



INTERIM REPORT

TO THE 88TH TEXAS LEGISLATURE

SELECT HOUSE COMMITTEE ON
HEALTH CARE REFORM
JANUARY 2023

**SELECT HOUSE COMMITTEE ON HEALTH CARE REFORM
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2022**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
88TH TEXAS LEGISLATURE**

**SAM HARLESS
CHAIRMAN**

**COMMITTEE CLERK
SCOTT CROWNOVER**



Select Committee
On Health Care
Reform

January 3, 2022

Sam Harless
Chairman

P. O. Box 2910
Austin, Texas 78768-2910

The Honorable Dade Phelan
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm 2W.13

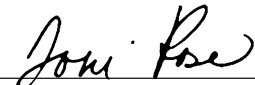
Dear Mr. Speaker and Fellow Members:

The Committee on Health Care Reform of the Eighty-seventh Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-eighth Legislature.

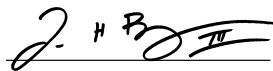
Respectfully submitted,



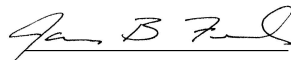
Sam Harless, Chair



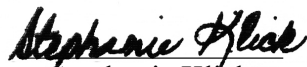
Toni Rose, Vice-Chair



John H. Bucy III



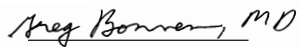
James B. Frank



Stephanie Klick



Tom Oliverson, M.D.



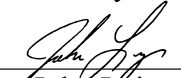
Greg Bonnen, M.D.



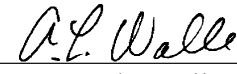
Giovanni Capriglione



R.D. "Bobby" Guerra



John Lujan



Armando Walle

Toni Rose
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Greg Bonnen, John H. Bucy III, Giovanni Capriglione, James B. Frank, R.D. "Bobby" Guerra, Stephanie Klick, John Lujan, Tom Oliverson,
Armando Walle

INTRODUCTION

In the 87th Legislative Session, pursuant to Rule 1, Section 16(b), Rules of the House of Representatives, the Honorable Dade Phelan, Speaker of the Texas House of Representatives, appointed eleven members to the Select Committee on Health Care Reform.

The Committee's membership is comprised of Representatives Sam Harless (Chair), Toni Rose (Vice Chair), Greg Bonnen, M.D., John H. Bucy III, Giovanni Capriglione, James B. Frank, R.D. "Bobby" Guerra, Stephanie Klick, John Lujan, Tom Oliverson, M.D., and Armando Walle.

The Committee conducted two interim hearings. On August 4-5, the Committee covered interim charges 1, 2, and 3. On October 3, the Committee covered interim charges 4 and 5.

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INTERIM CHARGES

1. Study the implications of excessive health care costs on the efficacy of Texas Medicaid and the private health insurance market and the resulting impact on individual Texans, businesses, and state government. Specifically, the committee shall:

Examine the interaction of specific factors of health care affordability such as transparency, competition, and patient incentives. Make recommendations to expand access to health care price information to allow consumers to make informed decisions regarding their care;

Examine the impact of government benefit, administrative, and contractual mandates imposed upon private insurance companies and their impact on employer and consumer premiums and out-of-pocket costs, including the effects of specific benefit and any-willing-provider requirements. Make recommendations for state and agency-level mandates and regulations that could be relaxed or repealed to increase the availability and affordability of private health coverage options in the state;

Review access to and affordability of prescription drugs.

2. Monitor the implementation of, and compliance with current price transparency requirements and study ways that the state can support patients and increase competition. Make legislative and administrative recommendations as appropriate.

3. Evaluate innovative, fiscally positive options to ensure that Texans have access to affordable, quality, and comprehensive health care, with an emphasis on reaching low-income and at-risk populations. The evaluation should include a study of strategies other states and organizations have implemented or proposed to address health care access and affordability. Make recommendations to increase primary health care access points in Texas.

4. Study ways to improved outreach to families with children who are eligible for, but not enrolled in, Medicaid or CHIP, including children in rural areas.

5. Examine the potential impact of delayed care on the state's health care delivery system, health care costs, and patient health outcomes, as well as best practices for getting patients with foregone or delayed health interventions back into the health care system. The study should consider patient delays in obtaining preventive and primary health services, such as well-child care, prenatal care, screenings for cancer and chronic disease, behavioral health, and immunizations, in addition to delays in seeking urgent care or care for chronic illness.

INTERIM CHARGE I

Study the implications of excessive health care costs on the efficacy of Texas Medicaid and the private health insurance market and the resulting impact on individual Texans, businesses, and state government. Specifically, the committee shall:

Examine the interaction of specific factors of health care affordability such as transparency, competition, and patient incentives. Make recommendations to expand access to health care price information to allow consumers to make informed decisions regarding their care;

Examine the impact of government benefit, administrative, and contractual mandates imposed upon private insurance companies and their impact on employer and consumer premiums and out-of-pocket costs, including the effects of specific benefit and any-willing-provider requirements. Make recommendations for state and agency-level mandates and regulations that could be relaxed or repealed to increase the availability and affordability of private health coverage options in the state;

Review access to and affordability of prescription drugs.

Testimony

The committee heard testimony from Dr. Marty Makary, representing himself.

Dr. Makary is a New York Times bestselling author and health care expert at Johns Hopkins University. He writes for The Wall Street Journal and served in leadership at the World Health Organization. Marty is the recipient of the 2020 Business Book of the Year Award for his most recent book, *The Price We Pay*.

Dr. Makary stated that the U.S. healthcare system is one full of pricing failures, inappropriate care, and middlemen who take a large amount of the money out of the system. He stated that it is estimated that up to a third of our collective health care spending is going to things that have nothing to do with health. He stated that the U.S. spends roughly 48% of all federal dollar on healthcare and its many hidden forms.

Dr. Makary advocates for greater up-front pricing by hospitals. He stated that the U.S. needs open and efficient marketplaces. Dr. Makary described that hospitals state that they operate on very thin profit margins, but he stated that hospitals are about to have their largest profit margin in history. Dr. Makary states that some many hospitals price their services and bill fairly, but that predatory billing prices are a disgrace.

Dr. Makary stated that Pharmacy Benefit Managers (PBMs) serve as a middleman in the U.S. healthcare system. He stated that most countries do not have a PBM industry. He stated that these middlemen accept "kickbacks," called rebates, from pharmaceutical companies. He stated that sometimes PBMs share a portion of these rebates to the patient.

Dr. Makary mentioned that value can be found for patients using services such as GoodRX.com. He stated that the price of a drug can be significantly lower without the influence of artificial co-pays created to steer patients to more expensive medications, with the employer paying the cost.

Dr. Makary stated that when employers want to provide healthcare for their employees, they buy health insurance and a pharmacy plan. He stated that employers frequently do not fully understand the operations of a pharmacy plan, and oftentimes go with one suggested by insurance companies. He stated that there is oftentimes price gouging on the pharmacy plans that employers cannot understand.

Dr. Makary stated that it is the right of the patient to demand an ability to appeal a bill if they think that it is unfair. He stated that a large amount of bills from hospitals have errors on their itemized bill.

Dr. Makary stated that he is pleased with the emergence of relationship-based clinics. They get paid in a lump sum format, either from an employer, or from Medicaid. He stated that they attempt to address the root causes of chronic illnesses.

Dr. Makary stated that it is a mistake to throw good money after bad into this broken healthcare system, and if this continues, it will erode into every other national priority.

The committee heard testimony from Antonio Ciaccia, representing 46brooklyn Research and 3 Axis Advisors.

Mr. Ciaccia stated that while there are many smaller, independent players at each layer of the drug channel, it is reasonable to assume that the primary goal of the largest publicly traded companies is to increase returns to shareholders. The profit incentive is not wrong, but it is vital to understand the incentives that drive supply chain behavior. In the effort to control prescription drug costs, a proper calibration of incentives is necessary to ensure efficient spending and maintain robust access to pharmaceuticals. When prices are hidden, and set by private deals, they become prone to manipulation.

Decades ago, as more medicines entered the market and prescription drug costs grew, plan sponsors sought ways to hold spending accountable. Pharmacy Benefit Managers (PBMs) were brought in to act as friction against drugmakers, wholesalers, pharmacies, and other members of the supply chain. As PBMs worked to control one end of the drug supply chain, they began to develop business interests in the very marketplace that they were hired to control.

Mr. Ciaccia stated that PBMs advertise that they are the only entity working to control prescription drug costs, but data shows that PBM profits generated off prescription drug transactions heavily distorts their incentives to control drug spending for their clients.

Prior to 2021, the number of annual drug price increases on brand-name drugs had declined each year since 2015. In 2021, more brand drugs went up in price than in years past, with 1,260 list price increases, the highest number of price hikes since 2018. However, the size of price increases was smaller. The 2021 median price increase was down to 4.8%, the lowest amount in a decade. The weighted average price increase was down to 5.3%, also the lowest price in a decade.

Brand drug manufacturers offer rebates to insurers and PBMs for preferential formulary placement, thus lowering net costs. However, federal officials have questioned the utility of these rebates, due to the likelihood that manufacturers are inflating their list prices in order to accommodate for rebate concessions.

Mr. Ciaccia stated that it is difficult to accurately understand if true brand drug costs are going up or down. Brand drug manufacturer rebates to PBMs, insurers, and "rebate aggregators" are confidential and vary widely from plan to plan, and program to program, therefore, it is difficult to pin down the net price being actually paid. Because governmental entities such as Medicaid command such large rebates, smaller payers and patients who pay out-of-pocket pick up a disproportionate share of the overall cost. Each plan/PBM promotes utilization of different drug mixes, therefore "apples to apples" comparisons of overall net costs are very difficult to make.

The inability to objectively determine what a fair price should be hinders the ability for true market forces to pressure drug supply chain margins and promote quality and efficiency. List prices for prescription drugs are wildly overinflated relative to their actual cost. PBMs use Average Wholesale Prices (AWPs) as the basis for their pricing guarantees to pharmacies and plan sponsors. Brand name drugs with high AWP that are offset by negotiated rebates and discounts that make those net prices much lower. Generic drugs have high AWP (derived from brand drugs) that in no way reflect the actual prices pharmacies pay to acquire those drugs. The "actual" prices of both brand and generic drugs are hidden from the plan sponsor and patient.

Mr. Ciaccia stated that as more and more states uncover the variety of ways that PBMs and pharmacies can generate unwarranted profits from subjective, over-inflated prescription drug mark-ups, Medicaid managed care programs have worked to eradicate the problems and generate significant savings by carving out pharmacy benefits from managed care or to move to alternative single PBM models where the state has full line of sight into the flow of money into the drug channel and prices are based on objective pricing benchmarks (AAC, NADAC) that reflect the actual costs of medicines and services rather than the invented prices of conflicted vendors. Mr. Ciaccia recommended adopting similar philosophies into the Texas Medicaid pharmacy program and other state pharmacy benefits programs as a means to better align incentives, ensure state priorities aren't compromised, create a more equitable payment model amongst pharmacy providers, and save taxpayer dollars on drug spending as a whole.

In his experience auditing PBM contracts and drug pricing data, Mr. Ciaccia stressed the importance of understanding the compensation models that PBMs rely upon to generate revenue. Often, he reported that prescription drug costs become most inflated when the PBM is given excess latitude to add hidden, undefined spreads or markups on top of pharmacy transactions. This can be done through traditional spread pricing, effective rate "claw backs", specialty pharmacy upcharges, patient steering, and drugmaker rebate harvesting. Mr. Ciaccia's counsel to plan sponsors is to isolate PBM compensation to transparent revenue streams that do not present conflicts with the plan sponsor's desires to control prescription drug costs, with all other forms of revenue to be passed through in full to the plan sponsor.

Mr. Ciaccia stated that issue of patient steering is complex. In an ideal world, the patient would be able to choose whichever healthcare provider best meets their needs. While many plans still grant patients a vast amount of choice, there are others that do not. If we were to suppose that some plan sponsors may prefer to confine patients to providers preferred by the PBM or health plan for reasons of lower cost or higher quality, then it may seem reasonable to allow for more restrictive networks that nudge or even force patients to use PBM or plan preferred providers. However, Mr. Ciaccia reported that this power is also often used by PBMs to create networks that can push or force patients to use higher cost or lower quality providers – often directing patients to use pharmacies owned and operated by the PBMs themselves. While a number of states, including Texas, have attempted to curtail the collateral damage that can arise from patient steering, Mr. Ciaccia recommended that plan sponsors either control for or eliminate this conflict of interest that allows PBMs to push patients to pharmacies they own, where the PBM can set the rates that are paid and charged to its affiliated pharmacy.

Mr. Ciaccia stated that a number of states are pursuing policies that disallow hidden PBM markups on prescription drug claims. This includes bans on spread pricing, which is where

PBMs pay pharmacies one rate for a drug, but then bill an entirely different rate back to the plan sponsor that ultimately pays for the claim. The PBM and/or health plan then retains the difference or “the spread.” Mr. Ciaccia strongly recommends that plan sponsors disallow the non-transparent, arbitrary PBM spreads.

Mr. Ciaccia stated that across the country, one of the first unilaterally agreed upon pieces of policy were state and federal prohibitions on PBM “claw backs”, where PBMs would direct a pharmacy to collect patient cost sharing amounts that would be later clawed back partially or in full by PBMs. Mr. Ciaccia believes that this policy is captured within the spirit of transparent, pass-through pricing requirements mentioned above.

Mr. Ciaccia discussed another warped incentive within the prescription drug marketplace, where PBMs can be compensated by drugmakers in exchange for preferred status on PBM formularies. These “rebates” can be retained by the PBM, passed through to the health plan, or some combination of both. Mr. Ciaccia stated that in recent years, what is technically labelled as a “rebate” in PBM contracts with plan sponsors changed, with loose contract language and pricing complexity enabling PBMs with latitude to pocket drugmaker price concessions without passing them on. Mr. Ciaccia reported that these incentives can cause PBMs to prefer or even require patients to take higher priced medicines than cheaper alternatives. Unfortunately, for many patients – especially those in high-deductible health plans – they are stuck paying the inflated price at the pharmacy counter, even though the PBM may have received a sizable rebate concession from the drugmaker that is tied to that patient’s transaction. In an effort to ensure that patients benefit from drugmaker discounts, a number of states have pursued “share the savings” legislation where patients are required to receive the discounted rate rather than PBMs or health plans keeping the discounts for their own purposes. Again, as mentioned above, this is also a policy philosophy that is captured within the spirit of transparent, pass-through pricing requirements mentioned above. Mr. Ciaccia stated that patients and plan sponsors should receive all applicable discounts that are available on medicines and that PBM profits generated on rebates can create perverse incentives to inflate the costs of medicines or over-utilize high-priced medicines, and thus should be prohibited.

Mr. Ciaccia stated that a number of states have implemented reverse auction bidding processes for PBM services in their state. While the integrity of the PBM contract terms is the most important from Mr. Ciaccia’s perspective, he felt that a reverse auction with a well-defined and well-aligned PBM contract can be an effective way to optimize efficiencies within the PBM contracting process.

Ultimately, a lot of the reforms and strategies that can be implemented to optimize PBM functionality and maximize savings on prescription drugs stem from returning PBMs to their origins where their incentives were almost exclusively aligned with controlling costs on behalf of plan sponsors, according to Mr. Ciaccia. He explained that any PBM revenue stream that can conflict with the desires of the plan sponsor can and should be eliminated, or at a minimum, should be transparent and right-sized relative to the value being provided. Some states have

pursued similar strategies, and even seeking fiduciary obligations for PBMs when it comes to their work on behalf of plan sponsors. Regardless of the policy debate involved with fiduciary status for PBMs, Mr. Ciaccia argued that the spirit of the policy goal is consistent with approaches he recommends for better aligning PBM incentives with controlling the costs of medicines for payers.

The committee heard testimony from Blake Hutson, representing the Texas Association of Health Plans

Mr. Hutson started by stating that Texas spends nearly \$20 billion dollars on drugs in the commercial market. This is 46% more than the next largest state in regards of spending, California, which has a 34% larger population than Texas. Mr. Hutson stated that the average initial list price for new drugs went from \$2,115 in 2008 to \$180,007 in 2021, equivalent to 20% annual inflation.

He went on to explain that list prices aren't up for negotiation or rebates as they have no competitor and mentioned House Bill 2536 from the 86th session that created drug price transparency but noted that drug manufacturers are frequently not following this law. Mr. Hutson went on to discuss what he called the most expensive drugs on the market, which are those administered in hospitals and cancer centers. He explained that new transparency laws have really given us some great information about what's happening with the markups for those drugs in those facilities and noted that even Pharma has research that found that over 80% of hospitals markup drugs 200% or more, and other research shows that National Cancer Institutes were marking up drugs up to 634%. As a comparison, he noted that Medicare states that you can't mark up these drugs more than 6%. Mr. Hutson explained the health insurer's response is to bring in the same drugs from outside specialty pharmacies to meet the patient for their appointment through a process called "white bagging" to ensure that high-cost markups could not be applied.

Mr. Hutson added that we need incentives for patients to make smart value driven health care decisions and this is a big part of what health plans try to do through different cost sharing. He explained that when there's a name brand and a generic on the market, the generic is going to be quite a bit cheaper with a lower copay or out-of-pocket cost. He then explained that pharmaceutical manufacturers want to keep a patient on the more expensive brand drug, so they offer to pay off that cost-sharing with coupons and remove the incentive for you to choose a lower cost alternative. Mr. Hutson stated that Medicare bans the practice as a kickback and these coupons don't go to uninsured people, but only the people with commercial insurance, while they are in their deductible period. Mr. Hutson then showed an example of what he called the fine print language that explains these limitations. He added that as we talk about the need for incentives to get people to move to higher value lower cost options in the market this is a clear way that manufacturers are getting in the way of it. He added that pay for delay agreements are sort of complicated lawsuits and counter lawsuits where a brand manufacturer will sue the generic manufacturer to delay market entry and settle with a payoff in exchange for the delay.

Mr. Hutson added that some states have looked at banning this practice and suggested Texas should too. He added that his group is also seeing a lot of money spent on direct marketing to

physicians and that while not all doctors take money from pharmaceutical companies, we do know that about half of them do and studies show that these payments influence prescribing. He cited a study by Memorial Sloan Kettering Cancer Center where researchers looked at 36 studies and found a very clear tie between prescribing patterns and this kind of marketing.

Mr. Hutson then showed a slide showing the amount that nine drug manufacturers spend on sales and marketing versus research and development.

Next Mr. Hutson discussed the committee's charge to review mandates that could be relaxed or repealed to increase affordability in healthcare. He mentioned HB 1919 from the 87th Session that prevents insurers from doing any kind of steering to an affiliated pharmacy, even if it's cheaper and even if it can save the employer or patient money. He said that TRS estimated the bill would cost the program \$70 million per biennium so all state provided coverage was removed from the mandate. He also stated that new innovators in the coverage market have been harmed by the law and told the story of a new smaller health plan that will offer employers a no copay or deductible plan for employees that do a wellness visit annually. The plan wanted to control pharmacy cost by using only an in-house mail order pharmacy but discovered that would be illegal. Mr. Hutson stated that HB 1919 will cost Texas employers and families with insurance over \$4 billion in the first 10-year period.

Mr. Hutson closed by stating that the committee should look at these hospital and physician drug markups, should do better job of enforcement on drug price transparency bill, should review the negative impact of copay coupon schemes and patent games from drug companies, and consider repealing HB 1919 to ensure Texans can get access to the lowest cost drugs.

The committee heard testimony from Dr. Darin Okuda, representing himself.

Dr. Okuda stated that medications meant to address chronic diseases, such as disease-modifying therapies (DMTs) for Multiple Sclerosis (MS), as well as other chronic diseases, are distributed to patients in batches, with patients frequently receiving 30-days of a 3 month refill in close succession. Patients often struggle with medication compliance and persistence, particularly in the face of tolerability issues.

With nearly two dozen approved MS DMTs now available, switching drugs, due to patient preference, side effects, cost, or efficacy, is relatively common. When a patient does switch drugs, the remaining supply of the initially prescribed drug stays with the patient, unused, or is discarded.

Dr. Okuda stated that the problem may be far greater than most clinicians realize. The magnitude of unused DMTs from patients with MS has never been quantified and the impact of such therapies in the context of the overall burden of care in MS remains poorly understood. Despite widespread concern about the costs of DMTs in MS, the true prevalence of the problem of wasted medication remains.

Investigators led by Okuda set out to quantify just how much DMT waste was occurring and why. What they weren't prepared for was to fill an exam room of an MS clinic with millions of dollars worth of unused, life-altering drugs in a matter of months.

The findings suggest a much more pervasive problem than what is visible at the surface, implying that a one-size-fits-all approach to treatment counseling and patient education may not be sufficient, especially in underserved populations and those at greater risk for more aggressive disease based on race or ethnicity.

This not only represents a mechanism for reducing medical waste, but also emphasizes the necessity for enhanced education and mindful communication with patients to ensure proper management and long-term care.

To better understand the problem, Okuda and colleagues launched a single-center study that included new and existing patients seen in the clinic from January 1, 2018 to December 31, 2018, during which patients voluntarily disposed of their FDA-approved DMTs within the clinic. Participants could complete an optional survey about treatment experience and therapy transition, with discontinuation data captured via a comprehensive questionnaire. In addition, Okuda and colleagues conducted a 1-month prospective study between November 1, 2018, and December 1, 2018, during which a more pronounced push to collect unused DMTs occurred, with all participating patients required to complete a comprehensive survey that included information on past clinical history and reasoning for treatment transitions.

Ultimately, 422 patients were enrolled in the study, of which 73.2% were female and 86.3% were white, with a mean age at disease onset of 32.9 years, mean disease duration of 12.8 years, and mean treatment duration of 2.86 years. The majority of patients were covered by commercial insurance (79.9%) or Medicare (19%).

Notably, nearly 60% of patients switched DMTs for non-medical reasons, 54% for medical reasons, and 41% for reasons related to medication tolerability. Men were less likely than women to switch DMTs due to injection fatigue or wanting an oral medication. Black or African American patients with MS were 91% more likely to want to switch to an oral medication due to injection fatigue and 221% more likely to switch based on perceived lack of efficacy relative to white patients with MS. Patients taking injectable DMTs had a 396% greater risk of switching based on perceived efficacy compared with those on monoclonal antibody treatments, with a similar trend observed among those taking oral DMTs compared with those receiving infusion-based therapies.

A lower risk of switching due to medical reasons was observed in patients on oral or injectable DMTs versus those taking infused or monoclonal antibody treatments. Black or African American patients were 50% less likely to switch treatments due to side effects compared with whites, with a general trend showing that a history of exposure to a greater number of prior DMTs resulted in decreased risk of switching due to side effects.

In terms of status of the unused medications, nearly 29% reported continued use of previously prescribed DMTs before starting new treatment, 22.7% reported discarding them, 22.4%

reported storing the unused treatments in their home, 15.4% returned them to the clinic, 7.8% returned them to their local pharmacy or fire department, and nearly 3% reported giving their unused DMTs to other patients with MS.

Over the course of the 1-year study, the commercial value of the retrieved unused DMTs amounted to \$5,152,632.02 based on average wholesale price (2018), with projected cost increases of approximately 10% adjusted for 2021 values. Among those enrolled in the 1-month prospective study (n=49), acquired unused DMTs amounted to an average wholesale price of more than \$1 million based on 2018 costs, translating to roughly \$21,600.00 per patient.

The staggering degree of waste observed, both in healthcare costs and unused drugs, emphasizes the need for treatment strategies aimed at more than just factors related to therapeutic efficacy. It is hoped that the data about unused DMTs provide insights that shed light on reasons for lack of compliance and discontinuation and inspire clinicians to look at the implicit biases in our system and our practices that disrupt medication adherence so that we may provide more individualized counseling and culturally competent care.

Given active and ongoing discussions surrounding costs of specialty therapies, and the likelihood that DMT discontinuation will only continue to increase over time given the aging MS population, new treatments slated to hit the market, and an increasing number of people diagnosed with MS due to advances in diagnostics and disease treatment strategies, identifying a solution to this problem is paramount and would ultimately benefit the healthcare system.

Dr. Okuda stated that reducing U.S. health care cost may be as simple as only paying for treatments that are actually used by consumers.

The committee heard testimony from Leigh Purvis, representing the American Association of Retired Persons (AARP).

Ms. Purvis stated that AARP is interested in prescription drug issues due to their prices. There are now prescription drugs with seven-figure price tags. Increasing drug prices hit older Americans particularly hard. Most Medicare beneficiaries live on relatively modest incomes. The median income is just under \$30,000 and one-quarter have incomes of less than \$17,000. They also have limited financial resources—one-quarter have less than \$8,500 in savings. In other words, this is not a population that has the resources to absorb high and increasing prescription drug prices, and many are facing the very real possibility of being unable to afford the medications they need. High-priced specialty drug approvals have exceeded traditional drug approvals since 2010 and the number of people using such drugs is growing. Meanwhile, the research pipeline is full of products like orphan drugs, biologics, and personalized medicines that do not face much competition and will undoubtedly command even higher prices in what appears to be a never-ending race to the top. A recent analysis found that average prices for newly marketed prescription drugs in the United States grew by 20 percent per year from 2008 to 2021, amounting to a tenfold increase in just over a decade. Further, nearly half of new drugs launched in the past two years were priced at more than \$150,000 per year, compared with fewer than 10 percent of drugs introduced at this price level in 2008.

Additionally, the prices of existing prescription drugs are also growing rapidly. AARP Public Policy Institute's latest Rx Price Watch report found that the retail prices for widely used brand name prescription drugs increased at more than double the rate of inflation in 2020. The average annual increase in retail prices for the products that we study has exceeded the corresponding rate of inflation every year since at least 2006.

