BILL ANALYSIS

C.S.H.B. 5186
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Pensions, Investments & Financial Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Health care costs across Texas consistently escalate above anticipated medical trend indicators. Without any intervention, the cost to provide quality health coverage for Texas' state employees and teachers, both active and retired, will continue to strain financial resources of both the state and its vital workforce. These cost increases consume valuable state revenue and will ultimately constrain the ability of future legislatures to appropriately address critical funding needs as they arise. C.S.H.B. 5186 seeks to provide cost savings and equalize payments received across similarly sized and situated hospital systems by creating the state health benefit plan reimbursement review board charged with adopting a reimbursement structure for services or supplies provided to certain plan enrollees by a facility, thus ensuring the cost charged to the state, and ultimately to taxpayers, for state employee health care is not artificially inflated.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 5186 amends the Government Code to establish the state health benefit plan reimbursement review board for the purpose of controlling present and future cost growth for state health benefit plans while maintaining access for enrollees to high-quality health care services and supplies. The bill establishes that the board consists of the lieutenant governor, the speaker of the house of representatives, the chair of the senate finance committee, the chair of the house appropriations committee, three members of the senate appointed by the lieutenant governor, and three members of the house appointed by the speaker. The bill designates the lieutenant governor and the speaker of the house of representatives as joint chairs of the board and establishes that the board must meet as often as necessary to perform the board's duties and that meetings may be held at any time at the request of either of the joint chairs. The bill sets out the following provisions with respect to board meetings:

- a majority of the members of the board from each house constitutes a quorum to transact business, which allows the board to act on any matter that is within its jurisdiction by a majority vote;
- the board must meet in Austin, but the board may meet in any location determined by agreement among the majority of board members from each house;
- as an exception to state open meetings law and other law, any number of board members may attend the meeting by use of telephone conference call, video conference call, or

other similar telecommunication device so long as the joint chairs of the board are physically present at a meeting located in Austin;

- that exception applies, without regard to the subject of the meeting or topics considered by the members and for purposes of constituting a quorum, voting, and any other purpose allowing a board member to otherwise fully participate in any board meeting; and
- provides requirements applicable to a meeting held by use of telephone conference call, video conference call, or other similar telecommunication device.

C.S.H.B. 5186 requires the board to adopt a provider reimbursement structure, regardless of methodology, that each applicable state health benefit plan will use to determine reimbursement to a facility for a health care service or supply, determined by provider type and class and according to whether the facility is an in-network or out-of-network facility. The bill makes that requirement applicable with respect to a health benefit plan provided under the following:

- the Texas Employees Group Benefits Act;
- the Public School Retired Employees Group Benefits Act
- the Texas School Employees Uniform Group Health Coverage Act; and
- the State University Employees Uniform Insurance Benefits Act.

The bill defines "facility" as the following:

- a hospital;
- a licensed ambulatory surgical center;
- a birthing center; or
- a freestanding emergency medical care facility, including such a facility that is exempt from certain licensing requirements.

The bill prohibits the board from adopting a reimbursement structure that is in excess of the aggregated provider reimbursement, regardless of methodology, reported by participating state health benefit plans under the bill's provisions for that health care service or supply.

C.S.H.B. 5186 requires each applicable state health benefit plan to submit to the board, in the form and manner prescribed by the board and after allowing for public comment, a report that includes the following:

- information on reimbursements and costs for applicable provider types and classes paid by that plan during the preceding plan year;
- recommendations to the board regarding the provider reimbursement structure to be adopted by the board; and
- a summary of public comments received by the plan on the recommendations provided to the board.

The bill requires the board to analyze the submitted reports, including the recommendations provided, and issue a report on the reimbursement structure for state health benefit plans that is applicable to a state health benefit plan for each plan year beginning after the date the report is issued until the plan year beginning after the date a later report is issued. The bill requires the board's report to specify that applicability, establish the reimbursement structure in accordance with the bill's provisions, and be made publicly available on a website.

