INTERIM REPORT

TO THE 88TH TEXAS LEGISLATURE

HOUSE COMMITTEE ON
INSURANCE

DECEMBER 2022

HOUSE COMMITTEE ON INSURANCE
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2022

A REPORT TO THE
HOUSE OF REPRESENTATIVES
88TH TEXAS LEGISLATURE

TOM OLIVERSON, M.D.
CHAIRMAN

COMMITTEE CLERK
SCOTT CROWNOVER

Committee On
Insurance

December 19, 2022

Tom Oliverson, M.D.
Chairman

P.O. Box 2910
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The Honorable Dade Phelan
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

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

Respectfully submitted,

Tom Oliverson, M.D.

Herbert Vo

Jessica González

Lacey Hull

Celia Israel

Mayes Middleton

Dennis Paul

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INTRODUCTION

In the 87th Legislative Session, the Honorable Dade Phelan, Speaker of the Texas House of Representatives, appointed nine members to the House Committee on Insurance. The Committee's membership is comprised of Representatives Tom Oliverson, M.D. (Chair), Herbert Vo (Vice-Chair), Jessica González, Lacey Hull, Celia Israel, Mayes Middleton, Dennis Paul, Ramon Romero, and Scott Sanford.

Pursuant to House Rule 3, Section 18, the Committee was given jurisdiction over all matters pertaining to:

- insurance and the insurance industry
- all insurance companies and other organizations of any type writing or issuing policies of insurance in the State of Texas, including their organization, incorporation, management, powers, and limitations; and
- the following state agencies: the Texas Department of Insurance, the Texas Health Benefits Purchasing Cooperative, and the Office of Public Insurance Counsel.

The Committee conducted two interim hearings. On May 17-18, 2022, the Committee covered interim charges 1 and 5, and on September 6, 2022, the Committee covered interim charges 2, 3, and 4.

INTERIM CHARGES

1. Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 87th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:

- **HB 18, relating to the establishment of the prescription drug savings program for certain uninsured individuals;**

- **HB 3459, relating to preauthorization requirements for certain health care services and utilization review for certain health benefit plans;**

- **HB 3752, relating to the offering of health benefit coverage by subsidiaries of the Texas Mutual Insurance Company; and**

- **HB 3924, relating to health benefits offered by certain nonprofit agricultural organizations.**

2. Review existing state laws, administrative regulations, and agency practices to identify barriers to competition in the insurance marketplace. Examine existing business practices in the industry to determine if additional laws or regulations are needed to promote competition, lower premiums, and protect consumers.

3. Monitor the implementation, compliance, and enforcement of legislation related to freestanding emergency rooms to determine whether patients are adequately protected and if further safeguards and disclosures are needed.

4. Review Texas' insurance anti-rebating laws and model legislation related to rebates. Make recommendations for legislation that would preserve the purpose of the current statute while allowing certain services for and benefits to insurance consumers.

5. Study the impacts of the U.S. Supreme Court's 2020 decision in *Rutledge v. Pharmaceutical Care Management Association* and the federal *No Surprises Act* (2021 Consolidated Appropriations Act, Public Law No. 116-620) on the Texas insurance market.

INTERIM CHARGE #1

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- **HB 18, relating to the establishment of the prescription drug savings program for certain uninsured individuals;**

- **HB 3459, relating to preauthorization requirements for certain health care services and utilization review for certain health benefit plans;**

- **HB 3752, relating to the offering of health benefit coverage by subsidiaries of the Texas Mutual Insurance Company; and**

- **HB 3924, relating to health benefits offered by certain nonprofit agricultural organizations.**

HB 18

Background

Stakeholders contend that for those who are uninsured and do not have access to prescription drug benefits, the out-of-pocket costs for prescription drugs are high, and can force individuals to forego much-needed medications, such as insulin. HB 18 sought to ensure that qualifying Texans without health benefit plan coverage for a prescription drug benefit are not forced to do without prescribed medications due to cost. The bill sought to establish a program for Texans without health benefit plan coverage for a prescription drug benefit through which those individuals will be able to purchase prescription drugs at the post-rebate price.

HB 18 amended the Health and Safety Code to enact provisions to be known as "Texas Cares" which provide for the development of a program that assists qualifying Texans without health benefit plan coverage for a prescription drug benefit to purchase prescription drugs at the post-rebate price. The bill required the Health and Human Services Commission (HHSC) to develop and design a prescription drug savings program that partners with a pharmacy benefit manager to offer prescription drugs at a discounted rate to qualified individuals. The bill set out program requirements related to providing the greatest value to those served by the program by considering the adequacy of the prescription drug formulary, costs to enrollees, and net cost to the state. It required HHSC, in developing and implementing the program, to ensure that program benefits do not include prescription drugs to be used for the elective termination of a pregnancy. The bill makes U.S. citizens and lawful permanent residents who reside in Texas and are uninsured, as determined by HHSC, eligible for program benefits. The bill authorized HHSC also to consider an applicant's financial vulnerability as an additional factor for determining program eligibility if it determines doing so necessary.

HHSC's general powers and duties in relation to the program included requirements to do the following:

- oversee the implementation of the program and coordinate the activities of each state agency involved in the implementation of the program;

- design the program to be cost neutral by collecting prescription drug rebates after using money in the fund in amounts equal to the rebate amounts to purchase prescription drugs;

- develop procedures for accepting applications for program enrollment, including a process to determine eligibility, screening, and enrollment procedures that allow applicants to self attest to the extent authorized by federal law and resolve disputes related to eligibility determinations;

- publish online all average consumer costs for each prescription drug available through the program;

- integrate manufacturer and other third-party patient assistance programs as possible into the program, preferably by including links on the program's website, given those parties' consent; and

- ensure an adequate pharmacy network and give preference to conducting the program through a state pharmaceutical assistance program.

The bill requires HHSC to conduct or contract a community outreach and education campaign to provide information on the program's availability to eligible individuals. It requires HHSC to contract with a pharmacy benefit manager to provide discounted prescription drugs to program enrollees and requires HHSC to monitor the contracted pharmacy benefit manager through reporting or other methods to ensure performance under the contract and quality delivery of services. The contracted pharmacy benefit manager must report to HHSC, on request, information related to the program, such as rebate amounts, contracted prescription rates, and certain costs. HB 18 authorizes HHSC to contract with a third-party administrator or other entity to perform any or all program functions for HHSC and also authorizes HHSC to delegate decisions about the program's policies to the administrator or other entity. The bill authorizes the contracted administrator or other entity to perform any tasks under the contract that would otherwise be performed by HHSC.

HB 18 provided for the establishment of a trust fund outside the state treasury for purposes of the program, contingent on the state receiving federal money that may be used for the program and the federal money being directed to be deposited to the credit of the fund as provided by law.[1] The bill set out the money comprising the fund and restricted the use of that money to administer the program and the provision of program services. The bill required HHSC to administer the fund as trustee for the benefit of the program and authorizes HHSC to solicit and accept gifts, grants, and donations for the fund. HHSC must ensure that the money spent from the fund to assist enrollees in purchasing prescription drugs is cost neutral after collecting the prescription drug rebates under the program. HB 18 prohibited HHSC from implementing the program without federal money having first been provided and deposited to the fund and requires HHSC to pay the program's one-time start-up costs exclusively with federal money in the fund. The bill required HHSC to suspend the program on the fourth anniversary of the date it was established and to seek legislative approval to continue the program if the federal money in the fund available to be used for the program's one-time start-up costs is depleted and the ongoing costs of administering the program are not fully funded through enrollee cost sharing.

Update

Lindsay Rodgers, Associate Commissioner for Health and Developmental Services at Texas Health and Human Services Commission, provided testimony to the Committee in response to the formal request for information related to this interim charge.

HB 18, also known as "Texas Cares" is a top priority for the HHSC. HB 18 charged HHSC to find the best possible value to individuals, while considering the adequacy of the drug formulary and the net cost to the state. It requires an adequate pharmacy network, a partnership with pharmacy benefit managers, and a requirement to integrate manufacturer and third-party assistance programs when feasible. HHSC is currently looking at the coverage which exists for individuals, and where gaps exists which could be covered by this program. HB 18 established general parameters for eligibility. These include citizenship or lawful permanent resident, being a resident of Texas, and being uninsured.

Insulin was mentioned in the bill as part of the required study, but Texas Cares didn't limit the scope to a single drug class. It charged HHSC to look a the gaps in access and affordability across various drug classes, and then help to find solutions for Texans looking to gain access to these drugs.

For this biennium, HHSC has focused on identifying the landscape of drugs that are cost prohibitive to Texans. Based on this research, HHSC is working to strategically hone in on how Texas Cares can fill in these gaps in coverage. HHSC is working to obtain information needed for informed decision making around program design on Texas Cares. HHSC is working to form proposed solutions for client eligibility specifics, the drug formulary, the dispensing fees for the pharmacy, and the structure of the program overall. HHSC is looking at requirements and scopes of work, and working through possible amendment language for existing contracts at HHSC, and also looking into initiating new procurements where they might be needed.

HHSC is currently working on establishing the infrastructure needed to make Texas Cares successful They have hired a program manager, a pharmacist, and others who are 100% dedicated to Texas Cares. They are working on the basic setup of the agency's financial structure, and looking at the mechanics of setting up the trust fund charged by the bill, and they are researching options to implement the core components of the program: client eligibility, pharmacy benefit management, and pharmacy enrollment in the program. HHSC is looking at the legality and functionality that would need to align in order to ensure Texas Cares' success.

HHSC conducted a request for information in July of 2021 which was open for 30 days in order to understand the landscape of vendors which they could partner with which they currently do not partner with.

HHSC did an assessment of work that has been done across the county. They identified 20 other programs to date that have been implemented across the nation in other states. Some of these are specific to certain drugs, and others are broader in scope. Some are still in place today, and some are not. HHSC is making a concerted effort to understand which programs or aspects of these programs have been successful, and which have not, in order to learn from these examples.

HHSC has engaged directly with pharmacy stakeholders. They have been in contact with the Texas Pharmacy Association, the Texas Healthcare and Bioscience Institute, Pfizer, Sanofi, Eli Lilly, and have had in-depth discussions with them to understand how they project HHSC can be successful with the pharmacy adequacy and the network of participation, and to also understand the more granular aspects of their existing patient assistance programs.

HHSC launched a survey on April 20 and closed on May 4 for health care providers across the state. The survey attempted to find out where patients are struggling with drug coverage, whether it is related to specific drug classes, or conditions the clients may have, as well as what they are seeing, and where do they refer their patients when their patients bring up affordability. HHSC received 646 responses to this survey. They are currently analyzing these results.

HHSC has partnered with the University of Texas School of Pharmacy, which has a center for Health Outcome Research and Evaluation. This partnership is hoped to help with concentrating on doing focus groups with the uninsured population of Texas, and also with health care providers, in an attempt to further inform HHSC. HHSC has worked on institutional review board approval both at UT and HHSC. The contract between the two was anticipated to be signed in June of 2022.

The first legislative report is due December 1st of 2022. In February of 2023, HHSC plans to publish rules in order to receive public input on what this program design will look like. HHSC plans to share what the trust fund associated with Texas Cares will look like, and how big it needs to be in order to ensure the success of the program.

Kentucky Prescription Assistance Program

The 2008 Kentucky General Assembly enacted a provision in House Bill 406 (HB 406 (H)5(4)) authorizing the establishment of the Kentucky Prescription Drug Patient Assistance Program (KPAP). The program has been operational since June 2009.

Many high-cost prescription drugs are available free or at low cost through assistance programs established by pharmaceutical manufacturers, commonly referred to as patient assistance programs (PAPs). However, identifying which PAPs are available while navigating the complex application process of these programs can be daunting. The application and eligibility requirements differ substantially among the various manufacturers' programs and may even vary between different classes of drugs from the same manufacturer.

KPAP, within the Kentucky Department for Public Health (KDPH), facilitates clients through the PAP application process using specialized software (Drug Assistant), trained navigators statewide and a 1-800 line. Navigators include volunteers and advocates across the state who assist clients in the PAP application process. Kentucky has a population of 4.5 million people, and all Kentucky residents are eligible to reach out to a navigator for assistance. This service is provided at no cost to clients.

Currently, KPAP has five state funded positions and 292 volunteer KPAP navigators throughout Kentucky.

In its first eight months of operation, KPAP generated $14.4 million in free prescriptions for low-income Kentuckians. An ongoing investment of approximately $600k per year has assisted tens of thousands of Kentuckians obtain $90 - $600 million of free prescription drugs per year.

Recommendations

While HB 18 can potentially be successful in reducing drug prices for uninsured people, it faces a few implementation challenges. The federal government programs that can provide the most significant cost offsets may not agree with Texas's innovative approach, limiting access to lower drug prices. Additionally, after the passage of HB 18, various private ventures are attempting to find success in the affordable drug market. Legislative efforts to correct market failures have spotlighted the issue of drug pricing and spurred innovation and private enterprises to find market-oriented solutions complementing the legislature's efforts.

The Committee will continue to monitor programs in other states which have been successful in providing cost savings to individuals who are in greatest need of costly, but essential, medications, such as the Kentucky Prescription Assistance Program.

The Committee will continue to monitor the progress of HB 18.

HB 3459
Background

There are concerns that the preauthorization and utilization review processes for health care benefit plan coverage may be burdensome to physicians and providers and may have the potential to prevent patients from receiving the care they need. HB 3459 seeks to address this issue by ensuring that physicians who are the most familiar with the delivery of health care in Texas are involved in utilization reviews for health benefit plan coverage. The bill also exempted certain physicians and providers from preauthorization requirements if they had at least 80 percent of their preauthorization requests approved by the insurer in the preceding calendar year. HB 3459 amended current law relating to preauthorization requirements for certain medical and health care services and utilization review for certain health benefit plans.

Update

Rachel Bowden, Director of Regulatory Initiatives at the Texas Department of Insurance, provided testimony during the hearing updating the Committee on HB 3459.

TDI has been working through the rulemaking process for the implementation of HB 3459. They started with a request for information last year and a stakeholders' meeting. TDI published proposed rules on April 8th, 2022 in the Texas Register. TDI had a hearing on May 12, 2002, and posted the comments they received concerning the hearing on their website.

TDI looks at all of the pre-authorization requests received during a six month evaluation period. It also provides that this exemption would stay in place unless the issuer later rescinded it. This recission would be based on a retrospective review of a random sample of the claims. This retrospective review would not allow the issuer to deny a claim when an exemption is in place. The review would serve for the purposes of auditing the providers' continued eligibility for that exemption. The proposed rules provide for the initial exemption or denial to be made by and communicated to providers by October 1st of this year. This date was based on the first evaluation period running from January 1st through June 30th. This will provide three months between the end of the first evaluation period and the dealing for the notice. This keeps in mind that the rules are not yet final, and the issuers are going to need to implement systems changes to operationalize the bill.

The exemption cannot be rescinded based on fewer than five claims. TDI specifically requested that a minimum threshold for the initial exemption be created. TDI wanted to ensure that exemptions are for frequent services, which was their understanding of the legislative intent of HB 3459. The initial threshold in the proposal was 20 procedures.

TDI also attempted to interpret the meaning of the term adverse determination regarding a pre-authorization exemption. They determined that the term used in the bill was very similar to the traditional definition, which defines adverse determination as a determination with respect to a specific claim that is did not meet the medically-necessary criteria. Currently the recissions are subjected to an appeal by an IRL. An initial denial would be based on the calculation of 90%. Each preauthorization request that reached that 90% would be subject to the appeals process.

The committee heard testimony from Dr. Zeke Silva, representing the Texas Medical Association.

Dr. Silva stated that HB 3459 was introduced and passed last session to address the real issue of overutilization of preauthorizations by health plans, burdening physicians and delaying care for patients. The legislature agreed that pre-authorizations were being used excessively by insurers and HMOs. Rather than serving as a check on the health care system, preauthorizations were being applied to physicians and other healthcare providers who were having services approved the vast majority of the time. HB 3459 was a landmark victory for the practice of medicine and for patients. Texas law has become the national model for a balanced prior authorization process and patient protections. Members from the vast majority of other states and members of Congress have reached out because they are interested in implementing similar bills. However,

we have yet to see how this law works in practice because it has yet to be implemented. The bill took effect on September 1, 2021, which was around the time, August 24th, that TDI put out a Request for Information to help start the rulemaking process. The RFI was thorough and a broad spectrum of stakeholders submitted input, including offering a practical perspective on how to best implement the bill while staying true to the intent of the law. TDI then had a stakeholder meeting on September 23, 2021 and stakeholders were permitted to provide supplemental comments for consideration by September 30, 2021.

Dr. Silva stated that several months passed by without any informal rule proposal drafts from TDI soliciting further stakeholder comment or even any indication from TDI as to when formal rules would be published. Last month, TDI formally published the proposed rules on HB 3459. To say they are problematic is an understatement. The proposed rules basically flip the intent of the legislation, turning what was supposed to be an administrative simplification law into a complication of the process .If implemented as proposed, the rules make prior authorization, or "Gold Carding," unfeasible for physicians. That is TMA's concern. TMA is also concerned that a state agency is going beyond its statutory authority by effectively rewriting some provisions of the law through the administrative process.

TMA has strong opposition to components of the rules that are counter to the letter and the spirit of the law. One primary example of this is the 20 service per plan threshold the rules put in place over a six month evaluation period, when the statute has no minimum number of services for a physician to qualify for a preauthorization exemption. Another instance in which the rules significantly depart from the statute is the timeline for evaluation periods laid out in Section 19.1730(c).

Dr. Silva stated that under HB 3459, issuers are provided five days after the physician qualifies for an exemption to notify a physician whether they are granted an exemption. The proposed rules set the deadline for issuers to notify physicians of a grant or denial as October 1st for the initial evaluation period between January 1 through June 30, 2022, which is more than ninety days. Moreover, the proposed rules go on to give issuers a full sixty days for all subsequent evaluation periods. We believe this statutory five-day time frame is generally reasonable for both grants and denials of preauthorization exemptions. While we understand that TDI's publication of rules in June or early July may inhibit compliance with this timeframe for the initial evaluation period, we recommend that TDI require the notice of the initial granting or denial to be provided no later than August 1, 2022. Thereafter, we would ask that the statutory five days' notice requirement be applied for the subsequent periods in compliance with the law. The second overarching theme of our concerns is that several terms and processes defined by the rules are unclear and overcomplicated. One such instance of this is in the definition of "adverse determinations." The intent of the legislation is that a physician or provider has their preauthorization requests approvals reviewed for potential qualification for a gold card, the plan can approve or deny based upon whether the 90 percent approval threshold was satisfied, and if denied the physician has a right to appeal that denial. Similarly, after an exemption is granted, the health plans can review a random sample of claims for another evaluation period and seek a rescission of the exemption if the approval threshold for those claims was not satisfied. If a plan attempts to rescind an exemption, again the physician can choose to appeal that decision. The rules diverge from this, defining an adverse determination to only mean a rescission. This has the

effect of applying the appeal process only to the rescission and not to an initial denial. Another area of ongoing concern with the proposed rules concerns TDI's proposed allowance of physicians with Texas administrative licenses, rather than full Texas licenses to practice medicine, to conduct the peer-to-peer call occurring prior to an adverse determination. The intent of the legislation is clear, the peer-to-peer call during the utilization review process is meant to review the medical necessity of an ordered procedure, which is to be assessed by a Texas licensed physician with the same or a similar specialty. Itis a very clinically driven function. However, an administrative license does not include the authority to practice clinical medicine, prescribe dangerous drugs or controlled substances, or delegate medical acts or prescriptive authority. For a reviewing physician on a peer-to-peer call to recommend denying coverage to a patient based upon a determination that a drug being prescribed is medically unnecessary when that physician has no authority to prescribe that drug himself or herself makes little sense from either a clinical or a public policy perspective. And, if an adverse determination is issued due to this disconnect in clinical authority, it is likely to cause unnecessary delay in the patient's care, as the ordering physician would then have to appeal the determination. This delay is harmful to the patient, who in this case is denied care due to unnecessary red tape. Overall, the rules create unnecessary delays and an unreasonable barrier to entry for physicians seeking an exemption, thwarting the intent of the legislation and denying patients this protection of their right to timely delivery of quality care.

Dr. Silva stated that he feels House Bill 3459 clearly spells out the gold card process to help patients get the timely care they need. TMA has urged TDI to review our filed comment letter and supplemental comments and to revisit the proposed rules to ensure they are clear, grounded in statute, and faithful to the intent of the legislation of promoting the delivery of timely, quality care to patients and streamlining the preauthorization process.

The Committee heard testimony from Jamie Dudensing, representing the Texas Association of Health Plans.

Ms. Dudensing stated that TAHP has significant concerns about the impact of HB 3459 on the cost of health coverage in Texas. Ms. Dudensing states that TAHP is concerned about its effects on patient safety, and that it will create a potential for fraud, waste, and abuse.

Ms. Dudensing recommended that issuers be allowed to hold providers accountable for fraud, waste, and abuse. She stated that HB 3459 prevents health plans from holding providers accountable. It is TAHP's belief that "goldcarded" physicians will commit fraud, waste, and abuse with impunity.

TAHP supports maintaining TDI's long-standing precedent of allowing insurers to utilize physicians with administrative medical licenses. Ms. Dudensing stated that if physicians with administrative licenses were suddenly unable to perform this function, it would put an end to prior authorization and utilization review in this state.

Ms. Dudensing stated that TAHP supports goldcarding being reserved for providers with a history of exemplary care, and supports TDI's determination that a sample size must be at least

20 claims. The intent of HB 3459 is to reduce the administrative burden for physicians and providers that are considered exemplary in determining what care is medically necessary and appropriate for each patient's particular circumstances. It is impossible to determine whether a provider is exemplary without at least 20 claims.

Ms. Dudensing stated that TAHP supports that the requirement for a same-specialty provider should be available only when requested by the provider. If the provider agrees that a same-specialty provider is unnecessary, then the statues should not mandate this very expensive and burdensome process to be used automatically. Same-specialty review should apply only to the cases in which it matters most, helping prevent the unnecessary cost of always using a limited pool of specialists.

Ms. Dudensing advocated for the removal of some of the riskiest and potentially abusive procedures and care from the exemption. She stated that some types of care are especially risky, such as opioid drugs, Schedule II controlled substances, and drugs with black box label warnings. A black box warning, or "boxed warning," is an FDA warning to alert consumers about serious or life-threatening side effects the drug may have.

Recommendations

The Committee recognizes the unique aspects of HB 3459, and realizes that implementation of its policies must be carefully considered. The Committee will continue to monitor the progress of the implementation process in the near future.

