Senate Committee on Health and Human Services, March 17, 2021

The Senate Committee on Health and Human Services gathered to consider the following:

SB 64 Nelson | et al. Relating to a mental health program that includes peer-to-peer counseling for certain law enforcement personnel. **SB 73 Miles** Relating to providing access to local health departments and certain health service regional offices under Medicaid. **SB 199 Nelson** Relating to automated external defibrillators. **SB 224 Perry | et al.** Relating to simplified certification and recertification requirements for certain persons under the supplemental nutrition assistance program. **SB 284 Seliger** Relating to a study of out-of-state physicians who practiced in this state during the COVID-19 pandemic.	**SB 383 Powell** Relating to disclosure requirements of certain facilities that provide care for persons with Alzheimer's disease and related disorders. **SB 672 Buckingham | et al.** Relating to Medicaid coverage of certain collaborative care management services. **SB 809 Kolkhorst | et al.** Relating to health care provider reporting of federal money received for the coronavirus disease public health emergency. **SB 827 Kolkhorst | et al.** Relating to pricing of and health benefit plan cost-sharing requirements for prescription insulin. **SB 863 Blanco** Relating to the temporary relocation of a residential child-care facility during a declared state of disaster.

Committee makeup: here.
Committee informational materials: here.

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SB 64 by Nelson | et al. - Relating to a mental health program that includes peer-to-peer counseling for certain law enforcement personnel.
There is a Committee Substitute (CS).

Increasingly high risk for fatal mental health challenges. Bill directs Texas Commission on Law Enforcement to develop a peer support system; allows commission to contract with institute of higher education with expertise on mental health issues. Specifies that training hubs cover suicide prevention; ensure they have support in both rural and urban. This bill patterns itself after the peer support network for our Veterans that Nelson carried years ago.

Q: State v local responsibility for implementing this? Right Ratio.

A: Bill targets the most local level. State will help establish the program; program executed at local level by local law enforcement officers. State's role will be to select an institution of higher ed to help train peer counselors in how to be counselors. From there it will fall squarely within local jurisdiction.

Q: Cost? Unfunded mandate?

A: No. Cost exists in start-up and training; idea came from local police officers. Local volunteers will not charge to provide counseling for peer officers.

Q: Any mechanism in here to allow us to review this program in a couple of years?
A: Not in the bill but it'll be easy to do.

Q: Originally had a fiscal note; you moved provisions to TCOLE – erase fiscal note?
A: Yes. They said it was indeterminate. It will not have a fiscal note.

Invited Witness (IW): Jeff Spivey, Texas Police Chief's Assoc.
Suicide leading cause of death among law enforcement professionals, far surpassing all other forms of death in the line of duty. Texas is a leader in number of police officers who die by suicide. We appreciate CS moving this program out of HHSC/public mental health system and allowing services to remain in law enforcement family.

No public testimony.

Registered but not testifying: 13 for; 0 against.

CSSB 64 passed out of committee 7-0.

SB 73, Miles: Relating to providing access to local health departments and certain health service regional offices under Medicaid.
CS applies provisions of bill to "local public health entities – includes local health departments, local health units, and public health districts.

Local public health departments vital part of health care delivery. LPHDs participated in 1115 waiver with tremendous success, providing preventative services. Not listed as provider type under managed care. Not receiving full reimbursement.

Bill would amend human resources code to create a separate provider type for LPHDs and health service regional offices acting as local health departments to the Medicaid managed care network.

Original version of bill applied to LPHDs and HSROs but omitted public health districts. Would have omitted 21 major local health entities. CS ensures inclusion of these entities.

DSHS and HHSC have a $1 million fiscal note for the bill. Exploring whether adding Nelson amendment or removing HSROs from the bill will zero out the fiscal note.