C.S.H.B. 5186 amends the Insurance Code to require an applicable facility that bills the following for a health care service or supply provided to an applicable plan enrollee to be reimbursed for the health care service or supply in accordance with the reimbursement structure adopted for the service or supply by the state health benefit plan reimbursement review board for the applicable plan year:

- the state employees group benefits program, an administering firm, or a health benefit plan provided under the Texas Employees Group Benefits Act, or a designee of the program, firm, or plan;
- the Texas public school employees group program, a health benefit plan or an administrator of a health benefit plan provided under the Texas Public School Retired Employees Group Benefits Act, or a designee of the program, administrator, or plan;

- the Texas school employees uniform group health coverage program, an administering firm, or a health coverage plan provided under the Texas School Employees Uniform Group Health Coverage Act, or a designee of the program, firm, or plan; or
- the uniform insurance benefits program for employees of The University of Texas System and The Texas A&M University System, an administering carrier, or a health benefit plan provided under the State University Employees Uniform Insurance Benefits Act.

The bill requires a facility that receives such reimbursement for a health care service or supply to consider the reimbursement as payment in full for the service or supply and prohibits the facility from charging an enrollee to recover from the enrollee the balance of the facility's fee for a service or supply received by the enrollee from the facility that is not fully reimbursed. However, the bill authorizes the facility to charge the enrollee an applicable copayment, coinsurance, or deductible under the enrollee's health benefit or coverage plan, as applicable. The bill prohibits a facility from discriminating against an enrollee or the group benefits or coverage program based on the limitation on reimbursement either by refusing to provide health care services or supplies to the enrollee or by providing health care services or supplies of a lower quality to the enrollee than those the facility provides to similar patients who are not enrolled in such a health benefit or coverage plan.

C.S.H.B. 5186 applies to a plan year beginning on or after September 1, 2024, and a contract entered into or renewed on or after September 1, 2023.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 5186 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

While both the introduced and the substitute provide for limitations on reimbursements paid for certain services provided to enrollees in state health benefit plans, the versions differ in the following manner:

- the substitute includes provisions that were not in the introduced relating to the creation and administration of the state health benefit plan reimbursement review board, its duty to adopt a reimbursement rate structure, and relevant reports created by the board and each applicable state health benefit plan;
- whereas the introduced applied its provisions to a facility as defined by reference to Health and Safety Code provisions, the substitute defines "facility" for purposes of its provisions;
- whereas the introduced established that any facility that bills an applicable program, plan, administering firm, carrier, or designee for health care services provided to an enrolled employee, retiree, or dependent, as applicable, will never be entitled to a rate for such services that exceeds the rate established in the applicable rider in the General Appropriations Act, the substitute establishes that a facility that bills an applicable program, plan, administrator, or designee for a health care service or supply provided to a plan enrollee must be reimbursed for the health care service or supply in accordance with the reimbursement structure adopted for the service or supply by the board for the applicable plan year;
- the substitute includes a provision not in the introduced requiring a facility to consider such reimbursement as payment in full and prohibiting the facility from charging an enrollee the balance of the facility's fee for a service or supply received by the enrollee from the facility that is not fully reimbursed, with the exception of an applicable copayment, coinsurance, or deductible under the enrollee's health benefit plan;

- whereas the introduced prohibited a facility from discriminating because of the maximum rating schedule imposed by the introduced, the substitute prohibits a facility from discriminating based on the limitation of reimbursement imposed by the substitute;
- the substitute omits a provision from the introduced prohibiting a facility from discriminating by refusing to participate in an applicable network; and
- whereas the introduced made its maximum rating schedules applicable to any bill for health care services provided by a facility with dates of service beginning on or after September 1, 2024, the bill makes its provisions applicable to a plan year beginning on or after September 1, 2024, and a contract entered into or renewed on or after September 1, 2023.