HB 3752

Background

One of the issues facing Texans looking for better access to affordable health care is a lack of health insurance provider competition in many parts of the state, especially outside of the main population centers. Near-monopoly conditions in many parts of Texas have contributed to higher health insurance premiums and health care costs. The Texas Mutual Insurance Company (Texas Mutual) was established in the early 1990s by the Texas Legislature in response to rapidly increasing workers' compensation rates and an unstable market—not unlike today's individual health care marketplace. Although it was required to be the insurer of last resort, the company was the only option available in many parts of the state. Within two years of its creation, the company was one of the state's largest workers' compensation insurers and it successfully paid the state back for all initial funding. The company was later granted the authority to operate as a mutual company, meaning it is fully owned by its members, and to operate as a domestic insurance company fully regulated by the Texas Department of Insurance. Today, Texas Mutual has about 40 percent of the state's workers' compensation market share and maintains an "A" rating from AM Best. HB 3752 sought to allow Texas Mutual to create, acquire, or otherwise own or operate subsidiaries to offer innovative, cost-effective solutions and bring the same level of affordable and effective success to the health insurance marketplace that it brought to the workers' compensation market.

Update

The Committee heard testimony from Paul Schlaud, Senior Vice President of Texas Mutual Insurance Company.

Mr. Schlaud stated that he serves as the executive leader of Texas Mutual's new health exploration team, which is charged with implementing HB 3752. For 30 years Texas Mutual has been only a workers' comp carrier, and so HB 3752 gives us the option to possibly start getting into health coverage. Mr. Schlaud stated that his group has done a lot of meetings with health policy experts, insurance carriers, agents and brokers, hospitals, direct primary care providers, start-ups and innovators, and actuaries. They are conducting case studies and are surveying small employers.

Mr. Schlaud stated that the Texas health system is too expensive, complex to navigate, that it lacks competition, it often lacks price and transactional transparency, and it often fails to meet the needs of sick Texans. He said that wished that he could tell you that they have found something that Texas Mutual could do that would transform the Texas health care system, and that they have not given up on finding a really big solution, but it's increasingly clear that there may not be a silver bullet for the problems the Texas health system faces. He stated that Texas needs many people coming together, innovating, disrupting, experimenting, connecting with other like-minded reformers who want the next decade of Texas health care to be better than the last.

Mr. Schlaud stated that they are Texas Mutual is looking into the possibility of combining their worker's compensation insurance with their general health coverage for small employers He stated that there is a potential synergy which could exist if employees had the same carriers for both policies. However, he stated that it is a complex and difficult situation at the core. In worker's compensation they must make determinations about how an injury happened. In the case of an on-the-job injury, they would owe compensation for lifetime benefits. Health insurance, on the other hand, sees people flow in and out in a more fluid manner. There would be a cost savings, or bundling, for small employers. They will continue to look into this matter.

They will have a report due to the legislature on September 1st, 2022. They do not have to make a determination about whether or not they decide to enter into this bundling of worker's comp. and health insurance. The earliest that they could sell any product on the market is September 1st, 2023. Mr. Schlaud stated that if this were to take place, they would start from scratch and build a program internally, instead of acquiring an existing organization.

Recommendations

The Committee is encouraged by the testimony received concerning HB 3752. The Committee will continue to monitor its progress in the future.

HB 3924

Background

H.B. 3924 aims to emulate health plan programs similar to other Farm Bureau states: Tennessee, Indiana, Iowa, South Dakota, and Kansas. These states offer health plans exclusively for Farm Bureau members and have proven to be affordable and dependable coverage for those facing few choices in the health insurance market. Many Texans, especially those in rural areas, find themselves with very limited health coverage options, sometimes only one or two plans to choose from, and are forced to go without health coverage due to exorbitant deductibles, costs, and very narrow provider choices. Farm Bureau health plans are a unique, free-market option that many Texans need. Texas has both the highest number and highest percentage of uninsured residents in the nation. It is estimated that more than five million Texans are uninsured, and some of these individuals and families are without health coverage because of the financial burdens and lack of options. H.B. 3924 allows the Texas Farm Bureau to offer quality, affordable health plans to its members. H.B. 3924 presents an innovative opportunity to provide rural Texans with access to quality affordable health coverage in places where insurance is historically limited. The five states already offering these plans have seen prevalent success, robust benefits, and more affordable options while helping to lower the number of individuals without health coverage. H.B. 3924 aims to emulate health plan programs similar to other Farm Bureau states. H.B. 3924 allows the Texas Farm Bureau to offer quality affordable health plans to its members. Farm Bureau health plans are health coverage options offered exclusively to members of state farm bureaus. H.B. 3924 exempts these plans from the definition of insurance. 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. H.B. 3924 amends current law relating to health benefits offered by certain nonprofit agricultural organizations.

Update

The Committee heard testimony from Si Cook, Executive Director for the Texas Farm Bureau.

Mr. Cook spoke about the new health plan coverage offered to Farm Bureau members. He stated that this healthcare model is new to Texas, but is modeled on models from other states. They worked extensively with the Tennessee Farm Bureau, who has been offering health plans as a member benefit for more than 75 years. These plans are offered in four other states as well.

They continue to collaborate with the Tennessee Farm Bureau on implementation of these plans. Because these plans are not insurance products, employees and agents of the Texas Farm Bureau and affiliated companies will not be involved in servicing and selling these plans. These plans will be sold and serviced exclusively through a website and a toll free number, which goes to a U.S. based call center and is staffed with people who understand and can explain the plans that they offer to their members. Offering a one-size-fits-all plan is not what would be of interest to their members. They are offering several products to their members, so they can select which one suits their individual and family needs. These include comprehensive health plans that include health, dental, and vision in one plan, major medical in another, and a high deductible plan.

Texas Farm Bureau health plans utilize the extensive United Healthcare choice plus network for hospitals and doctors. In addition to their collaboration with Tennessee Farm Bureau, they are also using the same third party administrator that they use for their employee health plans at Texas Farm Bureau.

As long as the policyholder makes a premium and the membership payments, that coverage will never be canceled. These plans differ from a regulated plan in that the individuals are medically underwritten. This means that not everyone who applies will qualify for coverage. However, someone with a preexisting condition may still qualify. Mr. Cook stated that Farm Bureau will do their best to find a way to offer coverage. Medical underwriting occurs only one time during the application process. After that an individual's rate will not be adjusted based on their experience loss ratio. Mr. Cook said that the Texas Farm Bureau members expect good customer service and robust coverage. These plans do provide a dispute resolution process that reflects the language of this legislation.

Any waiting period required for those applicants who have preexisting conditions and qualify will not last longer than six months. While these plans are not regulated, Mr. Cook stated that they have a very good relationship with TDI, and they have been keeping them updated on our progress.

In their rollout, they have targeted members who are most likely to be involved in agricultural operations and who live in rural areas or who are self-employed. They expect to quickly follow up with offering these plans to our entire membership. Agricultural producers and other self-employed people find obtaining health care coverage very challenging. They have heard the

same concern from all areas of our membership, and their goal is to provide a viable health care option for as many people as they can.

Mr. Cook stated that this is a pivotal moment for their organization. He said that Texas Farm Bureau is proud to offer this affordable, reliable health care option to their members. This has truly been a team effort by so many different entities to develop a way to provide this innovative health care. They have gone to great lengths over the past 10 months to ensure that they do everything properly.

Recommendations

The Committee will continue to monitor the implementation and progress of HB 3924.

HB 2090

Background

Historically, the rapid growth in health care spending has been driven by increases in price, rather than the overall utilization of health care services. Furthermore, the variation in the price paid for the same health care services is also rising. Price variation in traditional markets allows consumers to pick the product or service that is right for them, but a persistent issue in health care markets is that prices remain opaque, leaving health care consumers without adequate information to make decisions regarding health care services. With better information, health benefit plan enrollees would be able to make more informed decisions about where to get the health care services they need at the most valuable price, while employers would be able to make more informed decisions with regard to the value of health benefit plans purchased on behalf of employees. H.B. 2090 seeks to address these issues by requiring health benefit plan issuers and third-party administrators to disclose to enrollees the real, provider-specific price of a health care service, as well as the out-of-pocket expense incurred by a patient.

Update

The Committee heard testimony from Lee Spangler, representing the Center for Public Health Data, University of Texas School of Public Health.

HB 2090 grants the Texas Department of Insurance and the Center for Health Care Data(CHCD) with the authority to establish an all payor claims database (APCD) in Texas. The CHCD is a qualified entity under the Medicare Data Sharing for Performance Measurement Program, making it a natural site to house the Texas APCD. Fewer than 35 entities nationwide are so designated. To be a QE means that one has demonstrated the appropriate organizational structure and ability to maintain the security and privacy of the CMS claims information as well as the expertise to perform research and issue reports. The purpose of the Texas APCD is to increase public transparency of health care information and improve the quality of health care in Texas. The CHCD is directed to administer the database and engage in public health research and other analysis. Most importantly, the APCD is to produce statewide, regional, and geo-zip consumer reports available through a public access portal. Information in the public portal may not identify a specific patient, health care provider, health benefit plan, health benefit plan issuer, or other payor. It is to provide the public–Texas consumers–health care transparency into healthcare costs, quality, utilization, outcomes, and disparities. Information that will inform decision-making. Reports must also include information on population health and the availability of health care services. Even though there was no funding for the APCD last legislative session, efforts on complying with the provisions of the new law began shortly after the bill was signed by Governor Abbott on June 7, 2021. Staff began regular meetings with the Texas Department of Insurance (TDI) to begin work on regulations that are highly technical. CHCD staff began accepting applications from stakeholders and interested persons for the purpose of serving on the Stakeholder Advisory Group required by the subchapter. After consideration of submitted applications for membership on the Advisory Group, it was finally established in late 2021 and successful applicants were notified. At around the same time the Advisory Group was created, TDI issued informal draft rules to gain insight from stakeholders on the current efforts to establish a regulatory framework for data submission. Further, the CHCD obtained a license to utilize the APCD Council Common Data Layout (CDL). The CDL is an attempt to harmonize the claims collection effort across states. This lays the foundation for state to state comparisons, and, importantly, tends to reduce the burden of data submission by multi-state insurance carriers and other national entities.

The Center for Health Care Data will utilize the Texas Advanced Computing Center (TACC) at the University of Texas to provide the storage and systems for the APCD. TACC is a leader in super-computing and currently works with the Center on other projects. There is already a memorandum of understanding in place to facilitate the working relationship for the APCD's development. It is upon this foundation that information will be provided to researchers and eventually drive the APCD public portal. TDI has formally proposed regulations on the submission of data to the APCD and held a hearing on those rules. It is anticipated that the final regulation will be timely adopted according to the deadlines in HB 2090. HB 2090 has not introduced any operational or technical obstacles regarding the establishment of the APCD. In other words, no necessary changes to law have been identified. We are working at the center to

be ready to accept data submissions from required submitters in 2023. However, as mentioned previously this effort did not receive funding last session. UT Health will seek full funding for the APCD next legislative session in order to fully comply with state law and provide this valuable resource to Texas consumers and lawmakers.

Mr. Spangler reiterated that APCD is not for commercial use. UT Health will never charge for this data.

The Committee heard from Charles Miller, representing Texas 2036.

Mr. Miller stated that APCB provides an opportunity to learn a lot about the quality of healthcare in Texas. Mr. Miller stated that we, as a whole, will be able to learn more about which doctors and facilities have the lowest rates of complications for certain procedures, how certain types of health benefit plans impact the utilization of care or overall health of their members, and which providers are delivering the best value to patients and employers.

Mr. Miller stated that there are restrictions in the way data can be accessed. Mr. Miller does not advocate for APCD to provide patient information. Currently patient data is stored on a separate database. CHCD then effectively transposes this data and creates unique identifiers, so that data can be analyzed relating to long-term patient tracking that does not identify a patient in any way.

Mr. Miller stated that there are difficulties relating to the way data gets releases from APCD. Data is released from APCD in two ways: a public portal and through researcher access. Both the public portal and the researcher access have a common limitation in that nothing can identify a particular provider or payer in those reports. So if you are trying to find out information about well, which provider is actually having the lowest complication rates, and use that to evaluate or which facility or healthcare system or payer, and none of that can be reported. Mr. Miller suggests that the data garnered from APCD is too highly aggregated and does not allow for a granular look to provide meaningful assessments. Mr. Miller suggests that the restrictions on commercial uses also might hinder new and meaningful programs in the future.

The Committee heard testimony from Rachel Bowden, Director of Regulatory Initiatives at the Texas Department of Insurance.

Ms. Bowden stated that HB 2090 aligns heavily with federal transparency and coverage rules. One is the requirement that health plans have a price transparency or cost estimate tool for their customers, and the second is the requirement that health plans publish machine readable files publicly on their websites.

There are three required machine readable files that line up with federal transparency rules. They apply only to Texas plans that are not subject to federal rules. There is one concerning in-network rates, one for out-of-network payment amounts and one for prescription drug payment amounts. TDI is aligning their rules with federal ones. TDI has aligned plans with the guidance put out by federal regulators. If plans are compliant with federal rules, they will be deemed to be compliant with TDI's rules. If the federal regulators were to delay implementation, they would be enforcing it until July 1 2021. If rules were delayed again, TDI's rules would track that

delay, but not later than January 2024. With respect to the prescription drug file, if federal regulators are not enforcing these rules, TDI will not either. But, in January 2024, TDI will be looking for compliance for those rules.

Ms. Bowden stated that the UT School of Public Health is the administrator of the Texas APCD. TDI has been collaborating with them to establish rules on the scope of data required to be reported, and the technical requirements for reporting. TDI published an informal draft of rules back in November of 2020. We proposed the formal rules April 8, and held a hearing on May 4. TDI is currently considering the comments received on the all payer claims database rules. The rules address the types of health plans subject to reporting, and those include major medical plans, including grandfathered ones and short term limited duration plans, dental plans, and public plans, including Medicaid and CHIP Medicare Advantage. Medicare Supplement was also proposed to be included, as well as state and local governmental employee plans. The proposed rules also addressed the required data files. There are five required data files, addressing first enrollment and eligibility data, another data file for healthcare provider data, and then three claims data files, one for medical, one for pharmacy and one for dental. Depending on the type of plan or issuer, they might not have, you know, medical data if they're a dental issuer. And the rules adopt a common data layout, which UT Health developed based on the national standard for all payor claims databases, which provides the data requirements for each of those data files. The rules also addressed the timing and frequency of data submissions.

And then it also talks about the timeline for when reporting rules. Start and really we leave it to you to give them some flexibility to get the process up and running. So they will give notice to issuers with a minimum notice of 90 days for when issuers must register and submit test data files a minimum of 120 days for submitting historical data files dating back to January 2019. And 100, at least 180 days notice for before the monthly data submissions we'll start with the rules also address the terms for the stakeholder advisory group as well as some conflict of interest standards. And they do build in some flexibility for small players. So if a payer with fewer than 10,000, covered lives would have an extra year to before they need to begin reporting. And Payers can request an extension or a temporary exception from certain submission requirements if they aren't able to meet those at the at the beginning. And, you know, we the rules would allow the center to grant those exceptions, subject to kind of a consideration of how much the burden is being imposed versus how much value is being gained by full compliance with rules. We've gotten, you know, several comments on the rules focused on a few issues. One is the applicability with respect to Medicare plans. There's a lot of been a lot of discussion about whether Medicare supplement data provides enough value relative to the cost of collecting it. Whether it's appropriate to collect data on Medicare Advantage, and Medicare Part D plans. We've heard some concerns about the timeframes and whether you know, 180 days is sufficient time for issuers to start reporting on a monthly basis given the need to build out systems for reporting. And we've also heard comments on the process for adopting the common data layout. So if we adopted by rules, is it is it too difficult to change? And there were some specific technical comments on, you know, particular data fields that might need to be modified based on how payer systems work. And then finally, just the process about how payers will get feedback from the center with respect to a request for an exception or if their data submission has errors,

or needs any changes. So that's kind of a summary of where we are, we will be working quickly to finalize those rules and get them adopted. So that reporting can begin with

The Committee heard testimony from Blake Hutson, representing the Texas Association of Health plans.

Mr. Hutson stated that TAHP is supportive of the machine-readable files section of HB 2090. He stated that there some limitations in state law that make it difficult to share cost and quality transparency with providers so they can make informed decisions about to where they direct care of their patients. He added that TAHP is 100% in support of HB 2090.

Recommendations

The Committee is enthusiastic about the possibilities that APCD might offer in the years to come. The Committee will continue to support APCD as it was imagined, as a unique opportunity that will have the potential to positively change the lives of Texans for generations. The committee is encouraged by UT Health's insistence that it will never become a vehicle for profit-making, and that UT Health will never put limitations on findings related to the data gathered from APCD.

SB 1137

Background

The lack of price transparency regarding health care costs has long been seen as contributing to increased health care costs. Others propose that the quality and price of services have improved for the consumer in certain health care fields where there is price competition. In November 2019, the Centers for Medicare and Medicaid Services established rules that require certain facilities to disclose and publish their pricing across the wide range of services that they provide. SB 1137 seeks to codify these disclosure requirements into state law by providing for the required disclosure of charges for certain items and services provided by certain facilities.

Update

The Committee heard testimony from Stephen Pahl, Deputy Executive Commissioner, Regulatory Services, at Texas Health and Human Services.

Mr. Pahl stated that SB 1137 added Health and Safety Code (HSC) Chapter 327, which requires a hospital licensed under HSC Chapter 241 to prominently display a list or dedicated link to a list of all standard charges for hospital items and shoppable services on the home page of the hospital's website. SB 1137 took effect on September 1st, 2021.

SB 1137 requires general and special hospitals to maintain a list of standard charges, also known as a chargemaster, that includes all facility items or services maintained by a facility for which the facility has established a charge. The list must reflect the standard charges applicable to that location of the facility, regardless of whether the facility operates in more than one location or operates under the same license as another facility. The list must include applicable charges for services provided in both and inpatient and outpatient settings. The list must be free of charge, publicly accessible, searchable, and be updated annually.

SB 1137 requires hospitals to make publicly available a consumer-friendly list of shoppable services, which are services provided by the hospital that a consumer can schedule in advance. The list must have a plain language description of the service, as well as the applicable charges and billing codes. It must include at least 300 shoppable services, which must include the 70 services specified as shoppable services by the Centers for Medicare and Medicaid Service (CMS). It must prioritize the selection of services that are among the services most frequently provided. It must state each location at which the facility provides the shoppable services and whether the standard charges included in the list apply at that location, and it must be free of charge, publicly accessible and searchable by service description, billing code, and payor.

In lieu of providing a list of shoppable services, a facility may create a price estimator that provides a cost estimate for each shoppable service. This price estimator must also allow a person to obtain an estimate of the amount the person will be obligated to pay the facility if the person elects to use that facility to provide the service. It must be prominently displayed on their website, publicly accessible, and free of charge. It must be accessible without the user having to establish a user account or password.

Mr. Pahl stated that HHSC evaluates hospital compliance of SB 1137 by investigating complaints made to HHSC regarding noncompliance, auditing the internet websites of facilities for compliance with this chapter, and confirming that each facility submitted the required lists. HHSC has posted a complete list of SB 1137 requirements on the HHSC public website. HHSC has also created a mailbox where hospitals can send questions about SB 1137 requirements.

As of April 21st, 2022, there are 648 licensed hospitals that are required to comply with SB 1137. HHSC has received a total of 79 hospital submissions and all were in partial noncompliance. 569 hospitals did not submit information to HHSC and are considered fully noncompliant.

The Committee heard testimony from David Balat, director of Right on Healthcare for the Texas Public Policy Foundation.

Mr. Balat stated that, under the last presidential administration, hospital price transparency came to the forefront by way of an executive order that was hotly contested by the hospital industry. The current Biden administration has not only supported that effort, but it has sought to increase penalties to increase compliance. In addition to the federal efforts, the state of Texas codified a price transparency law in the 87th Legislature that saw unanimous support in every committee and both chambers before being signed by Gov. Abbott. More importantly, these efforts are incredibly popular among all Americans. According to Patient Rights Advocate, over 50% of Americans have received or know someone who has received an unexpected and overpriced medical bill. 89% of Americans support requiring hospitals to post actual prices, not estimates. 82% support strengthening penalties on noncompliant hospitals. A recent article co-authored by my colleague at Johns Hopkins University, Dr. Ge Bai, Ph.D., stated that, "knowing hospitals' pricing information, self-insured employers can improve their network design, create incentives, and build beneficiary support systems to steer patients away from high-price hospitals and navigate them to low-price, high-quality alternatives." Despite the popularity of freely available pricing, the compliance rate among hospitals is still woefully low particularly among the larger systems. Some of the examples of recalcitrance and misdirection are commonly met with frustration by patients who had a certain expectation that price transparency meant that tests and procedures would give them an expectation and consequent peace of mind when going to the doctor or hospital. Some of the things we are finding are that: Hospitals are focused on "estimates" rather than prices, and these estimates are highly variable depending on who you might have on the phone. One particular "good faith estimate" for a CT of the brain without contrast provided a range between $909.30 and $1,363.94. One hospital system wrote, "Please keep in mind, due to many variables for different coverage plans, your estimate may fluctuate." However, if the hospitals were compliant with posting prices of negotiated rates, there would be no fluctuation for a particular patient on a particular plan.

Mr. Balat stated that a great majority of the systems have developed price estimators that require personal information and details of their particular plan prior to disclosing the information which is contrary to the current state law. Oftentimes finding any information on the hospital website can be an arduous task as any information on the topic is not readily available to the general public. Our position at TPPF is that partial compliance is equivalent to non-compliance with the law and not serving the interests of the communities these facilities serve. These are still significant problems that need to be resolved and I applaud this committee for giving this issue the seriousness it deserves. I applaud HHSC for their ongoing discussion to properly implement penalties for non-compliant hospitals as was intended in SB1137/HB2487and look forward to the rule-making process in that effort. Thank you to members of this committee for continuing to be involved. I would also like to work with the members of this committee to see about making prices available in advance of ordered/scheduled tests/procedures with at least 10 days' notice so patients and employers can make sound decisions for those they represent. I mentioned earlier something about an opportunity for something better and I'd like to briefly share what I mean. Many employers around the country are working with advisors to find price transparent hospitals, surgery centers, laboratories, imaging service providers, and so on. These relationships

among honest brokers are resulting in predictable pricing for both employer and patient. Mr. Balat stated that he recognizes that the hospitals are saying that the information that they are putting out is too confusing for the regular lay person and that maybe true today, especially given the level of non-compliance; however ,price transparency stands to empower employers that want to offer their employees and their families benefit plans and options that make sense. What has been done in Texas and the other states that seek to follow in our efforts is the pinnacle first step to reform our healthcare system, and it is incredibly important that tax exempt, community-based organizations and for-profit entities alike contribute to rebuilding the public trust.

