Interim Report

TO THE EIGHTY-NINTH TEXAS LEGISLATURE

HOUSE COMMITTEE ON INSURANCE

JANUARY 2025

HOUSE COMMITTEE ON INSURANCE
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2024

A REPORT TO THE
HOUSE OF REPRESENTATIVES
89TH TEXAS LEGISLATURE

TOM OLIVERSON, M.D.
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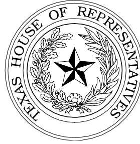

Committee On
Insurance

January 10, 2025

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-eighth Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-ninth Legislature.

Respectfully submitted,

Tom Oliverson, M.D.

Ann Johnson

Briscoe Cain

Caroline Harris-Davila

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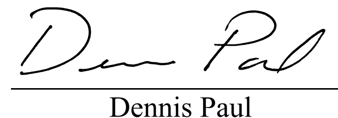

Dennis Paul

Julie Johnson

Mary Ann Perez

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Vice-Chair

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INTRODUCTION

In the 88th 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), Ann Johnson (Vice Chair), Briscoe Cain, Philip Cortez, Caroline Harris-Davila, Lacey Hull, Julie Johnson, Dennis Paul, and Mary Ann Perez.

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;
- 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 June 11th, 2024, and on September 5th, 2024.

INTERIM STUDY SUBJECTS

- Study current factors affecting the property and casualty insurance market in Texas. Compare the Texas insurance market to other states with respect to affordability in homeowners' insurance. Study appraisals within property and casualty insurance policies. Review the growth in the Texas surplus lines market to determine if surplus lines market share indicates market challenges that can be addressed with additional laws or regulations.

- Review current funding mechanism for The Texas Windstorm Insurance Association (TWIA). Examine the role of reinsurance in relation to TWIA.

- Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 88th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure intended legislative outcome of all legislation. Monitor relevant legislation passed in previous sessions to ensure continuing progress and/or concerns. Monitor compliance and enforcement by appropriate agencies relating to existing state laws.

- Study the options for Texas to establish a state health insurance exchange. Consider population changes in Texas; costs including any cost savings, per enrollee cost and other considerations; the impact on the small business and individual health insurance market; other states' experience and considerations for multi-state or shared services exchange; operational and regulatory issues; and technological and operational considerations for carriers, brokers, and other stakeholders.

- Study issues relating to consumer protection in the Texas health care market. Review current practices which prohibit competition, inhibit transparency, and negatively affect the Texas consumer. Study the current state of network adequacy in Texas. Review the efficacy of the prior authorization process in ensuring the appropriateness of medical treatments. Study how rebates play a role in the operations of pharmacy benefit managers (PBMs), and how these rebate arrangements impact drug pricing and access to medications.

- Study how artificial intelligence (AI) has impacted the insurance industry. Examine what functions AI serves in enhancing efficiency and risk assessment within the sector and examine concerns regarding this practice.

- Study how other states review proposed health insurance mandates, including by assessing their fiscal impact and the implications on the market. Make recommendations for establishing a mandate review process in Texas that incorporates best practices identified by the committee.

Current Factors Affecting the Property and Casualty Insurance Market in Texas

Study current factors affecting the property and casualty insurance market in Texas. Compare the Texas insurance market to other states with respect to affordability in homeowners' insurance. Study appraisals within property and casualty insurance policies. Review the growth in the Texas surplus lines market to determine if surplus lines market share indicates market challenges that can be addressed with additional laws or regulations.

Background

Over the past two years, the Texas property and casualty insurance market has seen rising premiums become a major concern for residents and businesses. Severe weather events, including hurricanes, hailstorms, and winter freezes, have resulted in significant catastrophic losses, prompting insurers to reassess risks and adjust premiums. Inflation has further exacerbated costs by driving up prices for materials and labor, increasing claim payouts.

Additionally, challenges within the insurance industry, such as insurer withdrawals from high-risk areas and reduced competition, have left consumers with fewer options and higher prices. These factors combined have left many Texans struggling to afford coverage, underscoring the need for solutions to stabilize the market, encourage competition, and improve disaster preparedness.

Testimony

The Committee heard testimony from Cassie Brown, Commissioner of The Texas Department of Insurance.

Ms. Brown began by stating that globally, the Texas market is bigger than all but four countries. Last year, across all lines of insurance, Texas accounted for nearly $290 billion in premiums. In the past four years, the market saw a net growth of more than 130 property and casualty insurers. More than 1600 insurers do property and casualty business in Texas, with about 160 companies writing homeowners' coverage. She stated that the market continues to grow. Currently, across all lines of insurance, the Texas market includes 3,400 companies. In the last fiscal year, there were over 913,000 agents and adjusters licensed in Texas, including more than 191,000 new licenses issued by TDI. That count was up more than 40% from 2020.

Ms. Brown stated that TDI strives to provide excellent customer service, seeing themselves as a partner to all Texans. One of the ways they are doing this is by regulating the business of insurance across all lines of property and casualty, plus about 17% of the state's health insurance market. She stated that they protect and ensure that fair treatment of consumers, and that they ensure fair competition in the insurance industry to foster a competitive market. They regulate property and casualty insurance, which includes homeowners' insurance, auto insurance, title insurance, and commercial and liability insurance. Some lines of insurance are subject to various levels of review and regulation. For example, many large commercial levels of risk are not subject to rate filing and review. TDI does not regulate body shops, building contractors, or roofers. This means that TDI can help with questions on insurance coverage claims of these services, but cannot help with billing practices, quality of service, or other claims about these professions. TDI has limited authority over surplus lines and risk retention groups, and they do not regulate interlocal government pools. The Government Code and Local Government Code allow governmental entities and political subdivisions to create self-funded pools that are not regulated by TDI. Some examples of those organizations are the Texas Municipal Leagues and the Texas Association of Counties. TDI does not have the insight into how many pools are operating, their rates, or their claims handling practices. Surplus lines insurance is a specialized coverage available from certain insurers not licensed in Texas, but eligible as surplus lines carriers. To be eligible, the must be licensed in their domiciled state for the same line of insurance they provide in Texas. However, TDI does license and regulate surplus lines agents. Surplus lines agents are responsible for placing coverage with eligible carriers, and except for certain commercial lines that have been exempted, a surplus lines agent must make a diligent effort to obtain the insurance form an insurer authorized to write that kind of insurance in Texas before placing that coverage with a surplus lines carriers. Risk retention groups are created under the Federal Liability Risk Retention Act and are limited to offering liability coverage. They are a type of mutual company, meaning that they are owned by the members of the group that they are servicing. They must be licensed in their state of domicile, and then they can offer coverage in states where they are registered. They are not subject to rate filing and are not covered by the guarantee funds. Home and auto insurers regulated by TDI must file their rates for review.

Like most states, Texas is a file and use state. This means that once an insurer files its rates, it can use them immediately or at a future date, as determined by the insurer. However, this does not mean that there is no state review of these filed rates. TDI thoroughly review rate filing for compliance with state

law, ensures that the company's math adds up, and often gets companies to make changes to their filings. State law requires that rates be adequate, not be excessive, be based on sound actuarial principles, be reasonably related to all costs, not be based on the insured's race, creed, color, ethnicity, or national origin. If a company's filed rates do not meet any of those standards, TDI notifies the insurer. If the insurer does not change, withdraw, or provide better supporting information for its filing, TDI can take action to disprove it. TDI requested additional information on almost 75% of the filings which are subject to review. It is also common for companies to resubmit filings at a different rate, based on feedback received from TDI. In the last year, TDI resolved issues and company rate filings that saved consumers almost $57 million.

Commissioner Brown stated that, in 2023, auto rates increased on average by 25.5%, while homeowners' rates increased on average by 21.1%. There are several factors that contribute to these increases. Inflation continues to drive up the cost of supplies and labor. Supply chain disruptions have affected the pace of construction and repairs. Frequency and severity of losses are also a major contributing factor. In 2023, Texas had sixteen confirmed weather events with losses exceeding $1 billion each. This year Texas has seen several major weather events: flooding in Harris County, tornadoes in Temple and the North Texas area, and hailstorms in West Texas, Central Texas, and the D/FW area. Commissioner Brown said that these factors do not tell the whole story. A consumer's bill or their premium also reflects the value of the property that they are insuring, and for homes and vehicles, that value has increased significantly. The average home value in Texas is currently more than $350,000. This is a 40% increase in the last five years. The average cost of a new vehicle is currently more than $48,000. This is a 30% increase in the last five years. All of these new values need coverage, which results in bigger bills for consumers. Another contributing factor for auto insurance is driver behavior. According to the Texas Department of Transportation (TxDoT), vehicle incidents remain far above pre-COVID levels. In 2023, Texas experienced 559,000 vehicle collisions, resulting in 250,000 injuries and 4,283 fatalities. These numbers reflect a tragic impact on the lives of Texans. They also represent real claim cost of insurers, which is reflected in the premiums we pay.

Insurance fraud impacts everyone, and it also contributes to increased costs for insurance. TDI's fraud unit included forensic accountants, investigators, and embedded prosecutors in County District Attorneys' offices across the state. In the last fiscal year, TDI's fraud unit opened over 200 investigations. The unit also recovered nearly $3 million in restitution for Texas consumers. This year, the unit has recovered over $7 million in restitution.

Commissioner Brown stressed that severity of losses can be reduced by focusing on mitigation. TDI has partnered with Texas A&M University to study incentives to encourage insurers to provide wind and hail coverage in coastal areas of the state. The study is focused on programs related to incentivizing more resilient home construction. It includes analyzing programs in other coastal states, like Alabama, Florida, and Louisiana. The study will survey insurance companies, look at lessons learned in developing the programs, and will look at how incentives could impact what the companies offer to write in Texas. Results will be included in the TDI annual report, which will be coming out prior to the 89th legislative session.

The Committee heard testimony from Paul Martin, Vice President of The Reinsurance Association of America.

Mr. Martin began his testimony by talking about pricing and availability. He stated that two main drivers affect those things, which are availability of capital and future expected loss costs. He said that the market is seeing unprecedented events recently. He stated that globally, in 2023, there were 34 $1 billion events which took place. Twenty-four of these happened in the United States. The vast majority of these are called severe convective storms, more traditionally known as severe thunderstorms. He stated that for this year, the U.S. is on track for the largest ever number of tornados in the month of May. He stated that eleven of these events were multi-billion-dollar events.

Mr. Martin stated that he frequently tells legislators five different things about the current economic situation. The first is that reinsurers and insurers have the same kind of losses. When insurances companies suffer large losses and submit these claims to their reinsurance broker, the reinsurance broker reimburses them on an indemnity basis. When the reinsurers have a contract with the insurance companies, the reinsurer accepts a premium to transfer some of the risk away from the insurance company to the reinsurer, and that allows that insurance company to write more policies in a given state.

The second thing is the fact that many events are happening simultaneously at the present time. He said that the fact that frequency of storms, severity of storms, inflation, and interest rates happening concurrently is unprecedented. Previous trends in volatility have not been observed in recent years. That is, the cyclicality that was observed decades ago is not present in our current situation.

Third, he emphasized focusing on what can be controlled. In Travis County, home values have risen 130% in the last ten years. This is a factor that is driving not just losses, but home premiums. He reiterated that the Legislature cannot control this. He stated that the things that can be controlled are building codes and land use. Moving forward, how we build and where we build are critical. Louisiana and Alabama are examples of states which have started mitigation funds to put new roofs on peoples' houses to reduce the amount of damage they suffer in storms. The other factors are underwriting, rating flexibility, as well as fair claims handling. He reiterated that the Texas market is in far better shape than states such as California and Florida, in part due to the Legislature's understanding that it must not excessively interfere with the market.

Fourth, Mr. Martin stated, catastrophe funds are not a good option. These are also known as state government reinsurance pools. Reinsurance pools are sometimes known as catastrophe funds. The way reinsurance works is that a reinsurer will take some tsunami risk from Japan, some hail risk from Texas, some flood risk in Europe, some other weather risks in Australia, and they will combine these uncorrelated risks. As a result of these uncorrelated risks, they can offer reinsurance to those people at a lower cost. The catastrophe fund takes the risk in a small geographic area the size of the state of Texas. The same risk it collects requires the taxpayers to then become the reinsurers of the private market. He stated that there is only one catastrophe fund currently, The Florida Hurricane Catastrophe Fund.

Fifth, Mr. Martin stressed that legislators should always be aware of the following question when contemplating the nature and effects of future legislation: will it encourage or discourage more insurance capital from coming into the marketplace?

Mr. Martin said that there is some good news with respect to the Texas marketplace. All nations are competing for a finite amount of global reinsurance. There was a significant drop in in 2022 in reinsurance capital due to rising interest rates and increased losses. Many investors subsequently pulled money out of the reinsurance market and insurance investments. He said that we are now seeing insurance capital coming back into the marketplace. He also stated that rates are slowly coming down for reinsurance.

The Committee heard testimony from Scott Kibbe, Vice President, Southwest Region, at The American Property and Casualty Insurance Association (APCIA).

Mr. Kibbe stated that his members recognize that this is a difficult time for Texans as they struggle with rising costs, including insurance. In the property and casualty market, recent loss trends and rising costs have resulted in significantly higher losses than premiums collected. Between 2018 and 2022, Texas insurers paid $1.07 for every $1.00 in premiums collected. The increasing frequency and severity of natural disasters, population growth in catastrophe-prone areas, cumulative high inflation, elevated building costs, and legal system abuse are all converging to create challenges in the Texas marketplace and across the United States.

Mr. Kibbe stated that in the last five years trade services have risen 38.4% and the cost of goods have risen 37.8%. He listed several common items used in construction and listed how their price had risen in the past year. For example, the price of lumber has risen 16% ,plywood has risen 12.20%, ready-mix concrete has risen 7%, rebar has risen 6.9%, and structural steel has risen 7%.

Mr. Kibbe stated that the auto insurance market has also been hit by substantial cost pressures. Many costs associated with the auto insurance market have risen much faster than overall inflation, for example, in the last five years auto repair costs have increased by 21% and parts prices have increased by nearly 40%. Auto repair labor rates have risen between 6-10%, driven in large part by higher repair costs for today's increasingly more technologically sophisticated vehicles.

Mr. Kibbe stated that driving habits have also played a significant role in the past several years. He stated that since the pandemic, there have been more speeding incidents, red light running, and aggressive and distracted driving. The result is that countrywide. Auto insurers have sustained $1.12 in losses and expenses for every dollar of premium.

Mr. Kibbe stated that more frequent and severe natural disasters are a significant factor in the rising cost of insurance and stated that this is especially true in Texas. In 2023, there were sixteen separate events in Texas with losses over $1 billion each, according to the National Oceanic and Atmospheric Administration (NOAA). In 2024 there have already been several weather events that are likely to exceed the $1 billion mark.

In addition, the growth in Texas' population is driving up insured losses. According to the United States Census Bureau, our state added more than 9 million residents since 2000, which is more than any other state, and it shows no signs of slowing down. Much of the population growth is in areas that have traditionally been or are becoming catastrophe-prone. As more homes are being built in catastrophe prone areas, and these are increasingly expensive to repair and rebuild, the impact of the increased insurance costs is felt by consumers.

Mr. Kibbe stated that one other factor, although not typically in the purview of the insurance committee, is the prevalence of nuclear verdicts which are defined as those in favor of the plaintiff which exceed $10 million. A recent report from the Institute for Legal Reform (ILR), revealed that Texas ranks fourth in the nation in the number of nuclear verdicts. Inevitably, these costs are passed down to consumers and businesses in the form of higher insurance rates.

Mr. Kibbe stated that the good news for Texas is that our regulatory environment for insurance has not exacerbated the problems for consumers in ways that it has in other states. He listed several examples of legislation passed in Louisiana, which has been hit by severe hurricanes in recent years. In 2021 and 2022 Louisiana passed several bills into law which increased regulation of insurance providers. The effects of growing uncertainty amid deteriorating market conditions have resulted in at least 10 companies withdrawing entirely from Louisiana since 2020, and at least five more ceasing to write new policies, according to the Louisiana Department of Insurance staff in a report issued in May 2023. This year, the Louisiana legislature has recognized the problems that were created by these bills and have taken several steps to improve the regulatory environment.

Mr. Kibbe used California as another example. Like Texas, California must deal with many types of natural disasters. Wildfires have caused much of the damage in recent years and state leaders attempted to address those issues through a number of laws and rules. It is no secret that California is now experiencing an accessibility and affordability crisis. Facing constant regulation and barriers to being able to price their risk, several large carriers have left the state or reduced the coverage the offer. This has left many consumers struggling to find coverage in the nation's largest market, and has caused uncertainty for anyone wanting to invest in the state.

Mr. Kibbe stated that Texas has a better regulatory environment, and as a result, Texas has a more competitive market. There are 174 companies writing personal auto policies, 325 writing commercial auto policies, and 161 writing homeowners' multiple peril insurance in Texas. While some companies have paused renewals or taken other steps to meet the challenges they are facing, Texas has not had companies pull out and stop offering coverage, as has occurred in other states. Texas is likely to remain a challenging state in which to offer coverage as we grapple with extreme weather events and other factors, but we are confident our state can weather the storm with stabilized rates and continued accessibility. To do so, however, Texas must maintain the regulatory environment that has kept the state's insurance marketplace from falling into the crises that other states are experiencing. He concluded his testimony by stating that he hopes Texas will not take action, however well-intentioned, that can cause greater problems for carriers, businesses, and consumers in the future.

The Committee heard testimony from Jon Schnautz, Regional Vice President, Southwest Region, National Association of Mutual Insurance Companies (NAMIC).

Mr. Schnautz began his testimony by emphasizing the importance of preserving a competitive and functional insurance market in Texas by avoiding regulatory measures that could destabilize it, such as artificial price caps or unfunded mandates. Legislators were urged to focus on policies that reduce long-term losses while ensuring that premiums remain tied to risk and expected losses, as this alignment sustains market viability.

He said that Texas has faced significant challenges due to rising insurance costs, driven by an increase in catastrophic weather events, inflation in repair costs, and other external factors. These issues are not unique to Texas, but are part of broader national and global trends. Over the last five years, billion-dollar disasters have more than doubled, creating unprecedented stress on insurers. This reality underscores the need for risk-based pricing to ensure market sustainability.

Inflation has exacerbated these challenges, particularly in home and auto repair costs, which have far outpaced general Consumer Price Index inflation. Such external economic forces are beyond the Legislature's direct control, emphasizing the importance of addressing factors like building codes and land-use decisions to mitigate risks at the community level.

Mr. Schnautz recommended mitigation efforts were highlighted as a viable path forward. Programs that fund or incentivize resilient construction, like fortified roofing, can reduce claim costs and losses over time. Examples from other states, such as Alabama, demonstrate the success of funding mitigation efforts over mandates alone, which have shown limited effectiveness, as seen in Oklahoma. Legislators were cautioned against policies that mandate discounts without improving structural resilience, as these do not address underlying loss drivers.

Finally, Mr. Schnautz stressed the need to attract and retain insurance capital in Texas. Ensuring a predictable and fair regulatory environment is essential to encourage insurers to stay in the state, benefiting consumers by improving availability and affordability. The guiding principle for future legislation should be whether it encourages more capital to enter the Texas market and reduces losses effectively.

He concluded his testimony by stating that legislators should be advised to focus on fostering a business-friendly environment for insurers, investing in mitigation strategies to reduce losses, and resisting regulatory interventions that distort market dynamics, ensuring a stable and sustainable insurance landscape for Texas consumers.

The Committee heard testimony from Brian Powell, Catastrophe Risk Specialist at the National Association of Insurance Commissioners.

Mr. Powell stated that within the National Association of Insurance Commissioners (NAIC) exists the Center for Insurance Policy and Research (CIPR), which provides data and education to drive discussion and advance understanding of insurance issues among policymakers, insurance commissioners, other regulators, industry leaders, and academia.

In 2022, the CIPR established the Catastrophe Center of Excellence (COE). The COE is designed to provide regulators with technical expertise, tools, and information to regulate the insurance markets successfully. One tool that is available to agencies within the COE around mitigation is the Resilience HUB. Its function is to assist states with issues around resilience and natural catastrophe risks.

Mr. Powell stated that the NAIC has identified opportunities to address the increasing number and severity of weather events which impact state insurance markets. He said that more effective building codes offer stronger protection of life and property.

Mr. Powell spoke about the climate of the insurance market in Alabama prompting action to reduce catastrophe risk in the state. Between 1998-2001, nearly three-fourths of the catastrophe claims paid were for damage to homes. The value of claims paid for homes was about 66% of the total payout for claims. Between 1998-2011, the insured losses across Alabama totaled $8.4 billion. Return on net worth for the Alabama homeowners' insurance market averaged negative 7.9 %.

In 2011, the Alabama State Legislature, through ACT 2011-643, established the Strengthen Alabama Homes (SAH) program, designed to aid Alabama homeowners to improve their homes with updated building modifications, also know as wind retrofitting, which minimizes property loss due to hurricane or other catastrophic wind events.

The SAH program was created in response to the devastating impacts of Hurricanes Katrina (2005) and Ivan (2004). The Alabama Department of Insurance (ALDOI) oversees the program, which adopted the FORTIFIED™ standard developed by the Insurance Institute for Business Home & Safety (IBHS), which is an independent, nonprofit, scientific research and communications organization supported solely by property insurers and reinsurers. This standard focuses on a systems approach to protecting homes from storm damage. The program provides grants to homeowner for wind retrofitting of their homes. These grants can cover up to $10,000 of the retrofit costs. Funding for the program comes from the insurance industry in Alabama, not from the state's general budget. Since its inception, the program has awarded over $70 million in grants, helping retrofit roofs on nearly 70,000 homes. This program required no changes to existing building codes in the state of Alabama.

Mr. Powell stated that the FORTIFIED™ home program was created by the Insurance Institute for Business and Home Safety (IBHS). IBHS tests a variety of construction and retrofitting methods at its research facility in Richburg, South Carolina. The facility has a large wind tunnel which can fit the entirety of a two-story house for testing, and this facility runs simulations for rain, hail, wildfire, and wind speeds up to 130 miles per hour.

Licensed professionals certify homes at one of three fortified levels: FORTIFIED™ Roof, Silver, or Gold. The FORTIFIED™ Rood level focused on roof strength and resistance to wind. The Silver designation requires reinforcement of the rood, adding use of impact-resistant windows and doors. The Gold designations addresses the first two levels and further requires a "continuous load path," ensuring that buildings are adequately load-bearing and secured to the ground. Another set of FORTIFIED™ standard is used to protect commercial buildings and ensure continuity of operations despite hurricanes, high wind, and hail. This building and retrofitting process requires no changes to existing building codes set by states.

Mr. Powell discussed what makes a FORTIFIED™ roof more resistant to wind and hail damage. He said that instead of common smooth nails, FORTIFIED™ requires ring-shank nails, installed in an enhanced pattern, to help keep the roof deck attached to your home in high winds. Using ring-shank nails nearly doubles the strength of your roof against the forces of winds. The nails are spaced more closely together to further enhance the roof's strength. He said that they install a sealed roof deck, which involves sealing the gaps between the roof decking with a moisture barrier, called a continuous membrane, which prevents water from entering the home if the roof cover is damaged. The edges of the roof are reinforced to resist wind uplift and protect the roof's structure. Mr. Powell said that in hail-prone areas, homeowners are encouraged to opt for the Hail Supplement to their FORTIFIED™ designation. To

achieve this added level of protection, shingles must score “Good” or “Excellent” on IBHS Hail Impact Ratings. These outperform typical Class Four shingles when tested against realistic hailstones and will better protect homes from hail up to two inches in diameter. Class Four is the current highest level of impact-resistant shingles available to the public.

Mr. Powell talked about the economic impact of the SAH program. He stated that it has significantly reduced the number and severity of insurance claims related to wind damage. Homes retrofitted to meet the FORTIFIED™ standards are better protected against hurricanes and severe storms, leading to fewer claims and lower repair costs. This reduction in claims has helps to stabilize the insurance markets and reduces the financial burden on insurance companies. Homeowners who retrofit their homes to meet the FORTIFIED™ standards are eligible for substantial discounts on their wind insurance premiums. These discounts can range from 20% to 55%, depending on the level of FORTIFIED™ certification achieved. By reducing the frequency and severity of claims, the program helps to maintain more stable insurance pricing. This stability benefits both insurers and policyholders by preventing drastic premium increases. Mr. Powell stated that this program costs roughly $600,000 per year to administer.

Mr. Powell said that the SAH program has made residential insurance more accessible and affordable in high-risk areas. By mitigating the risk of wind damage, insurers are more willing to offer coverage in regions previously considered too risky. The increased availability ensures that more homeowners can obtain the necessary insurance to protect their properties.

Homes retrofitted to meet FORTIFIED™ standards often see an increase in property values. The program enhances community resilience by reducing the overall impact of severe weather events. This resilience helps communities recover more quickly and reduces the long-term impact of catastrophe events. The premium discounts and reduced risk of damage provide significant financial relief to homeowners, especially those who live in areas prone to hurricanes and storms.