The average annual cost for widely used brand name prescription drugs—now around \$6,600—would have been almost \$3,700 lower if retail price changes had been limited to general inflation between 2006 and 2020. Unfortunately, older adults are particularly vulnerable to these trends. Older adults take an average of between 4 and 5 prescriptions per month, and over two-thirds have two or more concurrent chronic illnesses. Thus, when AARP talks about high prescription drug prices, we're often talking about costs that patients will face every year for the rest of their lives. Regrettably, AARP is very familiar with how high prescription drug prices affect older Americans. AARP regularly hears from members who are desperately seeking help because they cannot afford their prescription drugs. These calls are not limited to just a few drugs and conditions. She stated that she heard from people who need everything from insulin to eye drops to multiple sclerosis drugs. And in most cases, there was very little that AARP could do. Unfortunately, these patients are ultimately forced to make trade-offs. Do you pay rent, or do you take your prescription drugs as prescribed? Or do you simply go without, which ultimately increases health care costs down the road. AARP is also mindful that the problems created by high drug prices are not limited to people who are actually taking prescription drugs. Spending increases driven by high and growing drug prices will eventually affect all Americans in some way. They are passed along to everyone with health coverage in the form of increased health care premiums, deductibles, and other forms of cost sharing. Further, increased costs for taxpayer-funded health programs like Medicare and Medicaid will eventually affect all Americans in the form of higher taxes, cuts to public programs, or both. In other words, every single person in this room is already paying for these products.

Ms. Purvis stated that AARP supported Texas' new laws that improve drug price transparency, which will counterbalance the longstanding argument that high drug prices are a reflection of various unknowable factors. Texas' transparency law sheds some light into what has been a tightly sealed black box. The information gathered will finally help us begin to evaluate the true impact of growing prescription drug prices, as well as whether price increases are based on anything more than what the market will bear. Ms. Purvis stated that they already know that public payers (and therefore taxpayers) will benefit from this type of mechanism. Given the realities of state budgets and the budget process, it can be incredibly difficult for them to successfully accommodate unexpectedly high drug price increases. AARP is particularly supportive of any efforts that get at the heart of the problem—the prices set by drug manufacturers. While AARP appreciates that there are always efficiencies to be gained in a system that's worth hundreds of billions of dollars, it's also important to recognize that a great deal of effort has been devoted to diverting attention to other parts of the drug supply chain over the past several years. Ms. Purvis stated that the reality is that drug companies and drug companies alone are responsible for setting drug prices and the most effective solutions will reflect that fact. Prescription drug price reforms are also very popular with the public: multiple surveys have found that the vast majority of the 50+ population--on both sides of the political aisle—say that policymakers should take action to make medications more affordable. Ms.

Purvis stated that AARP has no interest in solutions that will hamper true innovation. However, research has consistently demonstrated that there is no correlation between drug prices and innovation. In addition, some experts believe that drugs are increasingly becoming innovative in name only, as evidenced by the fact that more than three-quarters of the drug patents awarded in recent years were for recycled or repurposed drugs. At the patient level, it's important to keep in mind that the most innovative drug in the world will be worthless if they can't afford to use it.

Ms. Purvis stated that current prescription drug price trends are not sustainable or manageable, especially when it's not right to ask patients and taxpayers to continue spending on prescription drugs that have been priced on the basis of what the market will bear. Thoughtful efforts to help reduce prescription drug prices could save Texas millions of dollars. More importantly, they will help ensure that all patients have affordable access to the drugs that they need to get and stay healthy.

The committee heard testimony from Melodie Schrader, representing the Pharmaceutical Care Management Association.

Ms. Schrader stated that a pharmacy benefits manager (PBM) is a health care company hired by insurers, employers, and government programs to administer their prescription drug benefits. She stated that PBMs aggregate the buying clout of millions of health plan enrollees, enabling plan sponsors and individuals to pay less for prescription drugs.

Ms. Schrader stated that PBMs perform a variety of services to ensure high-quality, cost-efficient delivery of prescription drugs to consumers. She stated that 93% of employees are satisfied with their PBM. Ms. Schrader stated that 266 million Americans rely on PBMs to help meet their prescription drug needs.

Ms. Schrader stated that pharmacy benefits account for 23% of the medical dollar. According to Ms. Schrader, PBMs negotiate on behalf of plan sponsors and administer the outpatient prescription drug portion of the health care benefit, in a high-quality, cost-effective manner. She stated that PBMs are expected to save one trillion dollars in ten years nationally. She stated that PBMs are the only entity in the prescription drug chain whose purpose is to lower costs for their customers.

Ms. Schrader stated that 66 full-service PBMs create a diverse and competitive marketplace. She stated that PBMs differentiate themselves through product innovation and customer service. Ms. Schrader explained the Request for Proposal (RFP) process. The RFP process dictates the terms and conditions of the PBM services, including performance guarantees, audits, controls, and compensation models. Multiple PBMs bid in a highly competitive market. PBMs offer various design models and compensation terms, depending on a plan sponsor's specific needs. The plan sponsor may utilize benefit consultants for direction. The plan sponsor determines its financial and care management need. According to Ms. Schrader, the plan sponsor makes the final decision about the drug benefit plan.

Ms. Schrader stated that health plans and PBMs do not have any control over the price the manufacturer sets for a drug, but she said that they do have some tools to drive down drug costs. She stated that patient cost-sharing often represents only a small fraction of the total cost of the drug. She said that brand drug manufacturers establish prices within a monopoly established by federal patent law. She stated that until other drugs are approved for the same disease or condition, manufacturers have little incentive to reduce their prices.

Ms. Schrader stated that the plan sponsor always has the final say when creating a drug benefit plan. According to Ms. Schrader, PBMs offer various design models depending on a plan's specific needs. Plans may choose how to compensate PBMs. Performance guarantees and audit rights protect plans and ensure transparency. The plan sponsor determines how drug rebates are used. The plan sponsor determines benefit design, cost-sharing levels, and deductibles. Ms. Schrader stated that clients are not forced to use a PBM but choose to do so.

Ms. Schrader stated that the value of PBM services to society is estimated at \$145 billion annually. If payers had to act as their own benefit managers, without PBMs performing these services, 40% (\$58 billion) of the \$145 billion in value would be lost. Ms. Schrader stated that for every \$22 billion of resources used by PBMs, they return \$168 billion to the system, a 7:1 return on investment for the healthcare system.

Ms. Schrader stated that without management of prescription drug benefit, the market would experience 40-50% more in costs. In this scenario, she stated, there would be no one to make drug manufacturers compete with each other. She said that there would be no competition on price or quality in the pharmacy space. There would be no auditing of pharmacies for fraud, waste, and abuse. There would be no utilization controls that reduce waste and increase adherence. She stated that there would be longer processing times, and that there would be a lack of real-time reimbursement and coverage information for consumers at the pharmacy counter. She stated that there would also be less utilization of generic drugs.

Ms. Schrader stated that there are 23,254 independent pharmacies in the United States as of 2022. She stated that the growth of independent pharmacies in the U.S. was an increase of 13.8% through the years of 2010-2022.

Ms. Schrader stated that over 80% of independent pharmacies in the U.S. are represented by Pharmacy Services Administrative Organizations (PSAOs). PSAOs pool purchasing power of many pharmacies to leverage strength and contracting strategies with payers. PSAOs negotiate and enter into contracts with payers on behalf of independent pharmacies, including reimbursement rates, payment terms, and audit terms. PSAOs also provide inventory and back-office functions to pharmacies. The largest PSAOs are owned by the three major drug wholesalers. Ms. Schrader stated that PBMs have no insight into private contract terms between PSAOs and pharmacies.

Ms. Schrader stated that the state can pass laws that set rates that pay providers more, but the employers and the consumer will pay for these higher costs.

The committee heard testimony from Chris Skisak, representing Texas Employers for Affordable Healthcare.

Mr. Skisak stated that employer-sponsored insurance plans cover half of all Americans. The cost for health care in the United States was \$1.2 trillion dollars in 2018. Hospital costs were estimated at \$480 billion dollars for the same year. Mr. Skisak stated that 50% of all Texas residents were covered by employer-provided health coverage. 75% of employees are reported to consider health benefits in a decision to accept a job. The largest tax break for employers, valued at \$329 billion nationally, lowers the costs of premiums by 32% for employers. Since 1986, small businesses have ranked the cost of healthcare as the biggest problem they face. Medical care services and hospital services have risen above average wage increases for the last twenty years. Hospitals in Texas on average are charging employer-sponsored insurers more than triple the amount that Medicare would pay, raising health care costs for companies and their workers. Mr. Skisak stated that facility fees are also increasing prices for Texas employers and patients.

Mr. Skisak stated that policymakers can restore healthy competition. by adopting the National Academy of State Health Policy's (NASHP) Model Act, which prohibit gag clauses (which prohibit disclosures of price or quality information), all-or-nothing clauses (which prohibit inclusion of all providers and facilities), most favored nation clauses (which prohibit contracting at a lower price), anti-steering clauses (which prohibit navigation to a competitor on price or quality), anti-tiering clauses (which prohibit tiering based on price or quality), and any other clauses which promote exclusive contracting and non-compete clauses.

The committee heard testimony from Christopher Whaley, representing the RAND Corporation.

Mr. Whaley stated that 13.5 million individuals, representing 48% of Texans, receive employer-sponsored insurance through and employer or union. He stated that employers provide health benefits to workers and their families as a form of compensation. He stated that while the employer-sponsored market is large and important, it also faces many affordability challenges. Most notably, the costs to provide employer-sponsored health insurance have increased. It now costs over \$22,000 to provide health insurance coverage to a family, a \$7,000 increase from 2011. Health insurance costs come directly out of worker wages and other benefits. In addition to downward pressure on wages, one prominent response to increasing health care costs has been the rise of high-deductible plans, which require families to cover most health care costs before insurance takes effect. Over the past decade, the average deductible for an individual employer-sponsored insurance plan increased by over \$700, to nearly \$1,700 (a 71 percent increase). The share of workers with a deductible of at least \$1,000 has almost doubled, to 58 percent. Mr. Whaley stated that over half of families with employer-sponsored insurance must pay \$1,000 out-of-pocket before their insurance coverage fully goes into effect. These costs have a substantial impact on consumer finances. In addition to rising costs and higher out-of-pocket expenses, recent attention has focused on consumer debt owed to health care providers. As of February 2022, an estimated 19 percent of Texans have medical debt that is in collections, with an average debt amount of \$835. 34 of the top 100 counties with the largest share of adults who are unable to pay their medical bills are in Texas. Both in Texas and nationally, the share of

adults with medical debt and the amount of medical debt are larger in communities of color than in white communities. Medical debt can have long-lasting impacts on well-being and household finances, including reduced medical care, worse mental health, and lower credit scores.

Mr. Whaley stated that a key driver of rising health care costs for the privately insured population is prices paid to providers. Medicare and many state Medicaid programs set prices administratively. While some variation exists across providers and markets, prices are relatively uniform. In contrast, prices for the privately insured population are negotiated between providers and insurers. This negotiation process has led to wide variation in prices, both across markets and among providers in the same market. It also incentivizes provider consolidation and market concentration as a tool to enhance negotiation leverage. Starting around 2000, prices paid by private insurers relative to Medicare and Medicaid began to diverge, and the gap in payments has grown since. 10 Our recent work has highlighted that employers and other private insurers pay prices that are above 200 percent of Medicare for hospital care. In Texas, private insurance prices are 252 percent of Medicare. Our work and other studies have found that prices also vary widely, with many markets experiencing an order of magnitude variation in prices for the same service. Among major Texas hospital systems, prices vary from below Medicare rates to over 300 percent of Medicare.

Mr. Whaley stated that these prices are not consistently driven by differences in clinical quality or patient outcomes. Prices are also not explained by underpayments from Medicare, Medicaid, or patients without insurance. Instead, prices are driven by the market factors that enable providers to negotiate higher prices with insurers. An important contributor to negotiation leverage is provider market power. Using definitions of market concentration used by the Federal Trade Commission and the Department of Justice to monitor competitive market activity, 90 percent of U.S. hospital markets in 2016 were highly concentrated and were not considered competitive markets.

Applying the same 3 measures to Texas metro areas, only Dallas is a noncompetitive hospital market. Over the 2016–2021 period, there were 490 total hospital transactions, with 44 in Texas. Mr. Whaley stated that a wide body of evidence has linked hospital mergers to increases in prices, with no accompanying change in quality.

Mr. Whaley stated that the competitive landscape for physicians is also rapidly changing. Over the past decade, the share of physicians employed by a hospital or health system has doubled and is now above 50 percent. Hospital employment of physicians leads to price increases through both increased negotiation power and increased referrals of “downstream” services to higher-priced hospital settings. A growing number of physicians work for a practice that is owned by a private equity company, raising concerns of price increases or changes to practice patterns.

Mr. Whaley suggested that a first option is to promote price transparency. While research shows that consumers do not effectively use price transparency to shop for care, price transparency is critical to employer purchasing and state policy decisions. Employers have used price transparency to design benefit programs that incentivize the use of lower-priced and efficient providers. Employers have also used price transparency to monitor prices negotiated on their behalf and, in cases in which these prices do not align with value, have pushed for lower negotiated prices. Price transparency information also enables innovators and entrepreneurs to

develop programs that improve care efficiency. Recent federal policies have expanded the scope of available price information, with requirements that hospitals post rates for common services and insurers post all negotiated rates. In part to improve compliance with these requirements, Colorado recently passed legislation that prohibits hospitals that do not post price transparency information from sending medical debt to collections. While these data are valuable, they do not contain information on the volume of care across facilities or differences in patient composition. These data can be supplemented with data from state-administered all-payer claims databases (APCDs). Currently, 25 states operate an APCD. These APCDs vary in scope and data breadth. Because of the *Gobeille v. Liberty Mutual Insurance Company* Supreme Court ruling, private sector self-funded plans submit to an APCD on a voluntary basis.

Mr. Whaley suggested that a second area of policy innovation comes from the state's role as a large purchaser of health insurance benefits. In many states, the state employee plan is either the largest or among the largest purchasers of health insurance. The size and importance of state employee health plans positions them as an innovator for how insurance benefits can improve the efficiency of care. Mr. Whaley stated that, following the Great Recession in 2009, the California Public Employees' Retirement System (CalPERS), which is the second largest public purchaser of private health insurance in the country, faced budgetary consequences caused by rising health care costs. In collaboration with its workforce, CalPERS designed and implemented a reference-based pricing model, in which patients are given financial incentives to receive care from lower-priced and high-quality providers. Across several procedures, this model has led to sizable financial savings. In addition to CalPERS serving as a model for other employers, the size of the CalPERS population placed downward pressure on provider prices, which benefited non-CalPERS patients. Similarly, the State of Montana employee plan implemented a program that caps hospital reimbursement at a fixed percentage of Medicare. This model led to large savings for the state employee health plan and enabled the plan to avoid rising premium and deductible costs that have dominated the rest of the employer-sponsored market. Other notable examples include the tiered network plans implemented by the State of Massachusetts and State of Minnesota employee health plans. These examples illustrate the power of state purchasers to drive health innovation for private insurance markets. In Texas, the Employee Retirement System and Teacher Retirement System could play a similar role in driving benefit design innovation. Mr. Whaley stated that these innovations would both reduce spending and drive innovation for other employers in Texas.

Mr. Whaley stated that a third potential policy option is to address the underlying market structure factors that contribute to high and variable pricing. Even perfect price transparency and high-powered benefit design programs are of limited efficacy in markets in which patients have few provider options. To promote market competition, some states have proposed additional approval and oversight of hospital mergers. He said that, while well-intentioned, policies such as Certificate of Need and Certificate of Public Advantage laws can lead to anticompetitive behavior and discourage market entry. These policies can prevent further market concentration, they will have little impact on markets that are already concentrated. Reversing decades of market consolidation is likely not feasible. However, in markets that are likely to remain concentrated, policymakers have options to limit the price effects of market concentration. Some policies propose to limit patient exposure to high prices in noncompetitive markets. Federal and state legislation remove anti-steering and "all-or-nothing" restrictions. The State of California

successfully challenged the prevalence of gag and all-or-nothing contracts used by a dominant health system. Existing evidence finds state restrictions on “most-favored-nation” clauses, in which health care providers and insurers agree to not lower prices, lead to meaningful reductions in prices in markets with concentrated hospital and insurer markets.

Mr. Whaley stated that these policies use direct regulations to limit the price consequences of market power. Alternative approaches include policies that place indirect pressure on prices. One such example includes limiting out-of-network and surprise medical bills. In existing research, we have highlighted how limiting out-of-network bills can place downward pressure on in-network prices. According to Mr. Whaley, if designed appropriately, these restrictions can both protect patients from unexpected bills and limit the ability of market-dominant providers to negotiate high prices.

Mr. Whaley stated that health care markets in the United States face several challenges. While substantial state and federal policy efforts are focused on Medicare, Medicaid, and uninsured populations, there is relatively less attention given to individuals with employer-sponsored insurance. However, this population is large and faces unique challenges that threaten health care affordability. In particular, rising costs that are driven by price increases place downward pressure on worker wages and other forms of benefits and burden employers that provide health insurance benefits. Without market or policy intervention, it is unlikely that these trends will abate.

Recommendations

- **Consider opportunities to leverage the Texas All-Payor Claims Database to determine true cost impact of benefit mandates.**
- **Continue to review prescription drug rebate data and consider opportunities to ensure rebates are used to lower the cost of coverage.**
- **Ensure that Medicaid prescription drugs maintain continuity of care for members who move between managed care plans and minimizes administrative burden for physicians.**
- **To increase competition, the Legislature should consider prohibiting providers from engaging in price discrimination against those who are uninsured or choosing to not pay with their insurance.**
- **Explore ways to empower patients to shop for their care, select the options that suit them best, and be financially rewarded when they choose lower-cost services (as consumers are in any functioning market). In particular, the Legislature should address that insurance plans are currently prohibited from offering enrollees lower cost-sharing amounts for seeking more-efficient, high-quality care.**
- **Consider removing the prohibitions on Multiple Employer Welfare Arrangements serving employees across industries and self-employed people.**
- **Explore ways to prohibit hospitals from charging facility fees for services not provided on a hospital's campus.**
- **Explore the Legislature's role in keeping costs down for state paid medical plans, specifically ERS and TRS.**

INTERIM CHARGE II

Monitor the implementation of, and compliance with current price transparency requirements and study ways that the state can support patients and increase competition. Make legislative and administrative recommendations as appropriate.

Testimony

The Committee heard testimony from David Balat, representing the Texas Public Policy Foundation.

Mr. Balat is a former healthcare executive and hospital CEO of nearly two decades prior to his current position. Mr. Balat testified that health expenditures grew nationally by 9.7%, or 4.1 trillion dollars in 2020, averaging \$12,530 per person. 1.3 billion went to paying for hospital care alone and those numbers continue to climb.

Revenue growth for hospitals continues to climb year after year since 2010, largely due to consolidation while the number of hospitals in Texas is on the decline, due to hospital closures. According to an Arcadis report, 90% of Americans are living in a “non-competitive environment where hospitals have become more and more powerful. Such an environment is less competitive and more expensive for communities and the hospitals that serve them. This was the focus of price transparency laws passed during the 87th Session of the Texas Legislature. According to Mr. Balat, these laws were an important first step in making hospital care a more competitive and affordable market. Mr. Balat indicated that hospitals seem to be dragging their feet in becoming compliant. Some hospitals are posting their prices and some benefit is being realized. An important component of price transparency is the employers seeking high quality and low-cost providers.

Organizations such as the Texas Public Policy Foundation have been able to identify great variations in pricing within the same hospital, for the same procedure. That same variability surfaces across hospitals, with the same insurer, for the same procedure type, even within a given region. There’s just no consistency in billing for Texas patients. Even with price transparency laws, it is still difficult for patients and employers to navigate. This is largely due to a billing tactic known as “unbundling.”

Mr. Balat gave examples of hospital systems that use and advertise “bundled” services that include facility costs, surgeon, anesthesia, and other services. The Texas Family Hospital System in Texas is just such an example. Some of these systems offer discounts for those paying in cash for imaging services. Another examples of service-based pricing from a Texas system is Green Imaging, who offers computerized tomography (CT) scans for \$450 to \$500 dollars.

The majority of hospitals work in “non-competitive” markets, so information is being hid from consumers, not competitors. Patients should know the price, not the estimated price, so as consumers they can compare the costs of a scheduled procedure among providers. While the “No Surprise Billing Act” requires a good faith estimate for those scheduled services, that estimate can be rendered meaningless due to a wide range of prices.

Representative Oliverson asked the question of Mr. Balat about being able to compare pricing structures across different types of facilities. Under the Emergency Treatment And Labor Act (ETMALA) certain facilities do not get to pick and choose who they provide services for and other cash-based discount programs or facilities do not. Representative Oliverson suggested that the cost of services for those unable to pay was being spread across other patients as a "baked in" cost.

Mr. Balat responded that there was a way to do pricing for both hospitals and surgery centers, particularly for scheduled procedures. Patients should be able to see bundled pricing "up front". Other businesses have to deal with some of those same decisions for issues of profitability when there is waste or theft that is built into their pricing structure.

Representative Bonnen questioned the witness's understanding about who would pay for "bundled costs" on procedures such as knee replacement, arthroscopy, or spinal surgery, since the costs are so high that many elect to use the insurance and just pay their deductible and co-pay costs. Representative Bonnen felt the program hasn't gained in popularity like they thought it would.

Mr. Balat responded that a number of companies that are self-funded are paying out of their own pocket and giving employees the ability to choose the provider and even removing deductible costs for selecting providers that offered bundled services. Agreeing that progress has been slow, they hoped that would improve and become more recognized in the future.

In response to Mr. Balat's testimony Representative James Frank commented the difficulties of employers providing incentives for alternative approaches in healthcare savings and the obstacles to following that path. He felt like insurance companies increased costs based on claims, so their risk was marginalized.

Representative Bonnen also commented that employers can be intimidated because some the larger carriers would discourage those forms of alternate payment paths, while the state, through the Texas Teacher Retirement System (TRS) or the Employees Retirement System (ERS) could address that approach straight on.

Representative Harrison asked Mr. Balat what his organization was seeing regarding the Health Reimbursement Arrangement rules approved by the federal government in 2019 that provided different health-care options for employers and employees.

Mr. Balat responded that they are seeing a little bit more health reimbursement and it allows the employer to provide a pool of money for the employee to purchase ACA compliant plans, but not exactly the same thing.

Representative Lujan had questions regarding a Texas Public Policy Foundation (TPPF) article about Pharmacy Benefit Manager (PBM) reform in West Virginia and whether he recommended Texas investigate a similar approach.

Mr. Balat responded that West Virginia's approach passed all the rebates back to the patients according to state law and while most insurers felt there would be a commensurate increase in premiums, that in fact did not appear to be the case. There were more experienced witnesses who had testified already that Texas' focus should be on the lowest drug price and not the biggest dollar savings.

The Committee heard testimony from Marilyn Bartlett, representing the National Academy for State Health Policy (NASHP).

Regarding "reference-based pricing". Ms. Bartlett testified that through her work on the Montana State Employee's Health plan, she learned that obtaining reliable pricing data was often difficult and that "value-based systems" did not provide as much savings as a "reference-based pricing" approach. "Reference based pricing" would change the focus on billing to a pricing starting at a reference price for a service as opposed to a process based off of a discount for charges for services billed. Ms. Bartlett compared it "cost plus". In their case, they used Medicare pricing as the benchmark and paid a percentage of the Medicare price. She said Medicare pricing was commonly used and are intended to be fair. Medicare pricing is also adjusted index, severity, and risk-based geography. The Medicare cost reports are the only public source of hospital costs.

In the case of hospital costs the breakeven median for Texas hospitals over time is 135% of Medicare. She indicates that on median Texas hospitals could charge the average rate of 135% of Medicare to break even.

In the case of the Montana health care costs, the "referenced based pricing approach" was able to stabilize the viability of their actuary and saved them twenty-five (25) million dollars.

The Committee heard testimony from Dr. Peter Cram, representing himself and the University of Texas Medical Branch.

Dr. Cram stated that he is a physician and health policy researcher, doing this work for over 20 years. His research focuses on comparing cost and quality in acute care hospitals and comparing the US healthcare system to that in other countries. In the US we spend about 20% of the total economic output from our GDP on healthcare. That equates to something like \$11,000 per individual on healthcare. In Canada, for example under single payer, they spend something like \$7,500 per person per year. In spite of paying more per person per year, we aren't healthier, happier, or have better healthcare.

For the last fifty years in America, healthcare prices have grown faster than the US economy. While inflation drives up prices on goods and services, healthcare prices outpace them all, while wages remain stagnant, and the average worker see no changes in the paycheck. Historically, patients have the motivation to seek better pricing, but don't have the means. They don't know what their co-pay will be at the drugstore, the doctor, or the imaging center, making them at the mercy of the provider location where they are referred.

The era of accessible health data is new and tools for analyzing and researching it haven't really even been developed at this point, but what we are seeing is eye opening. We are seeing

differences in hospital pricing from 50% to 400% or 500% for what are identical services. Price transparency initiatives have a chance to be incredibly transformative but could be highly disruptive, but that isn't always a bad thing. Given the outcome, transparency could push the outcomes to a financial benefit for the patient or begin to limit choices.

Representative Frank asked Dr. Cram about the variation of cost in a competitive market when researching or shopping for providers and he wanted to know the difference in an individual would pay based on insurance. Dr. Cram responded that some states have programs set up to return rebates back to the consumer, but Texas has not yet done that. Representative Frank commented that currently, the consumer's cost is so high that they aren't motivated or incentivized to shop elsewhere, so they don't.