The Committee heard testimony from John Hawkins, representing the Texas Hospital Association.

Mr. Hawkins stated that SB 1137 has many similarities to the federal hospital price transparency rule that went into effect last year. Mr. Hawkins said that he acknowledged that THA initially gave pushback to the bill when it was filed. He stated that hospitals have long held negotiated rates with health insurance companies, and considered this proprietary information. However, Texas hospitals are now committed to complying with this law. He stated that the cultural shift and widespread acceptance of the obligation to publish this pricing data is astounding. There has been a delay in compliance, but, according to Mr. Hawkins, a lot of these delays have been related to limited resources due to COVID-19 data reporting, the use of vendors to publish this data, compliance with the federal No Surprises act, and general industry workforce shortages. It was their understanding that enforcement letters from HHSC went out at the end of April. These letters gave hospitals 30 days to correct any discrepancies HHSC identified. SB 1137 includes a lot of technical requirements, and many hospitals that they were following the lay have been notified that they did not meet one or more of the specific parameters of the bill.

Mr. Hawkins stated that he wanted to stress that hospitals are in varying stages of compliance, and still have a ways to go, but their membership is committed to complying with this law. Their goal is to have the best compliance rate in the country. They have provided significand member education on how to comply with SB 1137. They have provided a detailed analysis on the law in the summer after the 87th regular session. They have sent numerous alerts to their members and given presentations on compliance. They have developed a detailed checklist relating to this law. The federal rule went in effect July 1 2022. Mr. Hawkins stated that it was his hope that the next time THA appeared before the committee that they could report widespread compliance with SB 1137.

Recommendations

The Committee is pleased with the progress of SB 1137's implementation and efficacy. It is the hope of the Committee that greater compliance will be achieved. The Committee will continue to monitor SB 1137, and will support future legislation that focuses on increased price transparency, which will ultimately protect all Texas patients.

SB 790

Background

Travis County operates STAR Flight, a public emergency helicopter service that conducts air ambulance, technical rescue, firefighting, and law enforcement support missions in a number of Central Texas counties. As emergency services providers, air ambulances, including STAR Flight, often are our-of-network for their patients, which can lead to balance billing. While Travis County may prefer as a public entity simply to not balance bill for STAR Flight services, it has been reported that the county's interpretation of state law is that it must attempt to recoup and all money owed to the county. Accordingly, the county used third-party debt collection for unpaid bills, which is largely unsuccessful and actively undermines STAR Flight's reputation with the public. S.B. 790 seeks to address this issue by authorizing a county to elect to consider a health benefit plan payment towards a claim for air ambulance services provided by the county as payment in full for those services regardless of the amount the county charges for those services.

S.B. 790 amends the Local Government Code to authorize a county to elect to consider a health benefit plan payment towards a claim for air ambulance services provided by the county as payment in full for those services regardless of the amount the county charged for those services. The bill prohibits a county from practicing balanced billing for a claim for which the county makes this election and defines "balance billing" as the practice of charging an enrollee in a health benefit plan to recover from the enrollee the balance of a health care provider's fee for a service received by the enrollee from the provider that is not fully reimbursed by the enrollee's health benefit plan.

Update

The Committee heard testimony from Rachel Bowden, Director of Regulatory Initiatives at the Texas Department of Insurance.

Ms. Bowden stated that the Texas Department of Insurance (TDI) has been working in collaboration with the Department of State Health Services (TDSHS) within the Texas Health and Human Services Commission (HHSC). They have a survey available on their website that was sent in November 2021, and they have had a difficult time getting an adequate response rate. They have received responses from 293 organizations, which is approximately 50% of the ambulance providers, but they recognize that some of them are very small entities. They have received aggregated responses, in one case receiving a response from an organization representing 15 providers. Originally the data was due on January 2022, but the deadline was extended to February 2022. TDSHS sent a follow-up request in February for those who had not yet responded in an attempt to get as high a response rate as possible. The survey is designed to segment the data by type of ambulance provider, like county hospital, volunteer for profit , nonprofit, as well as by Texas region which divides the state into six regions: north, south, east , west, panhandle, and central. The survey had 24 questions which focused on the following topics: volume of dispatches, patients served by average standard charges for common services, and mileage billing codes. Ms. Cook noted that were a number of questions which arose in relation to this data. There are questions relating to how Medicaid or Medicare enrollees are billed. Similar confusion exist with how to bill commercial plan enrollees and uninsured patients. Confusion also exist when considering whether to send balance bills to patients and whether they send unpaid bills to a third-party for collection, and whether the provider contracts as in-network, and whether the their contracting practices have changed, to either do more or less contracting with plans in the last five years. The report on SB 790 will be due on December 1st, 2022.

Recommendations

The Committee will continue to monitor the progress of SB 790.

INTERIM CHARGE #2

Review existing state laws, administrative regulations, and agency practices to identify barriers to competition in the insurance marketplace. Examine existing business practices in the industry to determine if additional laws or regulations are needed to promote competition, lower premiums, and protect consumers.

Health Sharing Ministries

Background

Texas currently has language in the Ins. Code (Sec. 1681.001) from the 2013 legislative session which exempts sharing ministries from the insurance code. However, this statutory language predated the implementation of the Affordable Care Act (ACA). After the ACA was implemented in 2014, sharing began to see a significant increase in participation that was not anticipated during the 2013 session. Since that time, sharing in Texas has grown to involve participation of approximately 250,000 Texans. Nationwide, Texas is the largest state by total population of members involved in sharing.

Under the current law, Texas has no way to know how many Texans are participating in sharing. These individuals are then improperly categorized as part of the uninsured population which significantly skews the numbers of the truly uninsured. Furthermore, Texas has no way of even knowing which sharing ministries are actually operating in Texas. Non-profits are required to register with the Secretary of State but investigation has uncovered that a good number of sharing ministries have not even complied with registration with the Texas Secretary of State.

Of greatest concern, as the sharing concept has grown in Texas, in recent years there have been reported instances of serious consumer abuse that involve more than one sharing entity.

These issues demonstrate the need for modernization of the current Texas law. Such modernization should require more information on which sharing entities are operating in Texas, provide consumers with useful information about those sharing entities so that consumers interested in sharing can make an informed choice to participate in sharing and which sharing entity may best fit their needs and provide Texas with the ability to quickly move against a sharing entity that is operating without notifying the state it is operating in Texas.

Update

The Committee heard testimony from Keith Hopkinson, representing Christian Healthcare Ministries.

Mr. Hopkinson recommended that three items were needed to avoid insolvency, and to protect participants in healthcare sharing ministries. A sharing entity that intends to operate in Texas should register with the state and provide basic contact information for the sharing entity. Registration should include information demonstrating that the entity meets the definition of a sharing entity, information on key officers, a copy of the guidelines used for sharing of members' needs, and copies of an annual audit of all dollars used for sharing of members' health costs and the administration of the sharing entity performed by an independent CPA to generally accepted accounting practices. This registration should be held annually, but can be automatically renewed for a sharing entity that is accredited by an independent third party entity that has shown to have high standards of practices and an established history of such review of the business practices of such entities.

Mr. Hopkinson stated that it is his wish that healthcare sharing ministries should annually report information on their total number of Texas members, total monetary amounts contributed by Texas members, total Texas health care costs shared, average time between submission of health costs and the date that said health costs are shared. Mr. Hopkinson stated that reporting of all third parties, such as affiliated entities providing administrative services to the sharing entity and membership should be made publicly available on the TDI and AG websites for members and prospective members to review and compare so that the Texas consumer can make informed choices. He stated that the ministries should separately report on a quarterly basis to their current Texas members the amount of money shared by Texas members, and the amount of eligible health costs shared by Texas members.

Mr. Hopkinson stated that TDI and AG should have the ability to issue a cease and desist order to any sharing entity that is operating in Texas that has not registered and is not reporting to the state. It is Mr. Hopkinson's belief that this significantly simplifies the standard for the state to act and greatly reduces the time needed for the state to react to potential bad actors. This would avoid the highly burdensome and very difficult task of trying to prove that a bad actor is operating as an unauthorized insurer in violation of the Texas Insurance Code or the Texas Consumer Protection Act.

The Committee heard testimony from Joe Petrelli, president and co-founder of Demotech, Inc., which specializes in evaluation of the financial stability of regional and specialty insurers.

On July 10, 2022, the Securities and Exchange Commission Office of Credit Ratings issued a registration to Demotech, Inc. as a nationally Recognized Statistical Rating Organization. Demotech has recently developed their accreditation criteria for self-regulation and internal analysis by health care sharing ministries. Demotech's philosophy is to review and evaluate insurers based on their area of focus and execution of their business model, rather than soley on financial size.

The core qualifications which Demotech examines when evaluating a health care sharing ministry are as follows:

- A health care sharing ministry must be established as a not-for-profit corporation as described in 26 U.S.C.§501(c)(3) and exempt from taxation under§501(a).
- They must have an exemption letter from the Internal Revenue Service (IRS). They must file a Form 990 annually with the IRS, if required under the Internal Revenue Code.
- They must provide the latest three years of Form 990.
- They must have received a letter of certification from the Centers for Medicare & Medicaid Services which confirms that the ministry complies with 26USC § 5000A(d)(2)(B)(ii). Demotech must receive a copy of the letter of certification from Centers for Medicare & Medicaid Services.
- They must have responded in a timely and appropriate manner to inquiries or requirements of regulatory bodies, courts, or other governmental entities. They must operate and market themselves under their legal name(s) for which they are legally registered in order to avoid confusion with other health care sharing ministries or insurance companies.
- They must have a board of directors and leadership who possess expertise and backgrounds relevant to the operation of the ministry, and must provide continuing education to its board of directors. Its members must share a common set of ethical or religious beliefs and voluntarily share certain medical expenses among themselves in accordance with those beliefs.

Mr. Petrelli stated that the organizations must state that they are a religious ministry, and must not state or imply that they are in the business of providing insurance. They must not allow itself to be advertised in any manner as part of, or in conjunction with, an offer of or quote for health insurance products. They must not make statements in their advertising concerning financial solvency or a successful history of sharing unless those statements are supported by the organization's annual audits and other corporate records. They must publish an online explanation of the expenses eligible for sharing by the ministry.

They must operate under a code of conduct which requires ethical behavior on the part of all of its employees, managements, and board of directors, and they must voluntarily disclose potential conflicts of interest. They must show that they have established, documented, and implemented a credible and reasonable whistleblower policy and reasonable record keeping policy.

The ministry must have a clear, written mission statement indicating that religious ministry is its primary purpose. They should actively support and educate members to be healthier. They should also educate its members in support of fostering better doctor/patient relationships.

Regarding financial accountability, ministries should subject their entire operations, including all operating costs, incoming gifts, and all bills shared, to an audit performed annually by an independent certified public accounting firm in accordance with generally accepted accounting principles. This audit should be made available to the public upon request. They should be governed by a board of directors of not less than fiver persons, a majority of whom should be

independent, who meet at least quarterly to establish policy and review the ministry's finances, controls, operations, and plans.

Mr. Petrelli stated ministries must ensure that no individual who is otherwise qualified shall be excluded or terminated from membership, or asked to provide additional gifts or donations, based on health history.

Ministries should not compensate insurance agents of other persons based on the number of members solicited or enrolled, or the amount of contributions received from enrolled members, including by commission. This does not apply to a new member referral program in which existing members are given credit for referring new members, if the credit is limited to a reasonable number of referrals in a twelve-month period. When for-profit contractor services are necessary to the operation of the ministry, the ministry should contract with individuals or companies who have no affiliation with the ministry's management team or any member of the board of directors, unless proper disclosure is present. There should be a majority of the ministry's directors who have no familial relationship to any member of senior managements or any other director of the ministry. The ministry must have a policy in effect that a candidate for director who has such a relationship may be elected, or a director may be re-elected, to the ministry's board only by vote of the unrelated directors after full disclosure of the relationship.

The member bill processing times should routinely mee the following standards. First, the ministry should share 90% or more of submitted eligible bills withing 120 standard business days of the date of receipt of the submitted eligible bill. They should have in place a viable Incident Response Plan, or similar plan, for the protection of the sensitive personally identifiable information of its members.

They should have taken reasonable steps to protect its data systems from intrusion. If the ministry allows payments of gifts with credit cards, they should be Payment Card Industry(PCI) compliant.

Mr. Petrelli stated that ministries should promptly respond to consumer complaints and have established, documented , and implemented procedures for the reporting and resolution of member complaints and grievances. They should not penalize its member for utilizing particular medical treatment providers.

The Committee heard testimony from Joel Noble, representing Samaritan Ministries, and the Alliance of Health Care Sharing Ministries.

Mr. Noble stated that over 35,000 individuals are currently being served by Samaritan Ministries. He expressed gratitude that Texas, like 30 other states, has explicitly recognized in the State Insurance Code that healthcare sharing is not insurance. To his knowledge, no member of of Samaritan Ministries has ever made a complaint to the Texas Department of Insurance, or any other regulatory agency or consumer advocacy group.

However, Samaritan Ministries saw value in taking part in a new independent accreditation process, and has applied for accreditation with the healthcare sharing accreditation board. He

stated that they have considered applying with Demotech, Inc. However, two of Demotech's criteria appear to disqualify two of the three largest healthcare sharing ministries, both of which have been successfully sharing for 27 years.

Mr. Noble said that healthcare sharing accreditation board will delve into each ministry that applies and examine over 80 critical organizational characteristics to decide whether they meet the exacting standards of a transparent, true healthcare sharing ministry, while not disqualifying any simply on philosophical operational differences. These include, but are not limited to, standards in the following categories: legal structure and governance, organizational management compensation, conflicts of interest and related party transactions, external communications and marketing, enrollment processes, written acknowledgement from members regarding its non-insurance nature, public sharing guidelines, financial sharing processes(including processing time), dispute resolution and appeals, total amounts shared and not shared among members with monthly disclosures to members, ratio of administrative overhead expenses to program expenses, membership contribution guidelines, and management processes, extensively-scrutinized, audited financial statements, and IRS form 990.

Mr. Noble stated that the professional achievements of the healthcare sharing board members conducting these evaluations are also worth noting. Members of the accreditation board include The Honorable Diane Black, former U.S. House of Representatives Budget Committee chair, and registered nurse Mary Mayhew, President and CEO of the Florida Hospital Association, who has in the past served as an agency chief for former Governor LePage of Maine and Governor DeSantis, current Governor of Florida, and as the former head of Medicaid. James Lansbury, the former Executive Vice President of Samaritan Ministries left that position over two years ago. Also serving on the accreditation board is Dave Cram, a CPA who specializes in religious nonprofit accounting, and who has served in the past as an auditor for the Evangelical Council for Financial Accountability and the Evangelical Christian Credit Union. Lastly, Josh Heidelman, of Castañeda and Heidelman LLP, an attorney experienced in nonprofit law, who was the former general counsel of the global mission organization Wycliffe Bible Translators.

Mr. Noble stated that he, and those in his organization want to protect citizens of Texas from bad actors pretending to be healthcare sharing ministries and mimicking the important ministerial work that they do.

Recommendations

The Committee is enthusiastic about the possibility of third-party accreditation, and its ability to ensure that participants in Health Sharing Ministries are protected from bad actors. The Committee feels that, in light of recent issues involving another Health Sharing Ministry, that legislation requiring independent, third-party accreditation may be necessary to protect Texans participating in Health Sharing Ministries.

County Mutuals

Background

In 1955, county mutuals were authorized to write all lines of automobile insurance , both liability and physical damage, on a statewide basis. Because county mutuals are exempt from a number of insurance laws in Texas, including laws establishing the benchmark rating system imposed on other auto insurers, Texas county mutuals wrote 22.4% of the private passenger vehicles in Texas as of December 31, 1999.

It is commonly understood in Texas and countrywide that individual drivers should pay rates that reflect the risk they present. This is why it is common for drivers with at fault accidents and DWIs to pay more than drivers with clean driving records. It is important to remember that the reason these drivers are charged more is not to punish them for their moving violations or for the insurer to get the money back it paid out due to an accident. The reason is that a driver with this record is statistically more likely to have an accident in the future.

While Texas generally follows this generally accepted insurance rating practice, Texas adds an extraordinary unique and costly complicating factor. In Texas, traditional insurers are prohibited from increasing premiums for certain moving violations. However, Texas permits county mutual insurance companies to increase premiums for these moving violations. This creates a statutory monopoly for county mutuals to write policies that accurately reflect the risk of insuring drivers with moving violations.

Under current law, only 23 county mutuals exist in Texas that can write these types of policies, and no more can be created. If a traditional insurer wants to write a policy for a person with a moving violation they must write the policy through a county mutual. It appears many insurers choose to write these types of policies through a county mutual. Many name brand, nationally known insurers have purchased one of the 23 existing county mutual and can thereby simply place a customer with moving violations in that county mutual in order to charge an actuarially appropriate rate. Other insurers, who have not purchased one of the 23 permitted county mutuals, rent an independent county mutual. The traditional insurer, however, maintains all of the risk associated with that policy. The county mutual is just an administrative passthrough and receives a percentage of total premiums written.

Because of this statutory monopoly on writing moving violations, auto insurance premiums for drivers with moving violations are higher than they otherwise need be. TDI estimated that, in 2011, the amount required to pay for writing moving violations added approximately $45m to the cost of automobile insurance for policyholders in Texas.

Besides increasing premiums, the current statutory monopoly also distorts the market and creates a barrier to entry for new market entrants. Any new insurance company that wants to enter the Texas market and write policies for customers with moving violations needs to consider whether to rent or purchase a county mutual.
The moving violation surcharge issue has been around since at least 1979 when the legislature passed a bill to prohibit fully regulated insurers from surcharging their auto policyholders for

moving violations. The prohibition, however, was not made applicable to county mutual insurance companies and, even to this day, it never has been.

Update

Note: Representatives from different Texas county mutual insurance companies were invited to testify at this hearing. They declined the invitation.

The Committee heard testimony from Mark Worman, Deputy Commissioner, Property and Casualty Division, at the Texas Department of Insurance.

Mr. Worman stated that county mutuals have been around for a very long time. In the mid 1950s, the legislature actively prohibited the formation of new county mutuals, but at the same time, authorized county mutuals to write all forms of automobile insurance. A county mutual can write property insurance and auto insurance. They cannot write any other form of liability insurance other than auto insurance. They are exempt from insurance laws other than the laws that are specified in their chapter, unless that the law specifically provides that it applies to a county mutual. They can rate policies according to moving violations, and other companies cannot. There is a statute that prohibits companies from assigning a premium consequence for moving violations.

There were 23 county mutuals in Texas, with 22 being currently active in 2021. These county mutuals wrote $12.2 billion dollars in personal auto premiums in 2021, which accounts for approximately 50% of the market for personal auto insurance. They wrote $1.55 billion dollars for commercial auto, which represents approximately 30% of the commercial auto market.

Mr. Worman reiterated that county mutuals are the only insurance organizations in Texas that can write policies based on moving violations. He stated that Texas is unique in the United states in that regard.

The Committee heard testimony from Austin Bailey, representing Branch Insurance.

Mr. Bailey stated that Branch Insurance, domiciled in Ohio, offers personal lines of insurance, including personal passenger and auto and homeowners insurance, and is currently available for over half of the United States population. Branch Insurance is owned by its members and acts as a steward of the community's funds. They offer products through three channels: independent agents online which interact directly with consumers with help from in-house licensed sales agents, through partnerships with larger mortgage companies, auto, finance, and home security providers.

Mr. Bailey stated that Branch Insurance seeks to remove unnecessary fees and expenses, as well as leveraging data and technology to make insurance better and more affordable to all, and in 2020, entered the Texas market as their third state. Texas has grown to be their largest state, with over 21,000 homeowners' policies and 16,000 auto policies.

Mr. Bailey stated that Branch Insurance offers a unique perspective in this dialogue as a smaller, new market entrant that does not possess the funds necessary to purchase a county mutual. The current law restricts the ability for new players in the market to grow and compete with companies who are able to rate based on minor moving violations.

Mr. Bailey stated that they are left with two options. The first is to set a higher overall rate level and attempt to account for these risks. This leads to the lower-risk group in their policyholders paying more to subsidize higher-risk policyholders. Additionally, this can lead to adverse selection where our rates are too high for those drivers without traffic violations, and too low for those with traffic violations.

The second option would be Branch Insurance restricting their underwriting guidelines and only accepting drivers without traffic violations. This would reduce availability for Texas insurance consumers and goes against their mission of providing affordable rates to more people.

Mr. Bailey stated that if Branch had the ability to segment their risk more accordingly, they would be able to offer their products to more Texans. Both of the options listed above impact their ability to compete in the Texas market and impact the growth of their business and their ability to provide affordable insurance products to more Texans. This impact is not just felt in the personal auto market, but also affects their ability to expand their homeowners product in coastal and higher risk areas, as they need growth in the personal auto business in order to balance that risk.

Mr. Bailey stated that Texas Insurance Code instructs the Texas Department of Insurance shall ensure fair competition in the insurance industry in order to ensure a competitive market. The current law is in direct conflict with this statute, as the county mutuals have been given an unfair competitive advantage. Mr. Bailey stated that legislation that would allow all insurers the ability to surcharge for minor moving violations would level the playing field and allow for a more competitive insurance market.

The Committee heard testimony from John Marlow, Senior Vice President of Chubb Insurance.

Mr. Marlow stated that if an auto insurance market was created today, county mutuals would not exist. He stated that the current options available for Chubb are unfair. First, they could by a county mutual, which is something which many of the top insurance writers have already done. They could rent the license of an independent county mutual, add a 6% fee, which would be about five or six million dollars. The costs of doing so would likely be passed along to policyholders, which is not something that they find to be agreeable. Currently Chubb chooses to write everyone the same - safe drivers receive the same rate as unsafe drivers. Chubb does not feel that this situation incentivizes safe driving appropriately.

Recommendations

The Committee believes that fair competition is necessary to ensure that a fair, robust marketplace exists. The Committee will continue to monitor this situation.

Farm Mutuals

Background

Farm mutual insurers operating under Chapter 911 of the Insurance Code are required to write a majority of their business on rural property. The term rural property is defined in Sec. 911.301 as "rural property" means property located outside an area of land subject to the taxing authority of a municipality with a population of more than 2,500.

Generally, a farm mutual can only write certain property risks and a majority of their business has to be in rural areas. A farm mutual cannot write automobile insurance or liability insurance. Thus, a farm mutual cannot write a homeowners policy because it includes liability insurance. Some farm mutual groups have formed stock insurers in order to provide liability coverage to the owner of a dwelling or other structure allowed to be insured for property coverage.

