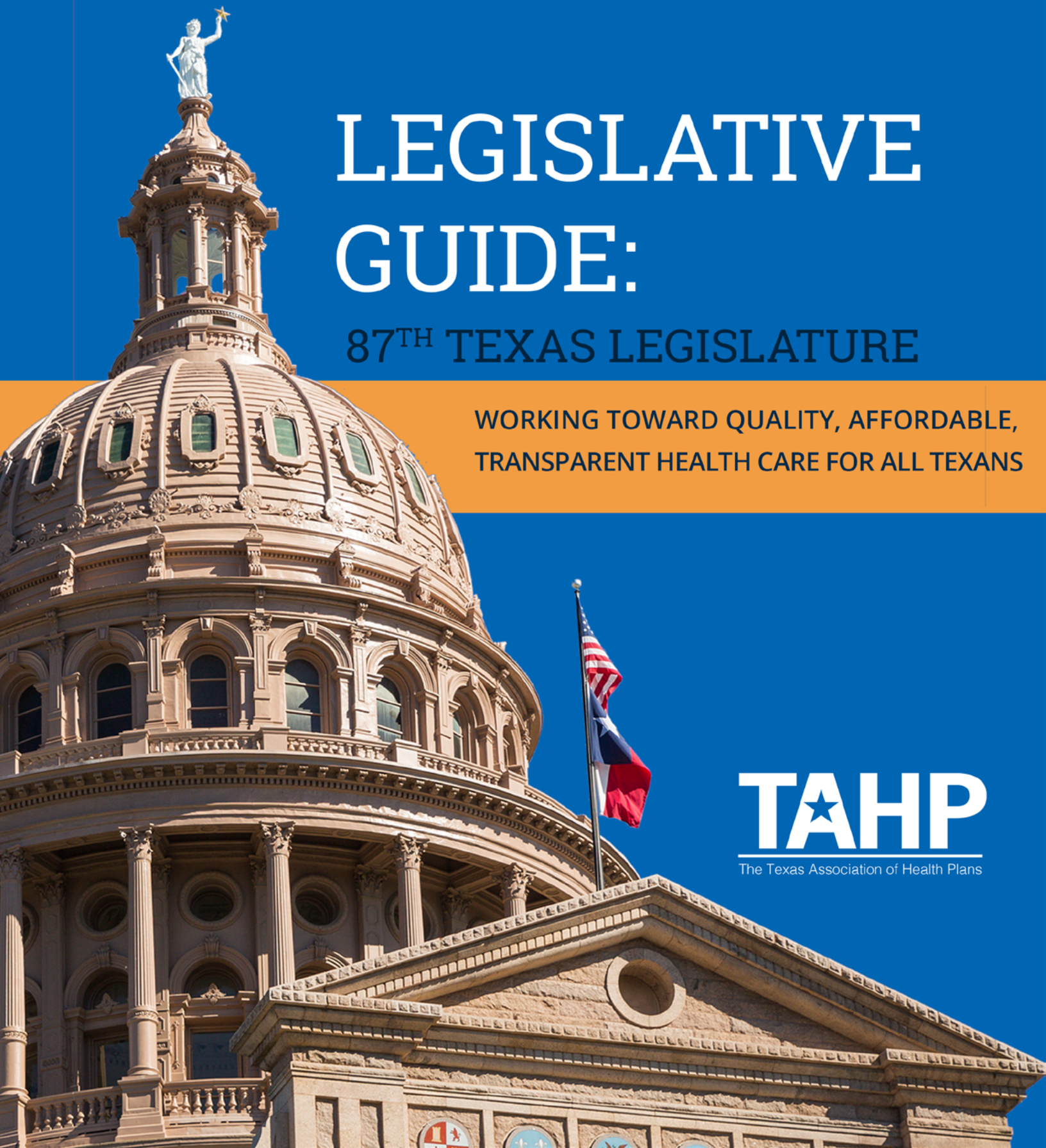
LEGISLATIVE GUIDE:

87TH TEXAS LEGISLATURE

WORKING TOWARD QUALITY, AFFORDABLE, TRANSPARENT HEALTH CARE FOR ALL TEXANS



TAHP

The Texas Association of Health Plans

About TAHP

Led by a team of experienced health care policy experts, the Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, Medicaid plans, Medicare Advantage plans, and other related health care entities operating in Texas.

For three decades, TAHP has been a leader on issues that improve the lives of Texans and strengthen health care in Texas.

TAHP is dedicated to promoting affordable health care for all Texans through advocacy and education. It is our goal to increase public awareness about our members' services, health care delivery benefits, and contributions to communities throughout the state. TAHP strives to build and foster valuable relationships with its members, industry, and community stakeholders, as well as with representatives of the Texas Legislature and state agencies.

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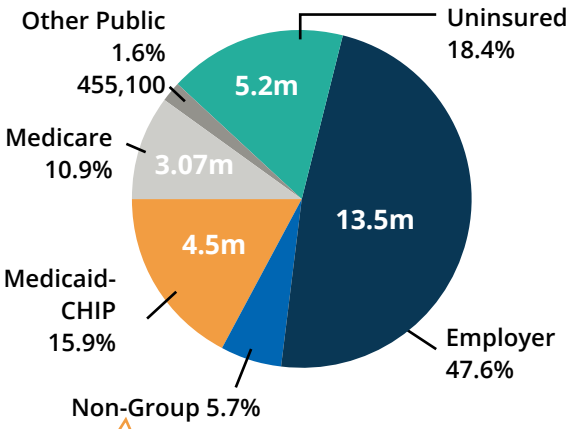
During the 87th Session, the Texas Association of Health Plans will fight to reduce health care costs and make sure all Texans have access to affordable, high-quality health care, no matter how much money they make or if they have preexisting conditions — more choices, better quality, and lower costs.

Health Coverage Keeps Texans Healthy

Health insurance helps keep families and communities healthy. In 2019, 82% of Texans had some form of health coverage while 18% did not. People with health insurance are usually healthier, have their own doctor and receive important preventive health care services. People with health insurance are also better off financially because they are protected in the event of a serious illness or injury. Health insurance providers coordinate care for their members, invest in communities, and make sure their members get the care they need.

Health Insurance Coverage of Texans, 2019



Individual Market: 5.7% of Texans
1.6 Million People

- **Texans with subsidized marketplace coverage: 822,509**
- **Texans with full-cost non-group insurance: 780,691**

The Truth About the High Cost of Health Care

Despite efforts by health plans to hold down the cost of premiums, the cost of health care is high and still rising. The problem is health care prices. As the prices of health care services like hospital stays, medical screenings, and prescription drugs continue to increase, the price of insurance has to go up to cover these costs.

In the United States, average per capita health care spending increased by more than 18% from 2014-2018, to $5,892. Texas had a 14% increase in spending during this same time, becoming the 14th most expensive state at $6,110 per person. Almost all of Texas' spending increase was due to prices, not utilization. In Texas, prices increased 12.2% while utilization only increased 1.5%.

Texas is the
14th
most expensive state for health care per capita

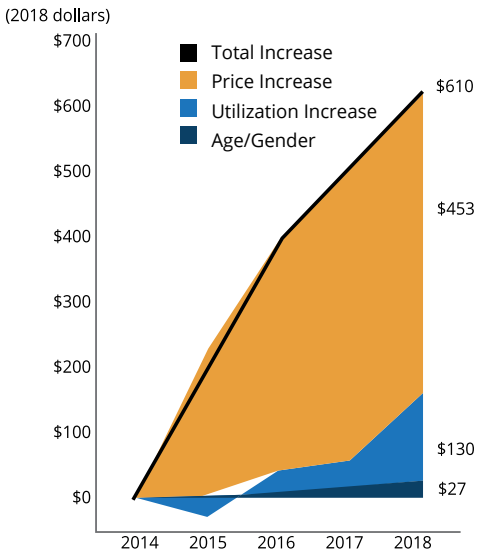
Per capita health care spending in Texas
increased by 14%
from 2014-2018

Prices, not utilization
are driving increased health care spending

The Problem Is Price

Leading health care economists widely agree that in the U.S., health care prices—not utilization—are the primary cause of increased health care costs, one of the largest drivers of wasteful spending, and the main reason that our health care system is so inefficient compared to the rest of the world. Pricing failure, overtreatment, low-value care, and fraud and abuse are responsible for 50% of this wasteful spending in health care. Wasteful spending in the U.S. health care system amounts to as much as $935 billion annually, accounting for about 25% of total health care spending.[1] Pricing failure alone accounts for 30% of U.S. health care waste.

Prices Are Responsible for 75% of Spending Increases



Prices Are Also Responsible for 75% of Spending Increases

Higher prices for health care were responsible for about 75% of spending increases from 2014-2018, while increase in utilizations accounted for only 21%. Out-of-control billing practices have led to rapid inflation of health care prices and health care costs. While health insurance premium rates are transparent and subject to strict state and federal regulatory requirements, providers' billed charges are unlimited, unregulated, and typically have no relation to real costs or to what providers actually accept as full payment. As stated by the USC-Brookings Schaeffer Initiative for Health Policy, "We don't have a particularly unified or rational way of finding out what the value of health care is in this country. Billed charges are effectively just made up." The unregulated and opaque nature of billed charges has led to a disturbing trend of increased egregious and predatory billing practices.

The Texas Health Care Price Problem

The need for increased protection against price gouging and other unfair billing schemes has been starkly demonstrated in recent months with some providers taking advantage of the current COVID crisis. While COVID testing provides many recent examples of price gouging, fraud, upcoding, and other egregious billing practices, excessive prices and improper—even fraudulent—billing are not new. Texas law does not provide sufficient consumer protections against excessive charges or improper billing on claims for medical and health care services and supplies. Provider licensing agencies need more clear regulatory and enforcement authority to address excessive and unconscionable pricing and improper billing

Texas Needs to Address the Health Care Cost and Price Problem

Throughout the session, we will be advocating for solutions to lower health care costs and prices, including:

- ✓ Holding freestanding ERs accountable for the predatory actions and blatant failure of many to comply with current patient protection laws and regulations
- ✓ Protecting Texas patients and employers from out-of-control health care prices and price gouging—especially for COVID-related care
- ✓ Expanding Texas' efforts to hold providers accountable for fraud, waste, and abuse—especially in the private market
- ✓ Addressing anticompetitive consolidation and the role of private equity in driving up health care prices
- ✓ Eliminating incentives, such as billed charges payment factors, that drive up prices for emergency care
- ✓ Reducing and avoiding future government health care mandates that drive up prices and costs

1 Shrank, William, MD, MSHS et al. "Waste in the US Health Care System Estimated Costs and Potential for Savings" JAMA. 2019

TEXAS ASSOCIATION OF HEALTH PLANS

SOLUTIONS FOR AFFORDABLE, HIGH-QUALITY HEALTH CARE FOR TEXANS

February 2021

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Solutions for Affordable, High-Quality Health Coverage for Texans

TAHP
The Texas Association of Health Plans

87th Texas Legislature

The COVID-19 crisis poses unprecedented challenges to Texas and our nation, touching every facet of American life. In the face of these challenges, Texas health insurance providers and Medicaid managed care plans are taking decisive actions to help patients and curb the spread of the virus, including proactively eliminating out-of-pocket costs for COVID-19 diagnostic testing, treatment, and vaccination; waiving out-of-pocket costs for telehealth services and expanding telehealth programs; and fully covering the doctor visits and treatments needed to recover from this disease.

The COVID-19 crisis reminds us of the value of affordable health insurance coverage and the peace of mind it brings to Texas families. Every Texan deserves access to affordable, high-quality health coverage, but health care is unaffordable for too many families. While health care does work for someTexans, health care prices have been a financial burden for too many families for too long. A broken bone shouldn't break the bank. That's why we need to improve what's working and fix what's not. Now is the time for Texas to focus on bringing down health care costs for everyone, regardless of how much money they make, whether they have preexisting conditions, or where they get their care and coverage. We need to focus on proven, free-market solutions to achieve affordable, high-quality health coverage for every Texan.

During the 87th Session, the Texas Association of Health Plans will fight to reduce health care costs and to make sure all Texans have access to high-quality health care they can afford no matter how much money they make or if they have preexisting conditions—more choices, better quality, and lower costs.

Solutions for Affordable, High-Quality Health Coverage

Coverage:

Ensuren hardworking Texans get the comprehensive, high-quality health coverage they deserve, no matter their income or if they have preexisting conditions.

Affordability:

Address out-of-control prices and mandates, price gouging, and abusive and fraudulent billing.

Access:

Increase access to care by eliminating outdated regulatory barriers for telemedicine and advanced practice registered nurses (APRNs).

Coverage

All Texans Should Be Able to Receive COVID-19 the Testing,Treatment and Vaccines they Need

Every Texan should be able to get the coverage they need for COVID-19 tests, treatment, and vaccines. As businesses and the health care system prepare to safely reopen, leaders are looking for answers to determine what testing and vaccine strategies will best protect against spread of the virus, how much these strategies may cost taxpayers and health care consumers, and what investments might be necessary moving forward. Testing and vaccines need to be part of a holistic public and occupational health strategy, and state guidance should consider funding for testing in that context and clearly articulate the roles of insurance providers, employers, and public health officials. Unfortunately, many health care providers—mostly freestanding ERs—are using COVID-19 as an excuse to price gouge Texas patients. TAHP and its members stand ready to work with employers, public health leaders, and the Legislature to develop and execute robust strategies to protect Texans and reduce the risks of spreading of the virus.

- TAHP supports additional funding for COVID-19 testing, which is critical to account for the magnitude of tests that will be required to achieve occupational and public health goals.
- TAHP recommends that the Legislature prohibit price gouging and surprise billing for COVID-19-related health care in Texas to protect families and employers.
- TAHP recommends that the Legislature prohibit providers from charging expensive facility and observation fees for providing drive through or asymptomatic COVID-19 testing.
- TAHP recommends that health plans are given access to vaccine data to help coordinate care and support the state's vaccine distribution plan.

All Texans Deserve Comprehensive Coverage Regardless of Preexisting Conditions

In an environment of continually evolving health care laws, it is more important than ever for us to make sure Texans have access to a stable and affordable health insurance market. Texas has the highest rate of uninsured people in the country, and most uninsured Texans are members of low-income working families. All Texans deserve access to high-quality health care they can afford no matter how much money they make or if they have preexisting conditions. For coverage to remain affordable, it is important that solutions to increase access to coverage and protect coverage for preexisting conditions protect market stability, encourage broad participation in the market, and help lower health care costs for everyone.

