Limited Government ◆ Individual Liberty ◆ Free Enterprise ◆ Traditional Values

Texas Conservative Coalition
Research Institute

Healthcare & Human Services Task Force

FINAL REPORT

January 2025

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For more information about this document, please contact the Texas Conservative Coalition Research Institute:

Texas Conservative Coalition Research Institute

P.O. Box 2659, Austin, TX 78768

(512) 474-6042

www.txccri.org

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Introduction

Americans are paying more than ever for healthcare yet are sicker than they have been in decades. While the rest of the world's average life expectancy has continued to increase, the U.S. numbers have decreased to levels not seen in 30 years. While the COVID-19 pandemic was certainly a contributing factor to this problem, the trend began before COVID and has continued to linger after the Public Health Emergency ended. Medical debt continues to be the leading cause of personal bankruptcy.[1] The outlook and challenges facing healthcare issues have remained unfortunately consistent since TCCRI's last Healthcare and Human Services Task Force Report: the cost of care continues to increase; Texans still grapple for affordable coverage options; transparency remains more of a pipe dream than a reality; government mandates have grown; and access to care continues to be a significant burden for many across the state. These issues are not new. TCCRI's task forces and healthcare policymakers have been working to tackle them for years. Accordingly, some of these recommendations will echo those of previous years, because TCCRI remains steadfast in the belief that the only way to truly attack these challenges head on is through free-market principles.

For years, TCCRI has convened a series of task forces during the legislative interims to study a number of health care issues. While topics have spanned the full purview of the healthcare marketplace, all of the issues and challenges in the private healthcare sector can be summarized into three primary needs: freedom from mandates, making healthcare providers more accessible, and creating competition, though there is significant overlap between these categories. This report will also discuss the issues and challenges facing the public healthcare sector, including identifying opportunities to make this sector more effective. Texans deserve to be able to access care and coverage at affordable prices in a manner that preserves a high-quality of care in the health care marketplace. Regardless of the consumer, payor, and/or provider involved, policy proposals must earnestly seek to preserve all of these standards.

Some of the drivers in healthcare costs are both positive and beyond state government's control, such as longer life spans and advancements in medical technology. However, burdensome government regulations and mandates on insurers have played a considerable role not only in pricing some consumers out of coverage altogether, but also in making high-value care more difficult to access. And, while some of these regulations and mandates would require a literal act of Congress to reform, there are free market policies that state leaders can adopt in the 89th Legislative Session which would help address the most critical issues facing healthcare today.

The "Freedom from Mandates" section of this report discusses how unnecessary government intrusion has driven up the cost of health coverage while often decreasing consumer choice. While much of this has occurred at the federal level, the state does have the ability to rein in its regulatory role. This portion focuses on reforms that the 89th Legislature should consider implementing in the private sector to help increase affordable, high-quality coverage options - initiatives which TCCRI has championed for many years. These reforms include rolling back existing mandates and rejecting any new ones; shielding ERISA plans from state mandates; and continuing to explore and adopt alternative coverage options for small business owners and individuals who have been priced out of the individual market.

The "Making Providers more Accessible" portion explores Texas' well-documented provider shortage and discusses non-physician providers that can help fill access to care needs in the medical and dental fields. It also examines how telehealth and licensing reform can help meet critical access needs. Policy recommendations include allowing the independent practice of advanced practice registered nurses; finding pathways to increase the number of physicians practicing in Texas; implementing "Test and Treat" for pharmacists; examining how physician assistants and pharmacists can be better utilized to meet patient

needs; and increasing access to telehealth and teledentistry services.

The "Creating Competition" section of this report is the most varied because it addresses policies that promote transparency for consumers, how to ensure that incentives encouraging high-value care are in place for payors, providers, and patients. A transparent system empowers consumers, incentivizing them to hold providers and payors more accountable, while better alignment of incentives is needed to create competition in an industry with considerable obstacles to a functioning free market. Recommendations in this section include continuing consumer shared savings incentives programs in ERS and TRS; ensuring no statutory barriers exist that prohibit private companies from implementing shared savings or incentives models; funding the All Payor Claims Database and ensuring price transparency requirements are uniformly applied to all providers and payors in the healthcare system.

The final segment of this report focuses on public sector health care issues, most notably the Texas Medicaid program and the need for that multibillion-dollar program to remain accountable to taxpayers, lawmakers, and recipients. A background on the program and the use of Medicaid managed care is provided, as well as recommendations to review current Medicaid contracting policies and consider adjustments to ensure Medicaid patients have consistent and reliable access to healthcare services.

This Report lays out the policy issues that the Healthcare and Human Services Task Force and TCCRI staff focused on over the past interim. As discussed above, the recommendations made in this final report range in subject matter and scope but collectively offer a package of legislative initiatives that advance the high-quality, cost-effective healthcare and the accountable state government that Texans deserve, while upholding the LIFT principles of Limited Government, Individual Liberty, Free Enterprise, and Traditional Values.

Private Sector Health Care

Texas has made strides in recent years in attempting to expand the traditional marketplace for health care coverage. These reforms include the following bills:

- House Bill 3924 (Oliverson, et al.; 87R), which allowed the Texas Farm Bureau to offer health care benefits to its members; and
- House Bill 3752 (Frank, et al.; 87R), which allowed the Texas Mutual Insurance Company, through a subsidiary, to offer health benefit coverage to individuals and small businesses.

But Texas still leads the country in the number of uninsured residents, with an estimated 21.7 percent of the adult population being uninsured in September 2024,[2] and an estimated 11.9 percent of children being uninsured. Both rates are nearly double the national average.[3] Notably, those figures of 21.7 percent and 11.9 percent are likely higher today than in recent years due to many Texans being removed from Medicaid rolls after the expiration of federal rules which essentially all but barred states from disenrolling Medicaid beneficiaries during the COVID-19 pandemic. Texas leads the country in the number of uninsured children, both in absolute terms and as a percentage of all children in the state. The uninsured rate is highest among Texans aged 19- 34.[4]

Texas' unfortunate rankings on the number and rates of insured naturally prompt the question of how more of its residents can obtain health care insurance. For 2024, 3.5 million Texans have health insurance through government-subsidized coverage through the federal marketplace exchange set up by the Affordable Care Act (ACA).[5] Additionally, as of September 2024, Medicaid provides coverage to more than 4.1 million Texans.[6]

A social safety net for the disabled and for those in dire poverty is necessary, but policymakers should focus on employer-sponsored health insurance when analyzing how to expand coverage to more Texans. When Medicaid was enacted in 1965, its primary purpose was to act as a safety net for the needy who could not work and obtain coverage on their own (e.g., children and individuals with disabilities).[7] Over time, it has become the insurer of first resort for the low income, including individuals who could reasonably be expected to secure employment and either purchase coverage or get it through their employers. Growth in an entitlement program that is inconsistent with the original purpose of the program is cause for concern. The state's unemployment rate was a low 3.9 percent in March 2024,[8] suggesting that many Texans- perhaps those in the age 19 to 34 group in particular- are not obtaining health insurance through their employers. If working Texans had insurance through their employer, they would likely be able to obtain coverage for their children as well.