In 1947, the farm mutuals passed a law to distinguish a farm mutual from a county mutual insurer. In this law, “rural property” was defined as any property with at least five (5) acres of cultivated or grazing land used exclusively with such insured property. The farm mutual act was recodified in 1951 as Chapter 16. The county mutual law was recodified in 1951 as Chapter 17. Chapter 16 has now been recodified as Chapter 911 and Chapter 17 has now been recodified as Chapter 912.

In 1973, the legislature amended the farm mutual laws in Ch.16 and specifically change the definition of “rural property” to include the population of 2,500 requirement. Generally, farm mutuals are exempt from rate regulation, policy form regulation, premium taxation, and are not required to be a member of the TWIA or other residual type market mechanisms.

There are approximately 17 farm mutual insurers licensed and operating in Texas. Many of these are small insurers that operate in only a few counties. Unlike county mutual insurers, a new farm mutual could be formed in Texas. Unlike county mutuals, the law allows the formation of new farm mutual type of companies.

In 2019, Rep. Lambert filed HB 3056 that was also designed to change the definition of “rural property” to include a municipality with a population of more than 50,000. HB 3056 was heard before the House Insurance Committee. The bill analysis for the bill provided:

A farm mutual insurance company is required to maintain a majority of its total insurance in force on rural property at all times the insurance is written. It has been suggested that the definition of "rural property" applicable to farm mutual insurance companies is outdated and too restrictive. CSHB 3056 seeks to provide a more appropriate definition of that term.

H.B. 3056 was reported favorably as substituted but did not reach a House calendar in 2019.

In 2021, Rep. Lambert filed HB 2026 that would have increased the threshold for the definition of rural property from 2,500 to 6,500 and also would have required the threshold to be changed based on the increases/decreases in the Texas statewide population using census data. HB 2056 was filed but did not receive a hearing.

Update

The Committee heard testimony from Wiley Shockley, representing the Texas Association of Mutual Insurance Companies (TAMIC).

Mr. Shockley stated that farm mutuals were the original grassroots property insurance providers in Texas, created to provide fire coverage for farmers and agricultural communities to cover property which included farm equipment, such as poultry houses, barns, sheds, and certain types of structures related to growing and storing agricultural crops. Farm mutuals would insure structures other companies would not due to issues due to lack of fire protection, for example, because the structures were not in the vicinity of a working fire hydrant.

Farm Mutuals are mutual insurance companies owned by their members, and are governed by Chapter 911 of the Insurance Code. This code states that the control of a farm mutual company is ultimately vested in the members to a supreme legislative, or governing body. Mr. Shockley stated that farm mutuals only operate in Texas, so they live and die by what happens in this state.

Mr. Shockley stated that, in profitable years, the farm mutuals take profits and put them back into the surplus to be there if the members need it in the future. For example, in 2021, during the February freeze, farm mutuals were there for their members, and had sufficient money available to cover losses and damages filed by members. Mr. Shockley stated that farm mutuals are not county mutuals, and none of the 17 farm mutual insurance companies own a county mutual company. County mutual companies provide a totally different class of insurance coverage than farm mutuals.

Mr. Shockley stated that farm mutuals adhere to strict requirements and statute that allow them to only write certain types of policies. Farm mutuals cover rural and urban dwellings, tenant houses, yar buildings and all content for home and personal use, barns, ranch buildings, agricultural products, implements kept on farms or ranches, churches, fraternal lodge halls, non-industrial use buildings, buildings owned by nonprofit organizations, and mobile homes.

Chapter 911 of the Insurance Code requires that the farm mutuals write at least 50% of the company's total insurance coverage in rural areas that lack fire suppression. These areas have long been abandoned by big insurance carriers, having been deemed too risky for a traditional policy. The ability of the farm mutuals to write rural and non-rural policies allows farm mutuals to offer an affordable product to its members. Rural property was defined in the early 1970s, and has not been updated since 1973. This definition defines rural property as property located outside an area of land subject to the taxing authority of a municipality with a population of 2,500 individuals.

Mr. Shockley gave population numbers for a number of Texas towns: San Saba with 3,151 individuals, Llano with 3,347, Columbus with 3,587, Halletsville with 2,742, Navasota with 1,068, Hempstead with 6,027, Rusk with 5,537, and Brookshire with 5,501. Mr. Shockley stated that no one would classify these towns as urban. However, when farm mutuals write a policy in these areas, they must be classified by law as urban.

Farm mutuals are not allowed to write liability coverage on with the property coverage they write. In order to fully serve their members, some of the TAMIC member companies have formed their own subsidiary companies to offer the liabilities to go along with the property policies that the farm mutuals write. These subsidiary companies are standard insurance companies, and are not governed by Chapter 911 in the Insurance Code.

These subsidiaries are subject to Texas Windstorm Insurance Association (TWIA) assessments, as well as premiums and maintenance taxes. Farm mutuals collectively write policies in all 254 counties in Texas. Texas has all kinds of environmental perils: hail, tornadoes, floods, wildfires, and hurricanes. Farm mutuals who write policies on the coast focus on taking care of their members. Farm mutuals retain the wind and hail coverage on their policies in tier one areas most susceptible to risk. TAMIC members write approximately $1.5 billion in coverage in these areas. They do not cede wind and hail coverage to TWIA.

Mr. Shockley stated that, much like Texas has changed over the years, so has the property and casualty market. There have been many challenges in the past, such as the mold crisis, and uncontrolled hail litigation, which was worked through several sessions ago. Through the unusual freeze of last year, and numerous hurricanes, farm mutuals have stuck by their members continue to be a reliable resource for Texans. Mr. Shockley stated that, unlike other insurance companies, they have never abandoned any of their members dues to insolvency, or other market decisions.

Recommendations

The Committee understands that situations change, and metrics established in the past may or may not be applicable to current situations and standards. The Committee recommends that further study may be necessary in order to establish current, effective means of classifying regions as rural or urban, in order to find out if these classifications retain their relevance by today's standards.

Appraisals

Background

Nearly every residential property and personal auto insurance policy in Texas allows the policyholder and the insurer to ask for an appraisal. Policyholders can ask for an appraisal if they disagree with the amount an insurer offers on a property insurance claim. The loss amount set by an appraisal decision is typically binding.

In 2015, TDI approved a large insurer's auto policy that eliminated the policyholder's and the insurer's right to an appraisal for disagreements about vehicle repair costs. With this change, policyholders and the insurer have a contractual right to appraisal only for disputes about total loss vehicle claims.

In July 2022, TDI rejected a filing from another large insurer with the same appraisal limitation for its auto policy. TDI rejected that filing because it didn't provide enough information to support the request.

In August 2022, an insurer filed residential property policies that would eliminate the right to ask for an appraisal for all claims. The insurer is an affiliate of the insurer with the approved limited appraisal provision in its auto policy. The insurer sent TDI data showing that almost 90% of homeowners insurance claims that went through appraisal over a three-year period were settled without litigation.

Update

The Committee heard testimony from Melissa Hamilton from the Office of the Public Insurance Counsel.

Ms. Hamilton stated that a consumer's right to invoke appraisal in disputes regarding the cost of repairs or the amount of a total loss has long been the market standard in Texas for both personal automobile and residential property insurance. The right to invoke appraisal is generally a policy form issue. Appraisal clauses are included in policy forms filed with the Department of Insurance on a prior approval basis.

Ms. Hamilton stated that he appraisal process itself is essentially a dispute resolution process. The consumer and the insurance company can each pick an appraiser to determine the cost of repair or total loss. If the appraisers cannot agree, they select a third appraiser to resolve the dispute. As the courts recognize, this is a less expensive, more efficient alternative to litigation, which involves no lawsuits, no pleadings, no subpoenas, and no hearings, but still efficiently determines the amount of loss.

Ms. Hamilton said that while appraisal has long been the standard in Texas policies, a small number of insurers have submitted policy forms to the Texas Department of Insurance in recent years that eliminate or unreasonably restrict Texans' ability to invoke appraisal. Only one of these forms has been approved, but that filing and the other similar filings raise concerns because they are a departure from a longstanding market standard. Moreover, they remove a traditional consumer protection that gives consumers an ability to challenge an insurer’s offer promptly and without having to file suit. Some argue that appraisal has created challenges for insurers. Appraisal is not without challenges, but other parameters can be added into policies, such as not allowing a consumer to assign their right to appraisal to someone else. These parameters can address insurer concerns yet preserve a consumer’s right to appraisal. Policy forms that altogether remove the consumer’s right to invoke appraisal, therefore, go further than is necessary to address insurer issues and place the consumer at a disadvantage in disputes about the cost to repair or replace their car or home.

The Committee heard testimony from Marianne Baker, Director of Property and Casualty Lines at the Texas Department of Insurance, and Cindy Wright, Director of Consumer Protection at the Texas Department of Insurance.

Ms. Wright stated that rates of appraisal relating to non-total loss have been relatively low in the recent past. She stated that TDI had pulled numbers from 2017 to the end of 2021. She stated that out of approximately 100,000 complaints, 544 of those were related to appraisal. She stated that TDI does not have the capabilities to distinguish between cases where the consumer wanted to invoke appraisal, but was denied, and cases where there was a complaint after the appraisal process has already taken place.

Ms. Baker stated that TDI does not have any specific requirements as to who can and who cannot be an appraiser in Texas, or how the appraisal process should be conducted. She stated that the requirements for appraisers and umpires are typically in the policy forms, and all require that the individual offering the appraisal be competent and independent. They have additional requirements as well. Some might require the appraiser to be someone who is related to that line of work. For example if one were to be a property appraiser, one would need to be an experienced contractor or adjuster.

Ms. Baker stated that TDI has not seen a huge influx in companies wanting to change the policy forms requesting a termination of the right of appraisal for non-total loss cases relating to auto claims. She stated that recently, a large homeowner's insurer has filed forms to entirely remove the right to appraisal from homeowners' policies for homeowners, condominium owners, and renters. She stated that if TDI were to approve that policy, it would be a significant change in the market.

The Committee heard testimony from Douglas Heller, representing the Consumer Federation of America.

Mr. Heller stated that the auto insurance appraisal process can serve consumers, taxpayers, the insurance system, and the public generally in several ways to serve and strengthen the consumer protection process. He stated that decisions and efforts by some insurers to limit access to the appraisal process could have a long term effect of reducing public safety and increasing litigation. The appraisal system creates a check and balance on the insurance company process of determining how much to pay to repair a vehicle. Vehicle repair can oftentimes involve complex assessments and decisions. It is important to provide consumers with assurances that they are not being lowballed, and the appraisal process can create a mechanism for a second opinion that helps prevent dangerous mistakes and oversights in post-crash assessment and repair. The appraisal process creates a back and forth in which the consumer has the opportunity to present an expert analysis of the repair needs of the care, and the ability for the insurance company's adjuster to share notes and look for common ground and the best resolution of a claim. If they cannot find common ground, the appraisal process has another step of heading to a technically expert umpire who can make a final determination.

Mr. Heller stated that if the insurance companies are always providing fair, reasonable, and safe estimates and claim settlement offers, there would not be the need for appraisals. However, frequently there is a spread between what the issuer recommends and what an independent appraiser recommends. There is also a difference with what the final umpire determines. The difference is in the amount that the consumer would have to pay to cover the full cost of repair. The result of appraisal is that consumers are more likely to get something approximating the full value of their claim. Insurance policy is a contract. Most people on the policyholder side do not have the expertise to know whether or not the insurance company adjuster is offering something that really meets the terms of the contracts to restore the car to its pre-loss condition. The appraisal process doesn’t exactly level the playing field, but at least it gives consumers an expert who works for them and not the insurer. And so the appraisal process also allows us some comfort that either the insurer is treating us right and getting it right, or that there's an expert who can speak on our to our repair needs in the language of repair and in a way that will identify and

help close the gap between what the insurer originally offered and what the contract is supposed to insure. It gives consumers some peace of mind that they got the repairs they paid for through their policy and the safety they need for their family. The second way that the appraisal process is important is because it is an alternative to litigation. The entire framework for the appraisal process is to create a way to resolve differences between two parties to the contract without having to go to court. When insurance companies deny consumers the opportunity to mediate through an appraisal process, they are encouraging increased litigation.

The Committee heard testimony from Robert McDorman, representing Auto Claims Specialists.

Mr. McDorman stated that he does not feel that every auto claim should go to appraisal. Mr. McDorman said that he believes that, due to the tremendous volume of auto claims, the valuation of loss must be automated. He recognizes that there is no perfect automated vehicle valuation system, but stated that automated valuation systems approved by the insurance carriers will always and understandably penalize any tendency of over indemnification. Thus, the inevitable valuation errors will always tend to be on the low side. Mr. McDorman stated that right of appraisal should be mandatory in every state of our nation, and presented to the insured as the means of resolution when values are disputed.

The Committee heard testimony from Burl Richards, representing the Auto Body Association of Texas.

Mr. Richards stated that there seems to be some misunderstanding of what insurance policies state. He said that policies do not require that the vehicle must be returned back to its pre-accident or pre-loss condition. He stated that since this void in policy exists, insurance companies decide how to dictate how these vehicles are repaired. He stated that this policy allows for no negotiation on price. He states that the appraisal process is the only thing that protects consumers from having to pay out-of-pocket costs, or having to employ the services of an attorney.

The Committee heard testimony from Jon Schnautz, representing the National Association of Mutual Insurance Companies(NAMIC).

Mr. Schnautz stated that the appraisal process is about first party auto claims. This is a collision or comprehensive claim. It is a contractual process that arises from the insurance policy. Mr. Schnautz mentioned that something that had not been discussed in the hearing so far was the issue of form freedom. This was a decision the legislature made 20 years ago, resulting from a crisis in the property and casualty market, specifically, the mold crisis, when promulgated forms had been interpreted to dictate that insurers cover certain things in certain ways. The legislature had to come around and make a huge series of changes around that. The legislature decided that they would not dictate what the insurance companies would cover 100% of the time. This allowed for the market to better respond to problems.

Mr. Schnautz stated that there is only one fairly large carrier who has removed appraisal for non-total losses, which TDI approved. He believes that the threat of increased litigation will encourage the market to keep appraisal processes for non-total losses intact. He stated that, since

the TDI-approved policy happened seven years ago, the market forces would show by decreased customer satisfaction and increased complaints concerning this issue.

The Committee heard testimony from Jay Thompson, representing the Association of Fire and Casualty Companies in Texas(AFACT).

Mr. Thompson stated that appraisal is a contractual provision that has been in numerous property and auto policies for several decades. Appraisal is not a right provided by statute or other law even though it has been historically included in policy forms when TDI promulgated forms. The purpose of such a clause is resolve differences on the "amount of the loss" without the delays, time, and expense of a court proceeding. Appraisal does not resolve coverage issues. Appraisal has evolved in the language used over the years, particularly after Hurricane Ike and the litigation abuses that were addressed by the Texas Legislature in 2019.
Even though some insurers have filed language on auto policies to use appraisal only for total losses, a large portion of the market has not filed such changes. Mr. Thompson stated that he is not aware of any widespread attempt by all insurers to restrict appraisal in auto policies to only total losses.

Mr. Thompson stated that the fact that TDI has approved forms for one large company in the market and failed to approve others gives a competitive advantage to the one company. There is no specific legal provision in the Insurance Code for disapproval. It was Mr. Thompsons's understanding that TDI did not disapprove the filing but instead closed the filing based on what they stated was failure to provide requested information in time deadline demanded.

Mr. Thompson said that Texas is a competitive market, both in terms of price and coverage. Consumers who want appraisal in a form can obtain that from a number of competing companies. Homeowners and residential property policies typically do not need appraisal for a total loss because of long-standing provisions in Texas law. Appraisal for homeowners and property claims are typically all partial losses and the appraisal is designed only to determine the "amount of the loss". He stated that he has heard of no carrier seeking to eliminate appraisal clauses in those types of policies.

Mr. Thompson stated that most of the abuses relating to appraisal in auto are the result of what is referred to as "Assignment of Benefits(AOB)". This has been a severe problem in Florida and other states and Florida recently had to enact legislation to curb the abuses from AOB.
Recent abuses in appraisal in homeowners include requesting a court "ex parte" to appoint an umpire, conducting appraisal and signing an appraisal between umpire and insured appraiser without notice to insurer appraiser.

Mr. Thompson stated that Texas promulgated forms have included clauses that prohibit the assignment or transfer of interests in an auto policy without the express written consent of the insurer. Most insurers in Texas have similar provisions in their auto forms. The inclusion of this language should stop some of the abuses in appraisals described earlier.

Recommendation

A consumer's right to invoke appraisal in disputes regarding the cost of repairs or the amount of a total loss has been the market standard in Texas for both personal automobile and residential property insurance. The Committee will continue to monitor this situation.

INTERIM CHARGE #3

Monitor the implementation, compliance, and enforcement of legislation related to freestanding emergency rooms to determine whether patients are adequately protected and if further safeguards and disclosures are needed.

SB 2038

At the beginning of the pandemic, COVID-19 tests were heavily sought after by Texans. During this time, many Texans went to freestanding emergency rooms (FSERs) to take these tests, as these facilities advertised that they would get results within 48 hours. What they did not expect was the high cost of the test, when they received their bill. There have been numerous articles documenting freestanding ERs charging insurance companies thousands of dollars for administering a COVID-19 test. One freestanding ER billed a Houston woman $2,500 for her son's drive-through test. The test itself was only $175, but the facility tacked on $2,300 in unnecessarily high facility, physician, and observation fees. While freestanding Ers are emergency facilities and treat patients for these situations, they are not required to treat patients who are clearly not experiencing an emergency. These facilities have the ability to charge whatever they choose for facility and physician fees, which means they are actively choosing to bill COVID-19 patients exorbitant amounts during a pandemic. While these costs are not coming directly out of the consumer's pocket immediately, they eventually will. When insurance companies are paying these high prices, which they are required to do during the pandemic, all of these costs will get wrapped back into premiums, raising them for everyone. This also contributes to the rising cost of healthcare overall, which is troublesome during a pandemic. At a time when people are worried about surprise medical bills, many Texans may think they need to cover these costs and do something drastic like take out a loan. To charge these kinds of costs during a pandemic, especially for a service that will help make people aware of if they have COVID-19, is extremely unnecessary and hurting the people of Texas. This bill addressed price gouging by freestanding Ers by prohibiting a freestanding ER from charging a facility, observation, or provider fee for testing or vaccinating from their vehicle. The bill would also prohibit freestanding Ers from charging a price that is unconscionable during a declared state of disaster. If a freestanding ER does price gouge, this bill would have the Health and Human Services Commission impose violations of administrative penalties and an eventual revocation of license. It will also add in clarifying language that freestanding ER's are not allowed to provide non-emergency care. SB. 2038 amended current law relating to fees and prices charged by freestanding emergency medical care facilities and provides administrative penalties.

There were concerns that freestanding emergency medical care facilities may provide inadequate or misleading information to consumers about health insurance network coverage. HB 2041 sought to address these concerns by requiring these facilities to provide additional written disclosures regarding the facility's fees and health plan network status.

HB 2041 amends the Health and Safety Code to require an independent freestanding emergency medical care facility and a hospital-affiliated freestanding emergency medical care facility to provide to a patient or a patient's legally authorized representative a written disclosure statement listing the facility's observation and facility fees that may result from a patient's visit and the health benefit plans in which the facility is a network provider or stating that the facility is an out-of-network provider for all health benefit plans.

HB 2041 sets out the required contents and form of that disclosure statement, which must include a place for the patient or the patient’s legally authorized representative and a facility employee to sign and date the disclosure, and limits the information that may be included in the statement to the information that is specified by the bill. The bill required the facility to update the statement annually and to provide each patient with a physical copy of the disclosure statement even if the patient refuses or is unable to sign the statement. The bill required a facility to indicate in the patient's file that the patient failed to sign if the patient refuses or is unable to sign the statement. The bill required the facility to retain a copy of a signed disclosure statement until the first anniversary of the date on which the disclosure was signed. The bill expressly does not require the facility to provide notice if the facility determines before providing emergency health care services to the patient that the patient will not be billed for the services. The bill established that a facility complies with these disclosure statement requirements if the facility posts its standard charges on the facility's website in a manner that is easily accessible and readable and requires the facility to post updated standard charges on its website at least annually or more frequently if appropriate. HB 2041 prohibited a facility from advertising or holding itself out as a network provider, including by stating that the facility takes or accepts any insurer, health maintenance organization, health benefit plan, or health benefit plan network, unless the facility is a network provider of a health benefit plan issuer. The bill prohibited a facility from posting the name or logo of a health benefit plan issuer in any signage or marketing materials if the facility is an out-of-network provider for any of the issuer's health benefit plans. The bill made a violation of these provisions a false, misleading, or deceptive act or practice under the Deceptive Trade Practices-Consumer Protection Act and makes such a violation actionable under that act. HB 2041 revised requirements relating to a certain notice of fees posted online and in certain places in each independent freestanding emergency medical care facility and prohibited a facility from adding to or altering the required language of such a notice. HB 2041 changed the fund to which an administrative penalty imposed on an independent freestanding emergency medical care facility is deposited from the general revenue fund to the freestanding emergency medical care facility licensing fund and limits the use of the money collected from those penalties to the administration and enforcement of the provisions relating to freestanding emergency medical

care facilities by the Department of State Health Services (DSHS). The bill removed the cap on the total amount of the penalty assessed for a violation continuing or occurring on separate days. HB 2041 included independent and hospital-associated freestanding emergency medical care facilities in the definition of health care facility for purposes of statutory provisions relating to health care data collection. The bill expressly did not require DSHS to collect data from such facilities unless money is available for that purpose.

HB 1941(86R)

Background

HB 1941 amends the Business & Commerce Code to establish that, for a freestanding emergency medical care facility, the provision of emergency care at an unconscionable price or demanding or charging an unconscionable price for or in connection with emergency care or other care at the facility constitutes a false, misleading, or deceptive act or practice for purposes of the Deceptive Trade Practices-Consumer Protection Act. HB 1941 set the minimum price alleged to be unconscionable for which the consumer protection division of the Attorney General's office may bring an action in the name of the state at 200 percent of the average charge for the same or substantially similar care provided to other individuals by emergency rooms of hospitals located in the same county or nearest county in which the emergency facility is located, as applicable, according to data collected by the Department of State Health Services (DSHS) and made available to the division. The bill authorized the Attorney General to adopt rules designating another source of hospital charge data for the division's use in establishing the average charge if the Attorney General determines that the division is unable to obtain the charge data collected by DSHS. HB 1941 authorized the division to request and the trier of fact to award the recovery of reasonable attorney's fees and court costs and the reasonable expenses incurred by the division in obtaining any remedy available through such an action. The bill expressly did not create a private cause of action for a false, misleading, or deceptive act or practice described by the bill's provisions.