Representative Bobby Guerra asked Dr. Cram what position Texas was in under the "managed care" program. Coordination doesn't seem to work, and the managed care approach seems to be a nightmare. Did managed care accomplish its intended goals? Mr. Cram responded that that he expected some oversight, but managed care hasn't delivered on its promises.

Representative Oliverson pointed out that Dr. Cram has mentioned hospital price transparency, health plan price transparency, and no surprise billing. This is being done at the federal and state level and while Texas is leading the curve in that area, higher compliance is necessary. Representative Oliverson asked what Texas was missing and what should be the next step for Texas? Dr. Cram answered that innovation and research tools would help with starting to solve some of the problems and it could be research tools like are being built by Turquoise or it could be a phone app from a young university student.

Representative Oliverson asked for Dr. Cram's thoughts on fiduciary responsibilities for ERISA plan administrators who paid outrageous amounts for claims, like \$10,000 or \$20,000 for things like simple COVID tests. Plan administrators are supposed to be working for the best deal and to protect consumers against unreasonable claims. What do we do when the system break down like that? Mr. Cram deferred to an upcoming and more experienced witness Chris Whaley from the Houston Business Coalition for a better explanation on that.

Representative John Bucy asked Dr. Cram about the impact of the uninsured on market prices. Dr. Cram responded that there are a couple of factors. First charge shifting happens where providers charge more to people with greater ability to pay or better coverage to pay, as a way to spread the cost of the 18% of uninsured patients across paying patients. He indicated that models works if everyone pays their fair share. But geography affects balancing out those costs because medical needs are shifted to where some hospitals have a less lucrative mix of patients. It is more evident in areas like preventive care. Representative Bucy asked if costs are going up by not having preventive care for the uninsured and Dr. Cram responded that not having access to preventive care does impact the quality of life and shows up in blood pressure, mental health, and diabetes. Representative Bucy asked that given the imbalance and the strain it has, what is the solution for the Texas Legislature. Dr. Cram responded that while his experience in Canada indicates you can achieve a basic level of service in that model, he didn't really have an opinion on whether that was the way to go.

Representative Harrison commented that given the impact of market competition on healthcare plan pricing, there remained a lot of benefit still waiting to further improve saving. Dr. Cram indicated he totally agreed with that sentiment and that price transparency could unlock some of the savings. Representative Bonnen commented that the reason it hasn't worked as well in Texas is because we don't have genuine competition. Therefore, I can't be as effective as it should be. Dr. Cram stated that it will take some time, maybe a couple of years until we know if the Texas experiment actually worked and can make better decision based on what changes we see.

Representative Bonnen asked Dr. Cram about appropriate role and relationship of employer and insurance providers when it comes to acting as an intermediary for their employee's medical needs. He wanted to know who was driving the relationship and looking out for the employee. It seems the employers are almost more afraid of the payer than they are a partner with them. The employer relies on the payer to represent the employee's needs, negotiate a plan with a fair price, and shop for healthcare, because the employer doesn't have that expertise. Employers have become so dependent on what is now four major players that employers have abdicated the opportunity to search for value and competition in the market and wanted to know Dr. Cram's observations on the subject. Dr. Cram responded that it is not currently working very well and in order for a transformation to occur everyone has to be on the same page and working in concert together. Representative Bonnen asked Dr. Cram another question about the cost spreading affect in covering the medical needs of insured and how revenue streams outside of medical billing support the costs of uninsured treatment. Dr. Cram responded that another part of the shift is revenue generated through the tax base revenues. People don't just pay the medical bills and costs; they also pay property taxes and a lot of that can go to paying the costs for medical treatment of the uninsured. Costs for treatment of the uninsured gets baked into the prices in almost every layer of business.

The Committee took testimony from Debbie Garza, representing the Texas Pharmacy Association.

Ms. Garza is the CEO of the Texas Pharmacy Association and a licensed pharmacist in Texas as well. Several factors account for the cost of prescriptions for a patient at the pharmacy. Generic drugs now represent 90% of all prescriptions filled while they only represent 18% of the overall drug spending. Brand name drugs represent 10% of all prescriptions but account for 82% of the overall cost.

Pharmacy Benefit Managers (PBM) determine and negotiate the cost as the middleman between the health plan, the manufacturer, and the pharmacy. The PBMs set the rules and determine medication type for efficacy, how much reimbursement goes to the pharmacy for dispensing the medication, or at which pharmacy it may be filled. Of the \$5 billion spent for drugs annually, 30% of that cost is attributable to drug rebates. As an example, in 2019 it was \$143 billion dollars. It is not uncommon for a PBM to prefer expansive brand name drug on their formulary, as opposed to cheaper drugs. As rebates increased, list prices for drugs have increased at an even greater rate.

The three largest PBMs now control 80% of the marketplace and all of them are owned by a national health plan or a pharmacy. They all operate retail mail order and/or special pharmacies. Through a system of vertical integration, PBMs have established an “opaque” system they use to steer patients to their own PBM affiliate pharmacies.

Specialty drugs are the fastest growing segment the overall prescription drug marketplace, with expectations for it to increase even further, based on drugs still in the developmental process. The Food and Drug Administration doesn’t define specialty drugs, rather that is a list defined and developed by PBMs, who can make efforts to restrict dispensing of those drugs to their own pharmacies to drive up revenues. Specialty drugs make up 1 to 2% of all drugs prescriptions filled but account for 53% of the overall drug spend. In 2020, just three pharmacies dispense 65% of all the specialty drug prescription medications. Ms. Garza stated that this is not coincidental, these three pharmacies are owned by the three big PBMs.

PBMs are often referred to as a “black box”, since they are the only ones that can see the full cost picture and they often oppose any effort to increase transparency, usually under the guise that it will increase costs, especially to employers.

Representative Frank asked Ms. Garza about how the money gets divided for a person paying \$1,000 a month for a drug. When does the rebate come in and who between the insurance company and the PBM gets the money? Ms. Garza responded that from the pharmacy perspective, they have no clue what the manufacture has paid to a PBM. The pharmacy has contracted a reimbursement rate based on a list price. When the patient comes into the pharmacy they pay a discount plus a dispensing fee for that prescription, which could be \$5 or \$10 if it’s a generic or a percentage off of the \$1,000 drug. The rest is based on the negotiated, contracted rate the pharmacy has with the PBM and don’t really know what that rebate from the PBM will be.

Representative Frank felt like insurance companies might be disingenuous when the claim to have paid out large dollars for pharmaceuticals because they often do not factor in their rebates, often times from PBMs they own themselves. Ms. Garza agreed that was a problem in the commercial marketplace.

The Committee heard virtual testimony from Maureen Hensley-Quinn, a Senior Program Director of Coverage Cost and Value representing the National Academy for State Health Policy (NASHP).

Her comments and testimony center primarily on hospital costs, who represent the largest proportion of healthcare spending nationally. The NASHP has developed a hospital costs tool that uses Medicare cost data submitted by hospitals as of price transparency, so that states and other stakeholders can determine the costs of care.

Texas has larger hospital systems with lots of hospitals in them and very few independent hospitals. In for-profit and non-profit hospitals, the median charge in Texas significantly exceeds their costs, as reported in their Medicare cost reports. This issue is not unique to Texas and the national trends reflect similar numbers. In her experience states like Texas might find is useful to

investigate legislation that improve transparency by preventing anti-competitive practices, or carriers from providing plans that contain gag clauses from contract language in determining costs.

Ms. Hensely-Quinn spoke about a model they have designed for states to create legislation placing restrictions on “facility fees”. As vertical consolidation happens and a health system buys a provider, they add a facility fee. Nothing changes in the services or the provider, but because they have been added to the suite of services under the system umbrella, the price goes up. She also added that it might be worthwhile to permit the Texas Department of Insurance to do audits on contracts with enforcement by the Texas Attorney General as needed.

The Committee heard testimony from Charles Miller with Texas 2036.

Mr. Miller emphasized some of the steps Texas needs to take to improve the healthcare industry. Texas needs to continue to improve price transparency, even considering the progress made thus far, that fight needs to continue. We need to empower employers to make a difference, particularly as they step up to be more involved in the discussions, where previously it has been dominated by insurers and hospital systems. Employers are the way that 50% of Texas get their health coverage and the employers need to take a role and responsibility there. Employers need to be able to take advantage of that information and design more innovative benefit plans that empower them and their employees to save money. Finally, we need to use the Employee Retirement and Teacher Retirement Systems as a market leading example to demonstrate what can be done with extremely large employee driven systems. They have the numbers to create stronger positions for price negotiation.

The purpose of transparency is to empower and enable the buyer. It is necessary to have a functioning market and a market without it does not work. Transparency alone does not create a functioning competitive market; you need to have both the access to the prices and quality information. There's work the state can do and there are barriers in state law from providing that quality information to enrollees that can be addressed.

In terms of compliance with the current transparency laws, Texas2036' data indicates that about 31% of Texas hospitals are “mostly” compliant. Many hospitals had insufficient or incomplete data and other listed only the charge master. In their experience most of the larger insurers are making the files available and the transparency is working. Mr. Miller referred to the requirement on January 1, 2023, begins stage two where insurers to have to provide self-service tools on the internet for consumers to permit individual price research for services within a given geographic area. Mr. Miller state that when consumer level research tools become available, it could become a game-changer and shopping behavior. All of the previous tools were only available for employers or institutional healthcare purchasers. Mr. Miller recommends expanding transparency laws to other from just hospitals to all providers. There is no reason other providers shouldn't have to provide “upfront” pricing as well. There are limitations placed under Chapter 1460 of the Texas Insurance Code that prevents insurers health benefit plans from providing quality rankings or quality assessments to their enrollees. While it isn't done explicitly, the burden in place creates a functional impossible and it should be repealed. If not totally repealed,

it should be amended in such a way that would provide some basic protections in place as part of a negotiated process.

Mr. Miller emphasized and quoted other speakers who reinforced the concept that billing transparency influences an individual's stress over medical billing. A recent Kaiser Foundation survey says that 44% of people with medical debt, say they have that debt because the bill isn't accurate. People need the tools to be able to challenge their bills and have some degree of confidence about what's on it.

Chairman Harless asked for Mr. Miller's opinion on the 1332 Colorado waiver program and the Pennsylvania state-based exchange program. Mr. Miller explained that the 1332 waiver is related to the Affordable Care Act's (ACA) individual marketplace. It is a method whereby a state can seek approval for the way their own marketplace is allowed to work. Whatever option they choose within the guardrails, it must be budget deficit neutral. Colorado took an interesting approach in that every insurer that offers a plan in the individual marketplace must offer this special plan and future plans must demonstrate a rate reduction. They offer the market the chance to force pressure on pricing as opposed to direct rate setting.

Mr. Miller explained that Texans pay roughly \$200 million into the federal programs under [healthcare.gov](https://www.healthcare.gov), which is about \$100 more than the cost of operating an exchange within Texas. There is money to be made in that space and other states such as Pennsylvania have demonstrated the savings, which can be used to operate reinsurance pools.

Representative Oliverson had other questions for Mr. Miller regarding the operation of a state-based exchange and using the potential savings for that approach to cover a portion of premium costs for smaller employers in Texas. Mr. Miller responded that there are ways to approach that. One of the issues right now is as a small employer you can only offer insurance or not, you can't combine an employer contribution with subsidies available on the individual market, which creates some inefficiencies. An existing effort called the "Three Share Program" (<https://www.tdi.texas.gov/reports/documents/three-share-report.pdf>) works in just such a manner as an example of a smaller program. Ultimately, until some technical problems are worked out, the risks outweigh the benefits.

Representative Oliverson inquired about next steps should Texas decide to operate their own insurance exchange and what would be the control points. Mr. Miller explained there were a couple of options, utilizing a state agency to run it entirely and be responsible for the exchange, but ultimately you would be contracting out to a third-party vendor to manage operations. By this time, this approach has been done in enough other states that it is common. The governance question comes down to a decision of state agency or creating a non-profit to run it, with compromises in contracting, employment practices, and the ability to be agile versus state control.

The Committee heard testimony from Dr. Clifford Porter, representing himself.

Dr. Porter stated that he is a physician with Texas Direct Medical Care, with a clinic in Austin who practices family medicine. Dr. Porter feels there are some opportunities available through direct dispensing of certain medications where they can do immediate help for individuals right away. To say that we have a convoluted system would be an understatement. He feels like patients are held hostage and their own healthcare and often have to make financial decisions that are not in their best interests. Dr. Porter's clinic is a cash-based facility and does not do insurance billing at all, so he has opted out of Medicare and doesn't have to follow their rules and can treat Medicare patients by them paying the direct expense. Direct expense would also benefit patients for certain drugs and Dr. Porter gave examples like epinephrine, or the "epi pen" which can be provided to patients pre-filled and ready to administer at 10% of the pharmacy cost. Pharmacies routinely charge \$120 to \$130 for a pair of pens, while he could do it for \$10. Direct expense completely bypasses that convoluted system.

Direct primary care works in 46 other states. In Montana the primary care community is working with the rural pharmacy groups to develop very good system based on states like Florida with a Medicare heavy population.

Dr. Porter also covered opportunities for direct expense facilities to improve access for chronic care patients. Under direct primary care, they can provide medications to this population immediately.

Representative Oliverson wanted to know if it was a reasonable compromise to permit pharmacies to continue to do immunization and permit physicians to dispense certain medications with limitations on what types they could dispense and what they could charge for the drugs. Dr. Porter responded that he could live with that and they could do it considerably cheaper.

The Committee heard virtual testimony from Chris Severn, representing himself and Turquoise Health.

Mr. Severn stated that he is the CEO of Turquoise Health, a venture backed small startup company focused on price transparency. Due to federal transparency laws, information other than charge master list prices have led to negotiated prices at hospitals for all services. Changes in transparency laws at the federal and state level create new possibilities for price transparency. From what was initially a slow response from hospital systems to publish data, now the majority have become posting useable data on pricing, this was probably due in large part to pressure from federal and state laws or the press. As of July 1st, all insurance company payers must reveal their negotiated prices with providers. This includes not just hospitals, but surgery centers, imaging centers medical groups, primary care practices, telehealth. Or anything that submits bills to be paid by insurance. This data provides consumers better information on which to shop prices for scheduled services. Having a fully competitive market where there is no barrier to access to data will ultimately result in lower price health care. Patients need to be educated so they can shop for more effective care and employers need to feel empowered with analytical tools when shopping for plans and services.

Representative Oliverson asked what needed to be done on issues like standardized file formatting, to improve access, or other recommendations for transparency laws. Mr. Severn responded that we were in a really good place from a formatting standard.

The Committee heard testimony from Lee Spangler, the Executive Director of the Texas All Payer Claims Database at the University of Texas School of Public Health.

Their organization takes claims data from as many players as possible, then organizes it for search capabilities. Their current database contains claims forward of 2019 according to the statutory requirements created in House Bill 2090 (87R), but they are working on seeking voluntary submissions from carriers prior to that time. Nearly 100% of all state regulated claims are going to be contained in the database. Examples of claims sources would be the Texas Teacher Retirement System, the Texas Employees Retirement System, local governments, or other political subdivisions. 60% of all the claims of all covered people will be in the database. The All-Payer Claims Database is required to provide the legislature with reports every other year of trends of healthcare, affordability, availability, quality, and utilization.

One of the cost drivers is the constant innovation in the medical space. Technology and treatments are getting better, which often means sometimes more expensive and in an aging population they use more healthcare which also drives up costs. (APCD presentation)

Representative Oliverson inquired about the process of accessing the database for research purposes and Mr. Spangler responded by saying that there are three entities permitted to access the data. You have to be a 501c3 organization researching healthcare quality in Texas, an institution of higher learning with the same purpose, or a healthcare provider. Any of the three have to request access from the APCD and affirm there is no commercial purpose for the access.

Representative Walle questioned whether the data had controls that prevented use of the APCD data for nefarious purposes and Mr. Spangler responded that the guidelines imposed under statute prevented any nefarious use. Representative Walle wanted to know when the data will be published and usable and Mr. Spangler advised it would be available during the first quarter of next year. Representative Walle then asked about the level of cooperation in the accumulation of data and if there was any pushback. Mr. Spangler responded that while there have been formatting questions, so far everyone is in favor of transparency.

Recommendations

- **Uniformly apply price transparency requirements for shoppable services to all provider types.**
- **Prohibit anti-competitive contracting terms, such as all-or-nothing contracts, gag clauses, etc.**

INTERIM CHARGE III

Evaluate innovative, fiscally positive options to ensure that Texans have access to affordable, quality and comprehensive health care, with an emphasis on reaching low-income and at-risk populations. The evaluation should include a study of strategies other states and organizations have implemented or proposed to address health care access and affordability. Make recommendations to increase primary health care access points in Texas.

Testimony

The Committee heard testimony from Dr. Robert Popovian, representing himself as a pharmacologist.

Dr. Popovian has a doctorate in pharmacy, is a health economist, has worked with the pharmaceutical industry for about 20 plus years, and is now an industry consultant. Dr. Popovian is also the Chief Science Officer for the Global Healthy Living Foundation, a patient advocate organization, a Senior Policy Health Fellow at the Progressive Policy Institute, a visiting Health Policy Fellow at the Pioneer Institute, and he serves on the Board of Counselors for the University of Southern California School of Pharmacy. Dr. Popovian suggested that Texas needs to have separate markets for the generic and brand name markets to have significant patient cost impact. He also emphasized that patients should never have to pay more out of pocket costs through insurance than they must pay with cash. Dr. Popovian feels the bifurcated system shows the corruption in the industry and makes no sense for insurance companies to bill or pay at a different rate and leads to overcharging. Greater vertical pharmacy integration and consolidation in the pharmaceutical industry has occurred since statutes were passed and a better definition should be created for the “issuer”. In some cases, the PBM and the insurance company are the same entity. He also suggested greater clarity in identifying distribution of rebates so that the amounts going back to the PBM, insurer, or patient were clearly identified. Currently it is difficult to identify who is getting what. Better numbers and data on the flow of rebates will help in the future.

80% of the processing for biopharmaceuticals or pharmaceuticals are done through three of the largest PBMs and likewise 80% of the dispensing of specialty pharmaceuticals are done through pharmacies that are owned or co-owned by pharmacy benefit management companies. When looking at the data, it appears that the rebates are retained within the PBM or their parent companies. Dr. Popovian suggest the legislature should look at it both in terms of how much money is collected in concessions, fees, rebates, but also how much of it is being passed back, but also who's collecting it and who retains the rebates.

Dr. Popovian suggests that the state utilize the larger Texas programs such as ERS and TRS and create rules to allow the patients to get the concession and rebates on prescription costs at the point of sale. Programs such as Optum are currently using this approach and providing the patient the savings at the point of sale. Based on an Optum study, patients save on average \$130, and adherence improved by 16%.

12 cents out of every dollar are being spent on prescription drugs, which is important because it has an impact on premiums. In California premium costs have gone up 16% while pharmacy profits have gone up 103% over the last four years. Attempts to correct the practice of kickbacks through Congress have been watered down and ineffective.

Another suggested consideration is formulary positioning. There has been a lot of discussion on how formularies are just profit maximizing tools for PBMs, instead of their intended purpose of channeling patients through the most cost beneficial drug intervention. In a study done for the Global Healthy Living Foundation, we looked at the Express Scripts Formulary and the

exclusionary formulary for 2022. In 10 occasions, Express Scripts excludes a generic drug in favor of a brand name drug, even when the cost differential ranges from 70% to 240% more for the brand name. Most of us are in a benefit design that requires a co-pay, deductible, or co-insurance. Deductibles and co-insurance are based on the retail price, not the net price of the medicine after rebate. Every other place in the healthcare system, patients benefit from the negotiated price, but not in pharmaceuticals. Whenever you force a patient to use the brand name drug, they will pay a higher price as a percentage of the full price to meet their deductible. In any other part of the healthcare industry the patient's financial responsibility is based on the negotiated price for care and services.

Another issue Dr. Popovian mentioned was "claw backs." Texas has a claw back law on the books which needs to be fixed. It is truly a bad thing when we are taking advantage of consumers in such a commoditized market. He gave an example of a study that included Costco's prescription services. The study indicated that California's Medicare Services would have saved 4.5 billion dollars over a two-year period in the prices paid for the top 200 generic drugs, based on volume, prescription, etc. as opposed to the Costco cash prices. There are PBMs like Costco, Capitol Rx, or Navitus that are really trying to create transparency in the market.

The Committee heard testimony from Dr. Madelaine Feldman, representing herself and speaking as the President at Coalition of State Rheumatology Organizations Inc. Dr. Feldman is a rheumatologist whose patients deal with lupus, arthritis, and other autoimmune diseases.

We are in a time that is seeing dramatic increases in innovation, which comes at a cost and unfortunately at the same time the prices of biologics have increased. We've gotten to "non-medical switching accumulator programs", all of which are known as utilization management tools.

Dr. Feldman indicates that the PBM and manufacturers essentially blame each other when it comes to increasing drug prices and to some degree, each does affect the other, but they control the costs. The PBM use the utilization management tools in creating the formulary, or the list that your insurance company will pay for, so that appears to keep the most profitable drugs on the formulary list. Dr. Feldman then spoke about "step-therapy", which refers to the method of using a particular drug before trying another as a utilization tool. You have to fail to get the desired outcome on one type of drug before being allowed to use another. 40% of rheumatoid patients will respond to an inexpensive drug, like methotrexate. After that, there is a certain set of drugs that have to be used, which is "step therapy" and for patients who pay a co-insurance on a \$10,000 a month drug, their cost is \$2,000.

We do have non-medical switching in Texas that keeps patients from being required to switch drugs in the middle of a plan year, but in just a few months they may have to. The affect it has on the patient may be to put the cost out of reach for patients. As formulary tier cost changes, consequently the cost share and pricing changes does for the patient. Some states such as Maine passed laws that required reporting every time formularies changed, including step therapy, non-medical switching, or exclusions for the formulary Dr. Feldman referred to studies indicating a

correlation between switched patients and increased emergency room visits and more outpatient visits and feels it truly harms the patient.

Representative Frank asked about competition driving up prices, while at the same time they are reducing competition. Dr. Feldman responded that competition only works when there is a level playing field and, in this case, competition is being removed, which is why pricing is going up. Representative Frank commented on the problems of have a safe harbor provision in the anti-trust laws, which should exclude and allows PBMs to do exactly what doctors would be put in jail for doing and Dr. Feldman agreed.

Representative Bonnen asked Dr. Feldman to clarify what she meant in referring to competition, as with the incentives widely used throughout the pharmaceutical channel, the more prices go up, the more attractive those drugs are for the “Big Three” PBMs, which seem to be a perverse incentive. Dr. Feldman responded that the motivation for pricing and rebates should be the cost to the patient, not the overall savings on a particular drug. Chronic disease patients are the ones that must take the more expensive drugs and the ones impacted the most.

The Committee heard testimony from Sharon Lamberton, representing herself as a registered nurse and as deputy vice president of state policy at PhRMA, a trade association of 33 biopharmaceutical companies based in Washington, DC. Sharon has worked in Washington for about 20 years, focused state policy.

Sharon testified that there is a lot of innovation going on in the pharmaceutical industry with over 8,000 medicines in the pipeline today, 5,000 of those are from US companies. There are currently around 1,900 clinical trials for COVID treatments and vaccines underway and 326 of those are right here in Texas. The discussion today is about policies that could directly impact innovation. We have strong research and development, and it needs to stay that way.

\$2.6 million dollars is the figure to bring a drug from “bench to bedside” in a 12-to-15-year timeline. 88% of drugs fail to pass from phase one to phase three and make it into the drug space. In the vaccine space 95% fail making any of it a risky proposition, probably one of the highest failure rates of any business.

Speaking on rebates Ms. Lamberton testified that there were \$236 billion provided in manufacturer rebates, \$2.2 billion of that from Texas. That comes from manufacturers to the State and Federal government. In addition to making and bringing in drugs, the industry provides 249,000 jobs in the State of Texas. 40,000 of them are direct jobs where we have an average salary of \$133,000 when other industries average \$65,000. This is data coming from national health expenditure data and the federal government, not from big pharma.

Pharmaceuticals comprise 14% of health care spending at the national level and for Medicaid in Texas its 3.8%, a relatively small portion of the overall spend. Medications are the one thing that has a return on investment. Preventative care saves future dollars on loss of time from work or school, future medical lor hospital expenses.

Ms. Lamberton indicated the pharmaceutical industry will have a patent cliff ahead in 2025 as patents expire that will cost their industry \$128 billion dollars. That is accepted as a part of the pharmaceutical life cycle just another reason why research and development is so important to make that process work.

Net drug pricing has fallen 2.6% while the spend on brand name medicines has gone up 0.8%. This is an indication that net prices are actually flat or falling, and in line with inflation. Predictions indicate this trend should continue through 2029.

In speaking on affordability and access, Ms. Lamberton referred to the MAT Program, or the Medication Assistance Tool. MAT is an internet-based program that pairs patients with resources that may lower costs, whether or not you have insurance. It has 3 steps, designed to find resources that may help with your out-of-pocket medicine costs. It includes 900 public or private programs that accept general information about their medication and demographic area and matches the patient with programs that offer free or low-cost medicines.

We wouldn't need such programs or companies to offer generous assistance if insurance worked the way it should. We know it isn't because "out of pocket" deductibles have increased by 50% and four or more tiering on prescription drug formularies where 52% of insurance plans now have drug deductibles in addition to the regular deductibles for medicine. They are seeing medications excluded from the formularies. Of the big three formularies, 1,156 medicines have been excluded, which means that is 1,156 fewer medicines that doctors and nurses can provide to patients that need it.

In referring to solutions, Ms. Lamberton talked about Texas having a single formulary, which expires in August of 2023. She highly recommends maintaining our formulary for Medicaid in Texas as an example of a simpler solution when compared to states with multiple formularies. She also spoke about "sharing the savings" where if patients were able to share in just a portion of the savings at the point of sale it would better help them afford their medicines and be very helpful.