To address the uninsured problem in Texas, policymakers should ask the fundamental question of why employer-sponsored health insurance is not covering more Texans. Data from the years 2020-2022 indicates that 84.2 percent of Texans working in the private sector had an employer that offered health insurance.[9] However, that number plummets to 47.4 percent when the analysis is restricted to Texans working at businesses with fewer than 50 employees.[10]

Freedom from Mandates

What is deterring smaller employers from offering health insurance? Or, if they do offer it, what is discouraging their employees from signing up for such coverage (along with making any required payroll contributions to premium payments)? Unsurprisingly, the answer comes down to cost. According to the Kaiser Family Foundation, in 2024 the average annual family premium for an enrolled employee- counting both employer and employee contributions- was $ 25,572 .[11] The head of the Texas Association of Business stated in a 2023 opinion editorial that a survey of Texas employers found that 87 percent believed that health care costs were rising at an unsustainable rate.[12] A 2022 survey by the National Federation of Independent Business (NFIB) found that 47 percent of small businesses offering health insurance to employees report that fewer than 70 percent of their employees participate in such

coverage,[13] suggesting that many employees find the price of insurance too high.

If the high cost of insurance is a primary reason why employers do not offer health insurance to employees, or why employees choose not to participate even if it is offered, what can be done to lower prices? State policymakers should focus on the following four topics to make the health insurance market more efficient and drive down prices:

- Allow true competition among health insurers by freeing them from mandates, thereby letting them tailor products to their prospective customers;
- Promote transparency in health care costs;
- Permit greater use of economic incentives to factor into heath care purchasing decisions; and
- Eliminate government regulation that interferes with free market forces while adding little or nothing of value.

These four factors overlap considerably, and they have the potential to make the health care industry more responsive to consumers- with consumers in this context including employers- thereby bringing down prices.

Rather than explore additional regulations or mandates that government could adopt to increase access and quality while lowering costs, policymakers instead should focus on where it is appropriate for government to remove itself from the equation, or at the very least diminish its presence. It is typically unnecessary government intrusion, though often well-intentioned, that results in higher costs and lower accessibility- the very opposite of what it sets out to achieve. To fully appreciate why some of this Report's policy recommendations are put forward, it is helpful to first briefly review some of the most common forms of government mandates and how they affect accessibility, quality, and cost.

Government Mandates

Healthcare spending in the U.S. in 2022 was $4.5 trillion, or $13,493 per capita[14] and is projected to grow to an astounding $6.2 trillion by 2028.[15] Therefore, it is no surprise that the crux of the challenges surrounding our healthcare system remains costs, and virtually all policy discussions are centered around how to reign in runaway expenses while promoting positive patient outcomes. Myriad factors contributed to the relentless increase in costs. Some are positive, such as longer life expectancies. Others- such as intrusive government mandates - are not. This rate of escalation is simply not sustainable and, based on current trends, does not appear to be headed toward any kind of course correction.

An area warranting examination by the Legislature is reducing government mandates on health insurance plans. This testimony will argue healthcare mandates have reached a point beyond diminishing returns, precluding small businesses in particular from being able to easily offer insurance as a benefit to their employees. This testimony urges the Legislature to reject new healthcare mandates and will further encourage the Legislature to consider repealing existing mandates that are not required by federal law.

Avoid Mandates and Allow True Competition

Consumers have different preferences. This is evident in virtually all markets, with automobiles being an obvious example. Even when a group of consumers wishes to purchase the same model vehicle, some will opt for lower "trim" levels, whereas others will want as many optional features as possible. In most markets, it goes without saying that consumers make tradeoffs between their desire for the best product with other considerations (e.g., their desire to save money). In health care, however, the federal and state governments have forced health insurers to offer a number of benefits in the coverage that they sell to employers, even though those mandated benefits may be of little or no interest to many of the enrollees (and prospective enrollees) in a given health plan.

True competition in a market cannot exist when the government dictates to sellers the products they must offer to buyers. Such inflexibility prohibits companies from innovating to respond to the wishes of their customers. Government mandates within the health coverage marketplace may take several forms, ranging from mandated contractual terms between two private entities to government price controls.

There are two types of mandates: benefit mandates and structural mandates. While they differ in their requirements, the results are the same: healthcare consumers are left with higher premiums and, often, decreased choice.

♦ *Benefit Mandates*

A significant amount of the consternation around the Affordable Care Act (ACA) was due to its substantial benefit mandates, designated by the law as essential health benefits (EHBs), which contributed in part to creating a crisis in the commercial health insurance markets. While benefit mandates are often designed to impact a relatively small number of the covered population, every insured person contributes to the cost of each one through increased premiums. Although some mandates may appear harmless, and well-intentioned in many cases, every single mandate drives up the cost of care. Most people, regardless of their stance on the issue of mandated benefits, agree that they drive up the cost of healthcare coverage, and each mandated benefit can increase monthly premiums between one and five percent *per benefit.*[16] With the federal Affordable Care Act (ACA) already requiring that plans cover ten categories of "essential benefits,"[17] - including maternity care, mental health and substance abuse disorder care, and oral and vision care coverage for children - the state should be looking to roll back any additional coverage requirements, rather than increase benefit mandates.

Often times, benefit mandates are difficult to deny because they target sympathetic populations, such as mandated cochlear implants for child deafness or hair prosthesis for cancer patients. Or they seem innocuous because they are limited to conditions that only impact a small number of the population, such as treatment coverage for people with certain conditions related to craniofacial abnormalities, which is obviously a population that deserves sympathy (all of these mandate bills have been filed in prior sessions with the former having passed into law). However, authorities on health policy warn against falling into this trap because these mandates have a cumulative effect. One policy expert explains:

> In general, it's politically palatable for lawmakers on both sides of the political aisle to pass benefit mandate after benefit mandate. This legislation shields them from being called out for explicit tax increases, and the per member per month (PMPM) cost of each imposed on policyholders is miniscule...
>
> The insignificant cost of each standalone bill also makes mandate legislation politically feasible for special interests and other medical providers to get their way, which explains why there are now 2,200 mandates nationwide – up from almost zero in the 1970s. But the issue becomes problematic when multiple bills are introduced simultaneously.[18]

Benefit mandates have continued to grow over the years, both in Texas and beyond, and an economist cautions that each mandate comes with its own trade off that should be carefully considered by lawmakers, who must decide whether the cost is justified or whether it will be ultimately detrimental to employers that drive the U.S. economy.[19] The Texas Department of Insurance provides a chart[20] of the state's mandated health benefits[21] that deserves careful study.