Freestanding Emergency Rooms
Update

The Committee heard testimony from Lisa Wyman, Director of the Center for Health Statistics at the Texas Department of State Health Services.

As defined by Texas Health and Safety Code Section 254.001, a freestanding emergency medical care (FEMC) facility is a facility, structurally separate and distinct from a hospital, that receives and individual and provides emergency care. FEMCs are required to report administrative, claims-level billing data on all outpatient emergency department visits, including self-pay(claims that do not go through insurance) or charity (free or discounted medical care).

House Bill 2041(86R) amended Section 108.002(10), Health and Safety Code by adding a freestanding emergency medical care facility that is exempt from the licensing requirements of Chapter 254 under Section 254.052(8). The amended language required all freestanding emergency medical care facilities to report all emergency room visits to their facility.

The Texas Health Care Information Collection (THCIC) within the Department of State Health Services started collecting FEMC data beginning with Quarter 4 2022. It collects FEMC data on a quarterly basis. Data is obtained from approximately 350 actively licensed FEMCs that provide emergency services throughout the state of Texas.

The total number of FEMCs in the state of Texas was calculated to by 350 locations(42.4%), compared to 476 (57.6%) traditional emergency departments(Eds), for a total of 826 combined. FEMCs received 3,411,513 (22.0%) visits during this time period, versus 12,132,960 (78.0%) for Eds, for a combined total of 15,544,473 visits. FEMCs' most common diagnoses during this time period were for COVID-19 (5.5%), acute upper respiratory infections, unspecified (2.0%), other chest pain (1.9%), urinary tract infections (1.7%), and chest pain, unspecified (1.6%). For Eds, COVID-19 accounted for 9.0% of diagnoses, followed by contact with and (suspected) exposure to COVID-19 (8.8%), contact with and (suspected) exposure to other viral communicable diseases (6.3%), acute upper respiratory infection, unspecified (2.8%), and encounter for observations for suspected exposure to other biological agents ruled out (2.2%).

Common procedures performed at Eds and FEMCs are ranked by levels of complexity of procedures. Procedures are ranked from the lowest level of complexity, level 1, and the most complex being level 5. FEMCs performed more procedures with the middle level of complexity, level 3(40.8%), versus Eds(23.9%). FEMCs also had a higher percentage of level 2 procedures (10.5% vs. 5.8%) than traditional Eds. Traditional Eds had a higher percentage of the most complex procedures, level 5(8.4% vs. 5.3%).

FEMCs had a higher percentage of individuals using private health insurance when paying(63.6% vs 30.6%). Traditional Eds had higher percentages of individuals self-paying or uninsured(22.3% vs. 13.0%), individuals using Medicaid(21.7% vs. 11.7%), individuals using Medicare(21.6% vs. 8.2%).

Certain procedures have significant differences in charge rates between traditional Eds and FEMCs.
Pantoprazole sodium injections, which are given to patients to treat stomach and esophagus-related problems, had a noticeable difference. In traditional Eds, patients were billed $14.61 per vial. For FEMCs, patients were billed $106.51, for a difference of 628.4%. For hospital observation service, per hour, traditional Eds billed $131.49, while FEMCs billed $1,293.91, for a difference of 884.0%. Traditional hospital Eds provide a larger number of hours of observation for patients. The volume of patients being observed in FEMCs is significantly less than for traditional Eds. Observation hours were the number 2nd most common procedure for patients to be in a traditional ED. Observation hours were the 14th most common procedure for FEMCs.[2]

The committee heard testimony from Kristi Jordan, the Associate Commissioner for Health Care Regulation at the Texas Health and Human Services Commission.

Texas Health and Safety Code Chapter 254 requires most FEMCs to obtain a license from the Health and Human Services Commission(HHSC) in the Texas Administrative Code Title 25(25 TAC). Chapter 131 and 26 TAC Chapter 509 contain operational standards for licensed FEMCs.

SB 2038(87R) requires an FEMC facility to disclose its prices for any testing and vaccination services the facility offers for an infectious disease for which a state of disaster has been declared. It prohibits an FEMC facility from charging a facility or observation fee for a health care service accessed from a vehicle. It prohibits an FEMC facility from charging an unconscionable price for products and services provided during a declared state of disaster. The bill prohibits a facility from intentionally charging a third-party payor a higher price that an individual for the same product or service during a declared state of disaster. It also grants HHSC authority to impose an administrative penalty for violations related to pricing practices during a declared state of disaster. With regards to implementation of SB 2041, HHSC has issued guidance to providers, trained staff, and proposed rules in the *Texas Register*. The new rules are currently in the final adoption phase and are anticipated to take effect by December 2022.

HB 2041(86R) requires facilities to provide each patient a written disclosure statement listing observation and other facility fees that may result from a patient's visit, and health benefit plans for which the facility is an in-network provider or a statement that the facility is an out-of-network provider for all plans. It requires an FEMC to prominently and conspicuously post a notice stating the facility's rates are comparable to hospital emergency room rates and that the facility may charge a facility fee. The notice must state that the physician providing care may be out-of-network for the patient's health plan. It must also inform the patient that the physician may bill separately from the facility for the medical care provided to the patient. It also must state which health benefit plans are in-network, or that the facility is an out-of-network provider for all health benefit plans, as applicable. HB 2041 prohibits an FEMC facility from falsely advertising as a network provider of a health plan issuer. It prohibits an FEMC facility from posting health benefit issuer's name or logo in any signage or marketing materials if the facility is an out-of-network provider for any of the issuer's health benefit plans. Lastly, it requires a closed FEMC facility to immediately remove any signs within public view that may indicate the facility is still in operation.

The Committee heard testimony from Steven Robinson, Chief of the Consumer Protection Division at the Office of the Attorney General.

Mr. Robinson stated that the Office of the Attorney General(OAG) has authority under Business and Commerce Code 17.464 on Freestanding Emergency Care facilities. The OAG may not bring an action for a price charged that is less that 3 times of what traditional Eds in the county(or nearest county) charge for the same or similar care. Under 17.464, a service that would cost $100 at a hospital emergency room in the county would need to cost $300 for the OAG to bring an action as it being unconscionable.

The Committee heard testimony from Kevin Herrington, representing the Texas Association of Freestanding Emergency Centers(TAFEC).

Mr. Herrington stated that patients are why their facilities exist. Ensuring their protection is their top priority. TAFEC is a member-based association representing more than half of the freestanding emergency centers in the state. Freestanding Emergency Centers(FECs) are fully equipped emergency departments staffed by board-certified, emergency medicine-trained physicians and registered nurses who are on-site 24 hours a day, seven days a week. These facilities are equipped for all medical emergencies, are highly regulated by the state and comply with all state Emergency Medical Treatment and Labor Act(EMTALA) requirements, which mandate treatment of all patients regardless of their ability to pay.

Mr. Herrington stated that TAFEC supports ensuring patients are protected, and stated that they are supportive of the strong regulatory structure created by the Texas Legislature, which ensures patient protection. He stated that Texas' FEC licensure requirements require FECs to comply with health and safely regulations which equal or exceed emergency departments operated by hospitals. For example, all FECs must always have an ER physician on site. In contrast, many hospitals as well as hospital-owned freestanding emergency departments, may only have a primary care physician or mid-level practitioner on site with no requirements for nursing staff, and some rural hospitals may only have a doctor or mid-level practitioner on call, but off-premises.

TAFEC endeavors to ensure that their members are educated on all of the laws and regulations they must follow. They deploy an array of education methods to membership, including, but not limited to, webinars, legal memos, membership meetings, handouts, email blasts, and educational seminars. He stated that, according to the HHSC website, no TAFEC member has been issued a citation by HHSC in nearly a year.

Mr. Herrington stated that, earlier in the year, TAFEC had a meeting with TDI Commissioner Cassie Brown to discuss challenges their industry has encountered with eh mediation process impacting patients. TAFEC members are finding that, contrary to the spirit of recent mediation legislation, insurers often refuse to participate in the mediation process entirely or agree upon a settlement during mediation, and then never pay the agreed-upon amount. Mr. Herrington stated that the Texas Legislature created a mediation process to keep patients out of the middle. He said that payors are not acting in good faith, ultimately hurting patient. TAFEC recommended

to TDI that an adjustment in data points captured in their SB 1264 report would provide a more complete picture of what insurer pay and whether the sums constitute the amount agreed upon as a result of the mediation process.

Recommendations

The Committee is pleased by the effectiveness of recent legislation designed to protect patients, and is encouraged by efforts of members of the Freestanding Emergency Room community to self-police. The committee appreciates that the they understand that protecting patients is the number one priority, and hopes that they will continue on this path. Furthermore, the Committee hopes that legislation will not be needed in the future to correct problems created by bad actors in the community.

INTERIM CHARGE #4

Review Texas' insurance anti-rebating laws and model legislation related to rebates. Make recommendations for legislation that would preserve the purpose of the current statute while allowing certain services for and benefits to insurance consumers.

Anti-Rebating Laws

Background

The Committee heard testimony from Beaman Floyd, who represents The Texas Coalition for Affordable Insurance Solutions.

Mr. Floyd stated that anti-rebating statutes exist in insurance financial regulation so that insurers can't file a rate that is actuarily sound and then rebate money, and in doing so, change it into a predatory rate that is actuarily unsound. Financial regulation in regards to insurers makes certain that they will have money to pay out when those customers file valid claims. TCAIS is a strong supporter of anti-rebating legislation that would prevent a company from taking a portion of that premium to offer lower rates in an attempt to gain a larger market share of clients.

Insurance companies have become very interested in risk reduction in the last several years. Risk-reducing technologies have advanced at an impressive rate in the recent past. Insurers see a lot of opportunities to mitigate risk in individual homes or individual automobiles with better, more advanced technology. Insurance companies have taken technologies with low cost risk-reduction capabilities, such as carbon monoxide detectors and leak detectors. Insurers can reduce risk by offering these goods and services in their policy.

Mr. Floyd stated that there is a temptation amongst insurers, when they have enough money, to undersell their competitors in hopes of gaining a market advantage. In industries where good are sold directly to a consumer, this is an acceptable strategy. The insurance market is different. With insurance, the product is sold, but insurers may have to pay on it at a later time. If the insurer has not charged a sufficient rate, and then becomes insolvent, current laws exist which require that competitors must pay for these insolvencies to a certain degree. There is a high shared cost in the insurance market for these unsound competitive strategies.

Interested parties contend that is unclear whether the current statute that prohibits insurers from providing rebates or inducements of unrelated gifts to consumers applies to loss control products and mitigation services that benefit both the insured and insurers by preventing damages and loss. These products and services may be offered in both personal and commercial lines, examples of which include water detection and shut-off valves and leak detection products, wildfire prevention services, or cybersecurity services.

H.B.3964(87R) sought to amend Section 543.003 of the Insurance Code to clarify that loss control and mitigation services are not deceptive trade practices, nor are they prohibited by the anti-rebating and anti-inducement statutes, as long as these services are integrally related to the policy and are aimed at predicting and preventing losses under the policy.

Recommendation

Ensuring that value-added products and services are not prohibited under Texas's anti-rebating laws will help encourage insurers to provide these products and services to policyholders. Advances in technology, as well as creative approaches to minimizing the risk of loss to the benefit of both the policyholder and insurer, make this a opportune time to reevaluate this particular aspect of the anti-rebating statute. The Committee believes that just as these changes are necessitated by innovation, future products and services that fit under this umbrella should be not only allowed, but encouraged. Thus, the Committee recommends legislation similar to HB 3964 that removes confusion about the difference between offering value-added products and services that reduce risk, and unsound, higher-risk competitive strategies which have the potential to place a burden on responsible insurers.

INTERIM CHARGE #5

Study the impacts of the U.S. Supreme Court's 2020 decision in *Rutledge v. Pharmaceutical Care Management Association* and the federal *No Surprises Act* (2021 Consolidated Appropriations Act, Public Law No. 116-620) and on the Texas Insurance Market on the Texas insurance market.

The 2020 Supreme Court Decision in Rutledge v. Pharmaceutical Care Management Association and its Impact on the Texas Insurance Market

Background

On December 10, 2020, the Supreme Court, in a unanimous opinion, held that the Employee Retirement Income Security Act ("ERISA") does not preempt an Arkansas law regulating pharmacy benefit manager ("PBM") reimbursement to pharmacies.[3]

The Court's decision is formative in that it specifies a potential avenue for states to increase regulation of PBMs and other service providers that help administer ERISA-regulated group health plans. The decision therefore holds potential significance for, among others, PBMs, pharmacies, pharmaceutical manufacturers, and employers that sponsor ERISA-regulated group health plans.

It also lays the foundation for states to play an even greater role in regulating drug pricing and reimbursement activities of various entities involved in the pharmaceutical supply chain. In the time since the decision, multiple states have continued to pursue regulation of PBMs and the pharmaceutical supply chain — reinforcing a growing trend at the state level.
While it is unclear whether states' recent legislative efforts are in direct response to the *Rutledge* decision, the decision affirms that certain types of state regulation are likely not subject to preemption under ERISA.

In recent years, an increasing number of states have sought to regulate PBM activities — oftentimes, as part of a state's broader efforts to address prescription drug pricing and reimbursement, or to rein in business practices such as pharmacist "gag clauses" that are seen as detrimental to patients or pharmacies.

The Pharmaceutical Care Management Association (PCMA), a trade association representing the largest eleven PBMs in the country, has played an active role in challenging many state statutes under the theory of legal preemption, with somewhat inconsistent results across cases and jurisdictions.

In 2015, the Arkansas state legislature passed Act 900 (the "Arkansas Law") to regulate PBMs' reimbursement rate for pharmacies. The Arkansas Law, in effect, establishes a reimbursement floor that requires PBMs to reimburse pharmacies at a rate that, at a minimum, reflects the pharmacy's acquisition cost for the drug in question. The Arkansas Law accomplishes this by tethering reimbursement rates to acquisition costs; providing for an appeals process when reimbursement falls below a pharmacy's acquisition costs; and allowing pharmacies to refuse to fill prescriptions if the applicable PBM will not reimburse at a rate at least equal to the acquisition cost.

In response to the passage of the Arkansas Law, PCMA filed suit in the Eastern District of Arkansas, claiming that the Arkansas Law is preempted under ERISA's statutory preemption

provision, which preempts those state laws that "may now or hereafter relate to any employee benefit plan.

The Eastern District of Arkansas and, on appeal, the U.S. Court of Appeals for the Eighth Circuit held that ERISA preempted the Arkansas Law. On December 10, 2020, however, the U.S. Supreme Court reversed the Eighth Circuit's decision regarding the Arkansas Law in an 8-0 ruling (with Justice Barrett abstaining).

HB 1763

Background

Pharmacy benefit managers (PBMs) engage in multiple practices that create barriers to fair competition for community pharmacies, impeding their ability to meet the needs of their patients. PBMs levy retroactive fees against pharmacies to level PBM costs or to penalize pharmacies for not reaching standards that are far beyond those set in other pharmacy quality platforms. They require pharmacies to attain excessive credentialing or certification to reduce their access to specialty drugs, which are frequently sold by a competing PBM-owned pharmacy. They pay their own affiliate pharmacies at a higher rate than they reimburse other pharmacies for the same services and often forbid pharmacy mail or delivery services while requiring patients to use a PBM-owned mail-order pharmacy.

Legislative efforts to regulate PBM practices often have been challenged in court by PBMs on the grounds such laws violate provisions of the Employee Retirement Income Security Act of 1974 (ERISA). However, the United States Supreme Court on December 10, 2020, ruled in favor of Arkansas in the seminal case of Rutledge v PCMA, holding a key Arkansas PBM reform law is not preempted by ERISA.

H.B. 1763 amends Chapter 1369 of the Insurance Code by creating Subchapter K to protect against these and other practices. Typically, a pharmacy adjudicated a claim at the time the patient picks up his or her medicine. Payment from the PBM was then received within a few weeks of that time. However, trends in pharmacy reimbursement PBMs began to include clawing back thousands of dollars from pharmacies months after the patient had received their medicine based on ever changing nontransparent formulations of fees.

HB 1763 ensures that PBMs may not assess retroactive fees or payment reductions against a pharmacy except as the result of a legitimate audit outcome or unless agreed to by the pharmacy and may not make agreement to such retroactive reductions a condition of a contract or network participation.

This bill allows PBMs to retroactively increase pharmacy payments based on performance incentives. The bill provides an exception to the prohibition on retroactive reductions in claims payments where the reduction is mutually agreed with the pharmacy and the health plan issuer and PBM may not condition the contract or network participation on the pharmacy's agreement to the retroactive reduction of claim payments. HB 1763 seeks to reinstill predictability and transparency into the pharmacy reimbursement system so pharmacies can plan how best to serve their patients and grow their pharmacy business.

PBMs must provide an easily accessible schedule of fee payments that specifies each service or procedure a pharmacy may deliver and the corresponding payment amount and that shows the methodology for calculating those payment amounts. With HB 1763, a PBM will be deemed to satisfy the fee schedule requirement if the information is otherwise available in the contract. Additionally, with H.B. 1763, a PBM may not reimburse a PBM-affiliated pharmacy at a higher rate than it reimburses a non-affiliated pharmacy for providing the same service. Typically, a

PBM requires its contract with a pharmacy services administrative organization (PSAO) to remain confidential, even from the pharmacy. As a result, the pharmacy cannot obtain a copy of the very contract that governs its rights and remedies in its relationship with the PBM. H.B. 1763 requires that pharmacies be given access to these contracts.
Often, independent pharmacies provide services beyond those offered by most other large retail chain pharmacies. These services include home delivery of patient medicine and compounding drugs suitable to the patient's specific needs. Though home delivery and compounding by licensed compounders are within the pharmacies' scope of practice as well as legal under state and federal law, PBMs have begun requiring various extra accreditation requirements to perform these traditional functions.

As permitted by law, H.B. 1763 states PBMs must allow pharmacies to deliver or mail drugs to patients on request and to charge a fee for that service if the pharmacy informs a patient before delivery that the fee will be charged and that it may not be reimbursable by the patient's health plan or PBM. A PBM may prohibit a pharmacy suspected of fraud from mailing prescriptions to its patients and may limit any pharmacy to mailing no more than 25 percent of its annual claims submitted to the PBM. This ensures patients can receive deliveries of vital medications from community pharmacies to their homes.

Because PBMs operate their own specialty pharmacies, they try to limit competition by making local pharmacies jump through more hoops to dispense certain drugs. But patients would rather get those life-saving drugs from the local pharmacy they trust, where they can be counseled by a pharmacist in person.

H.B. 1763 prohibits a health plan or PBM from requiring a pharmacy to meet accreditation or certification standards exceeding federal/state standards. A PBM or health plan may not prohibit a pharmacy from dispensing any drug it can dispense under state/ federal law unless its manufacturer requires specific certifications or credentials the pharmacy does not possess; however, it allows a PBM or health plan to require a specialty pharmacy to attain up to two accreditations from the referenced list.

Lastly, H.B. 1763 prohibits a PBM from retaliating against a pharmacy for exercising any rights or remedy allowed under this bill. HB 1763 amended current law relating to the contractual relationship between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager.

HB 1919

Background

Consolidation in the pharmacy benefits and health insurance industries has concentrated control of pharmacy benefits in the hands of a few huge conglomerates. These benefit managers collectively manage roughly three-quarters of the pharmacy benefits market and their control continues to increase due to recent mergers with insurers. A recent survey suggests a significant number of pharmacies reported their patients having prescriptions transferred to a benefit manager, with the steering of patients to certain retail and specialty pharmacies increasing as these new conglomerates use both their pharmacy benefit manager and health insurance arms to "refer" patients to their own mail-order, retail, and specialty pharmacies. There are concerns that these "referral" practices represent a conflict of interest and decrease both transparency and competition in the health services market.

H.B. 1919 seeks to remedy this situation by protecting the right of pharmacy patients to use their pharmacy of choice. H.B. 1919 amends current law relating to certain prohibited practices for certain health benefit plan issuers and certain required and prohibited practices for pharmacy benefit managers, including pharmacy benefit managers participating in the Medicaid and child health plan programs.

Update

The Committee heard testimony from Rachel Bowden, Director of Regulatory Initiatives at the Texas Department of Insurance.

Ms. Bowden stated that HB 1919 prohibits a health plan or PBM from requiring or inducing a patient to use an affiliated provider, and that includes an affiliated pharmacy or a durable medical equipment provider, in order to receive the maximum benefit under the plan, such as reduced cost sharing. It prohibits a health plan or PBM from soliciting a patient or prescriber to transfer a prescription to an affiliated pharmacy or durable medical equipment provider, or requiring the provider to transfer the patient's prescription without the patient's written consent. It imposes limitations on transferring records, and also communications using communications to steer a patient to an affiliated provider, unless they include accurate and comparable information for both affiliated and non affiliated pharmacies and DME providers. At a high level TDI's implementation of this has included training staff, monitoring, and compliance using complaints. TDI has also updated their product checklists in case they can see provisions in the plan that would have a differential and rate of cost sharing for affiliated and non affiliated providers. Not all such discrepancies might be apparent in the forms that TDI reviews. TDI does not require plans to file formularies for review. The primary avenue for compliance is hearing complaints. TDI has received a few complaints and are currently working through those and investigating further.

Ms. Bowden stated that the provisions of HB 1763 are really more focused on the contract between the pharmacy and the PBM, rather than kind of how the health plan and PBM interact with the patients. Our primary compliance approach, on this bill is through complaints and market conduct examinations. She stated that they perform triennial market conduct examinations on health benefit plans. TDI's plans for incorporating 1763 into those exams is to require when the company submits their claim samples to identify claims based on whether they are for affiliated and non-affiliated pharmacies so that we can see where they are they reimbursing affiliated pharmacies more for the same pharmacist service, and also requesting that they provide their contracts and fee schedules for those pharmacy contracts, and looking for the evidence of post adjudication claim reductions. If TDI gets complaints on these issues, they will be investigating. HB 1763 applies to contracts entered or renewed on or after September 1 of last year. She stated that it is possible that not all of those contracts have renewed yet. That will be one of the things to identify with respect to whether a complaint is in true violation of the law. Ms. Bowden stated that a limitation of HB 1763 is that it doesn't require health plans to contract with any particular pharmacy. And so theoretically, they could have an adequate network made up entirely of affiliated pharmacies.

The Committee heard testimony from Matthew Seiler, Vice President and General Counsel for the National Community Pharmacy Association.

Mr. Seiler stated that Texas is a leader in enacting commonsense laws that regulate pharmacy benefit managers (PBMs). However, Texas has applied these laws only when PBMs are serving plans subject to regulation by the Texas Department of Insurance (TDI). TDI does not regulate

self-funded ERISA plans. *Rutledge* clears a path for Texas to regulate PBMs even when they are serving ERISA plans, which makes sense, policy-wise, because the PBM function does not vary depending on what kind of plan the PBM serves.

