State & Local Compliance Update

USI EMPLOYEE BENEFITS

July 21, 2023

New Texas Mandated Benefits

The Texas legislature wrapped up its 88th legislative session in June having passed about 60 bills related to health insurance. Below are the bills signed into law that relate to employer-sponsored plans. They apply to insured medical plans written out of Texas only and are effective for health plans delivered or renewed on or after January 1, 2024, unless otherwise noted below.

SUMMARY

- House Bill 109 – If a hearing aid charge exceeds the maximum benefit allowed under the plan, the claim will not be denied. Instead, the maximum benefit allowed will be paid and the patient will pay the difference.
- House Bill 1649 – Coverage for fertility preservation services is required for patients who receive cancer treatments that may impair fertility. This mandate does not include storage related to fertility preservation.
- House Bill 2002 – Under a PPO plan, an insurer must credit toward an insured's deductible and annual maximum out-of-pocket an amount the insured paid directly to any provider for a medically necessary item or service if:
  - a claim was not submitted to the insurer; and
  - the amount paid was less than the average discounted rate for the item or service paid to an equivalently licensed or authorized network provider under the insured's plan.
- House Bill 3359 –There are measurable network adequacy standard requirements for insurers of PPO plans.
- House Bill 4500 – Effective January 1, 2024, insurers must make a website available to providers that:
  - confirms whether the patient has coverage; and
  - lists the cost-sharing for which the patient is responsible.

- Senate Bill 989 – Biomarker testing[1] is required to be covered for the purpose of diagnosis or treatment if the test is scientifically valid and predominantly addresses the acute issue for which the test is being ordered.
- Senate Bill 2476 – Applicable to emergency services provided on and after January 1, 2024, "surprise billing" protections are in place for out-of-network ground ambulance services provided by a political subdivision such as a county or city. Insurers pay rates filed with the Texas Department of Insurance, if submitted by the provider. Otherwise, insurers pay the lesser of the provider's billed charge or 325% of the current Medicare rate.
- House Bill 290 – Certain self-employed individuals may participate in an association plan. This change is to go into effect September 1, 2023. However, the federal regulations to which this state law is intended to align were set aside in 2019.
- House Bill 711 – Anti-steering,[2] anti-tiering,[3] gag clauses,[4] and most favored nation clauses[5] are prohibited in provider network contracts. The effective date is the earlier of:
  - the effective date of a provider network contract amendment that eliminates the anti-steering or anti-tiering provisions; or
  - December 31, 2023.

  Note that all group health plans, including self-funded plans, and insurers are subject to a federal law prohibiting gag clauses, effective December 27, 2020.
- Senate Bill 833 – Insurers cannot use environmental, social, and governance (ESG) factors when setting rates.
- Senate Bill 1040 – Insurers cannot cover a human organ transplant or post-transplant care if the transplant was performed in China or another country known to have participated in forced organ harvesting.

EMPLOYER NEXT STEPS

Employers with insured medical plans written out of Texas should be aware of the above changes. No employer action is required.

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[1] Biomarker testing is an objective way to look for substances such as gene mutations and protein expressions that can provide information about a patient's condition such as cancer.

[2] Restricts the ability of an insurer to encourage an enrollee to obtain a health care service from a competitor of the provider, including offering incentives to encourage enrollees to use specific providers.

[3] Restricts the ability of an insurer to introduce or modify a tiered network plan or assign providers into tiers; or requires an insurer to place all members of a provider in the same tier of a tiered network plan.

[4] Restricts the ability of an insurer or provider to disclose:
- price or quality information, including the allowed amount, negotiated rates or discounts, fees for services, or other claim-related financial obligations included in the contract, to a governmental entity as authorized by law or its contractors or agents, an enrollee, a treating provider of an enrollee, a plan sponsor, or potential eligible enrollees and plan sponsors; or
- out-of-pocket costs to an enrollee.

[5] A provision in a provider network contract that:
- prohibits (i) a provider from contracting with another insurer to provide health care services at a lower rate; or (ii) an insurer from contracting with another provider to provide health care services at a higher rate;
- requires (i) a provider to accept a lower rate for health care services if the provider agrees with another insurer to accept a lower rate for the services; or (ii) an insurer to pay a higher rate for health care services if the entity agrees with another provider to pay a higher rate for the services;
- requires termination or renegotiation of an existing provider network contract if: (i) a provider agrees with another insurer to accept a lower rate for providing health care services; or (ii) an insurer agrees with a provider to pay a higher rate for health care services; or
- requires: (i) a provider to disclose the provider's contractual reimbursement rates with other general contracting entities; or (ii) an insurer to disclose the insurer's contractual reimbursement rates with other providers.

This summary is intended to convey general information and is not an exhaustive analysis. This information is subject to change as guidance develops. USI does not provide legal or tax advice. For advice specific to your situation, please consult an attorney or other professional.