While most of these benefits are federally required, some are applicable only within the state. Of particular note is the state-only mandate for certain group plans to cover in vitro fertilization.[22] While people are naturally sympathetic to those dealing with fertility issues, this mandate can have exponential ongoing costs; the costs are not only those of the treatments themselves, but also those of the resulting high-risk and/or multiple-birth pregnancies (e.g., twins/ triplets), which carry an increased risk of premature delivery.[23]

Every legislative session, dozens of mandate bills are filed, and many of those become law. Mandate bills can be politically appealing because their positives (helping people with certain medical conditions) are easily identified, whereas their negatives (a diffuse and indeterminate effect on premiums) are more difficult to point to. But in the aggregate, they are a critical factor in driving up the cost of insurance, creating a formidable obstacle to lowering the number of Texans without insurance. The effect of mandates is similar to weighing down one side of a seesaw; as mandates are piled on one end, the other end (the cost of premiums)

must go up. As the bill author's statement of intent for Senate Bill 1581 (Bettencourt; 88R) (discussed below) pointed out, "In 2021, Texas reached a high-water mark for the number of mandates placed on health insurance. Following the session, Texans saw a 13 percent increase in premiums, while around the nation, year-over-year premiums were flat."

A critical deficit in the current fiscal note process is the inability to capture the true costs of proposed mandates unless they specifically apply to certain government-funded programs, such as Medicaid, CHIP, the Employees Retirement System (ERS), or the Teachers Retirement System (TRS). Because fiscal notes capture state and federal costs that impact the state budget, costs to private sector businesses, including Texas employers, are often omitted from the discussion.

- ***Structural Mandates***

A point about mandates that cannot be overstated is that they go well beyond benefits. A mandate is any requirement that a health insurer must follow in crafting the health plans it sells, which can encompass features such as network adequacy requirements, formulary requirements, and "any willing provider" requirements. For example, requiring a certain number of hospitals within X number of miles of an enrollee is a mandate. As with benefit mandates, these structural mandates drive up the cost of premiums.

The problem of non-benefit mandates is well illustrated by the example of any willing provider mandates. Under managed care, a health plan contracts with certain providers that make up the plan's network. The majority of Americans with private health insurance are enrolled in some form of managed care.[24] In addition to this coverage in the commercial market, the State of Texas utilizes managed care in its employee and teacher group coverage plans, as well as in Medicaid and the Children's Health Insurance Program (CHIP).

By only contracting with certain providers, health plans have the ability to negotiate lower prices and, most importantly, adopt standards that restrict lower-quality providers from joining their networks. This applies to both medical and pharmacy benefits.

Researchers at the Washington Legal Foundation explain how health plans, and ultimately health care consumers, achieve greater cost savings and better services through exclusive pharmacy networks (emphasis added):

> Many networks are highly exclusive. The greater a network's exclusivity, the more customers a member pharmacy can expect. The prospect of a large number of customers creates intense competition for exclusive networks; this competition leads pharmacies bidding for network membership to offer higher discounts in order to join the network. It is well understood that cost savings resulting from this exclusivity are generally passed on to consumers in the form of lower premiums, lower out-of-pocket costs, and better services.[25]

Since the 1980s, there have been attempts through various AWP laws to require that health plans include certain provider groups and/or hospitals in their networks.[26] Proponents of such laws argue that they "level the playing field," particularly for independent practitioners, and provide greater choice to consumers.[27] While the any willing provider concept may on the surface appear good for patients, experience has proven that these mandates actually have the opposite effect. AWP laws adversely impact consumers by driving up the costs of care (thereby further reducing access to low-cost, high-quality insurance coverage) and restricting competition.[28] One analyst described it thusly: "The preponderance of evidence and economic logic would counsel emphatic rejection of new or even existing AWP ... laws." To expound on that notion:

> The laws themselves suppress competition at the provider level in the name of enhancing competition at the point of service level. And by design they also suppress price competition at the point of service level, since all agree to the insurers' terms of what to charge consumers. They want consumers to have access to all providers but for price variation to the consumer to be off the

> table. But if all providers offer the same price to consumers and if all providers are in every plan, then no plan is different from another, either. So in practical effect, strong AWP laws ... also suppress competition at the plan level.[29]

The Federal Trade Commission (FTC) also has a strong history of opposing attempts to pass or enforce AWP laws deeming them anti-competitive and, ultimately, anti-consumer. Researchers quote the FTC, when discussing a state-sponsored AWP law, as saying, "AWP laws, 'preempt competition among providers, instead of protecting the interest of patients. In other words, such laws appear to protect competitors, not competition or consumers.'"[30]

In a separate letter to CMS, the FTC explains that AWP laws "can also limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of coverage, cost, and choice. These restrictions on competition may result in insurance companies paying higher fees to providers, which generally lead to higher premiums, and may increase the number of people without coverage."[31]

In addition, a report entitled "Making Health Care Markets Work: Competition Policy for Health Care," sponsored by a number of stakeholders, including the Robert Wood Johnson Foundation, Carnegie Mellon University, and the Brookings Institute has this to say about AWP laws:

> If providers know that anyone can be in a network due to an AWP law, then they have significantly less incentive to compete on price... Further, providers may also have little incentive to provide better quality or service, again because they must be included in any insurer's network. Research evidence shows that AWP laws increase health care costs. If some consumers desire broader networks that include more providers and are willing to pay for them, then a well-functioning insurance market will provide consumers with that choice. Similarly, consumers who are not willing to pay for broader provider choice should be allowed to select plans that cost less and have narrower networks.[32]

The report goes on to lay out a series of "actionable policy proposals for the Executive Branch, Congress, and the states" to foster competition in healthcare that includes eliminating any existing AWP requirements and not adopting any new AWP mandates.

By eliminating competition among providers and prohibiting health plans from employing innovative and quality-based contracting standards, AWP mandates can have the perverse effect, actually leading to lower-quality, higher-priced care and even reducing the availability of health insurance for Texans.

- ***Even Minor Mandates Have a Cumulative Effect***

Because of the sympathetic nature of a population whose situation would improve from a benefit, or because the financial impact seems to be small, legislators who do not generally support the expansion of government will nevertheless sometimes find it politically palatable to mandate a benefit. For example, HB 1164 (88R), which passed the House but stalled in the Senate, would have required health plans to provide at least $100 in benefits for a hair prosthesis for an enrollee undergoing treatment for breast cancer This is doubtlessly a sympathetic population, and no significant fiscal impact was anticipated in the fiscal note. However, like all benefits, regardless of whether a dollar amount impact to the state is captured, all mandates, no matter how limited, have an impact on employers, consumers, and taxpayers. While any of these single mandates might appear relatively small, when taken together they serve to significantly drive up the cost of healthcare. It is impossible for the government to appropriately determine which populations or benefits are and are not deserving of required coverage, so lawmakers must reject these benefit mandates in all forms.

Similarly, HB 5121 (88R) aptly illustrates the dangers of mandates. The bill would have broadened the range of insurers and plans subject to an existing mandate relating to treatment for chemical. The bill would have also removed the lifetime limitation on policy benefits for chemical dependency treatment in current statute. The bill offers a perfect example of how, once a benefit has been mandated in law, attempts to expand that mandates will likely be made, and it becomes

extraordinarily difficult to offer a principled argument against its expansion if the initial mandate was welcomed.