IW: Stephen Williams, Director of City of Houston Health Department
Acknowledged and expressed gratitude for work of the Legislature in this area. There are challenges that impede ability of LPHDs to get reimbursement for services rendered. Support SB 73 because it is crucial for LPHDs to receive reimbursement from MCOs for services that they are already providing to Medicaid recipients. LPHDs must have executed contracts and be considered in network to maximize reimbursement. Significant contracting challenges in MCOs and I hope SB 73 will be the first up in MCOs being more intentional in contracting with

LPHDs. PHDs have traditionally provided services to Medicaid clients, but the transition from traditional Medicaid to MMC presented significant barriers to full participation. In current environment, MCOs have been required by HHSC to reimburse certain provider types and "attempt" to contract with LPHDs. When services are covered by Medicaid high-risk services, they continue to seek services through LPHDs primarily due to access issues. This rec would not require additional Medicaid funding but would simply allow LPHDs to access funds and be reimbursed for services they are already providing.

C: Fiscal notes kill bills and it's important to pass this one.

A: Yes, they're exploring the cause of the note to zero it out. Biggest piece is likely technology.

Q: In LPHDs, you're not looking to become a clinic? Used to be reimbursed under FFS?

A: Under old practice, billed Medicaid directly for immunizations, treatment of Medicaid patients, family planning. If not reimbursed through Medicaid, then we have to cover services through grants or local GR dollars. Advocating for three proposals from Commission (directed payment programs allowing MCOs to make payments LPHDs to support Medicaid program goals and objectives; UC; public health prevention, coordination, monitoring—establish cost reimbursement methodology for services provided for Medicaid clients not currently covered through claims reimbursement). When we had access to DSRIP dollars, it provided for public health preventative services.

Q: "Family planning" does not include abortions, correct?

A: Correct.

IW: Robert Kirkpatrick, Director of Milam County Health Department
LPHDs experience barriers by not being a provider type. Fair compensation is key. Additional revenue would help augment local GR funds.

No public testimony.

Registered but not testifying: 14 for; 0 against.

Left pending in committee.

SB 199, Nelson - Relating to automated external defibrillators.
CS extends current liability protections regarding AEDs for business and property owners; repeals outdated requirements to better align with current AED technology; clarifies role of physicians and ensures they also have liability protections.

Bill updates current requirements to ensure that there are no disincentives to having AEDs readily available across the state.

Q: Do anything for increase liability on part of businesses?

A: No, it will protect them.

IW: Justin Bragiel, General Counsel, Texas Hotel & Lodging
Full support of the bill. Reducing liability for failing to train employees on the use of modern AED tech. Modern tech is extremely straightforward to use. Virtually impossible to misuse. AED itself guides the user through use of device. Only administers shock if properly placed. Hotel industry there's a lot of employee turnover; training employees on every aspect of hotel operations is a challenge. This will allow for broader use of AEDs without fearing liability for doing so.

Registered but not testifying: 7 for; 0 against.

CSSB 199 passed out of committee 7-0.

SB 224, Perry | et al. - Relating to simplified certification and recertification requirements for certain persons under the supplemental nutrition assistance program.
Author's/Sponsor's Statement of Intent: In 2018, Texas had the fifth-highest rate of senior food insecurity in the nation, with 11 percent of Texas seniors at risk for hunger. This figure has likely doubled due to the COVID-19 pandemic. Many are forced to choose between food and medicine, or food and utilities. Food insecurity in seniors exacerbates health problems and increases the cost of health care.

Many seniors and people with disabilities are eligible for the Supplemental Nutrition Assistance Program (SNAP) but are not enrolled due to barriers in the application process, including difficulty applying online and confusing requirements.

S.B. 224 helps address this by requiring the Health and Human Services Commission (HHSC) to implement a simplified application and recertification process for households comprised only of seniors (60+) or disabled individuals by:

- waiving the recertification interview requirements, initial interview is still required;
- using a simplified application form;
- extending the enrollment period to 36 months; and
- eliminating reporting requirements except for significant changes in income or assets.

If a person receives an increase in income, they must report that income to HHSC.

