



**TAHP**  
The Texas Association of Health Plans

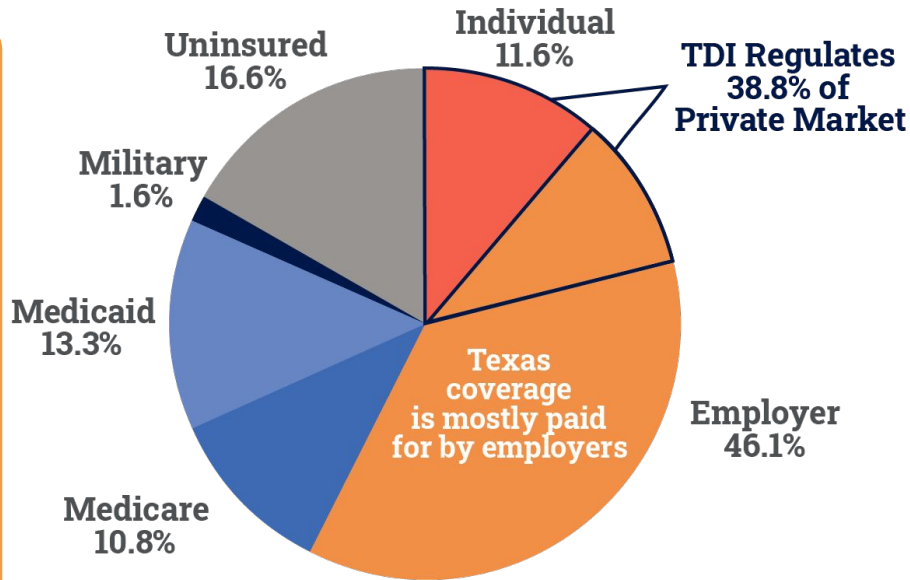
# Health Coverage 101 + What's Driving Premiums & What Texas Can Do

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May 27, 2026

**TAHP**  
The Texas Association of Health Plans

# Texas Health Plans Cover More than 25 million Texans

Texas coverage is mostly paid for by employers – government and individual markets fill in the rest



## 15M EMPLOYER COVERAGE

Largest single source – about 4 of 5 employees are in ERISA self-funded or level-funded plans

## 4M INDIVIDUAL MARKET

Quadrupled since 2020 (1M → 4M)

## 7.6M GOVERNMENT COVERAGE

Medicaid (4M) + Medicare (3.6M) = 25% of Texans

## 5M UNINSURED

Lack of job-based coverage cited as #1 reason

**Private market = 58% of Texans.** Employers purchase coverage for about 80% Texans covered in the private market. TDI regulates 39% of the private market – the fully insured share. Remainder of market under ERISA.

54% Texas employers offer coverage: 38% of small employers & 96% of large employers

# Most Texans with Employer Coverage Have Moved Away from State Mandates

Employers choose ERISA self-funded plans for flexibility and affordability – and that’s where the majority of the private market now lives

## TDI REGULATED · STATE MANDATES APPLY

~7M Texans

Individual market and small/midsize group fully insured plans. State mandates apply.

## ERISA FLEXIBILITY · FEDERALLY REGULATED

~12M Texans

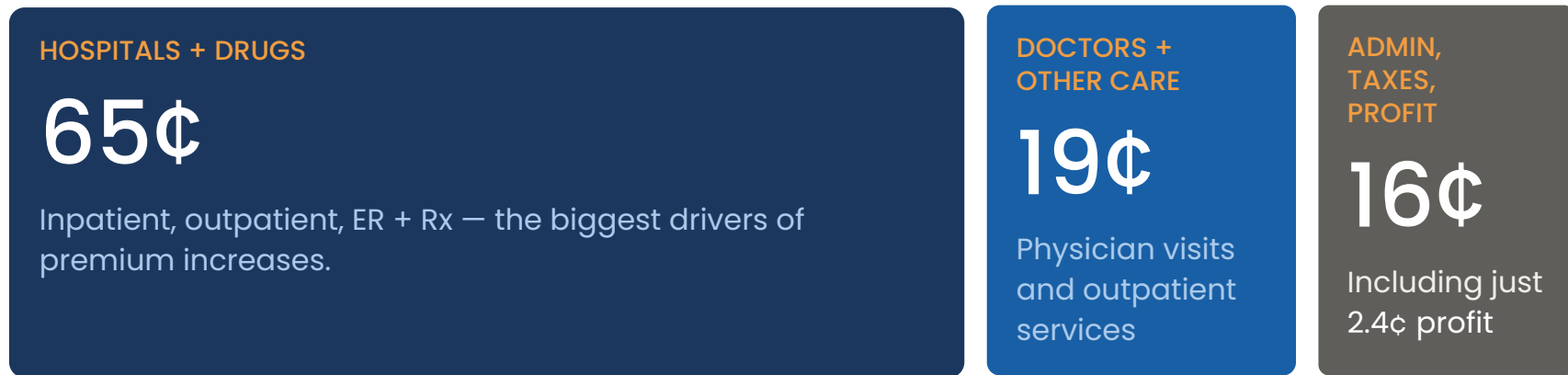
About 4 of 5 employer-covered Texans. Self-funded and level-funded plans that give employers the flexibility to design affordable coverage for their workers. State mandates do not apply.

**Inside the TDI-regulated ~7M:** ~4M individual market · ~670K small group (2-50 employees) · ~2.6 midsize and large fully insured employer coverage.