Policy Recommendation 1

Reject unfunded mandates

TCCRI has long supported rejection of unfunded government health care mandates in any form, be they benefit, price or rate controls, contractual, or administrative. The 89th Legislature should unwind any mandates that are not currently required by federal law and continue to reject all newly proposed mandates, and this standard should be applied to both traditional and non-traditional coverage products.

Texas has a long history of preventing government mandates from impacting the free market's ability to provide innovative, high-quality, cost-effective solutions across all industries. Allowing government mandates to dictate the daily operations of private sector businesses will only lead to negative outcomes for Texas healthcare consumers. In addition to the anti-competitive environment and rising healthcare costs that mandates usher in, they also set a dangerous precedent of allowing the government to dictate to private businesses with whom who they must contract and, in some cases, the terms of a contract between two private entities. Benefits that are very limited and only apply to a small percentage of enrollees must still be rejected, as allowing even a small mandate begins the path down a slippery slope that makes it very difficult to draw a line on which mandates are, and are not, acceptable. For this reason, mandates should be rejected in all forms.

Policy Recommendation 2

Require a Fiscal Impact Statement on legislation containing health coverage mandates

Proposed legislation from the 88th legislative session would have created the Texas Health Insurance Mandate Advisory Collaborative in partnership with the University of Texas Health Science Center at Houston to prepare analyses of bills that would impose new mandates- whether benefit mandates or structural mandates- on health plans in Texas. Senate Bill 1581 (88R, Bettencourt) would have established the Collaborative for the purpose of assessing the impact of proposed health insurance mandates. That bill, which passed the Senate but did not make it through the House, and HB 2403 (Paul), would have required this new Collaborative to issue a report on costs associated with proposed legislation.

The intent of this legislation is to equip the Texas Legislature with a comprehensive analysis of proposed mandates, providing a thorough assessment of costs to both the state, the health plans, and consumers. The analysis would also evaluate the potential need for the proposed mandate and the anticipated benefit of the proposed mandate, particularly as compared to the status quo of the marketplace. The goal of the new Collaborative would be to provide information to legislators, ensuring any new mandates are evaluated for their economic and healthcare impacts on all stakeholders, including employers, families, health plan issuers, and the public sector. More detailed analysis of proposed mandates would better enable the legislature to balance the introduction of new mandates with considerations of cost, access, and the overall sustainability of the healthcare system in Texas.

Legislative leaders, including the Lieutenant Governor, Speaker of the House, and chairs of relevant committees, could request the Collaborative to analyze proposed mandates. These requests could be made at any time, regardless of whether the legislature is in session, and the Collaborative would furnish a report within two months of receiving a request (within 45 days, if the request was made during a legislative session).

The scope of analysis by the Collaborative and subsequent information in the Collaborative's report would include the following:

- The impact the proposed legislation would have on total spending for health care services;
- The impact on utilization of healthcare services;
- The impact on administrative expenses for a health plan and impact on expenses for enrollees or policy holders;
- If the proposal has or will increase or decrease spending by individuals in the private sector, by public sector entities, and individuals purchasing individual health insurance or health plans in Texas;
- If coverage for the relevant health care service(s) was previously available or utilized, without a mandate; and
- If the relevant service is supported by demonstrated and generally accepted medical and scientific evidence.[33]

The proposed Collaborative would analyze both benefit mandates and structural mandates, providing a robust analysis of all facets of the potential costs associated with proposed mandates. The Collaborative would be authorized to consult with individuals possessing relevant knowledge and experience to inform its analysis.

SB 1581 instructed the Texas Department of Insurance to assess a fee on each health plan in the state to offset any potential costs to the state, resulting in no net cost to the state.[34] The fee would be adjusted each biennium to address any estimate increases in costs associated with implementing the bill, or any deficits that occurred in the preceding year as a result of implementing the bill.[35]

As of 2013, 29 states had established some form of mandated care coverage review system to provide a cost-benefit analysis of proposed legislation requiring new insurance mandates.[36] The California Health Benefits Review Program (CHBRP) is an example of one of the legislative advisory entities operating around the country for purposes of analyzing insurance mandates. The CHBRP is an impartial organization comprised of staff from the University of California, with a team of faculty and researchers from several campuses of the University of California. These individuals evaluate "the medical effectiveness, cost impact, and public health impact of bills related to health insurance benefits."[37] This organization provides analysis on proposed new mandates, or proposed repeal of mandates and considers available coverage for relevant health conditions, utilization of the available coverage, associated costs, and the anticipated impact of the proposed legislation on public health outcomes. CHBRP uses claims data to model the anticipated impact of the proposed legislation. Requests for analysis can be made by legislators who have introduced legislation or are considering introducing legislation that includes a health insurance benefit mandate or repeal. Legislative committees evaluating these bills can also request reports, which are typically completed within 60 days.[38]

For illustration, consider the analysis CHBRP prepared for Assembly Bill (AB) 2467, dated April 16, 2024. AB 2467 would have required health plans to cover treatment for menopause symptoms, including prescription drugs. The report, 58 pages in total, assesses that the proposed legislation would apply to 22.3 million enrollees, or 58.6 percent of Californians. Prior to the bill, 7 percent of enrollees had coverage for fezolinetant and 15 percent of enrollees had coverage for ospemifene. If AB 2467 had passed, these numbers would have increased to 92 percent and 100 percent respectively.[39] The report addresses the effectiveness of the medications affected by the bill, informing the legislature that fezolinetant and ospemifene have a preponderance of evidence supporting their efficacy, while the broader category of hormonal and nonhormonal therapies can be effective under some circumstances.[40] CHBRP noted that current utilization for fezolinetant and ospemifene is almost entirely as a noncovered benefit, meaning utilization would increase by 231 percent and 187 percent, respectively.

The mandates in the bill would increase the cost of health care coverage by $3,993,000 per year.[41] Employer premiums would likely have increased by $3,129,000 per year, while individual and employee premiums would have increased by $680,000 per year

and $897,000 per year, respectively. After passing both the Assembly and the Senate, the bill was ultimately vetoed by Governor Newsom. His veto message applauded the efforts of the legislature to improve the lives of women experiencing menopause, but cited concerns regarding a lack of utilization management, ambiguities in the bill, and concerns for cost containment, as outlined in the CHBRP report, that resulted in his decision to veto the legislation.[42] A one-page graphic summary of AB 2467 (2024) is provided in Appendix I.

It is worth nothing that the CHBRP also analyzes the number of individuals who would be likely to no longer afford insurance, and therefore become uninsured, if a piece of proposed legislation were to pass. In the case of AB 2467, the average change in premiums was not expected to exceed 1 percent for any market segment, so the CHBRP anticipated no measurable change to the number of uninsured individuals if the bill was enacted.[43] By comparison, California's SB 839 would have resulted in an increase in premiums by more than 1 percent for several market segments, resulting in 10,000 enrollees becoming uninsured.[44]

The CHBRP relies heavily on claims and enrollment data from commercial and state insurers to provide this analysis. Government sponsored data sources include the California Health Interview Survey, CMS, the California Department of Managed Health Care, and the California Department of Insurance. CHBRP also analyzes actuarial tables and, when appropriate, requests stakeholder feedback.[45]

Fortunately, bills similar to SB 1581 and HB 2403 have already been filed: Senate Bill 818 (89R, Bettencourt) and House Bill 1906 (89R, Paul).