Ms. Lamberton also referenced a recent West Virginia law passed in July 2022 under House Bill 2263 that establishes guidelines on the use of rebates and forces the rebate back into the supply chain, reducing hurdles for the pharmacist and benefiting the patient and making their medicine more affordable. 15 other states also worked on similar legislation.

Other solutions suggested included manufacturer adjustment bands, making sure that manufacturer assistance goes towards a patient's out-of-pocket deductible. Another solution suggested was to offer lower cost sharing options, covering medicines from day one, making sure medicines are covered from the moment of prescription before a patient must pay hundreds on a deductible to get it. Lastly, she suggested capping the patient's cost.

The Committee heard testimony from Anne Dunkleberg, a Senior Fellow at Every Texan, formerly known as Center for Public Policy Priorities, representing herself and Every Texan, an organization that focuses on access to healthcare.

The current Medicaid coverage gap affects about 1.5 million of the million uninsured in Texas and 800,000 of those are under the poverty threshold. There is a lot of confusion about who gets Medicaid and who doesn't. Their issue is that the Affordable Care Act is written in such a way that you can't get subsidies in the marketplace if you're below the poverty line. Texas is one of twelve states that doesn't have coverage for many of our low-income parents. In her presentation that HHSC has a severe worker shortage (up to 1,000 positions in Feb 2022) leading to extensive delays for Medicaid and SNAP and in July 2022, there were 322,798 applications for food benefits awaiting processing in Texas. HHSC is failing to meet timelines for timely processing (45 days) these claims, and their 2-1-1 help line has excessive hold times and too many dropped calls. Problems currently faced will be exacerbated when the public health emergency ends

Ms. Dunkleberg stated that Congress is considering an amendment to a bill that would permit a zero premium, low out-of-pocket cost program, but no one has seen the exact language at this point.

The Committee heard testimony from Racheal Means, representing herself.

Ms. Means is a veteran healthcare consultant for Employer groups in the state of Texas and elsewhere, specifically focusing on self-funding and creative benefit strategies to arrest and reverse the trend of ever-increasing healthcare costs. Mrs. Means delivered an overview of the Employer based healthcare market in Texas to the committee and presented solutions available to Texas Employers, which she deploys constantly and successfully with her client block.

Ms. Means went through a list of questions to ask regarding healthcare, including the below:

Ms. Means posed the question: what good is insurance if people can't afford their deductibles, and their out-of-pocket maximums are cost prohibitive?

She asked what is the purpose of an insurance carrier to negotiate with providers? How are discounts provided? What about when self-pay and direct agreements are less expensive than PPO discounts?

She asked what problems do networks solve that they do not first create?

She asked why do we not engage health plan members in the selection and build of health plans they pay for? Who stands to win if health care prices continue going up?

She stated that employers and employees do not. Insurance companies and health plans do. Traditional brokers benefit when paid through back-door undisclosed rebates, commissions, and overrides. Employers pay the bill when government caps out of pocket spend.

Ms. Means asked what market-driven solutions are available to employers, and why are these superior to regulation, both from the perspective of the plan members and the plan sponsor (employers)? What would a consumer say if she went to the grocery store and the items in the

basket had no price tags, and the cashier asked for a grocery network card to tell her what the bill was? And what would happen to the cost of automotive maintenance if every time someone went to have tires rotated or oil changed, the mechanic asked for an auto insurance card?

Ms. Means walked the committee through the PPO model versus direct agreements/cash pay arrangements with providers and facilities with direct primary care at the center of the health plan. The direct primary care (DPC) model is a business arrangement between an Employer group and a group of physicians where the Physician group is paid a membership fee to ensure the Employees of the Employer have access to \$0 copays for primary care, diabetes/chronic care management, urgent care, and minor emergency care.

She further advised that the Employer direct to facility and DPC model is a disintermediation model, stripping out redundant middlemen who add no value but increase costs for both plan sponsors and members. Additionally, at the heart of this model is revenue transparency, whereby the cost of the care and the compensation of all participants in the administration and delivery of care is known to all others, the plan sponsor, and the plan member. The model recognizes that health care expenditures are inevitable, and that insurance is for things that are rare, expensive, unpredictable, and that have not yet occurred.

The Committee heard testimony from Rachel Bowden, representing the Texas Department of Insurance, where she is the Director of Regulatory Initiatives.

Ms. Bowden spoke about 1332 waivers. At a high level the 1332 waivers are based on Section 3013.32 of the Affordable Care Act and allows states to take their own approach to federal health reforms, using some of the “pass-through funding” in a new state design if they wanted to. There is a great deal of fine print and a complicated process to obtain them, but 17 states have the waivers with 2 more currently pending approval. Some of the provisions that can be waived is the employer mandate, and the individual mandate if it is still relevant, the minimum standards for qualified health plans, including the essential health benefits requirements actuarial value, out of pocket maximums, limits on catastrophic plans, as well as exchange requirements, including open enrollment periods, navigators, single risk pools for individual and small group markets. Additionally premium tax credits and cost sharing reduction can be waived.

What cannot be waived under 1332 waiver includes kind of the big structural consumer protections that the Affordable Care Act put into place, including guaranteed issue and prohibition on excluding pre-existing conditions. The modified community rating, that limit of a three to one ratio between younger and older adults and prohibiting variations in rates based on gender or health status. The required coverage for preventive services can't be waived, nor can coverage for dependents up to age 26. And finally, the prohibition on annual and lifetime coverage limits also cannot be waived.

The guidelines of the 1332 waiver require that the solutions must be budget neutral for the federal government, which essentially means they can use the funds from the ACA in a different way, but you won't get more than you would if the waiver was not in place. Coverage obtain must still be at least as comprehensive as the coverage under the ACA exchanges. In 2021 the

fund created by premium tax credits totaled \$6.38 billion dollars, benefiting 1.16 million individuals with an average tax credit of \$478 dollars a month.

Only a couple of states have taken a different approach or added layers or more things on those programs. Texas has passed four different bills related to the 1332 waivers going back to the 85th Legislative Session in 2017 clarifying that the pool should be used to increase access to guaranteed issued health coverage. TDI has a study from 2021 which indicated that they could reduce premiums from 3% to 10% by spending between \$70 million to \$204 million which would only benefit 200,000 Texas, only 10,000 of those would have been currently uninsured. Shortly after completing the analysis, Congress passed the American Rescue Plan Act that significantly expanded subsidies and negated the need for the reinsurance program in Texas.

The federal Inflation Reduction Act extends those tax credits through 2023 so there is some uncertainty about the expanded subsidies after that. TDI doesn't know what the market will look like until after that happens. Senate Bill 1296 from the 87th Session gave TDI the authority to do rate review on plans, which will permit them to watch costs for the future. Under that legislation TDI created a rule that will lead to more consistency in pricing.

The other thing to note is geographic rating areas. Texas moved from federal default rating areas, or one rating area for each metropolitan area, plus one single rating area for all the rural rating areas. Through TDI rule, they expanded the areas to 27, including rural within metropolitan areas, where people are most likely to access health care and more accurately reflects healthcare costs in those geographic areas. This should provide better pricing accuracy models for rates for insurers over time. Rating rates for 2023 are not yet final. Those final decision could also be impacted by what Congress does with expanded subsidies.

Ms. Bowden talked briefly about the Colorado option, which is a "reinsurance" 1332 program designed with specific premium reduction targets that are enforced by their Department of Insurance. They actually require providers to accept required contract rates, subject to certain limits based on a percentage of Medicare. Other states such as Washington and Nevada have developed their own novel approach. In Colorado, they will save money through the reinsurance program as well as the reduced target premiums. Using that money, they will reinvest in state subsidies to enhance subsidies, or fill in gaps in the federal subsidy structure. Some of the more ambitious 1332 waivers can be very involved but requires you run your own state exchange program, without it there's not a lot you can do.

Ms. Bowden testified that when the Affordable Care Act was passed, Texas did not adopt conforming legislation and therefore lacks the authority to the ACA provisions, which some other states do through direct state authority or some other collaborative agreement.

Mr. Hutson explained that the Texas Association of Health Plans (TAHP) represents health plans working in all segment's healthcare coverage in Texas. He explained that there's extensive research on what it really means to be covered; people are significantly less likely to postpone care, in Medicaid new mothers have consistent access, in Medicaid you're less likely to postpone or go without needed care and the list goes on and on and on. He added that for the uninsured

they have to stitch together care but when you have coverage, whether it's through Medicaid or through a commercial insurance plan, you have something that you can count on.

Mr. Hutson directed attention to slide three of his presentation where he showed that 48% of Texans are insured with employer-based coverage, the ACA marketplace covers about 1.84 million Texans. He added that employer groups report that it's really important for them to offer good coverage to attract good employees. Three out of four employees tell us that health benefits were part of the decision to accept a job in the first place.

Mr. Hutson expanded on the individual market explaining that there are very positive trends, including in the last two years in Texas as premium tax credits increased, we saw an over 80% increase in enrollment. He added that what this demonstrates is when you make coverage more affordable, people want to go get covered and that competition among insurers in the individual market is up to 14 participants and we actually lead with Florida for the most plans in the marketplace. He added that we are set to add more plans next year and we've consistently lowered the number of counties with just one insurer down to about 30 now. Mr. Hutson added that we should "not rock the boat too much" and create uncertainty that might drive some of that away.

Mr. Hutson moved to discuss Medicaid coverage and the unique aspects that do not exist in the commercial market and types of care that doesn't happen such as nursing support and community-based care. He explained that Texas uses a risk based capitated managed care program where HHSC pays a health care premium to the MCO for each person, that's called a per member per month and for that premium, the MCO has to ask to provide all the care to that enrolling, right much like happened to the commercial market. And if they, if they do it in a way that is lower than premium, then they have a profit, through experience rebates profits are capped and have to be shared back with the state. He added that this system gives the state budget certainty. Mr. Hutson explained that in 2017 the legislature wanted to know if Medicaid Managed Care saved money and commissioned a study under Rider 61 that found from 2009 to 2017 taxpayers saved \$5 billion under Medicaid managed care. He added that additionally outcomes improved: 90% of kids are now receiving at least one doctor visit a year (up from 25% under fee for service), 90% of expectant moms now receive timely prenatal care (40% in FFS), and generally enrollees are avoiding more expensive hospitalizations that drive up the cost for taxpayers in Texas. He said that about 95% of all services are carved into managed care now.

Mr. Hutson offered recommendations related to Medicaid. First off, he explained the state agency is overwhelmed with staffing issues and the MCOs have come to an agreement with a new case assistance affiliates community partner program where MCOs can help with eligibility redetermination work like resetting passwords and application assistance. He suggested that the state continue the program beyond the end of the Public Health Emergency and as an innovative way to help HHSC out with enrollment. His next recommendation was to build on the success of managed care by carving in the remaining pieces including the management of the drug formulary in the vendor drug program. He added that there's significant savings in doing so (\$80 million per biennium) but also a better system for patients and physicians with less prior

authorizations, less non-medical switching, and more consistency. TAHP also supports closing the Medicaid coverage gap and supports addressing non-medical drivers of health.

Mr. Hutson explained that about 25% every dollar spent goes to long term care and 61% of all spending on Medicaid goes to aging and disabled populations. The biggest caseload is kids, but spending is older and disabled populations. What's unique about Medicaid versus the private market is that the driver in cost is really caseload gross, not prices, like we see in the commercial market.

Mr. Hutson then moved to discuss the commercial insurance coverage market. He first showed a chart comparing payments to ER physicians for the highest severity code. At the lowest amount is Medicaid, then Medicare, worker's comp and then the average in-network negotiated rate is about five times the Medicaid rate. He emphasized how Medicaid rates are very low and that's why caseload growth is the big driver of spending in Medicaid, not prices. Mr. Hutson then moved to hospital costs and explained that about 40 cents on every dollar goes to inpatient and outpatient hospital costs.

He reiterated his earlier point that in Texas the individual market is growing in competition but then highlighted that the associated "bad news" is that in Texas, from 2021 to 2022, the average increase in premiums was 13% while nationally premium changes for the year were flat as it should have been given delays in care associated with COVID-19. Again though, in Texas we saw an increase in premiums of 13%.

Mr. Hutson then moved on to discuss what he sees as driving this increased spending. He showed a slide from the Health Care Cost Institute that looks at millions of actual claims from around the country to analyze what's happening with health care spending. They found that three quarters of all the growth in private market spending is a result of price increases, not utilization, not technology improvements, not patient health. He dug in further, explaining that much of the previous day's discussion on hospital pricing disparities and irrationally high prices is a main driver along with markups on facility and physician provided drugs.

He next expressed a growing concern with the role of private equity involvement throughout the healthcare provider space. He explained that starting several years ago, you really were seeing this a lot in physician services, but now it's moved on and there's private equity involvement moving into nursing home care; there a study found that this resulted in 20,000 untimely deaths and 11% higher costs. His slides contained several links with examples of private equity involvement and the associated harms. He added that a February 2022 study found that anesthesia provided under private equity control cost 26% more. Mr. Hutson shared a personal story where his mother's recent colonoscopy was significantly more expensive and he showed her on her bill where the practice group had been acquired by GI Alliance, a private equity backed GI group based in Texas. That group adds facility fees and raises prices. He said that we are seeing PE involvement in group homeless. Some states are seeing this in rural hospitals, which is really scary given the challenges our rural hospitals are having. He closed on the topic explaining the ER is where a lot of PE involvement first took place and today most ER physicians are working under a private equity backed staffing firm. He added that depositions were accidentally uncovered from one of these ER staffing firms where they said they do not

actually take into account any real cost when setting prices and in some case charge nine times higher than Medicare.

He moved on to hospital consolidation and explained that a big associated problem is the additional of abusive facility fees after hospital acquisition of a provider. He added that Medicare actually prohibits hospital billing codes if a provider is 250 yards off of a hospital campus. He explained that for health plans it's not always clear where the procedure took place and thus hard to dispute these facility fees. He added that Rep. Klick shared a story with him about seeing facility fees added to urgent care clinics after hospital acquisition. The same issue happens with the acquisition of imaging centers who then begin billing as if the service was hospital based.

Mr. Hutson closed with solutions saying that people need incentives to make value driven decisions in health care. He explained that the Texas Insurance Code has some barriers. For example, "you can't tell a person if you go here, I'll lower your deductible, or I'll waive your copay. Versus if you go here, it's all on the same network." TAHP believes these prohibitions should be removed. He then explained that based on the way the insurance code is interpreted unless a plan is an HMO (because there's an exception for HMOs) you can't enter into a true capitated payment arrangement or value-based care. These arrangements are where you share downside risk and upside risk. He explained that concepts like advanced primary care where a clinic covers all the primary care and urgent care for an employee can't technically legally exist, even in the self-funded employer market, because state law considers the physician to be practicing the business of insurance if they are accepting that downside risk.

Mr. Hutson next discussed the establishment of new alternative health plan arrangements through the Farm Bureau and Texas Mutual where those companies are allowed to essentially just skip the whole Insurance Code and market coverage without any government regulations. He explained that in 2003 the legislature tried this with SB 541 by Senator Tommy Williams with the creation of Consumer Choice of Benefits plans. The concept allowed insurers to sell mandate-lite plans that don't meet all excessive state regulations. Insurers still had to sell fully regulated products, but businesses and families could choose. Over time this concept was eroded with additional mandates including expensive contract and administrative mandates that were applied to these plans. TAHP recommends the legislature hit reset and allow insurers to offer mandate-lite plans that meet all federal requirements only but not additional excessive state regulations that add to costs. He noted that the plans would still be ACA compliant and thus tax credit and tax deduction eligible.

Mr. Hutson added that TAHP supports ending any anti-competitive contracting provisions. He explained that in the Sutter Case in Northern California the attorney found that consolidation on the hospital side made even large national health plans subject to accepting anti-competitive terms. TAHP also supports banning abusive facility fees and one estimate found a national savings of 672 billion over 10 years and suggested the state could see substantial savings in ERS, TRS, and Medicaid. His organization also supports continued transparency including provider price transparency (does not exist today), additional price transparency for facilities like FSERs, lab and imaging price transparency, and private equity involvement transparency.

Mr. Hutson stated that TAHP also supports quality transparency. He explained that under current insurance code there are significant barriers to sharing quality information requiring a complicated month's long appeals process that is a barrier higher than most plans can meet so quality sharing doesn't happen. He stressed that a referring physician should be able to direct patients to high value options and need this information. Lastly, he added that state-imposed mandates are a significant cost driver. He urged the legislature to take a break on imposing new mandates, particularly when the legislature does not apply those mandates to its own health plan. He explained that the cost of these mandates are passed to employers and eventually to families to pay those premiums.

The Committee heard testimony from Fred Cerise, representing himself, Parkland Health, and the Texas Hospital Association.

Dr. Cerise gave recommendations that he stated would improve access to affordable care for Texans. Mr. Cerise stated that HHSC should move forward with applying for the Institutions of Mental Disease Exclusion Waiver. The Appropriations Act had this as part of HHSC's cost containment Rider. We have a psychiatric bed crisis in Texas, and this is one avenue to help pay for some of those bed needs. Additionally, the state should look at utilizing a 1915 (i) waiver or an 1115 waiver to provide enhanced community-based benefits and potentially expand eligibility for persons suffering from severe mental illness and/or substance use disorders. Multiple states have innovative waiver programs that Texas should look/review.

Dr. Cerise stated that Texas has a very robust competitive Medicaid managed care program as a result of a combination of non-profit, for-profit, and provider-based health plans. Provider-based plans such as those owned by public hospital districts are an integral part of that success, providing close coordination with the public delivery systems and investing earnings to address quality and access in their communities.

Dr. Cerise gave thanks to the House of Representatives for their support of virtual care and work on broadband access. While telehealth tools have proven successful at increasing access across the country, many Texans, including an estimated 75,000 homes in Dallas County, do not have broadband access. Nonetheless, Parkland has demonstrated success in managing uncomplicated pregnancies and chronic conditions through phone only approaches. Health systems across the country are experiencing significantly higher costs attributed to a shortage of nurses and many other clinical staff. A chronic health care workforce shortage has been exacerbated by the Covid-19 pandemic. Workforce initiatives that will increase the size of nursing school classes and other health professional and technical training programs are a critical component of any strategy to address these shortages that increase health system costs.

Dr. Cerise stated that Medicaid expansion will increase access to care for about a million Texans and there are several studies to show that Medicaid coverage helps avoid financial catastrophe for families who access health care. Dr. Cerise said that THA will continue to support for the Medicaid waiver and target payments to systems that demonstrate access to the full continuum of services that patients require for meaningful healthcare access. By better targeting supplemental payments to systems of care that ensure proactive preventive and chronic disease management

and not mostly reactive ED-based care, the state can increase the delivery of more appropriate services needed to improve meaningful outcomes for patients.

The Committee heard testimony from Chase Bearden, representing himself and the Coalition of Texans with Disabilities.

Mr. Bearden stated that the worst crisis facing many in the Medicaid system that has personally affected his organization is with those receiving community care services like attendant care to stay in their homes. Attendant care, also known as “personal care attendants,” are the front-line workers in disability care. These are the essential workers who come into a person’s home and help them get out of bed in the morning, dress, use the restroom, assist with personal hygiene, prepare meals, assist with doctors’ appointments and medications, etc. Personal care attendants are the front-line healthcare workers doing more for that patient at any time. They are also the lowest paid in the healthcare field, and currently, the lowest paid attendants in Texas Medicaid are only being paid \$8.11/hour.

Mr. Bearden stated that his organization sees these problems in real-time due to the meager wage for personal care attendants in the Medicaid program, along with inflation, is a mass departure from the field.

Mr. Bearden stated that Medicaid is not driven by the markets but by the state legislature. Attendants will continue to leave the Medicaid system if the legislature does not appropriate the funds needed to address this crisis. Mr. Bearden recommended an hourly wage increase for personal care attendants from \$8.11/hour presently to \$15.00/hour by 2024.

Mr. Bearden talked about the Medicaid waiver interest list. These interest lists are long, and those waiting to receive these services may get some but only some of what they need and qualify for. He referenced HHSC testimony in a previous hearing, where they said those waiting were getting some services. He stated that some of those people are only receiving an SSI check. He stated that they are not receiving the attendant care or the therapies they need. He stated that they need to ensure those on the waiting list receive the services they need. Mr. Bearden stated that the state needs to go through these lists, identify those who currently qualify for those waivers and services, and devise a plan to appropriate the necessary funds over the subsequent few sessions to end the 19-year wait many must endure.

Mr. Bearden stated that exploring different systems is worthwhile. Caveats must be in place to prevent unintended consequences. Parents add their child to the interest list to recognize their longevity as caregivers or, more likely, know that school-based services, intended only for educational support, will end after age 21. He stated that this is commonly referred to as “falling off the cliff.”

Mr. Bearden spoke about an issue many of CTD members face when dealing with their private health insurance policies and receiving the medications their doctor has prescribed.

Non-medical switching affects those with chronic health issues and disabilities more than anyone. Many in our community rely on access to these medications to maintain our health, slow a disease state, slow a loss of function, and keep us out of the hospital. He stated that being swapped off a medication for the simple reason of saving the health plan money can be a life-and-death situation for many.

He stated that for those stable on their mental health medication, rheumatoid arthritis, Crohn's disease, and many others coming off those meds even for short periods can result in a loss of function or for their disease state to progress. He stated that in many cases, this is not reversible, and those who are stable and have their health issue under control can find themselves unemployed if their health spirals. Non-medical switching can quickly affect an entire family when a family member loses their job and health insurance. He stated that the only winner is the health plan and the PBM for those in that situation. He stated that this person will then need the state Medicaid program to pick up the tab.

Mr. Bearden ended his testimony by speaking about the growing use of co-pay accumulators and their effects. Mr. Bearden stated that co-pay accumulators make it harder for patients to meet their deductible or maximum, resulting in higher out-of-pocket costs. Innovative treatments are helping Texans with rare or complex chronic conditions stay healthier and enjoy a better quality of life. To help with their rising out-of-pocket costs at the pharmacy counter, many of these patients rely on co-pay assistance programs from pharmaceutical companies or non-profit foundations to cover their co-pays and help them meet their insurer's annual deductible and out-of-pocket maximum.

However, a growing number of insurers and pharmacy benefit managers (PBMs) are adding Accumulator Adjustment Programs or "Co-pay Accumulators" to their plans, which prevent patients who receive co-pay assistance from counting those funds toward their annual deductible or annual out-of-pocket requirements. When patients reach their support limit, they are hit with a surprise bill where they must pay their deductible again, and they are no closer to achieving their annual out-of-pocket limit.

The Committee heard testimony from Glen Hamer, representing the Texas Association of Business (TAB).

Mr. Hamer stated that employers seeking to purchase health coverage for their employees generally have two options: a state regulated health plan, or an Employee Retirement Income Security Act of 1974(ERISA) regulated health plan. He stated that the likelihood of benefits increases with the size of the employer. Mr. Hamer stated that there is a difference in funding mechanisms employers utilize when selecting their health plans: a fully insured health plan, or a self-funded health plan.

Mr. Hamer stated that a fully insured health plan allows the employer to offer health benefits to their employees without inheriting the financial risk of unfavorable health outcomes. For example, he stated, if one of the employees has a \$300,000 medical bill, the employer with a fully insured health plan would not be liable for payment. The health insurance company inherits

the financial risks associated with the fully insured health plans they sell. Generally speaking, a fully insured health plan is preferred by smaller employers. In 2021, 58% of employers with less than 49 workers offered fully insured health plan. While fully insured health plans must provide the federally required “essential health benefits,” they are also subject to more stringent state regulations and laws. These state-imposed mandates in excess of federal law require certain benefits or services to be covered by the health plan. State regulations can also mandate certain contractual standards between the health plan and their providers or enrollees. Historically, TAB has advocated against state-imposed mandates since they reduce flexibility for the market participants and hinder the innovation of new insurance products, which then drive up the cost of insurance for employers and their employees. Some employers choose to pay for the health care benefits they offer their employees with their own funds instead of purchasing health insurance for them. This is called a self-funded health plan. Federal law (the Employee Retirement Income Security Act of 1974, or ERISA) exempts self-funded health plans from most state insurance laws and regulations. In 2021, 64% of all employees with employer sponsored health plans were in a self-funded plan. Larger employers are much more likely to have a self-funded health plan.

Last year, only 16% of employers with less than 49 employees had a self-funded health plan, while 86% of employers with over 1,000 employees used a self-funded health plan.

Mr. Hamer stated that these stark differences in the decisions made by small and large employers highlight the need for the Legislature to use different approaches for potential solutions to employer sponsored health coverage.

Mr. Hamer stated that smaller employers, who generally purchase fully funded health plans from the state regulated market, need more options in the marketplace. The increasing cost of insurance has forced many of the small employers out of the market for employer-based health insurance and into offering less valuable benefits in terms of tax purposes. Many employers have decided to offer additional salary, or “non-insurance” health coverage in lieu of traditional employer sponsored health benefits. These alternatives are not tax deductible for the employer therefore they provide a less valuable benefit to their employee.

Mr. Hamer referenced House Bill 3752 by Chairman Frank and House Bill 3924 by Chairman Oliverson, both of which would expand free-market offerings for competitive health coverage for small employers, people who are not eligible for Medicaid or those who do not have access to employer-based plans.” Mr. Hamer stated that these two bills created two new health coverage products in the marketplace, products that are exempt from conventional insurance laws. The bill analysis for HB 3924 provides an explanation for such provisions: Exempting these plans from the definition of insurance allows for advanced coverage options that are not subjected to conventional insurance laws and regulations, including stringent provisions of state and federal law that drive up coverage costs. Included in the exempted regulations for these two products are the mandates created by the legislature. Mr. Hamer stated that TAB recommends that the Legislature build on these efforts from last session and allow traditional health insurance companies to offer health plans with no additional state mandates.

