Texas Association of Health Plans
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April 2, 2025

Re: Concerns with SB 884

Dear Chair Kolkhorst and Members of the Senate Health & Human Services Committee,

The Texas Association of Health Plans (TAHP) is the statewide organization representing health insurers, HMOs, Medicaid managed care organizations, and other related entities that provide coverage to more than 20 million Texans. TAHP appreciates the intent behind Senate Bill 884, which seeks to increase consumer engagement in health care shopping. We share the goal of reducing costs and promoting transparency for Texas families; however, we have concerns that the bill's mandated "cash-back" model could lead to several unintended consequences.

The current regulatory landscape for creating patient shared savings incentives dates back to 2009, and it is nearly impossible to navigate. Under the rules created by HB 1888 from the 81st Legislative Session, TDI expressly states that "a health benefit plan issuer ranking system based solely on cost would not be compliant." In order to create an incentive program, a health plan must demonstrate compliance with quality ranking components included in Ch. 1460 of the Insurance Code. These requirements are extensive and unworkable for most health plans. SB 916 (Hancock) & HB 1959 (Frank) aim to remove these unworkable barriers and are nearly agreed to by all stakeholders.

While we agree with the overarching goal of SB 884, we have a broad concern about going from a near prohibition on incentive programs to a state prescribed and mandated program that has not been tested and does not follow what has been implemented and proven effective in other states and the large employer ERISA market.

SB 884 requires insurers to pay 50% of the savings in cash directly to enrollees and creates extensive new costly, administrative requirements on health plans through heavily prescribed process. We agree that cash payments create incentives; however, we are concerned that those incentives may lead patients to seek wasteful care. Health plan cost-sharing structures provide significant flexibility to create incentives, if allowed by state law. However, study after study shows that roughly 20% of care provided is wasteful. We recommend that the legislature test concepts like SB 884 in the ERS program to identify pitfalls, potential moral hazard concerns, and potentially excessive administrative costs before requiring these concepts in the fully insured market covering over 6 million Texans. Alternatively, we ask that the legislature remove the

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barriers created in 2009 that are prohibiting most plans from designing proven and evidence-based patient incentive programs.

Our Cost Concerns:

The administrative burdens created would almost certainly outweigh any potential benefits, even assuming the moral hazard concerns could be addressed. Creating the infrastructure for monthly rate disclosures, real-time cost tracking, check-writing to enrollees, and IRS Form 1099 reporting would be both complex and expensive—especially once enrollees surpass the $600 payment threshold and trigger federal tax obligations. Setting up automated systems to calculate and distribute these payments, educating enrollees about possible tax ramifications, and handling disputes or appeals would demand significant new technology and staffing.

This "cash-back" mandate unintentionally encourages overutilization and undermines existing quality safeguards. Plans negotiate discounted rates with credentialed providers to ensure consistency in quality, cost, and consumer protections. By steering patients to out-of-network "cash-back" providers, SB 884 effectively bypasses those negotiated arrangements and allows for the possibility that consumers will choose a provider with no direct oversight or credentialing from their health plan and thus no assurances against potential fraud, waste, and abuse.

Worse, the promise of personal financial gain can tempt some enrollees to pursue care they might otherwise skip or delay—such as opting for multiple imaging scans to "double-check" a minor injury or scheduling borderline elective procedures to pocket the difference in cost. In other scenarios, a patient who already has a referral for one diagnostic test may decide to add extra tests that a physician has not strictly recommended, purely because they believe they can earn money back. These choices can drive up claims costs, raise concerns about overtreatment, and dilute the plan's ability to maintain high standards for patient safety.

Other State Experiences:

Lessons from Other States reinforce these concerns. A handful of states—including Florida, Kansas, Kentucky, Missouri, New Hampshire, and Utah—have mandated "right to shop" programs for state employees, while Virginia and Maine have extended such mandates to certain commercial plans. These programs have largely failed to achieve widespread adoption or meaningful savings:

- **Florida:** The state employee program spends three times more on administrative costs than the resulting shared savings.

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- **Maine:** Its mandated commercial program had only 46 participants in 2023, saving a total of just $2,360—down from 61 participants in 2021.
- **Virginia:** Fewer than 1% of enrollees received incentive payments, reflecting minimal participation and limited impact.

Proven Approaches to Engaging Patients:

Lastly, a more measured and proven in-network approach aligns better with existing transparency initiatives. Many self-funded employers and certain state plans have successfully offered voluntary or lightly mandated incentive programs that reward patients for choosing high-value care while remaining in-network. Research also supports this strategy: a Health Affairs study found that tiered networks reduce medical spending by about five percent, and Mercer's 2024 National Health & Benefit Strategies Survey indicates that 21% of employers (and 46% of large employers) already guide employees toward higher-value care through tiered networks. Moreover, primary care clinics often adjust their pricing and services to deliver better value when they are held accountable for the total cost of care. By removing barriers to in-network "shopping incentives"—such as reduced copays or deductibles for value-minded patients—Texas can integrate seamlessly with recent transparency efforts without forcing a one-size-fits-all out-of-network mandate.

If a mandated incentive program is unavoidable, TAHP would urge consideration of a proven model like the Employees Retirement System's "ShoppERS" approach, which is both in-network and avoids many of the cost and administrative complexities of an out-of-network cash-back system. Under ShoppERS, consumers receive targeted incentives to seek lower-cost, high-value providers, but remain under the oversight of a credentialed network that ensures quality and consistency. This method keeps administrative burdens manageable and prevents confusion around tax implications or potential balance billing. Although the Employees Retirement System (ERS) uses health savings accounts (HSAs) to share some of these savings, fully insured carriers do not always have that same flexibility. Therefore, we support additional incentive options—like gift cards, reduced copays, or lower deductibles. Offering an in-network program modeled on ShoppERS would strike a balance between promoting cost-consciousness and avoiding the pitfalls of large-scale cash payments for out-of-network services.

TAHP greatly values your leadership in advancing innovative solutions that empower Texas consumers and lower health care costs. We respectfully ask you to weigh our concerns regarding SB 884 and explore avenues that facilitate market-driven, in-network strategies. These

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alternatives would preserve quality, minimize new administrative burdens, and ensure that any savings are both meaningful and sustainable. We stand ready to work with the committee on refining SB 884 or crafting alternative language that meets these shared objectives.

Thank you for your consideration and for your dedication to improving health care affordability for Texans.

Sincerely,

M. Blake Hutson

Blake Hutson
Texas Association of Health Plans