**Why this matters:** When the Legislature debates a mandate or a regulation, it’s setting the rules for 7M Texans – not for the 12M whose employers have chosen ERISA. Mandates that drive up fully insured premiums push more employers to leave for self-funded plans, shrinking the regulated market further.

# 65¢ of Every Premium Dollar Goes to Hospitals and Drugs

Federal law requires plans to spend at least 80–85% of premiums on medical care.



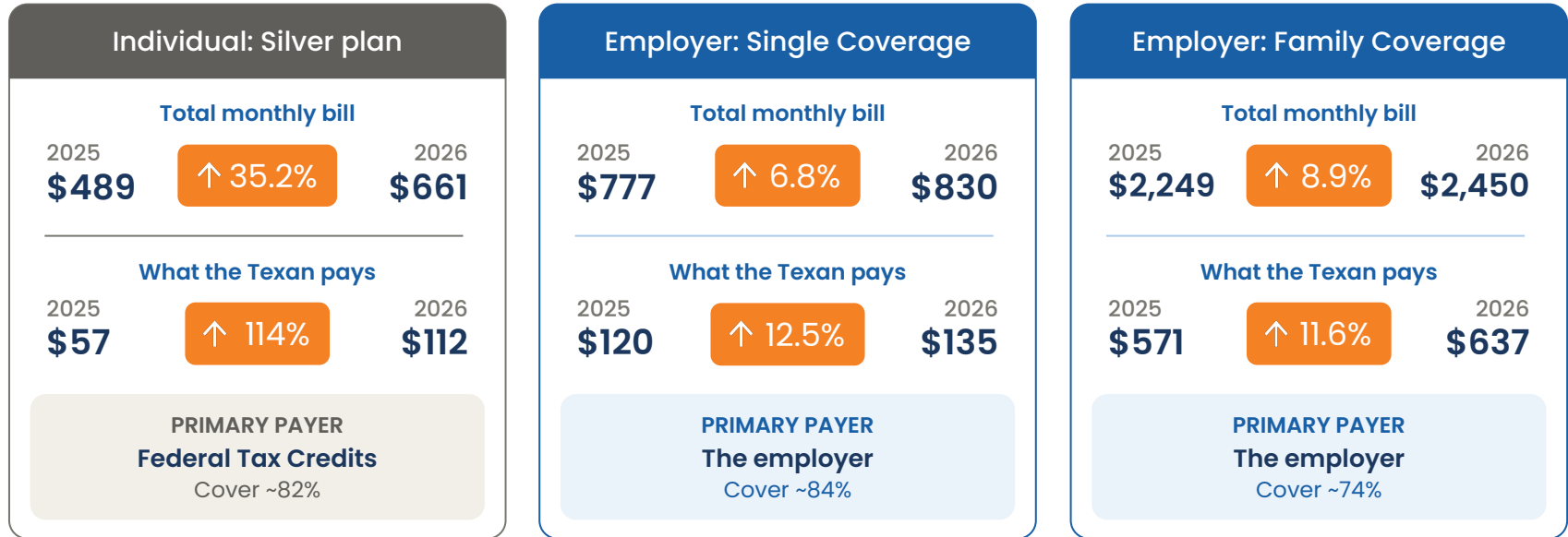
## FULL BREAKDOWN



Source: AHIP, "Where Does Your Health Care Dollar Go?"

# Texans Face the Biggest Premium Increase in Years

2026 monthly premium estimates – what Texans pay and who covers the rest



**Every Texan is paying more in 2026.** Individual market sees “extraordinary” 35% spike — driven largely by tax credits expiring. Employer coverage rises 6–9%, the steepest increase in over a decade.

Sources: TDI 2026 Rate Filings; KFF 2025 Employer Survey; Mercer 2026 Forecast; Texas 2036.

# It's Not More Care – it's More Expensive Care

Nearly 75% of premium increases are tied to rising prices, not more visits to the doctor

## SHARE OF PREMIUM INCREASE

# 75%

due to prices

Texans aren't going to the doctor more  
— every visit just costs more.

## PER-PERSON SPENDING GROWTH, 2018–2022

Prices

+13.9%



Utilization (how often Texans get care)

+4.4%



Prices drove 75% of the increase in per-person health spending from 2018–2022. Utilization barely moved.

Sources: Health Care Cost Institute.

# Hospital Care is the Largest Driver of Health Spending Growth

Hospital prices in 2024 grew faster than any year since 2007

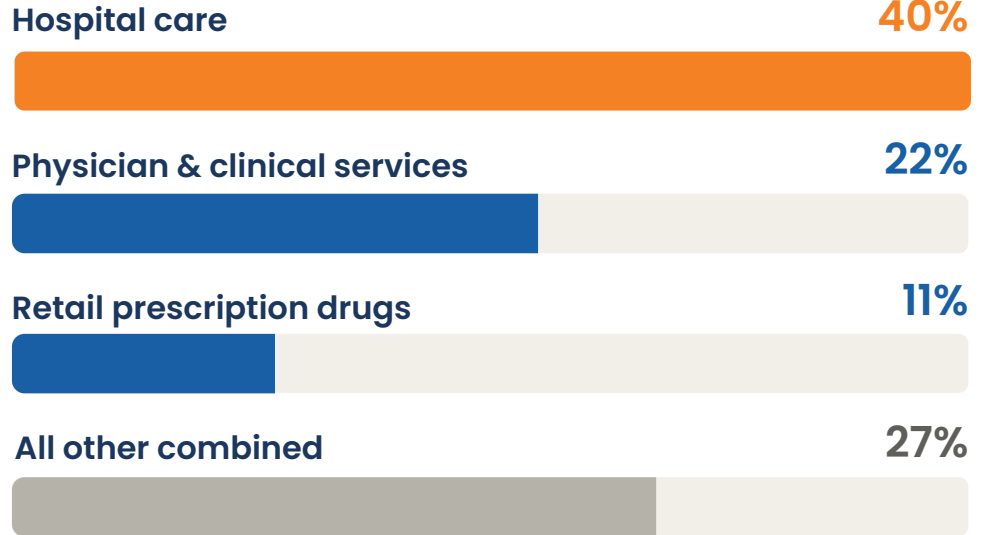
NATIONAL HEALTH SPENDING  
GROWTH,  
2022-2024