- TAHP supports protecting and covering individuals with preexisting medical conditions. But those protections must be coupled with solutions that stabilize the market and lower health care costs, such as continuous coverage requirements, limited annual enrollment periods, and subsidies to lower the cost of coverage. Guaranteeing coverage and other protections for preexisting conditions without solutions to stabilize the market will lead to increased premiums and will result in fewer options, fewer people covered, and a serious deterioration of the health insurance market.
- TAHP supports improving access to health coverage for uninsured, low-income Texans, including utilizing the innovative solutions and savings opportunities of 1332 waivers to stabilize the health insurance market, reduce premiums, and increase coverage.

The Coverage Gap Makes Health Care Unaffordable for Hardworking, Low-Income Texans

States that have not expanded Medicaid have a health insurance affordability issue called the "coverage gap." In Texas, individuals whose family incomes are between 100% and 400% of the federal poverty line are eligible for federal subsidies that substantially lower their premiums in the individual market, while Texans whose incomes are below 100% of the federal poverty line are not eligible for any subsidies and are forced to pay the full premium. It makes no sense that Texans above the federal poverty line receive substantial government support to purchase health coverage in the individual market while working Texans below the poverty line receive no support.

- TAHP recommends that the Legislature study policy options that expand access to coverage so that hard working uninsured Texans below the poverty line are not put at a disadvantage.

Affordability

Government Mandates Pose a Threat to Affordability

One of the most significant threats to health coverage affordability is the increasing number of government mandates that drive up the costs of coverage for Texas families and businesses. New government mandates related to provider payments, provider contracting, and new benefits drive up health care costs and limit innovation, private market negotiations, and consumer choice. While often well-intended, government mandates typically lead directly to higher premiums for consumers and employers. Texas employers shoulder the biggest burden when it comes to government mandates. Mandates shift costs to the private market, forcing Texas employers to decide between reducing benefits, lowering wages, requiring employees to share more of the cost for their health coverage, laying off employees, or even closing their doors altogether. In effect, mandates act as a hidden "tax" on Texas employers and families. For example, previously proposed mandates, such as a formulary freeze, would have increased health costs for Texas consumers and employers by more than $400 million over 5 years. A recent survey of NFIB members found the cost of health insurance was ranked as the single biggest problem and priority for small business owners in Texas. It is important to note that the ACA already mandates that health plans cover the "essential health benefits" (EHB) for health insurance coverage and that new Texas mandates are in excess of the Affordable Care Act. States can go beyond the ACA's mandates, but ACA rules require states—rather than insurers—to cover the cost of new benefit mandates that go beyond the ACA. It is critical to note that Texas' legislative efforts to avoid payment for new mandates likely violate federal law and Texas could be liable for any mandates adopted since 2014 and in the future.

- TAHP opposes all government mandates, including payment, contracting, administrative, and benefit mandates, which reduce private market competition, limit consumer choice, and drive up the cost of health care.
- TAHP recommends that the Legislature carefully review existing and proposed mandates. When a mandate does not create value, does not address a specific problem, or creates unintended consequences in the market, it should be reversed or not adopted. The Legislature should also consider any costs to be paid by the state for mandates exceeding ACA requirements.

- TAHP also recommends that the Legislature create a health insurance "fiscal note" that includes estimates of increased costs and premiums for any legislation proposing new health insurance payment, contractual, administrative, or benefit mandates for the private (fully-insured) commercial market, as well as ERS, TRS, and the UT/A&M health systems.
- TAHP supports a health plan's ability to competitively negotiate contracts with the highest value providers and pharmacies in the private market without restrictive government mandates that limit competition and access to quality, cost-effective health care.

Texas Needs to Address Out-of Control Prices, Price Gouging, and Abusive Billing Patterns

Leading health care economists widely agree that in the U.S., health care prices—not utilization—are the primary cause of increased health care costs, one of the largest drivers of wasteful spending, and the main reason that our health care system is so inefficient compared to the rest of the world. Recent studies have found that pricing failure, overtreatment, low-value care, and fraud and abuse are responsible for 50% of wasteful spending in health care. Pricing failure alone accounts for 30% of U.S. health care waste. While the health care cost crisis is a national problem, Texas has some of the highest health care costs and prices in the country. Out-of-control billing practices have led to rapid inflation of health care prices and health care costs. While health insurance provider premium rates are transparent and subject to strict state and federal regulatory requirements, providers' billed charges are unlimited, unregulated, and typically have no relation to real costs or to what providers actually accept as full payment. The unregulated and opaque nature of billed charges has led to a disturbing trend of increased egregious and predatory billing practices. The need for increased protection against price gouging and other unfair billing schemes has been starkly demonstrated in recent months with some providers taking advantage of the current COVID crisis. Texas law does not provide sufficient consumer protections against excessive charges or improper billing on claims for medical and health care services and supplies. Provider licensing agencies need more clear regulatory and enforcement authority and direction to address excessive and unconscionable pricing and improper billing practices.

- TAHP recommends that the Legislature address price gouging by holding providers accountable for price gouging patients and third party payers by giving the Texas Medical Board and other licensing agencies the authority and direction to penalize providers that price gouge Texas patients.

Eliminate Fraud, Waste, and Abuse in the Private Market

In 2018, $3.6 trillion was spent on health care in the U.S., representing billions of health insurance claims. Although fraudulent claims constitute only a small fraction of overall claims, they carry a very high price tag—both financially and in how they impact our perception of the integrity and value of our health care system. Health care fraud translates directly into higher premiums and out-of-pocket expenses for Texans and can even lead to reduced benefits or lost coverage. For employers, health care fraud increases the cost of providing insurance benefits to employees which, in turn, increases the overall cost of doing business. For many Texans, the increased expense resulting from fraud could mean the difference between having health insurance and choosing to forgo it. The Texas Legislature has devoted considerable resources to combating fraud, waste, and abuse in the state's Medicaid program—important work considering the amount of state resources spent on this essential safety net program. Although the prevalence of fraud in the commercial market is estimated to be 50% greater than in the Medicaid program, the state has devoted few resources to combat it and has not prioritized the elimination of fraud in the private market.

- TAHP recommends that the Legislature strengthen and prioritize enforcement of current anti-fraud laws and expand Texas' efforts to hold providers accountable for fraud, waste, and abuse - especially in the private market.

Increase Transparency of Provider Consolidation and Market Power and of Private Equity's Influence in Health Care

Any serious effort to bend the cost curve must address the prices Americans currently pay for health care, including the price markups that result from insufficient competition in U.S. health care markets. Put simply, less provider competition leads to higher prices for health care care. The lack of competition in the provider market and private investment in U.S. health care has grown significantly over the past decade thanks to investors who have eagerly joined the large, rapidly growing, and recession-proof market with historically high returns. Private equity investment firms are buying up physician practices, hospitals, and other health care providers. Their ownership of hospital, physician group, ambulance, freestanding ER, and air ambulance organizations has contributed to higher charges, egregious billing practices, and surprise billing, which drives up the cost of health care but does not lead to better outcomes for Texas patients. Private equity firms have played a major role in consolidating physician practices into large national staffing firms with substantial bargaining power against health insurance providers. These anti-competitive forces distort providers' market power and allow providers to artificially inflate the amounts paid by consumers—including as cost sharing under insurance coverage—and by insurance providers, which leads to higher premiums for Texas businesses and families.

- TAHP recommends that the Legislature study the effects of provider consolidation on the Texas health insurance market.
- TAHP recommends that the Legislature require provider groups with significant market share to publicly post provider, investor, and market share information for each specialty type controlled by the group.

Hold Freestanding Emergency Rooms Accountable for Price Gouging, Predatory Billing, and Misleading Consumers

Texas freestanding emergency rooms (FSERs) are a relatively new, lucrative business model. They often mislead patients about how much they cost and whether they are in-network, which causes huge health care costs for Texans and Texas businesses. Because FSERs usually look like urgent care centers, patients tend to visit them for care for minor, non-emergency conditions. In most cases, patients who receive care at FSERs could have been treated at a significantly lower cost in a different facility. FSERs are some of the worst offenders when it comes to outrageous high prices and misleading information. The sticker shock is alarming. Insurers are forced to pay higher prices for many health care services at FSERs that could have been dealt with in different settings at much lower cost. Those unnecessary medical costs get passed on to all Texans in higher premiums.

FSERs are responsible for more than $3 billion in unnecessary health care costs in Texas every year. The need for increased protection against price gouging and other unfair billing schemes by FSERs has been starkly demonstrated in recent months with some providers taking advantage of the current COVID crisis. While COVID testing provides many recent examples of price gouging, fraud, upcoding, and other egregious billing practices, excessive prices and improper—even fraudulent—billing are not new for FSERs. The FSER industry has a long history of misleading consumers, price gouging, and surprise billing Texas patients. It is also critical to note that most independent FSERs are still not in compliance with the notice and other consumer protection requirements adopted by the Texas Legislature and the federal CARES Act.

- TAHP supports holding freestanding ERs accountable for price gouging, predatory billing, and blatant failure to comply with current patient protection laws.
- TAHP opposes any expansion of the FSER licensure to include non-emergency services. Any expansion of services at FSERs would put more Texas patients at risk for price gouging, predatory billing, and inappropriate care.
- TAHP supports banning FSER charges for emergency care fees for urgent care and physician office services.
- TAHP supports legislation that would severely penalize FSERs for price gouging and other predatory actions during an emergency or pandemic.

Protect Texas Patients From Surprise Billing and Eliminate Billed Charges From the Dispute Resolution Process

It is clear that the new ban on surprise billing protects many Texas patients from unexpected balance bills. As a result of legislation last session, Texas went from being one of the worst states in the country for surprise medical bills to having one of the strongest protections against them in the country—an absolute prohibition on surprise medical billing for care in emergencies and other situations when insured Texans receive care from a provider they did not choose. According to a recent Texas Department of Insurance (TDI) report, SB 1264 has resulted in a 95% reduction in the number of Texans submitting consumer complaints of providers surprise billing them. While a ban protects insured patients from the initial surprise bill, new data now shows that payment dispute processes tied to these artificially inflated billed charges increases health care costs and drives up premiums.

A Congressional Budget Office accounting of the financial impact of a federal arbitration approach to end surprise medical bills estimates it would result in over $20 billion in additional federal spending over 10 years. Consequently, the federal surprise billing ban and dispute resolution process prohibits the use of billed charges during the dispute resolution process. There's a reason employers and independent experts agree using billed charges as a dispute resolution factor is harmful for our health care system. It encourages providers to stay out of network and continue overcharging for care, and does nothing to address artificially inflated health care costs.

In Texas, recent evidence shows that our new arbitration process' reliance on the 80th percentile of billed charges is raising these same issues, resulting in payouts that are substantially higher than average negotiated rates, which drives up the cost of health insurance. Data fromTDI shows that the average arbitration award for emergency room physicians exceeds $1,000, in addition to an average arbitration fee of $1,000. This total $2,000 cost is 4 times more expensive than the average network rate for an ER doctor treating the most serious level of emergency of less than $500, essentially driving up the cost of health care and wasting limited health care dollars.

- TAHP recommends that the Legislature revise SB 1264 so that the arbitration process does not require consideration of billed charges. Excluding excessive and unregulated billed charges as a factor for determining arbitration amounts will reduce the incentive for providers to remain out-of-network and continue to overcharge Texas patients.This would also disincentivize providers from artificially inflating billed charges to increase arbitration payouts.
- TAHP supports expanding the surprise billing ban and mediation to ground ambulances.

Health Care Transparency Lowers Prices and Gives Texans the Power to Control Their Own Health

Consumer access to essential health care information, including prices, quality standards, and network status, is currently limited, which hinders a consumer's' ability to choose the affordable care and coverage best suited for their unique needs. Allowing health insurance providers to share valuable health care provider quality and cost information with their members would help consumers determine the real value of health care or services provided by different providers. Texas law currently restricts health insurance providers' ability to provide quality information to their members about specific physicians. Patients should have the ability to compare both provider cost and quality to determine the real value of health care or services provided by different providers.

- TAHP recommends that the Legislature allow health insurance providers to share provider cost and quality information—when Texans are empowered with information on health care prices and outcomes, they do a better job of caring for themselves, protecting their families, and managing their health care costs.

Health Plans Use Prior Authorizations to Ensure Safe Effective Care

Texas health insurance providers are committed to providing Texans with high-quality, affordable health care. Medical management tools, especially prior authorization (PA), help health plans deliver on the promise of safe and effective care. Prior authorizations are a fundamental and integral part of how health benefits work, providing critical safeguards that help prevent harm, lower costs, promote appropriate use of medication and services, and ensure care is delivered at the right place and time. PA's are necessary because a significant amount of care being delivered to patients is not evidence-based. That care is not only unnecessary but potentially harmful. As Marty Makary, M.D., M.P.H., writes in his book, The Price We Pay, "Overtesting, overdiagnosing, and overtreatment are now commonplace in some areas of medicine." Research has shown time and again that there are wide variations in provider performance, and little to no correlation between spending and health care quality.

Research has also highlighted significant gaps between evidence-based practices and the care actually delivered to patients. Doctors themselves believe that at least 15-30% of all ordered medical care is unnecessary or unsafe. Texas law already provides significant protections throughout the UR process to ensure that members have access to medically necessary and appropriate care and Texas passed significant regulatory mandates and transparency requirements for PA last session. However, more can be done to reduce the administrative burden of PA, and these solutions can be implemented without undermining patient safety and outcomes.

The majority of health plans are taking steps to streamline the PA process for both prescription drugs and medical services, and a majority report that automation of the PA process is the biggest opportunity for improvement. For example, the 2019 Council for Affordable Quality Healthcare, Inc. (CAQH) Index report found that any kind of electronic health record adoption—partial or full—significantly reduces the cost of PA. Another solution to improve the prior authorization process would be to allow providers additional time to submit information supporting their PA requests. This would allow UR agents and health plans more time to review necessary information and result in fewer adverse determinations.

- TAHP recommends expanding transparency requirements passed last session to include data on providers' patient outcomes and appropriate utilization.
- TAHP recommends reconsideration of the timelines in Texas to reduce administrative burden for both health plans and providers. TAHP also recommends a move away from paper and fax toward more electronic and automated systems to reduce administrative burden
- TAHP opposes unnecessary new administrative and regulatory mandates limiting the ability to use medical management tools that provide access to safer care and more valuable coverage for members.

PBMs Negotiate Lower Prescription Drug Prices for Texans

When you pick up a prescription at your local pharmacy, you don't see the complex system that works behind the scenes to get your medicine to you at the lowest cost possible. One part of that system is pharmacy benefit managers, or PBMs—companies that work closely with health insurance providers to negotiate lower prescription drug prices on your behalf. PBMs provide a check on Big Pharma manufacturers' constant price hikes, helping you save more at the pharmacy counter. PBMs negotiate for low prescription drug costs and pass those savings directly on to patients and employers. Research shows that over the next ten years, PBMs will save Texans more than $80 billion—over 30%—on their prescription drugs. In addition to lowering costs for Texas patients and employers, PBMs also provide access to more affordable retail, specialty, and mail-service pharmacy. PBMs also offer care management tools to make sure patients actually take their prescriptions, helping improve health outcomes for all Texans.