Mr. Seiler stated that there is need for state regulation of PBMs. PBMs are powerful intermediaries who sit between patients and health plans. PBMs enter into contracts with benefit plans and insurers to provide beneficiaries with access to prescription drugs. PBMs deliver this access by contracting separately with pharmacies to create networks where beneficiaries can fill their prescriptions.

Mr. Seiler stated that PBMs should be in a position to realize efficiencies for the plans and insurers with whom PBMs contract, including ERISA plans. PBMs process claims on behalf of plans and insurers, and by aggregating the demand of all of the plans and insurers with whom PBMs contract, PBMs are able to extract price concessions from large pharmaceutical manufacturers. Notably, the three largest PBMs claim to provide PBM services for more than 268 million Americans—which amounts to over eighty percent of all Americans with healthcare benefits. The three largest PBMs also own or are owned by large health insurers, and these vertically-integrated corporations own some of the largest retail, mail order, and specialty pharmacies in the country. PBMs are under no obligation to act in the best interests of the plans and patients they purport to serve. Their business structure creates inherent conflicts of interest on many levels. For example, a PBM has a financial incentive to steer patients to pharmacies in which it has an ownership interest, a practice this committee has studied and addressed in previous legislation. A PBM's incentives also differ, depending on whether it is serving an employer-or government-sponsored plan (where that plan must pay the PBM's costs) or the PBM works for an affiliated insurer (where the PBM's affiliate bears the costs).

Mr. Seiler stated that a PBM's self-interest can deprive plans and insurers of the economic benefits that should come from a PBM's market power. Take, for example, a PBM's power to negotiate discounts with pharmaceutical manufacturers. That should result in lower costs for plans and insurers—but sometimes the opposite occurs. PBMs have demanded hidden rebates from manufacturers in order to place drugs on the PBMs' lists of approved medications. All things being equal, the plan would benefit from the lowest possible cost for the medicine in question. But they benefit from the drug that scores them the most profit. To illustrate this conflict, a generic drug might have a list price of $10 and generate only $5 in profit for the PBM, whereas a branded drug might have a list price of $20 but would result in $10 in profits for the PBM because the manufacturer has agreed to pay them a secret rebate. In this scenario, the PBM would profit more by preferring the branded drug, even though it costs patients more in copayment obligations. Relatedly, pharmaceutical manufacturers have claimed that they have been punished by PBMs for lowering drug costs, because it means there is less room for the manufacturer to provide a hidden rebate to the PBM. He stated that PBMs have had a negative effect on pharmacy. Because the three largest PBMs control over eighty percent of the market for beneficiaries with prescription-drug coverage, pharmacies have limited bargaining power when negotiating with PBMs. Refusing to accept a PBM's contract could mean that a pharmacy cannot serve the majority of patients in a pharmacy's community. As a result, PBM-pharmacy contracts generally grant PBMs unilateral authority to dictate the amount of reimbursement paid to pharmacies for drugs, require pharmacies to fill and dispense

prescriptions regardless of the amount the pharmacy is reimbursed, and impose a variety of other restrictions on the practice of pharmacy. PBMs have routinely used their position to steer patients to pharmacies that they themselves own, even if it means the plan sponsor ultimately pays a higher net cost. PBMs have prevented pharmacists from dispensing certain prescription drugs, even when a pharmacist is licensed to do so, in order to steer patients to mail-order pharmacies owned by PBMs. This is especially prevalent when it comes to "specialty drugs," which is a term coined by the PBMs themselves and is another way to steer high-reimbursement drugs to pharmacies the PBMs themselves own. Evidence suggests that PBM reimbursement practices have driven more than sixteen percent of independent rural pharmacies out of business. The states of Ohio, Oklahoma, Arkansas, and Florida have also found evidence that PBMs reimburse pharmacies that they own more than unaffiliated pharmacies, leaving plans and patients to pay the difference. In response to these and other practices, nearly all States and the District of Columbia have enacted laws regulating PBMs. These laws tend to regulate how PBMs interact with pharmacies, benefit plans and insurance companies, the State's Medicaid program, and the State's benefit plan for State employees.

Mr. Seiler stated that for many years, there was substantial uncertainty about whether states could regulate third-party service providers, like PBMs, when they were serving plans subject to regulation by ERISA. A federal statute, ERISA regulates private employer-and union-sponsored welfare benefit plans, including prescription drug plans. In one early case, the U.S. Court of Appeals for the Fifth Circuit, which includes Texas, held that ERISA preempts State insurance laws because they might have a tangential effect on ERISA plans. As a result, many States, like Texas, decided to regulate PBMs only when they were serving non-ERISA plans. The Supreme Court's recent decision in *Rutledge v. Pharmaceutical Care Management Association* rejected the logic that underpins those earlier decisions. In *Rutledge*, the Supreme Court considered a challenge to an Arkansas law that regulates PBMs. Act 900, as Arkansas's law is known, regulates the amounts PBMs reimburse pharmacies for generic drugs; requires PBMs to provide a reasonable administrative appeal procedure, and to update and disclose their reimbursement lists to pharmacies; and allows pharmacies to decline to dispense drugs to beneficiaries when a PBM intends to reimburse the pharmacy less than the pharmacy's cost to acquire the drug. The Pharmaceutical Care Management Association (PCMA), a trade association representing the eleven largest PBMs, claimed that ERISA preempts Act 900. A unanimous Supreme Court disagreed. According to the Supreme Court, ERISA preempts State laws that have a "connection with or reference to ERISA plans. A State law has a connection with ERISA plans when it governs a central matter of plan administration or interferes with national uniform plan administration. A state law has a reference to ERISA plans if and only if it acts immediately and exclusively upon ERISA plans or the existence of ERISA plans is essential to the law's operation. The Supreme Court held that Act 900 did not have a forbidden connection with ERISA plans. In so holding, the Court emphasized that not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. Rather, ERISA is "primarily concerned with preempting State laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status." Thus, the Supreme Court has deemed preempted State laws that dictate eligibility or benefits contrary to the terms of an ERISA plan.

Mr. Seiler stated that the Court explained that the main part of Arkansas's law was a form of cost regulation, which does not force ERISA plans to adopt any particular scheme of substantive coverage. Similarly, the Court held the law's enforcement mechanisms—the appeal, update, and decline-to-dispense provisions—simply regulate the relationship between PBMs and third-parties that sell access to the medical benefit that plans ultimately provide to their beneficiaries. The Court emphasized that State law has traditionally governed the relationship between plans and those third-parties who sell goods and services to the plan. The Court also held that Act 900 did not make a prohibited reference to ERISA plans. Act 900 does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan. And ERISA plans are likewise not essential to Act 900's operation, because Act 900 regulates PBMs whether or not the plans they service fall within ERISA's coverage. To summarize, *Rutledge* clarifies that States may regulate PBMs even when they serve ERISA plans, and ERISA preemption is concerned primarily with state laws only when they require payment of specific benefits or bind plan administrators to specific rules for determining beneficiary status. Typical State laws regulating PBMs do neither of these things—even if they are extended to apply to PBMs when they are serving ERISA plans.

Mr. Seiler restated that Texas has been a leader in enacting commonsense laws that regulate PBMs. So far, however, Texas has not extended these laws to apply to PBMs when they are serving ERISA plans. He stated that it is clear that Texas has the authority to do so. Following *Rutledge*, the U.S. Court of Appeals for the Eighth Circuit considered a North Dakota law that includes provisions similar to those enacted by the Texas legislature, but North Dakota's law also applies to PBMs serving ERISA plans. In PCMA v. Wehbi, the Eighth Circuit explicitly held that ERISA does not preempt North Dakota's law. That decision should give Texas comfort that it can extend its existing laws to apply to PBMs serving ERISA plans. Texas has enacted a number of laws to reform the PBM industry. Most notably, last session, the Legislature unanimously passed HB 1763, which Governor Abbott then signed into law. Among other things, HB 1763 amended the Insurance Code to prohibit PBM claw backs that reduce the amount paid to a pharmacy weeks or months after a prescription is filled, ensure patient choice by allowing local pharmacies to mail and deliver prescriptions if requested by the patient, prevent self-dealing by prohibiting PBMs from steering patients to PBM-owned specialty pharmacies by requiring accreditation or certifications above those required by State and federal law, prohibit PBMs from paying affiliated retail or mail-order pharmacies more than they pay other pharmacies in a network, and clarify that pharmacists must have access to PBM contracts handled through a pharmacy services administrative organization (PSAO).

As noted, these provisions apply only to PBMs serving plans subject to regulation by the Texas Department of Insurance, and that does not include ERISA plans. Under the logic of *Rutledge*, however, there is little doubt that Texas can extend these provisions to PBMs when they serve ERISA plans. As noted above, in PCMA v. Wehbi, the Eighth Circuit considered a North Dakota law that includes provisions similar to those enacted by Texas. Among other things, North Dakota's law limits the types of fees that PBMs can impose on pharmacies, permits pharmacies to mail and deliver prescriptions if requested by their patients, prohibits PBMs from imposing accreditation or recertification standards more onerous than State and federal licensing standards, Prevents self-dealing by PBMs related to affiliated pharmacies, and allows a pharmacy that belongs to a PSAO to receive a copy of the contract the PSAO has entered with a PBM on the

pharmacy's behalf. Unlike Texas's law, however, North Dakota extended these provisions to apply to PBMs even when they are serving ERISA plans. Yet after faithfully applying the Supreme Court's decision in *Rutledge*, the Eighth Circuit held that ERISA does not preempt North Dakota's laws.

Although Texas does not sit within the Eighth Circuit, that court's decision should give the legislature comfort that it may extend its existing laws to apply to PBMs serving ERISA plans. Like North Dakota's laws, Texas's laws do not require payment of specific benefits or bind plan administrators to specific rules for determining beneficiary status. In the wake of *Rutledge*, there is growing consensus that States should exercise their authority to regulate PBMs—regardless of the type of plan that the PBM is serving. Even before the Supreme Court decided *Rutledge*, the federal government, forty-six states, including Texas, and the District of Columbia filed briefs with the Supreme Court arguing that States have robust authority to regulate PBMs .As a result, there has been a recent surge of State-level regulation of PBMs ,and the push for such regulation has straddled the political divide. Red States and blue States—from Arkansas to California, and everywhere in between—have enacted or are considering legislation to further regulate PBMs. Texas should do the same by extending its existing laws to regulate PBMs when they are serving ERISA plans.

The Committee heard testimony from Nat Shapo, former State Director of Insurance in Illinois.

Mr. Shapo explained that Congress regulates interstate commerce, as defined in Article I, Section 8, in the U.S. Constitution. If Congress wants to regulate a practice, and reasonably preempt a state action, it can and should. If preemption is not clearly intended, the States may and should legislate as appropriate, in order to respond to identified needs in the areas of consumer protection and fair competition. Mr. Shapo stated that this is particularly true in areas of insurance and health care.

Mr. Shapo talked about the National Council of Insurance Legislators(NCOIL), which is comprised principally of legislators serving on insurance committees. He explained that NCOIL works to preserve that state jurisdiction over insurance as established by the McCarran-Ferguson Act. NCOIL, according to Mr. Shapo, works to assert the prerogative of legislators in making state policy when it comes to insurance. He stated that NCOIL is an adamant, vocal opponent of any Congressional initiative that would deprive consumers of key state protections and preempt state laws that respond to unique insurance markets.

Mr. Shapo stated that he has worked with NCOIL on preemption issues in many contexts and roles. NCOIL asked Mr. Shapo to review and consider whether it would be reasonable and appropriate under established Congressional policy and preemption doctrine to support Arkansas' PBM statute in the preemption challenge accepted for Supreme Court review. His analysis concluded that this was a sound and well-supported position.

Mr. Shapo stated that NCOIL promulgates model laws on state healthcare and insurance, including pharmacy benefit managers. NCOIL is well-suited to speak to ERISA preemption's negative impact on state insurance innovations and is similarly well-suited to speak on why ERISA preemption should not be expanded further.

Mr. Shapo stated that the Supreme Court commands that when States operate in fields of traditional state regulation there is an assumption that such laws are not preempted absent a clear and manifest purpose of Congress' to the contrary. He stated that ERISA preemption usually challenges two related areas of state power. One is related to issues concerning the healthcare of residents, and the other is the business of insurance. He stated that States are the primary regulators in these areas.

Mr. Shapo provided additional context concerning healthcare and insurance. He stated that the Affordable Care Act expanded the States' role in regulating healthcare and insurance He stated that after 2010, the lines between healthcare regulation and insurance regulation have become so intertwined that, for States to make a legislative impact, they must account for both plan coverage and insurance costs in passing reforms.

Mr. Shapo explained a concept which he termed "ERISA Creep." He stated that in the 1970s, only seven percent of workers had self-funded health plans. Today that number has increased to 61 percent. He stated that when ERISA passed, no member of Congress could seriously have foreseen a time when ERISA, a law primarily meant to regulate pensions, would have become such a stumbling block to national health care reform. He stated that though Congress did not envision a dwindling role for States in exercising their traditional powers over healthcare and insurance, ERISA preemption has caused just that.

Mr. Shapo explained the basic doctrine behind the Supreme Court's *Rutledge* brief. He stated that not among ERISA's fundamental areas is a concern for standard-setting on providers, insurers, third-party suppliers and coordinators, or the products plans consume. Mr. Shapo cited *Accord Metro*, 471 U.S. at 732, which states that ERISA contains almost no federal regulation of the terms of benefit plans. For this reason, Mr. Shapo stated, this Court has recognized that State laws targeted only at the health care industry carry the starting presumption against ERISA preemption.

Mr. Shapo stated that the Affordable Care Act, McCarran-Ferguson, and ERISA Savings Clause all combine to establish and recognize the key role for States in regulating healthcare and insurance. The Affordable Care Act affirmatively guarantees state flexibility in such matters. He stated that Congress viewed plan coverage and insurance costs as intertwined. Mr. Shapo said that the brief stated that States should maintain control over healthcare and insurance regulation. States, in exercising that control, operate under a regie that has increasingly blurred the lines among regulations of plans, providers, and insurers.

Mr. Shapo outlined basic practical policy concerns and massive challenges that policymakers face. The cost of health care affects every aspect of the U.S. health systems. 58% who spend more that $100 per month on prescriptions have difficulty affording them. He stated that half of adults have skipped treatment due to high costs. He stated that 24 million Americans in employer plans spend a large share of their income on health care costs.

Mr. Shapo stated that expansive preemption policies impede attempts to craft beneficial solutions. He stated that a broad view of ERISA preemption hampers State innovation in a fundamental way, in that it creates a disincentive for States to pass meaningful reforms. He

stated that the Supreme Court should not expand ERISA preemption further. A broader interpretation would further undercut States' ability to enact reform and address the nation's healthcare challenges.

Mr. Shapo explained the Supreme Court's decision in *Rutledge v. PCMA*. He stated that the Supreme Court unanimously reversed the 8th Circuit Court's decision. The Supreme Court found that the Arkansas Act 900, which effectively requires PBMs to reimburse Arkansas pharmacies at a price equal to or higher than the pharmacy's wholesale cost, held not preempted by ERISA. Mr. Shapo stated that it was notable how easily the Court reversed the ruling. Mr. Shapo stated that the only real disagreement involved Justice Thomas's concurrence, which called for more precise curbs on preemption.

Mr. Shapo stated that Congress's preemption intent was to ensure that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions. It was primarily concerned with preempting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits, or by binding plan administrators to specific rules for determining beneficiary status. He said that a state law may also be subject to preemption if acute, albeit indirect, economic effects of the state law force and ERISA plan to adopt a certain scheme of substantial coverage. Mr. Shapo described what he described as the preemption test used during the Supreme Court decision. The Court considered whether state law governs a central matter of plan administration, or interferes with nationally uniform plan administration. Mr. Shapo stated that ERISA does not preempt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme or substantive coverage.

Mr. Shapo stated that the Arkansas Act 900 is merely a form of cost regulation. He explained that PBMs may well pass those increased costs onto health plans, meaning that ERISA plans may pay more for prescription drug benefits in Arkansas than in say, Arizona. He said that cost uniformity was almost certainly not an object of preemption, and the effect of Act 900 was not so acute that it will effectively dictate plan choices. He continued that ERISA does not preempt a state law that merely increases costs, even in plans decide to limit benefits or charge plan members higher rates as a result. He continued that Act 900 does not refer to ERISA. A law refers to ERISA if it acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation. Act 900 applies to PBMs whether or not they manage an ERISA plan. The Act does not directly regulate health benefit plans at all, ERISA or otherwise. It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.

Mr. Shapo further explained Justice Thomas' concurrence. He stated that Justice Thomas wrote separately to protest vague and potentially boundless preemption standards which offer little guidance or predictability. He argued for more plain language, and a more strict preemption standard.

Mr. Shapo stated that the Court stated that Congress knows how to write sweeping preemption statutes, but it did not do so in this case. He continued that applying the statutory text, the first step is to ask whether a provision in ERISA governs the same matter as the disputed state law,

and thus could replace it. He stated that the Court found that a reasonable person conversant with applicable social conventions would not understand 'relate to' as covering any state law with a connection to employee benefit plans, no matter how remote the connection. A state law needs more than a 'tenuous, remote, or peripheral connection with ERISA plans to trigger this statute.

The Committee heard testimony from Stan Strickland, representing the Pharmaceutical Care Management Association.

Mr. Strickland stated that the *Rutledge* opinion was a very narrow decision reversing a lower court's decision, holding that the Arkansas Act is not preempted by ERISA. IT held that the Arkansas Act was simply cost regulation, something states are allowed to do, even when it impacts ERISA plan costs. He stated that it is a traditional exercise of traditional states' powers.

Mr. Strickland stated that regulating PBMs for ERISA plans is going to result in an increase in prescription drug prices that may differ from state to state. Ultimately the cost increases are borne by the Texas employers and consumers.

Regarding a court's decision on preemption, Mr. Strickland stated that it is for each court and each set of unique facts to come before them and make their way up through the federal court system so that they can apply this test and determine whether or not you've got a preemption. There's no presumption against preemption. So each case has its own facts as it makes its way through the Supreme Court. The Supreme Court has overruled cases that held there was a presumption against preemption. And both the fifth and eighth circuit courts have also recognized and acknowledged that there is no presumption against preemption in ERISA context.

Mr. Strickland stated that the ruling underscores that the area where ERISA regulates is still preemptive. That is something that future courts will continue to, to define and clarify. It have been noted that there has been a rash of states implementing laws in the PBM context, that raised the ERISA question and may be subject to challenges based on a risk of preemption. So as states passed new regulations against PBMs, there will likely continue to be preemption claims brought against states that will ultimately further define that that line between the McCarran Ferguson Act, which places the regulation in the state's hands, and the ERISA preemption.

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

Ms. Garza stated that she appreciated the willingness of staff at the Texas Department of Insurance to meet with pharmacy regarding implementation of these bills, and that she looks forward to continuing a dialogue with them as they move forward. She said that they understand that enforcement of these new measures has been largely complaint-driven up to this point. There are some elements of the legislation that will be difficult to enforce on a complaints-only basis. TPA has provided our members with detailed synopses of the new provisions in law and what to be on the lookout for with regard to PBM action. Additionally, TPA has provided detailed instructions on how to submit a valid complaint to TDI if they identify a likely violation of the new law. They have also created an online portal where pharmacists may submit patient

de-identified information regarding violations to TPA so that we can have a better understanding of what their members are experiencing and so that they may follow up with TDI regarding areas where they are seeing potential violations of the new law.

Ms. Garza stated that in both bills, the legislation to contracts entered into or renewed after September 1, 2021. For HB 1919, which dealt with marketing and steering practices, the bill applies to health insurance coverage that began or renewed after September 1 of last year. So determining whether a particular action taken by a PBM was in violation of that bill would require knowing the patient's policy renewal date, which most pharmacies would not have access to. For HB 1763, which dealt with the contractual relationship between the PBM and a pharmacy, this meant that the provisions apply only to contracts signed or renewed after September 1 of last year, so many pharmacies may still not yet be operating under contracts affected by the new law. She stated that they anticipated some period of confusion as the new bills applied to more patients, but they wanted to mention this as it likely resulted in fewer valid complaints, especially in the early months after the bills officially became law. Second, and certainly the much bigger challenge, has been the ability of pharmacies to determine whether or not a particular patient is subject to the new provisions. Because the provisions of HB 1919 and HB 1763 apply only to TDI-regulated plans, most patients with health plan coverage are not subject to the protections provided in the legislation. According to the Kaiser Family Foundation, approximately 2/3 of individuals with employee-based health coverage are part of a self-funded ERISA plan. That means that overall, only around 1 in 5 Texans receive coverage through a TDI-regulated health plan. The only way for a pharmacist to determine whether or not a patient receives coverage through a TDI plan, as opposed to a self-funded or other type of plan, is to look for TDI(Texas Department of Insurance) or DOI (Department of Insurance)on the patient's health plan or prescription ID card. As a matter of practice, most pharmacists do not have access to a patient's ID card, and the patient information that is captured in the pharmacy's claims software only captures things like the member ID, Group, BIN, and PCN numbers. If a patient does not have their health plan or prescription benefit card, which is very common, a pharmacy can determine the patient's coverage through an online system. That portal only provides the identifying information needed to submit a pharmacy claim, and does not allow a determination of whether a patient is covered under a TDI plan. She stated that they have recommended that pharmacies begin maintaining a copy of the patient's coverage card in case there is the possibility of a complaint related to this patient, but it is logistically challenging and results in many potential complaints being abandoned. Much of this sounds technical in nature, but it is the single greatest challenge that pharmacies have in determining whether or not a particular patient is subject to the laws enacted by this legislature or whether they are exempt. One potential solution would be for TDI to require all plans subject to its regulatory oversight to have unique BIN and PCN numbers. Think of the BIN number like a bank routing number that ensures a patient's pharmacy claim is directed to the correct payer, and the PCN differentiates different plans and benefit packages for a payer. PBMs already have multiple BIN and PCN numbers for various plans and networks, and it would seem to be a relatively easy solution to simply require identifiable BIN and PCN numbers for plans subject to TDI regulation that are not co-mingled with non-TDI covered lives. The better long-term solution would be to utilize the authority granted through the *Rutledge v. PCMA* Supreme Court decision and standardize PBM rules and regulations across all PBM activity in the state of Texas, regardless of plan type. Ms. Garza

mentioned some of the particular provisions of both HB 1919 and HB 1763 and offered observations related to implementation and/or oversight.

