas is spending 26% of its budget on Medicaid, and the Medicaid budget in Texas has almost doubled in the last ten years. Medicaid enrollment is expected to almost triple by 2040, consuming a larger and larger percentage of the state budget.

New Legislation.

Medicaid Reform. SB 10 (Nelson) includes a wide variety of Medicaid reforms, including:

- Implementation of standardized reporting of “uncompensated hospital care” by hospitals, pursuant to rules and a methodology created by HHSC and a newly-created work group. Hospitals that fail to timely report or submit incomplete or inaccurate information are subject to administrative penalties imposed by the Texas Attorney General, subject to a hearing appeal process.
- If cost-effective and feasible, SB 10 requires HHSC to contract for the implementation of an electronic billing coordination system for the FFS and PCCM delivery models by March 1, 2008 through an existing procurement process. The system would immediately identify, within 24 hours, whether another entity has primary responsibility for a claim and submit the claim to that primary payor. All Texas-regulated entities would be

required, subject to administrative penalties, to allow the contractor to access databases to create and implement the system, and after September 1, 2008, public funds may not be expended on entities not in compliance with this requirement. Accessed information would be confidential by statute.

- A Medicaid opt-out program that allows individuals to voluntarily opt out in exchange for the state paying the individual's share of premiums for employer-based coverage. The bill also amends requirements related to the health insurance premium payment (HIPP) program in order to help Medicaid-eligible individuals gain access to employer-based plans. An individual may participate in either the opt-out program or the HIPP, but not both.
- Authorization for HHSC to seek a federal waiver to develop tailored benefit packages, including for the disabled, elderly, children with special healthcare needs, and working parents and caretakers.
- Imposition of Medicaid co-pays for certain high-cost medical services, including non-emergency visits to hospital emergency rooms. HHSC may not, however, reduce hospital payments to reflect the potential receipt of such Medicaid co-pay amounts. In addition, if cost-effective, HHSC must require Medicaid recipients to designate PCPs to coordinate their healthcare.
- Managed care reforms for Medicaid MCOs—HHSC must (1) actively encourage Medicaid MCOs to offer value-added services, (2) conduct a study on implementation of an integrated Medicaid managed care model in areas in which STAR+PLUS or a capitated model is unavailable, (3) establish outcome-based performance measures and incentives to include in each value-based contract with an HMO, (4) assess the feasibility and cost-effectiveness of requiring the HMOs to provide pay-for-performance opportunities to their provider network, and (5) if feasible and cost-effective, develop and implement a pilot program in at least one managed care region.
- Establishment of various pilot programs, studies, and demonstration projects:
 - A pilot program to promote healthy lifestyles in which Medicaid recipients who participate in weight loss and smoking cessation programs would receive expanded benefits, while those following disease management programs would receive credits for purchasing non-covered health-related items.
 - If feasible, a voluntary Medicaid health savings account pilot that is limited to adults.
 - A feasibility study on providing a health passport to Medicaid recipients under age 19 and CHIP members.
 - A physician-centered nursing facility model demonstration project to evaluate paying an enhanced Medicaid reimbursement rate to a nursing facility that provides continuous, onsite oversight of residents by geriatric specialist physicians.
 - A joint study between HHSC and the HHSC OIG on the feasibility of increasing the use of technology to strengthen the detection and deterrence of Medicaid fraud, including with regard to verifying citizenship and eligibility for coverage.

HB 3571 (Rose) requires HHSC to enter into partnerships with private entities, including retail businesses, to conduct outreach efforts regarding CHIP, Medicaid, and other health and human services programs and establishes a food stamp program outreach and eligibility determination

pilot program in the South Texas region.

SB 22 (Nelson) addresses Medicaid estate planning by creating a long-term care partnership program that entitles individuals purchasing approved plans to asset protection—i.e., a dollar-for-dollar disregard of assets for purposes of determining Medicaid eligibility.