- TAHP supports health insurance providers and PBMs' use of private market solutions and competition to negotiate low drug prices for Texas patients and employers.
- TAHP opposes government mandates, including contract mandates, that undermine competition in the private market and increase the cost of drug coverage for Texans.
- TAHP opposes "Any Willing Provider" mandates, including mandates requiring health insurance providers and PBMs to contract with any health care provider or pharmacy regardless of quality standards, patient access, and impact on the cost of health care for Texans and Texas businesses.
- TAHP opposes forumary freeze mandates that would severely restrict PBM and health insurance providers' ability to negotiate lower drug prices. Milliman recently estimated that "frozen formulary" legislation would increase health insurance costs in Texas by more than $400 million over 5 years.
- TAHP opposes government rate or price setting. No other industry or business is guaranteed a profit by the legislature. Promising any business a profit without considering the market forces or the quality of business decisions of that entity guarantees higher costs for Texas consumers and employers.

Access

Eliminate Outdated Regulatory Barriers That Decrease Access to Care

The COVID-19 crisis has underscored just how important it is for Texas to address our systemic health care provider shortage. Before the COVID-19 crisis, millions of Texans were already experiencing shortages of primary care, dental care, or behavioral health care providers, including over 7 million Texans that currently live in a primary care shortage area. Texans need more choice and access—we shouldn't wait for another pandemic to address the shortcomings in our health system. Advanced practice registered nurses (APRNs) are a key part of

the solution to closing the state's provider gap. Under current Texas law, APRNs in Texas are required to sign—and sometimes pay thousands of dollars for—a contract with a physician before they can do the job they have been trained and licensed to do. These undue restrictions reduce health care competition and harm employers, patients, and taxpayers. A large and growing mountain of evidence—from organizations including the Institute of Medicine, National Governors Association, Federal Trade Commission, American Enterprise Institute, and Brookings Institute—supports the same conclusion: removing delegation requirements for APRNs eases health care provider shortages, improves quality of care, and reduces health care costs.

- TAHP recommends that the Legislature eliminate physician delegation requirements for APRNs and allow all health care providers to practice "to the top" of their educations and licenses.

Eliminate Regulatory Barriers and Obstacles that Undermine the Future of Telemedicine

Texas needs long-term policy changes to make sure telehealth can continue addressing patients' needs beyond the COVID-19 crisis. The largest obstacle to the future success of telehealth is lack of high-speed broadband internet access. In addition to the broadband infrastructure obstacles in rural areas of Texas, many Texans also face social barriers to health care, including a lack of access to technology and internet service.

We need solutions that expand—not limit—the use of telehealth, maintain or improve the standard of care, reduce costs, and increase innovation and efficiency in our health care system. Texas needs to embrace the reduction of unnecessary regulations and obstacles without permanently adopting costly health insurance mandates, particularly payment parity and audio-only mandates, that undermine the future potential of telehealth. While some of these mandates may make sense during a public health crisis, their use should be limited to an emergency because of the unintended, long-term consequences. Independent experts across the political spectrum, including Brookings, the John Locke Foundation, Americans for Prosperity, and the Progressive Policy Institute, have all said that payment parity mandates are harmful to the future of telemedicine and do nothing to improve the value of health care or increase access to telemedicine. Mandating the same payment for brick-and-mortar offices visit and telehealth visits is government rate setting and undermines telehealth's promises of efficiency and innovation.

- TAHP recommends that the Legislature invest in infrastructure that will ensure more Texans have access to telehealth and continue to explore ways to address social barriers to telehealth access.
- TAHP recommends eliminating any remaining telehealth restrictions regarding geography, patient or provider site, existing patient-provider relationships, and state licensure that prevent the organic growth of virtual health care. Additionally, the Legislature should consider new, innovative uses for telemedicine, including allowing Medicaid managed care plans to continue to provide service coordination, case management, and discharge planning activities via telehealth and allowing telehealth access to count toward network adequacy in provider shortage areas.
- TAHP opposes permanently adopting costly payment parity mandates, audio-only telehealth mandates and other coverage mandates. While these policies may make sense during a crisis, their use can create unintended, long-term consequences that undermine the future potential of telehealth.

TEXAS ASSOCIATION OF HEALTH PLANS

Solutions for an Affordable, High-Quality Texas Medicaid Health Insurance Program

January 2021

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Expanding Telehealth Beyond Covid-19

Telehealth Solutions to Strengthen and Improve Care Delivery

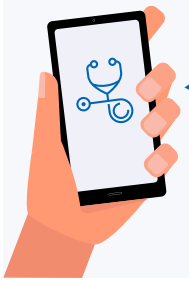
TAHP
The Texas Association of Health Plans

The COVID-19 crisis poses unprecedented challenges for Texas and our nation, touching every facet of American life. In the face of these challenges, Texas health insurance providers expanded access to and encouraged the use of telehealth during the COVID-19 crisis, ensuring Texans could receive the care and coordination they need from the safety of their homes by:

- ✓ Waiving out of pocket costs.
- ✓ Ensuring Texans have 24/7 telehealth access in their homes.
- ✓ Supporting providers with the infrastructure needed to transition to telehealth.
- ✓ Using telehealth to provide service coordination, case management, and discharge planning.

Telehealth Growth in Texas During COVID-19

Texas has seen an explosion in the use of telehealth across Texas, across all ages and types of health insurance.



4.5 million
Texans began using telehealth during COVID-19.

Nearly all respondents—94%
said they would continue using telehealth after the crisis.

Almost half—45%
said they now trust telehealth as much as or more than an in-person visit.

Texas Health Insurance Providers Will Continue to Expand Telehealth Post-Covid-19

For years, Texas health insurance providers have offered telehealth as an effective and efficient way to receive care—telehealth visits increased 52% per year on average from 2005 to 2014 (source: AMA Study).[1]

After the COVID-19 pandemic, Texas health insurance providers and MCOs will continue embracing and encouraging its use by:

- ✓ Paying network providers for covered telehealth and telehealth services.
- ✓ Providing insurance coverage for telehealth and telehealth services provided by a network physician or provider.
- ✓ Promoting telehealth in easy-to-find places on websites.
- ✓ Providing Texas patients with access to telehealth services 24 hours a day, 7 days a week.

Telemedicine has increased 52% a year since 2005

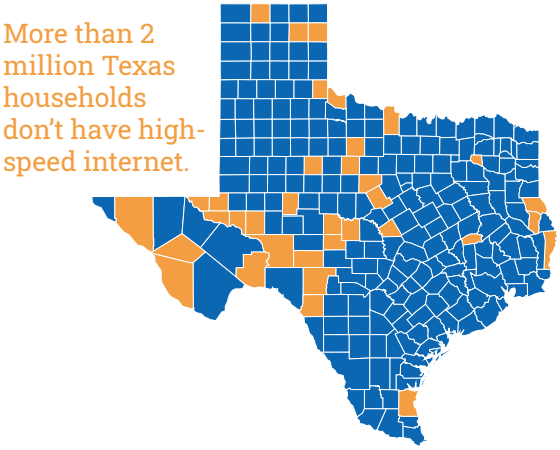
Expanding Telehealth Post-COVID-19

COVID-19 has proven that telehealth works and there is a demand for these services. To achieve the long-term promise of telehealth, Texas needs solutions that expand—not limit—the use of telehealth. This session, Texas needs to:

- ✓ Address infrastructure needs and invest in high-speed broadband access.
- ✓ Embrace the reduction of unnecessary regulations or government obstacles to telehealth and telehealth.
- ✓ Avoid permanently adopting costly health insurance mandates that harm the future potential of telehealth.

Address Infrastructure Needs and Invest in High-Speed Broadband Access

The largest obstacle to the future success of telehealth is a lack of high-speed—or broadband—internet access. In addition to the broadband infrastructure obstacles in rural areas of Texas, some Texans also face social barriers to accessing quality health care, including a lack of access to technology like smartphones.



Eliminate Unnecessary Government Regulations and Barriers to Telehealth

To maximize Texans' access to health care via telehealth—and to benefit from the improved health outcomes and significant savings that result from that access—Texas must eliminate unnecessary telehealth restrictions. As a result of the COVID-19 emergency, out-of-state health care providers were temporarily allowed to deliver services to Texans, and certain providers, including speech language pathologists, audiologists, and behavior analysts, were allowed to utilize telehealth with their patients. There is no reason these changes should not be made permanent.

Avoid Health Insurance Mandates that Harm the Future Potential of Telehealth

Independent experts across the political spectrum, including Brookings, the John Locke Foundation, Americans for Prosperity, and the Progressive Policy Institute, have all said that payment parity mandates are harmful to the future of telehealth and do nothing to improve the value of health care or increase access to telehealth. Mandating the same payment for brick-and-mortar office visits and telehealth visits is government rate setting and undermines telehealth's promises of efficiency and innovation. We need solutions that expand—not limit—the future potential of telehealth.

TAHP's Position

- TAHP recommends investing in infrastructure that will ensure more Texans have access to telehealth and continue to explore ways to address social barriers to telehealth access.
- TAHP recommends eliminating any remaining telehealth restrictions regarding geography, patient or provider site, existing patient-provider relationships, and state licensure that prevent the organic growth of virtual health care. Additionally, the Legislature should consider new, innovative uses for telemedicine, including allowing Medicaid, managed care plans to continue to provide service coordination, case management, and discharge planning activities via telehealth and allowing telehealth access to count toward network adequacy in provider shortage areas.
- TAHP opposes permanently adopting costly payment parity mandates, audio-only telehealth mandates and other coverage mandates. While these policies may make sense during a crisis, their use can create unintended, long-term consequences that undermine the future potential of telehealth.

1 Barnett ML, Ray KN, Souza J, Mehrotra A. Trends in Telemedicine Use in a Large Commercially Insured Population, 2005-2017. JAMA. 2018;320(20):2147–2149. doi:10.1001/jama.2018.12354

TEXAS ASSOCIATION OF HEALTH PLANS
Beyond the COVID-19 Crisis: Telehealth Solutions to Strengthen and Improve Care Delivery
January 2021
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PBMs: Negotiating Lower Prescription Drug Prices in Texas

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The Texas Association of Health Plans

When you pick up a prescription at your local pharmacy, you don't see the complex system that works behind the scenes to get your prescription drugs to you at the lowest cost possible. One part of that system is pharmacy benefit managers, or PBMs—companies that work closely with health insurance providers to negotiate lower prescription drug prices on your behalf. PBMs provide a check on Big Pharma's constant price hikes, helping you save more at the pharmacy counter.

- ✓ PBMs negotiate for low prescription drug costs and directly pass those savings on to patients and employers.
- ✓ PBMs provide access to more affordable retail, specialty, and mail-service pharmacies, and advocate for additional savings for patients.
- ✓ PBMs offer care management tools to make sure patients actually take their prescriptions, helping improve health outcomes for all Texans.

PBMs Save Texans Billions

Research shows that over the next ten years, PBMs will save Texans more than $80 billion—over 30%—on their prescription drugs.[1]

TAHP's Position

- TAHP supports health insurance providers and PBMs' use of private market solutions and competition to negotiate low drug prices for Texas patients and employers.
- TAHP opposes government mandates, including contract mandates, that undermine competition in the private market and increase the cost of drug coverage for Texans.
- TAHP opposes Any Willing Provider mandates, including mandates requiring health insurance providers and PBMs to contract with any health care provider or pharmacy regardless of quality standards, patient access, and impact on the cost of health care for Texans and Texas businesses.
- TAHP opposes "formulary freeze" mandates that would severely restrict PBM and health insurance providers' ability to negotiate lower drug prices. Milliman recently estimated that frozen formulary legislation would increase health insurance costs in Texas by more than $400 million over 5 years.[2]
- TAHP opposes government rate or price setting. No other industry or business is guaranteed a profit by the legislature. Promising any business a profit without considering the market forces or the quality of business decisions of that entity guarantees higher costs for Texas consumers and employers.

It's a Fact: Drug Prices are Out of Control

Health insurance costs for prescription drugs are now higher than they are for any other cost, including patient hospital costs and payments to doctors.

Today, more than 21.5 cents of every health care dollar go to Big Pharma to pay for prescription drugs—more than any other expense.

In January 2020, drugmakers increased prices on more than 200 prescription drugs, undeterred by the mounting affordability crisis.[3] Despite the economic hardships the COVID-19 crisis has created for tens of millions of Americans, drugmakers raised their prices on 67 brand-name medicines in July 2020 at an even higher rate than the previous year's hikes.[4]

At a time when Big Pharma continues to hike up prices, it is more important than ever that health insurance providers and pharmacy benefit managers (PBMs) have the tools they need to negotiate and advocate for the lowest possible prescription drug costs for Texas patients and employers.

Independent Pharmacies are Thriving and Profitable in Texas:

Independent pharmacies are essential partners in PBM pharmacy networks.They play a critical role in ensuring that the patients that pharmacy networks serve—particularly those in Medicare and Medicaid—have access to care.

Despite claims to the contrary, the number of independent pharmacies in Texas is increasing, not decreasing. Most independent pharmacies continue to operate profitably and significantly outnumber chain pharmacy locations in Texas.

- ✓ As of 2019, there were 1,944 independent pharmacies in Texas, outnumbering CVS, Rite-Aid, and Walgreens locations.[5]
- ✓ There were 539 more pharmacies in 2019 than 2010—an increase of 38%.[6]
- ✓ Independent pharmacists earn $127K on average—far higher than the state's median household income of $59K."[7]

[1] "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers". Visante, February 2020.
[2] Linger, David M. and Tra cy A. Margiott. "Estimated Cost of Potential 'Frozen Formulary' Legislation". Milliman, September 2017.
[3] Earman, Michael and Carl O'Donnell. " Exclusive: Drugmakers from Pfizer to GSK to hike U.S. prices on over 200 drugs". Reuters, 31 December 2019.
[4] Marsh, Tori. "Live Updates: July 2020 Drug Price Increases". GoodRx, 3 August 2020.
[5] "Independent Pharmacies in the U.S. are More on the Rise than on the Decline". PCMA, March 2020.
[6] Pharmacy Data. Data.gov, 2 December 2019.
[7] U.S. Census Bureau, 2019 American Community Survey, 1-Year Estimates; Table ID: S1903.