40%

came from hospital care

\$277 billion of the \$692 billion in total  
spending growth.

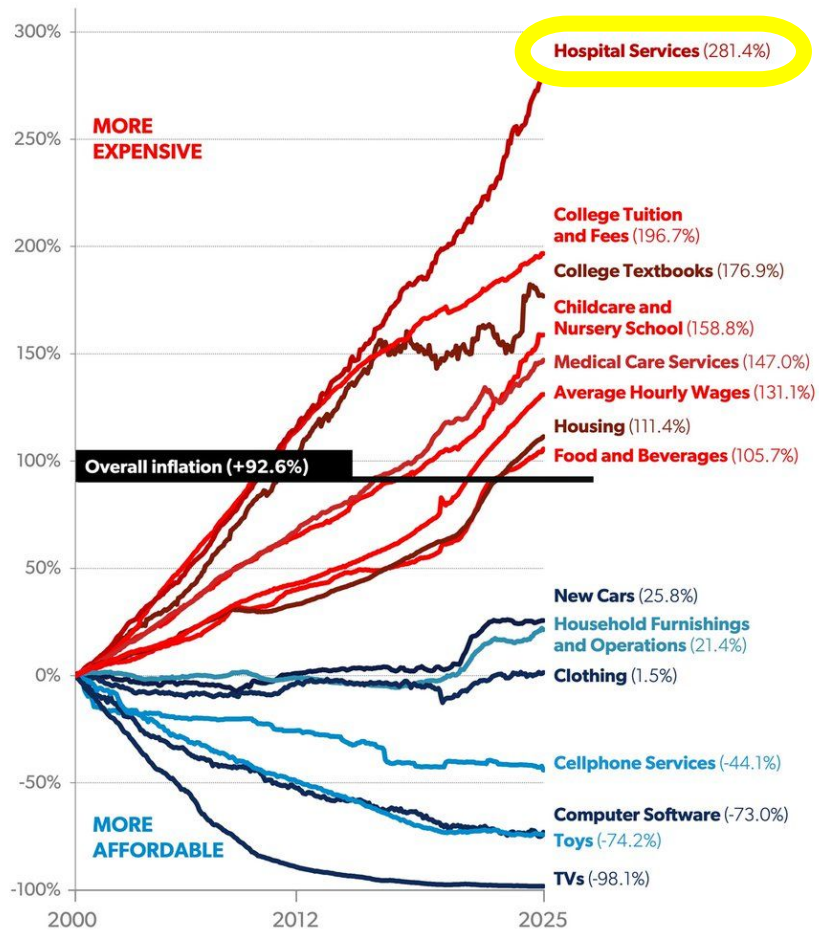
## SHARE OF GROWTH BY CATEGORY



Sources: KFF analysis of CMS National Health Expenditure Accounts (February 2026).  
Non-medical insurance expenditures contributed 2%

# Price changes (Jan. 2000–Dec. 2025)

Selected US Consumer Goods and Services, and Wages



## Hospital Services Have Outpaced Everything Else for 25 Years

Since 2000, U.S. hospital prices have grown 3x faster than overall inflation and more than 2x faster than wages

### HOSPITAL SERVICES SINCE 2000

**+281%**

The #1 fastest-growing price in the U.S. economy for a quarter century.

### WAGES HAVEN'T KEPT UP

Wages are 131%. Hospital prices grew more than twice as fast — families pay more for the same care with less buying power.

# It's Not More Care — It's More Expensive Hospitals and Drugs

Three pricing tactics drive premium increases

## HOSPITAL AND PROVIDER CONSOLIDATION

# 60%+

of Texans live in highly consolidated hospital markets

Health insurers must pay 250–320% of medicare rates in these markets.

## FACILITY FEES

# 13.5X

Hospital owned clinics charge up to 13.5 times more than doctor's offices for the same service.

Site-of-service markups add \$40 billion to U.S. premiums each year.

## HOSPITAL DRUG MARKUPS

# 3–7x

acquisition cost for cancer and other infusion drugs

Hospital markups added \$13 billion to premiums in 2024.

Source: Health Care Cost Institute; Committee for Responsible Federal Budget, Texas 2036, JAMA

# State Mandates Have Consequences: How Texas's 2013 Billed-Charges (List Price) Rule Reshaped the Market

In 2013, TDI required health plans to pay out-of-network hospital-based physicians at the billed charges rate. The rule was intended to protect consumers. Instead, it drove up prices.

## 2013

### New billed-charges mandate

Plans must pay out-of-network hospital-based providers at billed-charge rates

## PROVIDERS RESPOND

### Higher Payments

Specialty groups drop network contracts. Plans pay much higher rates to bring them in-network.