Many seniors on Medicaid are eligible for SNAP but are not enrolled. This bill includes a data matching section which would enable HHSC to identify and help enroll seniors eligible for SNAP. The bill allows HHSC to seek private funding and to contract with public or private entities for data matching.

As proposed, S.B. 224 amends current law relating to simplified certification and recertification requirements for certain persons under the supplemental nutrition assistance program.

IW: Jamie Olson, Director of Government Affairs for Feeding Texas
In support of the bill. Food insecure seniors face an increased risk for health conditions. SNAP increases access to good nutrition. Currently, only 50% of Texas' eligible seniors are enrolled.

Seniors struggle with the lengthy online application process, limited access to internet, limited mobility, and unreliable transportation to interviews. SB 224 will mitigate these barriers. Many states that implement these changes have seen significant administrative cost savings.

PT: Vance Ginn, Texas Public Policy Foundation (TPPF)
In support of SB 224. Good way to streamline SNAP process. Reiterated benefits enumerated in previous testimony.

Registered but not testifying: 16 for; 0 against.

SB 224 passed out of committee 7-0.

SB 284, Seliger - Relating to a study of out-of-state physicians who practiced in this state during the COVID-19 pandemic.
Not actually a study; a report on information that is available in the public and government sector. During the pandemic, the Governor worked with the Texas Medical Board to allow certain out-of-state licensed physicians to practice in Texas. Particularly important in border areas. This bill instructs Medical Board to conduct that study and present findings to Legislature regarding how many out-of-state physicians were brought before the Board for disciplinary reasons. This will tell us how well the program worked this time, inform future practices, and ensure that there were no qualitative deficiencies when out-of-state physicians are brought in for temporary licensure.

No invited witnesses.

No public testimony.

Registered but not testifying: 3 for; 0 against.

SB 284 passed out of committee 7-0.

SB 383, Powell - Relating to disclosure requirements of certain facilities that provide care for persons with Alzheimer's disease and related disorders.
This bill Increases and strengthens transparency in the way nursing and assisted living facilities disclose the Alzheimer's care that they offer. An Alzheimer's disease or related disorder license certification demonstrates that a facility has the advanced standards to care for residents with Alzheimer's. This bill offers consumer protection by requiring clear disclosure of facility's certification. Any facility can offer specialized "memory care services," like skilled staff and programming to bolster the quality of care. These services are critical tools. To many residents, the phrase, "memory care services" suggests but does not guarantee a certification. The distinction may not be transparent enough for residents and families to allow them to make an informed choice. Additionally, the current disclosure statement is often hidden within numerous other disclosures and documents they need to sign. Often overlooked. "Memory care services" can be misleading when not followed by an explanation of exactly what that entails.

IW: Chelsea Rangel, Public Policy Coordinator for Alzheimer's Association, San Antonio & South Texas Chapter
Support the bill. In Texas, 400,000 individuals diagnosed with Alzheimer's. Nationally, we rank fourth in cases and second in deaths. Texans spend more than 1.7 million hours a year caregiving for loved ones living with Alzheimer's. 42% of seniors living in residential care and 48% of seniors living in nursing homes have Alzheimer's and other dementia. The Alzheimer's Certification designation means that facilities have met the higher standards of care necessary to provide effective care to Alzheimer's patients. In an attempt to meet increasing need, many long-term care facilities have begun offering or marketing themselves as offering "memory care services." This marketing towards an already vulnerable population can be misleading, giving families a false sense of assurance in the level of care their loved ones will receive. Memory care centers or facilities are not required to have specialized staff in dementia care, nor are they required to have specially built environments. Alzheimer's Association wants families to have overt and easy access to information.