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Fighting For Lower Drug Prices For You

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The Texas Association of Health Plans

It's a Fact: Drug Prices Are Out of Control

Big Pharma controls drug prices—and Big Pharma can lower them for Americans. Instead, they continue to raise prices year after year—even several times a year—making health care more expensive for everyone.

Pharmaceutical companies make breakthrough treatments and cures. But this does not give them the right to price gouge hardworking Americans.

The problem is the price, not health plans or PBMs

652% Price Hike

for the drug that treats opioid overdose—**at the height of the opioid crisis**

596% Price Hike

for a leading antidepressant **in just 3 years**

248% Price Hike

for Humira—**12 price hikes in 5 years** to the world's biggest selling drug

Price Gouging Americans by Taking Advantage of a Broken System

Too many Americans must choose between **paying their bills and paying for their medications.**

Drug makers are making record profits through their record prices—not because they are launching new medications.

In January 2020, drug makers increased prices on more than 200 prescription drugs despite the mounting affordability crisis.[1] Despite the economic hardships the COVID-19 crisis has created for tens of millions of Americans, drug makers raised their prices on 67 brand-name medicines in July 2020 at rates even higher than in previous years.[2]

At a time when Big Pharma continues to hike up prices, it is more important than ever that health insurance providers and pharmacy benefit managers (PBMs) have the tools they need to negotiate and advocate for the lowest prescription drug costs for Texas patients and employers.

Today **more than 21.5 cents of every health care dollar** go into the pockets of Big Pharma to pay for prescription drugs— more than any other expense.[3]

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It's Time for Solutions – Not Distractions

Last session, the Texas Legislature passed some of the strongest drug price transparency disclosures in the country. However, some drug companies refuse to provide reasons for their rate increases or the provide is vague or meaningless information, undermining the goal of increased transparency. The Legislature should ensure that HHSC fully implements and enforces HB 2536 so that all required information for applicable price increases is reported and posted on a public-facing, consumer-friendly website in a timely manner.

Health Plans and PBMs Fight for Lower Drug Prices

Big Pharma and Independant pharamcists want you to believe that negotiating for lower drug costs for millions of Americans makes drug prices go up. Common sense—and a growing body of research—says that's not true.

In fact, an overwhelming body of independent research shows that, thanks to their ability to negotiate, health insurance providers and PBMs are part of the solution to lowering health care costs and premiums.

When drug prices go down, you pay less. That's why health insurance providers and PBMs negotiate with drug companies for lower out-of-pocket costs and premiums for Texans and Texas employers. They're not middlemen—they're your bargaining power. By combining bargaining power, they:

Save patients 40-50% on their annual prescription drug and related medical costs, compared to what they would have spent.[4]

Will save Texas consumers and taxpayers more than $80 billion—up to 30 percent—on drug benefit costs over the next decade.[5]

The Problem Is the Price of Drugs, Not the Savings We Negotiate

Big Pharma wants you to believe that rebates—the lower prices we win for patients—are to blame for out-of-control drug prices. The truth is, rebates mean lower prices. Health insurance providers and their PBM partners negotiate rebates to drive down costs, promote competition and provide more choice and control for patients. And new research shows it works.

Higher drug prices are **not caused by higher rebates**

Research shows there is NO connection between higher levels of rebates and higher prices for prescription drugs.[6][7][8] **Drug prices are still out of control** for brand-name drugs that do not offer rebates.

Rebates are higher on average for drugs that have more competition

When drug makers face competition from similar drugs, they use rebates to drop their prices. **This is how the market should work.** It's a stark difference for drugs that face no competition.

Savings from rebates go **DIRECTLY to consumers**

Consumers and patients absolutely benefit from rebates. One major player recently reported that they return 97% of rebates back to their customers.[9] This means **lower health insurance premiums and out-of-pocket costs** for millions of hardworking Texans and better, more affordable health care for you.

The focus on rebates **distracts from the real problem**

The focus on rebates is a distraction because most drugs are not even rebated by drug makers. Rebate levels are driven by market competition—not price. Rebates are nominal or non-existent if there is no leverage to negotiate them. 89% of prescriptions written in 2016—the vast majority of which include generic drugs that generally lack rebates—had no rebates.

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1 https://www.reuters.com/article/us-usa-healthcare-drugpricing-exclusive/exclusive-drugmakers-from-pfizer-to-gsk-to-hike-u-s-prices-on-over-200-drugs-idUSKBN1YZ1C4
2 https://www.goodrx.com/blog/july-drug-price-hikes-2020/
3 https://www.ahip.org/health-care-dollar/
4 https://www.admere.com/amr-blog/pbm-industry-growth-affordable-drugs#:~:text=PBMs%20save%20payers%20and%20patients,%241%20spent%20on%20PBM%20services.
5 "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers". Visante, February 2020.
6 https://www.pcmanet.org/new-research-pbms-save-941-per-person-annually/
7 https://www.pcmanet.org/new-data-rebates-are-unrelated-to-drugmakers-pricing-strategies/
8 http://investors.cvshealth.com/~/media/Files/C/CVS-IR-v3/documents/08-aug-2018/approaches-to-making-drugs-more-affordable.pdf
9 https://www.cnbc.com/2018/08/08/cvs-ceo-larry-merlo-defends-discounts-it-negotiates-with-drugmakers.html

Medical Management Means Smart Care for Texas Patients

TAHP
The Texas Association of Health Plans

Health Plans Use Prior Authorization to Ensure Safe and Effective Care

Texas health insurance providers are committed to providing Texans with high-quality, affordable health care. Medical management tools, especially prior authorization (PA), help us deliver on the promise of safe and effective care. One important way health insurance providers do that is by working with doctors, nurses, and patients to find ways to ensure health care is more efficient, effective, and affordable.

PA provides critical safeguards to prevent inappropriate treatment.

Just as doctors use scientific evidence to determine the safest and most effective treatments, health insurance providers rely on this same data and evidence to ensure patients are receiving safe, effective care. In fact, Texas law already requires that tools like PA be based on nationally recognized, evidence-based clinical standards that have been developed by the medical community. Medical management has been encouraged and endorsed by independent experts and government health leaders alike, and many experts have called for providers to adopt evidence-based guidelines in their practice for years.

PA is a fundamental and integral part of how health benefits work, providing critical safeguards that help prevent harm, lower costs, promote appropriate use of medication and services, and ensure care is delivered at the right place and time. PA is also the most important and effective tool to prevent fraud, waste, and abuse.

Patient Care Should Be Appropriate

Even though PA applies to less than 10% of prescription drugs and less than 25% of medical services, they are a fundamental part of how health benefits work, providing critical safeguards against unnecessary and inappropriate medical care.

Less than 10% of prescription drugs have a PA

Less than 25% of medical services have a PA

Prior Authorization Protects Patients from Unsafe and Unnecessary Care

PA is necessary because a significant amount of care being delivered to patients is not evidence based. That care is not only unnecessary but potentially harmful. As Marty Makary, M.D., M.P.H., writes in his book, *The Price We Pay*, **"Overtesting, overdiagnosing, and overtreatment are now commonplace in some areas of medicine."**[1] Research has shown time and again that there are wide variations in provider performance, and little to no correlation between spending and health care quality.

- ✓ Research has highlighted significant gaps between evidence-based practices and the care actually delivered to patients.[2]
- ✓ Between $200 billion and $800 billion is spent on unnecessary services, such as excessive testing and treatment, each year.[3]
- ✓ Doctors themselves believe that at least 15-30% of all ordered medical care is unnecessary or unsafe.[4]
- ✓ Over 20% of diagnostic imaging is inappropriate, including over 60% of lumbar spine MRIs and over 30% of MRI studies for shoulder pain and knee pain.[5]

Over $200 billion
is spent each year on unnecessary services.

15-30%
of all ordered medical care is unnecessary or unsafe.

20%
of diagnostic imaging is inappropriate.

Medical Management Processes are Heavily Regulated in Texas

Medical management, including the PA process, is heavily regulated by federal and state law. Each and every step of the process is regulated, from TDI licensure or certification as a Utilization Review (UR) agent through final and binding external IRO appeals. Texas law already provides significant protections throughout the UR process to ensure that members have access to medically necessary and appropriate care, including:

- ✓ Requiring all prior authorization criteria to be based on evidence-based care developed and adopted by the medical community
- ✓ Prohibiting PA for emergency care and reversal of PA approvals
- ✓ Requiring that patients are provided with information on how to appeal and how to file complaints with the Texas Department of Insurance (TDI)
- ✓ Providing extensive appeal rights for PA denials to an independent physician

Addressing Administrative Burden

More can be done to reduce the administrative burden of PA, and these solutions can be implemented without undermining patient safety and outcomes. For example, the 2019 Council for Affordable Quality Healthcare, Inc. (CAQH) Index report found that any kind of electronic health record adoption—partial or full—significantly reduces the cost of PA. Most providers still use manual processes despite the availability of online submission portals, and almost half of provider PA requests are still submitted by fax. The majority of health plans are taking steps to streamline the PA process for both prescription drugs (91%) and medical services (89%), and a majority (84%) reported that automation of the PA process is the biggest opportunity for improvement.[6]

Another solution would be to allow providers additional time to submit information supporting their PA requests. Texas has some of the shortest time frames in the country for PA decisions, even for requests missing medical information. The unintended consequence of this requirement is that denials are often issued because of insufficient information. Providing additional time for a provider to submit missing information needed for the health plan to make a decision reduces provider burden, unnecessary delays and denials for members. Many other states, the NAIC Model Act, and URAC accreditation all recognize the need for PA timelines that allow providers additional time to submit missing information without requiring a denial.

Most providers still use manual processes despite the availability of online submission portals, and almost half of provider PA requests are still submitted by fax.

84% **of health plans reported that PA automation is the biggest opportunity for improvement.**

TAHP's Position

- Texas passed significant regulatory mandates and transparency requirements for PA last session. TAHP opposes unnecessary new administrative and regulatory mandates limiting the ability to use medical management tools that provide access to safer care and more valuable coverage for members.
- To reduce administrative burden for both health plans and providers, TAHP recommends reconsideration of the timelines in Texas (and their application to incomplete PA requests), which are dramatically different than most other states. TAHP also recommends a move away from paper and fax towards more electronic and automated systems.
- TAHP recommends expanding transparency requirements passed last session to include data on a providers' patient outcomes and appropriate utilization.

[1] Makary, Marty. The Price We Pay. Bloomsbury Publishing, 2019
[2] Donaldson MS. An Overview of To Err is Human: Re-emphasizing the Message of Patient Safety. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 3.
[3] Institute of Medicine. 2013. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press.
[4] Lyu H, Xu T, Brotman D, Mayer-Blackwell B, Cooper M, et al. (2017) Overtreatment in the United States. PLOS ONE 12(9): e0181970.
[5] S Flaherty, E Zepeda, K Mortele, G Young. Magnitude and financial implications of inappropriate diagnostic imaging for three common clinical conditions. *International Journal for Quality in Health Care*, Volume 31, Issue 9, November 2019, Pages 691–697.
[6] AHIP: Industry Survey on Prior Authorizations, 2020

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Medical Management Means Smart Care for Texas Patients

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Texas Can Increase Access to Care and Reduce Costs by Eliminating Outdated Delegation Barriers

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The Texas Association of Health Plans

The COVID crisis has underscored just how important it is for Texas to address our systemic health care provider shortage. Before the COVID crisis, more than 7 million Texans were already experiencing shortages of primary care and almost half of all Texans were experiencing a shortage of behavioral health care providers. Texas should not wait for another pandemic to address the shortcomings in our health care system. Advanced practice registered nurses (APRNs) are a key part of the solution for increasing access and options for Texas patients.

Eliminating Outdated Delegation Barriers for APRNs Will Lead To:

- ✓ Direct cost savings for the state and health care system
- ✓ Increased health care access and quality care, especially in primary care, mental health care, and in rural and underserved areas
- ✓ Better business environment in Texas with increased competition and increased options for consumers

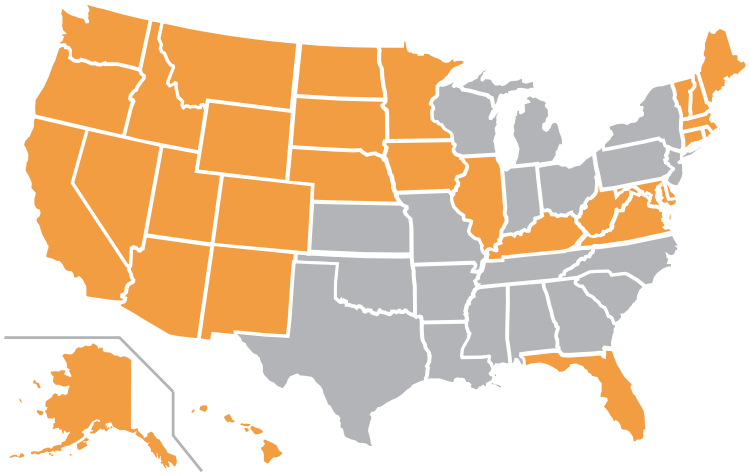
What Is a Delegation Barrier?

Under current Texas law, APRNs such as nurse practitioners are required to sign and pay thousands of dollars for a contract with a physician before they can do the job they have been trained and licensed to do. But a large and growing mountain of evidence from the Institute of Medicine, American Enterprise Institute, Brookings, and others shows that removing these requirements for APRNs would ease health care providers shortages, improve quality of care, and reduce health care costs.

Who Supports Removing Delegation Barriers?

- 31 States + D.C. have ended outdated physician delegation barriers for APRNs.
- 19 additional states, including Texas, waived delegation during the pandemic.
- The Department of Veteran Affairs also allows APRNs to practice without a physician contract.
- More than 30 Texas organizations—including TAHP, TCCRI, Every Texan, TAB, AARP, TPPF and TORCH—support ended these outdated regulatory barriers.

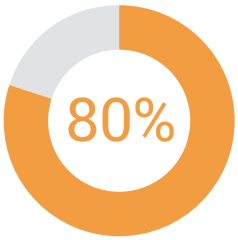
31 States + D.C. have ended outdated physician delegation barriers for APRNs



TAHP supports eliminating requirements for physician delegation contracts in Texas.

Outdated Delegation Barriers Are a Hidden Tax on Health Care

- Texas has been ranked one of the 10 worst states to be a nurse practitioner.
- Almost 80% of NPs in Texas are considering practicing telemedicine across state lines instead of in Texas because of delegation barriers.
- NPs in Texas report paying as much $87,000 a year for these outdated and wasteful contracts.