Mr. Powell stated that the SAH program has led to a notable reduction in insurance claims related to wind damage. Homes retrofitted in this manner have seen a significant decrease in wind damage claims. According to the Alabama Department of Insurance, homes that have been retrofitted report up to a 40% reduction in claims compared to non-retrofitted homes. The severity of claims has also decreased. Retrofitted homes experience less damage during wind events, leading to lower repair costs. This reduction results in lower overall payouts by insurance companies. The IBHS reports that for every dollar spent on retrofitting, there is an estimated $4 to $6 savings in reduced claims and losses. This cost-benefit ratio highlights the financial efficiency of the SAH program.

The Committee heard testimony from Craig Sepich, Director of Strategy, Policy, and Governmental Affairs at the National Insurance Crime Bureau (NICB).

Mr. Sepich stated that NICB is a century-old nonprofit supported by approximately 1,200 property and casualty insurance companies. They work closely with our members and Texas law enforcement to help detect, prevent, and deter insurance crimes. While NICB provides value to our member companies, they also serve a significant public benefit by helping mitigate the billions of dollars in economic harm that insurance fraud causes to policyholders each year.

Mr. Sepich stated that insurance fraud is not a victimless crime. The FBI estimates that over a 10-year period, insurance fraud costs the average American family between $4,000 and $7,000 in increased premiums. Beyond the financial losses, innocent victims can also suffer physical harm from crimes like staged accidents, arson, and carjackings. Combating insurance fraud is an effective way to target one of the major cost drivers of insurance premiums, protecting consumers and ensuring the affordability of insurance in Texas.

In Texas there has been significant progress in tackling insurance crimes, such as the comprehensive law passed in 2023 to combat catalytic converter theft. Other states have since followed Texas' lead, and there has been a notable reduction in these thefts. However, there are other proven measures that can further strengthen the fight against insurance fraud, such as roofing contractor licensing, establishing civil penalties for fraud, closing solicitation loopholes, and providing additional funding to the TDI Fraud Unit.

Texas is one of the top states for severe weather, particularly tornadoes and hail, yet it does not require roofing contractors to maintain a professional license. This creates an environment where unscrupulous contractors can take advantage of consumers. Requiring licensing would ensure contractors are properly insured, streamline enforcement, and allow consumers to verify contractors' credentials. Alternatively, Texas could create a mandatory or voluntary registration list for roofing contractors. Additionally, many states offer consumers a narrow window to cancel roofing contracts if a portion of the claim is denied. Establishing civil penalties for insurance fraud is another critical step, as it would provide an avenue for penalties against low-level fraud committed by individuals with otherwise clean records.

Mr. Sepich stated that Texas must address loopholes in solicitation laws. Currently, chiropractors and attorneys are prohibited from directly soliciting accident victims, but this should be expanded to include "runners," middlemen who solicit on their behalf. Lastly, the TDI Fraud Unit plays a pivotal role in fighting fraud, but its funding is currently insufficient. By comparing Texas' budget for fraud prevention with other states, it's clear that increased funding leads to more investigations and higher success rates. For example, when North Carolina increased its fraud unit budget in 2017, the number of cases investigated nearly doubled. Providing the TDI Fraud Unit with additional resources will enable them to continue their essential work and better protect consumers.

Appraisal

Background

In the Texas insurance market, appraisal is a dispute resolution process used to address disagreements between policyholders and insurers regarding the amount of loss or value of damaged property under an insurance claim. The process is designed to provide a fair, efficient, and cost-effective alternative to litigation.

Several major insurers, including State Farm and GEICO, have moved to restrict or remove appraisal clauses from policies. Critics argue this could force consumers to either accept lower settlement offers or engage in costly and lengthy court battles.

In response to these restrictions, several consumer advocacy groups have advocated for making appraisal rights mandatory in both auto and residential insurance policies. Proposed legislation, such as HB 1437(88R) and SB 554(88R), sought to reinforce these rights but faced resistance over fee-shifting provisions and administrative costs.

The Committee heard testimony from David Bolduc, Public Counsel for The Office of Public Insurance Counsel (OPIC).

Mr. Bolduc stated that OPIC is charged in the insurance code with representing the interests of insurance consumers in the state, and among other things, and peering in matters involving rates, rules, and forms affecting property and casualty insurance.

Mr. Bolduc stated that one of OPIC's major concerns in recent years has been attempts to limit the insurance consumers long standing right to invoke appraisal in disputes regarding the cost of repairs or the amount of a total loss. It is the general rule and personal automobile and residential property insurance policies in Texas, was contained in the promo UCLA good policies, and is enshrined in the Texas windstorm insurance associations governing statutes. As Texas courts recognize, it is a less expensive, more efficient alternative to litigation, it requires no lawsuits, no pleadings, no subpoenas, no lawyers, and no hearings, and efficiently determines the correct amount of loss.

Mr. Bolduc stated that in recent years some insurers have submitted policy forms to the Texas Department of insurance that would have eliminated or unreasonably restricted Texans ability to invoke appraisal. These filings would remove an important and well-established consumer protection that saves the jujitsu judicial system time and resources and is often the consumer's only realistic option for challenging the amount the insurer offers to repair their property.

Mr. Bolduc stated that the main problem is an imbalance in bargaining positions between insurance consumers and insurers. Without appraisal, a consumer who is not satisfied with the insurers offer can either pay the difference out of pocket or try to litigate with the insurer. Litigation is expensive so unless there is a $5,000 or $10,000 difference between the insurers offer and what the consumer believes is reasonable, it's difficult to see how hiring a lawyer is economically feasible. Consumers should not be forced to wait for the conclusion of litigation to have a drivable vehicle or livable home.

Mr. Bolduc stated that with appraisal, on the other hand, the short version is that if they disagree, the insurer and consumer each hire an appraiser. If the appraisers agree on a value, the problem is solved. If they don't, the appraisers pick an umpire, who resolves the dispute.

Mr. Bolduc said that since 2021, OPIC has objected to filings from nine companies with appraisal provisions that would limit consumers right to appraisal. This may seem like a small number, but these companies are some of the largest insurers in Texas, potentially impacting millions of consumers.

Mr. Bolduc gave a brief history of recent events involving appraisal in Texas. Between 2014 and 2015, the Texas Department of insurance approved policy forms from a major insurer that eliminated the right to invoke appraisal for disputes over the amount of repair and auto claims. In 2021, a major insurer filed an amended policy forms to limit appraisal if auto claims. OPIC objected, and the filing was withdrawn. In 2022, the same insurer again filed forms to limit appraisal in auto claims, OPIC objected again, and the company again withdrew the filing. Later in 2022 the same insurer filed forms again to limit appraisal in auto claims. OPIC objected to the filing again. TDI found that the filing lacked supporting information and rejected the filing when the company involved did not supplement it's failing in a timely manner. Also in 2022 a major insurer filed forms to eliminate appraisal altogether on homeowners’ claims. OPIC objected and asked for information supporting the filing but did not get responses that OPIC felt were sufficient. TDI made multiple requests for more information. The insurer involved withdrew the filing

pending the legislature's review of a legislative consideration in TDI's biennial report that the legislature established a policy form for appraisal guidance. He also stated that late in 2022 another insurer filed forms providing appraisal in homeowners claims only if both consumer and insurer agreed to it. OPEC objected to the filing and the insurer withdrew it.

Mr. Bolduc stated that OPIC recommended that the Legislature amend the Texas insurance code to require personal auto and residential property insurers in Texas to preserve the insurance consumers' right to invoke appraisal in disputes regarding the cost to repair and the amount of total loss. He stated that TDI submitted a legislative consideration that the Legislature established policy form appraisal guidance. He stated that studies found that the average appraisal award on auto claims was 40% higher than the insurers' offers. He said that three bills regarding appraisal passed out of the house committee on insurance and passed the house by large margins. One of those bills, HB 4194 by Representative Perez, was amended in Senate business and Commerce Committee and passed out without objection to the Senate intent calendar but time ran out before it came up for a vote in the full Senate. Mr. Bolduc stated that since last session six insurers made filings restricting the right to appraisal. OPIC objected to these, resulting in the insurance insurers withdrawing the proposed appraisal limitations. Mr. Bolduc stated that in April, TDI issued a homeowners and auto appraisal experience data call with responses due on July 12th from the top 10 homeowners multi peril groups and the top 10 private passenger auto groups listed in TDI's 2023 market conditions annual report. He stated that this data call is a major step forward, especially given insurers reluctance to answer detailed questions in the filing process. He said that OPIC appreciated TDI's interest in getting the facts and said that he is hopeful that it may result in giving the legislature both the picture of the status of appraisal in Texas, and a good idea of what needs to be done as a result. Mr. Bolduc stated that he suspects it will show both the difference between consumers and insurers in their initial estimation of losses and the difference between insurer initial offerings and appraisal award amounts.

He anticipates companies will continue to pursue policy language that seeks to eliminate or severely limit appraisal. OPIC will continue to intervene and attempt to preserve this important alternative dispute resolution option on behalf of Texas insurance consumers.

Mr. Bolduc concluded by stating that appraisal is not without its challenges; however, unilaterally removing or limiting a valuable alternative dispute resolution option and transferring a new garden to policy folders is not the solution.

The Committee heard testimony from Ware Wendell, Executive Director of Texas Watch.

Mr. Wendell gave testimony about the history of appraisal in insurance policies and why consumers need protection in a marketplace where they are not able to negotiate or write the terms of the contract. He emphasized for the committee that state lawmakers are the primary policymakers when it comes to the business of insurance. He noted that the TDI highlighted appraisal reform in their last Biennial Report and the Office of Public Insurance Counsel made it their recommendation to the Legislature.

Mr. Wendell detailed support for three appraisal bills last session: HB 1437, HB 4194, and HB 597. The first two made the final Senate Intent calendar. He stated that Texas Watch's 2023 study of 1,200 claims files demonstrated appraisal made a significant difference for consumers who went through the process, helping them to recover an average of $5,300 more on repair claims and $3,800 on total loss

claims. He highlighted TDI's current data call on appraisal. Mr. Wendell closed his testimony by noting difficulties for homeowners with weather-related claims posed by the Texas Supreme Court's *Rodriguez v. Safeco* decision, which enables insurance carriers to avoid paying attorney's fees if they pay the appraisal award and interest later, emphasizing the need for deadlines. He stated auto consumers have the greatest need for balanced appraisal clauses since they have few practical rights when it comes to body damage claims.

The Committee heard testimony from Ches Bostwick, representing the Texas Association of Public Insurance Adjusters (TAPIA).

Mr. Bostwick began testimony by giving a background on the issue of appraisal he stated that 1943 New York standard fire policy was the foundation for property insurance contracts written all over the country, and still provides the framework for today's modern policies. It provides for an appraisal when there is a dispute over the amount of the loss. Each side picks an appraiser, and the two appraisers pick an umpire. The three of them work together to resolve the dispute with an award signed by at least two of them establishing the amount of loss. He stated that this process sounds simple, but it is becoming more difficult all the time.

Mr. Bostwick stated that appraisal was intended to be a fast, inexpensive way to resolve disputes over the amount of a loss. Until the early 2000s, when appraisal was rarely used in Texas. But, following a series of hurricanes and hailstorms, a cottage industry emerged. He stated that appraisal today is anything but fast and inexpensive. It is not uncommon for an appraisal to take a year or more to resolve. To make matters worse, the associated fees to the appraisers to hire an umpire is often range into the tens of thousands of dollars. As a result, some carriers are beginning to exclude the process from their policies, or to make it optional to themselves. In those cases, policy holders are left with no other option but to hire a lawyer. Most won't, and often end up settling their claim for less than they may be entitled to.

Mr. Bostwick stated that TAPIA believes that appraisal should be part of all insurance policies covering real and personal property in Texas. Rather than do away with it, they believe that it can be salvaged by adding some guard rails and time frames. In 2023, Representative Perez introduced HB 4194, which was a great start to get in control of the process, he stated. It provided for a simple, and fair procedure for selecting an umpire if the parties can't agree on one, and for reasonable time frames including some extensions to complete the appraisal. It clarified and protected the legal rights of both the insured and the insurer, making certain that neither party can use the procedure as a weapon to delay the claim settlement or legal process. Mr. Bostwick concluded his testimony by stating TAPIA’s wish to make certain that appraisal remains a viable and effective part of all property insurance sold in Texas.

Surplus Lines

Background

The surplus lines insurance market in Texas serves as a vital segment of the insurance industry, offering coverage for unique or high-risk situations that standard insurers (known as the admitted market) are unwilling or unable to cover. Unlike admitted carriers, surplus lines insurers operate outside the regulatory framework of the Texas Department of Insurance (TDI), meaning they are not subject to rate and form filing requirements. However, they are regulated to ensure financial stability and consumer protection.

Surplus lines carriers can tailor policies to meet specialized risks, such as large-scale commercial projects, high-value properties, or emerging risks like cyber-liability. While surplus lines insurers are not directly licensed in Texas, they must be approved to operate, and transactions are facilitated through licensed surplus lines brokers. Policies issued in this market are subject to a surplus lines tax, currently set at 4.85% in Texas, which contributes to state revenues.

This market is essential in addressing coverage gaps and supporting innovation within the insurance landscape, particularly as risks evolve and require specialized underwriting.

The Committee heard testimony from Greg Brandon, Executive Director at the Surplus Lines Stamping Office.

Mr. Brandon stated that the Stamping Office is a quasi-governmental organization created to assist the Texas Department of Insurance by monitoring and reporting on the surplus lines marketplace. The Stamping Office does not collect loss data. Surplus lines insurance is a type of specialty insurance that fills coverage and capacity gaps for buyers and companies who need the ability to customize coverage and transfer their unique risks to the insurance community. In Texas, surplus lines predominantly insures commercial insurance risks, and functions to either supplement the admitted market, or step in when the desired insurance coverage cannot be procured from that market. Surplus lines insurers typically have underwriters with specialized knowledge unique to the risks covered, and those risks are challenging to standardize, therefore, the insurer is not subject to the same regulations as licensed insurers in the admitted marketplace. Rate and form are not regulated in the surplus lines market. Excess and surplus lines insurers are not included in the Texas guarantee fund, but there are requirements providing consumer protection, including higher solvency requirements and financial evaluations by the Stamping Office. Insurers domiciled in Texas and those based in the United States, but outside of Texas, which are known as “foreign” insurers, mist maintain a minimum of 15 million dollars in capital and surplus. Insurers based outside of the United States, which are referred to as “alien” insurers, are required to maintain 45 million dollars additionally. These insurers must meet NAIC’s international insurers department plan, and they must have been already admitted to the quarterly listing of “alien” insurers.

Mr. Brandon stated that there are currently 395 insurers authorized to write surplus lines business in Texas. Of those, seventeen are domiciled in Texas, and 203 of those are “foreign” insurance companies, meaning US-based, but not in Texas. Of the 395 insurers, 80 are non-US, or “alien” insurance companies, and 95 are Lloyd’s syndicates.

Consumers are generally not allowed to work directly with an excess and surplus lines insurer to obtain a surplus lines insurance policy. The buyer must work though an agent licensed in the state of Texas. The agent has the responsibility to make a diligent effort to find coverage first in the admitted market before seeking coverage in the surplus lines market unless the buyer meets certain commercial purchasing or industrially insured exemption requirements. There are also specific commercial lines of coverage that are exempt from the diligent effort requirement, largely third-party liability products, a few types of bonds, and specialty properties like boilers, machinery, and other highly-protected commercial property.

Mr. Brandon then discussed market data relating to the surplus lines market. From 2019 through 2023 and excluding 2024 data the surplus lines market has seen total premium grow from $6.95 billion to $14.58 billion, an average annual growth rate of just over 19%. 2022 and 2023 were particularly significant, as the rate of premium growth was 27% and almost 26%, respectively. Policy count is another key metric reflecting overall market conditions, and in 2019 policy count was almost 687,000, and in 2023 it had grown to over 727,000 making for an annualized growth rate of about 1.5%. Mr. Brandon stated that this masked the data a bit as policy count actually declined by almost 2% in 2020, and again in 2021, but grew by 2% in 2022, and over 8% in 2023. The most substantial growth was in commercial liability and property policies, which both increased at an annualized rate of roughly 6%. Similar to the overall policy count, the most substantial growth occurred in 2023, where commercial

liability policy count grew almost 12%, and commercial property grew 11% over the year prior. The market predominantly insures commercial risks. Personal lines policies typically represent 3-6% of the total premium in the state.

Recommendations

The Committee on Insurance realizes that the state should avoid state-managed catastrophe funds, as they concentrate geographic risks and pose potential liabilities to taxpayers. Instead, the state should support private reinsurance markets to spread risk globally. Premiums must remain tied to actuarial risks and expected losses to ensure insurers' financial health and attract capital investment in Texas.

The Committee recommends increased transparency and accountability in the insurance market, which requires mandatory comprehensive reporting by insurers and reinsurers on loss ratios, rate calculations, and risk assessments. Regular independent audits of these entities will ensure compliance with regulatory standards and identify unfair practices. Transparency in these areas will enable policymakers to address inefficiencies and protect consumers effectively.

Texas should develop guidelines to streamline claims processing, reducing administrative overhead and ensuring timely reimbursements to policyholders. Encouraging innovation through technology adoption, such as predictive analytics for pricing and claims, can enhance risk assessment and operational efficiency. Additionally, expanding consumer education initiatives will help Texans better understand their insurance policies, coverage options, and premium-reducing strategies, such as bundling policies or improving home safety measures.

The Committee on Insurance recognizes that to attract and retain insurance capital, it is vital to avoid overregulation that might deter insurers from operating in Texas. Excessive rate caps or unfunded mandates could hinder market participation. Instead, the state could offer tax incentives or other financial benefits to encourage insurers to expand their presence, particularly in underserved areas.

The Committee on Insurance recommends supporting fair legal practices to reduce costs by addressing nuclear verdicts through legal reforms aimed at mitigating their impact on insurance expenses. Measures to combat frivolous lawsuits will also help stabilize premiums and prevent unnecessary cost increases for policyholders.

The Committee on Insurance recommends, in order to strengthen mitigation and risk reduction efforts, the creation of state-supported programs that assist homeowners in fortifying their properties against natural disasters. This could include grants or incentives for installing fortified roofs or using impact-resistant materials, modeled after successful programs in Alabama. Importantly, such a program would not impose charges on taxpayers and would not draw funding from the state's general fund.

The Committee on Insurance recommends the adoption of stronger protections for Texas consumers regarding the right of appraisal in property insurance claims. Appraisal is an important consumer tool that allows policyholders to seek an independent, fair assessment when there is a dispute over the value of a claim. Currently, insurers and policyholders often face challenges in resolving differences related to claim valuations, and an accessible appraisal process can be a vital resource in ensuring that consumers are not at a disadvantage.

Texas Windstorm Insurance Association Funding Mechanism

Review current funding mechanism for The Texas Windstorm Insurance Association (TWIA). Examine the role of reinsurance in relation to TWIA.

Background

The Texas Windstorm Insurance Association (TWIA) is a critical component of the state's insurance landscape, designed to provide windstorm and hail coverage to homeowners, renters, and businesses in coastal areas that are at high risk for hurricanes and other severe weather events. Established in 1971, TWIA serves as the “insurer of last resort” for individuals who are unable to obtain coverage through the private market, often due to the high risk of catastrophic losses in Texas' coastal regions. The association is especially vital in the aftermath of devastating hurricanes, such as Hurricane Harvey in 2017, which caused widespread damage along the Gulf Coast, underscoring the importance of a robust windstorm insurance mechanism in the state.

TWIA is primarily funded through premiums paid by policyholders in windstorm-prone areas, but it also relies on the Catastrophe Reserve Trust Fund (CRTF) to help cover large claims in the event of a major disaster. The CRTF was established as a reserve fund to provide TWIA with financial stability during catastrophic events, ensuring that it has the resources to pay claims even when it faces substantial losses. The CRTF is funded by a combination of premiums collected from policyholders, along with the earnings from the investments made by the fund.

However, the CRTF has a cap, and its resources may be insufficient in the face of multiple large-scale weather events occurring in quick succession. As it currently stands, the CRTF is not fully funded to cover the extreme financial demands of a series of catastrophic events. In the event of a single major hurricane or storm, the CRTF may be able to cover claims, but if multiple catastrophic events strike back-to-back, the fund could quickly be depleted. When this occurs, the TWIA must resort to other funding mechanisms, such as borrowing from the State Treasury or issuing bonds, to raise additional funds to pay claims. This can lead to increased financial pressure and, in some cases, assessments on policyholders and insurers across the state.

The reliance on the CRTF and subsequent borrowing or assessments raises significant concerns, especially in a year with multiple disasters. Texas is particularly vulnerable to back-to-back catastrophic weather events, as the state regularly faces hurricanes, tropical storms, and severe flooding during its storm season. If multiple major hurricanes or windstorms were to hit the Texas coast in close succession, it could overwhelm the CRTF and TWIA’s ability to pay claims in a timely manner. The funding mechanism is not designed to sustain such a heavy burden in quick succession, which could lead to delays in claim payments and potentially force the association to pass the costs onto policyholders in the form of assessments. These assessments are additional charges added to insurance premiums across the state, even for those not covered by TWIA, creating financial strain on all policyholders.

The potential for a funding shortfall raises concerns about the long-term viability of TWIA’s model, especially if Texas continues to experience more frequent and severe weather events due to climate change. The need to maintain and adequately fund the CRTF is critical to ensuring that TWIA can meet its obligations to policyholders. Without a sufficient reserve fund and robust financial mechanisms, the state could face a situation where a prolonged recovery period becomes even more difficult, both for individuals and for the state’s economy at large.

Testimony

The Committee heard testimony from David Durden, Executive Director for The Texas Windstorm Insurance Association.

Mr. Durden began his testimony by stating that the Texas Windstorm Insurance Association (TWIA) was established by the legislature in 1971 after Hurricane Celia landed along the Texas coast, near the Corpus Christi area. TWIA is a residual insurer, meaning that they provide coverage to property owners who are unable to obtain coverage in the voluntary market. Applicants for TWIA coverage must meet a few eligibility requirements to be insured by TWIA. TWIA charges premiums to their policyholders, and they use those premiums to pay policyholders claims and expenses of the association. TWIA has experienced growth in excess of 20% in 2023 through 2024. As of May 31st of this year, there exposure is slightly over 103 billion dollars. In years without a major hurricane, TWIA revenue from policy premiums is enough to pay routine and non hurricane claims. In years where their losses exceed their premium, and other revenue generated in the normal course of operations, TWIA pays losses using the catastrophe funding mechanism, as authorized by law.

Mr. Durden stated that the first thing they have are premiums which are paid by their policyholders. He stated that when those payments are not enough to pay losses, the next source of funds available is the catastrophe reserve trust fund (CRTF). The CRTF is similar to a savings account for the association. Each year TWIA deposits all net income and other policy surcharges into the CRTF, and that account is administered by the Texas Treasury Safekeeping Trust Company of the Comptroller of Public Accounts.

TWIA deposited $156 million of 2023 net income into the CRTF. Earlier this year, the fund's balance was $446 million. The CRTF was depleted in 2017 to pay Hurricane Harvey losses, and it has taken six years to build the CRTF to the current $446 million. When their losses exceed the amount in the CRTF, TWIA uses fund generated from the issuance of public securities. Public securities are effectively a means for TWIA to borrow funds from the financial market to pay losses. TWIA is authorized to issue three classes of public securities.

Class one public securities may be issued either before or after an event. They may be issued in a maximum amount of $500 million. They may be issued for a maximum term of 14 years, and they are repaid by premiums, and if necessary, additional surcharges on policyholders. He said that they have never had to impose a surcharge on their policyholders, but he believes that, if there were a major hurricane, it would likely result in policyholder surcharges to repay public securities issued.

Next are class two and class three public securities. He stated that they are similar in nature. They may only be issued after an event. They may be issued for a maximum amount of $250 million. They may be issued for a maximum of 10 years, and they are repaid from TWIA premiums, and surcharges, if necessary.

When TWIA's losses exceed the $500 million in the class one public securities, the TWIA is authorized to assess member companies up to $500 million. This is the next source of funding, and this assessment is termed the class one member assessment. Members have 30 days to pay an assessment. This action must have the concurrence and approval of the Texas Insurance Commissioner.

After the member assessment, if additional funds are needed to pay losses, TWIA alternates between those classes of public securities and member assessments. In total, the amount of public securities and member assessments provided for in statute totals $2 billion. One important note about the public securities is that the amount available to pay policyholders' claims will be less than the maximum amount of public securities actually issued or authorized by statute, because TWIA will be required to set aside at least some portion of that borrowed amount in debt service reserve accounts.

If losses incurred by TWIA policyholders exceed the $2 billion in public securities and member assessments, they TWIA's next source of funding is reinsurance. The TWIA board of directors is required by statute to determine how much reinsurance the association needs be protected for a 1 in 100 probable maximum loss, which means the amount of policyholder claims and related expenses that need to pay for damage from a storm that has a 1% chance of occurring. TWIA retains a catastrophe modeling firm that provides model projections on potential losses. The board then considers these models and determines each storm season's probable maximum loss.