Medicaid Fraud. SB 362 (Janek) revises the Medicaid Fraud Prevention Act to comply with the requirements of the Deficit Reduction Act of 2005 (DRA) such that Texas would be eligible for an increase of ten percentage points in its share of any amounts recovered under the Act. On June 20, the DHHS OIG stated that the Medicaid Fraud Prevention, as amended by SB 362, did appear to comply with the DRA. **SB 1694 (Nelson)** revises the Government Code to provide a duty for the Medicaid fraud enforcement division of the Texas Attorney General and the licensing boards and agencies to share information regarding healthcare professionals and managed care organizations that are the subject of a Medicaid fraud or abuse investigation, and makes various revisions to the Medicaid Fraud Prevention Act, including the addition of stronger language with regard to prohibited inducements.

CHIP. HB 109 (Turner et al.), which was passed in lieu of a slew of similar bills, undoes some of the CHIP rollbacks from 2003 and includes:

- an extension of the CHIP enrollment period from 6 to 12 months;
- lower CHIP eligibility requirements—children under 19 whose net (rather than gross) family income is at or below 200% of the federal poverty level would be eligible and the calculation of net family income includes a deduction for child care expenses, while the asset test allows a family to own at least \$10,000 in assets and includes certain exclusions for vehicle assets;
- a modified 90-day CHIP waiting period that begins on the last date which the child was covered under a health benefits plan, rather than the date of the child's enrollment in the CHIP program; and
- a CHIP community outreach and education campaign and a toll-free CHIP hotline.

Funding. Funds have been set aside under the General Appropriations Act to partially rebase the Medicaid hospital inpatient payment system in fiscal year 2009, to cover the costs of the *Frew* settlement, which allows a 25% increase for physician rates and a 50% increase for dental rates for Medicaid services to children, and to allow for the CHIP expansions.

What's to Come. SB 10's Health and Human Services Transition Legislative Oversight Committee will also work to facilitate Medicaid reform.

For uncompensated care reporting by hospitals, HHSC must establish the required work group by October 1, 2007 and adopt rules by January 1, 2009. By March 1, 2008, HHSC will have procured a vendor to implement an electronic billing coordination system for the FFS and PCCM delivery models if such a system is created.

WORKFORCE SHORTAGES

The Issue. The workforce shortage problem in the health care industry is reflected in the more than 8,000 vacant nursing positions in Texas hospitals. Unfortunately, the shortage is expected to get worse as the state's population grows. For example, there is evidence that although the number of physicians is expected to double by 2040, the number of patient visits is expected to triple during that same time.

New Legislation. The Legislature took a variety of approaches to tackling the workforce shortage problem. **HB 2426 (Truitt)** establishes the Texas Hospital-Based Nursing Education Partnership Grant Program which would pair hospitals with existing nursing education programs. Under the law, grants will be made by the Higher Education Coordinating Board to assist partnerships in meeting the state's needs for registered nurses. Programs must meet certain requirements to receive grants, such as demonstrating that the nursing program would enroll additional students as a result of the partnership.

Two new laws, **SB 201 (Nelson)** and **SB 289 (Nelson)**, address the shortage of nursing faculty. SB 201 allows a preceptor and his or her child to qualify for a \$500 tuition credit at public institutions. SB 289 expands the permitted uses for Nursing Faculty Enhancement Grants by allowing them to be used to explore the use of part time faculty for clinical instruction.

To increase access to currently practicing medical professionals, the Legislature passed two telemedicine bills. **SB 24 (Nelson)** permits Medicaid reimbursement for certain telemedicine services that previously had not been reimbursable. Under the act, HHSC will develop rules to determine the allocation of the reimbursement between the distant professional and the professional present with the patient. **SB 760 (Nelson)** directs HHSC to encourage healthcare providers to participate as "telemedicine medical service providers."

HB 1973 (Delisi) could also produce workforce changes in the future. It requires the Texas Medical Board (the "TMB") to annually review its policies and procedures used to grant licenses, including performing a needs assessment and establishing performance goals. Under the new law, the TMB must ensure by August 31, 2008 that the average time to process a license application does not exceed 51 days and give priority to applicants who intend to practice in medically underserved areas.