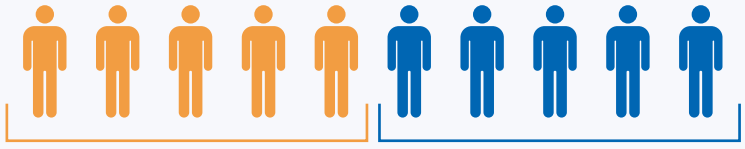
of NP's Are Considering Practicing Across State Lines Because of Delegation Barriers

- Texas invests millions educating the APRN healthcare workforce. 31 states—including California, Florida, New Mexico—have eliminated these regulatory barriers, making them a more competitive and attractive workplace for new graduates.

Outdated Delegation Barriers Waste Texas' Primary Care Workforce

Wasting Resources: Texas is Not Cost Effectively Utilizing Half of its Primary Care Workforce

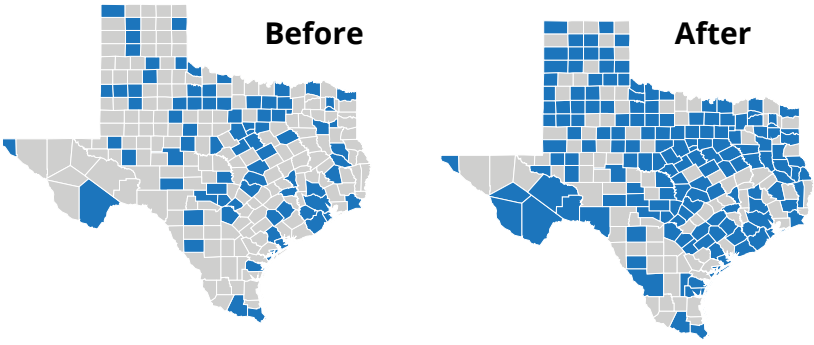
Primary Care Doctors and Nurse Practitioners in Texas



20,000 NPs **22,100 MDs**

Eliminating Outdated Delegation Barriers Improves Access, Quality and Reduces Costs

Eliminating APRN Requirements Immediately Closes Most of the Provider Gap



Texas areas with a primary care shortage

shortage of primary care

no shortage of primary care

- **Greater Access:** States with APRN delegation requirements have up to 40% fewer primary care nurse practitioners.
- **Cost Savings:** Florida estimated up to $44 million in annual Medicaid savings, up to $2.2 million in state employee health insurance savings, and $399 million in total health care savings by eliminating the delegation agreement.
- **Better Quality:** Wide body of evidence has found nurse Practitioners delivered care comparable and reduced hospitalizations, readmissions, and ED visits.

TEXAS ASSOCIATION OF HEALTH PLANS

Texas Can Increase Access to Care and Reduce Costs by Eliminating Outdated Delegation Barriers

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Protect Texans From Freestanding Emergency Rooms

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The Texas Association of Health Plans

Texas freestanding emergency rooms (FSERs) are a relatively new business model in Texas. Unfortunately, they often mislead patients about cost. Because FSERs usually look like urgent care centers, patients visit them for minor, non-emergency conditions. In most cases, patients could be treated at a significantly lower cost at a different facility. FSERs are some of the worst offenders when it comes to outrageous high prices and misleading information. The sticker shock is alarming. Insurers are forced to pay higher prices for many health care services at FSERs that could have been dealt with in different settings at much lower cost. Those unnecessary medical costs get passed on to all Texans in higher premiums. FSERs are responsible for more than $3 billion in unnecessary health care costs in Texas every year. The need for increased protection against price gouging and other unfair billing schemes by FSERs has been starkly demonstrated in recent months with some providers taking advantage of the current COVID crisis. While COVID testing provides many recent examples of price gouging, fraud, upcoding, and other egregious billing practices, excessive prices and improper—even fraudulent—billing are not new for some FSERs. The FSER industry has a long history of misleading consumers, price gouging, and surprise billing Texas patients.

FSERs are responsible for more than

$3 billion

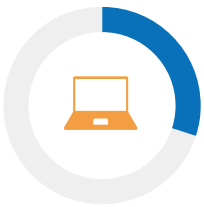
in unnecessary health care costs in Texas every year

TAHP's Position

- TAHP supports holding freestanding ERs accountable for price gouging, predatory billing, and blatant failure to comply with current patient protection laws and regulations
- TAHP opposes any expansion of the FSER licensure to include non-emergency services. Any expansion of services at FSERs would put more Texas patients at risk for price gouging, predatory billing, and inappropriate care.
- TAHP supports banning FSERs from charging emergency care fees for urgent care and physician office services.
- TAHP supports legislation that would penalize FSERs for price gouging and other predatory actions during an emergency or pandemic.

Many Freestanding ERs Intentionally Mislead Texans

In 2019, an AARP investigation found that many FSERs are not following Texas transparency laws. Instead, they are misleading Texans about being in network and about their prices, putting them at risk for price gouging and predatory billing. FSERs often use confusing advertising and language that misleads, but, in reality, they are chronically out of network. While the Texas Legislature passed legislation last session to address this problem, it is critical to note that most independent FSERs are still not in compliance with the notice and other consumer protection requirements adopted by the Texas Legislature or the federal CARES Act.



30%

of FSER websites do NOT comply with state transparency laws[1]

almost

30%

of FSERs claimed they were in BCBSTX network when they were not[1]

77%

of FSERs use misleading language like "take" or "accept" insurance but are not in major plan networks[1]

FSERs Don't Improve Access to Care

It may seem like having more medical facilities in more places can only be good for improving access to health care in Texas, but that is not the case for FSERs. Texas FSERs are usually located in areas where there are a lot of other options for care, including hospital-based ERs and doctors' offices—not in areas of Texas where there is reduced access to care.

Freestanding ERs Charge Emergency Care Prices for Non-Emergency Services

Though FSERs tend to have the same look and feel as urgent care centers, many consumers are unaware that, unlike urgent care centers, FSERs are chronically out of network and can charge patients up to 22 times what they would pay for the same service at a physician's office and 19 times what they would pay at an urgent care center. In Texas, the average cost of an FSER medical visit for a common condition that should have taken place in a non-emergency setting is $3,000 compared to about $150 at an urgent care or physician's office visit. More than nine out of ten patients who receive care at an FSER could have been treated at a significantly lower cost in a different facility. These unnecessary high prices drive up the cost of health care and insurance premiums for all Texans.

The 5 Most-Treated Diagnoses at Texas FSERs Are Not Emergencies

Only 2.3% of FSER visits are emergencies that require ER care

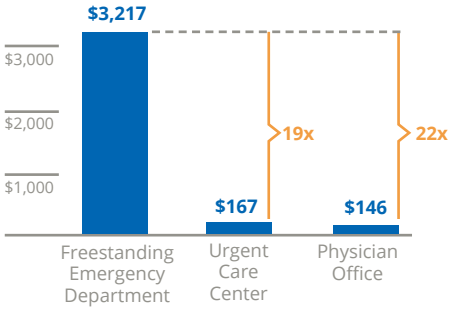
As a result, patients receive very expensive surprise medical bills for services that cost very little to treat.

The Top 5 Types of FSER Visits in Texas Could Have Easily Been Treated in Lower-Cost Settings Such as a Physician Office or Urgent Care Center

Top 5 Diagnoses at Texas FSEDs, 2016

Rank	Primary Diagnosis
1	Fever
2	Acute Bronchitis
3	Acute Pharyngitis (Sore Throat)
4	Acute Upper Respiratory Infection
5	Cough

Average Cost for Common Conditions by Site of Care, 2016



FSERs Drive Up Health Care Costs for All Texans

Almost all care received at FSERs could have been given in doctor's office or an urgent care center for a much lower price. Many times, FSERs cost even more than traditional ERs for the same services. The sticker shock is alarming. Insurers are forced to pay higher prices for many health care services at FSERs that could have been dealt with at much lower cost. Those unnecessary medical costs get passed on to all Texans in higher premiums. FSERs are responsible for more than $3 billion in unnecessary health care costs in Texas every year.

Case Study

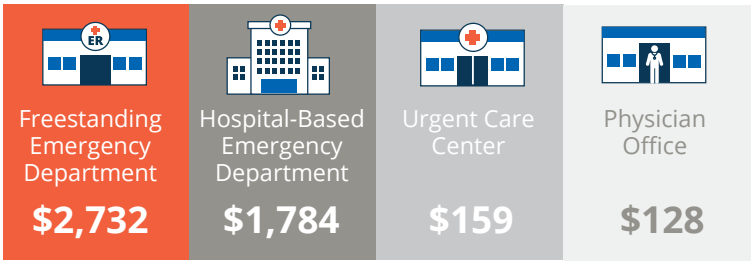
The cost of treating strep throat at a Texas FSED:

21 times higher than at a physician office

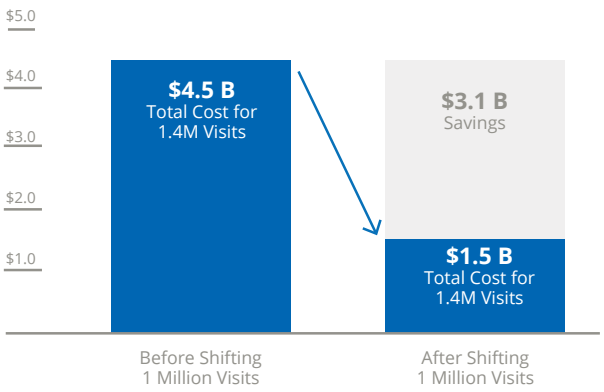
17 times higher than at an urgent care center

53 percent more than at a hospital-based ED

STREP THROAT



Savings Potential from Shifting 1 Million Visits to Physician Offices and Urgent Care Centers, in Billions



1 AARP, The Truth About Freestanding ERs, 12/18.

TEXAS ASSOCIATION OF HEALTH PLANS

Protect Texans from Freestanding Emergency Rooms

January 2021

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Government Mandates Raise the Cost of Health Coverage

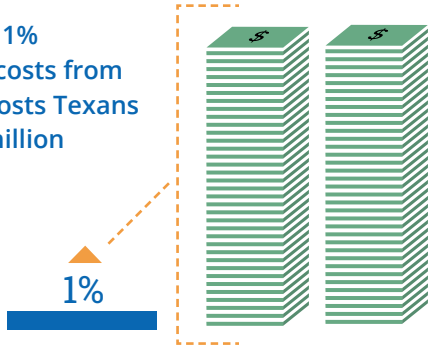
TAHP
The Texas Association of Health Plans

One of the most significant threats to health coverage affordability is the increasing number of government mandates that drive up the costs of coverage for Texas families and businesses. New government mandates related to provider payments, provider contracting, and new benefits drive up health care costs and limit innovation, private market negotiations, and consumer choice.

While often well-intended, government mandates typically lead directly to higher premiums for consumers. When the government mandates something in health care, a small population may benefit from the particular mandate, but premiums go up for everyone. **Depending on the mandated benefit and how that benefit is defined, the increased cost of a monthly premium can increase from less than 0.1% to more than 5%. A 1% increase may seem small when debating the addition of any new mandate, but every 1% increase in premiums costs consumers and employers more than $200 million a year in Texas' fully insured market.**

Government Mandates Cost Millions

Every every 1% increase in costs from mandates costs Texans over $200 million



Mandates are a Hidden Tax on Employers

Texas employers shoulder the biggest burden when it comes to government mandates. Mandates shift costs to the private market, forcing Texas employers to decide between reducing employer benefits, lowering wages, requiring employers to share more of the cost for their health coverage, laying off employees, or even closing their doors altogether. In effect, regulatory mandates act as a hidden "tax" on Texas employers and families. A recent survey of NFIB members found the cost of health insurance was ranked as the single biggest problem and priority for small business owners in Texas.[1]

One example of a government mandate that would result in significantly higher costs for Texans and Texas employers is a "formulary freeze." In 2017, Milliman estimated that "frozen formulary" mandates would increase the costs for prescription drug coverage in the Texas health insurance market by more than $400 million over 5 years.

Small business in Texas rank cost of health insurance the

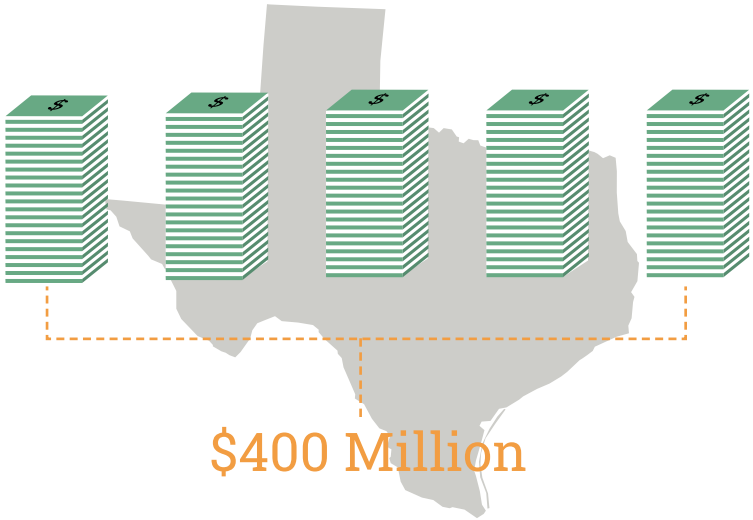
#1 burden

for small business owners in Texas

Health Insurance Mandates are Bad for Texas

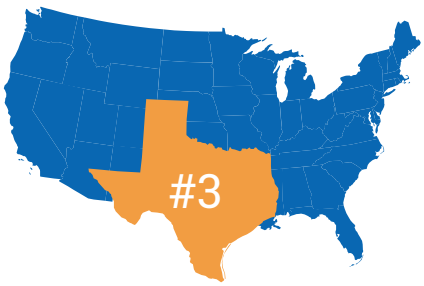
- ✓ Increase health care costs
- ✓ Creates a Hidden tax on Texas employers
- ✓ Put the State at Financial Risk to Pay Costs to the Federal Government

Frozen Formulary Mandate Would Cost Texans and Texas Employers More than $400 Million Over 5 Years



Texas Leads the Nation In Mandates

Texas leads the nation in the number of costly health insurance mandates, at more than 40 mandated benefits, ranking third in the nation for the most mandated benefits. The cost of healthcare in Texas is already the most expensive in the country. **TAHP is concerned about the number of new mandates considered each legislative session and their potential effect on Texans' access to high-quality health care they can afford.**



Texas is ranked
3rd in the nation
for the most health care mandates

Texas Mandates in Excess of the Affordable Care Act

It is important to note that the ACA already mandates that health plans cover the "essential health benefits" (EHB) for health insurance coverage that started in or after 2014. The ACA also already mandates that health plans cover preventive benefits (with no cost-sharing) as listed in the US Preventive Task Force as A & B recommendations. States can go beyond the ACA's mandates, but **ACA rules require states—rather than insurers—to cover the cost of new benefit mandates that go beyond the ACA's requirements**. It is critical to note that Texas' legislative efforts to avoid payment for new mandates likely violate federal law, and Texas could be liable for any mandates adopted since 2014 and in the future.[2]

Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

TAHP's Position

- TAHP opposes all government mandates, including payment, contracting, administrative, and benefit mandates, which reduce private market competition, limit consumer choice, and drive up the cost of health care.
- TAHP recommends that the Legislature carefully review existing and proposed mandates. When a mandate does not create value, does not address a specific problem, or creates unintended consequences in the market, it should be reversed or not adopted. The Legislature should also consider any costs to be paid by the state for mandates exceeding ACA requirements.
- TAHP also recommends that the Legislature require estimates of increased costs and premium impacts for any legislation proposing new health insurance payment, contractual, administrative, or benefit mandates for the private (fully-insured) commercial market, as well as ERS, TRS, and the UT/A&M health systems.
- TAHP supports health plans' ability to competitively negotiate contracts with the highest value providers and pharmacies in the private market without restrictive government mandates that limit competition and access to quality, cost-effective health care.