TWIA then purchases reinsurance in the amount necessary to meet that probable maximum loss. Reinsurance, by far, is TWIA's single largest expense, and the cost has a significant impact on TWIA's rate adequacy, or rate need. For the 2024 storm season, the TWIA board determined that their 1 in 100 maximum probable loss would amount to $6.5 billion. This is a $2 billion increase over the previous year. To meet that need, TWIA secured $4.05 billion in reinsurance at a cost of $370 million.

In 2021, TWIA purchased $1.9 billion in reinsurance at a cost of $99.8 million. This number corresponds to 25.2% of the TWIA premium. In 2024, TWIA purchased $4.05 billion of reinsurance coverage at a cost of $370 million, which is 45.5% of the premium.

The reinsurance is the primary funding source which grows as TWIA grows. The CRTF has increased from 5% of TWIA's funding mechanism in 2022, and it is currently at 7% in 2024. Therefore, as TWIA's exposure to probable maximum loss increases, the only alternative is to purchase more reinsurance.

Mr. Durden stated that, as reinsurance is the last source of funds in their funding mechanism, if TWIA policyholders' claims exceed that amount of reinsurance, there currently is no prescribed funding mechanism for funding those losses.

Mr. Durden concluded testimony by stating that the possibility of storms which could theoretically happen within a close time of one another would be a major concern for TWIA.

The Committee heard testimony from Beaman Floyd, Legislative Counsel for Texas Coalition for Affordable Insurance Solutions (TCAIS).

Mr. Floyd offered testimony on how the private insurance market interacts with TWIA. Three of the TWIA board members are from the private insurance market, bringing their insurance expertise as individuals to that board. TWIA is obligated to run statutorily sound in principles, and he stated that he is proud of his group's participation, and that it is a net positive to have these members on the board.

Mr. Floyd explained the differences between surcharges and assessments. He stated that surcharges have a virtue in that it is not on the books as potential risk liability. It is ultimately paid out by the customer.

An assessment is a risk factor. His organization may or may not have to pay up the $1 billion on 30 days' notice. Because of this, they must build it into their rating structure. It is expresses as part of a rate, which means that it is subject to premium taxes and aging commissions. The virtue of an assessment is that it is immediately liquid, compared to a surcharge, which takes much longer to collect.

Mr. Floyd stated that all storms are unique. He stated that Hurricane Harvey was unusual in that it came ashore in the Rockport and Bolton area and devastated those communities. It then drifted and stopped, dumping massive amounts of rain on these areas, creating a different kind of loss: flooding. Hurricane Ike took a more conventional path initially, but then flooded the backside of Galveston Island.

Mr. Floyd said that when people talk about Hurricane Ike, they refer to it as a $2.4 billion storm. This amount was TWIA's portion. But it also did $2 billion of damage for FEMA, and it did about $8 billion of damage to the private marketplace in Texas.

Mr. Floyd discussed House Bill 1588, from the 88th regular session. Its aim was to fund the CRTF with a pre-event amount, and this money would be available immediately, up to a certain threshold. If the CRTF drops below a certain threshold, it would reinstitute a pre-event surcharge. Instead of having post-event funding that is related to debt, interest, and related expenses.

Mr. Floyd concluded his testimony by stating that it is of upmost importance for the Legislature to not constrain TWIA's ability to seek their actual liabilities. If this happens, TWIA will underperform at the very moment when it needs to be able to perform.

Recommendations

The Committee on Insurance recommends the establishment of a sustainable funding structure for TWIA that ensures its ability to meet obligations to policyholders while protecting the state's interests in coastal infrastructure. The Committee recommends that TWIA prioritize reinsurance over debt-based solutions, such as bonds, and eliminate reliance on debt as a primary method for funding losses. Reinsurance offers a more cost-effective and predictable approach to managing catastrophic risk, as it transfers financial responsibility to global reinsurers and avoids the compounding debt burdens associated with bonds. Bonds, while providing immediate liquidity, are costly to issue, create long-term financial obligations, and ultimately increase costs for policyholders through repayment assessments.

TWIA should implement proactive risk management strategies, such as incentives for property fortification and mitigation efforts, to lower overall exposure to windstorm losses. By reducing reliance on bonds, strengthening reinsurance programs, and encouraging resilience, TWIA can build a more stable and cost-efficient funding model that safeguards policyholders, supports economic stability in coastal areas, and protects the long-term interests of the state.

Consumer Protection and Transparency in the Texas Health Care Market

Study issues relating to consumer protection in the Texas health care market. Review current practices which prohibit competition, inhibit transparency, and negatively affect the Texas consumer. Study the current state of network adequacy in Texas. Review the efficacy of the prior authorization process in ensuring the appropriateness of medical treatments. Study how rebates play a role in the operations of pharmaceutical benefit managers (PBMs), and how these rebate arrangements impact drug pricing and access to medications.

House Bill 2090 (87R)

Background

House Bill 2090, passed during the 87th Texas Legislative Session in 2021, established the Texas All-Payor Claims Database (APCD), a centralized repository for healthcare claims data. The APCD collects and aggregates data from various sources, including insurance carriers, pharmacy benefit managers (PBMs), and other health plan administrators operating in the state. This data includes medical, pharmacy, and dental claims, which is then analyzed to provide insights into healthcare costs, utilization patterns, and outcomes. The database enables the creation of reports that help policymakers, researchers, and the public better understand the state's healthcare landscape, driving more informed decision-making.

To ensure patient confidentiality, HB 2090 mandates stringent privacy protections. These include the de-identification of patient information before it is added to the public portal, as well as restrictions on how data can be used for research purposes. Data containing identifiers is stored in separate, encrypted databases, preventing the identification of individuals, providers, or insurers. This approach ensures compliance with both federal and state privacy laws, such as HIPAA. Overall, the APCD is designed to enhance transparency in Texas's healthcare system, providing crucial data for improving healthcare policy and outcomes, while safeguarding patient privacy.

The Texas APCD has yet to receive the necessary funding for complete data collection and public access features. Insufficient resources have delayed the full implementation of certain phases, such as the development of a public access portal and the validation of payor submissions, which are critical to its operation. These funding gaps also affect the timely use of data for health policy decisions, potentially limiting the APCD's effectiveness in addressing Texas-specific health care challenges.

The Committee heard testimony from Lee Spangler, Executive Director of Texas All Payor Claims Database (APCD) at The University of Texas Health Science Center at Houston (UTHealth) School of Public Health.

Mr. Spangler stated that this initiative was established to enhance healthcare transparency and quality in Texas by analyzing claims data using detailed records of healthcare services billed by providers and processed by payers. The APCD includes data from medical, pharmacy, and dental claims submitted by a wide range of payers, with exclusions for certain federal programs like the Veterans' Affairs Office and the Indian Health Service. Since its inception, the database has accumulated information from January 2019 to the present, representing over 25 million Texans and encompassing more than 7 billion claim lines. This comprehensive dataset provides vital insights into healthcare usage, costs, and trends.

Mr. Spangler said that to maintain data integrity, the APCD implements a two-step process: first, verifying the format of submissions against standardized requirements, and second, conducting a thorough review to identify anomalies. The APCD also supports pilot research projects, such as studies examining the costs and care pathways for multiple sclerosis and sickle cell disease patients. These efforts not only improve the database, but also generate meaningful insights for healthcare planning.

Mr. Spangler said that while the Texas legislature established the APCD, it has not provided direct funding. The project currently operates through grants, research projects, and partnerships. They are seeking additional funding to expand capabilities, such as indexing the database for easier access and supporting innovative public health initiatives like tracking health trends through wastewater monitoring.

Mr. Spangler concluded his testimony by stating that these enhancements will make the APCD a critical tool for researchers, policymakers, and public health professionals in understanding and improving healthcare across Texas.

Pharmacy Benefit Manager Rebate System

Background

Pharmacy benefit managers (PBMs) emerged in the 1960s as claims processors intended to help insurers and employers manage prescription drug benefits more efficiently. Initially, their role was straightforward: process claims, negotiate limited discounts with pharmacies, and help payers provide convenient pharmacy access. Over time, however, PBMs evolved well beyond their original function, taking on powerful roles in determining which drugs patients could access through formularies, negotiating complex rebate arrangements with pharmaceutical manufacturers, and influencing prices across the entire supply chain.

Today's PBM system, however, is marked by a lack of transparency. While manufacturers pay large rebates to ensure their drugs secure favorable positions on PBM-managed formularies, these discounts are often neither visible nor guaranteed to reach the patient at the pharmacy counter. Instead, the savings can be retained by PBMs and insurers, or allocated in ways that do not necessarily reduce patients' out-of-pocket costs. This opaque arrangement can mean that patients, instead of benefiting from lower net drug costs, face inflated list prices and expensive copayments that do not reflect the true, negotiated cost of their medications.

This lack of transparency and accountability is further exacerbated by the vertical integration trend in the health care industry. Many PBMs are now owned by large insurance companies or are affiliated with specialty pharmacies and other entities throughout the supply chain. As a result, they may have incentives to favor particular drugs or pharmacy outlets that they own, rather than prioritizing affordability and quality for patients. By controlling every link in the chain from drug negotiation to final dispensing, these vertically integrated entities can steer patients toward treatments that maximize corporate profit rather than optimizing clinical outcomes or cost savings for the individual.

Because PBMs often design formularies and utilization management programs to encourage the use of high-rebate, high-cost drugs over more affordable or equally effective alternatives, patients may receive less-than-optimal treatments. In some cases, therapies that could be clinically advantageous but offer lower rebates may be excluded, delaying or complicating patient care. The net effect is a system where commercial interests may overshadow patient needs, and where the supposed cost-saving measures that PBMs once promised are neither clearly evident nor reliably passed through to the consumer.

Testimony

The Committee heard testimony from Antonio Ciaccia, President of 3 Axis Advisors.

Mr. Ciaccia stated that his goal was to help shed light on the dynamics of the pharmaceutical rebate system, how it distorts pricing, and what reforms could ensure that these discounts directly benefit patients at the pharmacy counter.

His remarks focused primarily on how our current system of rebates and discounts has evolved, why it has produced persistently high list prices, and how patients, especially those who are the sickest and most vulnerable, are often forced to pay disproportionately high costs for their medications.

Mr. Ciaccia stated that we continue to see annual brand-name list prices grow at significant rates. Prior to 2016, we observed average growth of around 10% per year. Although this moderated somewhat post-2016, with weighted average list price increases around 5%, it remains clear that prices have not stabilized at levels beneficial to consumers. In fact, we also witness ever-increasing launch prices for new brand-name medications, meaning products enter the market at higher price points than we would have seen even a decade ago.

He stated that one might expect that when brands compete with one another, prices would come down as they do in more traditional, competitive markets. Unfortunately, that logic does not hold in the prescription drug supply chain. Instead of seeing price reductions, competition between brand drugs often leads to rising list prices. Even when a “competitive” dynamic exists, it fails to lower prices as it should. For genuinely innovative, patent-protected drugs with little competition, prices go up steadily regardless, further straining the budgets of employers, government programs, and most importantly, patients.

Mr. Ciaccia stated that to understand why this environment is so distorted, we must look beneath the surface at the complex network of rebates. The United States has fostered a system where competition revolves not around lower list prices, but around who can offer the biggest hidden discounts. This process originated with the federal government’s creation of the Medicaid Drug Rebate Program in the early 1990s. Manufacturers were required to pay substantial rebates, initially a mandatory 23% off the list price of a medicine, and over time, they started to build out what would be called “escalators,” meaning they would incur penalties based on price increases relative to rates of inflation. He stated that, like any business that can set its own prices in the marketplace, when you institute a tax on that business, do not be surprised when that tax is priced into what they are selling.

Drug companies back in the 1990s, when they instituted the Medicaid Drug Rebate Program, reasoned that Medicaid was not that large, and that paying this “tax” would at least ensure that the poorest beneficiaries in states had access to medications they otherwise could not afford. Although that seemed somewhat reasonable at the time, Medicaid grew, and with it grew the complexity of pricing. The Medicaid Drug Rebate Program introduced a best price requirement, meaning if a manufacturer offered its best discount to a local health system, it had to extend that same discount to Medicaid. This extrapolation discouraged manufacturers from offering deep discounts to certain entities, since doing so would trigger mandatory discounts for Medicaid. Health systems and clinics that once enjoyed the best prices soon found themselves losing access to those deals. They lobbied the federal government for the

340B program, which mandated that manufacturers extend their Medicaid-level discounts to a broader group of covered entities, including large health systems, children's hospitals, and Federally Qualified Health Centers.

Mr. Ciaccia said that what began as a small part of a manufacturer's book of business, offering steep discounts to a relatively small population, evolved into a major driver of pricing decisions due to Medicaid expansion and the rapid growth of the 340B program. The government's approach effectively created an addiction to rebates. Rather than focusing on truly lowering prices, our policies pushed the industry toward a model where high list prices were offset by back-end discounts and rebates. Thus, while you might believe drug companies set prices too high, it is critical to understand that these list prices are inherently inflated compared to what they might be in a more open and transparent market.

As government programs set the tone, other payers, including employers and private plans, followed suit. They did not want to pay inflated list prices either, so they began hiring negotiators and intermediaries. Throughout the late 1990s and beyond, we granted health insurers, PBMs, and Group Purchasing Organization (GPO) exemptions to federal anti-kickback laws, enabling them to secure rebates in exchange for preferential formulary placement. The commercial sector embraced the strategy of securing discounts off high list prices, further reducing any motivation for manufacturers to lower those list prices in the first place. Now everyone wanted bigger rebates, perpetuating a cycle in which list prices rose while the net prices, after rebates, became more complex and opaque.

Mr. Ciaccia stated that the net result is that our pricing "autopilot" pushes prices ever higher as government programs and private entities demand more rebates and discounts. The key question becomes, where do these rebate dollars come from? Ultimately, they originate with the patient. Unlike purchasing an appliance, where a mail-in rebate goes directly back to the purchaser, in the drug world patients pay an inflated list price at the pharmacy counter but rarely see any of the negotiated discounts that take place behind the scenes. Even though net prices may be lower, the patient still faces the full burden of that high list price when they pay out of pocket.

He stated that a striking example is insulin. The list price for a vial can be as high as $400, while the net cost after rebates might be closer to $35. However, if a patient is in a high-deductible health plan, they often pay the full $400 up front. The difference does not revert to the patient, but instead may be retained by a PBM, used by an insurer to keep premiums stable, or captured by other intermediaries. This arrangement shifts costs onto individuals who need medications the most, effectively taxing their illness to provide financial benefits elsewhere in the system.

Mr. Ciaccia said that some of these funds may support beneficial programs or help keep premiums stable, but he emphasized that we cannot ignore the inherent unfairness of making seriously ill patients subsidize others. This distortion is further compounded by the lack of transparency. Employers, state agencies, and auditors struggle to understand these flows of money. The complexity and opacity of the system create opportunities for intermediaries to capture funds that might otherwise benefit patients or payers directly.

He said that fortunately, states can intervene. Some have already begun requiring that a portion or even all rebates be passed directly to patients at the point of sale. Indiana's "share-the-savings" model and West Virginia's policy mandating 100% pass-through to patients are concrete examples of how incentives can be realigned. While concerns arise that passing rebates to patients may increase

premiums, we must confront the current injustice: our system maintains lower premiums for the general population at the expense of the sickest patients.

By adjusting these incentives, we can return fairness, promote genuine competition, and restore transparency. Patients who need life-sustaining drugs would pay something closer to the true net cost rather than an inflated list price. This shift could also reduce complexity by removing some of the layers of negotiation that currently fuel hidden profit-taking.

Mr. Ciaccia stated that our rebate system has evolved over decades due to policies and programs that, though well-intentioned, have distorted the marketplace and punished the sick. The Legislature now has an opportunity to enact reforms that mandate the direct pass-through of rebates to patients, ensuring that those who need medication most no longer bear the cost of hidden subsidies. Such reforms can help create a more equitable, competitive, and transparent prescription drug marketplace for all Texans.

House Bill 1763 (87R) and House Bill 1919 (87R)

House Bill 1763, passed during the 87th Texas Legislative Session in 2021, introduced reforms to enhance transparency and equity in Pharmacy Benefit Manager (PBM) operations. It prohibited PBMs from reimbursing their affiliated pharmacies at higher rates than independent ones for identical services, ensuring fairness in payment practices. The law also mandated that PBMs provide pharmacists and pharmacies with clear and accessible contract terms and fee schedules, fostering greater transparency. HB 1763 protected patients' access to medication by preventing PBMs from restricting pharmacies from delivering prescription drugs to patients under specific conditions.

House Bill 1919 addressed anti-competitive practices by limiting PBMs' ability to steer patients toward specific affiliated pharmacies. This measure safeguarded patient choice and ensured independent pharmacies could compete on equal terms with chain or PBM-affiliated pharmacies.

Testimony

The Committee heard testimony from Debbie Garza, Chief Executive Officer at the Texas Pharmacy Association.

Ms. Garza began testimony by thanking the committee and the entire Legislature for passing two landmark PBM reform bills during the 87th Legislative Session: HB 1763, authored by Chairman Oliverson and House Bill 1919, authored by Representative Cody Harris. She said that they were two of the most significant pieces of pro-patient and pro-pharmacy legislation to become law in Texas.

HB 1763 centered on the contractual relationships between pharmacies and PBMs. The law prohibits PBMs from clawing back reimbursements after a claim is adjudicated except in certain situations such as audits. This was a major issue at the time with Medicare prescription drug plans, and she said they strongly supported including this provision to ensure this practice did not spread to commercial PBM plans. The law prevents PBMs from requiring accreditations or certifications beyond what is required under state or federal law, which are practices PBMs use to limit the pharmacies that can fill a prescription medication. The law also prohibits contractual provisions that would restrict the ability of a pharmacy to mail or deliver a medication if requested by a patient. Finally, the law prohibits PBMs from reimbursing their own affiliated pharmacies more than it reimburses non-affiliated pharmacies for dispensing the same medication.

HB 1919 dealt with the ability of PBMs to steer patients to affiliated pharmacies they themselves own. It prohibits a PBM from steering a patient to use an affiliated pharmacy, either by requiring them to use that pharmacy to receive the maximum benefit, such as a lower co-pay, or through patient-specific messaging. The law also includes provisions prohibiting transferring patient- or prescriber-specific prescription information for commercial purposes.

She stated that these were incredibly good bills for pharmacists and the patients they serve, and that they are very grateful for the Legislature's overwhelming support in enacting these measures. She then mentioned a few areas where pharmacies are experiencing challenges with regard to their contractual relationships with PBMs, and overall PBM business practices.

Ms. Garza said the biggest challenge pharmacies continue to face are low reimbursements that pay pharmacies below the cost to acquire some drugs. This is increasingly common for many newer brand-name medications. The laws referenced above did not address reimbursement except to prohibit PBMs from paying their affiliated pharmacies more than non-affiliated providers. In order to file a valid complaint with the Texas Department of Insurance regarding a violation of that provision, a pharmacy would have to know what the PBM-affiliated pharmacy is reimbursed for dispensing the same medication, which is generally something that would never have been made known to a pharmacy. She said that they are aware of some instances where a patient's benefit portal has shown that using an affiliated pharmacy would result in higher overall payment to a pharmacy coupled with a lower co-payment, which would be a violation of two provisions – the prohibition on PBMs paying an affiliated pharmacy more than a non-affiliated pharmacy, and offering a financial inducement to a patient to use an affiliated pharmacy. In this case, the pharmacy did work with the patient to file a complaint with TDI.

The big three PBMs control nearly 80% of the prescription drug marketplace and are vertically integrated companies that have their own pharmacies and their own insurance companies amongst other entities. A recent study of more than 9 million commercial prescription drug claims in Washington state found widespread instances of PBM overpayments to their affiliated mail order and specialty pharmacies compared to traditional retail pharmacies. The study actually used the Texas Medicaid fee-for-service pricing as a benchmark for claims for which a National Average Drug Acquisition Cost (NADAC) price did not exist, and found that PBMs paid their own affiliated pharmacies around 20 times more margin per brand name prescription and 1,000 times more margin for generic prescriptions for a subset of drugs with limited pricing information that are routinely steered by the PBMs to their affiliated pharmacies. This study shows that without regulatory oversight and consumer and plan sponsor protections, PBMs will engage in rampant self-dealing that drives up the overall costs of prescription drugs.

Pharmacies are also experiencing below-cost reimbursements routinely when claims are adjudicated using prescription discount cards. Since the passage of HB 1763 and HB 1919, several PBMs have begun automatically processing claims using a prescription drug discount card. On its face, this might seem like a good program for patients, but there are several concerns with this practice. First, PBMs are generally selling access to their pharmacy networks to third-party discount programs without pharmacies' permission or consent. Second, these types of claims sometimes auto-adjudicate at a higher out-of-pocket cost to the patient than what would be required if the PBM covered the claim. Finally, adjudicating a claim via a discount card absolves the PBM from having to adhere to several provisions of the Texas Insurance Code enacted to protect patients and pharmacies, such as a prohibition on charging a fee in association with processing a claim and prohibitions on post-adjudication recoupment or clawbacks. These PBM-steered discount card claims regularly charge the pharmacy as much as $6.50 to $10 per claim, resulting in even lower net reimbursements than if the PBM paid the claim as set forth in a contract. These charges can be called various names, either at the time of processing or after weeks or months have passed, but in any circumstance would be against the Texas Insurance Code if it were adjudicated by a PBM or health plan directly.

Ms. Garza stated that many of these concerns related to below-cost reimbursement could be addressed via the following common-sense changes to the current laws concerning PBMs.

She recommended that the Legislature should require that all PBM contracts give pharmacies the right to refuse to fill a prescription at a loss. She stated that no business can operate if it is forced to sell its products at a lower rate than it can even acquire or purchase those products, and pharmacy is no exception.

She said that a PBM should obtain pharmacies' consent if it intends to sell access to a particular pharmacy network to a third party, such as a prescription discount program. If a pharmacy joins one network, a PBM should not be able to lease that network to other entities without the pharmacy's agreement or through indirect contracting.

She recommended that clarification is needed so that if a PBM facilitates the adjudication of a claim through a third-party entity, such as a prescription discount program, all laws that would have governed the PBM had it adjudicated the claim directly still apply. This would close a giant loophole that exists

under current law that allows flagrant violations of provisions such as prohibitions on adjudication fees and post-adjudication recoupment.

Ms. Garza stated that the challenge pharmacies face is in determining whether the laws discussed before are applicable to a particular patient or claim. She stated that there is a pending opinion request to the Attorney General of Texas asking him to clarify whether House Bill 1763 and House Bill 1919 apply more broadly to PBM practices, including those on behalf of ERISA self-funded plans and their patients. Ms. Garza believes that they do, and looks forward to General Paxton's commentary on the topic. That should provide some clarity to the situation, but there are still challenges that that can be addressed through some minor changes to current law.

Ms. Garza stated that it is impossible to know whether a patient or specific claim is subject to TDI regulation and enforcement based upon the contract, name, or any identifying number associated with the patient's member ID, group, BIN (bank identification number), or PCN (processor control number) numbers. A patient's prescription drug benefit card does have to include the words or initials "TDI" (Texas Department of Insurance) or "DOI" (Department of Insurance) on the card, but as a matter of practice, most pharmacies rely upon patient lookup portals to determine the current patient benefits. That means most patients never even show a pharmacy their prescription drug ID card, much less a health insurance card. It is all accessed via an online benefits portal that does not indicate whether a patient is subject to TDI regulation or not. Additionally, a PBM contract might contain a provision inconsistent with Texas law, but a pharmacy cannot usually determine from the contract whether or not the networks it references are subject to Texas commercial PBM regulation by TDI. Without knowing whether a patient or claim is subject to TDI regulation, a pharmacy cannot file a valid complaint with TDI that can ultimately be investigated properly.

She stated that her group is aware of dozens of complaints that have been lodged with TDI regarding patients that are allowed to fill an initial prescription with their local pharmacy, but any refills of those medications may only be filled by a mail order pharmacy owned by the PBM. This is a clear violation of both the spirit and letter of the law in both HB 1763 regarding mailing prescriptions and HB 1919 regarding steering to an affiliated pharmacy. TPA has reviewed dozens of complaints that have been submitted to TDI regarding this practice via open record requests submitted to the agency. She stated that she does want to applaud TDI for seeking to enforce Texas law with regard to this particular practice. However, it appears that at least one PBM has sought to achieve minimal compliance with this provision by simply adding a one specific pharmacy chain to the network at which patients may receive a refill request. This particular chain has less than 50 locations primarily in densely populated metro areas, meaning that the only realistic option for many Texas patients would be to receive refills through the PBM-owned mail order pharmacy. She believes this arrangement clearly subverts the Legislature's intention when it joined several other states in passing anti-steering laws, and we intend to work with lawmakers next session on strengthening these existing provisions to ensure competition throughout the prescription drug supply chain.