IW: Sue Wilson, Social Worker & member of Texas Silver Haired Legislature (TSHL)
Testifying in support of the bill. SB 383 would require nursing homes and assisted living facilities to simply prepare a written notice disclosing whether or not they hold and maintain an Alzheimer's certification. Enhanced staffing is critical when caring for individuals with dementia. Only three percent of the 1,200 nursing homes in Texas hold an Alzheimer's certification. Yet most if not all nursing homes serve a population which includes many individuals living with some degree of cognitive impairment, often severe. SB 383 will enhance transparency. TSHL supports passage; asks the legislature to strengthen language in health safety code to ensure that care communities that use a locked door to restrict residents' exits from a distinct part or all of the building be required to have an Alzheimer's certification.

PT: Diana Martinez, Pres./CEO of Texas Assisted Living Association
Testifying on the bill. Unclear on intent and how it would impact current disclosures. Speaking to portion of bill that addresses assisted living. Disclosure statements already provided. Community must provide a copy, explain the disclosure, and document receipt of disclosure. Disclosure statement generated by HHSC. Question of Alzheimer's certification is on the front page. If a community is Alzheimer's-certified, there is another disclosure statement also generated by HHSC that must be filled out by the community and provided. If a community advertises, markets, or otherwise promotes themselves as providing specialized care to individuals with Alzheimer's or related disorders, then that assisted living facility *has* to be Alzheimer's-certified. No specific objection to current disclosure; want to ensure that any changes would not create confusion or redundancy.

Brief discussion regarding ways to make the disclosure more noticeable, such as bold ink or a highlight.

PT: Kevin Warren, Pres./CEO of Texas Health Care Association
Testifying on the bill. Support intent to provide transparency and clarity. Texas Health and Safety Code explicitly prohibits caregiving facilities from falsely advertising themselves as Alzheimer's-certified. Our recommendation to improve the bill is to direct the disclosure requirements towards facilities identified as memory care facility or managing memory care or secured units.

Registered but not testifying: 4 for; 0 against.

SB 383 passed out of committee 7-0.

SB 672 - Buckingham | et al.: Relating to Medicaid coverage of certain collaborative care management services.

- CS is Legislative Council version of the bill. No changes.
- Allows for use of collaborative care model to address mental health conditions in Texas Medicaid.
- Sharp increase in Texans experiencing mental health conditions since the pandemic. According to CMS, only 25% of patients receive effective mental health care, including in primary care settings.
- Collaborative Care (CC) model integrates physical/mental healthcare under the supervision of a PCP in order to increase access to effective behavioral health treatment while maximizing capacity of limited behavioral health workforce.
- CC model emphasizes early intervention & measuring progress as is done for diabetes.
- Many commercial payors and Medicare have begun reimbursing for this type of care. Currently not covered under TX Medicaid.
- By adding reimbursement for CC model, TX can improve patient access/outcomes; saving taxpayer dollars.

Q: PCPs would be part of a team?

A: Yes. Team consists of psychiatric health professional and key new addition of behavioral health expert. Brings them under same umbrella; billed and coded the same. Patient is evaluated and plan is formed; BH specialist monitors to ensure that patient doesn't fall off. Regular contact. Prevents the patient reaching a crisis point because it emphasizes early intervention.

TESTIMONY. Dr. Andy Keller, Pres./CEO of Meadows Mental Health Policy Institute. Standard of care for mental health is outdated. Don't identify needs until there's a crisis. This bill allows us to implement early intervention. Our baseline for mental illness is that 8-10 years go by before we provide treatment, leading to excess morbidity. Milliman conducted a study of all the claims in the U.S. in 2018, showing that of the highest utilizers, 57% had mental health conditions not being adequately treated. On average, we saw less than $68 spent on care for people with mental illness whereas thousands are being spent for comorbid chronic health conditions. This bill will save money. COVID has caused a 4X increase in Texans reporting levels of clinical depression. Depression will get worse. It's in the years after a crisis that you see other conditions emerge. Primary care and early intervention are key. 17 states cover CC model under Medicaid; we've seen the costs go down.