What's to Come. Several new laws authorize studies that could lead to more concrete solutions in the future. For example:

- **SB 10 (Nelson)** authorizes the Texas Healthcare Policy Council to study increasing the number of medical residency programs and the number of physicians practicing specialties.
- **SB 139 (Nelson)** authorizes a study on how to reform the nursing curriculum.
- **SB 649 (Shapleigh)** authorizes a study on whether higher education institutions can effectively enter into joint partnerships for degree programs, research, faculty appointments, and facilities.

HEALTH INFORMATION TECHNOLOGY AND QUALITY

HEALTH INFORMATION TECHNOLOGY

The Issue. From the start of the session, the transformative potential of health information technology (“HIT”) for improving the quality and efficiency of the Texas healthcare system was widely recognized. Prior to the session, the Health Information Technology Advisory Council (“HITAC”), a Governor-appointed advisory council established by the 79th Legislature, published its final report, *The Roadmap for the Mobilization of Electronic Healthcare Information in Texas*. *The Roadmap* presented a strategy to accelerate HIT adoption in Texas and build a framework for a statewide electronic health information exchange (“HIE”) through a statewide HIT coordinating body. During the session, the Texas Healthcare System Integrity Partnership (the “Partnership”), a task force established by Executive Order of the Governor, published its report recommending the authority, governance and finance structures for the statewide HIT coordinating body envisioned by HITAC. The recommendations of these two policy-making bodies served as the blueprint for legislative action this session.

New Legislation. **HB 1066 (Delisi)** establishes the Texas Health Services Authority Corporation (the “Authority”), a public-private collaborative charged with promoting, implementing and facilitating the voluntary and secure electronic exchange of health information statewide. The Authority will be managed by a Governor-appointed board of directors, including representatives of physicians, hospitals, health benefit plans, clinical laboratories, consumers, regional health information exchange initiatives and rural health providers. The Authority will be authorized to:

- Establish statewide HIE capabilities for various clinical and administrative purposes, including electronic lab results, diagnostic studies, medication history delivery, and eligibility and coverage communications.
- Identify privacy, security, operational, and technical standards with reference to the standards of the Certification Commission for Healthcare Information Technology, the Health Information Technology Standards Panel, or other federally-approved certification organization.
- Seek funding to implement the statewide HIE and create incentives for voluntary participation.
- Support regional HIE initiatives by, among other things, administering grant and loan programs for the creation of new regional networks (subject to available funds) and applying operational and technical standards identified by the Authority to existing regional networks (on a voluntary basis except for those related to privacy and security).

Despite the recommendation of the Partnership that the Legislature appropriate at least \$1,000,000 in startup funding for the Authority, the General Appropriations Act does not include any funding for the Authority. Instead, the Authority will be funded through private sources, including user or subscription fees eventually generated by the statewide HIE.

HB 522 (Woolley), as originally filed, would have required all health plans to issue electronic identification cards. The legislation was pared down during the session. The final version:

- Establishes a technical advisory committee to advise TDI on electronic eligibility

transactions.

- Authorizes an electronic identification card pilot program.

SB 10 (Nelson)—the Medicaid reform bill—authorizes a number of HIT initiatives within the Medicaid program. Specifically, the legislation authorizes HHSC to:

- Adopt rules implementing an HIT system for the Medicaid program that would enable, among other things, electronic eligibility, enrollment, verification, and prior authorization communications and the exchange of recipient health information through e-prescribing and electronic health records.
- Implement a pilot program to provide HIT, including electronic health records, to primary care physicians who serve Medicaid recipients.
- Study the feasibility and cost-effectiveness of providing an electronic health passport for children who are enrolled in Medicaid or CHIP.
- Study the feasibility of increasing the use of HIT to strengthen the detection and deterrence of Medicaid fraud.

In addition to SB 10, other bills direct HHSC to undertake HIT initiatives in connection with the Medicaid program as follows:

- **HB 3261 (Chavez)** directs HHSC to establish standards for the use of electronic signatures in HHSC programs, including the Medicaid program.
- **HB 2042 (Dukes)** directs the HHSC to establish and administer an electronic, searchable, Internet-based database of all Medicaid participating providers that includes relevant practice and participation information.

What's to Come. Providers should look out for opportunities created by future incentive programs developed by the Authority to promote voluntary participation in the statewide HIE. Providers that choose to participate in the voluntary statewide HIE system will become subject to the privacy, security, operation and technical standards eventually identified by the Authority.