HB 711 (88R)

Background

HB 711(88R) addresses certain practices in health care provider network contracts. The bill prohibits the inclusion of restrictive clauses in contracts between healthcare providers and general contracting entities, such as anti-steering, anti-tiering, gag, and most favored nation clauses. These clauses previously hindered transparency and fair competition by restricting providers' ability to disclose pricing information or steer patients to the most suitable options. Under HB 711, any contract that includes these provisions is considered unenforceable, promoting more transparent and patient-centered care.

The bill also establishes that health benefit plans must operate in the best interest of enrollees when implementing tiered networks or encouraging specific provider use, emphasizing fiduciary responsibility. By banning these clauses, HB 711 aims to increase transparency, improve patient choice, and reduce unnecessary limitations on healthcare options. This is crucial for ensuring that providers can negotiate contracts that reflect fair practices and that patients can make informed decisions regarding their healthcare providers. HB 711 was a response to growing concerns about healthcare costs and the lack of transparency in the provider selection process, particularly for patients navigating complex insurance systems.

Testimony

The Committee heard testimony from Charles Miller, Senior Policy Advisor at Texas 2036.

Mr. Miller began by stating that healthy markets are informed, competitive, and engaged. A market that is informed needs to have information on price and quality. There has been a lot of work by the state recently and the federal government to increase price transparency. He stated that Texas 2036 has been tracking compliance with hospital price transparency requirements. Currently 81% of hospitals in Texas are now receiving their highest grade. This is a substantial increase from when they started several years ago when compliance was around 33%. Mr. Miller's stated that the question is what do they do with that information now? He stated that the next steps to in achieving a healthy marketplace is for them to be competitive. Texans need to have choices, and they need a market that is engaged, which means that the right incentives are in place. Mr. Miller stated that there is a wide extent of price variation. That means that for the same service in the same area, prices can vary by a factor of up to 10 to 1. He stated that a surgery may cost $6700, or it might cost $46,000. Once consumers have access to what those prices are, the consumer is incentivized to go with the provider who is providing the best value.

Mr. Miller said that smart employers and insurers will want to design benefit plans that include incentives for their patients or enrollees to get high-quality, low-cost care and two of the most common methods for doing this are known as steering and tiering. Steering would be offering incentives for your patient to go to a high-quality care provider. A common example is if one knows that there is a low-cost, high-quality hospital for childbirth in the area, a benefit plan provider could offer patients free diapers for a year to go there. That is an incentive for them to choose a particular provider and steer those patients there.

There are other strategies known as tiering. Benefit plan providers can offer tiered networks so that providers who offer the best combination of value are in the most preferred tier, and providers who offer a lesser combination of value are in a less preferred tier.

Mr. Miller stated that last session the legislature passed a groundbreaking law, HB 711, which was designed to enable these strategies to operate more effectively. He stated that steering and tiering are not without their risks. One of the risks that consumers face in a steering and tiering strategy is the risk of self-dealing, and this can occur if an insurer has a wholly-owned or controlled provider group, or if a health system, like a hospital system, actually runs a health benefit plan, there is the risk that they would want to steer or send patients to their wholly-owned or affiliated group, even if that's not necessarily in the best interest of the patient. What HB 711 included was a protection which stated that when a health benefit plan is going to utilize one of these strategies, it has a fiduciary duty, which is the highest duty that the law can impose, to do so only in the best interest of the patient or policyholder. He stated that this is a strong protection, but it is also a flexible against the risk of potential self-dealing. He stated that this is a strategy that could be applied in a number of different ways, which allows for the beneficial parts of steering and tiering to take advantage of the price variation that we see, while also protecting against the risk of the negative aspects.

In HB 711, this duty only applies to health benefit plans. It does not apply to pharmacy benefit managers. He suggested that the legislature might consider on how to apply the concepts in HB 711 to address inappropriate steering or tiering that is not in the patient's best interest. Mr. Miller discussed

the implementation of HB 711's fiduciary duty standard. Mr. Miller stated that while HB 711 did protect prohibit anti-competitive contracting terms that would have prevented employers' insurers from doing this, it did not directly address other potential state law barriers to our state regulated insurers from doing the same. He stated that the fiduciary duty standard is a good protection for Texans.

Mr. Miller said that there is a provision code in chapter 1460 of the Texas Insurance Code related to ranking physicians. This is a provision of the insurance code that basically says if an insurance plan is going to rank physicians in any way, it has to go through a set of procedures to do so. Mr. Miller stated that these procedures are outdated and overly burdensome. For example, if an insurer is going to use quality assessments or quality rankings, they are directed to use them from a nationally accredited institution. The two that are listed in statute and regulations don't even exist. This shows that this statutory provision may be in need of an update. He stated that there needs to be different ways of modifying this to make sure that insurance insurers are able to provide their patients with relevant quality information of providers, but again, imposing that fiduciary duty to make certain that that when they do it, they are doing it in the best interest of patients.

Prescription Drug Price Disclosure Program (PDPDP)

Background

House Bill 2536, passed by the 86th Texas Legislature, aimed to increase transparency in prescription drug pricing. The bill requires drug manufacturers, pharmacy benefit managers (PBMs), and health plans to report specific information about drug costs and pricing to the Texas Department of Insurance (TDI). It mandates the disclosure of information such as wholesale acquisition costs, price increases, and rebates, enabling TDI to compile and publish an annual report on drug pricing trends.

House Bill 1033, passed during the 87th Texas Legislature, strengthened transparency in prescription drug pricing. The legislation required health benefit plan issuers to provide consumers with detailed information about the costs of prescription drugs, including the availability of lower-cost alternatives. By mandating these disclosures, the bill aimed to help patients make more informed decisions about their medications and reduce out-of-pocket costs.

HB 1033 also required insurers to include drug pricing information in their online tools, enabling patients to compare prices and identify cost-saving opportunities. This initiative sought to enhance accountability in the pharmaceutical supply chain and empower Texans with greater access to critical information about their health care expenses.

Together, these two bills created a comprehensive Prescription Drug Price Disclosure Program (PDPDP), enhancing accountability across the pharmaceutical supply chain and equipping Texans with the information needed to navigate prescription drug costs effectively.

Testimony

The Committee heard testimony from Emily Brizzolara Dove, Policy Advisor at Texas 2036.

Ms. Dove began her testimony stating that she wished to speak on the Prescription Drug Price Disclosure Program (PDPDP), which was created by the legislature in 2019 to bring a level of price transparency to the pharmaceutical industry. The PDPDP requires that pharmaceutical companies submit information on drug costs, patents, and the reasoning for high price increases to the Department of State Health Services in two separate reports. While the program has produced some interesting insights into the scope of rising prices, the requirements of the program could be streamlined in compliance with the more qualitative requirements of statue. Ms. Dove stated that currently compliance with these requirements is low. She stated that this program lives in chapter 41 of the Health and Safety Code, and it requires a submission of two reports, the wholesale acquisition cost report, which is submitted by all drug manufacturers for all drugs sold in the state, and the price increase report, which applies only to drugs which cost more than $100 for a 30 day supply, and which have increased in price at least 15% in one year, or 40% in the preceding three years combined. When a high-cost drug triggers the reporting requirement, manufacturers have to submit information to these two separate reports and the Wholesale Acquisition Cost (WAC) report, the manufacturer must include company level research and development costs in the name of any drug that lost patent exclusivity in the preceding three years. For those same drugs, the manufacturer must submit a separate price increase report that includes a statement on the factors causing those increases. This leads to an unnecessary bifurcation of information that increases complexity and decreases the usefulness of the information that is submitted. The other issue, aside from clarity within the program, is compliance with the program which she stated is spotty at best. Manufacturers do submit the wholesale acquisition costs for thousands of drugs every year, but they generally do not provide much else. One of the requirements of the WAC report, is that manufacturers state their research and development costs for their more expensive products. This is not on the drug specific level, but more on a broader level. In the most recent report there were 213 drugs subject to reporting. 170 drugs were listed and no comment was given on research and development costs. Thirty five provided some sort of form comment. Ms. Dove stated that many of these reports offer a vague rationale for increasing costs. She stated that only eight reports actually had any numbers in the report. Statute also requires that the information submitted to any program be on par with the information submitted in certain federal filings, like the SEC 10K filing. She stated that those filings are very robust and usually they are approximately 150 pages long. The state program is not receiving anything as comprehensive as that. She stated that there is valuable information out there already that the manufacturers are submitting to the federal government that could be used to improve our state program. When manufacturers are penalized for noncompliance with the statute, they are being penalized for administrative reasons. They either get penalized for not submitting one of the reports at all, or for failing to submit the fee for submitting the report period to date. No penalties have been assessed for noncompliance with the more substantive elements of the statute. She stated that there are a few things that could be implemented to improve the program overall. One idea would be to merge the two reports. Another could be to increase penalties for noncompliance. Presently DHSH has the authority to penalize the manufacturer up to $1000 a day for noncompliance. She stated that currently they do not do this. Right now there are 18 active violations, and those are usually around $200, and the process usually takes approximately eight months of back and forth for that penalty to be assessed.

House Bill 2002(88R)

Background

House Bill 2002 addresses the way health insurers credit out-of-pocket payments toward a policyholder's deductible or annual out-of-pocket maximum. The bill mandates that when an insured individual pays a healthcare provider directly for medically necessary services or supplies, the insurer must credit that payment toward the insured's deductible or annual out-of-pocket cap. This applies as long as the amount paid is less than or equal to the average discounted rate for the service under the insured's preferred provider network. Essentially, the bill ensures that patients who pay directly for care can have their payments recognized by their insurance provider, helping them to meet their cost-sharing obligations.

HB 2002 seeks to make health insurance coverage more flexible for patients, especially those who prefer to pay out-of-pocket to avoid insurance bureaucracy or to get better pricing outside of network arrangements. By ensuring that these direct payments are credited to the insured's deductible or out-of-pocket maximum, the law effectively makes such payments more meaningful and helps patients reach their cost-sharing thresholds more quickly. This is particularly important for individuals who face high-deductible health plans (HDHPs) and would benefit from having their direct payments factored into the total costs required to meet their deductibles.

HB 2002 also places requirements on insurers to clearly document and report how these direct payments are applied. Insurers are now required to provide clear and accessible information to policyholders regarding how these payments are credited. This includes making such records easily accessible online through the insurer's website or app, ensuring transparency for consumers. The law also aims to simplify the process for patients and healthcare providers by establishing consistent rules for how insurers manage direct payments.

HB 2002 represents a step toward greater financial flexibility and transparency in healthcare billing, particularly benefiting consumers who wish to manage their healthcare costs outside the traditional insurance pathways.

Testimony

The Committee heard testimony from Tanner Aliff, Senior Research Fellow, Paragon Health Institute.

Mr. Aliff began his testimony by stating that Texas has made several notable strides in addressing the opaqueness within out health care system but emphasized that there is still much more to be done. Texans face astronomical cost of health care prices, care navigation troubles, medical debts, putting off essential care due to fear of an unexpected cost, and an inability to afford not just their medical bills, but their cost-sharing within their own insurance policies.

Mr. Aliff stated that Kaiser Family Foundation Texas reported that the average employer-sponsored insurance premium cost around $7,000 for individuals and $23,968 for family coverage. These average premiums each increased 7% in 2023 and 22% since 2018 with not much sign of slowing down. More broadly speaking, 31% of employers, large and small, have been stuck with offering their employees health plans with deductibles that exceed $2,000, which is problematic considering that there are reports showing that 57% of Americans don't have $1,000 in their savings account. He also mentioned that Texas has 4.9 million uninsured who are still not adequately able to navigate the cash-priced market and healthcare. He stated that 28% of Texans do not have a designated primary care physician, and 68% are put off essential care for fear of costs. He said that six out of ten Texans have $500 or more in medical debt.

He said that skyrocketing premiums and bankrupting medical debts are the consequence of patients being unable to exert their agency, their foot traffic, and their choice of care over providers and insurers. If Texans want to see the healthcare prices drop and premiums stabilize, our state needs patient to be able to reliably get more information, interact with and compare that information, and, more importantly, become incentivized to interact with cost-concerned healthcare professionals and developing price transparency tools.

He said that Texas is on the precipice of a new wave of transparency reform that can further incentivize the organic creation of comparison services that will place agency back in the hands of Texas patients. He said that he thinks of price transparency in three waves. The first wave with President Trump's executive order turned Centers for Medicare and Medicaid Services (CMS) rules saying that hospitals must share their machine-readable files as well as disclose their discounted cash prices on their websites. This served as a catalyst for many other states to reinforce and codify their like-state level versions of that, but also extend that hospital price transparency to other locations, like ambulatory surgical centers, imaging centers, and urgent care facilities. The second wave of reform, according to Mr. Aliff, resembles SB 490(88R), relating to itemized billing for health care services and supplies provided by health care providers, championed by Representative Harris and Senator Hughes. These reforms tend to revolve around enforcement, prospectively or retrospectively, to ensure that patients have protections. This bill protected consumers by, for example, stating that a hospital cannot issue any debt until they satisfactorily give a patient some form of itemized bill. The third wave, according to Mr. Aliff, exists when there is an incentive for the patient to actually engage all of the emerging price data.

He stated that HB 2002(88R) was special because it allowed Texans who pay a cash price lower than their insurance company's negotiated rate for a medically necessary and covered health care service can have that out-of-pocket spending applied to their in-network pool, meaning insured patients have more choices of providers outside their network and can face lower cost out-of-network spending still

counted towards their end network deductible. The deductible credit is an example of third wave transparency reform because of what it incentivized patients to do with this emerging data.

In the past, many Texans were stuck living in a world where they will get referred to a hospital imaging center charging $3,562 for a lower extremity MRI, despite there being an out-of-network, cash-based imaging center across the street. Now, because of HB 2002, patients who have a high deductible are incentivized to find the lower-cost MRI, and also save themselves from being gouged in their deductible, especially if they are not planning to hit that deductible in that calendar year. This brings patient volume to providers offering more affordable prices, and potentially saves insurance companies money by having less policy holders hit their deductible, which could theoretically translate into premium stabilization, and possibly decreases in price for the consumer.

Mr. Aliff said that he wanted the Committee to consider three ideas that could capitalize on the saving incentives and new consumer case uses. One idea is to have direct primary care physicians to have a new opportunity to integrate their version of value-based care with the insured Texas population. This could be an incredible boon for patients because they would be able to have their current out-of-pocket spending to be finally counted towards their health plans. Also, patients would be getting a very patient-centric physician that offers a new 24/7-hour access and is dedicated to maximizing the value of preventative health care services.

He stated that Direct Primary Care (DPC) physicians, due to the nature of their patients, who do not typically use insurance, have historically been cost-sensitive on behalf of their patients. DPC doctors are connected to a wide network of cash-based providers, like direct imaging centers, fertility clinics, and urgent care facilities. There is a parallel cash-based market that can be opened up. By allowing direct primary care businesses to be capable of having their monthly subscription fees counted as a service under HB 2002, they could provide the missing piece that could connect with the patient to be able to show them and help them get connected for all of their primary care needs. He stated that health plans could prosper because the flat monthly subscription fees the DPCs charge cover a whole host of services, such as prescription refills, wound care, and urgent care visits, things that insurers would be sent claims for under the traditional fee for service arrangements.

Mr. Aliff said that the Legislature should consider extending HB 2002's saving incentive structure to patients with chronic illnesses who usually hit their deductible. For example, imagine a patient with rheumatoid arthritis using a biologic like Remicade. Remicade has been known to be charged between $1,700 to $9,200 per infusion, sometimes in the same city market. A patient on this medication will have no problem hitting their deductible within that year, and once that patient hits their deductible and out-of-pocket maximum, they tend not to be cost-sensitive anymore, because their insurance is covering 100% of their bills.

Recommendations

The Committee on Insurance recommends that the Texas Legislature allocate funding for the All-Payor Claims Database (APCD). This critical resource would collect and analyze data on medical, pharmacy, and dental claims from payors across the state, providing valuable insights into pricing, utilization, and trends in the health care system. By equipping policymakers, researchers, and consumers with a clearer understanding of cost drivers, the APCD can support targeted reforms and promote a more efficient, fair, and accessible health care system for all Texans.

The Committee on Insurance acknowledges that health benefit plans can utilize steering and tiering plan designs to encourage and incentivize high-value care, and also acknowledges that these approaches could in some cases be abused by insurers with the potential for self-dealing. In order to allow for the beneficial aspects whole guarding against the risk of self-dealing, the committee recommends that the state pass legislation to clarify that beneficial steering and tiering be permitted for state-regulated insurance plans, subject only to the fiduciary duty standard established by HB 711 (88R).

The Committee on Insurance recommends that the Legislature enact measures to enhance transparency, fairness, and efficiency within the prescription drug supply chain. Participants, including manufacturers, wholesalers, PBMs, and pharmacies, should be required to publicly disclose key pricing and rebate information, encompassing wholesale acquisition costs, net prices after rebates, fees, administrative costs, and actual reimbursement rates paid to pharmacies. Legislation should ensure that rebates and discounts negotiated by PBMs or other intermediaries flow directly to patients at the point of sale, rather than being retained by these intermediaries or utilized to inflate insurer profits. The development and implementation of standardized metrics to assess the efficiency and value of supply chain participants will help quantify spread pricing practices, administrative costs as a share of total drug spending, and the impact of rebate aggregation on patient out-of-pocket expenses. Laws should be enacted to prohibit exclusive contracts designed to limit competition, while guaranteeing that independent pharmacies have fair opportunities to negotiate reimbursement rates and participate in preferred networks. Encouraging value-based purchasing arrangements, where reimbursement is tied to patient outcomes rather than transaction volume, will help eliminate incentives for unnecessary utilization and markups. Enforcement mechanisms should be strengthened by granting state agencies, including the Attorney General's office, broader authority to investigate pricing anomalies and anti-consumer practices, as well as to penalize noncompliant entities. Regular, independent audits of PBM and insurer practices, coupled with the publication of key findings, will inform both the Legislature and the public about financial flows within the prescription drug supply chain. To prevent closures in underserved or rural areas, minimum reimbursement standards should be implemented to shield pharmacies from unsustainable dispensing fees. Finally, PBM contracts must clearly define the networks they include and state whether they are subject to Texas laws governing PBM operations and TDI oversight. PBMs should maintain secure online portals providing pharmacies with access to all current contracts, amendments, or updates, thus reducing confusion and administrative burdens. Additionally, TDI should adopt rules incorporating a regulatory indicator into existing patient-specific identifiers to signal when prescription drug benefits fall under TDI jurisdiction, enabling pharmacies to verify patient benefits easily and allowing TDI to address complaints more effectively.

The Committee on Insurance, in an effort to enhance clarity and compliance within the Prescription Drug Price Disclosure Program (PDPDP), recommends that the Legislature could consider merging the Wholesale Acquisition Cost report and the Price Increase Report to streamline reporting and improve efficiency. Additionally, the Legislature should mandate penalties for non-compliance or increase penalty amounts to align with similar transparency initiatives, such as hospital price transparency, ensuring stronger enforcement. Finally, better leveraging existing federal filings, such as the SEC 10-K, which often contain relevant pricing data, could reduce redundancy and improve the utility of state-level filings while easing administrative burdens on reporting entities. These measures would strengthen the program's effectiveness and accountability.

The Committee on Insurance recommends that the Legislature should consider allowing direct primary care subscriptions to qualify for out-of-pocket credits under HB 2002, enabling patients to use these funds more effectively. Reforms should be introduced that incentivize patients, especially those with chronic conditions, by encouraging insurers to share savings when patients find higher-quality, lower-cost care that beats traditional insurance company rates. This would empower consumers to make better healthcare decisions and encourage competition in the marketplace. Furthermore, the state should protect insurers' ability to develop innovative tools and incentives that direct patients to more affordable care, while preventing anti-competitive practices from hindering progress. With healthcare costs continuing to rise despite efforts at transparency, the Legislature must take additional steps to make the transition from transparency to actionable savings, ensuring that patients who actively seek lower-cost, higher-quality care are rewarded for their efforts. These actions would not only help reduce the financial burden on patients but also create a more dynamic, consumer-driven healthcare system in Texas.

Efficacy of the Prior Authorization Process in Ensuring the Appropriateness in Medical Treatments

Background

Prior authorization is a process used by health insurers to determine whether specific medical treatments, procedures, or medications will be covered under a patient's plan. Before a service or prescription can be provided, the health care provider must submit a request and obtain approval from the insurer.

The process is intended to control costs and ensure that care is medically necessary, evidence-based, and consistent with a patient's coverage. Insurers aim to use prior authorization to promote the use of effective treatments and reduce overutilization of services.

Prior authorization has raised significant concerns for both patients and providers. Patients may experience delays in accessing needed care, creating frustration and uncertainty during critical health situations. For health care providers, the process often imposes undue financial and administrative burdens due to excessive documentation requirements, wasted time, and inefficient decision-making. These hurdles can detract from the time spent delivering patient care and lead to gaps in treatment continuity.

House Bill 3459, passed in Texas in 2021, established a process called "gold carding" to streamline prior authorization requirements for health care providers. Under this law, health insurers were required to exempt providers from prior authorization for certain services if they demonstrated a high approval rate for those requests over a six-month period.

The intent of HB 3459 was to reduce administrative burdens on providers and improve timely access to care for patients by rewarding providers with a proven history of compliance with medical necessity standards. Providers who qualify for gold card status are trusted to deliver care without needing repeated insurer approvals, promoting efficiency in the health care system.

Testimony

The Committee heard testimony from Rachel Bowden, Director of Regulatory Initiatives Office at Texas Department of Insurance (TDI).

Ms. Bowden said that despite the passage of the gold carding bill from 2021 they have heard a lot of concerns in recent years about prior authorization, including that it costs a lot of time and administrative expenses for doctors to keep up with, and that it creates delays and barriers to patients accessing made it care. She stated at TDI has heard that some plans are taking voluntary steps to address those concerns, including simplifying processes and scaling back prior authorization requirements when they're not adding value. She said that she thinks one of the biggest challenges in understanding the issues with prior authorization and finding effective solutions is the different market segments, all with different requirements regarding prior authorization. She reminded the committee that TDI only regulates the coverage that is covering 17% of Texans, therefore it is a challenge in finding solutions at the state level. She said that one of the common complaints with prior authorization is that care can be delayed for significant time periods while the patient is waiting on prior authorization. Ms. Bowden stated that Texas Insurance Code says that this period should not be longer than three days**.** She stated that these cases are most likely referring to ERISA plans, Medicare Advantage plans, or another market segment that TDI is preempted from regulating. Medicare Advantage in particular has been in the news a lot around concerns with prior authorization. Earlier this year, the Center for Medicare and Medicaid Services (CMS) finalize some rules addressing prior authorization. Some of these other markets include Medicare Advantage, Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) plans that TDI does regulate in Texas, but those rules don't apply to ERISA self-funded plans or prescription drug benefits.

Starting in 2026, those public plans will have tighter timeframes needed to make those prior authorization decisions in seven calendar days, or 72 hours for expedited requests. She said that this is an important improvement, but the Texas standards are still more robust. Those ACA plans are subject to Texas time frames. Ms. Bowden said that there is a current focus on improving the processes involving prior authorization application programming interfaces (APIs), which are a kind of technology used for systems to communicate with one another, and those standards allow them to do this. She said that these improving standards can improve efficiency, improve patient and provider ability to be more engaged with the prior authorization process, and make it easier to remove some of the barriers that negatively affect patients' health.

Ms. Bowden stated that the gold carding bill passed in 2021 was not as expansive as they had hoped. She restated that TDI regulates 17% of the market, and this made it difficult to find which of these providers are requesting a certain service frequently enough to have at least 5 attempts in the last six months. 74% of providers who met that threshold got a gold card, but that ended up equating to only approximately 3% of providers.

The Committee heard testimony from Ezequiel "Zeke" Silva, Chair of Council on Legislation, Texas Medical Association (TMA).

Dr. Silva stated that prior authorization has become a significant burden on patients and physician practices for years now, contributing to rising health care costs, threatening the viability of independent medical practices, and compromising patient care. Initially intended as a tool for controlling outlier health care costs and ensuring medical necessity, prior authorizations have proliferated into a cumbersome and often obstructive process. Dr. Silva stated that TMA has worked to reduce this burden for patients and physicians, but health plans continue to use these techniques to delay patient care.

He stated that the administrative burden of prior authorization is staggering. Approximately 92% of medical practices have either hired additional staff or reallocated existing resources solely to manage the increasing volume of prior authorization requests. This is according to the Medical Group Management Association's annual regulatory burden report from 2023. These requests often require significant time and effort, with practices completing an average of 43 prior authorizations per physician each week. He stated that this process not only consumes valuable time that could be better spent on patient care, but also imposes significant financial strain on practices. For independent physician practices, which already operate on thin margins, the costs associated with managing prior authorizations can threaten their financial viability.