Ms. Garza stated that HB 1919 was the anti-steering bill that addressed many of the marketing and plan design tactics used by PBMs to steer patients to affiliated pharmacies. One of the challenges in identifying valid complaints under the terms of this bill is that it deals more with the communication between a PBM and a patient, so pharmacies often are not aware of any potential steering activity unless a patient brings in a letter it received from a PBM. She stated that even if that happens, all of the challenges of determining whether or not a patient is part of a TDI-regulated plan still apply, as the marketing materials do not make that distinction. She said that they happened to have it because it was received by one of our independent pharmacists who purchased small group coverage for his pharmacy employees under a TDI-regulated plan. The PBM's communication to the pharmacist stated that he could get the maintenance medications you need at your plan's lowest cost through the PBM's mail order pharmacy. These solicitations are in violation of HB 1919's prohibition on using patient-specific messaging in an attempt to have a patient use a PBM-affiliated pharmacy, and the prohibition on using cost inducement or plan design to steer a patient to a PBM-affiliated pharmacy. Ms. Garza stated that they are aware of these particular violations only because it was mailed to a pharmacist, but they are sure that others covered under similar plans received a similar communication from a PBM.

Other provisions of HB 1919 deal with restrictions on sharing patient information for commercial purposes. Again, a pharmacist would be very unlikely to be made aware of a potential violation, so they believe it is incumbent upon TDI to issue guidance or adopt rules regarding permissible action by PBMs when it comes to prohibited steering of patients to affiliated pharmacies, and to take pro-active steps to identify and investigate potential violations of these provisions such as by reviewing plan design, reviewing examples of patient communications, and requiring disclosures regarding the transfer of any patient data to third-party entities. HB 1763. As this committee is aware, HB 1763 implemented major reforms that addressed the contractual relationship between a PBM and a pharmacy. One of the major provisions dealt with the prohibition on post-adjudication recoupment. This type of action by the PBM would likely be an aggregate reduction under terms of a PBM contract rather than an action on an individual patient-by-patient basis. Thus one challenge in determining whether or not a PBM is in violation of this prohibition would be determining whether a particular contract covered TDI-regulated patient lives or exempt patients. Many of the contracts that they see simply say things like "commercial insurance plans" and likely blend ERISA and non-ERISA lives under a single contract. The Texas State Auditor's office discovered a similar practice with certain PBMs, where Medicaid claims were bundled with non-Medicaid claims for recoupment adjustments. They believe contracts should clearly separate terms for TDI-regulated health coverage, and they would suggest that this committee review recent changes Texas Medicaid made to its uniform managed care contract related to post-adjudication recoupment, also referred to as reconciliation, by PBMs.

Another provision of HB 1763 is a prohibition on reimbursing affiliated pharmacies more than non-affiliated pharmacies for the same product or service. A pharmacy is unlikely to know if a PBM is paying its own pharmacy more, and would not be able to document a complaint regarding this practice. She said that they are aware of some instances where patients are able to

see the total amount that would be paid to various pharmacies through an online patient portal. They have included an example that was shared by a patient of one of our member' s pharmacies that appears to show a higher payment to an affiliated pharmacy than a non-affiliated pharmacy. This patient received coverage through a TDI-regulated plan. This provision could only be enforced through some type of regulatory oversight by TDI, and that they have asked that they include this as part of their PBM review process. HB 1763 also prohibited PBMs from requiring special accreditations or certifications beyond what is required by federal law or the State Board of Pharmacy to fill specialty medications or to prohibit a pharmacist from dispensing a drug if allowed under his or her license absent a federal or special manufacturer requirement. They are aware of examples where pharmacies are still seeing claims denied with the indication that it must be filled at a specialty pharmacy, which would appear to be in violation of the law. They have heard that at least one complaint was dismissed after the PBM changed its reason for denial from "specialty pharmacy required" to "must be billed under the medical benefit" after a complaint was submitted to TDI. Finally, the bill prohibited PBM restrictions on mailing or delivering prescriptions if requested by a patient. Ms. Garza stated that they are happy to say that, at least on this point, they are not yet aware of any clear violations of this provision.

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

Mr. Hutson said that drug prices are out of control in Texas, and prescription drug coverage is far too expensive for an overwhelming majority of small businesses. He stated that the passage of HB 1919 exacerbates the problem by eliminating private-market options for more affordable drug coverage. He stated that the legislation needlessly interferes with private contracting between businesses and makes it more expensive and more difficult for Texas employers to continue providing prescription drug coverage to more than 13 million Texans. He stated that HB 1919 will raise spending on prescription drugs in Texas by $350 million in the first year alone and will increase the costs of drug coverage by $4.4 billion over the next ten years. He stated that these figures reflect costs only for fully-insured benefit plans, which represent approximately 30% of the Texas market.

Mr. Hutson stated that HB 1919 did not apply to TRS, ERS, and Medicaid, and because of this, are placing a huge financial burden on Texas businesses. He stated that HB 1919 restricts the management of prescription drug coverage in a way that will slow down innovation in Texas. The cost of this financial burden will be passed along to Texas employers and families. He stated that TAHP requests that the Legislature take steps to repeal or significantly pare back the statues put in place by HB 1919 before any more employers permanently terminate prescription drug coverage.

The Committee heard testimony from Miguel Rodriguez, representing the Texas Pharmacy Business Council.

Mr. Rodriguez stated that the core PBM function is to design a pharmacy benefit for a health plan by determining the drugs which are covered by the plan, and which are preferred, determining how much a patient pays at the point-of-sale, determining where a patient can go to obtain their medicine, and determining how much a pharmacy will be paid for dispensing

covered drugs to a patient. Mr. Rodriguez stated that PBMs currently control 80% of the market for prescription claims. Because of this, pharmacies are forced to do business with PBMs on terms dictated by the PBM.

PBMs, according to Mr. Rodriguez, PBMs dominate other markets Three of the five largest pharmacy operations in the country are mail-order pharmacies owned by the three largest PBMs. Each of the three largest specialty pharmacies in the country are owned by one of the three largest PBMs, which dispense over 60% of all specialty medication in the United States.

Mr. Rodriguez stated that HB 1763 and HB 1919 are instrumental in removing key elements of PBM-imposed bureaucracy and barriers to competition.

HB 1763 has been successful in prohibiting post-adjudication fees, charged by the PBMs long after the patient has picked up his or her medicine. These fees, known as generic effective rate, a brand effective rate, or dispensing fee effective rate. HB 1763 prohibits these fees by prohibiting the direct or indirect reduction of a claim payment of a pharmacy after the adjudication of the claim, including through the use of an aggregated effective rate, DIR fee, or otherwise, except by a properly conducted audit. HB 1763 also prevents PBMs form preventing a pharmacy from mailing or delivering medicine to a patient unless it is prohibited by state law. It also prevents PBMs from requiring accreditation standards or recertification requirements more stringent than required by state or federal law. Tt also prohibits a PBM form reimbursing a pharmacy it owns more than what it reimburses a non-affiliated pharmacy for the same medicine. Mr. Rodriguez stated that because PBMs own their own pharmacies, they have an inherent conflict of interest to utilize the power they have as a pharmacy benefit manager to steer patients to the pharmacies they own. They utilize the data that non-affiliated pharmacies send them about their patients to send to the PBM-owned pharmacy, then use this knowledge of patient information to market their PBM-owned pharmacy. HB 1919 prevents these conflicted steering practices. As a result, patient choice, and free market competition are preserved.

The Federal No Surprises Act (2021 Consolidated Appropriations Act, Public Law No. 116-620) and Its Impact on the Texas Insurance Market

Background

After years of debate, Congress coalesced around legislation to end most surprise out-of-network billing as 2020 drew to a close, including the No Surprises Act in the year-end omnibus spending bill.[4]

Starting January 1, 2022, it will be illegal for providers to bill patients for more than the in-network cost-sharing due under patients' insurance in almost all scenarios where surprise out-of-network bills arise, with the notable exception of ground ambulance transport. Health plans must treat these out-of-network services as if they were in-network when calculating patient cost-sharing. The legislation also creates a new final-offer arbitration process to determine how much insurers must pay out-of-network providers. If an out-of-network provider is dissatisfied with a health plan's payment, it can initiate arbitration. The arbitrator must select between the final offers submitted by each party, taking into consideration several factors including the health plan's historical median in-network rate for similar services.

The root market failure that created the surprise billing problem is that patients lack meaningful choice of provider for certain services. In emergencies, patients can unavoidably end up at an out-of-network facility or being treated by out-of-network physicians. For elective care, patients choose their facility and principal physician, but typically not their anesthesiologist, assistant surgeon, or other ancillary provider; yet these ancillary providers contract with insurers separately from the facilities they practice at (and typically separately from the principal physician). As a result, emergency and ancillary clinicians are guaranteed a steady flow of patients regardless of their network status, creating an out-of-network billing option unavailable to specialties that typically derive patient volume from being in-network.
The law's prohibition of surprise out-of-network billing addresses this market failure, preventing providers from using leverage derived from the ability to surprise bill to extract high prices. With respect to services delivered at in-network facilities, policymakers could likely have stopped there and allowed payment for these services to be determined through negotiations among payers, facilities, and clinicians. But, for out-of-network emergency services and air ambulance services, barring surprise out-of-network billing creates a need for some sort of price support because these providers are required to treat any patient regardless of ability to pay and thus have no other leverage to draw on in negotiations with payers. The law's arbitration process fills that role.

Setting these payments exclusively via arbitration is a departure from initial proposals advanced by the Senate Health, Education, Labor, and Pensions Committee and the House Energy and Commerce Committee in 2019, which would have instead directly specified a "benchmark" payment rate equal to the median in-network rate for similar services. Using arbitration was a key demand of provider groups, who likely hope that they will be able to extract higher prices via an arbitration process. The particular version of arbitration used in the final bill is also somewhat more provider-friendly than the version in an earlier bill approved by the House Ways

and Means Committee, in that it expands eligibility for arbitration and requires arbitrators to consider certain provider-friendly factors drawn from a May 2019 arbitration proposal put forward by a bipartisan group of Senators.

Despite these concessions to providers, the No Surprises Act likely still represents a net win for patients and consumers more broadly. Critically, patients will no longer be at risk of large surprise out-of-network bills when receiving emergency care or elective procedures or being transported by an air ambulance. Eliminating the leverage certain providers derived from the ability to surprise bill patients has the potential to reduce contracted prices in certain specialties—and thereby premiums.

Taking into account this uncertainty and the administrative costs of arbitration, the Congressional Budget Office estimates that the No Surprises Act will reduce commercial insurance premiums by between 0.5% and 1%, saving taxpayers $17 billion over ten years and saving consumers about twice that much between reduced premiums and cost-sharing.

SB 1264(86R)

Background

There are concerns that consumers who receive surprise medical bills face unnecessary hurdles in addressing those bills under the existing mediation system. SB 1264 aims to address these concerns by making certain changes to the current mediation process, establishing an arbitration process, expanding the types of plans that are eligible for mediation, and prohibiting providers from sending surprise balance bills to consumers.

SB 1264 amends the Insurance Code to require certain health benefit plans that provide coverage for a health care or medical service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider or who is a diagnostic imaging provider or laboratory service provider, as applicable, to provide the coverage at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider or performed the service in connection with a health care service performed by a participating provider, as applicable.

Update

The Committee heard testimony from Randy Pate.

Mr. Pate stated that he is president of States Work, a newly formed educational non-profit organization that was established earlier this year with the goal of returning traditional state authority and oversight in the area of health care and health reform. Prior to these roles, during the Trump Administration, he served as Deputy Administrator of the Centers for Medicare & Medicaid Services and Director of the Center for Consumer Information and Insurance Oversight, or CCIIO. CCIIO is the CMS center charged with overseeing and implementing the health insurance provisions of the Affordable Care Act, especially as they relate to the individual and small group health insurance markets and the health insurance exchanges. Mr. Pate stated they opinions he expressed during the hearing expressing today are his own, and to not necessarily reflect the views of my clients, CMS, or the former Trump Administration or its members. He also led the team in CMS that drafted the Trump Administration's Transparency in Coverage Rule. Finalized in late 2020, just prior to the passage of the No Surprises Act (NSA) in early 2021, the primary objectives of this rule are two: first, to provide actionable, real-time price information to patients for the items and services they receive, prior to receiving care. In other words, they wanted patients, whether insured or self-pay, for the first time to be able to know (to the greatest extent possible) how much their care will cost them before they receive the treatment. Second, by interjecting market forces through the publication of negotiated reimbursement rates for thousands of health care items and services, they wanted to empower players in the market such as large employers to use this information to drive down the cost of health care. At the same time CMS was developing the Transparency in Coverage Rule, Congress was working in parallel to draft legislation addressing so-called surprise out-of-network bills. While both the rule and the Act are attacking similar problems in the health care system—hidden prices, lack of consumerism, and the potentially dire financial consequences for Americans that often result—Congress approached the issue in a slightly different way. For one, at CMS, they were restricted in our rulemaking ability to rely on legislative authority as it existed at the time, while Congress has the advantage of essentially starting with a blank slate. Mr. Pate's team provided technical assistance on several iterations of the No Surprises Act as it made its way through Congress, but they were unsure whether Congress would ultimately be able to pass a bill at all, much less what the final language would look like . Not knowing when or if Congress would act, CMS attempted to take as broad an approach as possible under the current law. As a result, there are some areas of significant overlap between the Transparency in Coverage Rule and the NSA.

Mr. Pate stated that there is some potential to harmonize certain key provisions of both initiatives. If properly implemented and enforced, the Transparency in Coverage Rule holds potential to be one of the most transformative health care regulations in years. Similarly, if properly carried out, the NSA holds the potential to become one of the most far-reaching pieces of health legislation in over a decade. Mr. Pate stated that he would focus on two subjects: one, how the independent resolution process works under the new law and its implementing regulations, and what can we expect in the near future in terms of new rules and guidance.

The *No Surprises Act* introduces new requirements for providers, health care facilities, providers of air ambulance services, and health insurers to protect individuals from surprise medical bills. The protections apply broadly to most items and services and to most individuals enrolled in private health coverage, as well as the uninsured. Most of the requirements apply to Federal Employee Health Benefits Plan, but do not apply to beneficiaries of public programs like Medicare and Medicaid. For two common surprise billing scenarios—out of network emergency, and in-network facility/out-of-network provider—providers and facilities can no longer balance bill patients for the difference between the amount they charge and the amount the individual's plan or coverage will pay. These requirements went into place on January 1 of this year, and CMS has launched a portal for receiving patient complaints. However, as usual, it is likely that states will serve as the primary avenue through which consumer complaints will be lodged, requiring some coordination between the states and the federal government.

On the issue of coordination with states, the Act creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply. For example, Texas's surprise billing statute will likely continue to apply because your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers. Mr. Pate stated that it is his understanding that HHS will be issuing future guidance essentially providing a map indicating where the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process. In such instances, the federal government will defer to the state process and will not accept such disputes into the federal process. However, for self-insured ERISA plans and other plans that may not be covered by the Texas statute, the federal process will apply. The federal rules speak to a potential opt-in process for such plans, who may, for example, wish to use the federal IDR process because it costs less. As another example, for states having an All-Payor Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-payer Model Agreement or other state law will generally determine the cost-sharing amount and the out-of-network payment rate.

To determine the amount of patient cost-sharing, where an all-payer agreement or other state law does not apply, the rule states that cost-sharing must be based on the lesser of the provider's billed charge or the issuer's median contracted rate for that item or service in the same geographic area in the statute as the Qualifying Payment Amount, or QPA. The primary justification for using the lesser of the two amounts, according to the rule, is to minimize the cost-sharing for the patient. The regulation states that this rule will apply to the covered out-of-network service seven if it results in the insurer having to pay before the enrollee's deductible kicks in.

To establish the reimbursement rate between the insurer and provider in covered situations, the Act establishes a new independent dispute resolution process, which providers (including air ambulance providers), facilities, and health plans can use to resolve payment disputes for certain out-of-network charges. As of January 2022, providers, facilities, and health plans can use this process to determine the payment rates for those services. While IDR entities have been selected,

a website has been set up, and the IDR portal has been up and running for several weeks. It is likely there is a significant backlog of cases that will need to be determined and worked through, and this will take some time to work through. When a provider or facility gets a payment denial notice or an initial payment from a health plan for certain out-of-network services, the health plan, provider, or facility must start an open negotiation period that lasts 30 business days. At the end of the negotiation period, if the health plan and provider or facility haven't agreed on a payment amount, either party can begin the independent dispute resolution process. In choosing between competing offers, IDR entities are required by statute to consider several factors, including the Qualifying Payment Amount, again defined as the plan's in-network median rate for that service in the same geographic area, information on additional circumstances submitted by the parties such as the provider or facility's level of training or experience, and any other information the parties present or requested by IDR entity. The statute prohibits IDR entities from considering either usual and customary rates billed by providers or public program reimbursement rates (i.e., Medicare and Medicaid). The IDR entity decides the payment amount, and must choose between payment offers submitted by the provider and the facility. Both the provider or facility and the health plan must abide by the entity's decision and payment must be made within 30 calendar days. In its implementing regulations, the Biden Administration HHS rule created a "rebuttable presumption" directing IDR entities to use the QPA as the starting point–unless a party submits credible information clearly demonstrating QPA is materially different from appropriate out-of-network rate. On February 23 2022, a federal court set aside key provisions of the HHS rule implementing the IDR process nationwide. The lawsuit, brought by the Texas Medical Association, argued that the rule was inconsistent with the statute; the judge agreed, setting aside a key provision of the rule that HHS argued was intended to keep health care costs down and provide consistency and efficiency to the IDR process. This is only one of at least 6 lawsuits that have been brought challenging the law or the regulations implementing the law on a wide variety of grounds, including allegations that the Act is unconstitutional. While whether the statute supports the rebuttable presumption in favor of the QPA can be debated, thus far it does not appear the Department of Justice is aggressively pursuing the appeal. However, HHS says it will issue new rules comporting with the ruling this spring or summer; in the meantime, according to the guidance issued in late February, the IDR process can move forward.

Insured, uninsured, and self-pay patients should all receive Good Faith Estimates (GFEs) from a range of providers that should reflect true expected charges. The GFE is the cash pay rate (inclusive of any expected discounts or adjustments, such as a hospital's financial assistance policy) or the amount that would have been charged to a plan or insurer if the patient were insured. For insured patients, the provider or facility must notify the plan or insurer of the expected charges, and the plan or insurer must use that information to prepare an "advanced" explanation of benefits that will then be sent to the patient. This provision has been delayed due to stakeholder concerns regarding the complexity of the requirements and the time needed to in essence build a new connection between the insurer and the provider. If a provider sends a health plan a "good faith estimate," or if a member requests an estimate directly, an insurer must send the member an Advanced EOB. The No Surprises Act requires health plans to send members an Advanced Explanation of Benefits(EOB) in certain instances: whenever they schedule a health care service at least three business days in advance of the service, and at a member's request if

the service has not yet been scheduled. The Advanced EOB must provide the following information:

- Information about whether the provider/facility is in-network,
- If the provider is in-network, insurers must include contract rate information,
- If out-of-network, the health plan needs to include information about accessing in-network providers,
- The "good faith estimate" from the provider or facility. That information should include likely billing and diagnostic codes,
- A "good faith estimate" of what the plan will pay,
- An estimate of the member's cost-sharing amount,
- A "good faith estimate" of how the member is progressing toward their plan limits on things like deductibles and out-of-pocket costs,
- The Advanced EOB should indicate prior authorization requirements, if any,
- A specific disclaimer that the Advanced EOB is an estimate based on information known at the time and could change,
- Any other information or disclaimers the health plan deems appropriate.

Good faith estimates should be based on the care that is reasonably expected to be provided. If the provider or facility is aware of changes that affect the scope of the original good faith estimate, such as changes to the type, frequency, or duration of treatment), the patient should receive an updated good faith estimate opportunity for harmonization with Transparency in Coverage. Many observers have recognized that competition, to the extent it occurs in health care, occurs at the wrong places and for the wrong reasons, and in ways that often do not benefit consumers.

Mr. Pate stated that he was skeptical in the beginning about the potential beneficial effects of price transparency. This was because of some evidence that requiring publication of negotiated rates led to increased rather than decreased prices. But through the process of listening to stakeholders, especially employers, he slowly came to the conclusion that:1) consumers should have a right to shop and have this information; 2) large employers in particular are in a good position to use the information to negotiate for lower cost of care for their members, which will hopefully have an overall impact of lowering costs. He stated that he recognized that there are always unintended consequences with any new policy, and so policymakers must remain vigilant during and after implementation of the rule. In Transparency in Coverage, they took an aggressive but measured approach wherever possible, recognizing that this rule is only a first step. In the future, they need more innovation around not only the tools consumers use to shop

for coverage and compare prices, but also need better grouping and bundling of services to drive true apples-to-apples comparisons between the prices charged by providers. That is one reason why we were intentionally not prescriptive about how third-party developers and others could display the data to users. Looking at No Surprises, both the Good Faith Estimate and the Advanced EOB are arguably getting at the same thing as the Transparency in Coverage Rule. At the moment there is no broadly adopted technical solution for Advanced EOB; unfortunately, it feels a bit like the beginning of the discussion on interoperability over a decade ago. However, under Transparency in Coverage, the consumer requires insurers to provide real-time negotiated rates for the 500 most shoppable services, and to include specific information on cost-sharing amounts for that particular member. This requirement will go into place on January 1 of 2023. In July of 2022, insurers will be required to post publicly their negotiated rates for these most shoppable services. It may be possible, therefore, to coordinate between the consumer shopping tool requirement in transparency in Coverage and the Advanced EOB. More work needs to be done to ensure workable transmission standards and that the information is usable and actionable for consumers. In conclusion, both of these initiatives are potentially game changers, but we are still in the first inning. There is much work left to be done, but I believe they represent positive first steps. Clearly, both initiatives will need to be adjusted and refined over time, perhaps significantly so. However, along with state-level actions to promote price transparency and address surprise billing, they represent strong initial efforts to push the system towards transparency, consumerism, and appropriate competition in health care. Almost everyone recognizes the current system is too costly and inefficient, doesn't serve patients, and for those reasons is ultimately untenable.

The Committee heard testimony from Dr. Doug Jeffrey, representing the Texas Medical Association.