In addition, new legislation grants HHSC broad authority to develop and implement various HIT initiatives within the Medicaid program by rule. Future rulemaking will likely have significant administrative implications for Medicaid-participating providers.

HEALTHCARE-ASSOCIATED INFECTION REPORTING SYSTEM

The Issue. Healthcare-associated infection (“HAI”) reporting was at the forefront of quality initiatives on the legislative agenda this session. As directed by last session’s SB 872, the Advisory Panel on Healthcare-Associated Infections issued an interim report recommending the establishment of a mandatory HAI reporting system for hospitals and ASCs. At the urging of the House Committee on Public Health, the Legislature carefully considered and ultimately adopted the Advisory Panel’s recommendation.

New Legislation. **SB 288 (Nelson)** requires DSHS to establish the Texas Healthcare-Associated Infection Reporting System, a mandatory HAI reporting system for hospitals and ASCs, by June 1, 2008. Among its key provisions, the new legislation:

- Establishes mandatory reporting requirements that include (1) surgical-site infections

occurring after certain common procedures, (2) laboratory-confirmed central line-associated primary bloodstream infections occurring in special care settings, and (3) respiratory syncytial virus in pediatric inpatient units.

- Directs DSHS to publish on its website a risk-adjusted summary of reported HAI data for each reporting facility at least annually.
- Mandates the development of a secure electronic interface for facilities to report HAI data at the State's expense.
- Establishes a permanent Advisory Panel on Healthcare-Associated Infections to guide the implementation, development, maintenance, and evaluation of the reporting system.
- Establishes confidentiality, disclosure, and evidentiary protections for reported data, including a provision that published HAI rates may not be used in civil actions against facilities to establish the applicable standard of care.

What's to Come. SB 288 grants HHSC general rulemaking authority to implement the reporting system. Among the issues to be addressed in rulemaking are the frequency of reporting (but no more than quarterly) and a process for a reporting facility to comment on its published HAI rates. Facilities that are subject to the new reporting requirements should also stay informed about the availability of DSHS-sponsored education and training programs for staff members.

TRANSPARENCY

HEALTHCARE COST TRANSPARENCY

The Issue. Healthcare cost transparency has been an issue of hot debate in previous legislative sessions. Going into this session, transparency was again placed as a high priority on the legislative agenda at the urging of various public and private policy groups. The overall goal of transparency legislation is to empower consumers with the information necessary to make informed healthcare decisions.

New Legislation. The Legislature passed **SB 1731 (Duncan)**, a comprehensive transparency bill designed to increase consumer access to information on healthcare costs and billing practices. The scope of the new legislation is expansive—it imposes increased disclosure requirements on all the key industry players from hospitals and health plans to facility-based physicians. Specifically, the new law:

- Requires DSHS and the TMB to develop and post online consumer guides to healthcare that include information on facility pricing data and practices and physicians' billing and reimbursement practices.
- Requires providers to develop, implement, and make available detailed written billing policies that address, among other things, discounting practices, the provision of itemized statements to patients and third-party payors, charging interest, handling complaints, and the written disclosure of network participation and balance billing practices to patients at the time of admission or when services are provided.
- Imposes increased disclosure requirements related to balance billing by out-of-network facility-based physicians on health plans, facility-based physicians, and network facilities.
- Requires facilities to provide written estimates of charges upon request.
- Requires health plans to provide written estimates of health plan payments and enrollee cost-sharing amounts upon request.
- Authorizes TDI to collect and publish reimbursement rate data from health plans on an aggregate, regional basis.
- Increases data collection efforts of the Texas Healthcare Information Council.
- Mandates a study on network adequacy (to be completed by December 1, 2008).

Legislation that would have increased drug pricing transparency died in committee. Specifically, **HB 533 (Dukes)** would have created a drug retail price registry on HHSC's website that included retail price information for the 150 most frequently prescribed prescription drugs.

What's to Come. DSHS, the TMB and TDI (as applicable) have broad rulemaking authority to implement SB 1731's various transparency initiatives by May 1, 2008. The legislation itself includes detailed billing policy and balance-billing disclosure requirements, which will be further fleshed out in the rulemaking process. Overall, the legislation will likely require providers to amend or modify existing billing practices and policies in order to comply.