Dr. Silva stated that the impact of prior authorization on patient care is profound. The most recent nationwide physician survey found that 94% of patients and their physicians experience care delays due to prior authorization, and 78% indicate these delays can lead to patients abandoning their prescribed treatments. Such delays are not just inconvenient; they can have significant consequences. Nearly one in four physicians reported that prior authorization has led to a serious adverse event for a patient under their care.

The administrative complexity and inefficiencies associated with prior authorization contribute significantly to overall health care costs. For example, physicians must navigate varying medical necessity requirements and submission protocols across different health plans leading to inefficiencies and delays in care. These delays often result in higher health care costs, as patients may require more intensive medical interventions including emergency room visits or hospitalizations, if appropriate care is postponed. Furthermore, patients frequently incur out-of-pocket costs when they are forced to pay additional copays or for medications or services due to prior authorization delays or denials.

These financial impacts extend beyond patients and physicians to employers and the broader health care system. Employees be less productive, or miss work while waiting for care, adding to the economic burden of prior authorization. For employers, this leads to higher indirect costs, as employees are either absent or less productive due to rescheduled medical appointments and unresolved health issues.

He stated that the passage of House Bill 3459 in the 2021 session, which allows physicians to earn exemptions from prior authorizations through a "Gold Carding" system, was a significant step toward reform. However, the law's implementation has faced challenges, with insurers employing tactics to complicate the exemption process, resulting in fewer than the expected number of physicians obtaining exemptions. This highlights the need for ongoing legislative and regulatory efforts to ensure prior authorization reforms effectively reduce the administrative burdens on physicians and improve patient care.

Dr. Silva said that there is a lack of transparency and accountability around gold carding and prior authorization practices in general. There is no requirement that insurers report data regarding exemptions granted or not granted under the gold carding law. As such, there is no way to track compliance by insurers or the efficacy of the law other than through anecdotal evidence.

Dr. Silva concluded his testimony by stating that the current prior authorization process delays patient care and imposes significant administrative, financial, and clinical burdens on physician practices, driving up health care costs and threatening the viability of independent practices. He stated that meaningful reform is necessary to streamline the process, reduce unnecessary barriers to care, and protect the financial stability of physicians and health care providers. Without such reforms, the prior authorization process will continue to impede the delivery of timely and effective care, to the detriment of both patients and physicians.

The Committee heard testimony from Heather De La Garza-Barone, J.D., Associate General Counsel for the Texas Hospital Association (THA).

Ms. De La Garza-Barone began testimony by stating that THA understands and acknowledges the need for reasonable and good faith prior authorization processes that seek to curb fraud, waste, and abuse. She said that prior authorization has been around for a long time. When it started it was used sparingly and for expensive treatments to be sure that they knew what was being ordered and that it was actually needed.

She stated that misuse of prior authorization can have irreversible consequences. She emphasized the need for reducing the cost of health care while maintaining high quality health care. For this to happen, prior authorization fraud, waste, and abuse cannot go unchecked.

Ms. De La Garza-Barone said that hospitals must employ a dedicated workforce and invest in technologies solely to address prior authorization and other utilization requests. One large hospital system reports having to ensure that they have extensive documentation memorializing communications with insurers/payors because more often than not there will be a denial requiring an appeal and those communications are necessary to make the case. In a 2022 American Hospital Association report, one large National Hospital system reported that in 2019 it spent 15,000,000 in a month on administrative costs to manage prior authorization and insurer charges. The New York Times recently reported that nationally we spend 35 billion in administrative costs per year. Ms. De La Garza-Barone said that, while this is beyond the scope of this committee, we are seeing a proliferation of waste and abuse in prior authorization in the Medicare Advantage program. A Kaiser Family Foundation analysis published on August the 6th found a 9 million increase in requests over a three-year period. Of those that are appealed, a majority of appeals (83.2%) were overturned. The United States Department of Health and Human Services-Office of the Inspector General has begun an investigation into Medicare Advantage prior authorization related to post acute care with findings scheduled to be published in 2026. At the national level, the Center for Medicare and Medicaid Services has taken steps to improve prior authorization for Medicare advantage, but many of the new policies won't go into effect until a few years from now.

Prior authorization requirements are unique to each insurer and are not consistent, leaving hospitals to manage varying requirements across a multitude of payors. One hospital member reports many insurers have aggressive policies, in other words, if you aren't meeting all of their requirements you don't get

paid. Another hospital reports that changes are sometimes notified through random newsletters sent by insurers. This implies that hospitals have to monitor these newsletters to catch any potential changes to prior authorization requirements. Ms. De La Garza-Barone said that unreasonable medical records requests remain a problem pre and post payment, even with a prior authorization being provided.

Ms. De La Garza-Barone said that current law does provide some metrics regarding some specifics about prior authorization that must be reported to the public for Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs). This information is requested to be conspicuous however, but initial searches discovered that this information is not necessarily conspicuous on some large insurers' websites. She said that the public and health care providers should have access to denial rates, denials overturned on appeal, use of retrospective reviews, and acknowledgement that medical necessity criteria are more expansive than Medicare. Beginning in 2026 Medicare Advantage and Medicaid and Qualified Health Plans (QHPs) on the Federally-Facilitated Exchange (FFE) plans have to publicly report certain metrics annually on their website. There is effectively no punishment for failure to comply with those provisions. At the national level, the federal government has taken steps to improve transparency for Medicare Advantage, but many of the new policies won't go into effect until a few years from now.

Ms. De La Garza-Barone said that their hospitals are reporting that not much has changed since the gold card law went into effect. Hospitals still seek some form of prior authorization because there is concern that not doing so will risk denial or payment. She stated that since there is not centralized portal to check for individual physician exemptions, there is still an administrative step to have to check the specific payor's portal for the exemption Some hospitals report that exemptions of physicians groups might be more beneficial than individual physician exemption, saving time and effort.

Ms. De La Garza-Barone concluded her testimony by stating that prior authorization fraud, waste, and abuse cannot be allowed to go unchecked. It raises the financial costs of health care and can have a result and significant consequences for Texas patients' health.

The Committee heard testimony from Chris Keane, Chief Operating Officer at The San Antonio Orthopaedic Group (TSAOG).

Ms. Keane stated that stated that her physician-owned group, The San Antonio Orthopaedic Group, has been in operation of over 75 years, longer than most insurance companies have been in business. While their group remains strong, the consolidation taking place in healthcare should be a concern for everyone in this country as we are witnessing a foundational shift in the way health care is being delivered.

Ms. Keane stated that both sides of the political aisle in Austin and Washington agree that patients must have choices in physicians and hospitals. She stated that decisions for how patient care is delivered are now being made at an alarming rate by non physician corporate entities.

Ms. Keane stated that her group has taken a strategic approach to ensuring their survival. They are a fully integrated, private health care entity consisting of non operative physicians, orthopedic surgeons, and anesthesiologists. Their physicians have built their group to help patients navigate an often-confusing health care environment by providing as much physician directed care as possible under a

seamless umbrella. Their patients obtain X-rays, or more advanced imaging, such as MRI/CT, receive their physical or hand therapy in person or even virtually all in one place. Their patients can see them after hours and Saturdays at their urgent care solution, Ortho Now. They even offer preventative bone health care services to treat osteoporosis, helping to prevent future fractures. If a patient requires surgical intervention, they have two outpatient ambulatory surgery centers that provide basic and complex orthopedic surgeries, including spine and joint replacement procedures. Lastly, if inpatient hospital care is required, this will also be directed and led by their physicians at one of three community-based hospitals in the region. Ms. Keane said to think of their group as a small ecosystem for orthopedic care in San Antonio.

The nearly 600 professional team members who work for the San Antonio Orthopaedic Group take their responsibility of continuously trying to improve care, reduce healthcare costs, and remove unnecessary barriers to access and care, very seriously. One of these unnecessary barriers is prior authorization for an ever-growing list of health care services mandated by insurance carriers.

Ms. Keane stated that her group has 16 dedicated team members that exclusively work to obtain authorization from insurance carriers to allow their patients to access the care they need at a cost of almost $750,000 per year. On top of the expense, this is a stressful environment, not only for the authorization team, but also for the physicians that participate in the peer-to-peer calls with insurance carriers, racing to ensure the practice is not wasting any time to get the service authorized. While this is going on, the patient is also under stress, wondering what is happening, why is this taking so long, and when can they get the care they need? She stated that, after all of this expense and stress, the service gets authorized 99% of the time.

Ms. Keane stated that Texas took the first step in 2021 by passing, with bipartisan support, HB 3459, known as the gold card prior authorization bill. Next to tort reform, it is one of the most impactful and positive influences for directing affecting patient care. It has made a significant impact in bending the curve and shedding light on the prior authorization processes with insurance carriers. Miss Keane stated that what we have done here in Texas has led the way for states across the country.

Ms. Keane stated that, although Texas should be very proud of what we have accomplished to date, the implementation of house bill 3459 was complicated and the rulemaking process to implement the intent of the bill has not produced the results that we expected.

TDI reports that only 3% of providers were positively impacted by the bill. The primary reason for this is due to providers not meeting the threshold for review. Representative Greg Bonnen introduced HB 2043 in 2023 as a cleanup bill, and HB 2043 would have addressed this by removing the threshold and allowing for review of all services ordered. It also allowed for a physician to request for review of a gold card denial and adds additional oversight from Texas Department of insurance requiring insurers to report the department gold card results. Unfortunately, HB 2043 never made it to the floor for a vote in 2023.

Ms. Keane stated that she is optimistic that in the 2025 legislative session, Texas can finally finish what it started and correct the major issues identified after implementation of HB 3459. She stated that time is of the essence to preserve the remaining private practices that are struggling to operate, so that physicians, not corporate executives, are in control of the health care provided in our state and across the country.

The Committee heard testimony from Blake Hutson, Director of Public Affairs at the Texas Association of Health Plans (TAHP).

Mr. Hutson stated that prior authorization is a proven tool that ensures patients get the most up-to-date evidence-based treatments and avoid care that strays from the latest medical evidence, may cause adverse events, and could complicate worsening conditions. He said that at the same time, health plans recognized the burden that prior authorizations can have on provider practices, and support collaborative efforts to improve the system.

Health insurers are committed to finding a better approach to prior authorizations which uses innovations and technology to enable a smarter, faster, and less burdensome system. However, Mr. Hudson said, blanket restrictions against prior authorizations risked patient harm and increased health care spending. Over a dozen studies, according to Mr. Hudson show that prior authorizations discourage physicians from ordering unnecessary tests, procedures, or treatments when approval for those services is subject to external review. Mr. Hudson stated that restricting prior authorizations, according to studies, could increase premiums by 5.6% to 16.7%. He stated that TAHP supports a more streamlined approach to prior authorizations which recognizes the importance of protecting patient safety and avoiding wasteful care, while limiting unnecessary burdens.

He stated that Texas has the strictest prior authorization requirements in the country. State regulated health plans in Texas are currently under the strictest prior authorization timelines in the country. Plans must respond to standard prior authorizations in three calendar days. This requirement shortens to 24 hours if the patient is hospitalized, and to only one hour if the request is for post stabilization care. Mr. Hutson stated that these standards go beyond federal requirements for Medicare, Medicaid, and self funded plans, as well as state Medicaid requirements.

Mr. Hutson advocated for the use of electronic prior authorizations (ePAS) to significantly reduce the burden that prior authorizations can cause. An ePA is a digital process that allows healthcare providers to request approval from health insurance companies before certain medical services, treatments, or medications are provided to a patient. It replaces traditional paper-based prior authorization methods, streamlining the approval process by allowing healthcare professionals to submit requests electronically, which can be processed more quickly and efficiently.

An ePA helps reduce administrative delays and errors, improves transparency, and enhances the speed of communication between healthcare providers, insurers, and patients. The system is designed to improve patient care by ensuring that necessary treatments are approved in a timely manner, while also reducing the administrative burden on providers. Additionally, ePAs can provide real-time feedback, allowing providers to quickly resolve issues or submit additional information if required, speeding up the approval process and reducing patient wait times.

Mr. Hutson concluded his testimony by reiterating TAHP’s wish to allow more flexibility in gold carding programs, such as eliminating rigid timelines required by HB 3459. He also stated that waste, fraud, and abuse are more likely to happen due to the law.

Recommendations

The Committee on Insurance recommends that the Legislature should enact reforms to streamline the prior authorization process and alleviate the administrative burden on providers while improving patient care. First, it should mandate uniform, transparent criteria and standardized electronic systems for all insurers, ensuring that physicians no longer must navigate a confusing array of differing requirements. The Legislature should also strengthen and simplify the "gold carding" program by removing restrictive thresholds, requiring clear reporting of physician exemptions, and granting the Texas Department of Insurance oversight authority to hold insurers accountable. Finally, setting definitive timelines for prior authorization determinations and making it easier for providers to challenge denials will reduce delays in treatment, lower overall costs, and ensure that Texas patients receive timely, effective, and accessible health care.

Current Economic Challenges on the Escalating Costs of Health Insurance Premiums

State-Based Health Exchange

Background

Prior to the advent of the Affordable Care Act (ACA), small group and individual market insurance regulation was almost entirely within the state's purview. States that use the federal exchange (FFE) rather than establishing a state-based exchange (SBE) cede significant authority, including the responsibility to define what constitutes a qualified health plan eligible for federal premium tax credit, to the federal government. Should the federal administration in power desire, it can pursue onerous regulatory measures including imposing price controls, increasing red tape, and driving up costs, picking winners and losers in the market, and allowing people to game the system by waiting until they get sick to enroll in coverage. This results in fewer choices and less access for Texans. It is more important than ever that Texas reclaims authority over its health insurance market to the maximum extent possible under current federal law.

The fee Texas consumers pay to use the federal exchange is unnecessarily high, the platform is limited and inflexible, and the shopping experience fails to meet consumer needs. Like with most other technologies, the cost of building an SBE has gone down significantly while performance has drastically improved since 2013 in the early days of state-based exchanges. Unlike the now decade-old architecture and fragmented technology employed by the FFE, states are implementing enhanced technology that is both less expensive and more versatile to better serve state residents.

In his first term, President Trump attempted to repeal and replace the ACA. After Congress failed to pass that bill, his Administration began to deregulate and devolve the FFE to the states. Since that time, eight states including Georgia passed legislation to establish their own SBE. Once Georgia completes its transition to becoming a SBE in late 2024, more than half (7.7 million) of the remaining 15 million enrollees still in the FFE will be represented by Texas and Florida alone.

The ACA gives states that establish their own exchanges significant flexibility to oversee their own health insurance markets, including by ensuring a level playing field, where any health insurer meeting minimum standards can participate, by promoting private sector partners like insurance carriers, licensed web brokers and traditional health insurance agents and brokers over government-funded navigators to help drive education and enrollment, by setting open enrollment periods and rules on special enrollment periods to prevent gaming of the system and promote program integrity, and allowing the inclusion of stand-alone dental plans and access to supplemental vision insurance, enabling consumers to have more comprehensive and customized coverage options beyond the standard health insurance plans.

Since 2014, enrollment by Texans in the FFE has more than quadrupled to an estimated 3.5 million consumers and is still growing. As a result, the federal user fee has also risen significantly. It is estimated that in 2024 Texas will pay approximately $590 million to use the FFE and this is financed by all insured Texans via a user fee paid by health plans participating in the FFE. Texas could establish and operate a SBE more efficiently while continuing to serve the same number of enrollees.

Testimony

The Committee heard testimony from John F. King, Georgia Insurance and Fire Safety Commissioner.

Commissioner King said that when he came to office in 2019, Georgia had one of the highest rates of uninsurance (1.3 million Georgians were uninsured). In March 2019, the Georgia Legislature passed, and Governor signed the Patients First Act, aimed at addressing some of the most pressing issues.

Georgia subsequently engaged in a two-part strategy: they implemented a reinsurance program to lower premiums and attract more carriers and began a plan to transition off the Federal exchange to a state-based exchange.

As a result of the reinsurance program, premiums were lowered by a statewide average of 10.1 percent in 2024. In addition, Georgia successfully attracted new carriers to its market, thereby giving Georgia consumers more choices. All of Georgia's 159 counties now have at least two carrier options, and the vast majority have more than three or more carriers.

The move to an SBE has been a huge victory for consumers and Commissioner King said it makes sense for 3 primary reasons.

First, it reduces federal regulatory authority and brings control back to the state. Georgia no longer relies on federal government for technology, outreach, enrollment assistance and plan oversight.

Secondly, it makes financial sense. The funds previously sent to the federal government now stay in Georgia, collected as user fees, to run the program and ensure program self-sufficiency.

Thirdly, a SBE opens the door for innovative solutions to address state specific solutions.

Commissioner King explained that all states must provide access and pay for exchange operations. The amount of the federal fee is determined by the federal government and pays for federal exchange operations. He further explained that the user fee is a hidden tax on consumers. When the federal government collects the fee from insurance carriers, the carriers pass the cost of that fee along to consumers by raising premiums across the state across their entire book of business, both on and off the exchange.

Commissioner King said the number of states participating in federal exchange continues to shrink.

Commissioner King closed his remarks by stating that he believes the SBE gives states more control as priorities change, allows a state to innovate and allowing greater flexibility. The SBE also provides better ability to police and deal with fraud.

The Committee heard testimony from David Cook, Spokesman of the National Association of Benefits and Insurance Professionals – Texas Chapter (NABIP-TX).

Mr. Cook stated that some employers are turning to level-funded or self-funded plans, which allow businesses to customize their health plans, negotiate directly with providers, and potentially save money if claims are lower than expected. Unfortunately, these plans typically require medical underwriting, and not all employers will qualify if the group has even a few members with chronic healthcare conditions.

In the individual market, Texans can take advantage of the open enrollment period through the ACA marketplace. Subsidies have been expanded in recent years, making coverage more affordable for those who qualify based on income. However, while the number of uninsured Texans has decreased since the implementation of the ACA, Texas still falls well behind the national average with approximately 17% of our population currently without adequate health insurance coverage. A premium subsidy directed at small businesses and low-income workers is desperately needed and could be better administered through a state-based exchange where Texas decides who the premiums go to.

Mr. Cook said that it is important to note that states who have created Exchanges but failed to include independent agents as paid navigators within the Exchange have not seen success. Health insurance is complicated whether purchased in an SBE, or outside of it. Consumer will need help to navigate the choices and terminology within an SBE. He said that agents must be included and compensated to ensure consumers have the help they need to make their best choice within an SBE.

Mr. Cook offered an alternative solution, and said that an important but underutilized tool to assist small businesses already exists in Texas in the form of two “Three-Share Plans.” The Three-Share Plans in Texas were created more than a decade ago in a very specific form, limited to serve specific areas of the state as a type of pilot project. Six regions initially sought to create and grow three-share plans. Over the course of the Affordable Care Act’s implementation, four of those plans folded. But two adapted and survived. Their capacity is only limited by the amount of their legislative funding. Both programs requested budgets that exceeded the amount available for distribution in the 2018-2019 biennium, and again in the 2020-2021 biennium. If modernized and expanded, these existing programs could provide a much-needed solution for small businesses with low-income workers who cannot afford the premiums for their employer sponsored policies.

Mr. Cook stated that a “three-share” program is a health insurance term referring to an employer health care program subsidized by local governments. These three-share premium assistance programs aim to lower the cost of health care coverage for lower-income employees, typically at small businesses. These programs use public funds to share coverage costs typically paid by only the employer and employee, making it more affordable for both of them. The programs use state funds to administer the programs and to pay a third share of the premiums.

Three-share programs already exist in Texas law. Health and Safety Code Chapter 75, enacted as SB 10 by the 2007 Texas Legislature, permits county commissioners courts to create health care programs for employers, including three-share programs. The programs are exempt from regulation under the Insurance Code. These programs are designed to: improve the health of employees of small employers in Texas by improving access to health care and insurance; reduce reliance on state-funded programs like Medicaid; improve small employers’ economic conditions by improving the health of employees and

providing health care benefits to help attract employees; and encourage innovative funding and providing of health care services.

With the passage of SB 10, several three share programs were created in various areas of the Texas. After the passage of the Affordable Care Act, the programs were forced to either disband of restructure their models of operation to comply with the ACA.

He said that today, two plans still exist: Tex Health (covering Central Texas and expanding to Houston) and the University of Texas Medical Branch (UTMD)'s Multi-Share covering the Galveston area. Rather than provide coverage directly as originally created, the programs help employees buy commercial small employer coverage.

He stated that both plans are funded by grants from TDI, consisting of income from fines and penalties levied against health insurance carriers. TDI began providing grants to three-share premium assistance programs in 2008-2009. It has paid more than $15.3 million in grants. HHSC provided an additional $1.3 million from a federal State Health Access Program (SHAP) grant. Grantees used the funds for premium assistance and program administration. Additional monies could provide funding for expansion of Three Share Plans and applied through TDI.

TexHealth Central Texas is an independent nonprofit organization. The program helps small employers, and their employees buy commercial coverage in the small employer group market. Central Texas is a regional program serving six counties in Central Texas (Bastrop, Burnet, Hays, Milam, Travis, and Williamson). Central Texas began serving Harris County in 2018-2019. Central Texas has received $9.2 million in TDI grant funds since 2008-2009. The program has grown steadily under the new model. As of August 2020, the program had enrolled an average of 94 employers with 604 employees, 427 of whom are eligible for third-share subsidies. The premiums vary by the health plan purchased. Employers are still free to craft and purchase the plan of their choice.

UTMB's Multi-Share Program contracts with UTMB health care providers to provide healthcare services for employees enrolled in the program. However, UTMB does not function as an insurer or health maintenance organization. Enrollment in the UTMB plan has been the most stable among current and previous grantees, averaging 101 covered businesses and 344 covered employees for FY 2020. UTMB maintains an enrollment cap of 500 members. Since the program began receiving TDI grant funding in September 2010, it has provided premium subsidies to an average of 235 employees per month, or 68% of enrolled employees. The number of recipients dipped in 2011 due to correction of a billing error. Drops in 2012 and 2013 were due to a lack of grant funds.

Mr. Cook stated that, as successful as their current programs are, they are limited in size and scope by their legislative appropriations. The programs can only serve as many employers as they have funding for. Despite strong demand and increasing struggles of small businesses, funding for these programs has been declining over the last three biennials.

While their existing three-share programs are serving many low-income workers at small businesses well, their current funding and limited structure severely limits their ability to help more Texans. Enrollment numbers show a constant increase in the number of employees served, indicating an increasing demand that is not being met under current funding.

Mr. Cook stated that Texas should draw from the experience of other states that have invested in three-share programs more robustly in recent years. Insure Oklahoma, created in 2004, provides a consistent history of a successful statewide program.

Mr. Cook stated that other states' programs differ from the Texas programs in several ways. Texas premium assistance is limited to employees only. Insure Oklahoma also serves spouses and dependents.

Texas premium assistance has a hard dollar cap of $110, regardless of price of premium. Oklahoma's assistance is based on a percentage of the premium, not an arbitrary dollar cap.

Mr. Cook said that Texas plans are limited to very small employers under 50, where Oklahoma's program stops at 250.

Mr. Cook said that because of these differences, Oklahoma currently serves nine times the number of employees that Texas does. Oklahoma assists fourteen times the number of employers compared to Texas.

Mr. Cook finished his testimony by saying that Texas could make progress toward solving its uninsured problem among small businesses by expanding existing programs to serve them. The Three Share Plans already exist and could we have modified and expanded through more funding.

The Committee heard testimony from Blake Hutson, Director of Public Affairs at the Texas Association of Health Plans (TAHP).

Mr. Hutson began his testimony by talking about the economic challenges that Texans face today stating that they are significantly impacting the cost of health care insurance premiums, particularly for small businesses and individuals in Texas. While the individual market has seen significant improvements in affordability and coverage, the small group market is still struggling with rising costs and limited options.

Mr. Hutson said that while most Texans are covered through their employer, millions of Texans, entrepreneurs, small business owners, and others looked for health insurance coverage on their own. The Affordable Care Act's individual market provides comprehensive coverage options for these Texans. The individual market in Texas is thriving due to enhanced subsidies, expanded eligibility, and reforms like SB 1296, which have made coverage more affordable. For example, the average premium paid by Texans after subsidies has dropped from $136 in 2018 to $50.00 in 2024.

Mr. Hutson stated that this affordability has led to a nearly threefold increase in coverage, with the number of Texans buying coverage soaring from 1.3 million in 2021 to 3.5 million in 2024. At 15 insurers, Texas now has more insurers serving the individual market than any other state. In 2024, more than 90% of Texans had a choice of three or more health plans.

Mr. Hutson stated that health insurance is increasingly expensive in Texas, driven largely by rising prices and new government mandates. Businesses are facing a nine percent increase in health spending this year, making it harder for them to continue providing benefits to their employees. The small group market is particularly challenged, with few competitors, less flexibility, and higher premiums and cost sharing. Many Texas small employers have dropped coverage altogether with only 27% of small employers currently offering coverage, and rising health costs are becoming unsustainable for both

businesses and employees. Thirty-seven percent of Texas employers say to healthcare costs are rising at an unsustainable rate, and employees have steadily lost 5% in wages due to these costs.