1 Wade, Holly and Andrew Heritage. "Small Business Problems and Priorities". NFIB Research Center, 2020.
2 "Biennial Report". Texas Department of Insurance, December 2020.

TEXAS ASSOCIATION OF HEALTH PLANS
Government Mandates Make Health Care Less Affordable for Texans
January 2021
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Any Willing Provider Mandates: Eliminating Competition & Increasing Costs

TAHP
The Texas Association of Health Plans

One of the most significant threats to health coverage affordability for Texans and Texas businesses is the increasing number of government mandates related to provider payments, provider contracting, and benefits. These mandates not only drive up the cost of health care, but also limit innovation, private market negotiations, and consumer choice. While often well-intended, government mandates typically have unintended consequences on health insurance costs, which lead directly to higher premiums for Texans.

What Are Any Willing Provider Mandates?

Any Willing Provider (AWP) mandates restrict private market negotiations by forcing health insurance providers to contract with any health care provider or pharmacy willing to meet the plan's contract terms—regardless of whether that provider meets quality standards, whether there is already enough patient access, or whether it will increase the cost of health care for consumers and businesses.

Any Willing Provider Mandates Reduce Competition and Drive Up the Cost of Premiums

AWP Mandates increase health insurance costs by 5%

The Texas Association of Health Plans Opposes Any Willing Provider Mandates

AWP mandates undermine competition in the private market and increase costs for Texans and Texas businesses.

Any Willing Provider Mandates Are Bad For Texas Patients and Employers:

- They increase health care costs and health insurance premiums.
- They reduce competition.
- They create a "Right to Hire" mandate.
- They risk reducing value and quality of care.

Texas Independent Pharmacists Do Not Need Guaranteed Contracts Through AWP Mandates—Texas Independent Pharmacies are Already Thriving and Profitable

- ✓ Despite claims to the contrary, the number of independent pharmacies in Texas is increasing, not decreasing. Most independent pharmacies continue to operate profitably, and significantly outnumber chain pharmacy locations in Texas.
- ✓ As of 2019, there were 1,944 independent pharmacies in Texas, outnumbering CVS, Rite-Aid, and Walgreens locations.
- ✓ There were 539 more pharmacies in 2019 than 2010—an increase of 38%.
- ✓ Independent pharmacists earn $127K on average—far higher than the state's median household income of $59K.

Texas Independent Pharmacies Have Grown by

38%

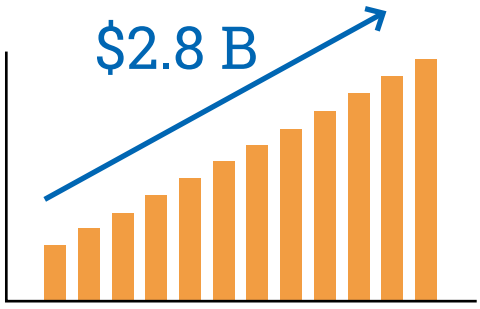
Since 2010

Any Willing Provider Mandates Eliminate Private Market Competition and Increase Costs for Employers, Consumers, and Taxpayers

Any Willing Provider Mandates Increase Costs:

- A growing body of evidence and experts, including the Federal Trade Commission (FTC), all agree that AWP mandates remove incentives for providers to offer competitive rates and reduce health plan competition, driving up the cost of health coverage for consumers, employers, and taxpayers.
- AWP laws concluded that such legislation leads to less competition and higher prices for consumers while providing no compensating benefits with "cost increases of ~5%."[1]
- A recent AWP mandate proposal was estimated to increase Medicare costs by $21 billion over 10 years.

Specialty Pharmacy AWP Mandates Increased Prescription Drug Costs



- A Specialty Pharmacy AWP mandate in Texas would increase prescription drug costs by $2.8 billion over 10 years[2]

Any Willing Provider Mandates Reduce Competition:

- According to the FTC, AWP requirements significantly reduce providers' incentive to engage in price competition. If pharmacies know they will automatically be included in a network, they have a reduced incentive to offer plans and PBMs their most competitive terms.
- The FTC has noted that "requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies."[3]

Any Willing Provider Mandates Create "Right to Hire" Mandate:

- "Guaranteed" employment and contracts do not exist in other industries.
- AWP mandates create a presumed "right to employment or contract"—to accept any provider, even if they are not the highest quality, takes away competition, and removes plans' ability to negotiate for the best providers available to deliver efficient, high-quality care.

Any Willing Provider Mandates Risk Quality of Care:

- AWP mandates restrict health plans' ability to promote high-quality care.
- Being forced to accept any provider, even if they do not meet quality standards, takes away competition, and removes

1 Klick, Jonathan and Joshua D. Wright, "The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures," Am. L. & Econ. Rev. 192 (2015)
2 "Increased Costs Associated with State Legislation Impacting PBM Tools". Visante, January 2019
3 Federal Trade Commission to Centers for Medicaid and Medicaid Services, 7 March 2014

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January 2021
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Solutions for an Affordable, High-Quality Texas Medicaid Health Insurance Program

TAHP
The Texas Association of Health Plans

87th Texas Legislature

The COVID-19 crisis reminds us of the value of affordable health insurance coverage and the peace of mind it brings to Texans and their families. While health insurance coverage is not the only determinant of whether a person has access to health care, it is the most important one. Medicaid has played a key role in helping provide coverage during this economic and health care crisis. Today's Texas Medicaid covers medical expenses, coordinates complex medical care, and helps Texans stay as healthy and active as possible—all while providing caring, compassionate one-on-one support.

Texas partners with private health insurers known as Medicaid managed care organizations (MCOs) to connect over 4 million Texans to health coverage. The focus on prevention, wellness, and care coordination—getting Texans the care they need to get healthy, stay healthy, and live in their communities—has translated into better care and lower costs. As a result, millions of Texans—including children and pregnant moms—have seen improved outcomes, and Texas taxpayers have saved over $5 billion.

The COVID-19 crisis is highlighting the power of the public and private sectors working together to lower costs, improve efficiencies, and provide the high-quality health care that Texans deserve. Medicaid managed care plans are taking decisive actions to help Texans and curb the spread of the virus, including providing access for COVID-19 diagnostic testing, treatment, and vaccines, encouraging and expanding telehealth, and fully covering the doctor visits and treatments needed to recover from the virus. Texas Medicaid managed care plans are committed to working together with state and local officials to ensure that Texans covered through Medicaid have access to the comprehensive coverage they need to get healthy and stay healthy during this crisis.

Now is the time for Texas to focus on making sure all low-income Texans have access to affordable, high-quality health coverage. We need to focus on proven, free-market solutions that improve what's working and fix what's not to maintain affordable, high-quality Medicaid coverage for the Texans that need it most.

Solutions for an Affordable, High-Quality Texas Medicaid Program

Coverage:

Ensure the Texas Medicaid program provides comprehensive, high-quality affordable health coverage

Affordability:

Encourage an affordable and high-quality Medicaid program by fostering innovation, stability, and efficiency

Access:

Ensure Texans have increased access to affordable health care by expanding coverage and removing regulatory barriers for APRNs and telehealth

Coverage

Ensure All Texas Have Access to COVID-19 Testing, Treatment and Vaccinations

Every Texan should be able to get the COVID-19 tests, treatment and vaccines they need to get healthy and stay healthy. Access and education on how to access testing, treatment and vaccines needs to be part of a holistic public health strategy. Medicaid health plans interact daily with highly vulnerable Texans and play an important role in ensuring their members have access and know how to access treatment, testing and vaccinations and need access to vaccine data to facilitate that work.

- TAHP recommends that health plans are given access to vaccine data to help support the state's vaccine distribution plan.

Medicaid is an Essential Part of Texas Health Care

Medicaid improves the health and financial security of over 4 million Texans every day, including over 50,000 veterans. Medicaid is safety net health insurance that is there for the Texans who need it most, including children, mothers, grandparents, and people with disabilities. It covers the benefits and services that families need to get healthy and stay healthy, translating into fewer hospitalizations and lower costs for Texas taxpayers. Texans enrolled in Medicaid have far better access to health care and preventive services than those without coverage.

- TAHP encourages the Legislature to maintain a strong Medicaid program to ensure coverage for the millions of Texans who need it most.

Provide Comprehensive Coverage to New, Low-Income Moms

Texas has an uninsured rate of 23% among women—the highest in the country. For women, health insurance coverage is a critical factor in making health care affordable and accessible. Women with health coverage are more likely to obtain needed preventive, primary, and specialty care services and have better access to advances in women's health. However, health plans still face barriers to improving care for new mothers due to the short timeframe for Medicaid eligibility before and after pregnancy. The Texas Medicaid program only covers women for 60 days past delivery, and research shows the majority of maternal deaths in Texas occur after the mother loses her Medicaid coverage. Thirty-six states and DC offer postpartum care past 60 days.

- TAHP recommends that Texas Medicaid provide new moms with comprehensive coverage for 12 months to ensure access to high-quality health care coverage post-delivery.

Addressing Social Barriers as a Part of Medicaid Coverage

A person's health is influenced by several non-medical factors, including the conditions in which they are born, grow, live, work, and age. Social barriers, such as food insecurity, transportation, housing, social isolation, and loneliness, can lead to poorer health. Some people also face higher costs for health care and services that might otherwise be avoided if the social barriers that prevent them from being fully healthy were addressed. One study shows that social determinants of health can drive as much as 80% of health outcomes. A growing number of states are implementing solutions to address social barriers to health including finding ways to use existing managed care rate setting processes to incentivize health plan investment

- TAHP recommends that Texas explore ways to incentivize and allow Medicaid coverage of services that help address social needs, improve health and social outcomes, and reduce long-term health costs.

Continuous Comprehensive Coverage for Texas Children

Continuous eligibility is a valuable tool that helps states ensure children stay enrolled in health coverage for a full year. Continuous eligibility works like employer-based coverage—families enroll a child into coverage once a year, eliminating the need to repeatedly complete renewal forms or report income changes during that time period. As a result, children do not lose coverage unnecessarily. Children who have health insurance continuously throughout the year are more likely to be in better health. Guaranteeing ongoing coverage ensures that children can receive appropriate preventive and primary care as well as treatment for any health issues that arise. Stable coverage also enables doctors to develop relationships with children and their parents and to track their health and development. Additionally, eliminating the cycling on and off of coverage during the year reduces time and money the state wastes on unnecessary paperwork and preventable care needs. Thirty states have 12-month eligibility for one or both of their Medicaid and/or CHIP programs.

- TAHP recommends that Texas adopt 12-month continuous eligibility in the Medicaid program to reduce administrative waste and improve the overall health of Texas children.

Affordability

Maximize the Use of the Texas Managed Care Model

Over the past 20 years, Texas transformed Medicaid into a modern, patient-centered health insurance program. Independent state and national reports continue to demonstrate that Texas' Medicaid managed care program has saved billions of dollars while improving quality of care for members. Texas has saved more than $5 billion and through the use of managed care, and MCOs have kept per member per month costs virtually flat even as health care costs continue to grow dramatically across the country. Medicaid managed care plans hire the best doctors, negotiate the most affordable prices, and focus on prevention and wellness to help their members get healthy, stay healthy, and live their lives to the fullest while saving taxpayer money for the state. As a result, millions of Texans have seen improved outcomes. While over 94% of Texans on Medicaid are receiving services through Medicaid managed care, there are still benefits, programs, and policies at HHSC that are administered through the older, more expensive fee-for-service program. TAHP recommends that Texas transition all remaining services, populations, and processes into managed care to maximize the full value of the managed care model. Moving all services into managed care—where health plans are held financially responsible for staying within the budget set by the state and contractually accountable for coordinating services and improving health outcomes—is a more efficient use of taxpayer dollars. It also reduces confusion for Texans on Medicaid and doctors and hospitals serving these patients.

- TAHP recommends reducing Texas' reliance on fee-for-service infrastructure that unnecessarily drives up cost and results in duplication and inefficiencies in the system.
- TAHP opposes any efforts to carve services out of managed care, reduce flexibility, stifle innovation, or jeopardize stability and efficiency in the Medicaid program.

The Prescription for a Healthier Medicaid Rx Program

Medicaid managed care prescription drug coverage not only helps Texans get healthy and stay healthy, it is also a more affordable and efficient prescription drug program. Medicaid health plans have prescription drug coverage programs in place that reduce opioid abuse and deaths, emergency room visits, and unnecessary hospitalization for kids with asthma. In fact, Medicaid managed care has reduced hospital stays for asthma and diabetes in Texas, chronic diseases that are typically expensive to treat, by more than 35% through better coordination of care and prescription drugs. As a result, millions of Texans have seen improved outcomes and Texas taxpayers have saved more than $5 billion. Prior to prescription drugs being covered by Medicaid managed care plans, costs were out of control for Texas taxpayers. Drug costs had almost doubled from 2001 to 2011, growing more than 6.5% on average a year. As a result of managed care, Texas Medicaid prescription drug cost growth dropped by half and is now three times better than the national average. Texas has an opportunity to achieve even more savings and improved outcome by fully maximizing the use of the Medicaid managed care model and allowing Texas Medicaid managed care plans to manage and negotiate the state's prescription drug formulary.

- TAHP supports allowing MCOs to fully manage the pharmacy benefit in order to bring down costs and provide more efficient and timely access to clinically appropriate medications to Texans in the Medicaid program.
- TAHP opposes a carve out of prescription drugs that would move the benefit back to an expensive, inefficient and fragmented fee-for-service program.
- TAHP opposes the government mandating NADAC pharmacy pricing which will add costs to the Medicaid program and reduce competition.