## MARKET RESHAPES

### Private Equity

PE buys up specialty groups across Texas. Billed charges and in-network rates rise sharply with each acquisition.

## 2020

### Consolidation and increased prices

TAHP lawsuit invalidates rule — but PE-backed groups now dominate Texas markets and prices.

## TEXANS ARE STILL PAYING — TODAY

TRS testified last month that one single anesthesiology group (USAP) drove **\$11 million increase** in TRS claims, alone. That's not surprising given market shares of 70% or more. Texas teachers and taxpayers are paying for this private equity consolidation.

# Texas Laws that Force Higher Prices

Texas is the outlier – these laws don't exist, or don't work this way, in most other states

## Prompt Pay tied to billed charges

“One of the most provider-friendly statutes in the country”

Texas calculates prompt-pay penalties from hospital list-prices, incentivizing inflation. Penalties run **up to full billed charges plus 18% annual interest**. One consulting firm brags about generating “hundreds of millions” for hospitals.

## Surprise billing IDR based on billed charges

TX dispute resolution ties to provider list prices

**550% increase** in billed charges submitted to IDR in just three years.

## Freestanding ER licensing abuse

Designed for rural areas, now driving 5M visits per year

A freestanding ER visit **can cost 13x more than urgent care** for the same condition. Texas cities and school districts are seeing over 20% higher costs as a result of freestanding ER use.

## 180-day overpayment recoupment Limit

Tightest in the nation – most states allow 18 to 24 months

Texas blocks recovery of wasteful overpayments after just 180 days. The tightest time frame in the nation shared by only two other states

Source: TDI SB 1264 Biennial Report 2024; Texas Prompt Pay Act (SB 418); Rice University, 28 TAC §11.901,

# Texas Laws that Block Plan Tools to Lower Cost

Texas is the outlier — these laws don't exist, or don't work this way, in most other states

## Shopping price Incentives Banned

TX blocks plans from rewarding patients who shop based on price.

A simple MRI can cost **10x more** at a hospital vs. a standalone imaging center — but TX law bars plans from rewarding price based shopping. **Shopping-based plans lower spending by 5%.**

## Site-of-Service Limits Banned

“Freedom of choice” mandates block plan steering

A year of outpatient chemotherapy averages **\$17K at a hospital vs. \$7K in a physician clinic** — but Texas blocks plans from limiting coverage to the more affordable setting.

## Excessive Network Adequacy Mandates

TX requires broader networks than federal rules

High-value networks have been shown to **save 5-20% in premiums** — but Texas mandates one-size-fits-all networks that exceed federal standards.

## Cost Savings Blocked

Texas law allows providers to opt-out of any contract change then force insurers to re-contract at higher rates.

Texas plans must give **90 days' notice** of any payment policy change, and providers can then **terminate within 30 days without penalty**. In consolidated hospital and physician markets, cost savings proposals and efforts to fight fraud, waste and abuse, get blocked before they are put in place.

Source: Health Care Cost Institute (HCCI); AHIP/Milliman high-value networks report; 28 TAC §11.901 and §3.3703; TIC 1451.

# Texas Laws that Block Lower Cost Coverage Options

Texas is the outlier — these laws don't exist, or don't work this way, in most other states

## One-year Frozen Formulary Law

Few states freeze formularies this long  
Without exceptions.

New biosimilars save 50%+ over brand biologics — but Texas freezes drug formularies for a year, blocking plans from immediately capturing savings. Mirroring the TX law nationwide would cost **\$4.5 billion** over 5 years

## Mail-Order Pharmacy Blocks

TX pharmacy mandates limit benefit design

Mail-order pharmacy **saves 4-7%** versus retail — but Texas pharmacy mandates block plans from prioritizing the lower-cost channel

## Mandate Expansion to Association Health Plans

HB 290 (88th session) imposed  
PPO-style Mandates on MEWAs

Association health plans are meant to be **affordable alternatives for small employers and trade groups**. Texas HB 290 imposed comprehensive state insurance mandates on MEWAs — adding cost back into what should be a more affordable, flexible coverage option.

## Employers Forced to Buy Expensive Coverage

"Two-plan" mandate forces PPO  
Alongside HMO

Texas employers offering an affordable in-network HMO are **required by state law to also offer a higher-priced out-of-network PPO option** — driving up costs for businesses and families who would otherwise choose the cheaper plan.

Source: Association for Accessible Medicines 2023 savings report; Milliman 2025 frozen formulary analysis; PCMA pharmacy benefit savings analysis; Texas HB 290 (88th Regular Session, 2023); Texas Insurance Code §1271.005 (two-plan requirement).

# Three Forces Driving up Costs – and One Lever to Fix Them

Texas is the 5th most expensive state for health care in the nation. Three drivers explain why – and the Legislature can address all three.

## PRICE INFLATION

### **75%** of premium increases are prices

Hospital prices are the single biggest driver – 40% of national growth, with prices up 281% since 2000. Texas consolidation pushes prices 15–30% higher.

## FRAUD, WASTE, & ABUSE

### **10%** of all health care spending

New schemes like AI-driven upcoding and other abusive billing continue to inflate bills but TDI authority is limited in addressing fraud, waste, and abuse.

## MANDATES & OVERREGULATION

### **3rd** most mandate-heavy state

Texas's mandates outpace other states and exceed federal requirements in nearly every way— forcing employers and families into expensive, one-size-fits-all plans.