Policy Recommendation 3

Enact legislation based on HB 1001 to allow small employers to purchase "mandate-lite" coverage from insurers.

To allow for a more competitive health insurance market, in which insurers can tailor plans to meet the preferences of consumers, the Legislature should reject any new mandates. But while rejecting proposed mandates would be a commendable achievement, it would not address the mandates that are already imposed by Texas law. House Bill 1001 (Capriglione; 88R) would have allowed health insurers to expand upon existing "mandate-lite" or "consumer choice" plans; these plans would continue to include the benefits mandated by federal law, but effectively would be granted an exemption from more of the mandates in state law. While critics of HB 1001 attacked it for paring back benefits, they refuse to address the tradeoff that is at the heart of HB 1001: scaling back health insurance benefits to allow more employers and employees to afford coverage. It makes no sense to effectively tell employers that they must either purchase very comprehensive health insurance coverage for their employees, or offer no coverage at all.

HB 1001 would have aided small businesses in particular. Many large companies have self-funded plans that fall under the federal Employee Retirement Income Security Act of 1974 (ERISA). Because ERISA generally preempts state law, these large employers are not subject to state mandates.[46]

Prior Authorizations & Gold-Carding

Prior authorization, or preauthorization as it is referred to in statute, has been the focus of key legislation in Texas each of the last two legislative sessions. House Bill 3459 (87R) passed into law; among other things, this bill required most health insurers (but not Medicaid, CHIP, or self-funded employer plans) to "gold card" physicians who meet certain criteria. Gold-carded physicians are those who, in the most recent six-month period of evaluation by insurer, had at least 90 percent of their requests for a given service approved by the insurer.[47] Importantly, gold-carding does not apply to a physician in every capacity, but only to the physician's requests for a specific service with respect to which he or she has a strong track record. Thus, a given physician can be gold-carded for some services, but not others. The final rule issued by TDI with respect to HB 4359 provided that the 90 percent rule described above applies only if a physician has been evaluated during the applicable 6-month period based on at least five requests for the given service.[48]

In 2023, the House Committee on Public Health approved House Bill 4343, but the bill did not reach the House Floor. The committee substitute in relevant part changed the evaluation period from six months to a year, thereby increasing the chances that a physician would have the minimum number of requests necessary to be eligible for gold carding. It also implemented what might be termed an "aggregation" element by requiring insurers to take into account any prior authorization requests by a physician that were approved by the insurers' affiliates, irrespective of whether those requests were made under a health benefit plan covered by HB 3459. If these requests were considered, more physicians would be eligible for gold card consideration.

In a December 2023 piece, the Texas Medical Association stated that, according to TDI, that "only 3 percent of physicians and health care professionals have received gold cards because of the current [strict] eligibility threshold."[49]

More generally, the American Medical Association has consistently criticized the widespread use of prior authorization by insurers. In 2024, it released a survey of 1,000 physicians conducted in December 2023 which found that:

- 94 percent of respondents said prior authorizations create delays in providing care;
- 22 percent reported that prior authorizations frequently lead to abandonment of treatment;
- 24 percent of physicians said prior authorizations led to adverse events;
- Shockingly, 7 percent reported that prior authorizations had led to a patient's disability, birth defect or death;
- The average practice completes 43 prior authorizations per physician, per week;
- Physicians and staff also report spending about 12 hours per week completing related paperwork;
- Thirty-five percent of physicians said they have staff who exclusively work on prior authorizations; and
- 87 percent reported that prior authorizations led to higher overall utilization, whether in the form of additional office visits, emergency department visits, or hospitalizations.[50]

It is undoubtedly true that prior authorizations can create additional work for physicians and/or their staff. But this burden must be weighed against the benefits that prior authorizations provide. One source describes utilization review, of which prior authorization is a subset, as follows:

> Utilization review is the process of making sure healthcare services are being used appropriately and efficiently, which is a key component of a value-based approach to paying for health care. The goal of utilization review is to make sure patients get the care they need, that it's administered via proven methods, provided by an appropriate healthcare provider, and delivered in an appropriate setting. This should result in high-quality care administered as economically as possible and in accordance with current evidence-based care guidelines.[51]

Insurers often require a PA before an expensive or potentially complicated service or prescription drug will be reimbursed. The purpose of a PA is not to discourage the benefit from being provided, but rather to do the following:

1. Examine whether a cheaper but efficacious treatment is available and has yet to be tried by the patient. This can generate significant savings; for example, identifying a cheaper drug in lieu of a brand name drug for just one patient can save a health plan thousands of dollars a year, which can translate to lower premiums.

2. Ensure that the patient has not been prescribed a drug with dangerous contraindications that was ordered by a different provider. Many clients, especially those with chronic or complex medical conditions, may see multiple providers and specialists who are not aware of what the others are ordering or prescribing. A crucial point is that an insurer, as the payor, is often the only entity able to see the entirety of a patient's medical history and, in that role, is uniquely positioned to identify potentially unsafe interactions. This unique position also allows an insurer to flag inappropriate amounts of a medication (e.g., opioids) being described to a patient.

3. Determine whether the patient has recently received the same or similar treatment. Again, an insurer is in the best position to detect duplicative treatments by different providers in a short period of time.

4. Verify that the prescribed service or product is medically necessary. As discussed below, overtreatment is a chronic problem in the U.S. healthcare system and contributes to rising health insurance premiums.

Placing PA in its proper context requires some brief discussion of background facts. Every year, the United States spends an enormous amount on healthcare, easily leading the world in both absolute and per-capita healthcare spending.[52] Unfortunately, much of that care is not necessary. An influential paper by the Institute of Medicine found that "unnecessary services added $210 billion (8.4 percent of national health spending) to health care spending in the U.S. in 2009."[53]

There is ample reason to believe that problem persists. In a 2017 survey of physicians (all of them members of the American Medical Association), the median estimate by respondents was that 20.6 percent of medical care in the U.S. was unnecessary; 27 percent of respondents believed that 30-45 percent of medical care is unnecessary.[54] Additionally, 30 percent believed that at least 30–45 percent of prescription medications are unnecessary; almost 38 percent said that at least 30–45 percent of tests are unnecessary; and 16 percent believed that at least 30–45 percent of procedures are unnecessary.[55]

The survey's respondents believed that malpractice concerns, patient pressure, and difficulty in obtaining the patient's prior authorizations medical records- in that order- were the three most important reasons for overtreatment and the wasteful spending that flows from it. Moreover, 71 percent of respondents believed that physicians are more likely to perform unnecessary procedures when they profit from them; attending physicians with at least 10 years' experience were more likely than others to express this belief.