Dr. Jeffrey stated that SB 1264 put in place a framework that addressed out-of-network surprise bills for enrollees of state-regulated plans(as swell as ERS and TRS plans). Its three major components included generally prohibiting balance billing for surprise bills, taking patients out of the middle of surprise billing disputes, and creating fair independent dispute resolution processes for plans and providers to resolve payment disputes over these bills. The legislation was the product of careful negotiation among interested stakeholders, ultimately passing with support from all major stakeholders including physician, hospital, health plan and consumer stakeholders. At the time of its passage, SB 1264 was widely touted as being one of the strongest consumer protection laws in the nation, making it a model that was influential in shaping other legislation–including federal legislation on surprise billing. SB 1264 has been in effect since January 1, 2020. And, based upon the Texas Department of Insurance (TDI)'s 2021 midyear report on SB 1264, it is clear that this important piece of legislation is serving its intended consumer protection purpose. More specifically, TDI's report noted that in the first 18 months of implementation, TDI received 98,586 eligible requests to resolve medical billing disputes totaling $450 million. Furthermore, TDI's report noted that Texas' balance billing protections under SB 1264 had resulted in sharp declines in consumer complaints, from 1,031 complaints in 2019 to only 40 complaints in 2020, and 28 complaints in the first half of 2021, with the most recent ones concerning coinsurance and non-TDI regulated plans.

With the passage of the federal surprise billing legislation, the No Surprises Act (NSA),which went into effect January 1st of this year, we have heard that some stakeholders have (despite the continued success of Texas' law in protecting consumers) been advocating for Texas to follow the federal legislation more closely or to cede jurisdiction on surprise billing disputes to the federal government altogether by pushing these disputes into the NSA dispute resolution process, effectively undoing SB 1264. TMA continues to support SB 1264 and believe that, from a consumer protection standpoint, efforts to undermine the current law are, at best, misguided and, at worst harmful. First it should be noted that the federal No Surprises Act intentionally was drafted so that state laws that provided comprehensive consumer protections regarding surprise billing, called "specified state laws" would remain intact after the passage of the federal law. Recognizing that states have proper jurisdiction to regulate fully-insured plans and to protect the health and welfare of their citizens, Congress did not want to disrupt state frameworks that were as protective or more protective of consumers than the federal law. The Centers for Medicare & Medicaid Services reviewed all existing state surprising bill laws to determine which state surprise billing laws met the specified state law test. In a letter dated December 22, 2021, CMS noted that Texas' law was one of those strong, comprehensive laws that would not be preempted by the federal law. Texas law is, in fact, more protective than federal law in certain ways. For example, while both the federal and Texas law provide protections from balance billing for out-of-network emergency care and out-of-network care provided at certain in-network facilities, Texas law also extends its protections to a third category of services not addressed by the NSA. This third category captures a service performed for an enrollee by an out-of-network diagnostic imaging provider or laboratory services provider if the provider performed the service in connection with a health care service performed by an in-network provider.

Texas law also is more protective of consumers in that it includes certain structures designed to promote fair payment and network adequacy that are absent from the federal law. More specifically, under SB 1264, the Texas Legislature established ten exclusive factors that must be considered in determining the reasonable amount for services in its arbitration process. While one of those factors is the 50th percentile of rates for the service or supply paid to participating providers in the same/similar specialty, the Texas Legislature also requires consideration, among other things, of the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geo zip as reported in a TDI selected database. Thus, the Texas Legislature took into consideration amounts primarily set by the plan (i.e., contract rates) and amounts primarily set by the physician or provider(i.e., billed charges). Inclusion of billed charges was a critical factor to a fair process under the Texas law. Without inclusion of this factor, the results of the arbitration under Texas' law would be more likely to be skewed in health plans' favor. And, health plans would have less motivation to contract with physicians, which would then put patient access to in-network care at risk for services not subject to the surprise billing protections, threaten physician practice viability as physicians would be forced to take payment cuts both in and out-of-network, and likely result in forced consolidation of physician practices, which usually result in higher prices. It is imperative that the Texas Legislature not alter the framework in SB 1264 that includes certain billed charges as factors for consideration in the arbitration process, as this cascade could result. The plans are likely to try to argue that higher payments in arbitration result in higher costs to patients in the form of premiums. However, we emphasize that patients are held harmless from the balance bill under Texas law, just as they are under federal law. The factors

considered in arbitration, therefore, directly affect plan payment, not patient payment. This was the point of taking the patient out of the middle of these disputes. If the plans pass along any arbitration costs to enrollees in the form of higher premiums, that is a plan choice, particularly at a time when health plan profits for several issuers were in the billion dollar range for 2021 and CEO bonuses were in the multimillion dollar range.

Dr. Jeffery stated that rather than modifying or disrupting SB 1264's basic framework, they recommend that the Legislature reduce inefficiencies and costs associated with accessing the SB 1264 independent dispute resolutions by increasing the statutory limit on bundling of claims, and giving TDI express authority to set a reasonable range or maximum on arbitrator fees. Currently, Texas law provides that the total amount in controversy for multiple claims in one arbitration proceeding may not exceed $5,000. This cap on bundling claims for arbitration is far too low, particularly in light of skyrocketing arbitrator fees. As of March of this year, the list of arbitrators on TDI's website reflected a drastic range of fixed arbitrator fees (from $400 to $6,000, which is up significantly from the $270 to $3,000 range of arbitrator fees around the same time in 2020). Increasing the bundling limit will make the arbitration process more accessible for smaller amounts in controversy, allow for quicker processing of multiple claims, and reduce the administrative burden for all parties involved, including TDI. Furthermore, giving TDI express statutory authority to set a reasonable range or maximum on arbitrator fees would allow SB 1264's independent dispute resolution processes to remain accessible to physicians. We are concerned that some of the fees currently charged by arbitrators are so high that physicians and other providers are deterred from seeking arbitration, and even if a physician or provider seeks arbitration and wins during the arbitration, he or she may walkaway with a net loss. This severely undercuts the utility of the arbitration process sand the fairness of SB 1264. Making these two small adjustments to the law would not only maintain the integrity of the law but promote its continued, effective operation going forward. Dr. Jeffery also asked that the Legislature continue to strengthen Texas' existing network adequacy laws (and enforcement of those laws) in order to ensure that the root causes of surprise billing are properly addressed. Surprise bills result when a patient unexpectedly goes out of network. A major cause of surprise bills has always been health plans maintaining inadequate networks.

Dr. Jeffery stated that SB 1264 and the No Surprises Act, unfortunately, do little to address health plan network failures. TMA asks the Legislature to focus its attention on this issue to ensure that patients get value for their premium dollars and have a wider selection of in-network physicians for their planned procedures. Patients are paying for a robust network. Plans must be required to hold up their end of that bargain.

The Committee heard testimony from Blake Hutson, representing the Texas Association of Health Plans(TAHP).

Mr. Hutson stated that TAHP nationally have advocated loudly for consumer protections against surprise medical bills form out-of-network health care providers. He stated that TAHP worked earnestly to support the passage of statutory protections in Texas, and in doing so, made Texas an early adopter of reforms that both protected consumers and created a dispute resolution process for payment resolution. Eventually, the federal government created a similar system to fully resolve these unexpected balance billing issues, the No Surprises Act(NSA).

Mr. Hutson stated that in Texas, arbiters must considers the health care providers billed charges as a guide post in determining the final state-mandated payment rate. Further, arbiters must consider the 80th percentile of billed charges, a number far above even the average, or 50th percentile, of billed charges. Billed charges are largely untethered by market forces and are determined solely by the billing provider. Mr. Hutson stated that under this approach, providers are able to game the system by using unusually high billed charges, with full knowledge that it will push the final arbitrated number upwards at no cost to themselves.

Mr. Hutson stated that an analysis from the New York Department of Financial Services found that arbitration decisions averaged 8% higher that the 80th percentile of charges.

Mr. Hutson said that, now that the state is now more than two years in to the Texas surprise billing law and arbitration system, several concerning results have arisen. He stated that there has been a steady rise in arbitration requests, and even a cottage industry that has sprung up to take advantage of the law.

Mr. Hutson stated that Texas health plans and health care providers are burdened by two differing systems for arbitrating surprise medical bills. He stated said that Texas facilities utilize a distinct third mediation system that does not follow the processes in either the state or federal arbitrations.

Mr. Hutson stated that patients are protected from the upfront costs in surprise medical bills in almost all circumstances at this point, regardless of whether they have a state or federally regulated health plan. He stated that the evidence is now clear that using billed charges in any dispute resolution has negative and expensive consequences for health care payers, and in turn will make coverage more expensive for employers and families in the long run. He stated that a coalition of employers, unions, patient advocacy groups, consumer advocacy groups, health policy experts, health plans, and health benefit advisors have all joined together in support for a system that determines payments by referencing in-network negotiated rates.

Mr. Hutson stated that health care providers in Texas are burdened with the complexity of sorting through different systems with different processes and different rules. This includes distinctly different requirements for providers to follow when asking patient to waive their balance billing rights. He stated that providers also must determine if their patient's health insurer is state or federally regulated when seeking dispute resolution for out-of-network bills to determine whether they must first file for arbitration before starting the informal settlement attempt or if they can start the processes ahead of filing for arbitration. He stated that the federal system for arbitration was born out of lessons from states like Texas and others, and the federal system's process better controls costs and administrative expenses. Mr. Hutson stated that TAHP is in support of modernizing and improving Texas' processes by moving towards the bi-partisan and multi-stakeholder supported system adopted on the federal level.

The Committee heard testimony from David Balat, Director of Health Policy for the Texas Public Policy Foundation.

Mr. Balat stated that the law enjoyed bipartisan support and accounted for many of the good things that Texas accomplished by passing into law SB 1264. Unlike what Texas did, HHS did not follow Congressional intent nor the text of the law. The interim final rule (IFR) regulations for the No Surprises Act represent a gift to the insurers while harming medical professionals that take care of patients. HHS was sued by the Texas Medical Association ,and the Texas Eastern District Court ruled in TMA's favor. The ruling vacated the disputed parts of HHS' regulations. As such, HHS revised its regulatory guidance and has promised to issue a new rule in accordance with the court's ruling. However, the Justice Department decided at the 11th-hourto appeal the Texas ruling in the 5thCircuit.

Mr. Balat stated that HHS' interim final rule (IFR) regulations for the No Surprises Act did not follow Congressional intent nor the text of the law, are illegal, and represent a huge hand out to the health insurance industry. The interim final rule's independent dispute resolution (IDR) process would enable health insurers to limit choice by narrowing medical networks; this would deny patients their choice of physicians and could delay diagnosis and treatment of illness and injury.

Concern among lawmakers resulted in a letter led by Representative Suozzi and Representative Wenstrup and signed by 152 members of Congress urging the agencies to implement the No Surprises Act in accordance with the law that Congress passed. Their concern was well founded. Within 90 days of the law going into effect, insurers throughout the country were terminating contracts with providers. Providers with whom they negotiated rates and agreed in writing. This shouldn't come as a surprise as we are seeing the same thing in Texas in the wake of the passage of SB 1264. For example, United Healthcare sharply reduced its networks of physicians, particularly hospital-based physicians, since the Law was signed. Contrary to this legislature's intent, United Healthcare is using the Texas statute to argue against the need for adequate networks at the expense of patients, particularly in rural areas. When the insurer filed a network configuration waiver request and access plan from the Texas Department of Insurance, the agency approved the access plan claiming, "that when members receive services from emergency medicine physicians, anesthesiologists, and radiologists who are not network healthcare providers. "SB 1264, which had nothing to do with network adequacy, became the rationale for narrow networks and a lack of medical professionals where they are needed most. It is important to note that the Texas case solely impacts the IDR process to determine provider reimbursement for out-of-network care. Despite health insurers' continued skewed talking points, the Texas ruling does not affect the No Surprises Act patient protections against out-of-network medical bills. The case, moreover, would not raise patient out-of-pocket costs. It is essential that we ensure the HHS final rule complies with the text and spirit of the No Surprises Act but more importantly that our Texas Department of Insurance continue to do the good work they do in promoting network adequacy and reversing the behavior exhibited by insurers.

The Committee heard testimony from Dr. Zach Jones, representing the Texas Medical Association.

Dr. Jones stated that TMA continues to support the patient protection intent of the No Surprises Act, but they have been concerned with multiple aspects of the legislation's implementation. As the committee may know, TMA was the first in the nation to file a lawsuit concerning one

component of the interim final rules relating to the implementation of the federal surprise billing arbitration/independent dispute resolution process. TMA did not challenge any of the law's patient protections in its lawsuit. Under the NSA, if a physician and a health plan disagree on the appropriate out-of-network rate for certain services that are subject to the law's prohibition on balance billing, they may engage in an arbitration process that removes the patient from the middle of any payment dispute. The federal law provides that, under that process, the independent dispute resolution entity must consider numerous statutory factors before deciding between the health plan's offer and physician's offer as the appropriate out-of-network rate. But when the federal agencies issued their interim final rules in September 2021, they effectively rewrote the law to largely limit the arbitrator's decision to only one factor ,the "qualifying payment amount," an insurer-determined factor that TMA believed would stack the deck in the health plans' favor. Reliance on only the "qualifying payment amount" or QPA would have been particularly problematic because while the QPA was supposed to be the median in-network rate for the same service in the geographic area, QPAs have been deflated by the rulemaking methodology .The federal government's failure to engage in any auditing of QPAs also raises questions as to the accuracy of these figures. After hearing both sides in court, the U.S. District Court for the Eastern District of Texas issued its decision on February 23, agreeing with TMA and ruling that the challenged portions of the interim final rules conflict with the unambiguous terms of the law passed by Congress. The vacatur ordered by the judge went into effect immediately, with nationwide effect, invaliding the challenged portions of the rules. As TMA noted at the time of this decision, the court's order was an important step towards restoring the process that Congress enacted to resolve disputes between insurers and physicians over appropriate out-of-network reimbursement rates. The decision was also important to promoting patient access to quality of care and guarding against health insurer business practices that give patients fewer choices of affordable in-network physicians and threaten the sustainability of physician practices. On April 22, the federal agencies filed their notice of appeal with the Fifth Circuit. The agencies later filed (and had granted) an unopposed motion to place a hold on the appeal, pending the issuance of final rules .In the meantime, the court's order remains in place. TMA will continue to monitor the implementation of the federal law's arbitration process, as we await the federal agencies' final rules. Although not challenged in TMA's lawsuit, because the QPA remains one (of many) relevant factors in arbitration, TMA remains concerned with how QPAs are calculated. Judge Kernodle stated, in his opinion, the QPA is typically the median rate the insurer would have paid for the service if provided by an in-network provider or facility. And because insurers had ultimate say on what in-network rates they accepted in 2019, insurers now hold ultimate power, and are charged by regulation, to calculate the QPA. TMA supported Texas' surprise billing law (SB 1264 during the 86-R), which was also supported by all other major stakeholders (the health plans, hospitals and consumers). Among the 10 factors to be considered in Texas' arbitration process is the 50th percentile of rates for the service paid to participating providers in the same/similar specialty in the same geozip as reported in a TDI selected independent benchmarking database .This factor is similar to but not exactly the same as the QPA.

Dr. Jones stated that TMA are thankful that the Texas Legislature had the foresight to require consideration of additional factors like the 80th percentile of all billed charges for the same service or supply in its exclusive list of factors, as well as the out-of-network provider's usual billed charge for comparable services with regard to other enrollees for which the provider is

out-of-network, for deciding arbitrations, as this aids in preventing the skewed results that would flow from tying arbitrator decisions to a plan-determined benchmark. It aids in preventing the expected result that prompted TMA to sue over the federal interim final rule's independent dispute resolution process. TMA believes that Texas' law is superior to the federal law, as it incentivizes plans to have adequate networks, ensures a more robust network of in-network providers for planned procedures, and promotes practice viability .It is important that the arbitration process for surprise billing be a balanced process. Thus, TMA was pleased when the NSA was drafted in a manner that would expressly defer to state laws (within their respective scopes, including any ERISA opt-ins) that were comprehensive in protecting consumers. TMA continues to strongly support Texas' surprise billing law and believes its continued application, with its current list of factors, is important to both Texas' physicians and their patients. Texas' law also is more protective of patients than the federal surprise billing law in that it includes a category of services not covered by the federal law, which is out-of-network services provided by diagnostic imaging providers or laboratory services providers if the service was provided in connection with service provided by an in-network provider.

The Committee heard testimony from Cesar Lopez, representing the Texas Hospital Association.

Mr. Lopez stated that the vast majority of time hospitals are in network with all major payers. Network interruptions that do happen are generally very brief, and very quickly resolved. The think that's bad for patients, hospitals, and payers. THA thinks that inserting an array into the dispute resolution process tends to help providers who are not in network with health insurance plans, but tends to cause network interruptions for those who are in network. He stated that they saw this directly, again with the passage of the federal act. When SB 1264 was enacted, there was little to no network interference on the hospital side. When that took effect early this year, they did see some large hospitals with little to no history of network interruption fall out of network with their respective plans. They think that the difference is in the mandatory consideration of a rate set by the arbitrator under the federal act for out of network payment.. Over the last few years, THA understand that there were 13,582 requests for mediation during the first half of 2021. However, only 10,322 of those were from freestanding emergency centers, only 3208 were from hospitals, and only about 80 of those requests actually went through the full mediation process. Mr. Lopez said that he wanted to make sure that we maintain the distinction between the hospital and then a true freestanding emergency center. The rest of those claims are settled informally. They are not aware of any situation where any of those informal agreements have been breached or not held up. Mr. Lopez stated that if that was the case, they would have heard something from our members. He stated that he can't say that they have but that they will certainly look into that as well. He thinks that the status shows that the hospitals and insurance companies are working with the best working out the vast majority of the differences on their own outside of the prescribed system. THA thinks that's a good thing. THA wants to contrast that with what we understood were about 50,000-plus request for arbitration, and about 13,000, just under 14,000 of those were settled by the arbitrator. So we do think that mediation process is working is working efficiently. THA has certainly have had a few issues with some of the mechanics of the bill, we would like to be able to batch some of these claims to mediate some of these claims in multiples as opposed to one at a time. THA doesn't think that's significant enough to warrant opening up the bill. THA does think some of these issues could be resolved through rulemaking. But in the end, THA does think that the bill does what it is supposed to do for the

facilities. It does hold patients harmless for out of network surprise bills and created incentives for negotiations between the plans and facilities to work out these issues on their own.

The Committee heard testimony from John Herrick, Deputy Commissioner for the Texas Department of Insurance.

Mr. Herrick stated that SB 1264 was put together to protect consumers primarily to prohibit surprise balanced billing, and to also provide a method for providers and carriers to work through payment disputes. After the bill passed, in the six months following it signing, TDI developed rules for SB 1264. They created the portal, and they selected the database that would be used for costs that the plans and the providers would use to submit to the arbitrators. They vetted and selected arbitrators and mediators. They delivered training to all of the parties, whether they be arbitrators, mediators, the plans and providers on the use of the portal. The bill established two parts. For providers, they created a section were disputes existed. For doctors, they created arbitration, and for hospitals and hospital related bills, they created mediation.

Mr. Herrick stated that the arbitration process is fairly rapid in nature. When a provider is paid or receives payment, after the 20th day they can submit a case or either party can submit a case for a payment dispute. That would be basically be the difference between what the bill charge was originally and what the health plan paid. Arbitration in total lasts 51 days, the first 30 days are allotted for the two parties to get together to try and work out a settlement to agree on an additional amount or payment to provide offers to each side. If, after that initial 30 days the settlement is not reached, then an arbitrator is assigned to look at various factors which tend to be specific, and make a decision on the cost for the healthcare service, and then look at the final offers made by each side and determine which one was closest to the costs. They've figured for this healthcare service to supply. Mediation, on the other hand, still has the same 30 day process at the beginning. The hospital and the hospital-related bills and the health plan should work through deciding on a settlement if one has an outreach to mediators assigned. In this case, unlike arbitration, where there's only 51 days for the process, there is another 150 days for them to try mediate through the use of a mediator and try to reach a settlement. In both cases, at the outcome of arbitration or mediation, the both parties have a right to go to court if they choose to do so.

The system, which began in January 2020, there have been 265,814 requests. Providers and health plans have agreed during that initial 30 day period on 154,000 of those cases, so they didn't have to get assigned. Total cases that went on and were assigned to an arbitrator amounted to over 55,000 cases. Total cases submitted to a mediator number over 1300. When looking at the total dispute, disputed amount, the difference between the build charge, and the initial payment from the health plan, which would include the cost sharing from the patient, that has a total to date over $1.2 5 billion. When one thinks about consumer protection, one thinks about that could have been sent as a surprise balanced bill before this legislation was put in place. When one looks at the settlements, they are agreeing on a majority of these cases. When one looks at how that relates to the initial, original bill charge in 2020, what they saw is that they agreed to an amount that equated to 30% of the original bill charge. In 2021, that came down to 24%, and in 2022, came down at 22% of the original bill charge. These percentages include the

original claim payment amount made by the health plan, and the patient for their costs share, and then the additional amount received through the IDR system.

Of the 55,000 that went through to an arbitrator, they were looking at the same percentages in 2020. The arbitrator decided on a cost that represented or resulted in an amount of 33% of the original build charge, and in 2021 It was 36%. And then in 2020 it went to 30%. Mr. Herrick mentioned that so far, there have been 1300 cases that have gone to a mediator, and, of those 1300, 32% did reach an agreement with the help of a mediator during that process, and the rest did not. When they look at the number of arbitrators that we have, 119, most of them are either attorneys or former or retired judges. They have 137 mediators to help them with this process.

The top five emergency room physicians represent the top the most claims, followed by freestanding emergency rooms, which would be on the mediation side. Number three would be anesthesiologists, again, on the arbitration side, fourth would be hospitals, using mediation, and then five would be certified registered nurses. One thing they did see at the department after the implementation of this bill is a significant decrease in complaints from providers regarding payment disputes, and from consumers who were receiving balanced bills.

Recommendations

The Committee is pleased to learn about the implementation progress and efficacy of both HB 1919 and HB 1763, and will continue to monitor them in the future.

Regarding the federal *No Surprises Act*, and its effect on the Texas market, the Committee understands that collectively we are either going to move in the direction of market-based competition, or government control. The Committee favors market-based solutions of the kind that have served Americans so well in nearly other sector of the economy for decades. The Committee feels that it will be important to remain vigilant as this transformation takes place to ensure that consumers are empowered, rather than government.

Regarding *Rutledge v. PCMA*, the Committee is pleased to learn about the ruling of the Supreme Court, which narrows the range of state regulations preempted by ERISA, and broadens those which are not. The Committee is optimistic that the removal of ERISA preemption uncertainty will empower state legislators to pursue legislation which will be positive for health policy and Texan health care consumers.

Citations

[3] Margaux Hall, Esq., Harvey Cotton, Esq., Christopher Gillis, Esq., and Sam Perrone, Esq., Ropes & Gray. *Rutledge vs. PCMA: The future of state regulation of pharmacy benefit managers in the wake of the SCOTUS decision.* Westlaw Today, 2021 PRINDBRF 0233.
[4] Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Benedic Ippolito, and Erin Trish. *Understanding the No Surprises Act*. USC-Brookings Schaeffer on Health Policy. February 2021.