## THE LEGISLATURE

### **Addressing** Texas-specific drivers

Repeal harmful mandates, prevent new ones, require real transparency, and protect employer flexibility.

Source: Forbes Advisor 2024 state health care cost rankings; KFF analysis of CMS NHEA (2026); Texas 2036; TDI; PwC Behind the Numbers 2026..

# Give Texans the Tools to Shop for Care

Patients can't make informed decisions if they can't see — or pay — the real price

## **Increase Competition**

Ban anti-competitive contracts + facility fee abuse

Ban anti-competitive hospital contract terms, stop inappropriate facility fees, and require full price and billing-location (NPI) transparency so patients see who's charging them, where, and why.

## **Guarantee Upfront Prices**

No surprises between the estimate and the bill

Require every Texas provider to give patients a guaranteed upfront price estimate that won't change in the final bill. Patients can't make informed choices about care they can't price.

## **Let Patients Shop the Cash Price**

Cash prices already posted — make them usable

State and federal laws already require providers to post cash prices, but some refuse to share or accept those rates from insured patients. Let every Texan pay the cash price when it's the better deal.

# Give Plans and Employers the Flexibility to Lower Costs

Let plans design coverage that lowers savings and meets the needs of different employers.

## Reward Patients for Smart Shopping

Repeal price-incentive bans

Eliminate all mandates that block rewarding Texans for choosing the most affordable care. Today, health plans are restricted in how they can incentivize patients based on price.

## Allow Innovative, Affordable Networks

Network adequacy reform

Texas mandates force oversized one-size-fits-all networks. Allow flexible network designs—narrow, high-performance—that promote competition and lower prices.

## End the High-Cost Site-of-Service Mandate

Fix “freedom of choice” laws that limit steering to lower-cost locations

Prices for the same service vary dramatically by location. Let plans limit coverage to the most appropriate and affordable setting so Texans avoid unnecessarily expensive care.

# Let Employers Offer Coverage that Fits their Needs

Different employers have different budgets and different needs.

## Stop Forcing Employers to Buy Expensive Coverage

Repeal the “two-plan mandate

Texas law forces employers offering an affordable HMO to also pay for a more expensive PPO. Give employers the flexibility to offer the coverage that fits their budget and their workforce.

## Protect Affordable Employer Coverage

Defend ERISA flexibility

Oppose new mandates on self-funded and level-funded employers. Employers choose ERISA because it’s more affordable and flexible –and 4 of 5 employer-covered Texans are already in these plans.

## Help Small Employers Afford Coverage

Support ICHRA options

New tax-advantaged ICHRAs(Individual Coverage HRAs) support small employers and their employees with a monthly allowance to buy coverage that fits each employee. Texas should look for opportunities to invest in employer coverage by supporting ICHRAs.

# Reduce Burden, Prevent New Costs, Recover Waste

Employers need less mandates and more support in reducing fraud, waste, and abuse.

## **Expand Affordable Coverage Options**

Mandate lite, innovative designs, and Association health plans.

Allow employers to purchase more affordable, innovative health insurance or association health plans that cover essential needs without the state-mandated requirements that drive up premiums.

## **Moratorium on Expensive Mandates**

Use the new fiscal note process (HB 138 HICCAP)

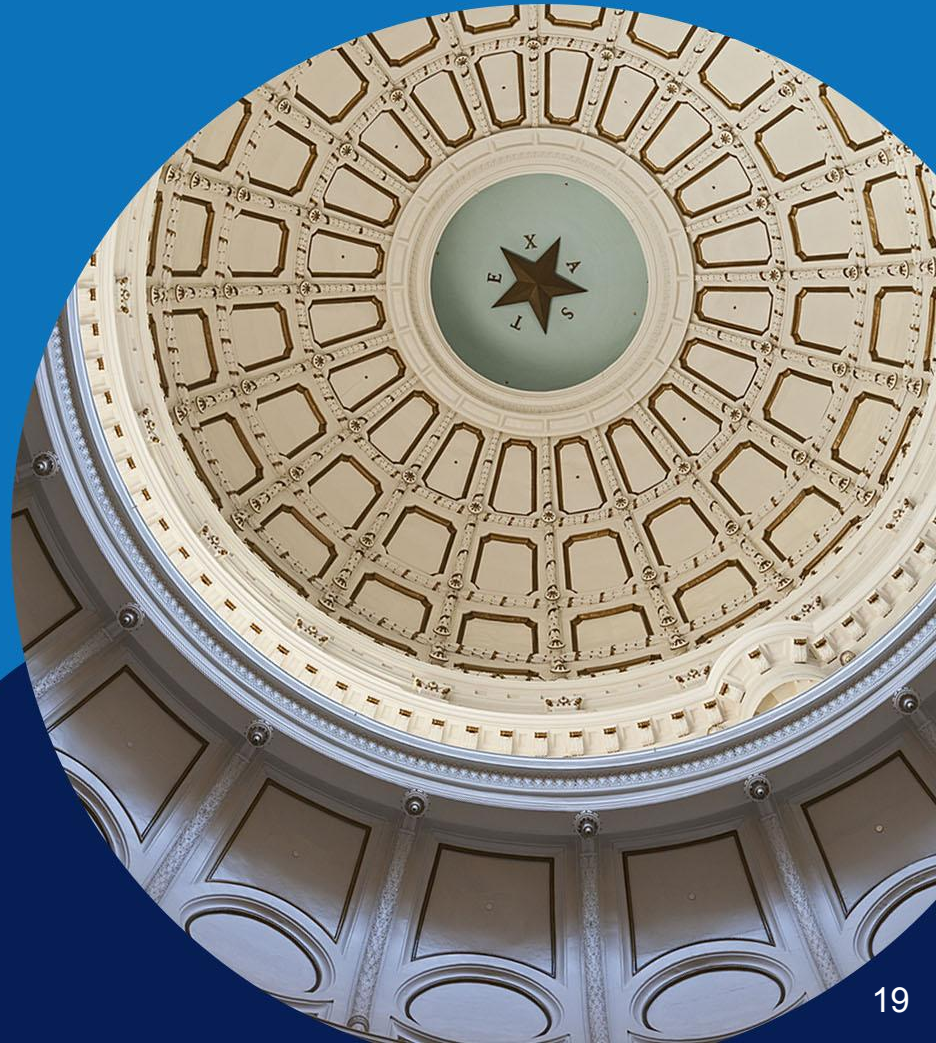
Avoid new mandates that raise costs for employers and families. Use the state's new mandate fiscal note to show the true cost — and never pass a mandate that state won't apply to ERS, TRS, and Medicaid.