Mr. Hutson stated that small employers are uniquely sensitive to higher prices. According to the National Federation of Independent Business, small businesses have ranked the cost of health insurance as their number one concern every year since 1986. New data from JP Morgan Chase business accounts showed that 12% of payrolls went to health care costs for small employers, compared to 7% for larger businesses. Small employers are uniquely sensitive to higher prices than 75% of small businesses that do not offer coverage stated that employees would prefer pay raises over benefits.

Mr. Hutson stated that Texas' laws are making the problem worse. Small employers' health plans are regulated by the state laws passed at the Texas Legislature, unlike large businesses self-funded health benefits that are exempt from state mandates. Mr. Hutson said that state laws block insurance plans from rewarding doctors that focus on value, sharing quality transparency with patients, and encouraging patients to shop for more cost-effective care. These restrictions are causing more employers move to self-funded plans, which allowed them to avoid excessive state government regulations that block innovative benefit designs. Kaiser Family Foundation's employer health benefits survey shows the proportion of employers covered by the self-insured plans increased from 44% in 1999 to 65% in 2023. Small businesses, defined as three to 199 employees, had the biggest increase, from 13% in 1999 to 18% in 2023.

Mr. Hutson stated that the small group market is vital for providing coverage to our states's workforce, but rising costs are making it increasingly difficult for small employers to offer benefits. He stated that if these challenges are not addressed, more small businesses will be forced to drop coverage, leaving their employers without affordable health care options. Meanwhile, the individual market has made significant strides in affordability and coverage expansion.

Mr. Hutson recommended that Texas should promote new tax advantage programs like Individual Coverage Health Reimbursement Arrangements (ICHRAs), to help small employers cover their employees, targeting the most strained market. He said that Texas should implement a process to estimate the cost of mandates before passing legislation ensuring that lawmakers are fully informed on the impact of businesses and families. He said that Texas should offer businesses alternative coverage choices that allow them to select plan designs and benefits that adapt to their needs avoid overregulation and are priced at a level that they can afford. He advocated that Texas should oppose legislative attempts to impose costly mandates on self funded ERISA alternatives for employers, maintaining affordable coverage options. Courts often strike down ERISA mandates unless they involve rate- setting arrangements that add costs. Mr. Hutson said that Texas should modernize outdated laws that disadvantaged patients and employers, such as those that prevent health plans and employers from rewarding patients who shop for high value, low-cost care by aligning state laws with federal transparency rules, Texas can encourage more cost-effective health care choices.

The Committee heard testimony from Glen Hamer, President and CEO of Texas Association of Business (TAB).

Mr. Hamer began by addressing the rising cost of health insurance premiums and the challenges these costs pose for small businesses and individuals in Texas. The current economic climate has intensified the difficulties businesses face and providing affordable health insurance. For many small businesses,

health insurance premiums are among their most significant expenses., second only to payroll. According to capital TAB's 2024 employer health care survey, 86% of businesses believe that health care costs are rising at an unsustainable rate, and more than half report that these costs interfere with their ability to increase wages or add employees. As costs continue to rise, we risk pushing more small businesses to drop coverage altogether, which would be detrimental not only to employees, but to the overall health of our work force and economy.

Mr. Hamer stated that his organization advocates for expanding the choices available to employers particularly small businesses supporting consumer choice of benefit health plans, which offer low-cost options without state mandates that exceed federal requirements, is crucial these plans provide small businesses with more affordable options to offer health benefits to their employees. Mr. Hamer emphasized the need to improve the efficiency and cost effectiveness of health care delivery. This includes expanding the use of telemedicine, removing barriers to practice for advanced practice registered nurses, physicians' assistants, and pharmacists, and supporting value-based care models that improve outcomes while reducing costs. Mr. Hamer stated that reducing the administrative burden on employers is another priority. Simplifying the regulatory landscape and ensuring transparency around the costs of new mandates can make health care more affordable and accessible for businesses and their employees. TAB supports the establishment of a review process for health insurance mandates, as proposed in SB 1581, which would provide lawmakers with independent evaluations of the impact of proposed mandates on health insurance costs the coverage. 92% of employers in our survey support requiring the legislature to provide a cost estimate for any mandates before passing them into law. Texas lawmakers should also have access to detailed fiscal notes and impact statements for health coverage proposals, using data from resources like the APCD to make informed decisions.

Mr. Hamer stated that TAB believes that by focusing on these priorities, Texas can better manage and control the rising costs in our health insurance market. He stated that his organization also supports exploring innovative solutions such as a small business health options program sharp and parentheses, to pool the buying power of small businesses, providing them with more affordable and comprehensive health plans.

Mr. Hamer concluded by stating that Texas is a state known for its pro-business policies and innovation. He emphasized that Texas has a responsibility to ensure that its small businesses can thrive in a challenging economic environment while also providing quality, affordable health insurance to their employees.

Recommendations

The Committee on Insurance recommends that Texas consider a state-based health exchange, which would grant Texas significant authority over its individual health insurance market, including the power to define which plans can be certified as Qualified Health Plans (QHPs) and sold through the exchange. This flexibility would allow Texas to design tailored solutions for residents, including integrating options like Individual Coverage Health Reimbursement Arrangements (ICHRAs) and three-share plans.

An ICHRA is an employer-funded program that provides employees with a fixed amount of money to purchase their own individual health insurance plans rather than being enrolled in a traditional employer-sponsored group plan. ICHRAs offer greater flexibility for employees to choose the coverage that best suits their needs, while allowing employers to control costs by setting a fixed contribution amount.

Three-share plans, where the cost of premiums is split between the employer, the employee, and the insurer, help make healthcare more affordable and accessible for employees. By distributing the financial burden across multiple parties, these plans can lower the cost for each stakeholder while ensuring that employees still receive necessary coverage. This model encourages shared responsibility, making it easier for employers to provide health benefits without absorbing the entire cost, and helps reduce the overall expense for employees compared to individual market plans.

Transitioning to an SBE would eliminate the more than $590 million Texans currently pay annually to the federal government for FFE operation, redirecting these funds to improve outreach, customer service, and access. By adopting a SBE Texas can ensure a cost-effective, efficient system while fostering innovation to reduce health disparities and expand care access in underserved areas.

Establishing an SBE will allow Texas to create a more responsive, affordable, and equitable health insurance system that prioritizes the needs of its residents while maintaining control at the state level.

Current State of Network Adequacy in Texas

Background

Network adequacy in Texas, particularly regarding health insurance, ensures that consumers have sufficient access to healthcare providers within their insurance networks. This issue has been increasingly scrutinized due to the prevalence of "narrow" or "skinny" networks, which are health plans with a limited selection of in-network providers. These networks aim to lower costs but can restrict patient choice and access, particularly in rural or underserved areas.

The Texas legislature has addressed these concerns through laws like Senate Bill 1264 (87R), passed in 2019, which primarily focused on limiting balance billing for out-of-network services provided in emergency situations. It also established mechanisms for resolving disputes between insurers and providers, reducing the financial burden on patients, and improving clarity in network operations.

House Bill 3359(88R), passed in 2023, further strengthened network adequacy requirements. It mandated the Texas Department of Insurance to assess and ensure compliance with quality-of-care and network adequacy standards for preferred provider benefit plans. It also required insurers to provide detailed, accessible data on their networks, helping regulators and the public better understand gaps in coverage and network limitations.

Some carriers have expressed concerns regarding the Texas Department of Insurance (TDI) rules that mandate two providers per specialty in a given service area. They argue that the requirement forces insurers to contract with not just a sufficient number of providers, but an excessively large network, claiming it stifles innovation. These carriers believe that the Texas network adequacy laws impose a rigid framework, which they view as creating an overly comprehensive network, rather than one that allows for flexibility and innovation.

The essence of the Preferred Provider model is to ensure the freedom of choice for insured individuals. This concept, which has been embedded in TDI regulations for over a decade, mandates that an insured person must have access to at least two preferred providers in each specialty to ensure adequate choice. This is not only a matter of quantity but also quality, as these providers must comply with all network adequacy standards, including time and distance criteria. HB 3359, alongside TDI rules, aims to guarantee that each insured individual has sufficient options within their network. By ensuring at least two providers per specialty, the goal is to offer real choice to consumers while maintaining necessary standards for access to care. This rule is designed to balance provider availability with patient choice and network adequacy.

The concern expressed by some carriers regarding TDI’s rules requiring two providers per specialty, compared to the federal Medicare Advantage Rule, highlights differences in network adequacy standards. While the Medicare Advantage program sets a benchmark for time and distance standards in terms of population size, TDI established its own time and distance regulations before HB 3359. The rules set by HB 3359 aim to provide more flexibility to insurers by adjusting requirements based on county size, which is similar to the Medicare Advantage approach but not identical. Importantly, the Texas statute was not intended to directly adopt the federal rule.
The complaint that Texas requires twice as many providers per specialty as the federal Medicare Advantage law overlooks the fact that the two-provider minimum is designed to ensure that insured

individuals have a real choice of preferred providers. Unlike Medicare, which serves a different population with distinct healthcare needs, commercial healthcare policies cover a broader demographic with a wider range of specialties. Therefore, more providers may be necessary in certain regions to meet the healthcare needs of the general population. The decision to set a minimum of two providers per specialty reflects a compromise among stakeholders and is meant to strike a balance between flexibility for insurers and ensuring consumer choice.

The Texas legislature did not intend to mirror the Medicare Advantage rules word for word. The requirements were crafted to address Texas-specific concerns, such as varying access to care in rural versus urban areas, and to ensure that networks are both adequate and accessible for all Texans, not simply mirroring federal guidelines. While the federal Medicare Advantage rules are more rigid, Texas' approach offers room for customization based on county size, population, and local healthcare needs, thus giving insurers more flexibility to design their networks effectively. The implementation of these standards, therefore, takes into account the diverse needs of Texas' insured population, which differs significantly from the population covered under Medicare Advantage.

Carriers argue that the restrictions on waivers under the TDI rules are too burdensome and should be repealed. However, prior to HB 3359, 90% of insurance plans failed to meet network standards, leading Texans to pay for coverage that was not accessible. To address this, limits on waivers were introduced, with exemptions for cases where no providers are available. Carriers automatically receive two waivers per county and can get additional waivers if they demonstrate good faith efforts to contract with providers. These standards took effect in September 2024, but carriers are already pushing to repeal them. TDI has stated that without good faith negotiations, most carriers will not qualify for waivers in 18 months, underscoring the importance of compliance with network adequacy standards.

Carriers have expressed that waiver hearings required by TDI are too burdensome, citing low participation from the public and physicians. However, public hearings are only required when a carrier requests a waiver for a county with available providers that they have failed to contract with. Carriers must submit basic information about their network and negotiation efforts, which should be readily available. TDI's online platform makes the process cost-effective, and the virtual hearings should minimize any inconvenience. Low participation likely stems from short notice or scheduling conflicts. TDI is required to notify physicians, but some carriers have failed to engage in meaningful negotiations, contributing to the lack of provider attendance.

Testimony

The Committee heard testimony from Debra Diaz-Lara, Deputy Commissioner of Life and Health at the Texas Department of Insurance (TDI).

Ms. Diaz-Lara stated that TDI has spent the past year working on implementing HB 3359 (88R) for network adequacy for Preferred Provider Benefit Plans (PPOs) and Exclusive Provider Benefit Plans (EPOs). This required a lengthy rulemaking process as they were changing the required standards for provider availability and accessibility by including specified time and distance standards for different provider types, as well as appointment availability. They proposed the rule on November 21st, 2023, and accepted comments on the rule through December 21st, 2023. TDI held a hearing on January 10th, 2024, accepted comments until January 22nd, 2024, and published the final rule on April 4th, 2024. The initial effective date of the rule was April 1st, 2024. They pushed that date back to May 1st, 2024, to allow plans more time to meet the requirements. They once again pushed the effective date of the rule back to May 30th, 2024, based on comments received during the rulemaking process.

Ms. Diaz-Lara said that some of the points of contention during implementation were benchmarks for sufficient access and choice, Texas requirements versus federal Qualified Health Plan (QHP) standards, the question of do providers outside service areas but within mileage count under this law, and conflicting viewpoints about the time for implementation.

She said that TDI had 121 networks filed on May 30th, 2024. Some of the networks were statewide and included all 254 counties in the state. Some were much smaller and included only 1-2 counties. Every one of the networks filed required a waiver request. The waivers included several provider gaps that ranged from 23 to 1,659.

As required, TDI held public hearings for each network that requested a waiver. The five hearings were on July 9th, July 11th, July 25th, July 30th, and August 1st, 2024. The recordings form the hearings are available on the TDI website. Hearing notices were published a minimum of two weeks in advance of the hearing, and written comments were accepted for up to a week after the hearing date.

The networks were reviewed based on providers in two categories, facility-based providers and major medical providers for availability and accessibility. Good faith efforts in contracting were evaluated on both categories as well. TDI found that the good faith efforts in contracting varied significantly for network to network, and carrier to carrier. The good faith efforts in contracting for major medical providers varied from 88% to 57%. The good faith efforts for facility-based providers were a 0% across the board. The networks provided a variety of reasons for the lack of good faith effort, including, but not limited to: non-contracted providers and network could not come to an agreement on terms, the inability to determine which facility-based providers were credentialed at a given facility, and the available non-contracted providers would not have resolved the gap deficiency even if they were to become contracted providers.

Ms. Diaz-Lara said that TDI also found that many contracting attempts consisted of one phone call or email, without follow-up or using an alternative method to reach the provider contact. Networks were frequently unable to provide documentation that multiple attempts or multiple offers were made to providers regarding contacting.

In instances where no providers were available to contract, a waiver hearing was not required. The gap was noted, and the network was required to submit a plan to demonstrate how the network would ensure care was to be made available.

Ms. Diaz-Lara said that implementation has largely been successful, but challenging. She said that some health plans struggle to submit adequate data. Some plans largely demonstrated good cause for their waiver requests. TDI is educating plans on where contracting efforts must be improved to be considered "good faith." She stated that to better educate carriers, networks, and providers on the requirements for the networks, TDI intends to update the templates made available for networks to provide drop down boxes for selection, which will help streamline the network's responses and will also help to automate the reporting process. She said that TDI will also provide guidance via a checklist for good faith efforts in contracting, and they will also provide additional guidance for availability and wait times. She stated that to make the next reporting year a smoother process, TDI plans to have the updated checklists and guidance available well before the end of this calendar year to allow networks to be better prepared for the April 1st, 2025, deadline.

The Committee heard testimony from John Hawkins, President, and Chief Executive Officer at the Texas Hospital Association (THA).

Mr. Hawkins stated that network adequacy is a key element of health insurance coverage, and therefore, patient satisfaction with both their insurance plan and their provider. For the provider, who is the in position of caring for a patient in their time of need, interruptions in health care coverage due to a narrow or skinny network, often unbeknownst to the patient, is both difficult and time consuming for everyone.

He stated that the legislature has prioritized policies that ensure both a healthy plan design for the patient and a healthy network for state-regulated plans. Where we have seen a proliferation of "skinny" or "narrow" networks in recent years has largely been in the ERISA market and the Medicare Advantage network, with hospital members reporting plans that don't include a hospital at all in certain networks or no providers for 40 miles. There has been a steady increase in the number of hospitals that seek mediation due to a patient being out-of-network. In 2019, when SB 1264 was passed, hospitals were generally in-network with Texas plans 98% of the time. However, the number of claims hospitals have brought forth for mediation have increased nearly 6-fold between 2020-2022. That indicates more state regulated plans are out-of-network with enrollees.

In order to begin addressing the problem of insufficient networks, last session THA joined with a coalition of other provider and physician groups to support House Bill 3359, authored by Chairman Bonnen, and is a comprehensive update to Texas' insurance laws that sets network parameters for preferred provider benefit organizations and exclusive provider benefit organizations and establishes a more transparent process for the granting of waivers to health plans who cannot meet the new requirements.

Before a plan can be offered to consumers it must be able to demonstrate an adequate network. For example, the law now requires that health plans ensure access to general, pediatric, specialty and psychiatric hospitals (with some exceptions for exclusive provider plans). These changes just went into effect for policies delivered, issued, or renewed on or after Sept 1st. He stated that it is still too early to determine whether the new requirements are making a difference in combatting insufficient networks,

we are continuing to monitor implementation of HB 3359 by TDI and see the impact it is having on our members. Some concerns have been noted to us by our members regarding additional administrative burdens being imposed upon them from insurers. We are monitoring these concerns and if we believe they warrant attention by the Legislature, we will ensure they are brought to this committee's attention.

Mr. Hawkins concluded his testimony by stating that hospitals want to be in-network. Ensuring that health plans provide their beneficiaries with the coverage they need to justify the premiums paid by Texans is and should be the ultimate goal.

The Committee heard testimony from Dr. Ezequiel "Zeke" Silva, Chair of the Council on Legislation at the Texas Medical Association (TMA).

Dr. Silva started by giving a brief overview of the issue of network adequacy by giving a definition. According to the National Association of Insurance Commissioners (NAIC), "network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in network primary care and specialty physicians, and all health care services included under the terms of the contract."

Dr. Silva stated that this is a core principle of insurance regulation. If you're selling a promise to pay for medical services, you must be able to deliver on that promise. Failure to do so leaves patient on the hook for the medical bills they believed were covered by their insurance. Dr. Silva stated that this is a twofold blow: the patient must pay the premium for a misleading health insurance policy plus out of pocket costs to receive needed care. An inadequate network can also contribute to surprise billing disputes, which further adds costs to both insurers and physicians.

Dr. Silva stated that, in Texas, we have historically had some of the strongest network adequacy standards in the country. They were established by administrative rules adopted by TDI over a decade ago.

However, beginning in 2021, right around or after the time the federal No Surprises Act surprise billing law took effect, physicians began reporting to us that they were seeing a growing number of insurers taking stronger positions when negotiating or renegotiating contracts, doing things like drastically cutting rates and saying "take it, or go out of network." Many physician practices that had been in network for years were suddenly forced into a Hobson's choice, in which only one option actually exists: either go out of network or stay in network by accepting terms that aren't sustainable for running a viable practice.

Dr. Silva stated that strong network adequacy protections Texas had in administrative rule were not being enforced, but instead over 90% of state-regulated health plans were operating under a waiver from the standards. These waivers, intended for unique circumstances and rural areas where it may not be possible to completely fill a network with all the necessary facilities and medical specialties, were being granted in areas like Harris County, one of the largest medical communities in the world. While the waivers were intended to be the exception, they had become the rule. This was allowing health plans to sell inadequate networks to patients (who thought they were getting a complete product) with little to no repercussions. He stated that waivers had basically become a "get out of jail free card" for health plans.

Dr. Silva stated that to rectify this problem, House Bill 3359 sought to codify the previous network adequacy protections and bolster the waiver process, strengthening our networks and ensuring patient access to care. HB 3359 defined post-emergency stabilization care, codified time and distance requirements, reformed the waiver process, requiring a public hearing, and restricted unilateral contract changes.

This bill was heavily negotiated throughout the process and ultimately passed unanimously and was signed by the governor. The final version of the bill that was heard had no registered opposition.

Dr. Silva stated that after any bill passes, the next hurdle is implementation. Earlier this year on April 5, TDI adopted final rules to implement the bill. Dr. Silva said that TMA initially had a number of concerns with the initial rules that were proposed at the end of last year. He stated that TDI's final rules addressed a number of their concerns. Doctor Silva said the rules established the reformed waiver process and submission guidelines. He stated that they required plan advertisements to inform potential customers slash insureds that the plan received a waiver. He stated that the rules updated required customer consumer notices, so insureds are aware of their right to an adequate network. Lastly, he stated that the rules established a notification process for physicians named in an insurer's request for a waiver. Dr. Silva stated that TMA will continue to assess the impact and implementation of the new law and corresponding rules. Dr. Silva stated that, at the end of the day, this law was meant to make sure that there is value in the insurance products our patients are buying and relying on to help them pay for their health care.

The Committee heard testimony from Chris Gay, Chief Executive Officer at Evry Health

Mr. Gay began testimony by stating that all contracted medical providers should be included in the calculation for network adequacy. He stated that this should be regardless of invisible county lines and underwriting service areas, as the overarching principle is to provide choice and access to members. Mr. gay provided an example. He stated that the principal city in Wise County is the small city of Decatur. He stated that they have a strong network in Wise County and Decatur; However, there are not enough local inpatient facilities and ER services. Therefore, they also contract with the nearest medical providers in Jacksboro, located in Jack County. The issue is that the current calculation does not allow them to include these Jack County Medical providers because Jack County is not one of their underwriting service areas. He stated that they did not want it to be included in the service area.

Mr. Gay also suggested more flexibility in the time and distance requirements for several counties. Terrain features, highway access limitations, and traffic all combined to impact a member's travel time and distance to needed providers. Additionally, medical providers tend to geographically cluster for key specialties. For example, Conroe in Montgomery County does not have all the required 49 medical specialties. The nearest specialties are just south in The Woodlands and Harris County. However, the drive time from Conroe to these specialists in Harris County exceeds the limits.

Mr. Gay suggested that as more and more people seek the Texas way of life, with quieter neighbors, and maybe a bit more property, they are creating new suburbs, and commuting longer distances. A single person seeking their patch of the Texas way of life can mean 100% network coverage is impossible. In many counties, the population is concentrated on a county border, favoring proximity to urban conveniences. For example, one person living on the border of Montgomery County north of Conroe, automatically means Montgomery County will not achieve 100% network coverage. He stated that

seeking perfection for network adequacy is exceedingly expensive. He stated that this cost is then borne by everyone, which he stated is arguably unfair.

Mr. Gay concluded his testimony by recommending numerically defining sufficient network choice so that 75% of all members have the choice of two or more providers within the time and distance requirements.

The Committee heard testimony from Blake Hutson, Director of Public Affairs at the Texas Association of Health Plans (TAHP).

Mr. Hutson stated that Texas' network adequacy requirements, while intended to ensure access to care, are unintentionally overly burdensome and add administrative costs that impact Texas families and employers. He stated that providers with significant market power can exploit these regulations to force health care plans into paying higher rates. In many cases, plans are forced to apply for hundreds, if not thousands, of waivers simply because there are no available providers in certain areas. He recommended that Texas should consider expanding the standards to account for innovative care models, such as those that employ telehealth.

Mr. Hutson stated that the current system fails to account for the real-world complexities of health care delivery in Texas. Even the largest health plan networks, which include nearly every provider, face a dramatically increased number of waiver requests without having made significant changes to their networks. He said that there are ways to ensure network adequacy patient protections without creating this level of unnecessary administrative burden and the opportunity for heavily consolidated provider groups to abuse these laws to inflate prices.

Mr. Hutson offered suggestions to improve the state of network adequacy in Texas. He advocated to align federal and state network adequacy standards, stating that Texas should revise its network adequacy laws to add a definition of "sufficient." This definition should align with the federal definition of sufficient, which is 90% of enrollees having access to one provider for each specialty type. This would provide consistency across CMS and TDI standards and significantly reduce the number of unnecessary waivers. He also advocated for the reform of the waiver process. He stated that Texas should streamline the waiver process to reflect the lessons learned during the last round of network adequacy filings. Providers and enrollees have shown no interest in attending waiver hearings, he said. Waiver hearing should be removed entirely or be required only upon request from a provider.

He stated that Texas should reform laws to allow for high value networks. Texas should embrace the trend towards networks that support employers and patients through a curated network of high value providers. Businesses are increasingly looking to these arrangements to address rising health costs. He further advocated for accounting for anti competitive health care provider market share in waivers. Mr. Hutson said that Texas should not reward consolidation that raises prices and harms employers and patients. Waiver hearings and network adequacy requirements should account for circumstances in which health plans lacked a meaningful opportunity to negotiate for fair in network rates in a functioning market.

Recommendations

The Committee on Insurance recommends that the Texas Legislature should direct TDI to strengthen its enforcement of network adequacy requirements to ensure that consumers have meaningful access to in-network healthcare providers. Despite existing standards, many Texans face challenges with "narrow" networks which fail to provide sufficient options for timely, geographically convenient care. Such limitations can result in higher out-of-pocket costs for consumers who are forced to seek out-of-network care or endure long wait times.

The Committee believes that enforcement of network adequacy requirements will protect Texas consumers from surprise medical bills and ensure that their health insurance provides the coverage promised. By empowering TDI to more effectively regulate and penalize noncompliance, the Legislature can promote fairness, transparency, and improved access to care across the state.

The Committee recommends that, to address the limitations of the current network adequacy requirements, an unlimited waiver option could be introduced for counties with facilities or providers in contiguous counties that meet the time, distance, and appointment standards for enrollees. This would allow carriers to bypass the county-specific location limitations while still ensuring access to care, provided they demonstrate good faith efforts in negotiations. This solution would balance the concerns of providers and the intent of the original legislation to ensure that enrollees have access to healthcare in reasonable locations.