Mr. Hamer stated that TAB successfully advocated for this type of legislation 20 years ago when then Senator Tommy Williams passed SB 541 into law during the 78th Legislative session–

creating the “Consumer Choice of Benefits Health Plan” (CCP). Unfortunately, over the past 20 years additional mandates have been applied to these health plans and has impacted their usefulness in the market place. TAB recommends the Legislature remove the mandates imposed on the CCPs to restore them to their original intent—an additional option for small businesses when seeking an employer-based health plan. Larger employers, who generally purchase self-funded health plans, are currently not subject to most state-imposed mandates. However, a recent U.S. Supreme Court (SCOTUS) decision opened the door for potential state-imposed mandates that could drive up the cost for larger employers and their employees. In *Rutledge v PCMA*, the SCOTUS ruled that the legislature could impose mandates so long as it “merely affects costs.” Mr. Hamer stated that TAB strongly opposes any mandates on ERISA regulated health plans especially in an inflationary environment for the business community. More broadly, as the Committee reviews improvements to the health care system, TAB recommends that the legislature extend the coverage for Medicaid from 6 months to 12 months postpartum. Numerous studies have shown the importance of this coverage to ensure the health of the mother and the newborn children. Lastly, TAB recommends that the legislature continue to support or system of intellectual property and patents. This system effectively balances the need for innovation and affordability. The competition driving our system has led to the most cutting edge, life-saving medicine in the world. TAB strives to continue to make Texas the number one place to do business and is committed to help businesses of all sizes offer their employees’ health benefits.

The Committee heard testimony from Dr. Alina Sholar, representing herself and Texas Physicians for Patients PAC.

Dr. Sholar stated that she would talk about the current physician shortage in Texas. She stated that the point of healthcare delivery is between a doctor and a patient.

She stated that Texas is short right now 2000 primary care physicians in Texas and more than 10,000 doctors overall. Texas ranks near the bottom in the country. She stated that the shortage is a supply and demand problem. More people are migrating into Texas, but the supply level of physicians has remained stagnant. Demand is outstripping primary care supply.

She stated that just three years ago, half of all Texas counties were identified as a primary care physician shortage area where there were more than 3500 patients to just one doctor. Question. Today 98% of the counties in this state have not enough primary care physicians, and 1/5th of all counties have no primary care physician. So, residents of rural areas are having to make some tough decisions. They're making hard choices about health care, especially as they age and with older and more unhealthy people who haven't gotten the primary care they've needed.

Dr. Sholar stated that, just like hospitals, clinics can't stay solvent if Medicare reimbursement is going down. Dr. Sholar stated that there are simply not enough physicians to go around. It's now estimated at Texas, we'll need an additional 6200 primary care doctors and greater than 10,000 physicians overall by 2032 to meet demand. Dr. Sholar stressed the importance of incentive programs as one of the ways that will drive primary care doctors over to rural areas. She stated that state and federal loan forgiveness programs worked to some degree, but that they are highly

underutilized. She stated that they are not really advertised by the medical schools as an opportunity.

Dr. Sholar stated that medical schools seem to be the next solution to the problem of the physician shortage in Texas. She stated that adding new medical schools is not the solution, however, because there is a bottleneck at the graduate medical education level.

Dr. Sholar stated that, in theory, there are enough doctors to go around in Texas that because Texas produces more medical school graduates than ever. And there's help for rural communities on the way because Texas has opened new medical schools specifically designed to address the shortage of physicians in rural areas. But, if increasing Texas medical graduates alone was the answer, we would actually need 88 new graduates per school per year to fill just the primary care role.

Dr. Sholar stated that, right now, if no changes are made, the supply of family medicine physicians is projected to only meet 78% of the goal. She stated that the bottleneck at the graduate level, meaning after medical school. She stated that residency programs outside of the state are getting our Texas medical graduates. She stated that higher education system is kind of like a farm system. It's a pipeline through which the state stockpiles talent and develops those physicians. She stated that once one passes the first four years of medical school, one must then pass to United States medical licensing exams in order to graduate medical school. Then, once one graduates, one must get into a residency program.

Dr. Sholar stated that there's not of residency spots for them to go to in Texas, and not across the country either. So, increasing the number of graduate medical residency positions is really much more impactful because that's where the bottleneck is. Texas needs to correct the fact that there are not enough residency positions.

Dr. Sholar stated that most of this is done by the federal government. Unfortunately, though, that funding has been kept for 25 years. Last year, Congress did pass a bill to allow 1000 More residency spots to be created. But that's 1000 across the country, and only 20 of those were actually codified for rural medicine.

Dr. Sholar stated that, like a lot of the time, when the federal government doesn't quite do what it needs to do, Texas has to pick up the slack. Dr. Sholar stated that Texas must increase the residency spots, especially since doctors who train here stay here, about 60% of the time. Those who do a residency in rural Texas also tend to stay in rural Texas.

Dr. Sholar stated that it is bad business to create medical schools and then not have a place for the physicians to go. She stated that Texas should not want to be a net exporter of doctors.

Dr. Sholar said that, going back a little more historically, in 2011, the ratio of residency positions to graduates and it was close to 1:1 . At that time, legislators did recognize that unless additional first year residency spots were made available and created by the state of Texas, that we would not have enough we would never have enough physicians to meet demand. So they estimated we

needed about 10% more. Unfortunately, that same year, they cut the budget for training family medicine doctors by 72%.

Dr. Sholar stated that there is a way to help Texans now in a way to help get more physicians into those rural areas. This opportunity exists with the subject of unmatched medical school graduates who do not have a spot in a residency program. Dr. Sholar discussed the Texas Physicians for Patients PAC physician graduate program. This program establishes a process for licensure of graduate physicians in Texas. She stated that this program is for M.D. and D.O. graduates of any medical school recognized by the Texas Medical Board.

She stated that they can take these medical students who have graduated and passed their United States medical licensing exams, but who can't get into a residency program. These unmatched graduates are not able to practice medicine. She stated that medical programs do not do much to help these individuals, because medical schools do not like to advertise their percentage of unmatched graduates.

Dr. Sholar spoke about the Physician Graduate Act. This legislation would allow an unmatched graduate to be paired with a fully licensed PCP in rural Texas who supervises their practice.

This would double the PCP workforce in rural Texas. It would also extend the geographic reach and availability of licensed PCPs already in place. By allowing these unmatched graduates to practice in this role, it allows them to relieve the debt burden that many medical school graduates face. This act would positively impact patients and entire communities.

The Committee heard Testimony from Dr. John Carlo, representing himself, Prism Health North Dallas, and as a member of the Texas Medical Association's Board of Trustees. Dr. Carlo is CEO of Prism Health North Dallas, with five facilities that see about 20,00 patients a year and as a member of TMA, represents the state's 56,000 physicians.

Texas, like the rest of the country needs to reduce health care costs. We know in this country we spend over \$12,000 a year per person. From 2020 to 2021 those costs increased by almost ten percent. As an employer he sees costs of health insurance rise yearly and it gets harder each year. According to the Commonwealth Fund, Texas ranks last on a number of measures, in terms of affordability, in spite of our access to world class medical schools, hospitals, and researchers and institutions.

Dr. Carlo suggested five topic areas to discuss. Number One is to reduce the number of people who cannot afford health care. Number two is to achieve higher value care. Number three is to better utilize our healthcare resources that we have. And number four, to reduce healthcare disparities. Number five, eliminate waste and inefficient care.

On the first issue, we have to do something for the 4.5 million Texans who lack insurance, the 625 25,000 children, over 18% of our residents who do not have insurance. Dr. Carlo thinks we should pursue all available federal dollars, bringing them to Texas to assure health coverage for all Texans. But Medicaid coverage or expansion alone is not going to solve all our problems. We

all know coverage does not equal access. Coverage takes additional work, particularly in disenfranchised neighborhoods and communities where they need to be able to access healthcare.

Dr. Carlo recommended extending postpartum coverage to twelve months as something that TMA and Texas physicians felt was very important. They have concerns about the end of the declared emergency and millions of people going off of Medicaid coverage. The final issue Dr. Carlo mentioned was that Texas needs to continue expanding coverage for the breast and cervical cancer program to the highest level, 250% of the federal poverty level.

Dr. Carlo testified that they suggest and support use of the All-Payer Claims Database to identify low and high value care as a means to reward better health outcomes under a value-based healthcare approach. Physicians, other medical providers, and hospitals get paid on whether patients achieve certain predetermined outcomes. Other states such as Colorado and Washington have used their All-Payer Claims Database to prompt assessments of low value care. He encourages the use of “value-based incentives” instead of a system that disincentivizes value over volume.

He also stated that we should look at how we can better utilize healthcare. Primary care is more cost effective and results in better quality and lower costs when compared to using emergency room visits for primary care purposes. 29% of Texans reported in 2021 that they did not have a usable place for health care. A study just two years earlier, in 2019, reported fewer patients had primary care than ever before. A number of factors are slowly eroding primary care in Texas, staffing shortages, burnout, payments, stagnation are all creating serious challenges. The emergency room is not a replacement for good primary care. Much of what is seen today in adult patients are completely preventable and treatable only if they had been seen earlier.

He suggests investigating paramedicine programs, such as have been explored as pilot programs in Austin which look at using the 9-1-1 system to deliver medical providers to the home before bringing them to a hospital. This might be a means to recover larger sums and have better outcomes. We also need to improve access and strengthen Medicare and Medicaid participation. We currently have a very low Medicaid participation by physicians in this state, which concentrates those patients across fewer physicians. Their medical situations are often more complex, and their visits take longer, yet the amount we can charge hasn't changed since 2007, even though inflation has gone up roughly 5% per year.

We know there is going to be a behavioral health crisis in the next generation, likely tied to the opioid addiction crisis we are currently seeing. This is an issue that will require continued attention.

Dr. Carlo referenced a Deloitte study from 2021, that found rising health disparities contributes billions of dollars in additional health care costs. He stated that health insurance and health inequities account for \$320 billion in annual spending and could grow to a trillion or more by 2040. Dr. Carlo testified that a Texas specific analysis found disparities resulted in \$2.7 billion excess in health care spending and 5 billion annually in lost productivity.

Goal five was to eliminate waste in inefficient care. Effective legislation such as the Gold Card Legislation passed in the last session allows us to better practice medicine and avoid unnecessary bureaucracy associated with it. Another issue to work on is the process of enrollment and credentialing for Medicaid providers. It is a complex and frustrating process, often taking months to complete. This frequently results in physicians who do not accept Medicaid patients and we are asking for better ways to get doctors in and approved for Medicaid patients, even though you only make a fraction of the amount of treating commercial patients.

The Committee heard testimony from Jana Eubank, representing the Texas Association of Community Health Centers (TACHC).

Ms. Eubank gave an overview of Federally Qualified Health Centers (FQHCs). She stated that there are 73 FQHCs in Texas. She stated that these include 650 clinics in 137 counties in Texas, including 96 school-based health centers. She stated that they serve 1.6 million patients annually, including 637,000 uninsured patients, and 485,000 Medicaid patients. They receive 5.6 million clinic visits annually, which includes 550,000 behavioral health visits.

Ms. Eubank stated that these health centers serve many hard-to-reach populations, including veterans, patients experiencing homelessness, public housing patients, patients best served in a language other than English, agricultural worker patients, and school-based health center patients.

Ms. Eubank explained the health center funding sources for FQHCs. They are funded through federal, state, and local sources. FQHCs receive federal grants from the federal Health Resource and Services Administration (HRSA) Health Center Program. Other operating funds are covered through Medicaid, Medicare, private insurance, patient fees, and other resources.

Ms. Eubank described characteristics of FQHCs. They are located in areas of high need. 41% of health centers are headquartered in rural areas. They must be located in medically underserved areas or serve medically underserved populations. They have a patient majority governing boards. At least 51% of every health center's governing board must be made up of patients. They are open to everyone, regardless of insurance status or ability to pay. Uninsured low-income patients pay a nominal fee based on a sliding fee scale. 66% of health center patients are at or below 100% of the Federal Poverty Guideline.

FQHCs are patient-centered medical homes providing comprehensive services, providing prescriptions, primary and preventative care, dental and vision, behavioral health, assistance for substance use disorders, lab services, and telemedicine. They offer enabling services, including transportation, nutrition counseling, case management, and general health education.

Ms. Eubank stated that since 2016, FQHCs have experienced a 28% growth in medical patients, and 59% growth in mental health patients.

Ms. Eubank explained the FQHC incubator program. Texas established the program to provide new funding to FQHCs to make them more competitive to receive large federal grants. The program helped increase the number of health center patients served by FQHCs by 65% from

2003 to 2009. Texas FQHCs brought in more than \$40 million a year in renewable, ongoing federal funds. In 2011, it was eliminated due to budget cuts. In 2021, the Legislature allocated \$20 million needed to fund projects to renovate, expand services, and increase access to FQHCs.

Ms. Eubank shared her recommendations with the Committee. Regarding access to care, she stated that 51% of adult health center patients are uninsured. Many working Texans cannot afford health coverage. She states that Texas must explore Texas-based solutions to minimize the coverage gap, extend Medicaid postpartum coverage to 12 months, and increase resources for Medicaid outreach and enrollment. Regarding infrastructure, according to Ms. Eubank, Texas should provide ongoing funding to increase health care access points through the FQHC incubator program, increase funding to establish more school-based health centers, and expand behavioral health capacity at health centers. Regarding payment innovation, she suggested that Texas should support Medicaid coverage and reimbursement for care management tools like remote patient monitoring for patients with diabetes, and she also recommended that Texas establish a pilot program to address non-medical cost drivers in the Medicaid program, such as nutrition services. Regarding the workforce, she said that FQHCs need additional workforce resources to address the going need. She stated that FQHCs need certified medical assistants, licensed vocational nurses, physicians, dental assistants and hygienists, billing and insurance staff, and behavioral health providers. She recommended that Texas increase funding for education, training, and loan repayment programs, and that Texas should support health centers that provide training for license or certification.

The Committee heard testimony from Stephanie Stephens, State Medicaid Director for Texas Health and Human Services.

Ms. Stephens stated that 5.5 million Texans are receiving services from Medicaid. 18% of Texans are covered, and 51% of Texas births are covered by Medicaid. 50% of Texas children are on Medicaid or CHIP. 57% of nursing home residents are covered by Medicaid. She stated that Medicaid is an entitlement program, providing federal funding, which is open-ended to provide eligible services to eligible persons. CHIP is not an entitlement program. Federal funds are capped for CHIP. When a state's CHIP funds are spent, no more are available.

Ms. Stephens said that federal law requires coverage of certain populations and services. This gives flexibility for states to cover additional populations and services. HHSC looks at both financial and non-financial criteria when determining eligibility. Regarding financial criteria, HHSC looks at how the applicant's income compares to the definition of the federal poverty level (FPL) for annual household incomes. Regarding non-financial criteria, age, residency and citizenship or alien status is considered.

Ms. Stephens stated that primary Medicaid and CHIP services include acute care services, long-term services and supports, behavioral health services, medical transportation services, and pharmacy services. There are two models for service delivery. Managed care accounts for 95% of clients. A managed care organization (MCO) is paid a capitated rate for each member enrolled. MCOs provide a medical home through a PCP and referrals for specialty providers, when needed. MCOs negotiate rates with providers and may offer value-added services. Ms. Stephens stated that the other 5 % of clients use fee-for-services (FFS) service delivery models. Clients

may go to any Medicaid provider, providers submit claims directly to HHSC's administrative services contractor for payment. Providers are paid per unit of service. Most FFS clients do not have access to service coordination.

Ms. Stephens explained HHSC's managed care programs. The STAR program serves children, pregnant women, and some families. STAR Kids serve children and youth with disabilities. CHIP serve children and youth who don't qualify for Medicaid due to family income. STAR Health serves children who get Medicaid through the Department of Family and Protective Services and young adults previously in foster care. STAR PLUS serve adults with a disability, people age 65 and older(including those dually eligible for Medicare and Medicaid), and women with breast and cervical cancer.

Ms. Stephens stated that HHSC has made improvements to the Texas Medicaid system by leveraging the managed care integrated delivery system, increasing access to services and the type of services available, using innovation and incentives to improve quality of care, and strengthening operations and oversight.

Ms. Stephens explained HHSC's quality initiatives. The Medical and Dental Pay-for-Quality(P4Q) improvement measure uses capitation recouped from plans that do not perform well, and redistributes funds to well-performing plans. Its measures focus on prevention, chronic disease management, including behavioral health, and maternal and infant health. MCOs are evaluated on their performance relative to their peers and their own prior year performance. Alternative Payment Models (APMs) are payment approaches that incentivize high-quality and cost efficient care by linking portions of payments to measures(s) of value. APMs may apply to a specific clinical condition, care episode, or population. They may involve financial risk and rewards, or simply be rewards-based. They may span the full continuum of risk from no shared risk to full risk-sharing. Ms. Stephens explained value-based enrollment.

Implemented September 1, 2020, this measure lets MCOs with better performance than others on weighted factors (40% cost and efficiency, 20% cost and quality, and 40% quality and member satisfaction) to receive a higher share of default enrollments.

Ms. Stephens stated that SB 7(82R) and SB 7(83R) required HHSC to reduce potentially preventable events, including potentially preventable readmissions(PPRs), which are readmissions that are clinically-related to the initial hospital admission, and potentially preventable complications(PPCs), which are harmful events or negative outcomes, such as infection or surgical complication, that occur after a hospital admission.

The Committee heard testimony from Trey Wood, Chief Financial Officer for HHSC.

Mr. Wood explained that HHSC projects a net supplemental appropriation need of approximately \$3.7 billion in General Revenue for the 2022-23 biennium.

Mr. Wood explained the 1115 waiver, which since 2011, has enabled the state to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded

supplemental payments to hospitals. The waiver is the federal authority that Texas uses to deliver Medicaid managed care. The following programs are under the 1115 authority: STAR, which delivers acute care services primarily to low income families, children and pregnant women, STAR PLUS, which provides acute and long term service and supports primarily to older adults and adults with disabilities, STAR Kids, which provides acute and long-term service and supports to children with disabilities, and the children's dental program, which provides dental care to most children under 21.

Recommendations

- **Establish new alternative coverage option that allows insurers to offer "Consumer Choice" plans that forego certain state-imposed regulations and mandates.**
- **Explore opportunities to expand coverage requirements in Medicaid Managed Care to include preventive services that reduce or eliminate the development and/or progression of chronic disease.**
- **Explore ways to implement a pilot program in which low-income or at-risk Texans could access Direct Primary Care at Federally Qualified Health Centers.**

INTERIM CHARGE IV

Study ways to improved outreach to families with children who are eligible for, but not enrolled in, Medicaid or CHIP, including children in rural areas;

Testimony

The Committee heard testimony from Anne Dunkelberg, representing Children's Health Coverage Coalition.

Ms. Dunkelberg stated that it's the Coalitions belief that no child or pregnant woman in Texas should be without care because Texas has either affordable health coverage today or temporary maternity care, for nearly every child or pregnant woman. Yet numerous barriers keep many Texans who qualify from enrolling, and our state's uninsured rates are the highest in the nation. The Coalition believes the Texas Legislature should remove these barriers to coverage and be an active partner in connecting eligible kids and pregnant women to coverage by investing in needed staff, increased outreach, and streamlined systems that reduce burdens on state eligibility staff and families.

Furthermore, the Coalition believes the state's outreach efforts aimed at reaching eligible uninsured children and pregnant women are not as robust as they once were, and Texas' enrollment systems are not nearly strong enough to meet the heightened need during the unwinding of the Public Health Emergency (PHE). When the PHE ends 3.7 million Texans, most of them children, will be at risk of losing coverage, testing our outreach efforts and enrollment systems like never before. It's the Coalitions belief that, before the end of the PHE, Texas should commit to urgently taking the steps needed to keep eligible children enrolled, and once the PHE-unwinding period ends, Texas should commit to continuing successful outreach and enrollment strategies.

Through submitted written testimony, the Children's Health Coverage Coalition made a handful of recommendations aimed at reducing the number of children in Texas who are eligible for Medicaid or CHIP but not enrolled.

The first recommendation related to revitalizing the state's outreach and application assistance efforts to connect more eligible children and moms to health coverage. In order to enroll the most hard-to-reach populations and connect with community-level stakeholders to reach historically uninsured children, the Coalition believes the legislature should fund outreach, including outreach and application assistance performed by community-based organizations by no less than \$15 million per biennium.

Funding for Medicaid and CHIP outreach has been cut back since 2009, and funding to Community Partner organizations that perform outreach and enrollment assistance activities at the community level was completely eliminated. Funding these Community Partners would not only help applicants, but it would also help relieve burdens on both state eligibility workers and the 2-1-1, Option 2 call center.

Ms. Dunkelberg specifically highlighted the issue of outreach to mixed-immigration-status families with children who may be eligible but not enrolled in Medicaid or CHIP. An estimated one in four Texas children has a parent who is not a U.S. Citizen (of any immigration status), and within these families there is often a fear that utilizing these programs for eligible children could

negatively impact family members and their ability to become citizens, or that information may be used to track and deport undocumented family members.

Ms. Dunkelberg stated that HHSC should conduct targeted outreach for these families in order to correct any misinformation and alleviate these concerns.

The Coalition believes that Texas should also ensure that any innovative outreach approaches implemented due to the PHE are permanently incorporated into Medicaid.

The Coalition's second recommendation relates to removing barriers in state enrollment systems that keep eligible Texans from receiving initial coverage and then staying covered.

The Coalition believes that Texas cannot meaningfully reduce its eligible yet unenrolled population without first addressing artificial barriers that discourage or prevent enrollment or renewal of eligible kids. It's their belief that outreach alone is not sufficient to keep families from struggling to get or keep coverage.

When the PHE ends, the Texas eligibility and enrollment system will face a task that is unprecedented in scale while grappling with substantial workforce constraints. Given this, the Coalition believes that Texas should work now to streamline systems and leverage flexibilities to mitigate the loss of coverage by eligible children at the end of the PHE.

Some of the efficiency changes and barrier removals advocated for by the Coalition include the access to, and leveraging of, reliable third-party data by HHSC to increase the efficiency of application and renewal determination and the updating of client contact information.

The Coalition also believes that HHSC should adopt an "Express Lane Eligibility" that utilizes qualifying information that has already been verified by HHSC through SNAP or other programs.

The Coalition also supports efforts to remove barriers in client-facing systems to ensure that individuals can easily complete simple and critical tasks such as electronically updating their contact information, resetting their password, and getting full access to their case on the web portal and mobile app.

The Coalition also recommended that the legislature adequately fund the state's eligibility and enrollment systems to allow HHSC to better compete in the tight labor market. Adequate staffing will help prevent harmful delays in coverage now and will help to prevent a large loss of coverage among eligible kids at the end of the PHE.

During questioning, Representative Walle referred back to the testimony regarding mix-status families and how this impacts one in four Texas children. He asked if this data could be broken down into a number of actual households that are impacted.

Ms. Dunkelberg was unable to accurately answer the question. She stated that in order to come up with that number, it would take in-depth analyzing of census data in order to come up with any kind of accurate number.

The Committee heard testimony from Mr. George Hernandez, who was representing University Health and the Texas Hospital Association.

Mr. Hernandez began his testimony by providing a brief overview of University Health. University Health is a public health system in San Antonio and Bexar County that provides a comprehensive health network for the community as well as a robust ambulatory network.

Being a larger public health system that offers such a comprehensive health network, United Health sees and treats numerous uninsured individuals from around the state, many of whom may qualify for Medicaid or CHIP. Mr. Hernandez stated that University Health provided roughly 30 million dollars in uncompensated medical care in 2021 to individuals without insurance.

By providing such a large volume of service, both compensated and uncompensated, this has driven University Health to invest heavily in Information Technology (IT). University Health believes that strong investments and upgrades in IT will lead to better and faster health care. Mr. Hernandez provided an example of University Health's IT investment through their 150-million-dollar investment in the electronic health record Epic. This particular health record is probably the dominant health record in the country today, particularly among academic medical centers.

University Health data-mines the Epic EHR information on a weekly basis and that information is then used when an uninsured child or mother comes to University Health to see if those individuals can qualify for Medicaid, CHIP or another program.

Along with their investment into the use of Epic HER, Mr. Hernandez expanded on University Health's commitment to helping eligible individuals enroll in Medicaid or CHIP. Given that University Health provided 30 million dollars in uncompensated care, they have a strong incentive to try to figure out how to enroll people for Medicaid or CHIP. In an effort support this enrollment, University Health invested into a program called CareLink Medicaid/CHIP Enrollment Assistance.

CareLink is a safety-net medical assistance program for uninsured residents of Bexar County. The processes used by CareLink check a patient's eligibility for Medicaid, CHIP, and grant supports before enrolling the individual in CareLink. CareLink also administers a federal Connecting Kids to Coverage grant and provides year-round education and assistance to families in applying for and renewing Medicaid or CHIP.

From 2019-2022, the Connecting Kids to Coverage Grant has helped hold 349 outreach events and activities which has resulted in over 10,000 individuals being reached, 7,905 applications for children being submitted, and 5,888 children either newly enrolled or re-enrolled.

Mr. Hernandez then discussed University Health's ongoing partnerships with HHSC. For over 20 years they have partnered with HHSC to have eligibility employees in their hospitals and clinics

in order to immediately process application for persons who potentially qualify for Medicaid or CHIP.

University Health has also partnered with school districts during back-to-school events, local food banks, non-profit agencies and faith-based groups to help spread awareness about Medicaid and CHIP enrollment. It's their belief that community involvement and connection is very important. These groups can often help bridge digital divides by having computers and internet that can be used by individuals.

To wrap up his testimony, Mr. Hernandez highlighted the use and impact that various forms of media have had with outreach and educational efforts.