Promote Value in the Texas Medicaid Program

Over the past 20 years, Texas transformed Medicaid into a modern, patient-centered health insurance program. Recent evaluations of Texas' managed care program have shown that the program is efficient, achieves significant savings, and improves quality of care. Texas' Medicaid managed care program also has some of the strongest and most transparent financial safeguards and oversight in the nation. The managed care contract is one of the most thorough, transparent, and enforceable contracts in Texas and in the country, with details of MCO contracts, performance and funding posted online for the public to view. Texas is also one of the few states which require MCOs to assume all the financial risk of downside losses and return upside gains (cost savings) to the state. These safeguards protect taxpayers from financial losses and provide the state with budget certainty. Through strong data and systems, Texas can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. These efforts will provide the foundation that enables Texas to deliver on its commitment to usher in a new era of Medicaid centered on innovation, accountability, and improved program outcomes.

- TAHP recommends that the Legislature and HHSC continue to monitor and evaluate contracted Medicaid managed care health plan performance by using nationally recognized quality of care and efficiency measures.
- TAHP recommends that criteria to evaluate and select plans to serve the state's most vulnerable populations be fair, objective, transparent, and appropriate to deliver on best value to the program. Criteria for procuring health plans should include operational and quality measures that align with current statutory requirements and should not solely focus on financial performance, create adverse incentives, or put the success of Texas' Medicaid managed care program at risk.

Modernize Provider Directories

It is vital that clients have access to an up-to-date provider directory. Recognizing that electronic versions of directories are more reliable than printed directories, which can be outdated as soon as they are printed, the Centers for Medicaid and Medicare Services (CMS) has amended federal statute to allow MCOs to provide provider directories electronically, unless otherwise requested by the client. Additionally, CMS is encouraging MCOs to offer a mobile-enabled directory. CMS notes that 67% of U.S. adults living in households with incomes under $30,000 a year owned smartphones in 2018. They also state that lower-income adults are more likely to rely on a smartphone for access to the internet because they are less likely to have an internet connection at home, and recent studies show that the majority of Americans have used their smartphones to access information about their health and consider online access to health information important. However, due to existing law in Texas, HHSC requires health plans to send a printed provider directory to every client in the Medicaid STAR Kids and STAR+PLUS programs even if they do not request it. Due to requirements about what must be included in a printed directory, some of these directories are so large they do not even fit in mailboxes, requiring a client to go to the post office to pick them up. Costs associated with printing and mailing large Medicaid provider directories have also continued to increase.

- TAHP recommends that the Legislature amend existing state statute to align with federal requirements that require health plans to print and mail a directory only if the client requests it, resulting in reduced costs and burden in the Medicaid program.

Access

Increase Access in the Medicaid Program

More than 80% of all Texas doctors participate in Medicaid health plan networks, delivering vital care to some of the most vulnerable Texans. To help maintain and increase access to high-quality care, Texas needs to increase access to all available provider types in Texas. Over 7 million Texans currently live in a primary care shortage area—a problem that is compounded in the Medicaid program. Advanced practice registered nurses (APRNs) are a key part of the solution to close the state's provider gap. Under current Texas law, APRNs in Texas are required to sign—and sometimes pay thousands of dollars for—a contract with a physician before they can do the job they have been trained and licensed to do. These undue restrictions reduce health care competition and harm employers, patients, and taxpayers. Thirty states plus DC have already ended physician delegation for APRNs. These states found that APRNs who have full practice authority are far likelier to serve individuals that are uninsured, rely on Medicaid, or live in rural areas. Additionally, states such as California and Florida have estimated significant Medicaid savings. A large and growing mountain of evidence from organization including the Institute of Medicine, National Governors Association, Federal Trade Commission, American Enterprise Institute, and Brookings Institute supports the same conclusion: removing delegation requirements for APRNs eases health care provider shortages, improves quality of care, and reduces health care costs.

- TAHP recommends that the Legislature eliminate these outdated physician delegation requirements for APRNs and allow all health care providers to practice "to the top" of their education and licenses.

Eliminate Regulatory Barriers and Obstacles That Undermine the Future ofTelemedicine

The COVID-19 crisis has demonstrated the importance of telehealth in the Medicaid program. Texas needs to create greater access to health care by ensuring that telehealth can continue to address patients' needs beyond the crisis. We need solutions that expand—not limit—the use of telehealth, maintain or improve the standard of care, reduce costs, and increase innovation and efficiency in our health care system. The largest obstacle to the future success of telehealth is high-speed broadband internet access. In addition to the broadband infrastructure obstacles in Texas, many Texans also face social barriers to health care, including a lack of access to technology and internet service, especially for Medicaid clients. The Legislature should invest in infrastructure that will provide more Texans with access to telehealth and continue to explore ways to address social barriers to telehealth access. To maximize Texans' access to telehealth—and to benefit from the improved health outcomes and significant savings that result from it—Texas must get rid of telehealth and telemonitoring restrictions regarding geography, patient or provider site, diagnosis, and state licensure that prevent the organic growth of virtual health care. Additionally, the crisis has demonstrated that telehealth can be used to conduct service coordination activities for Medicaid clients and may even be a preferred option for some families.

- TAHP recommends that the Legislature expand access to telehealth and telemonitoring and allow health plans to offer telehealth assessments as an option for Medicaid clients.

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The Value of Texas Medicaid

TAHP
The Texas Association of Health Plans

Texas Medicaid is more than just health care—it is an investment in the future of Texas. It goes beyond the doctor's office and into our schools, our workplaces and our communities.

Medicaid is safety net health insurance that is there for the Texans that need it most, including Texas children, mothers, grandparents and people with disabilities. It helps provide for everything from routine checkups and heart surgeries to home health and at-home nursing care.

A Deeper Dive Into Texas Medicaid

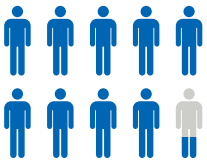
Texas Medicaid helps one in seven—or more than 4 million—Texans receive the care and support they need to get healthy, stay healthy and live life to the fullest as members of their communities.

- **2.9 million** low-income children
- **140,000** low-income pregnant moms
- **140,000** low-income parents of children on Medicaid
- **800,000** older Texans and Texans with disabilities
- **31,000** children in foster care
- **50,000** veterans

Who is Texas Medicaid?

4.3 million
Texans receiving services

Medicaid covers
15% of all Texans



94% **served through managed care**

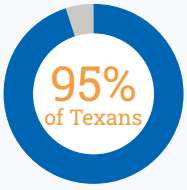
Medicaid and CHIP cover
43% of all Texas children

Medicaid covers
53% of all Texas births

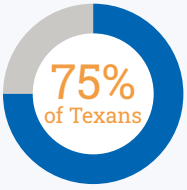
25% of Texans on Medicare
depend on Medicaid for long-term care services

Medicaid covers
62% of nursing home residents

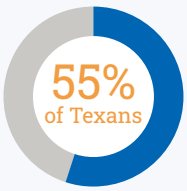
Texans Value Medicaid



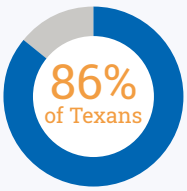
believe it is important to have a strong, sustainable Medicaid program



oppose cutting the Medicaid program



on Medicaid say they would have "very little" or "no" access to health care without it



on Medicaid are satisfied with their health care services

Source: Texas Statewide Medicaid Survey, 04/18.

Source: Morning Consult, National Tracking Poll #180546, 05/18.

Texas Medicaid Works

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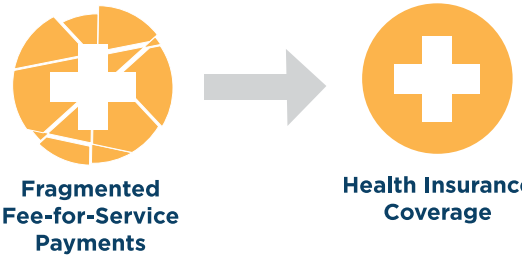


Over the past 20 years, Texas transformed an outdated Medicaid system that provided fragmented care into a modern, patient-centered health insurance program that provides more than 4 million Texans with the coverage and care they need.

Today, Texas partners with private health insurers known as managed care plans. They administer Medicaid and CHIP and cover the costs associated with delivering care.

How Does Medicaid Managed Care Work?

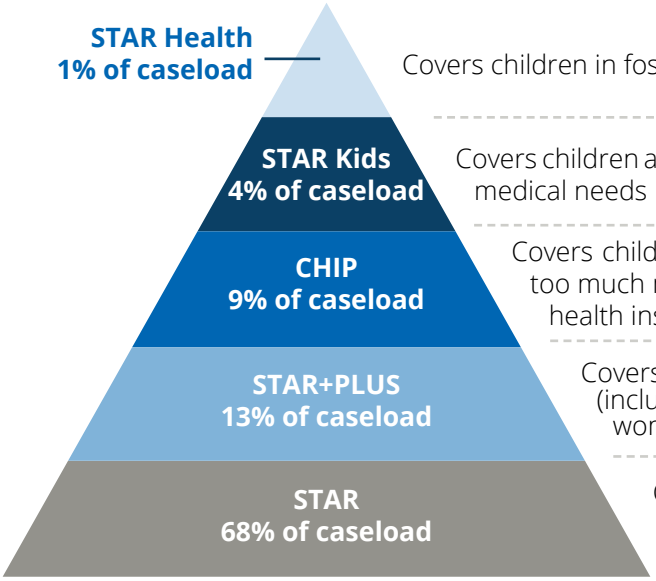
Managed care plans make Texans healthier and save taxpayers money by prioritizing preventive care and coordinating health care for Texans on Medicaid and CHIP.

Managed care works just like insurance. Every month, Texas pays a health care premium to the Medicaid health plans for each person they cover. In turn, the health plans accept all financial risk for providing needed services to their members.

The managed care program incentivizes health plans, providers and doctors to keep Texans on Medicaid healthier and encourage them to access preventive care and live healthier lives.

> Medicaid managed care is a critical program in Texas that has both saved taxpayers money and improved health outcomes."
>
> - Gov. Greg Abbott

Managed Health Insurance Coverage in Texas



- **STAR Health** — Covers children in foster care and young adults previously in foster care
- **STAR Kids** — Covers children and young adults age 20 and younger with disabilities or complex medical needs
- **CHIP** — Covers children and unborn children (CHIP Perinatal) in families that earn too much money to qualify for Medicaid, but cannot afford to buy private health insurance
- **STAR+PLUS** — Covers adults with a disability, people who are age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer
- **STAR** — Covers children, newborns, pregnant women and some families with children

STAR and CHIP

Pays for doctor visits, hospital stays and prescription drugs for children, newborns, pregnant women and some parents with children on Medicaid

STAR+PLUS

Pays for the same services as STAR, but also pays for long-term care services like home health care and nursing home stays for older Texans and Texans with disabilities

STAR Health

Provides specially-tailored health care and support for children in the Texas foster care and kinship care programs

STAR Kids

Pays for the same services as STAR, but also covers long-term care and coordination for children with disabilities and children with complex medical needs

Medicaid Managed Care is Healthier for Texas

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Medicaid managed care plans hire the best doctors, negotiate the most affordable prices, and focus on prevention and wellness to help their members get healthy, stay healthy and live their lives to the fullest while saving taxpayer money for the state.

Today's Texas Medicaid provides more than health coverage. It also:

- Improves access to care for Texans by emphasizing the role of primary care doctors
- Promotes preventive care like vaccines and routine primary care visits to keep Texans healthy
- Reduces costly hospitalizations and unnecessary emergency room visits
- Connects Texans to the compassionate one-on-one support and personalized care coordination they need to get healthy, stay healthy and live their lives to the fullest
- Provides services that go beyond the walls of a doctor's office, including arranging transportation, coordinating meals, and navigating challenges with school and work

Today's Texas Medicaid Keeps Texans Healthy

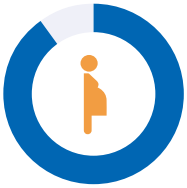
As a result of Texas' transition to Medicaid managed care, millions of Texans—including children and pregnant moms—have seen improved outcomes and increased access to preventive and timely care. Medicaid plans have also improved care coordination for Texans with complex medical needs, reducing hospital stays and ER visits. The focus on prevention, wellness and care coordination—getting Texans the care they need to get healthy, stay healthy and live in their communities—has translated into lower costs for Texas taxpayers. Texas has saved over $5 billion through the use of Medicaid managed care since 2009. Today's Texas Medicaid keeps Texans healthy, improves lives and saves taxpayer money.

As a Result of Medicaid Managed Care:

90%

of Texas children receive at least one doctor's visit a year[1]

Prior to Medicaid managed care – **less than 25% received recommended services**

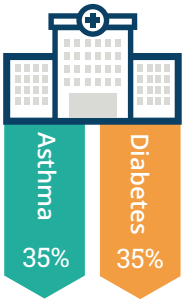


90%

of expecting moms receive timely prenatal care[1]

Prior to Medicaid managed care – **less than 15% received timely care**

Reduced hospital stays and ER visits by keeping Texas families healthy and out of the hospital[2]



Managed Care significantly reduced hospital stays for expensive chronic diseases by 35%

Helps more older Texans and Texans with disabilities live independently in their own homes
reducing the need for nursing home stays

Reduced ER visits in STAR Kids by 6% in the first year of the program[3]
Managed Care reduced preventable ER visits for children with disabilities and complex medical needs

Medicaid Managed Care is Smarter for Texas

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As health care becomes more expensive in Texas and across the country, Texas Medicaid health plans have the important duty of keeping costs low for the state of Texas. Medicaid health plans are meeting that challenge head on, hiring the best doctors, negotiating the most affordable prices, and focusing on prevention and care coordination to avoid costly hospital stays and ER visits.

As a result, **millions of Texans—including children, pregnant moms, older Texans, and Texans with disabilities—have seen improved outcomes**, and Texas taxpayers have saved more than $5 billion.