## **Root out Fraud, Waste, and Abuse**

Extend Medicaid-level protections to commercial coverage

Texas estimates 10% of health spending is lost to fraud, waste, and abuse. Extend the same strong protections Texas uses to fight fraud in Medicaid and Medicare to TDI for employer and families health plans.

# Appendix



# How Prescription Drug Benefits Work: PBMs

## WHAT A PBM IS

A pharmacy benefit manager (PBM) is a third-party administrator that manages prescription drug coverage for health plans and employers. With tens of millions of patients across many plans, PBMs negotiate prices no single plan could – the only player in the drug supply chain whose job is to lower drug costs.

### Negotiate with drugmakers

Secure rebates from manufacturers, then pass savings to plans.

### Build the formulary

The list of covered drugs, organized by clinical effectiveness and cost – often in tiers.

### Manage pharmacy networks

Contract with retail, mail-order, and specialty pharmacies for in-network coverage.

### Process pharmacy claims

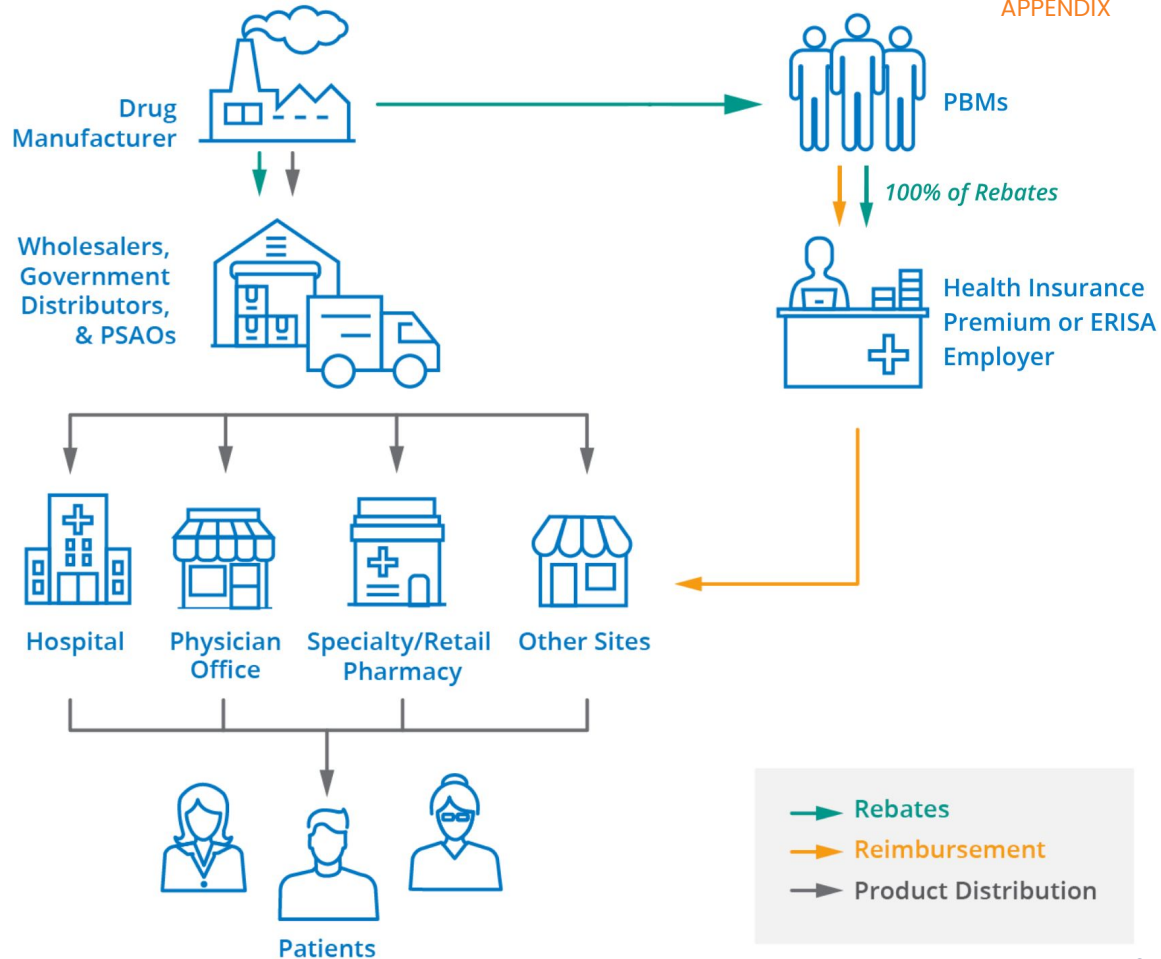
Adjudicate every prescription at the point of sale, applying coverage rules and patient cost-sharing in real time.