With impressions being the number of times that a piece of media is seen or consumed, traditional media, which includes TV, radio, and print, have had 253,164,048 impressions. Total social media ads and outreach had an estimated 13 million impressions.

Representative Walle then asked how many of the individuals that University Health has helped to re- certify or re-enroll into Medicaid or CHIP before the end of the PHE will actually end up qualifying and being able to continue receiving benefits once the PHE has ended.

Mr. Hernandez responded that University Health is not able to know who will actually end up re-qualifying at the end of the PHE, but he said that the work has to start somewhere in order to help avoid a mass falloff of coverage for qualified individuals and each person help re-enroll will cut into that number.

The Committee heard testimony from Alec Mendoza, Senior Policy Associate for Health Care with Texans Care for Children, on the importance of the Legislature addressing unintended bureaucratic barriers for coverage and improvement of outreach and education while taking proactive opportunities to enroll current eligible children into Medicaid or CHIP.

Mr. Mendoza explained that having access to health care helps kids attend regular checkups, identify disabilities, adjust mental health challenges, and get back into the classroom after being sick. Having access to needed health care also makes kids more likely to succeed in school, graduate high school, attend college, earn higher wages throughout their lifetime, and just grow up to be overall healthy Texans.

Mr. Mendoza then discussed how access to health care is out of reach for many in Texas and that Texas has the highest uninsured rate in the country. The national average of eligible children participating in Medicaid or CHIP is 91.9%, while Texas sits at only 84.5% which translates to around 400,000 Texas children who are eligible for coverage but not enrolled.

He then talked about how many of the eligible but unenrolled kids tend to fall in to a few specific categories.

The first group are children who are eligible and come from a mixed immigration status family. This can lead to complex situations which may cause parents to think their children are not eligible for health coverage even though many of these children come from low-income families and are either U.S. citizens or are lawfully in the country.

The second population consists of children who are eligible but not enrolled are those whose parents either are attempting or have attempted to enroll them but have been blocked by various bureaucratic barriers.

Mr. Mendoza explained that enrollment in these programs is already complicated enough, and it's made even more difficult thanks to the lack of user friendliness of YourTexasBenefits.com, long 2-1-1 wait times, difficulty in resetting passwords or updating personal information, field office closures and eligibility workforce vacancies.

The third population of children are those whose parents are not aware of Medicaid or CHIP health insurance options.

In order to address this group, Mr. Mendoza advocated for the revitalization of the state's health coverage marketing, outreach, and application assistance efforts. He also noted support for including funding for community-based organizations, food banks, and local health centers. Mr. Mendoza said that this was funded by the state in the early 2000's but has since stopped. He explained that this limits the state's ability to communicate to families who may not know their child is eligible or are having trouble navigating the process.

Mr. Mendoza then moved on to talk about proactive steps the state could take to improve enrollment. He explained that Texas' current enrollment process makes it possible for children to only be enrolled in one program per application even if they may qualify for multiple assistance programs. For example, a child could be eligible for both SNAP and Medicaid benefits, but the parents would have to submit two separate applications in order to be enrolled. Not only does this process take up a lot of time for the parents but it also leads to families missing coverage because they may not be aware of the need to submit multiple applications.

In order to combat this, Mr. Mendoza recommended that the Legislature adopt Express Lane Eligibility (ELE) in order to allow HHSC to rely on already-verified eligibility information from the SNAP program to expedite and simplify enrollment in health coverage. It was noted that other states have implemented similar programs and it's lead to higher enrollment as well as lowered administrative costs to the state.

Mr. Mendoza next discussed how Texas newborns are falling through the cracks and not receiving health care despite their mother being enrolled in Medicaid.

Mr. Mendoza talked about how, if a mother is enrolled in Medicaid when she delivers her baby, the newborn is automatically eligible for Medicaid for the first full year of life. However, in 2018, a reported 64,775 Texas newborns had some type of coverage interruption during their first year of life. (Source: CMS-416 annual report with numbers reported by Texas. Page 16 of slides.)

He also discussed how there is no uniform process for Texas hospitals and birthing centers to properly handle the discharge process for mother and this leads to newborns not receiving coverage. The mother then has to call 2-1-1 in order to enroll their newborn and they are faced with the previously mentioned wait times and lack of options to enroll online.

As a potential solution, Mr. Mendoza recommended that the Legislature require HHSC to use current information to generate and issue separate Medicaid identification numbers for the child before their birth or allow for the mothers Medicaid information to be used for pediatric clinic visits. He also recommended the development and circulation of handouts for hospitals to provide to mothers which would have clear and easy-to-read instructions for ensuring that their child is enrolled.

The final recommendation from Mr. Mendoza for connecting more eligible children to health care coverage was leveraging the School Health and Related Services (SHARS) program.

Schools are a place where many children already receive services, such as physical therapy, speech therapy and mental health support. Texas is missing an opportunity to connect more eligible kids to health coverage by partnering with schools.

Mr. Mendoza stated that Texas schools are currently able to receive Medicaid reimbursement for certain health services, but only for student with disabilities and who have an individualized education plan. He recommended that the state allow schools to receive Medicaid reimbursement for health and/or mental health services through the SHARS program for any Medicaid eligible student.

This would broaden the scope of services offered by schools would allow more access to care for kids, and costs could be covered through a mix of federal and state Medicaid funds.

Mr. Mendoza noted that several states have already done this, including Florida, Missouri, South Carolina, and Louisiana.

Wrapping up his testimony, Mr. Mendoza talked about how the end of the PHE could spell disaster for Texas and create chaos for families if it's not handled properly. With the PHE predicted to end in January of 2023, Texas will need to process an estimated 5.5 million Medicaid applications. This already poses a serious problem and will only be exacerbated by the aforementioned barriers and problems if HHSC initiatives and improvements are not implemented in a timely manner.

Vice Chair Rose stated that a lot of Mr. Mendoza's recommendations seem like no-brainer solutions. She asked if any such legislation had been introduced in previous legislative sessions.

Mr. Mendoza answered that, aside from funding, none of these recommendations had been introduced. He noted that these changes could be implemented directly by HHSC, but history has shown that the agency often waits for legislative direction before acting and this might be a similar case.

Representative Bucy asked for Mr. Mendoza to expand on the Express Lane Eligibility and what it would look like tangibly.

Mr. Mendoza explained that HHSC has an integrated application system. Meaning, applications for services look the same for SNAP, Medicaid, CHIP, and all other programs. Applicants just have to check the box for which benefit they're applying for. With ELE, HHSC would be able to automatically check every application for possibly qualification of other benefits and then notify the families who could then decide which benefits they would like to register for.

The Committee heard testimony from Bee Moorhead, Director of Texas Impact.

Ms. Moorhead focused her testimony around working through faith and community-based organizations. While she said that's not the only solution, it is certainly an important one. Ms. Moorhead stated Texas Impact's support for the HHSC Community Partner Program (CPP) and stressed its importance and effectiveness. She explained that these faith and community based organizations are a good way to granularly get into local communities. And while these groups are not casual or low-cost partners, they are often extremely trusted within their communities especially with reluctant parents who might be in mixed-status households. She then said that if the state were to decide to lean into the CPP, it would need to ensure that it provides proper resources for these groups. There's a significant amount of training and support that goes into the level of assistance the CPP groups provide.

Ms. Moorhead then talked about the unique position that Legislators are in when it comes to recruiting assisters and getting these faith and community-based organizations to become involved. She urged Legislators to meet and work with these groups within their districts, because their involvement could have a measurable impact.

Next, Ms. Moorhead discussed the possibility of utilizing the Interagency Coordinating Group and the Texas Nonprofit Council. She explained that these two bodies have statutory roles and responsibilities that could make them ideal partners, and the Legislature could charge these bodies to work on the issue of making an effective outreach campaign. At the end of this topic Ms. Moorhead disclaimed that neither she nor Texas Impact had talked to either of these two groups about if they believed this would be a good and effective approach.

The Committee heard testimony from David Preston, Director of Marketing & Outreach and Public Information Office for Community Health Care Center, and he was representing the Texas Association of Community Health Care Centers (TACHC).

Mr. Preston began his testimony by providing an overview of what health centers do and the services they provide. Health centers are a safety-net provider that offers a variety of comprehensive primary and preventative care services, which may include medical, dental, behavioral health, pharmacy, and vision services all under one roof. These services are open to everyone from infants to the elderly.

Health centers also help reduce barriers to care by offering various social support services, including outreach and enrollment support to assist and enroll eligible patients in Medicaid, CHIP, SNAP, TANF, Healthy Texas Women's Program, and the Health Insurance Marketplace.

By offering these services, in 2021 health centers served over 1.7 million Texans. Roughly 35% of those patients were children ages 17 and under, and more than 400,000 children treated at these health centers annually are covered by Medicaid or CHIP.

Along with caring for the insured, health centers also provided care to almost 100,000 uninsured children in 2021. By serving eligible but unenrolled patients, health centers absorb this cost and are forced to use resources that would normally be intended for outreach and care of patients who are truly uninsured and ineligible for any other coverage or programs.

Given this uncompensated cost of care for uninsured individuals, TACHC has a vested interest in connecting eligible patients with coverage in order to promote health center sustainability so they can continue providing services.

Mr. Preston explained that health centers can streamline the application process for patients seeking Medicaid coverage because of the coordinated system between Outreach and Enrollment (O&E) health center staff, HHSC's Community Partner Program, and HHSC out stationed eligibility workers.

Many health center O&E staff are able to provide additional support to patients because of their participation in the Community Partner Program through HHSC. Statewide, 64 health centers participate in the program, and it allows Texans to get help applying for or managing benefits from a trusted organization that they visit regularly. The state provides direct support and training to participating O&E staff and the program has three levels of partnership:

- Level 1: Self-service sites must provide a computer with internet capability for the public to submit an application or manage their benefits on [YourTexasBenefits.com](https://www.yourtexasbenefits.com).
- Level 2: Application Assistance sites must offer the same capability as Level 1, but also have trained and certified staff and/or volunteers to assist individuals with submitting applications or managing their benefits on [YourTexasBenefits.com](https://www.yourtexasbenefits.com).
- Level 3: Case Assistance sites offer the services provided by Levels 1 and 2 Community Partners. In addition, Case Assistance Navigators can provide a greater level of support including case management and password resets.

Moving on in his testimony, Mr. Preston confirmed that there are a number of misconceptions regarding Medicaid and CHIP eligibility and enrollment that are leading to higher numbers of eligible but unenrolled individuals.

These problems include the stigma and perception around receiving these benefits and also the preference that many individuals have for in-person help, but they're often deterred by long wait times or travel requirements for assistance at official offices.

Another set of problems is that many individuals are unsure of the specific eligibility requirements to receive assistance and many people, if they were previously denied, are under the belief that they cannot re-apply for benefits.

In his closing comments, Mr. Preston provided some recommendation brought forth by TACHC:

- Leverage federal funds to increase eligibility access through outstation eligibility workers and offset funding costs.
- Dedicate funding to HHSC's Community Partner Program.
- Invest in public awareness campaigns in collaboration with community partners.

Following Mr. Preston's testimony, Chairman Harless asked if the health centers assist in any way with the enrollment of children who come to them for services.

Mr. Preston said that the centers try to do eligibility screenings on all their patients to see if they would qualify for any benefits. However, not everyone wants to take the time needed to visit with eligibility staff, but the centers offer the option of appointments or walk-ins on later dates.

The Committee heard testimony from Wayne Salter, Deputy Executive Commissioner of Texas Health and Human Services Commission (HHSC).

According to Texas census data from 2020, roughly 17% of Texans are uninsured. And of those uninsured, 10%, or 510,173 individuals, are eligible for Medicaid or the Children's Health Insurance Program (CHIP) but are unenrolled. Mr. Salter provided a brief overview for how Medicaid eligibility is determined, identified various issues that could be contributing to the cause of eligible individuals not enrolling in Medicaid or CHIP, and he explained what HHSC has done to attempt to bridge this gap as well as identifying additional steps that could be taken by the Legislature and the agency.

Mr. Salter explained that when determining Medicaid eligibility, HHSC looks at two primary factors. One factor is a financial review where HHSC eligibility staff look at an applicant's annual income as it compares to the federal poverty level. The second factor is non-financial information which will include the individuals age, residency status, and citizenship status. For the eligible population in Texas, the State covers children and youth, parents and caretaker relatives, women, people aged 65 and older, and children and adults with disabilities. Mr. Salter did note that the specific eligibility criteria and population will vary by program.

Moving on to impacts to enrollment, HHSC worked closely with various stakeholders and advocates in order to identify the most common potential reasons for why eligible individuals are not enrolling in Medicaid or CHIP. Mr. Salter outlined the top impacts that were identified which were, difficulty navigating through the eligibility process; administrative procedural requirements; 2-1-1 Option 2 call wait times; and the stigma associated with receiving public assistance. Mr. Salter proceeded to explain some of the ways that HHSC has acted to mitigate some of these concerns and foster enrollment for those who are uninsured.

Mr. Salter discussed how HHSC has implemented new administrative processes, with the most recent being that HHSC has gained access to the Centers for Medicare and Medicaid Services (CMS) data hub. This allows HHSC to gather additional employment and income information from individuals who are applying for Medicaid services. This has helped reduce the amount of times that HHSC has to reach out to individuals who are applying for, or receiving, Medicaid and their employers. HHSC has also reduced their periodic income checks for individuals receiving children's Medicaid from four to one in the 6th month of the 12-month certification period.

In response to 2-1-1 call capacity issues and wait times, HHSC has increased the number of agents taking calls by 98% from March 2022 to September 2022. Mr. Salter explained that HHSC has also implemented a virtual lobby where they are able to use specially trained clerical staff to assist call center agents with password resets during peak call times. They have also begun utilizing a courtesy call back feature that is activated during peak volume times. This allows individuals to virtually reserve their place in the call line and then have an available HHSC agent automatically call them back once their turn has arrived for assistance. Mr. Salter stated that this call back feature has been a relief to those who are unable to actively wait on the phone for assistance.

Mr. Salter continued his testimony by explaining to the Committee certain initiatives that HHSC has implemented with the focus of increasing eligibility production capacity.

Mr. Salter explained that, like all other agencies, HHSC has been faced with serious staffing challenges and they currently have roughly 400 vacancies. To fill these vacancies, HHSC has taken what they describe as "aggressive steps" in addressing these problems.

HHSC has implemented on-the-spot hiring in 73 eligibility offices across the state. This means that when an individual comes into one of these eligibility offices seeking assistance, they are provided with information on employment opportunities within HHSC for enrollment support, they are screened and interviewed on-the-spot, and they are able to leave the office that day with a conditional offer of employment.

HHSC has also taken the following actions: conducting targeted job fairs in communities where their starting wage is competitive; offering part-time employment focused at HHSC retirees who are already trained in eligibility determination; have reduced the time from hire to start of training by 50% for critical eligibility staff; and, increased starting salaries of critical hard-to-fill eligibility staff positions.

Together, all these initiatives have realized a net gain of 800 eligibility staff from April to August 2022 and have reduced the vacancy rate from more than 20% in February 2022 to 11% as of September 2022.

Mr. Salter then touched on HHSC's Community Partner Program (CPP), which is a statewide network of faith- and community-based organizations who help Texans apply for, renew, and manage their food, cash and health care benefits online. This program strengthens local communities by building relationships between HHSC, community organizations, and those needing services.

Mr. Salter explained that, in order to be most effective, HHSC trains and certifies Community Partners to: provide application assistance and case management services using YourTexasBenefits.com; educate clients to manage their benefits, leading to increased self-sufficiency and reduced 2-1-1 calls or visits to local benefits offices; and, provide computer access, online support, and application assistance at trusted local locations that clients visit regularly.

Through the CPP there are currently 604 community partner organizations and 1,674 partner sites, and in fiscal year 2022 these partners were able to directly assist thousands of constituents.

Mr. Salter continued his testimony by touching on various education and outreach initiatives. One of these is HHSC's recently implemented Case Assistance Affiliate (CAA) Program.

Through this program HHSC is working closely with their Managed Care Organizations (MCOs) and Dental Contractors (DCs) to provide eligibility renewal assistance for Medicaid and CHIP to members whose eligibility is about to expire, as is required by the MCO and DC contracts.

HHSC has leveraged the infrastructure of the previously mentioned CPP to allow MCO and DC staff to assist with the completion of health benefit renewals, as well as help with password resets when an individual is locked out of their YourTexasBenefits.com account.

Continuing discussion on education and outreach initiatives, Mr. Salter discussed the implementation and role of out-stationed eligibility staff.

Per federal law, HHSC is required to have out-stationed eligibility staff in locations other than state benefit offices. This staff is typically housed in Federally Qualified Health Centers (FQHC), disproportionate share hospitals, revenue generating hospitals, clinics, and nursing facilities. HHSC currently has agreements with 1,024 out-stationed facilities and have 429 of their eligibility staff posted at these facilities.

These out-station workers have proven effective with over 129,000 applications and renewals having been submitted and processed during the calendar year for 2021.

Mr. Salter then moved on to discussing HHSC's outreach partnerships that they have as a part of the HEALTHY KIDS Act. This is a federal outreach grant that funds initiatives geared at reducing the number of children who are eligible for, but not enrolled in Medicaid and CHIP.

HHSC is currently partnered with MHP Salud through a Memorandum of Understanding to share certain patient data. HHSC provides MHP Salud with data on the number of individuals who are currently insured or receiving Medicaid. MHP Salud then uses this data to conduct community outreach efforts and HHSC follows up with an additional data true up. MHP Salud then examines their efforts to see whether or not they have been able to increase the enrollment of children who are eligible but not enrolled in Medicaid or CHIP.

While HHSC does have this current agreement with MHP Salud, they are exploring ways to foster additional agreements with local community outreach efforts.

To wrap up his testimony, Mr. Salter discussed additional considerations and initiatives being taken by HHSC to further reduce the eligible but unenrolled population by removing roadblocks and making the process more user-friendly.

HHSC as started the expansion of their community partner program, as they believe this is a critical program for closing the unenrolled gap. At the start of fiscal year 2023, HHSC began utilizing an evidence-based recruitment plan, where they're looking at targeting and increasing their community partner presence in high poverty areas. HHSC is also comparing the estimated number of people in poverty by county to the number of community partner sites located within the same county in an effort to properly expand their community network to target areas with a high percentage of eligible but unenrolled individuals.

HHSC is also working to resolve one of the more common problems they're contacted about, which is trouble with resetting account passwords. HHSC plans to follow some of the private industry standards and best practices for unlocking and resetting passwords through the use of multi-factor authentication via text or email. This would remove the need to call-in to the 2-1-1 line.

Mr. Salter also highlighted certain customer service initiatives that are currently being worked towards. This includes the "Pizza Tracker" initiative which would allow individuals to track the status and life of their application from submission through authorization. He also noted HHSCs work towards automating the processing of referrals received from healthcare.gov, more commonly known as the "marketplace", which would free up eligibility staff.

Following Mr. Salter's testimony, the members moved into asking clarifying questions.

Representative Frank questioned why they Insured vs. Uninsured breakdown provided by HHSC did not provide additional information on the roughly 3.8 million Texans who are uninsured but ineligible for Medicaid. He asked if there is additional information on how many of those 3.8 million are eligible from "Obamacare" subsidies, who is ineligible due to too high of an income, and if HHSC eligibility staff inform ineligible Medicaid applicants of these potential subsidies.

Mr. Salter was unable to provide clarification on the uninsured and ineligible population at the time but said that HHSC would follow up with Representative Frank. As for eligibility staff informing individuals about marketplace subsidies, those who are not eligible for Medicaid are automatically referred to the marketplace and eligibility workers help explain the process. However, once an individual has been deemed ineligible for Medicaid and is referred to the marketplace, HHSC has limited visibility into what steps individuals take towards receiving coverage and subsidies.

Chairman Harless asked when HHSC expected the password reset updates would be implemented and when the 2-1-1 wait times are expected to improve.

Mr. Salter responded that the password reset updates should be implemented within the first quarter of 2023. As for the 2-1-1 wait times, those are already improving. In May and June of

2022, wait times were in excess of 35 minutes. As of September 2022, the average wait time was under 11 minutes.

Representative Walle asked if HHSC had looked into the possibility of using targeted advertisement technology for outreach efforts, similar to targeted ads that are often experienced on the internet.

Mr. Salter said that specific tactic is not something that had been considered yet by HHSC, but it's something that could definitely be looked into as technology discussions continue. Representative Klick expressed concern that the application/approval time for Medicaid takes so long that many pregnant women are missing out on vital prenatal care. She asked if HHSC has any special programs to expedite the process for that population

Mr. Salter stated that HHSC does not have any special program for that population, but they are looking at increased communication and visibility for that population in order to better assist them and get them signed up sooner.

Representative Klick then followed up noting that within the CPP, health plans have been allowed to assist due to the Public Health Emergency (PHE). She asked if HHSC is proposing that that ability be permanent thanks to its effectiveness in assisting individuals and relieving stress load from HHSC staff.

Mr. Salter said that HHSC is having those conversation of continued assistance with their health plans and will continue those conversations post-PHE, but was unable to provide a full confirmation or denial at the time.

Representative Bucy asked what the current turnaround time is for responding to applications and then getting individuals registered and signed up for benefits.

Mr. Salter said that HHSC has been working to reduce their backlog of application and have approximately 70,000 remaining that are at or past the 30-day mark waiting for determination. It's anticipated that by the end of November 2022 these backlogged cases will be resolved, and any new applications can expect to be fully responded to within a 30-day window.

Representative Bucy then asked, with the PHE expected to come to an end at the end of 2022 or beginning of 2023, what is HHSC doing in regard to outreach and communication to help ensure that a drastic number of eligible enrollees do not fall out of coverage?

Mr. Salter responded that HHSC is utilizing the CPP for outreach and has also started an "Ambassador Campaign" where they're working with a lot of major stakeholders in order to get information to individuals and receive updated contact and address information.

Representative Bucy finished his questioning by asking what HHSC needs from the Legislature in order to help identify the over 400,000 kids that are believed to be eligible but unenrolled.

Mr. Salter said that, of course technology and additional funding is always welcomed, but that HHSC would prefer to come back with a really holistic answer for members after speaking to stakeholders and working internally to identify what is truly needed.

Recommendations

- **Consider funding for outreach initiatives, including state funding for community-based organizations to conduct outreach and provide application assistance to families with eligible children. Additionally, HHSC should continue the "case assistant affiliate" designation to allow Medicaid Managed Care Organizations to assist with applications and case management.**
- **Consider legislation directing HHSC to review eligibility processes to identify efficiencies, including allowing the state to utilize already-verified data from other state programs to assist in determining eligibility for Medicaid and CHIP.**

INTERIM CHARGE V

Examine the potential impact of delayed care on the state's health care delivery system, health care costs, and patient health outcomes, as well as best practices for getting patients with foregone or delayed health interventions back into the health care system. The study should consider patient delays in obtaining preventive and primary health services, such as well-child care, prenatal care, screenings for cancer and chronic disease, behavioral health, and immunizations, in addition to delays in seeking urgent care or care for chronic illness.

Testimony

The Committee heard testimony from Jessica Boston with the Texas Association for Home Care & Hospice.

Speaking on delayed care, Ms. Boston explained that home care is a critical part of the health care continuum that many vulnerable Texans receive, and for some, it may be their only option for care. As was demonstrated during the pandemic, home care prevented the delay in care by allowing those who were fearful, immunocompromised, and most at risk to continue to receive the critical care in the home. Home care allows critical care settings to continue absorbing the needs of Texans when parts of the health care system are limited or overwhelmed by a public health crisis or other disaster. Ensuring that home care is considered as an investment in the overall healthcare continuum to ensure preventative care continues, avoiding costly health care interventions such as nursing home placement, or increased emergency department use or hospitalizations.

She continued that however, due to the workforce challenges facing Texas across industries, providers are unable to offer all the medical care to children, seniors and individuals with disabilities resulting in families losing access to necessary care. In Texas, over 7,000 children with multiple disabilities, or who are medically fragile, require care by nurses that have special skills, knowledge, and training in order to remain at home with their families and out of institutions and hospitals. Furthermore, over 300,000 seniors and individuals with disabilities require long term services and supports in their homes. Children who receive private duty nursing services have lower hospital costs, fewer hospital admissions, and are less likely to be readmitted compared to medically fragile children who do not receive these services. Private duty nursing services are a Medicaid cost containment solution that keeps families together. Likewise, seniors and individuals with disabilities also experience lower hospitalization rates and preventable emergency visits when home care is accessible. When home care is supported and accessible, the state saves money and individuals experience better health outcomes.

Unfortunately, Texas home health agencies are struggling, and this has caused a real access to care issue for medically fragile children, seniors, and individuals with disabilities and their families. Agencies are not able to fill all of the authorized hours and children are being hospitalized as a result. Providers and families report that children are unable to be discharged from the hospital because of the lack of nurses in the home care PDN space. Services at this level of care cannot be delayed. Likewise, the lack of access to LTSS, has resulted in unnecessary nursing facility placements.

Continuing her testimony by speaking on patient health outcomes, Ms. Boston said that Home health care is an often overlooked component to the health care system. However, as the industry finds itself fighting to keep the doors open, the demand is also at some of its highest levels. The competition for healthcare workers has been insurmountable for providers. For example, as nurses left the home health field to accept signing bonuses and exponentially larger salaries in institutional settings during the pandemic, providers were unable to keep up and unable to meet

the demand. This lack of hours staffed results in patients unable to get the care they need or delaying essential health care for those most at risk.

Many patients are still fearful of seeking care despite the knowledge gained during the pandemic. Home health is an exceptional option for those who are immunocompromised or aging to receive preventive health care services in the home and prevent expensive emergent care due to inability to access home health care. Homecare was able to lead the charge during the pandemic by providing in-home immunizations ensuring that prophylactic options are available, and necessary routine care and life- saving care is able to continue.