Dr. Carol Alter, Psychiatrist/Lead Behavioral Health at Baylor Scott & White Health System. Most mental health conditions present in primary care and most can be managed there. Four years ago, we were able to provide integrated services consistently and effectively because of CC model reimbursement in Medicare & commercial health plans. More than 500 patients have been referred to our CC program to-date (less than six months); more than 30% of patients have seen their depression remit; more than 60% have seen at least some improvement. Providing this service in Medicaid would give us the ability to reach all of our patients.

Q: BSW has started the model?
A: Yes, with great results. Remission results are roughly three times better than the national average in primary care without this kind of program.
Q: Buckingham bill would set up model and reimburse under Medicaid?
A: Yes. Patients that are the most vulnerable and expensive are under Medicaid.
Q: Do we have enough mental and behavioral health providers in TX?
A: The model is scalable. BH care manager, often a nurse or social worker, does the heavy lift. Provides support; does not do psychotherapy. Psychiatrist role is indirect as a consultant—providing guidance to PCP. Program does not burden mental health workforce in same way that others might. Targets patients that might need psychiatrist or psychologist. They are referred to mental health specialists in a much more thoughtful manner.

No public testimony.

Registered but not testifying: 17 for; 0 against.

CSSB 672 passed out of committee 7-0.

SB 809, Kolkhorst | et al. - Relating to health care provider reporting of federal money received for the coronavirus disease public health emergency.
CS adds a requirement for a public health provider to report federal funds received under the American Rescue Plan Act of 2021. Additionally, clarifies that first report given by public health providers should include money received during the period for which the CARES Act was retroactive.

Requires healthcare providers to report federal funds from CARES Act and the Consolidated Appropriations Act on a monthly basis. This will give us a better understanding of the amount and type of funds flowing to providers during COVID-19. Typically, such an influx of federal funds would flow through HHSC and through a traditional state budget. Due to the emergency nature of fund distribution, state does not have an adequate picture of those funds. We need to have a better understanding as we craft our state budget.

Bill is not concerned with money for PPE. We are looking at big funding going to hospitals and nursing homes, etc. We're receiving large requests to backfill certain dollars, and we need more transparency so that we can better understand and meet the needs of Texas' most fragile citizens.

No invited testimony.

PT: John Hawkins, Texas Hospital Association
Testifying on the bill. Generally support intent. Couple issues: 1) timing – still don't have final guidance from federal HHS on how funds are to be accounted for, and deadline for reporting has been pushed back; 2) please include language that HHSC rely as much as possible on data that's already being reported to federal HHS so that we don't duplicate any efforts.

PT: Amanda Fredriksen, Associate State Director of Advocacy, AARP
Support the bill. Transparency is key. Nearly 9,000 deaths of Texas residents in nursing facilities. Resident safety and quality of care was a problem before COVID; Texas has the most one-star nursing homes of any state. Infection control is the most frequently cited violation. Through the federal government, Texas nursing facilities had roughly $1.5 billion dollars available to them through the provider relief fund. That averages about $1.2 million per facility; also received a bump in Medicaid rate. QIPP program bumped up to $1.1 billion for the current fiscal year. These are taxpayer dollars and there must be transparency. Very vulnerable population.

PT: Vance Ginn, Texas Public Policy Foundation (TPPF)
Support the bill. Important at state and federal levels. Recommend having this for any national disaster and/or pandemic. Additional recommendation would be to provide this information online.

Registered but not testifying: 2 for; 0 against.

Left pending in committee.

SB 827, Kolkhorst | et al. - Relating to pricing of and health benefit plan cost-sharing requirements for prescription insulin.
There is a Committee Substitute.

Author's/Sponsor's Statement of Intent: Ensure that patients are able to access and afford lifesaving and medically necessary insulin. Approximately 2,800,000 people in Texas, roughly 14 percent of the adult population, have diabetes. The price of insulin has increased 1,000 percent over the last 25 years, making it more and more difficult for Texans to afford. Diabetes and prediabetes costs Texans an estimated $23.7 billion each year. Texans frequently spend anywhere from $300 to over $1,000 per month on the cost of their supply of insulin, not including any additionally needed diabetes-related medical supplies.