## Overview of the Drug Supply Chain

Health plans and PBMs do not set drug prices -They negotiate rebates to lower prices.

**Congress recently passed substantial PBM reforms:** 100% Rebate Transparency & 100% Rebate Pass-Through

**What's missing?** State and federal laws reforms should focus on the whole supply chain - not just pbms - and focus on savings or costs on consumers.



# Existing Rebate Requirements

Why rebates exist, and the state and federal rules governing them

## WHY REBATES EXIST AT ALL

Legal action in the 1990s by independent pharmacists limited bulk price discounting from drug makers leaving rebates as the dominant mechanism to get lower prices from drug companies.

**Medicaid, Medicare, and commercial plans** all use rebates to create savings on brand name drugs.

### 100% Rebate Pass-Through (Jan 2028)

PBMs must pass 100% of rebates to ERISA self-funded employers and fully insured group health plans.

### Complete Rebate Transparency (federal)

PBMs must provide aggregate rebate and pricing detail to all group plans, with drug-level reporting for large employers.

### Rebates Reduce Premiums

Rebates passed through from PBMs are required to be factored into premiums under the ACA's medical loss ratio rule and rate setting laws.

### Aggregate Rebate Data (TX State Law)

Texas law requires PBMs to report the amount of rebates retained or passed through to plan sponsors.

Source: Consolidated Appropriations Act 2021; ACA medical loss ratio rule (42 U.S.C. §300gg-18); Texas Insurance Code; *In re Brand Name Prescription Drugs Antitrust Litigation* (1996); TAHP analysis.

# Existing PBM and Pharmacy Benefit Requirements

State and federal rules already in place

## Gag Clauses Banned

PBMs may not prohibit pharmacists from sharing lower-cost options.

*SB 1076 85R · HB 711 88R · SB 493 89R*

## PBM Clawback Ban

No retroactive reduction of pharmacy reimbursement after claim adjudication. *HB 1763 87R*

## Claims Adjudication Fees Banned

PBMs may not charge pharmacists for claims adjudication. *SB 94 84R*

## Formulary Freeze

No mid-year formulary changes, even for biosimilars and lower-cost options. *HB 1405 82R*

## Affiliated Steering Banned

Limits on steering to PBM's affiliated pharmacy, even with lower patient costs. *HB 1919 87R*

## Contract Change & Audit

**Limits** Limits on PBM audits and contract changes without pharmacy approval. *SB 1236 89R*

## Copay Coupon Mandate

Drugmaker coupons must count toward deductibles even if patient didn't pay.

*HB 999 88R*

## Prior Authorization Limits

No PA at 90%+ approval rate. Max 1 PA/year for autoimmune drugs. Standard form required.

*HB 3812 89R · HB 755 88R · SB 644 83R*

## Step Therapy Limits

Extensive exceptions to step-therapy use by plans and PBMs.

*SB 680 86R*

Source: Texas Insurance Code; cited bills.

# Existing Transparency Requirements

Already in state & federal law

## Hospital & facility price transparency

Must post machine-readable files of charges, negotiated rates, and cash prices, plus consumer-friendly pricing for common shoppable services. Physicians are exempt.

## Health plan patient cost calculators

Real-time tools showing patient expected out-of-pocket costs, negotiated rates, and coverage details before care.

## All-payer claims database (APCD)

All health plan claims (except ERISA) submitted to the state's research database.

## Real-time API access

Patients and providers get real-time electronic access to coverage, PA status, claims data, and cost-sharing through standardized APIs.

## Prior authorization criteria

Transparent, physician determined, medical necessity and PA criteria insurers use to evaluate coverage.

## Health plan price transparency

In-network negotiated rates and out-of-network allowed amounts published in machine-readable files.

## Formulary transparency

Public access to drug coverage details including whether a drug is covered and its formulary tier placement.

## Aggregate rebate reporting

State law requires PBMs to report total rebates and the amount passed through to plan sponsors.

## Detailed rebate reporting (Jan 2028)

PBMs must provide employers drug-level and plan-level detail on rebates, fees, spread pricing, and other compensation — including retained rebate.

## Provider directory transparency

Publicly accessible, monthly-updated directories showing which providers are in-network and accepting new patients.

# Not All Health Coverage is Health Insurance

Texas employers cover workers through three different structures — only one is regulated by Texas as insurance.

	Fully Insured Traditional insurance	Level-Funded Hybrid / ERISA	Self-Funded ERISA
<b>WHO TAKES THE RISK?</b>	The insurer collects premiums and pays claims.	The employer pays claims, with stop-loss insurance for catastrophic costs.	The employer fully assumes the risk of paying claims.
<b>WHO REGULATES IT?</b>	Texas (TDI) All state mandates apply.	Federal (ERISA) No state mandates.	Federal (ERISA) No state mandates.
<b>WHO USES IT &amp; WHY?</b>	Individuals and small/large businesses For predictable premiums and full state consumer protections.	Small and mid-size employers Flexibility with cost predictability, off-ramp from fully insured.	Very large employers Flexibility to design benefits and innovate without state mandates.