HEALTHCARE QUALITY TRANSPARENCY

The Issue. Throughout the session there was debate regarding what, if any, role Texas should have in developing and implementing healthcare quality transparency initiatives. The Governor initially proposed quality transparency initiatives, such as the development of common quality metrics and model pay-for-performance programs, as a potential purpose for the Authority created by **HB 1066 (Delisi)**. However, given the emergence of national physician performance and quality measures through existing collaborations, the Texas Health Care System Integrity Partnership ultimately recommended excluding such purposes from the Authority's powers.

New Legislation. Following the Partnership's recommendations, no legislation was passed this session that would give the State an active role in developing and implementing quality transparency initiatives. **HB 1066 (Delisi)** even goes so far as to prohibit the Authority from comparing physicians based on quality metrics, creating tools to measure physician performance and disseminating any information publicly that rates, tiers or measures physicians' performance, efficiency or quality. However, the online consumer guide to healthcare mandated by **SB 1731 (Duncan)** will include links to facilities' quality of care data from other sources, such as the Hospital Compare website within the U.S. DHHS, the Joint Commission website, and the THA's Texas PricePoint website.

MANAGED CARE

BALANCE BILLING BY OUT-OF-NETWORK, FACILITY-BASED PROVIDERS

[Requirements included in **SB 1731 (Duncan)** on Healthcare Cost Transparency, p. 10]

INCREASED REGULATORY AUTHORITY

The Issue. During the interim, TDI observed that complex PPO networks had evolved to perform a number of different services, such as processing and repricing claims with no regulatory oversight. The lack of regulation over the secondary market in provider discounts (a.k.a., the “silent PPO market”) and non-insurance discount healthcare programs were also slated as issues for legislative attention this session.

New Legislation. Although proposed legislation to regulate the silent PPO market died, a number of bills passed this session that will increase regulatory authority over third party administrators and certain non-insurance discount healthcare programs and benefits as discussed below.

Third Party Administrators. **HB 472 (Solomons)** generally expands the scope of the third-party administrator statute to include delegated entities and administrators of workers’ compensation benefits, including a workers’ compensation network that administers workers’ compensation claims for insurers. Entities affected by the amendments to the TPA statute will have until January 1, 2008 to obtain a certificate of authority. The legislation also enhances regulatory requirements for all TPAs, including but not limited to:

- Authorizing TDI to adopt rules establishing financial standards, reporting requirements, and mandatory contract provisions for contracts between TPAs and insurers.
- Requiring insurers to conduct semi-annual reviews and biennial on-site audits of a TPA that administers benefits for more than 100 covered persons on behalf of the insurer.

Discount Healthcare Programs. **HB 3064 (Delisi)** requires registration and minimal regulation of discount healthcare programs through the Texas Commission of Licensing and Regulation. Discount healthcare programs include any business arrangement in which an entity, in exchange for fees, dues, charges, or other consideration, offers its members access to healthcare services at discounted rates. Among other things, the legislation:

- Requires registration of operators of discount healthcare programs by April 1, 2008.
- Creates specific duties for program operators, including administrative duties, such as supplying identification cards, contracting requirements, and maintenance of a surety bond.
- Applies the consumer protection laws to discount healthcare programs.
- Regulates advertising and marketing by such programs.

Discount Card Programs/Non-Insurance Benefits. **HB 1847 (Hancock)** potentially increases TDI’s regulatory authority over discount card programs and other noninsurance benefits. The legislation authorizes insurers to offer noninsurance benefits as part of an insurance policy and grants TDI rulemaking authority to implement the legislation. Examples of noninsurance

benefits include (1) discount cards for healthcare, vision, dental, prescription or physical fitness programs; (2) financial planning, will preparation or similar services; and (3) contributions for education savings on behalf of a policy holder or certificate holder.