Leaving aside the other benefits of PA, mitigating overtreatment alone would justify some PA. Intuitively, PA would seem to have potential to combat at least some overtreatment attributable to the three most important causes respondents mentioned. For example, an insurance company employee conducting a PA for an overtreatment that was prescribed due to patient pressure is not likely to feel the same pressure as the physician dealing face-to-face with the patient requesting the service or treatment. Similarly, access to the patient's medical history could sometimes help combat overtreatment that is prescribed when the prescribing physician lacks those records.

It is understandable that physicians, with years of studying and practicing medicine to their credit, object to having their findings reviewed by an insurer. But even flagging just a small percentage of PA requests as unjustified can save the health care system as a whole, especially given that prior authorizations tend to be required for high-cost procedures and drugs. Even the best-trained physicians can make mistakes. Moreover, there is sometimes a significant lag between current medical research and translation into practice.[56]

Unsurprisingly, health insurers in every context- commercial, Medicaid, Medicare, etc.- utilize PA, although some may utilize it considerably more than others. There is a lack of quality data on the system-wide net savings (or costs) of PA, but evidence supports the claim that they can flag what would be unnecessary medical spending.[57]

The Teachers Retirement System of Texas Annual Health Report for FY 2023 offers one example of an entity that saved significant dollars due to PAs:

> TRS-ActiveCare has required prior authorization for multiple categories of prescription drugs since the inception of the program in 2001. This currently includes prior authorizations for more than 400 drugs. For FY 2023, using this strategy saved the plan approximately $82.5 million. This was saved through $41.8 million for prior authorizations and step therapy related controls of specialty drugs, $40.4 million for non-specialty drugs and $0.3 million for generic drugs.[58]

Most patients do not find prior authorizations burdensome. According to the Kaiser Family Foundation, in 2022, 31 percent of adults who had more than 10 physician visits in the prior year experienced problems with prior authorization. Unsurprisingly, that figure dropped for adults with 3-10 visits (20 percent) and fewer than 3 visits (10 percent).[59] In Texas, prior authorization requests are generally processed within 3 business days.[60]

It should be emphasized that insurers, not just providers, incur costs as a result of time spent on prior authorizations, and that they have an incentive to improve the PA process. This is evidenced by several insurers in recent years eliminating or greatly reducing prior authorizations in various contexts. For example, on September 1, 2023, United Healthcare began a phase-in that will eliminate roughly 20 percent of its PA volume.[61] The full program went into effect on October 1, 2024 to expedite provider care coordination, and assist patients in maximizing health benefits and programs.[62] In September 2023, Cigna also announced that it was eliminating PA for 25 percent of medical services.[63] The company noted that, "With the removal of these more than 600 additional codes, the company has now removed prior authorization on more than 1,100 medical services since 2020."[64]

A 2022 AHIP survey indicated that 58 percent of respondent health plans gold carded physicians to at least some extent for medical services requests, up from 32 percent in 2019. However, that number was only 21 percent for prescription drug requests, which was still an increase from the 9 percent in 2019. A surprising result from the survey was that roughly 60 percent of providers' PA submissions for medical services and 40 percent of the requests for prescription drugs were done manually rather than electronically. There is room for insurers, not just providers, to improve in terms of electronically processing PA requests; the survey indicated that 75 percent of insurers process PAs electronically for prescription drug requests, and 88 percent for medical services requests. Regulations announced by CMS in 2024 will go into effect in 2026 and 2027 and require certain providers to adopt electronic processing, which hopefully will spur even greater adoption among providers in general.[65]

Policymakers in Texas should be wary of eroding health plans' ability to implement PA. The state is already one of five with a gold carding law as of February 2024.[66] Some insurers offer gold carding voluntarily- more evidence that supports the claim that health plans are incentivized to improve the PA process. A 2022 survey of 26 health plans with 122 enrollees (under commercial health insurance) indicated that insurers' collective experience with voluntary gold-carding has been mixed: 46 percent believed that it increased provider satisfaction and reduced administrative work for plans and 23 percent believed that quality and patient safety had improved or remained stable, but 20 percent believed that was a decline in the quality of care, 20 percent said it increased costs without increasing quality.[67] The survey was conducted by AHIP, a trade group for health insurers.

In addition to being one of the few states with a gold card law, Texas allows a physician to be eligible for gold carding with respect to a particular service if the physician submits only five requests for the service in a six-month period, and the 90 percent approval benchmark is met. If a physician is not prescribing a given service more than once a month on average, it is debatable how much of an administrative burden obtaining prior authorizations for the few requests for that service is.

One last point about the AHIP survey should be emphasized: insurers indicated that they are more willing to ease PA requirements on providers who enter into risk-based contracts. This is not surprising; if providers are financially responsible for the cost of prescribing medical care that is not necessary, common sense dictates that they will have a greater incentive to ensure that all prescribed care is necessary.

As noted later in this Task Force Report, HB 1073 (Hull, 88R) would allow providers and insurers to enter into risk-based contracts. Reforms such as this bill would likely significantly reduce the number of PA requests made.

Policy Recommendation 4

Refrain from placing additional limits on health insurers' use of PA

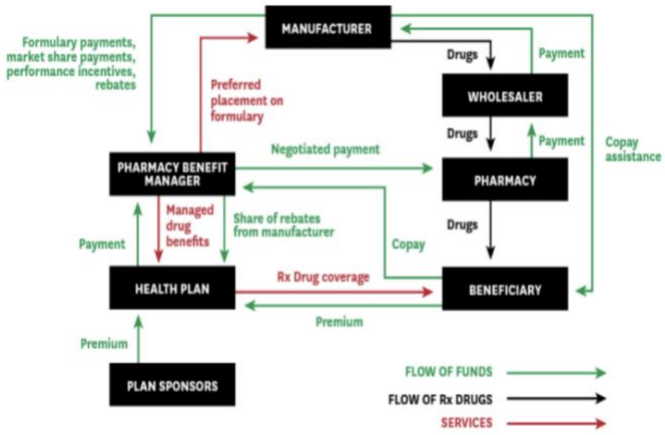
Pharmacy Benefit Managers & ERISA Preemption

Pharmacy benefit managers (PBMS) are entities hired by employers and insurers to perform a variety of services related to prescription drugs. These services include establishing pharmacy networks, negotiating prices with drug manufacturers and pharmacies, utilization management (e.g., conducting prior authorizations, setting enrollees' co-pay amounts), and formulary design.

Figure 1 provides a helpful visual depiction of the flow of funds and services in the prescription drug area.

Figure 1

Prescription Drug Funds and Service Flow



Source: University of Southern California's Leonard D. Schaeffer Center for Health Policy & Economics[68]

The PBM industry is dominated by a few companies. According to a 2024 interim staff report by the Federal Trade Commission (FTC) ("the FTC Report"):

> In 2004, the top three PBMs served a combined 190 million people and managed 52 percent of prescription drug claims. Today, the top three PBMs—CVS Caremark, Express Scripts, and OptumRx (together, the "Big 3")—manage 79 percent of prescription drug claims for approximately 270 million people. With the next three largest PBMs—Humana Pharmacy Solutions, MedImpact, and Prime—the six largest PBMs (together, the "Big 6") now manage 94 percent of prescription drug claims in the United States.[69]

Other than MedImpact, these PBMs are owned by insurance companies.