## THE BOTTOM LINE FOR THE LEGISLATURE

Texas can only regulate the **fully insured market** — about 20% of employer coverage in Texas. State mandates cannot apply to the **80% of Texans** with employer coverage in level-funded or self-funded ERISA plans.

# The ACA Fundamentally Changed the Health Insurance Market

The 2010 Affordable Care Act did two things: set baseline patient protections across most of the market, and built a new individual market for Texans without employer coverage.

## PATIENT PROTECTIONS APPLIED TO MOST OF THE MARKET

These ACA rules apply to fully insured plans, ERISA self-funded plans, and the individual market.

- No denial or higher rates for pre-existing conditions
- No annual or lifetime caps on coverage
- Preventive care with no cost-sharing
- Essential Health Benefits (10 categories)
- Dependents covered to age 26
- Medical Loss Ratio (MLR) – rebates if MLR < 80–85%

## A NEW INDIVIDUAL MARKET FOR TEXANS WITHOUT EMPLOYER COVERAGE

Before 2014, Texans with health conditions and no employer plan had limited options. The ACA changed that.

### Guaranteed issue

Insurers must offer coverage to any applicant regardless of health history.

### Cost-sharing reductions

Lower deductibles and copays for enrollees earning 100–250% of the poverty line.

### Premium tax credits (subsidies)

Income-based federal subsidies that cap a family's premium as a share of income.

### The Marketplace (Healthcare.gov)

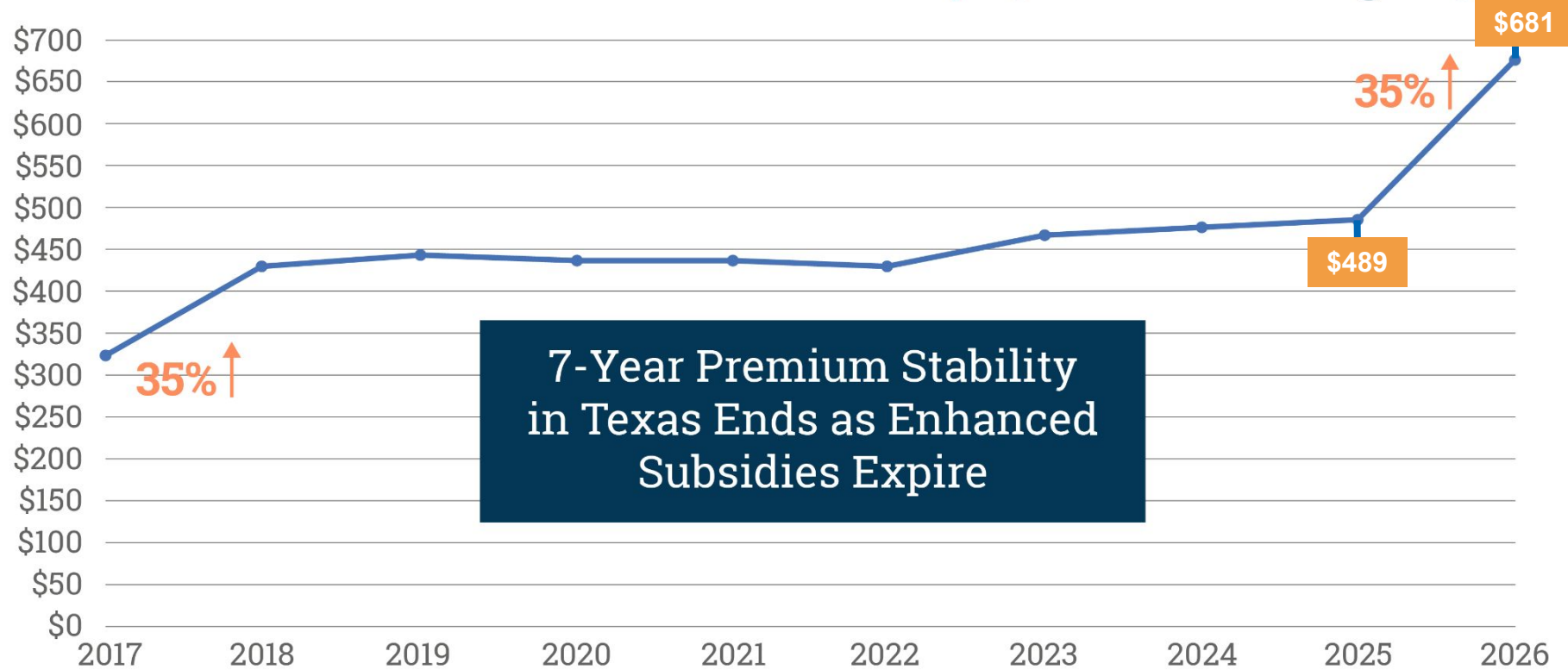
A single shopping platform where Texans compare plans, qualify for subsidies, and enroll.

### TEXAS INDIVIDUAL MARKET

**<700K → 4M**  
covered Texans

Before the ACA, fewer than 700,000 Texans had individual-market coverage. Today, **~4 million Texans** buy coverage through the individual market – and **97% receive federal subsidies** to lower the monthly premium.

# Individual Market Premiums Up (Healthcare.gov)



**Note:** Full price monthly premiums (w/o tax credits) shown, actual increases are greater as shown on next slides.

**Source:** [KEE](#), Single Marketplace Avg. Monthly Premium Before Tax Credits.