A new nationwide survey showed that the 34 million Americans living with diabetes face unique, acute, and intensified challenges to their health as a result of the COVID-19 pandemic challenges that may increase their COVID risk for complications. Recent studies show that the financial and economic toll of the pandemic has left countless Americans with diabetes without access they need to properly manage their diabetes or even survive during this time. Implementation of a co-pay cap during this time can alleviate some of this burden and reduce the occurrence of individuals rationing their insulin or being unable to afford it completely.

To date, 14 states have implemented similar insulin co-pay cap legislation. The co-pay caps range from $25 to $100 dollars, with the average amount being around $65.

This bill implements a cap of $50 on the out-of-pocket monthly cost on insulin for those covered by insurance.

This does not change or limit what insulin manufacturers can charge insurance companies, instead only capping what patients are required to pay.

As proposed, S.B. 827 amends current law relating to pricing of and health benefit plan cost-sharing requirements for prescription insulin.

Sen. Kolkhorst stated that she's a free market person excepting cases where the free market fails, hence this bill. She believes the role of government is to step in and correct when the free market is not working for people, and she approached this legislation cautiously.

IW: Veronica De La Garza, Director of Government Affairs for the American Diabetes Association
Support SB 827. There is federal precedent for this effort under President Trump's administration. There are 2.3 million Texans diagnosed with diabetes. It costs the state about $26 billion a year in direct medical expenses and indirect costs such as productivity. The cost to produce a vial of insulin runs from $4-$6. The cost for the public is typically $300 or more. People with diabetes are cutting back and/or skipping doses, and that puts their lives at risk. One in four insulin users have told ADA that cost has impacted their insulin use. Skipping insulin doses can have devastating consequences. This bill provides a sustainable systemic way to provide insulin cost-share for the patient. Regarding cost, there have been some studies and I have brought two as examples: 1) Washington State after the insulin co-pay cap passed—15 health insurers filed an average proposed decrease of 1.79% for the 2021 individual health insurance market; 2) in Kentucky the bill is still pending, but they have done their financial impact statement and it showed that any potential premium increase would be as little as $0-$0.80 per person per month for all fully insured policies in the state.

IW: Dr. Carol Howe, Representing Association of Diabetes Care & Education Specialists
Support SB 827. Provided anecdotes of patients forced to cut back on their use of insulin due to cost and patients switching to cheaper insulins that do not give them good control. Good control prevents health complications such as blindness and amputations. The American Diabetes Association did a study which showed that the most significant costs associated with diabetes are due to complications. SB 827 helps families immediately.

Q: You mentioned "modern" or name brand insulins. Have costs gone up appreciably to produce these or does the formulary stay roughly the same?

> **A:** My understanding is that the costs for the three Pharma companies that make insulin, including the modern insulin, have not gone up. There are actors in the middle that drive up the cost.

IW: Melissa Denny, Mother of a Type I Diabetic
She described her son's positive academic and social engagement, stating that he is only able to do so because of insulin. The cost required to keep him alive is shocking, even with insurance. Each year she spends roughly $1,000 for a one-month supply of insulin. That has increased significantly over the past 15 years. He has very good control. Each year, we spend $13,000 out of pocket before our insurance kicks in.

Q: How much has the cost increased since the years he has been diagnosed, and has there been any change to the insulin or the formulary?

A: We've seen the increases. Different policies and agreements between insurance companies and insulin providers will force us to change insulin types frequently. We have ups and downs until we can get it under control again. When he was first diagnosed at two years old, it was about $100 a month; now, we just pay outright as a high deductible. We would pay $20,000 out of pocket if we did not go with the high deductible insurance.