PBMs have several sources of revenue:

- "Spread" pricing refers to the gap between what a PBM pays a pharmacy for a drug and what is charges an

employer/health insurer for the same drug.

- PBMs negotiate rebates from drug manufacturers in exchange for a manufacturer's drug being included in the formulary designed by the PBM. A large portion of these rebates are passed on to the plan sponsor, but the PBM usually retains a portion.

- PBMs charge their clients an administrative fee for their services.

- PBMs often own mail-order and/or specialty drug pharmacies, which generate profits. Specialty drugs are noteworthy because they tend to be expensive and are a rapidly-growing component of the prescription drug market. The cost of these drugs was $301 billion in 2021, an increase of 43 percent since 2016.[70] More, the FTC states that "revenue (estimates range from nearly 40 percent to over 50 percent), but only a small fraction of total prescription volume (roughly two percent)."[71]

Criticisms of Large PBMs

PBMs, the Big 3 in particular, have drawn intense criticism in recent years for alleged anti-competitive behavior. For example, a 2024 report by the congressional House Committee on Accountability and Oversight (the "House Report") stated that PBMs have placed expensive drugs in their formularies to obtain large rebates from the manufacturers of those drugs, when much cheaper and equally efficacious drugs were available.[72]

Another recurring complaint is that PBMs "steer" consumers to pharmacies the PBM owns through a variety of mechanisms, such as charging consumers a higher co-pay for using other PBMs.[73] This steering complaint was echoed by the FTC report.[vi] PBM-owned pharmacies have been accused of charging unusually high prices in many cases; the FTC report found that from 2020 through part of 2022, PBM-affiliated pharmacies took in $1.6 billion more than NADAC[i] with respect to two specialty generic drugs.[74]

PBMs have also been accused of failing to provide consistency and transparency on how they calculate direct and indirect renumeration (DIR), which consists of post-sale fees that PBMs charge pharmacies based on a pharmacy's performance metrics.[75] These fees increased by a factor of 450 from 2010 to 2017.[76]

The market dominance of the Big 3 provides them with the clout to negotiate with drug manufacturers, wholesalers, and pharmacies. This clout, however, also makes possible anti-competitive behavior to some extent. The PBM industry is striking not only because of the market share of the Big 3, but also because it exhibits an unusual degree of vertical integration: an insurer owns a PBM, which in turn owns a pharmacy.

Given the unusual degree of industry concentration, the extent of vertical integration among PBMs, the alleged abused above, and the skyrocketing cost of prescription drug spending, it is unsurprising that PBMs have become a target of criticism. The view of many is summed up by the House Report: "PBMs frequently tout the savings they provide for payers and patients through negotiation, drug utilization programs, and spread pricing, even though evidence indicates that these schemes often increase costs for patients and payers."[77]

It should be noted that at least some of the criticisms in the FTC Report and the House Report are not well-founded. For example, the House Report criticizes PBMs for requiring prior authorization and step therapy, when these can be critically important cost-savings measures.[78]

ERISA Preemption in the PBM Context

Regulation of PBMs has increased in Texas in recent years, with the following bills being particularly important:

- HB 2536 (86R), codified in relevant part as Subchapter K of Chapter 1369, Insurance Code, requires PBMs to file an annual report detailing the rebates collected from manufacturers and what portions were retained, passed to consumers, or passed to health plans.

- HB 1763 (87R), codified in relevant part as Subchapter L of Chapter 1369, Insurance Code, prohibited PBMs from paying affiliated pharmacies more than non-affiliated pharmacies for the same service. The bill also eliminated the extent to which a PBM can reduce a payment for a pharmacy claim without conducting an audit in accordance with statute.

- HB 1919 (87R), also codified as part of Subchapter L of Chapter 1369, Insurance Code, prohibits PBMs from requiring patients to use an affiliated provider as a condition of receiving maximum benefits under the applicable plan.

- HB 2021 (88R) did not become law but deserves special mention. The above bills, codified in Chapter 1369 of the Insurance Code, do not apply to PBMs in the context of self-funded plans established by private employers (SFPs). These plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA), which in relevant part preempts state laws that "relate to SFPs."

The breadth of this exemption from state law pursuant to ERISA is noteworthy. A full 65 percent of workers with health insurance coverage through their employer are in SFPs.[79] The more employees a business has, the more likely it is to be self-funded. Of companies with 5,000 or more workers, 91 percent were self-funded in 2022.[80]

In a 2020 case, the U.S. Supreme Court held that an Arkansas statute which, among other things, effectively required PBMs to reimburse pharmacies for a drug in an amount equal or greater than the pharmacy's wholesale cost of the drug, did not conflict with ERISA's preemption rule.[81] Subsequently, however, the Tenth Circuit stuck down an Oklahoma statute which attempted to regulate PBMs to a greater extent because it interfered with ERISA preemption, [82] although has been appealed to the U.S. Supreme Court.[83]

HB 2021 would have extended the provisions of Chapter 1369 of the Insurance Code to PBMs in the ERISA context, subject to certain exceptions. While it is understandable that policymakers wish to regulate PBMs to a greater extent, there are reasons to be wary of regulation in the ERISA context.

As noted above, based on data from 2020-2022, large Texas employers (who are likely to have SFPs) are much more likely to offer health insurance benefits than small Texas employers. A partial explanation of that is the greater resources of large employers on average, but ERISA preemption also plays an important role.

Erosion of ERISA preemption is an especially significant concern for multi-state employers (which tend to be large employers), who face the prospect that other states will pursue policies similar to HB 2021. That would force them to design state-specific polices, an expensive and cumbersome process that would drive up premiums.

The Texas Association of Business (TAB), which opposed HB 2021, stated that its 2022 survey of Texas employers revealed the following:

- 87 percent agree that Texas businesses should oppose legislation that attempts to increase the cost of employer health care coverage;

- 77 percent agree that the legislature should give employers more flexibility to contain costs;

- 75 percent oppose legislation that would allow the state to interfere with an employer's ability to design its offering of health benefits for employees; and

- 68 percent want to keep the ability to offer patients lower-cost prescriptions by using in-network or PBM-affiliated pharmacies.[84]

If measures such as HB 2021 are not ideal ways in which to regulate PBMs, the question is: what can be done to address concerns about alleged anti-competitive practices by some industry actors?