As a Result of Managed Care:

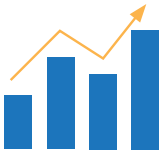
More Than $5 Billion
of taxpayer money has been saved since 2009

Texas Drug Cost Growth Has Been Cut in Half

and is now 3x lower than the national average[6]

Texas Medicaid Caps Profits and Requires Profit Sharing Back to Taxpayers

$1B+ saved or shared with Texas since 2009



Accountability to Taxpayers Has Increased

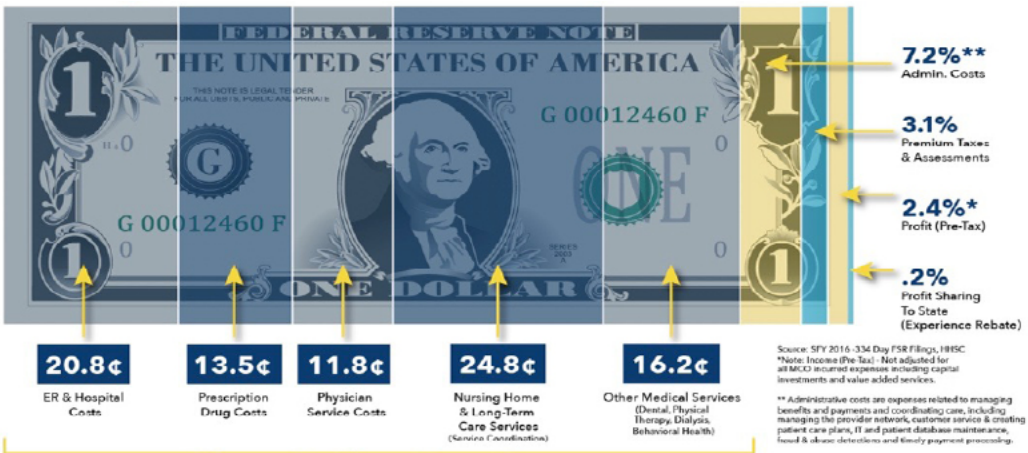
Medicaid performance and financing is transparent and available online

90% of Every Medicaid Dollar is Invested Directly in Patient Care

Texas Medicaid Caps Administrative Spending

As a result, Texas Medicaid managed care admin costs are some of the **lowest nationally**

90%
of every dollar is invested in direct care



Direct Patient Care Costs [4,5]

1 EQRO Summary of Activities, State Fiscal Year 2002 and Fiscal Year 2018. ICHIP HEDIS Report
2 HHSC, 2011 - 2016 Analysis of HEDIS
3 HHSC, 2018 Report: Transition of Medically Dependent Children Program Waiver Recipients to STAR Kids, 12/18.
4 HHSC, SFY 2016 - 334 Day FSR Filings.
5 HHSC, Rider 61: Evaluation of Texas Medicaid & CHIP Managed Care. 08/18.
6 The National Bureau of Economic Research, A Dose of Managed Care: Controlling Drug Spending in Medicaid, 10/17.

TEXAS ASSOCIATION OF HEALTH PLANS
The Value of Texas Medicaid
January 2021
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Medicaid Managed Care: The Prescription for a Healthier Texas

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How Does Medicaid Managed Care Work?

Today, Texas partners with private health insurers known as managed care plans. Managed care plans cover the costs associated with delivering care, make Texans healthier, and save taxpayer money by prioritizing preventive care and coordinating pharmacy and health care for Texans on Medicaid and CHIP.

Managed care works just like your insurance. Every month, Texas pays a health care premium to the managed care plans for each person they cover. Medicaid health plans use that premium to cover medical expenses and prescription drugs, coordinate complex health care, and help Texans with Medicaid coverage lead healthy, active lives and live independently in their own homes and communities.

Texas Medicaid Works

The focus on prevention, wellness, and care coordination—getting Texans the care they need to get healthy, stay health, and live in their communities—has translated into better care and lower costs. **Millions of Texans, including children, pregnant moms, older Texans, and Texans with disabilities, have seen improved health outcomes, and Texas taxpayers have saved more than $5 billion since 2009.**

Medicaid Managed Care Is Healthier and Smarter for Texas

Reduces Hospital Stays and ER Visits by Making Sure Texans Have the Care and Prescription Drugs They Need

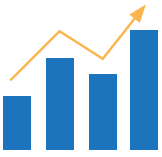
Managed care significantly reduced hospital stays for expensive chronic diseases by 35%[1]

Saves Money by Focusing on Prevention, Wellness, Care Coordination and Medication Adherence

Managed care has saved Texas more than $5 billion since 2009[2]

Texas Drug Cost Growth Has Been Cut in Half

and is now 3x lower than the national average[3]



Accountability to Taxpayers Has Increased

Medicaid performance and financing is transparent and available online

Texas Medicaid Prescription Drug Coverage

Medicaid managed care prescription drug coverage is an affordable and efficient prescription drug program that helps Texans get healthy and stay healthy. It has improved health outcomes for millions of Texans and has saved Texas taxpayers more than $5 billion.[2]

Texas Medicaid Managed Care Has Cut Drug Cost Growth in Half

Prior to prescription drugs being managed by Medicaid managed care plans, costs were out of control for Texas taxpayers. Drug costs had almost doubled from 2001 to 2011, growing more than 6.5% on average each year. As a result of Medicaid Managed Care, Texas Medicaid prescription drug cost growth dropped by 50% and is now three times better than the national average.

6.5% Growth
Before Managed Care from 2001 - 2011

2.8% Growth
After Managed Care since 2011

Texas Medicaid Managed Care prescription drug costs are 3 times better than the national average[3,4,5,6,7]

Improving Quality of Care

89%
reduction in use of the Houston cocktail

Medicaid health plans have prescription drug coverage programs in place that reduce opioid abuse and deaths, emergency room visits, and unnecessary hospitalization for kids with asthma. In fact, Medicaid managed care has reduced hospital stays for asthma and diabetes in Texas, chronic diseases that are typically expensive to treat, by more than 35% through better coordination of care and prescription drugs.[8] One Medicaid plan in Texas successfully reduced the use of the Houston Cocktail, a dangerous and deadly mix of drugs including Viocodin, Xanen, and Soma. Carving prescription drugs out of managed care would not only cost Texas taxpayers hundreds of millions of dollars, but would also create barriers from the care and coordination Texans on Medicaid need to get healthy and stay healthy

TAHP's Position:

Texas has an opportunity to achieve even more savings and improved outcome by fully maximizing the use of the Medicaid managed care model and allowing Texas Medicaid managed care plans to manage and negotiate the state's prescription drug formulary.

- TAHP supports allowing MCOs to fully manage the pharmacy benefit in order to bring down costs and provide more efficient and timely access to clinically appropriate medications to Texans in the Medicaid program.
- TAHP opposes a carve out of prescription drugs that would move the benefit back to an expensive, inefficient and fragmented fee-for-service program.
- TAHP opposes the government mandating NADAC pharmacy pricing which will add costs to the Medicaid program and reduce competition.

1 HHSC, 2011 - 2016 Analysis of HEDIS.
2 HHSC, Rider 61: Evaluation of Texas Medicaid & CHIP Managed Care. 08/18.
3 The National Bureau of Economic Research, A Dose of Managed Care: Controlling Drug Spending in Medicaid, 10/17.
4 The Menges Group, Prescription Drug Costs and Utilization in Medicaid: FFS and MCO Comparisons, 10.18.
5 HHSC, Rider 60: Prescription Drug Benefit Administration in Medicaid, CHIP, and Other Health-Related Services, 08/18
6 HHSC, Medicaid Prescription Drug Carve In, 10/11.
7 The Menges Group, Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States, 05/15.
8 HHSC Analysis of HEDIS Measures 2011-2018

TEXAS ASSOCIATION OF HEALTH PLANS
MEDICAID MANAGED CARE: THE PRESCRIPTION FOR A HEALTHIER TEXAS
January 2021
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Addressing Social Barriers to Care During COVID-19 and Beyond

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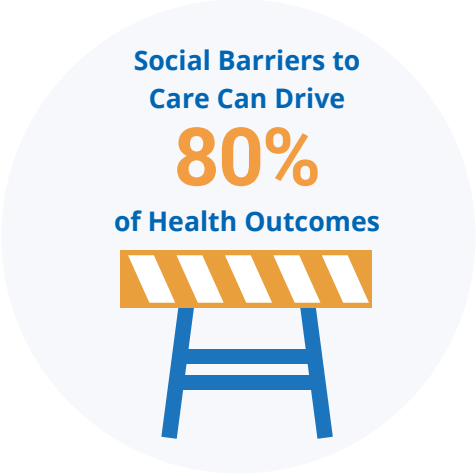
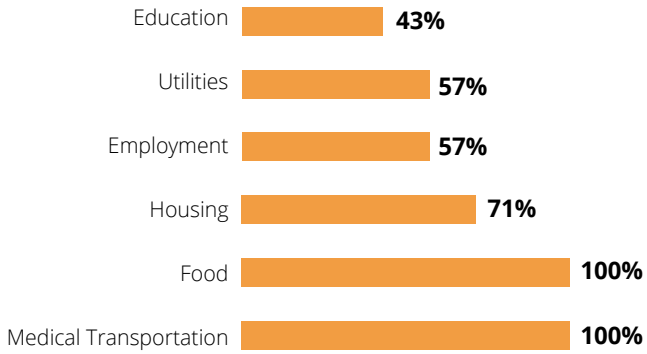
Texas Medicaid connects people with the health care, doctors, and medications they need to get healthy and stay healthy. While the quality of health care Medicaid clients receive plays an important role, health outcomes may also be driven by the conditions that people live, learn, work and play.

Individuals with inadequate access to food or stable housing are at greater risk of developing chronic conditions and managing these conditions. They also face increases to health care costs and services that might otherwise be avoidable. These conditions are known as social determinants of health (SDOH). Health plans are increasingly recognizing the important role that social and economic factors, such as housing, healthy food, and income play in a "whole person" approach to health care. These factors can drive as much as 80% of health outcomes.[1]



That is why Medicaid health plans go beyond just providing health coverage for vulnerable Texans—they also help individuals get jobs, find secure housing, coordinate transportation to doctor's visits, and help older Texans and individuals with disabilities live independently in their communities. Across the board, Medicaid is strengthening local communities and ensuring a brighter future for Texas.[2]

Texas Medicaid Health Plans Go Beyond Health Coverage and Address Barriers to Care

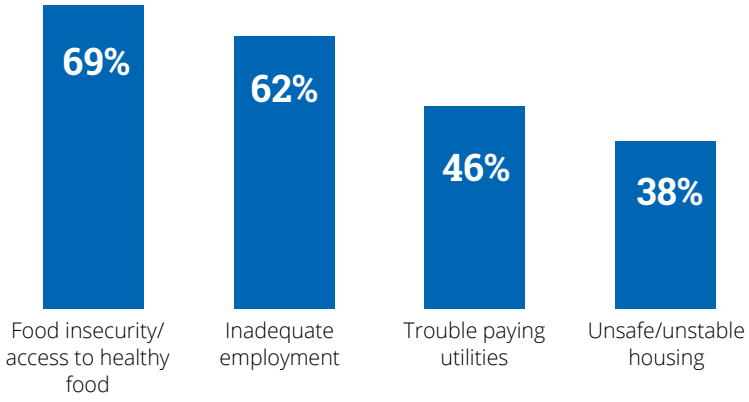


Based on a survey of Texas' 14 Medicaid managed care plans[2]

COVID-19 and Social Barriers to Care

With Americans isolated in their homes and over 40 million recently unemployed, the need to address food insecurity, housing instability, and social isolation is greater than ever. During the COVID-19 crisis, Texas Medicaid managed care plans have seen a 69% increase in food insecurity, a 62% increase in inadequate employment, and a 38% increase in unsafe or unstable housing.[3] In working with nonprofit partners, health plans observed that many community-based organizations are overwhelmed with increased social service needs but were short on funding resources.

Texas Medicaid Managed Care Plans Identified Increased Needs During COVID-19



Texas Medicaid Managed Care Plans are Innovating to Address Socioeconomic Needs During COVID-19 and Beyond

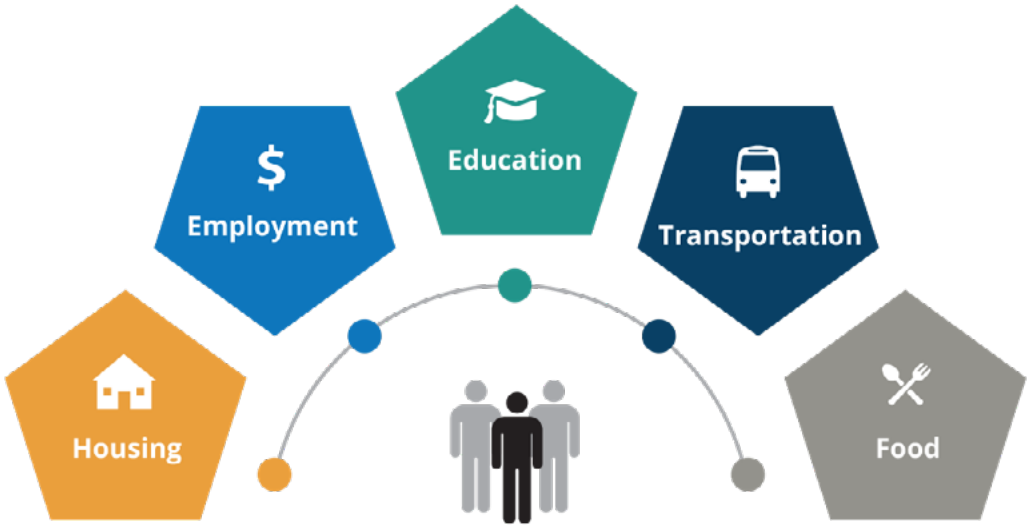
Medicaid health plans, local health care and social service providers, communities, and other partners are rallying together to innovate and build new service delivery models to deliver critical resources to people experiencing greater socioeconomic needs during this time. Texas Medicaid managed care initiatives to support vulnerable communities include:

- ✓ Building new food distribution models
- ✓ Helping Texans secure employment
- ✓ Removing transportation barriers to COVID-19 testing
- ✓ Providing digital resources to telehealth
- ✓ Securing emergency temporary housing
- ✓ Reaching out to at-risk individuals
- ✓ Financially supporting local organizations

TAHP's Recommendations

- A growing number of states are implementing solutions to address social barriers to health including finding ways to use existing managed care rate setting processes to incentivize health plan investment. In a recent survey, the three top solutions identified for addressing social barriers to care in Texas Medicaid were:
  - Covering benefits that address social barriers such as transportation and meals,
  - Incentivizing Medicaid managed care plans to invest in solutions that address social barriers, and
  - Building these efforts to address social barriers into the Medicaid managed care rate setting process.

TAHP recommends that Texas explore ways to incentivize and allow Medicaid coverage of services that help address social needs, improve health and social outcomes, and reduce long-term health costs.



1 Medicaid's Role in Addressing Social Determinants of Health. Robert Wood Johnson Foundation. 2019.
2 Moving Upstream: How Health Plans in Texas Are Addressing the Social Determinants of Health. Episcopal Health Foundation, 2019.
3 Social Determinants of Health Strategies During the COVID-19 Pandemic. Epsicopal Health Foundation Survey of Texas Medicaid MCOs. December 2020.

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ADDRESSING SOCIAL BARRIERS TO CARE DURING COVID-19 AND BEYOND
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