Ms. Boston concluded her testimony by discussing health care costs and lack of investment, specifically to that of pay rates for attendant services.

She explained that homecare has experienced tremendous financial hardship for over a decade related to the lack of investment and this is translating into a desperate situation for the homecare industry.

Provider rates have been inadequate to recruit and retain employees for over a decade and are worse in the post-pandemic world. We have employees that can go elsewhere for higher wages, greater benefits, less complex environments, and greater flexibilities. Adding to this pressure is the fact that providers have seen the cost of operations continue to rise especially during the height of the pandemic, yet this aspect of the reimbursement rate has not kept up. In fact, has actually decreased.

Providers have not seen a rate increase to the attendant service support cost area for over 16 years. This portion of the rate supports all the regulatory compliance, supervision, fraud prevention, quality controls, infection controls, benefits for attendants, employment taxes, attendant training, and retention to name just a few. Furthermore, add the level of inflation of today, and this amount is even lower. This is an unsustainable situation. We have to find away to support the attendants with a competitive wage rate and the providers with a service support rate that can cover rising costs. This chronic neglect has also led to more hours of needed services going unfilled, and individuals going into nursing homes and hospitals at great cost to Texans and to Medicaid.

The demand for nurses as a result of the COVID 19 pandemic, and the shrinking pool has also created unprecedented inflation in the hourly wage to hire qualified nurses. Because home care agencies have not received similar tranches of provider relief funds to offer hazard pay and sign on bonuses as other industries, they are no longer able to compete for nurses who are leaving for higher paying hospital positions.

The Committee heard testimony from Katrina Daniel, Chief Health Care Officer for the Teacher Retirement System (TRS) of Texas.

Beginning her testimony by providing an introductory to the TRS programs, Ms. Daniel explained how TRS administers two health care programs, one for active members and one for

retirees. The program for active members has about 1,000 public education employers across the state enrolled in active care and nearly 500,000 members. The retiree health program has about 240,000 members. Together, both of these plans spend about \$4 billion per year.

Ms. Daniel said that, like many others, TRS experienced increased COVID expenditures during the pandemic. During the interim, TRS received \$721 million in federal funds to offset their COVID claims cost. These funds were able to be used to offset premiums in both Active Care and Care. TRS was able to give retirees basically what amounted to a premium refund of about \$448, which is about two and a half or three months of premiums depending on the plan that an individual is enrolled in.

Ms. Daniel continued on by saying that TRS had also been able to hold premiums constant in the Active Care program.

Moving on to how the programs are funded, Ms. Daniel explained that the Care and Active Care programs are funded separately through different sources of revenue.

The Care program is funded from a range of sources including state funds, employer and employee contributions, and plan participant contributions.

For Active Care, Ms. Daniel explained that it acts more like a fully insured plan for employers that participate, and generally all the funds come from the employer in the form of premiums. With that being said, the recently received federal funds is the first time that TRS has received funds outside of premiums for the Active Care plan. So, in the way that other businesses operate, the employer contributes a portion and then the employee picks up the rest.

Ms. Daniel then transitioned to deferrals for health care that they experienced during COVID. According to TRS data, they saw a significant dip in early 2020 for non-COVID costs. Estimates show a 7-10% decrease in preventative care. This drop was a result of people deferring care. TRS has since seen a recovery in those costs which indicates that more people are beginning to actively seek medical care again, but it is still not quite to pre-pandemic levels.

In an effort to ensure that people continued to have access to care, and recognizing that TRS plans generally have a higher deductible and more out-of-pocket costs, TRS implemented increased cost-sharing with their members.

TRS waived COVID costs and they provided primary care visits at a co-pay in a couple of primary care driven plans that they've put in place in active care.

Continuing her testimony about deferrals of care in Active Care, Ms. Daniel noted that TRS' most popular plan as of late has been their high deductible plan. Typically, this is supported because it would result in the patient being more active in shopping for their care and using resources and tools to find the best price, but data has shown that many employees are not availing themselves of the tax benefits associated with participating in a high deductible plan, and instead they're choosing to defer care.

Recognizing that employees are seeing the initial deductible as a barrier to care, TRS put in place two primary care-driven plans with both of them having first-dollar coverage, and the primary plan, which is TRS' lowest benefit plan, has a bit of a higher deductible but it has co-pays for doctor and pharmacy visits.

Ms. Daniel continued to discuss how TRS is working to make their plans more affordable. TRS has implemented a couple of pilot programs around musculoskeletal conditions with the goal of trying to appropriately steer individuals toward more physical therapy in an effort to avoid unnecessary surgery.

TRS also offers \$0 telemedicine visits and they've started a new program called Prudent RX. Because specialty care drugs are a significant cost for TRS, they are trying to offer a plan where some of the out-of-pocket costs is offset by the PBM and manufacturer.

Ms. Daniel concluded her testimony by explaining how TRS is driving towards increased transparency, both in the contracts that TRS has with its vendors and transparency through tools that are made available to their membership.

Representative Frank spoke on the data showing that members of the high deductible plan were deferring care due to the cost barrier. He noted that, in many cases, no matter what, the medical procedure a person is seeking will likely be more than their deductible, whether it be a high or low deductible. Representative Frank then asked if TRS has explored providing various incentives so that members are really encouraged to truly shop for care.

Ms. Daniel explained that TRS does have an incentive program that they initially put around certain shoppable events where quality is not a big variation, such as MRIs, but was unable to go in-depth at the time. She said she would follow up with Representative Frank on that question.

The Committee heard testimony from Khrystal Davis with the Texas Rare Alliance.

The Alliance is a nonprofit dedicated to making Texas a state of access for patients through education and advocacy. Most importantly, Ms. Davis is a parent and caregiver of a child with Spinal Muscular Atrophy Type 1, a rare disease that is the leading genetic cause of infant mortality.

Ms. Davis explained that Texas rare disease patients directly demonstrate the impact of delayed care in the Texas health care delivery system and how delayed care impacts health care expenditures and outcomes.

She said that improving timely and accurate access to the diagnosis, clinical care and medications helps rare disease patients lead healthier and happier lives while maintaining their baseline health. In turn, this helps pediatric and adult rare disease patients remain active and productive in our Texas schools and workforce, as well as their parents, spouses, partners and children who are often caregivers.

Ms. Davis continued explaining that delayed care is well demonstrated in the rare disease community because we cannot treat what we do not diagnose. Ms. Davis stated that it takes an average of seven years to secure an accurate rare disease diagnosis and includes an average of two to three misdiagnosis.

Providing some statistics, Ms. Davis stated that one in ten, or nearly 3 million Texans, live with a rare disease and that approximately 10% of the U.S. rare disease population are Texans. She continued that half of rare disease patients are children and that 30% of children living with a rare disease don't survive to their fifth birthday. Additionally, 95% of rare diseases lack a disease modifying FDA approved rare disease treatment and 28% of NICU deaths are attributed to genetic conditions.

Statistically, rare disease patients are also hospitalized twice as often and for significantly longer periods of time. Health care costs for rare disease patients are also much higher.

Ms. Davis said that not only should Texas aim for more timely and accurate diagnosis, but that we should also strive to attain a pre-symptomatic diagnosis when possible. She said this will help patients access the appropriate disease-specific standard of care specialists and medications needed to help keep them stable at their baseline level of health.

Ms. Davis recommended a three-pronged approach to improving access to these timely and accurate diagnosis. This includes expanding the newborn screening program, funding Project Baby Dillo, and providing coverage to precision medicine and biomarker testing.

For the newborn screening, Ms. Davis said that it is one of the most successful public health programs in the U.S. and that Texas is a leader in the conditions it screens for. Texas screens roughly 400,000 newborns yearly, and it's one of only two states to screen babies twice. Even with this, improvements are needed in the newborn screening program to properly screen for conditions as they are added to the Recommended Uniform Screening Panel (RUSP), creating an environment for newborn screening pilot programs in Texas, and screening for qualifying conditions prior to RUSP inclusion.

Ms. Davis acknowledged that this would be a heavy lift but said it could be achieved by retaining more of the newborn screening kit fees in the newborn screening preservation account. Ms. Davis continued by saying that, as great as newborn screening is, Texas is screening for fewer than 60 rare genetic conditions. That is fewer than 1% of the more than 8,000 rare conditions.

Stating a need to investigate and implement other diagnostics, Ms. Davis recommended a one-time funding of \$4 million for the Project Baby Dillo to improve access to the diagnosis for critically ill Texas newborns.

Ms. Davis explained that this would provide rapid whole-genome sequencing to low-income NICU patients with unknown etiologies. She continued by saying that Project Baby Dillo would improve health outcomes of critically ill newborns and decrease health care spending by

reducing the number of diagnostic tests, decrease the number of days spent in hospitals, and result in actionable diagnosis for about 40% of NICU patients.

Next, Ms. Davis discussed her recommendation of providing coverage for precision medicine and biomarker testing. The model language she discussed is diagnostic and condition agnostic, meaning it could help in the diagnostic odyssey and avail treatment options for many more conditions that go undiagnosed. These diagnostics and treatments must be FDA approved as well as peer-reviewed and published.

She recommended that Texas continue to cover accelerated approval pathway treatments to help ensure access to innovative lifesaving and life-improving treatments, or the alternative would mean shifting from lower-cost high-value treatments that keep patients at home with their families and a return to paying for higher-cost low-value emergent and critical care where patients are in ERs and admitted to hospitals.

To help address this and many other issues connected to access to medications and biopharmaceuticals, Ms. Davis recommended maintaining the vendor drug program designed for Medicaid and CHIP within HHSC.

The Committee heard testimony from Blaise Duran, Group Benefits Actuary at the Employees Retirement System of Texas (ERS).

Mr. Duran first provided a brief overview of ERS plans. ERS' HealthSelect plans cover more than 500,000 Texans with the largest plan, HealthSelect of Texas, covering about 80% of those participants.

Mr. Duran explained that HealthSelect of Texas is a point-of-service plan. This means that in order to receive the highest level of care, a participant has to select a primary care physician (PCP) and get a referral from that physician when seeking specialist care.

ERS uses this model because they feel that it encourages engagement with their PCPs, and therefore members see their PCPs more often which leads to increased preventative care.

Mr. Duran next went over some of the results of what ERS has seen when it comes to preventative care over the last few years during the course of the pandemic.

Discussing preventative cancer screenings, Mr. Duran presented data for colon, breast, cervical, and prostate cancer screenings for participants who were eligible for those screenings. The numbers showed that in 2020 there was a drop in screenings and numbers for 2021 improved but they were still slightly below pre-pandemic levels.

To go along with the drop in cancer screenings, there was also a smaller reduction in the number of cancer diagnosis due to the reduced screenings along with a similar increase in diagnosis in 2021 due to increased number of screenings.

Upon seeing these changes in screenings and diagnosis, ERS took a look at the cost per case for these cancers to see what fiscal impact there might have been, but they were not able to find a significant impact to the cost per cancer case as of yet.

Moving to childhood immunizations, for participants under the age of 18, ERS did see a decline in both 2020 and 2021. However, Mr. Duran stated that this was driven primarily by a reduction in the number of flu vaccines that were received by participants, and that immunization rates for other vaccines were received at similar rates.

Mr. Duran next spoke about chronic conditions, particularly heart disease diagnosis and cost. Similar to the cancer screenings, ERS saw a slight downtick in the number of claimants in 2020 and then a return to pre-pandemic levels in 2021. During this time the associated costs have remained relatively flat.

For diabetes care and management, there was another similar trend with the rate of hemoglobin A1c screenings decreasing in 2020 and then strongly rebounding in 2021. One difference though is that the total cost per claimant or participant with diabetes has been increasing each year. For this fiscal data though, ERS included all medical and pharmacy claims per participant and not just costs related to the management of diabetes. Mr. Duran explained that this was done because what often drives the cost of a diabetic is the comorbidities and not just the direct cost of care for treatment and control of diabetes. Mr. Duran stated that, due to the way ERS tracks the cost, these increases are to be expected to an extent.

Mr. Duran then discussed some of the approaches that ERS has taken in an effort to keep their members engaged with their plan during the pandemic.

ERS has what's called Virtual Visits, which is where the participant uses one of two platforms, Doctor on Demand or MDLive, to seek care. ERS then also has telemedicine visits, and that's a remote visit with a provider using the providers own telemedicine platform.

In 2017 ERS began offering virtual visits with no co-pay to their members and this has lead to gradually increasing utilization by their members. As for telemedicine, Mr. Duran stated that ERS has always allowed it on their plan and they reimburse the provider at the same cost as if there was an in-person visit. The telemedicine option had not been highly utilized until the start of the pandemic, at which point the saw a very large uptick in its utilization. ERS then chose to wave co-pays of telemedicine visits for their members until June 30, 2022. At that time the co-pays for telemedicine visits were reinstated, but utilization still remains high and has proven to be an effective way of keeping members engaged with their provider.

Mr. Duran concluded his testimony by stating that ERS is currently concerned about the potential downstream impact of delayed care on their members due to the pandemic because that could obviously lead to diseases going uncaught and result in worse and more expensive medical outcomes. The good news though is that there's currently no strong evidence of these impacts occurring in their member population and utilization of preventative services is back to where it was pre-pandemic.

The Committee heard testimony from Dr. Titilope Fasipe regarding sickle cell disease. She spoke on behalf of Texas Children's Hospital where she cares for children with sickle cell disease, and she also spoke on behalf of herself as an individual living with the disease.

Dr. Fasipe began her testimony by explaining that sickle cell disease is a genetic disorder of the red blood cells that can present complications in any organ of the body. For example, sickle cell can lead to stroke, kidney failure, and the most defining complication, excruciating pain episodes.

There are an estimated 100,000 individuals within the U.S. who suffer from sickle cell and roughly 200 babies are born with the disease and another 5,000 are born with the sickle cell trait every year. Texas actually has the third-largest sickle cell population, with thousands of Texans being affected, and Texas Children's Hospital treats over 1,200 children with sickle cell and is one of the largest treatment centers in the U.S.

Dr. Fasipe continued by saying that sickle cell disease intersects with three different disease segments: the chronic illness category, the rare disease category, and as a minority health issue due to the fact that it predominantly affects those from African descent. Those with sickle cell disease usually experience shorter lifespans by decades.

Dr. Fasipe then discussed the impact of delays in care for sickle cell. She explained that if a newborn screen shows signs of the disease, it's crucial that the child is referred to a pediatric hematologist with expertise. Delays in this process can result in the family not being aware of or understanding the diagnosis and will lead to a lack of preventative care. Particularly, delays in the initiation of penicillin, vaccines, and also fever protocols can lead to increased critical illness and death in early childhood due to sepsis, which is preventable.

Another example of impacts of delayed care provided by Dr. Fasipe is delays in transcranial doppler ultrasound screening. This screening allows doctors to screen for the risk of stroke in children with sickle cell. The availability of this screening means that death by stroke is preventable for these children, but a national study recently found that only 50% of children, on average, are being screened and that percentage sometimes drops as low as 25%.

Furthermore, when a young adult with sickle cell transitions from pediatric care to an adult healthcare system, their access to high-quality care from knowledgeable providers becomes very limited. This generally results in the individual receiving fragmented care, discontinuation of life-saving therapies, and a preventable increase in morbidity and premature mortality.

The final example of impacts of delayed care provided by Dr. Fasipe centered around what happens when a person with sickle cell enters the health care system. Most often these individuals enter the system through the emergency department. National guidelines state that sickle cell disease should be triaged at a high level. So, whether it's for fever or pain, it can be a reflection of something life-threatening that is taking place. However, despite national guidelines, these individuals typically receive delayed care.

Dr. Fasipe concluded her testimony by providing a few recommendations to the Committee. First, in order to ensure that every Texan with sickle cell has access to comprehensive evidence-based care throughout their life, she recommended that Texas enact health policy that reduces disparities and inequities in sickle cell. She also recommended increased funding for research and development related to sickle cell and she supported the idea of medical home for sickle cell in order to receive comprehensive care tailored to the individual.

Following Dr. Fasipe's testimony, Representative Oliverson voiced his support for supporting research and development in order to more quickly arrive at a cure for the disease and be able to cure children at a young age. Representative Oliverson then asked if cures that are currently being worked on would actually cure the disease permanently, or act more as a disease management.

Dr. Fasipe responded that researchers don't know for sure yet if medicine that is currently in clinical trials would act as a full treatment of the disease because the trials haven't gone on long enough yet. She said that current results are looking hopeful, but she continued by saying that everyone also needs to focus on social determinants related to the health of individuals who suffer from the disease. Not everyone may be able to get this treatment for various reasons, even if they medically qualify.

Representative Bucy then brought up a bill filed by Representative Jarvis Johnson during the 87th regular legislative session, HB 3673. This bill, which passed through the House of Representatives but was not heard in the Senate, would have created a sickle cell disease registry. Representative Bucy asked if Dr. Fasipe could explain the importance of having such a registry.

Dr. Fasipe explained that having such a registry would be extremely important to help identify unknown adults who are living with this disease without care and are subsequently utilizing a large amount of health care dollars. This would allow for a better understanding of exactly how many Texans are affected by this disease and it would allow the state and health care system to better help them.

The Committee heard testimony from Carol Howe who is an associate professor of nursing at Texas Christian University. She is also a diabetes care and education specialist and spoke on behalf of the American Diabetes Association.

Ms. Howe began her testimony by providing some brief information and context about diabetes. Ms. Howe stated that about 12%, or roughly 2.7 million, Texans live with diabetes and approximately one third of adults in Texas have pre-diabetes. As a chronic illness, if diabetes is not properly managed it can result in complications including blindness, amputations, kidney failure, and heart disease.

Diabetes can also result in a significant fiscal impact. In 2017 the cost of diabetes in Texas exceeded \$25 billion, and the assumed annual cost for 2022 is much higher.

Ms. Howe then moved on to highlight a few types of delays that she identified as being important.

First, there are the delays in determining that someone has pre-diabetes. Most people with pre-diabetes do not know they have it and this is a missed opportunity to provide evidence-based interventions, like the National Diabetes Prevention Program, and other interventions that help prevent an individual from progressing from pre-diabetes to diabetes.

The second major delay highlighted by Ms. Howe is the delay in diagnosing diabetes. Ms. Howe stated that, although we know that 2.7 million Texans have diabetes, it's estimated that there are about 600,000 more individuals who have gone undiagnosed.

Without the proper diagnosis these individuals are missing out on early care in terms of treatment to prevent them from progressing to more serious complications. Ms. Howe stated that, in her experience, many times people learn they have type two diabetes when they're presenting in clinical care because of complications.

The third delay discussed by Ms. Howe was that of delays in the delivery of care or the intensification of care for people who are living with diabetes.

When patients with diabetes lack regular care, they may fail to get periodic lab tests to check on their conditions. They also fail to receive proper education on managing their disease and they may fail to be prescribed proper medication.

In wrapping up her testimony, Ms. Howe noted that, while there are a lot of opportunities to first prevent type two diabetes and then prevent complications that could affect someone living with diabetes, there are two primary recommendations she wanted to provide.

The first is to strengthen the messaging and awareness of diabetes, its causes, and its signs. The second is to strengthen awareness and outreach efforts to help enroll those who are already eligible for Medicaid and connect other with Marketplace health care plans so that these individuals can receive proper treatment and care.

The Committee heard testimony from Tiffany Jones-Smith, who was speaking on behalf of the Texas Kidney Foundation. Ms. Smith is the President and CEO of the Texas Kidney Foundation and is also a gubernatorial appointee for the Texas Chronic Kidney Disease Taskforce.

Ms. Smith began her testimony by explaining that chronic kidney disease (CKD) is considered a public health issue and costs the state of Texas an estimated \$4.8 billion a year. It's also known that one in three people are at risk for kidney disease and nine out of ten people who are living with CKD are not even aware that they have it.

Circling back to the cost of CKD care and management, it's broken up into various stages. In a 2014 to 2019 study of 52,599 adults who suffered from CKD and Type 2 Diabetes, CKD management costs ranged from \$7,725 for Stage 1; \$11,879 for Stage 2; and for Stage 5 kidney

disease (without Renal Replacement Therapy), with high additional costs for dialysis and kidney transplantation, it cost \$87,538 and \$124,271, respectively.

Ms. Smith then touched briefly on a three-year initiative started by the Texas Kidney Foundation called the Silent but Deadly campaign. This initiative is a COVID-19 and CKD response that aims to screen a total of 24,000 people and follow them year-over-year to see what the progression of their kidney disease is.

Ms. Smith noted the importance of supporting this program and other similar organizations because they're able to write for grants and do public-private partnerships, similar to what they have already done in Bexar County.

The Texas Kidney Foundation has been able to utilize this ability for public-private partnerships with a company called Healthy IO. This company has a mailable screening kit that they are able to send out. An individual can then take the test at home and use their smartphone to upload the test and receive their results.

Shifting to recommendations on what the Legislature could do, Ms. Smith provided a handful of recommendations.

One of the major problems noted by Ms. Smith is the lack of information and identification of CKD within the first two stages. So, the Legislature could support public awareness campaigns and free and/or affordable early detection screenings.

Another recommendation was the possibility of requiring doctors to test for kidney disease and report the results.

Ms. Smith also recommended legislative support for "upstream" and "downstream" prevention measures. Upstream prevention would include lifestyle (eg, tobacco control, balanced diet, mental health, moderate exercise), obesity prevention, and various social factors. This has been shown to reduce the prevalence of chronic disease.

Downstream prevention would include clinical treatment of chronic disease and would help to reduce additional complications resulting from the disease. It would also improve quality of life, reduce medical costs, and reduce mortality.

The Committee heard testimony from Dr. David Lakey. Dr. Lakey currently serves as the Vice Chancellor for Health Affairs and Chief Medical Officer for the University of Texas System. He also has previously served as a Commissioner for the Department of State Health Services.

Beginning his testimony by speaking on the impact of delayed health care, Dr. Lakey noted that delayed and forgone health care is unfortunately all too common.

Before the pandemic, 25% of Americans postponed medical care for serious conditions due to the associated costs. This delay in care was found to be common even for those individuals with significant life-threatening chronic disease, such as heart failure.

Dr. Lakey noted that these rates of delayed care continued to increase for low-income populations, Black populations, and Hispanic populations.

These delays in care were only worsened by the COVID-19 pandemic with 36% of adults having reported delaying or forgoing care because of COVID. Among these adults, 32.6% reported that their delay in care worsened one or more of their health conditions.

Dr. Lakey then discussed some of the various identified reasons for people opting to delay their care. One of the common reasons was individuals thinking the problem would "go away" or that it was not serious enough to warrant seeking medical care.

Other common reasons include the cost of receiving medical care, a lack of insurance, a lack of available providers, previous poor experiences and low levels of trust in the healthcare system, a lack of transportation, difficulty receiving time off work, or other obligations being prioritized over health care visits.

Dr. Lakey explained that these delays in care can result in serious and costly medical and health consequences.

Many individuals who choose to delay their care will likely miss opportunities to prevent chronic disease, screen for cancer, screen for developmental delays in children, and prevent infectious diseases through immunization.

This culminates in longer hospital stays and higher mortality rates, which also results in higher medical costs.

Other negative consequences include delay in individuals receiving initial mental health services which results in not only poorer health, but also poorer educational, social, and economic outcomes.

Dr. Lakey then transitioned into discussing delayed prenatal care and its impact.

Dr. Lakey stated that the U.S. average for late or no prenatal care is 6%, but Texas sits at 10%, and furthermore an estimated 21% of mothers who give live births were receiving inadequate care while the national average is 15%. Inadequate prenatal care is determined as pregnancy-related care beginning in the fifth month of pregnancy or later or fewer than 50% of the appropriate number of visits for an infant's gestational age.

This forgone or delayed prenatal care causes the health care system to lose crucial opportunities to do really important things that will improve the health outcomes of the baby and the mother. This prevents

doctors from treating gestational diabetes, high blood pressure, and a variety of other pregnancy related health issues that can result in a poor birth outcomes and higher infant mortality rates. Data has also found that women who receive no prenatal care experience a seven fold higher risk of preterm birth.

Dr. Lakey then touched on the shortage of health professionals that is currently being experienced.

Health Professional Shortage Areas (HPSA) are designated by the Federal Health Resources and Service Administration. In Texas 224 out of 254 counties are a HPSA for primary care providers and 248 out of 254 counties are HPSA for mental health providers.

Dr. Lakey stated that this shortage leads to delays in care and the subsequent negative impacts. As an example, he referenced a natural experiment that was conducted in the VA system regarding delayed access to health care and an associated increase in mortality. The study found that the VA had a wait list time of 31 days or more and this lead to a 20% increase in mortality compared with veterans who visited other VA medical centers with a facility-level wait time of less than 31 days.

During questioning, Representative Frank discussed how medical costs in the U.S. are typically double that of other developed nations, with the average U.S. family spending roughly \$20,000 a year on health insurance that they might not necessarily be able to afford. He asked what could be done to help drive down these costs and what specifically is the UT Health System doing.

Dr. Lakey said that the all-payer claims database that the Legislature is importing will be useful in this effort because it will allow you to see the cost of care and you can then use that data analytically to figure out what the differences to care really are.

He also recommended that general day-to-day health care needs to be addressed. The state and they system need to figure out how to better address social determinants, unhealthy food, and transportation issues that are preventing people from accessing care.

Representative Frank then stated that Texas law requires hospitals to provide their pricing of medical care, but that information is still hard for individuals to find and receive, and not knowing the cost of care acts as a direct deterrent. He asked what could be done to address this. Dr. Lakey responded that he had no answer as to recommended action the Legislature could take, but he agreed that access to this pricing information would likely reduce the levels of delayed care.