PT: Blake Hutson, Associate State Director for AARP
Testifying on the bill. Concern that we're missing the root cause. Co-pay cap is limited to those on state-regulated health plans. Inadvertently gives drug manufacturers a free pass to keep raising them. Would love to see a study associated with the bill regarding rising costs, root causes, etc.

Q: Insulin market has bypassed generic production?
A: Yes.
Q: Is AARP working on that at a federal level?
A: Yes, but still room to work at state level.

PT: Sheila Hemphill, Texas Right to Know
Thank you for bringing this bill. She would like to know what the state of Texas is paying for testing strips to go along with insulin.

PT: Dawn White, Nurse and Mother of Child with Type I Diabetes
Support the bill. Described exorbitant costs for child's care.

Q: What do families do when they can't afford insulin for children?
A: Anecdote about a family that had to rely on people donating insulin through basically a black market. Doesn't include other necessary tools such as continuous glucose monitors or insulin pumps.

PT: Reva Verma, Small Business Owner
Support bill. Dealing with diabetes is a constant struggle. In order to keep our health insurance costs in check for my company, we contracted for a high-deductible insurance plan for our employees and myself. For the first few years, it was manageable. Over the last few years, the cost of insulin has soared. Described the extreme financial strain. Has had to make changes to company insurance. Continuous glucose monitor technology has not evolved at the pace of other technology, like phones and computers, etc. It is inefficient in its use of insulin, leading to unnecessary waste. Need better and more efficient technology. If we place a cap on out-of-pocket costs of insulin which does not get passed back to us through increased insurance costs, it will force the development of better technology for blood sugar control.

PT: Bill Hammond, President of Texas Employers for Insurance Reform
Opposed to the bill. Prices for insulin are unconscionable. However, this bill would affect tens of thousands of small businesses in Texas. Businesses in Texas are struggling; health insurance costs are number one issue and this bill will exacerbate that. Please look to other areas to deal with this issue.

PT: Jason Baxter, Director of Government Relations, Texas Association of Health Plans
Oppose the bill. Association is opposed to all co-pay caps. Caps would increase premiums for Texas families and employers. Caps do nothing to lower price of insulin and they do not limit what pharmaceutical companies can charge health plans for the drug. Caps give drug companies an incentive to continue to raise prices with no accountability or transparency. Cap mandates create more problems; give drug manufacturers more power over prices, ultimately driving up cost of care and increasing premiums. Estimates show that cap mandates increase cost of health insurance premiums for employers and families $20-$200 million per year. We believe a better solution is to lower the cost of insulin specifically for Texans with high out-of-pocket costs. Referenced HB 18 as a positive solution.

Registered but not testifying: 6 for; 4 against.

CSSB 827 passed out of committee 7-0.

SB 863, Blanco - Relating to the temporary relocation of a residential child-care facility during a declared state of disaster.
During COVID-19 and in order to comply with public health orders, it became necessary for residential childcare facilities (RCF) to move the children in their care to different locations that were not included on the facility's license application. Current law states that a license or permit is not transferrable, and that their license is automatically revoked if they move the children in their care to facilities not listed on the application. As of February 22, 2021, there were 227 RCFs that reported at least one positive case of COVID-19 of a child or adult who had contact with a child in care. This puts facilities in the position of trying to isolate children within a single setting, which was ineffective and resulted in more cases of COVID-19.

This bill authorizes HHSC to allow RCFs to temporarily relocate children to a new location or provide care to one or more children in an additional location not listed in their application in emergency circumstances.

PT: Jamie McCormick, VP of Public Affairs, Texas Alliance of Child and Family Services
Support the bill. COVID-19 placed an enormous strain on child-serving organizations. Regulatory restrictions impeded proper caregiving. Winter Storm Uri created an additional burden. Residential operations are required to have emergency plans, but the events of the last year are unprecedented. Bill would allow child-serving organizations operational flexibility in times of crisis.

Registered but not testifying: 2 for; 0 against.

SB 863 passed out of committee 7-0.

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