The Committee recommends that TDI should clarify its rules to adopt tiered standards based on county population, expected utilization for non-facility-based providers, and the size/type of facilities for facility-based providers. This would better align the standards with the unique needs of different counties, providing flexibility for carriers while ensuring adequate provider networks across Texas.

The Committee on Insurance recommends that the Legislature maintain the existing network adequacy requirements and not repeal the law so soon after implementation. TDI should continue to hold carriers accountable for conducting genuine, good faith negotiations with providers to ensure that sufficient, in-network options are available to consumers. Prematurely repealing this law would undermine its original intent and reward carriers that have not demonstrated reasonable efforts to build adequate networks. Instead, preserving these requirements will encourage carriers to put forth the necessary effort to contract with providers, thereby improving network adequacy and ensuring better access to care for patients.

The Committee recommends that TDI should be required to notify all relevant stakeholders, including providers listed in waiver requests, medical associations, and specialty societies, at least 20 days in advance of any waiver hearings. This advance notice will ensure greater transparency and allow affected parties sufficient time to participate in hearings, which would increase public engagement and help guarantee that all relevant perspectives are considered.

Hospital Facility Fees

Background

Hospital facility fees are additional charges imposed by hospitals or hospital-affiliated outpatient clinics when providing certain services, often to cover the overhead costs of maintaining the facility's infrastructure, equipment, and staffing. These fees are billed separately from the professional fees charged by physicians and can increase the total cost of care for patients.

Site neutral payments refer to a policy approach that aims to align reimbursement rates for equivalent medical services, regardless of whether they are provided in a hospital setting or a non-hospital, such as an independent physician's office or outpatient clinic.

The Committee heard testimony from Christine Monahan, J.D., Assistant Research Professor at the Center on Health Insurance Reforms (CHIR), McCourt School of Public Policy, Georgetown University.

Ms. Monahan stated that she had been studying outpatient facility fee billing for the past two years. She and her colleagues have conducted several dozen interviews with on-the-ground stakeholders, reviewed existing laws and pending legislation across the country.

Ms. Monahan said that there are two types of claims typically used to bill for medical services, a professional bill, the CMS 1500, and the facility bill, the UB-04, also known as CMS-1450. If you received care at an independent provider practice, the provider who treated you will submit a professional bill to your insurer. This bill notionally covers their time and labor as well as any practice overhead costs like nursing staff, rent, and equipment and supplies. On the other hand, if you receive care at a hospital outpatient department, generally speaking, any professional who treated you, as well as the hospital, will each submit separate bills. Any professional bill should just cover the providers' time and labor, while the hospital bill, or facility fee, ostensibly covers overhead costs. What counts as overhead hospital overhead costs, and what else goes into that facility fee is complicated. As you would expect, a facility fee generally will cover the overhead costs related to the patient visit for which is being billed, including nurses or support staff involved and any equipment and supplies. Outpatient departments need to meet extra licensure and regulatory requirements, and they likely also have some additional costs that don't apply to independent practices. In addition, a facility fee is likely to cover other hospital overhead costs. Some of these are necessary and desirable services at the population level, but they're not necessarily related to the care delivered to the patient was getting billed. For example, facility fees might help fund things like hospital emergency services or 24/7 staffing and security at the hospital, even though the patient was at the facility they're in normal business hours and didn't need any emergency care. Hospital overhead costs can also include things of more debatable value. Other factors unrelated to the cost of care or other expenses a hospital has also play a big role in determining how much a hospital bills for, and gets paid by insurers through these facility fees. These include things like historical billing patterns and market power, particularly as hospitals and health systems get bigger and particularly in vertically-integrated organizations, they have much more power than your solo physician or independent group practice to demand higher reimbursement when negotiating with insurers. So when economic experts compare the prices paid for the same services at hospital outpatient departments and independent physician offices, they find much higher prices in hospital settings, for example a patient going for a week of weekly chemotherapy visits would see, on average, a 2.7 fold difference in price if they switch from an independent practice to a hospital outpatient department. Ms. Monahan stated that in many cases they are not the ones making that choice to switch. Rather, one day in the middle of treatment, they may go into the same office building as always for the same care as always, and come away with a bill that's more than $400 higher than what they're used to, because a hospital acquired their practice and converted it to a hospital outpatient department. It is this recent history of aggressive hospital acquisition of outpatient practices that is driving this issue today. Facility fee billing is not a novel practice, but it is more common than it used to be, following years of vertical integration, where hospitals are acquiring or building their own outpatient physician practices and clinics. One of the reasons hospitals and health systems have expanded their ownership and control over outpatient physician practices over the past decade is so they could charge the second bill and increase their revenues. Another reason we are likely hearing about facility fee billing now are

inadequacies of insurance coverage. As the hospital industry will emphasize, patients increasingly are coming in with high deductible health plans, which left them exposed to more charges including facility fees. Higher spending on outpatient care from facility fees is increasing the cost of health insurance for all of us: consumers who enroll in insurance, employers who are sponsoring insurance for their workers, paying more than 70-80% of planned premiums, and taxpayers who heavily subsidized the private health insurance market. Economist Steven Parenti, who served on the White House Council of Economic Advisers in the Trump administration, recently released a study finding that employer plan premiums could go down more than 5% annually if insurers paid the same amount for care and hospital outpatient department as they do an independent physicians office. This, in turn, would result in $140 billion in savings to the federal government over 10 years to reduce tax subsidies. Insurers are responding to these increases by increasing cost-sharing for otherwise limited benefits. As the hospital industry will point out, health insurance deductibles are increasing in size and prevalence. Ms. Monahan said that these costs are going straight to the patient. This can be because the facility fee is trying its own distinct cost-sharing obligation from the professional bill, or because insurers at higher cost-sharing rates for services provided at the hospital outpatient departments, to try to discourage patients from going there. Additionally, some insurers may simply not cover a service when it is provided at a hospital outpatient department, to contain their own spending, while potentially opening up patients to balance billing. So, some inadequacies in insurance coverage are playing a role in exposing consumers to high medical bills, and this is driving media attention towards facility fees, but, if insurance covers these charges without any cost savings, consumers, as well as employers and taxpayers, would still be paying for it.

What can be done to address these concerns? One option is to continue to wait to see if the private market will reform. There are barriers to private reforms, however, including a lack of information, a lack of leverage, and a lack of motivation. With respect to information, one of the refrains she says she constantly hears from stakeholders is that there are significant gaps on claims data that may be challenging for private payers and regulators alike to understand. Specifically, she reported that it can be very difficult, if not impossible, to identify the actual brick and mortar location where health care is being provided on a claims form and database. The address line that bill may just refer to the main campus or hospital that owns the practice, or even an out of state billing office for the health system. In terms of leverage, as we know, dominant health systems frequently have the upper hand in negotiations with insurance companies. A key selling point for insurers is that they have the name brand hospital or physician group in their network. In Massachusetts, one of the major insurance groups proactively sought to eliminate outpatient facility fee billing by in network providers, but they could only do it in a budget neutral manner by agreeing to raise rates elsewhere.

Regarding motivation, insurers generally don't benefit from lowering health care costs, as they take home a percentage of spending, but public scrutiny on egregious facility fees in Massachusetts motivated the insurer she mentioned previously to act, and could encourage other insurers elsewhere to follow suit. Additionally, large employers increasingly are engaging on this issue, and other health care spending issues, and they may be able to pressure insurance to eliminate facility fee billing in their contracts with providers. Ultimately, though, facility fee billing and other aggressive pricing and billing practices are an uphill battle for the private market to tackle alone. Accordingly, she said that she is seeing states across the country, reflecting broad geographic and political diversity, begin to pursue legislative reforms. By her account, 20 states nationwide have enacted one or more of six potential

solutions. Ms. Monahan's group identified site neutral payment reforms, facility fee billing bans, billing transparency requirements, public reporting requirements, cost sharing protections, and consumer notification requirements. Ms. Monahan discussed the first three of these. She stated that these reforms are not mutually exclusive. They simply tackle the issues from different but complementary angles she said that Colorado, Nebraska, and Nevada now require off campus hospital outpatient departments to acquire a unique location specific identifier number known as NPI to be included on claims forms. This is a simple and minimally burdensome reform that could greatly enhance claims data, as Colorado has learned. Pairing this data with a system for tracking the NPI to which it belongs can make it even more useful to give one visibility into both the location of care, and who owns that site. This information, in turn, could help private payers or regulators and policymakers rain and outpatient facility billing. It could also be valuable in helping payers adopt and provider network to steer patients towards different provider locations based on quality or cost. A state seeking to go further could prohibit outpatient departments from charging facility fees for specified services. Texas, of course has already done this very narrowly for services like COVID-19 testing performed at drive through clinics. States like Connecticut, Maine, and Indiana, however, have more broadly prohibited hospitals and health systems from charging facility fees for outpatient evaluation and management services, or other office care in certain settings by prohibiting facility fees for specified services. By prohibiting facility fees for specified services, policymakers protect patients from potentially bearing the cost-sharing burden of two bills. For example, rather than owing a $30 copay on the physician bill and a 40% copay charge on the facility fee, the patient will go back to just a $30 copay if they have received care in an independent setting for the large percentage of the population who don't have enough cash to pay typical private plan cost sharing amounts. At the same time, the system wide savings from such reform likely will be relatively muted in the longer term, as market powerful hospitals renegotiate their contracts and increase other prices to make up for the loss of revenue from facility fees, as was seen in Massachusetts. Policymakers who are feeling particularly ambitious may want to consider site neutral payment reforms. These reforms call for insurers to pay the same amount for the same service, regardless of whether the service is provided at a hospital, outpatient department, or an independent practice.

The Committee heard testimony from John Hawkins, President and Chief Executive Officer at the Texas Hospital Association (THA).

Mr. Hawkins stated that limiting facility fees only addresses a small segment of the healthcare system and will have unintended consequences that will reduce access to care and ultimately drive up costs. He stated that hospitals are the only part of the health care system with the responsibility to serve all comers regardless of their ability to pay, and their 24/7 existence is essential to the health and well-being of the communities they serve. Hospitals and health systems, just like the communities they serve, are not monolithic in the services they offer or how they operate. Texas hospitals also face considerable challenges due to uncompensated care since nearly one-fifth of the population is uninsured. While the hospitals and health systems across the country have faced skyrocketing costs challenges acquiring drugs, supplies, and labor. How these cost challenges impact each hospital inherently depends on the hospital's financial situation and the unique needs of the patients and communities they serve. Despite the variety of hospitals and their unique challenges, he stated that eliminating facility fees will negatively impact all hospitals, and Texas already leads the nation in the number of hospital closures.

More specifically, a hospital that cares for higher proportions of Medicare and Medicaid patients may face more financial challenges due to chronic underpayments from government payers. According to the Medicare Payment Advisory Commission (MedPAC), the federal body charged with advising Congress on the Medicare program, hospitals' Medicare margins for inpatient care in 2022 were negative 11.6%. In other words, hospitals lost $100 billion by providing care to Medicaid patients. Losses from Medicaid and Medicare combined nationally totaled over half a trillion dollars between 2018 and 2022.

Mr. Hawkins stated that facility fees are a critical part of paying for a patient's care and they ensure outpatient clinics remain open and Texans continue to have access to lower-cost, more convenient options for health care. As medicine and health care have evolved, more and more care is provided in outpatient, less-costly settings, and hospitals have responded to the needs of the community by establishing more outpatient settings for that care.

Mr. Hawkins said that there are many common misconceptions relating to facility fees.

One is that professional fees pay the doctor. He said that facility fees payments cover a patient's care and environment beyond the doctor's bill. They pay nurses, supplies, equipment (including required back-up generators, which has been particularly important in times of grid uncertainty), housekeeping, property taxes, and administrative expenses including prior authorizations, and required governmental reports.

Another misconception is that in Texas, due to the corporate practice of medical doctrine, hospitals (except for rural and public hospitals) cannot directly employ physicians. Therefore, two separate billing systems have historically existed in Texas.

Mr. Hawkins stated that researchers who have published work on facility fees often point to other states, but due to the corporate practice of medicine, these are not "apples-to-apples" comparisons. For example, states like Connecticut, Maine, and Indiana all allow physician employment, which impacts billing practices. More importantly, states all have different payor mixes and insurance coverage rates.

He also noted that it is important to remember that hospitals are not the only entities that own outpatient facilities. He said that from 2019 to 2023, health insurers, private equity, and other entities were responsible for most purchases of physician practices, with hospitals only accounting for eight percent of these purchases.

He added that the impact of high deductible and high out-of-pocket expenses are a driving factor in patient confusion and complaints about facility fees. Nationally, high deductible health plan availability increased from 33% in 2014 to 51% for workers in 2023. More insured patients are finding their coverage does not cover facility fees, or their deductible may be so high that they're effectively paying for nearly all of their health care costs out-of-pocket.

Mr. Hawkins said that Texas hospitals have invested heavily in expanding services offered in the outpatient setting, expanding access to health care and jobs. Hospital Outpatient Departments (HOPDs) are vital in moving patients away from the inpatient setting and reducing health care costs. Importantly, hospital outpatient services have led to new access to care points for counties across the state that were unable to see specialists or receive non-emergency care in their communities.

He said that in one particular instance, a critical access hospital has been able to significantly increase access to specialty and advance care in a deeply medical underserved region by recruiting physicians in order to establish hospital outpatient departments in specialties such as gastroenterology, neurology, cardiology, urology, and therefore, reduced the need for local residents to travel hundreds of miles simply to see a specialist. These areas of the state are often difficult areas to attract specialists to without the backing of a hospital system. The outcome of that investment in the community resulted in reduced lengths of stay at the hospital (due to the availability of specialty outpatient preventative care) and reduced transfers to hospitals outside the area. These outcomes lower the cost of care. Mr. Hawkins said that refusing to pay facility fees will not.

Mr. Hawkins said that research supports that patients who seek car in HOPDs are not always the same patient populations that seek care in a non-HOPD. They are often older, sicker, and need a higher level of care, which means a higher level of cost and reimbursement is necessary to treat that patient population. More importantly, the licensing and regulatory requirements of a hospital-owned outpatient facility are not the same as others. HOPDs have enhanced regulatory requirements that others do not have. If a HOPD is neither a remote nor an on-campus facility, they cannot charge a facility fee.

Mr. Hawkins addressed some of the reasons why physicians are selling their practices to a hospital or other entity. He said that, according to the AMA, their survey information suggests that 80% of physicians indicated that their inability to negotiate higher payment rates with payors was a major factor in their decision to sell their practice to a hospital or health system. Another factor frequently listed is the burden of managing payors' regulatory and administrative requirements.

Mr. Hawkins concluded his testimony by stating that THA wholly supports physician reimbursement increasing to also reflect the true cost of delivering care. He stated that if physician reimbursement was higher, Texans would have more access to care points in counties across Texas. He stated that dismantling facility fee payments would dismantle access to care across Texas, and increase the cost of care, particularly for low-income residents, underserved populations, seniors, and people in rural communities who rely on outpatient care.

The Committee heard testimony from Charles Miller, Senior Policy Advisor at Texas 2036.

Mr. Miller stated that this issue was a symptom of our consolidated system and is happening more frequently due to expanding practice of vertical integration in our health care system. He said that he does not want to take on the concept of facility fees head-on, but instead wants to address this bigger issue of consolidation. He stated that this issue is not so much the fact that it exists, but that in some cases the combined amount may be three times more than it is at an independent practice for the same service. He noted that, hypothetically, when a practice is bought out, facility fees might possibly help to lower professional fees accordingly, so that the overall price that is being paid for the service stays relatively the same. He said that currently it is difficult to tell how a facility fee is related to a given service. One of the things that might be very helpful in reducing confusion, according to Mr. Miller, would be for Hospital Outpatient Departments (HOPDs) to receive a unique National Provider Identifier (NPI), a unique 10-digit number that identifies health care providers. He stated that HOPDs receiving a unique NPI number would be a great way to identify problematic actors from the places that are providing quality care by providing more information so that the contracting process is more transparent.

The Committee heard testimony from David Balat, Chief Executive Officer at Healthcare Finance Specialists.

Mr. Balat stated that one of the primary factors contributing to increased healthcare costs is the consolidation of both providers and insurers. In Texas, Blue Cross Blue Shield of Texas holds a commanding market share exceeding fifty percent. This dominance gives insurers extraordinary leverage in negotiations, often leaving providers with little choice but to consolidate themselves. Hospitals and physician groups have merged or formed alliances to remain financially solvent. However, this response has led to increased administrative burdens, which drive up operational costs and, consequently, the prices patients and payers face.

Mr. Balat said that another significant driver of costs is the practice of hospitals acquiring or employing physician groups. This practice has created a captive environment that promotes the rise of facility fees, which are charges assessed for the use of a hospital's resources, even for services not performed on the hospital's primary campus. Texas has Corporate Practice of Medicine laws that are meant to prevent hospitals from controlling physicians' medical judgments, but he stated that these laws are poorly enforced. Employed physicians are often discouraged from referring patients to outside facilities, as hospitals view such referrals as "leakage," and may impose financial or administrative burdens on the referring physicians. This not only increases costs, but also limits patient choice.

Mr. Balat said that, to address these issues, insurers should negotiate contracts that explicitly exclude facility fees for services performed at locations other than the hospital's main campus. Furthermore, the Health and Human Services Commission (HHSC) could require hospitals to exclude facility fees for off-campus services as a condition of their licensure. These off-campus facilities, often classified as Hospital Outpatient Departments (HOPDs), should not be allowed to impose facility fees that are unrelated to the cost of care provided on a hospital's main campus.

Mr. Balat concluded his testimony by stating that by implementing these measures, Texas can reduce unnecessary costs associated with facility fees, improve transparency for consumers, and ensure a more competitive and equitable healthcare market.

The Committee heard testimony from Blake Hutson, Director of Public Affairs at the Texas Association of Health Plans (TAHP).

Mr. Hutson stated that facility fees have become a significant and growing concern in Texas, as they are increasingly imposed on patients without their knowledge or consent. These fees, often charged by hospitals and health systems for services that do not require the use of hospital facilities, are driving up health care costs for patients and creating a new type of surprise medical bill.

He stated that the facility fees were originally intended to help cover the overhead cost of hospitals and their emergency departments that must stay open at all hours to meet patient needs. However, hospital systems are rapidly buying up doctors' clinics and imposing hospital level billing by turning these clinics into hospital outpatient departments (HOPDs). Hospitals in Texas are now applying these fees to a wide array of outpatient services, preventative health care visits, and even telehealth services. He stated that all of these were never meant to include a facility fee or even to be performed at a hospital.

He stated that patients in Texas and around the country have been caught off guard and left on the hook for hundreds, or even thousands, of dollars in an unexpected facility the charges. Surprise facility

fees are the latest addition to out-of-control healthcare costs that result in higher out of pocket spending for patients and increased premiums for employers and families. States are increasingly becoming aware of the need to step in on set limits on these abusive provider pricing schemes.

Mr. Hutson stated that by examining hospital facility fee bills, there exists one of the biggest opportunities to address runaway health care spending and to improve affordability for Texans. He stated that by prohibiting or limiting facility fees in specific contexts, such as telehealth, preventative services, and clinician administered drugs, Texas can protect patients from unnecessary cost and promote a more transparent and equitable health care system.

Mr. Hutson said that U.S. House and Senate proposals focused on broad health reforms include provisions to address surprise facility fees. Legislation moving in both chambers includes site of service billing transparency to ensure medical bills match the true location where health care services are performed. the US house passed the lower costs more transparency act of 2023, which would address facility fees added for clinician administered drugs, such as chemotherapy treatments, saving Medicare roughly 3.7 billion / 10 years, and cutting copays by about $40 per patient. Several states have also taken action in recent years to address these surprise fees. An Indiana law aimed at addressing the price facility fees and other dishonest billing tactics limits the use of hospital billing for services provided off of a hospital's campus. Ohio and several other states banned facility fees for telehealth visits, and both New York and Colorado limit facility fees for preventative services.

Connecticut extended its COVID-era ban on facility fees for telehealth while also banning facilities for simple, non-emergency physician visits. Maine lawmakers now require health care claims to identify the physical location where a service was provided, including hospital off campus locations, a move aimed at getting a handle on when facility fees are applied outside of a hospital.

Mr. Hutson recommended establishing facility fee billing transparency by requiring hospital affiliated facilities to use a unique National Provider Identifier (NPI). He stated that this honest billing requirement will ensure patients and payers know whether a facility fee was inappropriately applied. He also recommended that patients be protected from inappropriate and excessive surprise facility fees for services that could have been provided outside of a hospital, such as telehealth services and preventative care. Mr. Hutson also advocated for the prohibition of facility fees for clinician administered drugs, such as chemotherapy. He stated that patients should not have to pay more for these life saving drugs just because of where they received them.

Recommendations

The Committee on Insurance recommends the assignment of unique National Provider Identifier (NPI) numbers to hospital outpatient facilities as a critical step to increasing transparency in hospital billing. Currently, many hospital systems bill for outpatient services under a single, overarching NPI number tied to the main hospital, obscuring the cost and location of care provided. This practice complicates efforts to identify the source of charges, making it difficult for patients, insurers, and regulators to fully understand the healthcare costs associated with outpatient services.

By requiring unique NPI numbers for outpatient facilities, Texas can provide patients with clearer information about where their care is delivered and what services contribute to their bills. This level of transparency would enable consumers to make more informed decisions about their healthcare, fostering greater accountability among providers. Additionally, unique NPI numbers would improve the accuracy of data collection, allowing policymakers and researchers to analyze trends in outpatient care and costs more effectively.

The Committee on Insurance recommends that the Legislature require facilities to provide at least ninety days' advance written notice to all existing patients before imposing facility fees related to imaging, pediatric primary care, adult primary care, physical therapy, and clinician-administered drugs. "Existing patients" should be defined as those who have received care from the facility within the past three years. The notices must make it clear that future costs for services will increase and explain that patients will receive two separate bills, one for professional services and one for facility fees.

In addition, facilities should be required to give ninety days' advance written notice to participating health plans before they begin charging facility fees for the specified services. If the new combined charges exceed twice the prior professional fee rate, this notice will trigger a 120-day renegotiation period. During this period, all remaining terms of the existing facility and professional contract remain in force and cannot be renegotiated until the current contract term ends. Facilities must also provide an annual list of any outpatient imaging, pediatric primary care, adult primary care, physical therapy, or clinician-administered drug services subject to facility fees, and health plans must indicate these fee-related services in their provider directories.

The Committee further recommends eliminating the imposition of facility fees for clinician-administered drugs, such as chemotherapy. This step would help protect patients from excessive cost burdens and ensure that essential treatments remain both accessible and affordable.

Artificial Intelligence (AI) in the Insurance Industry

Study how artificial intelligence (AI) has impacted the insurance industry. Examine what functions AI serves in enhancing efficiency and risk assessment within the sector and examine concerns regarding this practice.

National Council of Insurance Commissioners – AI Model Law

The National Association of Insurance Commissioners (NAIC) has developed a Model Bulletin to guide insurers on the use of artificial intelligence (AI) systems, ensuring their compliance with state laws against unfair trade practices and discrimination. This initiative focuses on fostering accountability, transparency, and fairness in the deployment of AI tools in the insurance industry. This bulletin was adopted on December 4th, 2023.

The Model Bulletin outlines that insurers must create a comprehensive AI governance program, termed an "AIS Program." This program should identify and mitigate risks associated with AI usage, including potential unfair discrimination. The AIS Program should be commensurate with the scope and complexity of AI applications within the insurer's operations.

The AIS Program should establish internal oversight structures, such as dedicated committees and defined chains of command, ensuring ongoing monitoring and management of AI systems. It requires insurers to document AI system lifecycles, maintain transparency, and provide consumer notifications when decisions are impacted by AI.

Insurers are expected to implement robust mechanisms for assessing and addressing risks such as data integrity, bias in predictive models, and the fairness of AI-driven decisions. The guidelines emphasize oversight of third-party AI tools to ensure compliance with legal standards.

For AI systems developed externally, insurers must perform due diligence and enforce contractual terms requiring adherence to their AIS Program. This includes audits and cooperation with regulatory inquiries to address compliance issues.

Although the bulletin is not legally binding, it offers critical standards and guidance, signaling the regulatory expectations for insurers using AI tools. Adoption of these practices by state regulators will vary, and further refinements to the model are anticipated as AI technologies and their implications evolve.

Testimony

The Committee heard testimony from Miguel Romero, Director of Property and Casualty Services at The National Association of Insurance Commissioners (NAIC).