Silent PPO Market. Proposed legislation to regulate the silent PPO market did not pass. Specifically, **HB 839 (Eiland)** would have, among other things, required registration of entities engaged in leasing or selling access to provider networks, limited access to discounted rates to payers specifically identified in a provider contract, and given providers the right to opt-out of proposed network lease arrangements. HB 839 was approved by the House Committee on Insurance but ultimately died in the House Calendars Committee. **HB 2016 (Smithee)** and **SB 1170 (Hinojosa)** would have prohibited insurers, HMOs, TPAs, networks and other entities that contract with healthcare providers from reimbursing providers on a discounted fee basis unless the entity held a direct contract with the provider or met certain procedural and notice requirements. Neither bill made it out of committee.

What's to Come. The implications of the increase in regulatory authority granted by this new legislation remains to be seen in the rulemaking process. **HB 3064** requires TDI to adopt rules regulating discount healthcare programs by January 1, 2008. The other bills described above do not include rulemaking deadlines.

PROMPT PAYMENT

SB 1884 (Williams) amends the prompt payment law's underpayment penalty provisions. At the urging of health plans, the new legislation revises the formula for calculating the underpayment penalties so that the amount of the penalty does not exceed the underpaid amount. Under the revised formula, the penalty increases in proportion to the underpaid amount. In addition, the amendment extends the deadline for providers to notify health plans of underpayments from 180 to 270 days and decreases the deadline for health plans to pay the balance on an underpaid claim without incurring penalties from 45 to 30 days.

The version of **HB 839 (Eiland)** passed by the House Committee on Insurance, which was primarily a silent PPO bill, would have extended the State's prompt payment requirements to entities engaged in selling and leasing provider discounts and most payers, excluding self funded ERISA plans. As originally filed, the bill would have extended the State's prompt payment laws to all payers, including self-funded ERISA plans, but was met with opposition from TAB on the basis of its potential fiscal implications to self-funded employers. As stated previously, **HB 839** died in the House Calendars Committee.

WAIVER OF COPAYMENTS

As originally filed, **SB 1731 (Duncan)**—the comprehensive transparency bill—included amendments to the Insurance Code sections related to the waiver of copayments. These amendments would have permitted providers to waive copayments or deductibles for financially indigent or government program beneficiaries in certain circumstances. In addition, the legislation would have required providers to notify TDI and the applicable health plan of any waivers. The proposed amendments were deleted from the bill by the Senate Committee on State Affairs.

FUNDING FOR CANCER RESEARCH

The Issue. An estimated 35,000 Texans die of cancer every year, and 85,000 new cases are diagnosed each year. Governor Perry made fighting cancer a priority this legislative session. Historically, the federal government has been one of the major funding sources for cancer research. Governor Perry challenged that paradigm by proposing the creation of a Texas cancer research institute, which would make Texas a global leader in cancer research.

New Legislation. **HJR 90 (Keffer) [SJR 43 (Nelson)]** proposes a constitutional amendment, subject to voter approval, to establish the Cancer Prevention and Research Institute of Texas (the “Cancer Research Institute”), which would make grants and loans to institutions of learning, advanced medical research facilities, and collaborations. The grants would be used for research into the causes and cures for cancer, research facilities, and research to develop therapies, protocols, medical pharmaceuticals, or procedures for treating cancer. Under the resolution, funds would come from a \$3 billion bond issuance spread out over a ten year period.

HJR 90 authorizes grants to “public or private persons to implement the Texas Cancer Plan.” Only “institutions of learning,” “advanced medical research facilities,” and “collaborations” would be eligible for funding to accomplish the specific goals of the Institute.

The resolution requires that grant recipients have an amount of funds equal to one-half the amount of the grant dedicated to the research that is the subject of the grant request.

HB 14 (Keffer) establishes the powers and duties, the structure, and reporting requirements of the Institute. The legislation requires the Institute to ensure that all grants and loan awards are subject to an intellectual property agreement that allows the state to collect royalties, income, and other benefits realized as a result of research projects. HB 14 also requires HHSC to publish a standardized written summary of the advantages, disadvantages, risks, and descriptions of all medically efficacious and viable alternatives for the treatment of lung cancer.

What’s to Come. In November, voters will decide whether to approve a constitutional amendment that would allow the state to issue up to \$300 million a year in bonds to be distributed by the Cancer Research Institute.