Representative Oliverson then touched on Dr. Lakey's previous comments about healthy eating. He noted that healthy eating is very important and could be a low-hanging fruit issue. Representative Oliverson said that there is most likely a cross-over, due to socio-economic criteria, for Medicaid recipients and poor access to healthy eating options. He then noted that healthy eating acts as a "natural medicine" and is certainly cheaper than providing diabetes medication.

Representative Oliverson then asked what could Texas do to be more proactive about diet, particularly in food deserts and other underserved areas where there is not as much access to healthy food.

Dr. Lakey agreed that healthy food could act as a "natural medicine" and that healthy options and habits could help prevent certain medical issues and diseases. He went on to say that being unhealthy is incredibly expensive in the long-run and intervention that the state could provide could help prevent kidney disease and dialysis, heart disease, strokes, diabetes and amputation, etc.

Representative Walle asked in regard to post-partum care for mothers, did Dr. Lakey have an opinion on extended Medicaid care of 12 months versus 24 months. Dr. Lakey said that the longer care a mother can receive post-partum, the better for her and the child.

The Committee heard testimony from Hannah Mehta who was speaking on behalf of Protect TX Fragile Kids.

Ms. Mehta began her testimony by providing background and statistics to help the Committee understand why the medically fragile kid population is important and an integral part of Texas' healthcare system.

While being a very small population, Ms. Mehta said that it is quickly growing, partially because of life- saving advances in medical technology. She continued by saying that all these children have very expensive complex chronic medical needs that require access to multi-disciplinary and very highly specialized healthcare services with each child, on average, requiring 10 or more different pediatric specialty providers.

Ms. Mehta then went on to say that pediatric medical complexity is a primary determinant of health inequity. Nationally, approximately 0.5-1% of all U.S. children account for more than one-third of overall pediatric healthcare spending, 55% of all pediatric inpatient costs, 85% of all pediatric 30-day readmission costs, and 40% of all pediatric deaths.

In Texas, children with complex medical needs account for less than 1% of the total Texas Medicaid system and Texas currently ranks 49th in the nation for support and services provided in homes and communities that are necessary to keep children out of institutions and hospitals. Ms. Mehta stated that Texas must be prepared for this population of medically fragile kids to grow exponentially faster due to the Supreme Court's recent Dobbs decision. She then said that even if a family has commercial insurance coverage, they must utilize Medicaid waiver programs in order to access the plethora of needed services that are not typically covered by commercial insurance plans. In Texas today, more than 50% of children with disabilities that are enrolled in Medicaid waiver programs are also covered by commercial insurance plans.

Ms. Mehta then explained that the negative impacts due to lack of access to care do not impact only the child, but it impacts the entire family unit.

Caregivers, most often the mother, typically ends up with major health issues of their own due to lack of appropriate supports and forgoing their own care in order to focus on their child. Financially, families face a loss of at least one income and typically accrue enormous amounts of medical debt, if not medical bankruptcy.

This financial, mental, and emotional stress ends up leading to a more than 80% divorce rate amongst families of medically fragile kids.

Ms. Mehta next discussed the severe impact that a delay or interruption in care has on the medically fragile population.

The equipment and care that these children receive is highly specialized and must be ordered by a physician and delivered by a specialty service. When a delay or interruption is experienced, that starts a chaotic domino effect of delayed, denied, and inaccessible care that are extremely far-reaching and long lasting.

Touching on the Medicaid waivers again, Ms. Mehta explained that Texas has an extensive waiting list for access to critical home and community-based supports and it takes an average of 15 years.

Ms. Mehta stated that, furthermore, finally receiving this coverage does not equate to access or timely care. She pointed out woefully inadequate networks and provider rates, bureaucratic red tape and administrative barriers, including pre and prior authorization, delays, reductions, partial denials, geographic restrictions, staffing shortages, coverage gaps, and much more.

All of these complications add up to create an extremely complex and challenging system that is virtually impossible for the average person to navigate.

Ms. Mehta said that a 2018 LBB report determined that patients with the highest needs experienced the largest gaps in access to services in Texas.

A 2019 survey of families in the STAR Kids program found that more than 53% have experienced significant delays in access or obtaining medically necessary services, medications, and home medical equipment and supplies. It also found that more than 55% experienced denials for medically necessary services, equipment, and medication, and more than 52% have lost home therapy or were completely lacking in therapy options.

Bringing this together, Ms. Mehta referenced a Dallas Morning News investigative review of over 70,000 documents which found that fragile Texans are more profitable within the medical system than the average Texans. She said that this creates a perverse incentive within our current medical system to deny access to care.

Ms. Mehta said that our health care system needs to be changed in a way that aligns incentives to promote long-term stability for children with medical complexity. It's currently designed around what is best for the payor and not around what is best for the patient or the state.

Ms. Mehta said that in order to fix this, Texas must have a creative multi-pronged and systematic approach to both immediate and long-term solutions. The state's approach must shift from a one-size-fits-all, penny-wise but pound-foolish focus on short-term cost containment, and instead have a laser focus on quality, appropriateness, improved outcomes, and long-term cost effectiveness for the medically fragile population.

She said that, in the long run, this approach would be more cost effective for the state, would be a more appropriate use of taxpayer dollars, will improve outcomes for this vulnerable population, and will help to maintain the stability for these patients.

Ms. Mehta also said that the Legislature must act in the coming session to set up a directed payment program, similar to what is currently in place for nursing homes, specifically for this population. The state must also direct the agency to set up a phased implementation of an alternative model pilot through the Dell Medical School and UT Value Institute.

For the short term, Ms. Mehta said the legislature or HHSC could put certain patient protections in place to help families coordinate benefits so that they can maximize the use of their private insurance coverage and ensure continuity of care with their existing medical team.

The Committee heard testimony from Dr. Kenneth Mitchell on behalf of the Texas Hospital Association. Dr. Mitchell is the Chief Medical Officer at St. David's Healthcare in Austin.

Dr. Mitchell began his testimony by recapping the start of the COVID-19 pandemic and how many hospitals had to cancel or delay non-emergent care because of high infection rates within their community.

Dr. Mitchell said that, just because a procedure is planned or categorized as non-emergent does not mean it isn't critical to the future health of a patient. Examples of procedures that were stopped or prohibited for a time include insertion of a chemo pump in a cancer patient waiting to begin necessary chemotherapy, women needing breast surgery for breast cancer, a hysterectomy in a woman experiencing endometriosis and palate reconstruction on an infant aged 10-to 12-months-old born with a cleft palate. One of the hard lessons of 2020 was that there is very little truly elective surgery being performed in most acute-care hospitals. Most purely elective surgery is being performed in outpatient surgery centers or specialty hospitals.

Outside of hospitals having to delay medical procedures, many Americans, fearful of contracting the virus, avoided or delayed seeking medical care. It is difficult to pin down a number, but Dr. Mitchell said that data suggests that around 30 percent of Americans put off seeking routine medical care. As a result, hospitals are now seeing sicker patients present to hospital emergency rooms and surgical programs.

Dr. Mitchell also pointed to data from the American Hospital Association and Kaufman Hall suggests that the length of hospitalizations has increased for all patients nationwide. Patient stays have increased 9.9 percent from 2019 to 2021, which is an indicator of higher acuity. Put simply, patients are sicker and require longer hospitalizations.

The rate of appendectomies, mastectomies, and hysterectomies in Medicare patients (individuals 65 or older, younger people with disabilities or people with End Stage Renal Disease) has nearly doubled.

Dr. Mitchell then referenced a survey of primary care physicians by the Primary Care Collaborative and the Larry A. Green Center, 37% said that their patients with chronic conditions were “in noticeably worse health resulting from the pandemic.” In addition, 56% of physicians reported an increase in negative health burdens due to delayed or inaccessible care.

There is also an impact on maternal health due to interrupted access to prenatal care. There is a whole generation of mothers and babies who have or will soon present to hospitals for childbirth that run a higher risk of encountering poor outcomes and requiring greater interventions.

At the same time, according to Kaufman Hall, hospital expenses have increased. Between 2019 and 2021, prescription drug costs have risen 36.9 percent. Labor costs are up 19.1 percent (this is a hospital’s largest expense accounting for about 50 percent of overall expenses). Supply costs are up 20.6 percent. The combined effect is a 20.1 percent increase in expenses over this time-period.

Dr. Mitchell said that he is seeing similar results in his system. Throughout the pandemic, his hospitals and hospitals across the nation have had to rely on contract labor to meet the demand. Many of the nurses and respiratory therapists left the hospitals to become travelers. The cost of contract labor to hospitals across the US is up over 200% from before the pandemic. Contract labor agencies have charged as much as \$180 per hour for a nurse at the peak of our COVID surges. Contract labor rates for nurses remain \$100 per hour or more. Dr. Mitchell said that these rates are not sustainable in our hospitals.

Speaking on getting Texans with foregone or delayed care back into the health care system, Dr. Mitchell said that would take a deliberate approach.

The overall message would need to be one reassuring the public that hospitals are safe spaces. In some examples hospitals have used social media and their web presence to detail their infectious disease protocols aimed at preventing COVID spread to increase public confidence while others have been transparent, publishing their COVID-specific data (patients with COVID, number of tests performed) with an emphasis on the number of patients that have recovered from COVID within their facility. Many hospitals are targeting video communication that utilizes respected health care leaders to convey that the worst of the pandemic is hopefully over and it’s time to return to the doctor or pursue follow-up medical treatment. Some hospitals have detailed their cleaning and sterilization procedures as an indication of the efforts being made to keep clinicians, patients, and their visitors healthy.

Dr. Mitchell said that any plan should have a particular focus on populations who are at high risk and historically have limited access to healthcare due to cultural and economic factors.

Providing an example, Dr. Mitchell said the greater Austin area has had a high level of coordination between the health systems, EMS, public health, the Travis County Medical Society, and elected officials throughout the pandemic. The level of collaboration between the competing health systems has been unprecedented and the community is better off for this. Among many notable efforts on the part of the Austin COVID Healthcare Task Force was to collaborate on unified messaging to the public through a variety of channels that they should not delay routine care, health screening and that our hospitals were safe places when they needed care.

Dr. Mitchell summarized his testimony by stating that, although the worst of the pandemic appears to be over, we are still seeing its impact on the health care system as a whole – in patients, in our workforce, in costs and in morale. He said the pandemic has dramatically worsened the staffing shortages that hospitals were already facing. The stress of the pandemic experience on care givers, compounded by ongoing staffing shortages in our hospitals and many hospitals running at or near capacity every day due to the growth of our major cities, has led to industry-wide burnout.

Dr. Mitchell concluded his testimony by saying that, while the solutions to these problems are complex and he believes it will take years to recover from the standpoint of replenishing the workforce and burnout, he believes there are positive signs. We are seeing staffing turnover start to decline; contract labor rates, while they remain much higher than pre-pandemic, are starting to decline; we are seeing some nurses and therapists who left to travel during the pandemic return to our hospitals; and, thankfully, there appears to be increasing numbers of applicants enrolling in nursing education programs.

The Committee heard testimony from Dr. Debra Patt on behalf of herself. Dr. Patt serves as an Executive Vice President of Texas Oncology - a multispecialty cancer practice.

Dr. Patt began her testimony by explaining that Texas is impacted greatly by cancer - 1:2 men and 1:3 women will be impacted in their lifetime and Texas diagnosed an estimated 131,000 new cancers in 2021. Healthcare has faced many headwinds that have stood in the way of timely cancer care causing delays in patient care, stage migration to more advanced diagnosis, and poorer outcomes for the patients.

Dr. Patt said she is concerned that the challenges we face in community cancer care today, if not managed or mitigated more effectively, will result in poor health and increased mortality for Texans and diminished productivity and livelihood for Texas.

Dr. Patt continued by saying that we are observing delays in cancer screening that are leading to more advanced cancer, challenges in access to care including network inadequacy, and when a diagnosis of cancer is made, we experience delays and detours in care due to the prior authorization process and other barriers to care from insurance companies as they reroute some

aspects of care that cause delays. We are also facing challenges of staffing shortages and fear new delays will come as medical providers anticipate additional barriers to appropriate care in the form of white bagging mandates from insurers.

Dr. Patt said she worked with collaborators to characterize changes in cancer screening that they observed during the pandemic which were published. In the first 6 months of the pandemic, cancer screening was reduced 40-90% throughout the country, and while in 2022 these rates have improved, they have not yet returned to normal and certainly have not made up for the misses from lapses in screening.

She said that the natural consequences in delaying a cancer diagnosis is cancer growth, stage migration, and increased cancer mortality. An undetectable olive sized breast cancer that would have been caught on screening mammography can grow to a plum size and metastasize to regional lymph nodes before it is detected by the patient, and then chances of cure are lower and treatment is more complex.

Texas also has a large number of patients that don't have access to cancer screening due to lack of insurance, an issue which has grown as some of the extensions have expired and issues of network adequacy continue to plague care for Texans.

Dr. Patt said that in her communities they work with collaborators to find solutions for these patients, but alterations to emergency Medicaid to make more new uninsured cancer patients eligible would be one way to improve access.

She also recommended that other vehicles to explore screening and emergency treatment for breast cervical and colon cancer should be explored.

Dr. Patt continued by explaining that medical providers also face insurer delays. When patients present with a diagnosis of cancer and she meets them and they decide on the appropriate therapy for the cancer, they then have to go through the prior authorization process. This can delay appropriate therapy by 7-28 days based on various different factors.

Dr. Patt said this can seem like an eternity for a cancer patient and can put them at risk of having an adverse outcome due to delays in appropriate treatment when they have a known cancer.

Dr. Patt then referenced a survey of physicians by the American Medical Association. They reported that insurers prior authorization policies delay access to care often causing serious harm to patients; with 94% of physicians reporting delays and 79% reporting that patients have chosen to abandon treatment because of the prior authorization process. In addition, aside from the time of delays, managing prior authorization hurdles requires abundant staffing amidst a tremendous staffing shortage.

Dr. Patt acknowledged that the Texas legislature has taken steps to pass Gold Carding legislation and anti-steerage policies to diminish delays in care, but prior authorization remains a daily burden on practice that delays and detours appropriate patient care and the Legislature needs to take action to ensure timeliness of prior authorization.

An additional barrier to care that was brought up by Dr. Patt is the staffing shortage. It was known before the pandemic that Texas was facing a tremendous staffing shortage, but it has been exacerbated by the pandemic when some nurses chose to leave the workforce and begin retirement early, or many nurses found more lucrative jobs traveling or elsewhere. In addition to the already anticipated shortage, as the baby boomers age in Texas, the demand for nurses simply outstrips supply of an already limited resource.

Dr. Patt said this legislature has taken steps based on recommendations from the nursing shortage reduction coalition to improve the supply of trained nurses and they have been effective, but still fall short of a solution. These include: The nursing shortage reduction program, The nursing faculty loan repayment program, and the nursing innovation grant program.

According to Dr. Patt, Increasing investments in these programs would likely continue to improve the supply chain of nursing shortages. Expanding programs to offer loan repayment to nurses and physicians, especially in underserved areas, would help Texans have improved access to care.

Concluding her testimony, Dr. Patt wanted to make the Committee aware of the practice of white bagging, as she anticipates we will see implementation of white bagging mandates from insurers. White bagging pharmaceuticals is an alteration of the normal process of therapy delivery by requiring that drugs are procured at an outside pharmacy prior to administering at a clinic in a different location. These white bagging mandates have been observed in other states and it's feared they will be implemented by insurers in Texas.

Dr. Patt went on to say that when she writes for chemotherapy to cure cancer, she writes for a dose of a drug administered intravenously to kill cancer. The drug is usually dosed very specifically based on the patient's weight on the day of treatment, the kidney function, liver function or blood cell counts on the day of treatment. These modifications are critical because in excess chemotherapy is poison and when too little is given it may be ineffective. Each day in clinic, Dr. Patt makes last minute adjustments to chemotherapy.

In some states, insurers have instituted white bagging mandates where after a prescription is written for chemotherapy, and prior authorization is obtained, patients have to call a different payer pharmacy, and pay for a drug before it is shipped to the cancer center adding additional steps in the supply chain for often a fragile good.

Dr. Patt said that when this white bagging occurs, not only are there additional processes that complicate treatment, but she is limited in her ability to make last minute dose adjustments to optimize the efficacy and safety of a treatment.

Dr. Patt said that a prohibition on white bagging mandates would preclude insurers from interfering in care delivery in this way.

Representative Walle asked if Dr. Patt sees a large number of uninsured people who are diagnosed with cancer avoiding treatment due to costs. He then asked the same about insured individuals.

Dr. Patt said this would be tough to tell with uninsured individuals and it's a moving target. Her experience as a breast cancer specialist is different since she is able to connect individuals with Texas' emergency breast or cervical Medicaid program which means that not as many patients are avoiding care.

Responding to his similar question about insured individuals, Dr. Patt said that she certainly sees insured people delaying care due to the associated costs.

Representative Klick then asked Dr. Patt to weigh in on site-neutral payment for chemo infusion. Dr. Patt said that chemotherapy costs about half at a private clinic versus a hospital-based clinic for commercial payers, and it could even be a three- or four-fold difference depending on the center. But generally speaking, private clinics are a substantially lower cost because the reimbursement that is received from commercial payers is substantially less.

The Committee heard testimony from Alec Puente. Mr. Puente is the Director of Government Relations for the American Heart Association.

Mr. Puente began his testimony by stating that regular and timely care, whether for chronic disease or for an acute emergency like a heart attack, drastically changes the likelihood of positive outcomes across a wide range of different conditions and diseases. As we look ahead to next session, it's important that we support patients and providers to develop durable, long-term plans for chronic disease management.

Citing data and statistics, Mr. Puente said that, since before the pandemic, the risk of dying from heart disease has increased by more than 4%, and by more than 6% for a stroke. Those impacts, of course, are not evenly distributed, with certain populations like Black peoples seeing a nearly fivefold higher risk of dying from heart disease.

Mr. Puente said that, while there are many contributors to this trend, one of the most important has been the pandemic's unprecedented disruption in routine care and chronic disease management, with more than 40% of US adults avoiding or delaying care due to the pandemic. These types of delays in care waste crucial time and resources and make it much more likely that the first line of treatment for a patient will come in an emergency scenario, where the relevant timeline is minutes rather than weeks and months, and even short delays may reduce the lifespan of survivors. For a heart attack, for every minute that passes without CPR intervention, chances of survival decrease by about 7%. In the case of a stroke, for every 10-minute delay between arrival to the ER and start of stroke treatment, patients can lose eight weeks of healthy life. In these emergencies, every minute can mean a drastic difference in patient outcomes and quality of life.

Mr. Puente continued by saying that it's important that we look at the issue of delayed care from both perspectives: one, how we can best support patients seeking regular care for chronic disease, and second, how we can save crucial time in an emergency.

For chronic disease, Mr. Puente said it's crucial that we encourage Texans to seek regular care and reestablish a relationship with their healthcare providers. For example, DSHS has done vital programming during the pandemic about the importance of taking preventive measures to protect your health.

Mr. Puente said that as we emerge from the immediate crisis of the pandemic, we should consider ways to shift that messaging to match the moment with a public health campaign, encouraging Texans to think about their plans for chronic disease management and, if they're able, to make an appointment to check in with their health provider. This type of regular care can make a huge difference for conditions like high blood pressure, which affects more than 1-in-3 Texans and is a major risk factor for other serious conditions like stroke, heart disease, and diabetes.

For emergency scenarios, like a heart attack or stroke, Mr. Puente said we also know a lot about how we can strengthen our systems of care and the chain of survival. Just as one example, Mr. Puente referenced Representative Oliverson's legislation last session ensuring that all 9-11 telecommunicators are trained to walk a caller through CPR over the phone.

Mr. Puente said that they know from experience that this policy will save lives, and they hope next session to continue looking at ways to increase the number of Texans empowered to save a life through CPR, for example by ensuring that all students are trained in high-quality CPR before they graduate high school.

Concluding his testimony, Mr. Puente mentioned other resources for information on these issues. Mr. Puente said that his association works closely with the Texas Cardiovascular Disease and Stroke Council. His association is also a member of The Partnership for a Healthy Texas, a coalition of over 50 organizations that identify and support policy that will have the most impact on the obesity epidemic.

Mr. Puente said that both groups are in the final stages of developing their legislative recommendations and would be a great resource for further action on these topics.

The Committee heard testimony from Cindy Weston on behalf of Texas Nurse Practitioners. Ms. Weston is the current President of Texas Nurse Practitioners and serves as an academic leader in nursing.

Ms. Weston began her testimony by expressing how Texas is feeling significant impacts of delayed access to care across all regions and across all health care settings. Over a quarter of adults reported that they delayed or did not get care because of COVID-19. In a national survey of primary care providers, 85% of clinicians said that the mental health of their patients

decreased during the pandemic. Another 56% reported an increase in negative health burdens due to delayed or deferred care.

Simply put, patients are sicker; they are re-entering the system with multiple, severe chronic conditions; and there are not enough providers to take care of them.

Ms. Weston continued by saying that the lack of access to primary care or delayed access to care has had a rippling effect across Texas. She said that she has spoken with nurse practitioners who are practicing within different regions of the state, and their stories are stark.

These nurses report about patients who were previously hospitalized with severe COVID and are now struggling to get appointments for primary care to manage their multiple chronic conditions. There are also stories of patients diagnosed with stage 4 colon cancer due to lack of preventative care and screenings. And other patients, many school-aged or teenagers, have been on the brink of suicide when they showed up at the ER or a safety net health facility.

Ms. Weston then moved into her recommendations for how Texas can remove barriers to primary care and build back the front line of our health care delivery system to improve access to care and patient outcomes, while also constraining costs.

The first recommendation is to help increase access to the primary care workforce.

Ms. Weston said that the health care workforce has been a longstanding crisis, and the COVID pandemic has only made it worse. Surveys of primary care physicians show that nearly two-thirds personally know someone who had retired early and an additional 25% expected to leave primary care in the next three years.

According to Ms. Weston, the good news is that nurse practitioners are poised to address the shortage of primary care providers. While nationally the supply of primary care clinicians has steadily declined, since 2007 the number of nurse practitioners has increased by 179% percent, almost tripling. And in Texas, over 80% of nurse practitioners are licensed in an area of primary care, including family primary care, pediatrics, and women's health.

She said that one solution that's been deployed by multiple states is providing a pathway for nurse practitioners to provide care, especially in rural and underserved areas, after a period of required physician supervision and delegation. Currently under Texas law, nurse practitioners are required to obtain a contract with a physician, what's called a delegation agreement, in order to take care of patients. This is a lifelong requirement, regardless of the number of years the nurse practitioner has been in practice. Over half the country has eliminated the requirement for lifelong delegation, and 20 additional states relaxed or waived these requirements during the pandemic.

Ms. Weston recommended Texas consider a proposal that would provide a pathway for nurse practitioners to serve as primary care providers after a period of time working under physician

delegation. She noted that states who have made these changes have seen significant growth in their health care workforce, improved patient outcomes, and lower costs across the health care system.

The second recommendation is to design, and fund integrated, holistic primary care providers. Ms. Weston said that, in Texas, we should fund and design health care programs to provide comprehensive, coordinated primary care that integrates physical and mental health and delivers through multiple modalities including in-person, virtual, and in some cases mobile or home health.

Ms. Weston's third and final recommendation was to continue to advance value-based transformation efforts.

Ms. Weston noted that, during the pandemic, many health care practices, especially primary care practices, struggled to stay afloat. Only a fraction of total health care spending, around 5-6%, goes towards primary care.

She said that Texas needs to continue to advance initiatives such as accountable care organizations, medical homes, alternative payment models, and valued-based payment reform efforts, and increase primary care reimbursement rates where appropriate, to prioritize health and prevention over treating patients when they are already sick. Many states have deployed similar valued-based models with significant savings for their Medicaid, CHIP, and other state-funded health care programs.

Recommendations

- **Pass legislation extending Medicaid coverage for pregnant women to 12 months post-partum.**
- **Increase funding for medical education and health care workforce development initiatives to increase the number of physicians, nurses, and mental health professionals.**
- **Continue to explore opportunities to increase access to telemedicine and telehealth services.**

Texas House of Representatives



Greg Bonnen, M.D.
District 24

Dear Chairman Harless,

Thank you for your leadership as Chair of the Texas House of Representatives Interim Select Committee on Health Care Reform. The committee's report provides well-informed guidance to the 88th Texas Legislature, and I look forward to working with you to enact critical health care policy reforms during the upcoming session based on its recommendations.

I appreciate this opportunity to share that I have concerns about possible interpretations of the following recommendation: *"Prohibit anti-competitive contracting terms, such as all-or-nothing contracts, gag clauses, etc."*

Health insurers have suggested prohibiting contracts that require the inclusion of all providers and facilities within an organization. This would be an existential threat to hospitals, physician practices, and other medical providers and would allow health plans to choose who is put out of business and who wins in the healthcare "market." This is a direct consequence of the tremendous consolidation of the health insurance industry which has resulted in individual insurance companies dominating and, in some instances completely controlling entire geographic regions. A prohibition on contracts where an entire provider group or facility is in network would be a disservice to consumers as it would threaten already tenuous network adequacy, confuse consumers, and exacerbate the national consolidation and corporatization of providers who are consolidating to find protection from the destructive and predatory practices of insurers.

I support the prohibition of gag clauses and anti-competitive contracting terms. I have advocated for price disclosure since I was elected and have filed bills to address the lack of price transparency in the medical market. Competition is an important factor in preventing healthcare costs from rising. Gag clauses hinder our ability to offer additional information to the patients who should know what they will be charged for services.

I look forward to continuing our collaboration to ensure Texans can make informed health care decisions based on transparent, consumer-friendly information. If you have questions, please don't hesitate to contact me or my office.

Sincerely,

A handwritten signature in black ink that reads "Greg Bonnen, MD".