Mr. Romero began his testimony by talking about a document that his regulators adopted through NAIC, which they refer to as a model bulletin on the use of artificial intelligence system by insurers. This discusses how they understand how insurers are using artificial intelligence. By way of background, in 2020 the NAIC, through their regulators, of which TDI is a member, issued AI principles. Those principles ask that or set the expectations that AI actors will work in a way that is accountable, compliant, transparent, safe, secure, fair, and has robust outputs. Since then, these regulators were then studying what comes next, and what they decided was to issue a model bulletin explaining the way that they think the existing regulatory framework applies in the context of AI. This took the form of a model bulletin. Mr. Romero said that most people are familiar with model regulations, or model laws, which come out of the NAIC, but in this case this model bulletin is slightly different it's a template to be used by departments of insurance. The difference is that usually these are issued directly by departments of insurance, and they typically take the role of explaining the way that laws apply. They're not creating any new requirements, although that practice does vary based on the authority of each Department of Insurance. They issued the bulletin, and this was adopted in the fall national meeting for the NAIC. The document explains the way the state law applies and has four key sections. It has an introductory section that cites the authority on which the regulators expectation rests, generally pointing to unfair trade practices and unfair claim and discrimination statutes. The way that those are adopted across the United States varies from state to state. The intention was to write something explaining the way the regulatory framework applies across the board. Section 2 discusses technical definitions for key terms. The terms covered here are artificial intelligence machine learning predictive models, and adverse consumer outcomes. Generally, these definitions were written from a technical perspective. Section 3 sets forth regulatory guidance and expectations related to insurers, the development of and the development of AI systems programs. Because AI is such a potent tool, the NAIC Believes that the proper use of that tool requires that they take certain steps and measures to ensure that the tool is not leading to adverse consumer outcomes. It contains general guidelines in the bulletin describing the way that they expect the use of AI systems to be mitigated from a risk perspective. It describes examples of governance framework elements, risk management, and internal control practices. This represents the culmination of several years of effort and discussion.

Mr. Romero stated that NAIC’s Regulators operate on the premise that bad policy comes from bad data. They are undertaking a process to survey insurance company use of AI. Starting back in 2022, they have been engaging in the process of serving companies by line of business. In 2022 they completed a survey of private passenger auto. In 2023 they completed surveys of homeowners and life insurance, and they are currently working on health insurance specific surveys, as their regulators engage how AI is going to be a transformative piece of technology for everyone.

Mr. Romero stated that the NAIC support industries use of this important technology. They are of the mindset that responsible use comes with certain expectations. Some of the insights that were included in the model bulletin are as follows. The private passenger auto survey was completed by 194 companies. The homeowner survey was completed by 193 companies. 9 states participated in the private passenger auto survey. 10 completed in the homeowner survey. Mr. Romero said, from the

companies surveyed, 70% of auto insurance companies were using it for claims 50% were using it for marketing, 49% were using it for fraud detection, 27% for writing, 18% for underwriting, and 2% were using AI for loss prevention. Many companies were using it to assess the effectiveness of their marketing campaigns. He said AI helps them understand what the data is telling them. AI is extremely good at pattern recognition, and a lot of the process of marketing is recognizing how a company's choices reflected themselves in marketing patterns. From a rating and underwriting perspective, he stated that they did see that companies are generally using AI across the board, most commonly using generalized linear models (GLMs).

The Committee heard testimony from Naomi Lopez, Senior Fellow at The Goldwater Institute.

Ms. Lopez stated that AI holds tremendous promise in enhancing customer service, improving patient outcomes, and fostering innovation, particularly within self-insured health plans. She emphasized the importance of ensuring that this innovation should go hand-in-hand with strong consumer protections and robust regulatory oversight.

AI technology is rapidly transforming many sectors, and insurance is no exception. Often referred to as "InsurTech," the application of AI and Machine Learning (ML) within insurance is not just about automation traditional processes, but also about fundamentally changing how insurers assess risk, interact with consumers, and deliver products to consumers.

Ms. Lopez stressed that AI has the capability to streamline underwriting and claims processing, reducing manual intervention and human error. AI systems can instantly evaluate claims, assess damages, and make decisions on payments based on historical data and predictive algorithms. This capability not only speeds up the overall process, but also enhances accuracy and reduces costs. AI excels at identifying patters and anomalies in large datasets, which can be instrumental in detecting fraud. In the insurance context, AI can automatically flag unusual claims or suspicious behavior, helping insurers reduce fraud-related losses. AI-driven chatbots and virtual assistants are improving customer services by answering policyholder queries in real time, providing 24/7 support, and guiding consumers through the often-complex insurance process. These innovations enhance the customer experience by offering personalized service and minimizing wait times. However, the true power of AI lies not just in automating these existing processes, but in its ability to make insurance more proactive and predictive. Through continuous learning and adaptation, AI enables insurers to anticipate customer needs and offer products that are tailored to individual risk profiles.

AI technologies offer a significant opportunity to improve the insurance customer experience by delivering faster, more personalized service. Today's consumers demand greater transparency, efficiency, and control over these insurance products. AI-powered mobile apps allow consumers greater real-time access to information. It allows consumers to instantly check coverage for medical procedures, calculate out-of-pocket expenses, and determine deductibles. These tools enable policyholders to access the information they need when they need it, without waiting for human intervention.

Ms. Lopez stated that insurers are increasingly using AI to create customized products that align with the unique needs and preferences of individual customers. By analyzing data from multiple sources, such as health records, wearable devices, and social media, AI systems can assess individual risk factors and

offer personalized coverage options. This leads to more accurate pricing and a better overall fit for the customer.

Automation through AI accelerates claims processing by evaluation claims data in real time and determining appropriate outcomes. In many cases, claims can be processed and paid within hours, if not minutes, which drastically improves the customer experience. This also reduces operations costs for insurers, which produces savings that can be passed along to policyholders in the form of lower premiums.

Ms. Lopez stated that AI has the opportunity to provide many innovations to self-insured state health plans, which provide coverage for public employees, retirees, and other beneficiaries. She stated that these plans face significant cost pressures while striving to provide high-quality care to their enrollees.

AI can analyze vast amounts of patient data, such as medical history, genetic information, and lifestyle factors, in order to recommend highly personalized treatment plans. These plans ensure that patients receive the most effective care based on their own unique health profiles. This not only improves health outcomes, but also helps to reduce costs by avoiding unnecessary treatments and hospitalizations.

Ms. Lopez stated that AI powered tools can monitor patients' health in real time and predict potential health issues before they become serious. This is particularly important for managing chronic conditions such as diabetes, heart disease, and hypertension, which often require ongoing monitoring and early intervention. By identifying potential health risks early, AI can help prevent costly medical complications and reduce the overall burden on our healthcare system.

In addition, AI has the potential to revolutionize elder care by enabling seniors to remain in their homes and communities longer. AI driven health monitoring systems can alert caregivers and medical professionals to the emergencies, such as falls or sudden changes in vital signs, allowing for timely intervention. This improves the quality of life for elderly individuals while reducing the costs associated with long term care facilities.

She stated that the integration of AI with telemedicine platforms can enhance access to care, especially for patients in rural or underserved areas. AI can assist doctors in diagnosing conditions remotely by analyzing patient data and offering recommendations for treatment. This reduces the need for in person visits and helps ensure that patients receive timely care, regardless of their location.

Ms. Lopez stated that one of the most promising applications of AI in Healthcare is its ability to analyze large datasets and tailor treatments to individual patients. AI can uncover patterns in patient data that are not readily apparent through traditional analysis, leading to more effective and efficient treatment plans. However, to fully realize these benefits, it is essential that we enable responsible data sharing between health care providers, insurers, and other stakeholders.

AI can analyze historical patient data to identify when off label treatments have been effective for certain conditions this can help insurers make informed decisions about covering treatments that fall outside of standard protocols. By allowing for the use of off label treatments in appropriate cases, AI empowers healthcare providers to offer more innovative care to patients who might otherwise have limited options.

She stated that AI's ability to process vast amounts of data enables insurers to make more accurate, data-driven decisions regarding coverage and reimbursement. For instance, AI can evaluate the effectiveness of different treatment plans based on real world outcomes, helping insurers determine the most cost-effective care strategies. This reduces waste and ensures that health care dollars are spent on treatments that provide the greatest value to patients miss Lopez stated that, while data sharing is essential for AI to function effectively, it must be done in a way that protects patient privacy and complies with relevant regulations. Advances in encryption and data anonymization techniques can help safeguard sensitive information while still allowing AI systems to extract valuable insights. It is critical that state governments establish clear guidelines for how patient data can be used, ensuring that privacy concerns are addressed without stifling innovation.

She stated that, as with any powerful technology, the adoption of AI in insurance raises important ethical considerations. AI has the potential to enhance fairness and transparency, but it also carries risks if not implemented properly.

AI systems are only as good as the data on which they are trained. If the underlying data contains biases, whether related to race, gender, or socioeconomic status, AI systems may inadvertently perpetuate these biases in their decision-making processes. Regulators must ensure that AI systems are transparent and that their decisions can be audited to prevent discriminatory outcomes. New paragraph miss Lopez stated that one of the challenges with AI is its black box nature. It is critical that there is a rapid and responsive process in place for appeals, building trust between insurers and consumers.

As AI systems become more integrated into the insurance industry, there is a risk that vulnerable populations, such as the elderly, low-income individuals, or those with preexisting conditions, could be disproportionately affected. Regulators must ensure that AI driven insurance products do not exclude or disadvantage these groups. Policies should be put in place to protect vulnerable consumers and ensure that they have access to affordable, equitable coverage.

Ms. Lopez commented on the role of regulators in ensuring fairness and accountability while using AI systems. Insurance. Regulators play a vital role in ensuring that AI systems are implemented in a way that benefits all stakeholders while minimizing risks. As AI continues to reshape the insurance industry, state regulators must focus on several key areas. Regulators should set high standards for data quality to ensure that AI driven decisions are based on accurate, reliable information this includes in ensuring that the data used by AI systems is complete, up to date, and free from errors or biases.

She stated that regular audits of AI systems should be conducted to verify that they are functioning as intended, and that their outputs are fair and nondiscriminatory. These audits can also help identify any unintended consequences or biases and have arisen in the system's decision-making process.

While AI offers exciting opportunities for innovation, it is essential that these advancements do not come at the expense of consumer protection. Regulators must ensure that AI driven insurance products are designed with consumer needs in mind and that appropriate safeguards are in place to prevent abuses.

Ms. Lopez concluded her testimony by stating that AI and machine learning present unparalleled opportunities to transform the insurance industry, improving customer experience personalizing healthcare, and enhancing efficiency within self-insured state health plans. However, it is crucial that

these technological advances are implemented in a way that protects consumers, and shares transparency, and promotes ethical decision making. By leveraging AI responsibly, Texas can lead the way in creating an insurance landscape that is not only innovative but also fair, equitable, and accessible to all its residents.

The Committee heard testimony from Kev Coleman, Visiting Research Fellow from the Paragon Group.

Mr. Coleman said that artificial intelligence is not a singular technology. Instead, it represents multiple categories of programming that emulate human learning and reasoning to various degrees. In some cases, these categories evidence significant differences from one another. Four forms of AI that are particularly relevant to health care are large language models, machine learning, artificial neural networks, and generative AI.

A large language model is a type of artificial intelligence system, typically based on deep neural networks, that is trained on vast amounts of text data to learn patterns and structures in human language. By analyzing billions (or even trillions) of words, these models develop an understanding of grammar, context, and semantics that allows them to generate or interpret language in human-like ways. Large language models can be used for a wide range of natural language processing tasks, such as text generation, summarization, translation, and question answering.

Machine learning is a branch of artificial intelligence that focuses on developing algorithms and statistical models that enable computer systems to learn and make predictions or decisions without being explicitly programmed to do so. In other words, machine learning systems improve their performance on a task by analyzing data and identifying patterns, rather than following a set of rigid, hand-coded rules. This allows them to adapt to new information and make more accurate predictions or decisions over time.

Artificial neural networks are computational models inspired by the structure and function of the human brain. They consist of interconnected units (often called *neurons* or *nodes*) arranged in layers. Each connection carries a weight that can be adjusted based on the data the network is fed, allowing the ANN to learn patterns and relationships. By processing large amounts of labeled or unlabeled data, artificial neural networks can adapt their internal parameters to perform tasks such as classification, regression, pattern recognition, and more complex operations.

Generative AI refers to a category of artificial intelligence models designed to create new content, such as text, images, music, or code, rather than simply analyzing or classifying existing data. By learning patterns from large datasets, these models can generate output that mimics or expands on the style or structure of the training material, often appearing novel or creative. Examples of generative AI include language models that produce human-like text and image synthesis models that generate realistic or stylized pictures.

Mr. Coleman stated that these four types of AI have already made remarkable inroads within the field of medicine and have achieved results that, at times, defy the imagination. We now have AI software That can review single low radiation chest scan and predict a patient's lung cancer risk for the following six years without input from a radiologist. In some instances, the system has been able to detect early lung cancer signs that radiologists did not recognize to lung nodules were visible on scans years later. While many of AI's medical applications are associated with medical imaging, AI is found throughout the

health care system in areas such as drug discovery, administrative automation, precision medicine, patient care, mental health, population health management, claims fraud detection, and surgical robotics.

The subject of AI is as closely related to data as it is to software algorithms. Unlike traditional software, where programmed commands account for much of an application's performance, AI software is reliant on large data sets to train the system to produce desired outputs. Given that many health care AI systems need patient data for their training, there are concerns around consumer privacy.

Turning from AI data issues, there is the economic context of current AI development. AI's rise within medicine coincides with growing anxiety over the American healthcare systems fiscal challenges. In 2009, the Social Security Advisory Board warned the nation's healthcare cost trajectory was unsustainable and perhaps the most significant threat to the long-term economic security of workers and retirees. At that time, the United States spent approximately 2.5 trillion on healthcare, which represented $8160.00 per US resident. By 2022, the United States spent $13,493.00 per person on health care totaling $4.5 trillion. This amount represented 17.3% of the nation's gross domestic product. In comparison the nation spent only 6.2% of its GDP on health care in 1970.

The financial unsustainability of American healthcare suggests that, in addition to its potential for clinical improvements, AI should also be explored as an instrument for cost reduction. Its ability to replicate or exceed human reasoning opens the possibility of replacing some high-cost human labor with lower cost AI functionality. Mr. Coleman stated that among the complications for policymakers considering AI regulation is the technology's integration across the healthcare spectrum. Notably, it will be as prevalent outside clinical settings as it is inside. Email systems will have AI for spam filtering, threat detection, composition assistance, and other functionalities. The same will be true for accounting software, human resources software, word processing, spreadsheet, customer relationship management, and search engine marketing. Poorly reasoned and overly broad regulation of healthcare AI could cast a wide net that inflates compliance costs while achieving little to improve patient safety.

Mr. Coleman stated that equally problematic is the overlap between traditional software functionality and AI functionality. Traditional software, for example, can make statistical predictions and recommendations, detect patterns, generate novel outputs that were not preprogrammed, and receive inputs based in natural language. Broad regulation intended for AI would bring chaos to simpler software systems whose functionality would trigger the same regulatory obligations.

Policymakers drafting laws related to AI must be exceptionally careful to specify criteria to differentiate AI from non-AI systems. Furthermore, given the differences in operation and risk, even among categories of AI, a blanket AI regulation may be irrelevant for some AI implementations and counterproductive for others. This reality necessitates a cautious approach to regulation that leans heavily on the expertise of independent AI experts. Mr. Coleman stated that, by independent, he means persons not in the employment employ of large AI development entities with deep pockets. Such large companies often prefer higher regulation because it can reduce competition entering the market.

Mr. Coleman stated that the mention of large developers raised raises another consideration in the potential regulation of health care AI: the need for a framework whose compliance costs will not bankrupt innovative startups that lack the financial resources of Microsoft or Oracle. If such frameworks are not provided, the market may be reduced to a few powerful companies controlling one of the most

important technologies of the 21st century. The risk of excessive market consolidation should motivate federal regulators to examine acquisitions carefully from an antitrust perspective. Time magazine has noted that apple, Microsoft, Google, Meta, and Amazon have collectively acquired at least 89 AI companies over the last decade, and these acquisitions tended to target younger startups, a signal that the tech giants may be targeting innovative AI firms before they can pose a competitive threat. For AI startups, monopolies are not only a concern with respect to software applications, but also the infrastructure resources AI software needs for its massive data processing.

Alongside these, regulators must also resist unrealistic and unhelpful standards of perfection for AI medical devices. He stated that human doctors are not perfect, and they and society still allow allows them to practice. With respect to AI safety, we should insist on an accurate accuracy rate at least the same as exhibited by clinicians. Perfection is not always possible in the context of medicine, and the expectation would prevent lower cost AI solutions from replacing expensive human labor that has been at the heart of the nation's health care cost problem. If an AI system can be demonstrated to have the accuracy equivalent to human doctors, safety risks are not being increased.

Mr. Coleman stated that the risk of harm is a key dimension in this technology's appropriate regulation. He stated that our greatest attention and granularity of response should be directed at AI implementations where the risk of patient harm is highest. Likewise, where there is no risk of patient harm, for example, using AI to detect claims fraud in Medicaid, the impulse to regulate should lessen.

The matter of acceptable risk is especially pertinent to autonomous AI solutions where system accuracy and low patient risk eliminate the necessity for clinician assistance. For such tools it is crucial that clinical assistance not be made a regulatory requirement if an AI system can empirically demonstrate to regulators that it satisfies the following three criteria: accuracy levels equal to or exceeding the average rate for clinicians performing the same function, no amplification of health risks as compared to when the same function is performed by a clinician, and output communications that are comprehensible and actionable for the patient.

Mr. Coleman stated that given the continuing evolution of AI software systems, it is also advisable that federal regulators provide an economic pathway for innovators to reapply for FDA approval on their devices where the functionality remains the same, but system autonomy increases over time. On this front, the FDA could leverage work already performed by the US Department of Transportation for self-driving vehicles with differing levels of system autonomy, for example, driver-assistance versus self-driving.

Mr. Coleman stated that AI regulators also must become comfortable with the new levels of complexity AI presents. An artificial neural network, for example, can have millions of neurons contributing to its output. As a consequence, the system can provide desired clinical results through its response to data correlations that developers cannot easily recognize and tease out of the system. In some cases this may mean the system produces clinically desirable results although the process may not be fully understood even by system developers. While this may seem controversial, the situation already exists in pharmacology, and has for decades, where we have FDA approved medicines where the scientific basis for their positive results is not always understood. Mr. Coleman stated if we can live with this in pharmacology, we can do the same with AI, so long as the AI system can produce empirically verifiable

and repeatable outcomes acceptable to the safety standards of the FDA. These safety standards may also require more scrutiny of the underlying data used to train the AI system.

Mr. Coleman concluded his testimony by stating that he recommends a thoughtful and cautious approach to AI regulation which prioritizes regulation around concrete patient risk, rather than hype and fear mongering that often surrounds discussions related to artificial intelligence.

Recommendations

The Committee on Insurance recognizes that the insurance industry is undergoing significant changes as it adopts new technologies. These tools have the potential to make operations more efficient, improve decision-making, and offer better experiences to customers. However, responsible use and careful oversight are essential to ensure ethical and effective outcomes.

The Committee believes that oversight is critical to ensure these tools are used fairly and responsibly. Skilled professionals must monitor their use to catch errors and address unexpected issues. Companies should ensure compliance with laws and ethical standards, particularly regarding privacy and fairness, and regularly review these systems to maintain reliability. Involving a range of voices, including customers and regulators, will help build trust and align efforts with public expectations.

Mandate Review

Study how other states review proposed health insurance mandates, including by assessing their fiscal impact and the implications on the market. Make recommendations for establishing a mandate review process in Texas that incorporates best practices identified by the committee.

Testimony

The Committee heard testimony from Blake Hutson, Director of Public Affairs at the Texas Association of Health Plans (TAHP).

Mr. Hutson said that Texas lags behind other states in using data to show lawmakers how new laws impact the cost of private health coverage for patients and employers. That leads to costly new mandates each session and restrictive regulations that take away the flexibility businesses need to lower costs and offer more affordable coverage.

Lawmakers lack info on the cost of mandates and regulations on Texas employers and families. At least 29 states have a process to estimate how a bill will affect the cost of private health coverage, helping lawmakers make informed decisions before adding costs to businesses and families.

Mr. Hutson said that Texas has an All-Payor Claims Database (APCD), which is a repository of all health care claims and cost data. This data can be used to analyze the impact of health care legislation and mandates on the market, as well as potential costs or savings for employers and families. Texas should fund the APCD to fully utilize this resource, ensuring lawmakers are informed about the costs of health care mandates before they become law.

Businesses are facing a nine percent increase in health spending this year, making it harder to offer benefits. Employers, not state governments, cover fifty percent of Texans, pay most of the cost of insurance premiums, and make tough choices about what health plans to offer. He stated that Texas lawmakers owe it to employers to be more thoughtful about adding costly mandates to their health plans.

Mr. Hutson said that the Texas Legislature is increasingly interested in lowering costs and ensuring quality coverage, they often consider bills that raise the cost of coverage. Without a full, independent analysis of the potential impact or savings, lawmakers lack the information needed to understand the impact of these proposals on Texas employers and families.

He recommended that Texas needs a new process to estimate the cost impact of health care legislation on employers and families. He said that lawmakers should use the APCD's independent expertise and data to provide transparent, detailed analyses before enacting new laws.

The Committee heard testimony from Glen Hamer, President and CEO of Texas Association of Business (TAB).

Mr. Hamer stated that health care mandates, while often well-intentioned, significantly impact employers providing health insurance to their employees. Mandates requiring insurers to cover specific treatments, procedures, or services, typically increase overall health care coverage costs. These increased costs are passed on to employers and employees, resulting in higher premiums for employees and their dependents. According to their 2024 taxes employer health care survey, 86.36% of employers believe health care costs are rising unsustainably, with 34.36% identifying it as the fastest growing cost in business.

Mr. Hamer stated that when premiums rise, employees take home pay is affected, impacting their economic well-being. Over 50% of businesses reporting reported that rising health care costs have interfered with their ability to increase salaries or hire new employees. This also discourages business expansion, affecting not only employers, but the broader economy. For patients, while mandates may improve access to certain services, they also lead to unintended consequences. As total health care costs rise small employers may offset costs by increasing out of pocket expenses, narrowing provider networks, or reducing other benefits. While a mandate may benefit a small number of employees, it could harm the majority. Legislators may respond compassionately to a proposed mandate but must consider the broader economic consequences.

Mr. Hamer stated that before implementing new mandates, the state should require thorough cost benefit analysis evaluating the impact on employers, insurance, providers, and patients. He stated that their survey shows strong support for this approach, with 92.05% of employers agreeing that the legislature should provide cost estimates for mandates before passing them into law. This step is crucial to fully understanding the costs and benefits for implementation. He stated that instead of rigid mandates, the state should explore flexible solutions encouraging innovation in healthcare delivery and insurance design. He believes that this could promote value-based care models, expanding telemedicine, and supporting Wellness programs that improve outcomes while controlling costs. Mr. Hamer stated that the Legislature should ensure that mandates do not disproportionately affect small businesses, discouraging them from offering health benefits. This will, according to Mr. Hamer, help maintain a level playing field and prevent small employers from being unfairly disadvantaged.

Mr. Hamer stated that while ERISA, the Employee Retirement Income Security Act, is currently preempted from state mandates, the Texas business community strongly opposes any effort to pierce ERISA. He stated that ERISA ensures many employers, particularly those with multi state operations, can offer consistent health care benefits across all locations, preventing a costly patchwork of state specific mandates. Mr. Hamer stated that any erosion of ERISA protections would greatly increase the administrative burdens and compliance costs for Texas employers, potentially reducing the benefits they offer and hurting the state economically. He stated that the legislature has been clear on this topic previously, and he urged the Committee on Insurance to ensure that important ERISA preemption remains intact.

The Committee heard testimony from Chris Jones, Senior Fellow at the Cicero Institute, and Vice President of Healthcare Policy.

Mr. Jones began his testimony by stating how current healthcare incentives are misaligned, prioritizing revenue generation over patient value. He said out that the complexity of the system excludes patients from making informed decisions. Consumers often don't choose their health insurance directly, but rely on employer-sponsored plans, which limit choice and transparency. This lack of consumer empowerment creates a system where prices keep rising without pressure to improve value.

Jones advocated for policy changes that allow smaller insurance companies to compete under the same rules as large ERISA plans. He argued that this could foster innovation and give consumers more control. He warned that if these changes aren’t made, the system might collapse, leading to a government-run single-payer healthcare system.

Mr. Jones concluded his testimony by stating that the system makes it hard for consumers to see or influence healthcare spending. He emphasized that removing barriers and increasing transparency could drive innovation. He also pointed out the unsustainable trajectory of healthcare spending, projecting it could reach 19.7% of GDP by 2032. Without reform, he stated, the system might break, leading to either government takeover or a shift toward consumer-driven models.

Recommendations

The Committee on Insurance recommends further study on the financial impact of health care mandates on both the healthcare and health insurance industries. Mandates, while often aimed at improving access and quality of care, can impose significant costs on providers and insurers through increased administrative requirements, compliance obligations, and potential shifts in risk. Understanding these economic effects is essential to ensure that mandates achieve their intended goals without creating undue financial strain or inefficiencies within the health system.