Two preliminary points should be considered. First, thanks to the enactment of HB 2536, it is possible to see how PBMs in Texas allocated their rebate revenue. TDI reports that, in 2022, 15 PBMs received approximately $4.39 billion rebates, fees, and price

protection payments from drug manufacturers.[85] Of that amount, $3.99 billion was passed on to health plan issuers, less than a million dollars was passed on to health plan enrollees, and $409 million (9.3 percent) was retained by the PBMs. This information, at least, indicates that PBMs are passing on the vast majority of rebates to health plan issuers (although again, many PBMs are owned by insurers, i.e., health plan issuers). This allocation is consistent with a 2023 report by Nephron Research, which found that PBMs retained 13 percent of rebates and price protection payments in 2022, down from 46 percent in 2012 (the report found that PBMs were instead receiving more of their revenue from their specialty pharmacies).[86]

Second, and much more fundamentally, it should be emphasized that PBMs, whatever their failings, would presumably not be paid by employers and insurers if they added no value whatsoever. The reality is that performing the services provided by PBMs is an undertaking with which most companies would struggle. It is certainly fair to question whether large PBMs are using their market power to extract a high percentage of the savings they generate, but if they were adding no value whatsoever, many insurers and employers would choose not to use them.

Improving the PBM Marketplace

The preceding sentence is noteworthy given that some companies are pushing back against large PBMs. The market, however concentrated it may be, is showing progress. A November 2023 article in *The Wall Street Journal* detailed how some employers and organizations, such as Foot Locker and a Teamsters health fund in Pennsylvania, recently dropped their large PBMs for smaller PBMs that delivered greater transparency and cost savings.[87] A similar trend was noted in a 2024 *Bloomberg Law* article:

> More and more employers are migrating to smaller pharmacy benefit managers—which manage the prescription drug benefit of insurance plans—in an attempt to curb rising costs and comply with strengthened fiduciary duties. But ditching the industry giants can be scary in the complex world of drug negotiation and delivery, where the three major PBMs control 80percent of the market... Newer PBMs have entered the market in recent years with promises to cut costs through transparent and innovative business models, like passing through manufacturer rebates, swapping brand-name drugs for generics, and sourcing medications through cost-based vendors like the Mark Cuban Cost Plus Drug Company.[88]

At least one small PBM is willing to assume a fiduciary role to its clients.[89] While this PBM might lack the market power of the Big 3 and thus have less negotiating leverage, it might still be a better option on a net basis for employers if it refrains from the practices of large PBMs that have drawn intense criticism. If employers and insurers want PBMs to act as fiduciaries, they should be willing to pay for the PBM assuming greater legal risk and duties. Doing so may well generate net savings.

The Texas Association of Counties (TAC) Health and Employee Benefits Pool (HEBP), one of the nation's largest public sector benefit pools, faced escalating pharmacy benefit costs under its traditional PBM arrangement. The challenges included opaque contract terms, ambiguous drug pricing algorithms, and limited access to data and audit rights. These issues enabled the PBM to increase its revenue while burdening TAC HEBP with rising claims. Motivated to address these inefficiencies and improve financial oversight, TAC HEBP sought a more transparent approach to pharmacy benefits management, ultimately partnering with Navitus, a pass-through PBM provider.[90]

Navitus' pass-through model offered transformative transparency, allowing TAC HEBP to gain unprecedented visibility into drug pricing and expenditures at the claim and invoice level. This partnership enabled the pool to implement comprehensive strategies for cost containment and member access enhancement. Key initiatives included expanding 90-day prescription availability at retail and mail-order pharmacies, particularly for maintenance medications. To minimize disruptions, TAC HEBP grandfathered most existing prescriptions for chronic conditions such as cancer, rheumatoid arthritis, and multiple sclerosis. This approach preserved continuity of care while fostering cost efficiency.[91] Additionally,

TAC HEBP adopted utilization management tools, including prior authorization and step therapy, which ensured members accessed the most clinically appropriate and cost-effective medications. Navitus' lowest-net-cost formulary emphasized recommending alternatives based on clinical guidelines and drug efficacy. This dynamic approach was bolstered by quarterly reviews of formulary recommendations, allowing TAC HEBP to adapt quickly to new-to-market drugs and evolving clinical evidence. The introduction of a copay assistance program further enhanced cost management, particularly for specialty medications dispensed through Lumicera Health Services, a subsidiary of Navitus. This program alone contributed over $3.4 million in savings during the first year.[92]

The results of these reforms were transformative. TAC HEBP experienced a 23 percent reduction in total net pharmacy costs within the first year of implementation, along with a 26 percent reduction in per-employee-per-month plan costs. These achievements underscored the effectiveness of combining a pass-through PBM model with targeted cost-saving programs. The partnership not only stabilized drug costs but also granted TAC HEBP the flexibility to customize plan designs according to the specific needs of its members. This model serves as a case study in leveraging transparency and innovative benefit management to reduce costs while preserving or improving member access to necessary healthcare services. The experience of TAC HEBP provides critical insights for other public sector benefit pools and organizations grappling with rising healthcare costs and complex pharmacy benefit arrangements. By embracing a transparent PBM model and actively engaging in formulary and utilization management, organizations can achieve substantial financial savings while safeguarding member access to high-quality care. This case underscores the importance of challenging entrenched practices in healthcare administration and prioritizing models that align cost containment with member well-being.[93]

When possible, the market should be allowed to correct itself rather than government imposing mandates in an attempt to reform the market. There are indications that PBMs are responding to the criticisms that have been lodged against them and the surge of competition from smaller PBMs. A May 2024 news article discussed the transparent pricing models that the country's three largest PBMs are rolling out.[94] For example, one such arrangement sets the fee charged by the PBM by using a formula based on the drug cost, a set markup, and a fee for pharmacy services.[95]

It should also be noted that, despite the concentration in the PBM market, competition among dominant market players is still possible, such as Samsung versus Apple in the cellular phone context, although employers and insurers may have to put forth greater effort to take advantage of competition in the market. According to the National Association of Insurance Commissioners (NAIC), there are 66 PBMs in the country today.[96]

Finally, it should be noted that employers may soon have a greater incentive to shop among PBMs, which would force PBMs to improve their service. Earlier this year, a group of former Wells Fargo employees sued the company due to its retaining a PBM that allegedly "paid more than $69,000 for a tube of cancer medication bexarotene that cost as little as $3,750 at other pharmacies, and a markup of nearly 400 percent on generic 'specialty drugs' used to treat certain conditions."[97] A similar case was filed earlier against Johnson & Johnson.[98] This legal strategy drew a great deal of attention and, regardless of how it plays out in a particular case, should put employers on notice. Although a PBM may not owe a fiduciary duty to an insured employee, an ERISA employer does have a fiduciary obligation in providing health coverage to its employees, and this may entail greater due diligence in selecting a PBM.

It is worth quoting a commentator who points out that, even if PBMs are regulated to a greater extent, and even assuming that PBMs cannot adopt their behavior to circumvent new regulation, "it is far from clear that plan sponsors and patients, as opposed to other players in the pharmaceutical supply chain, would actually benefit. Plan sponsors and patients may only benefit if pharmaceutical manufacturers, wholesalers, and pharmacies are willing to offer lower prices in the absence of PBMs or with PBMs that are significantly weakened.[99] The best solution to alleged PBM anti-competitive practices is more competition. There are signs that competition to the dominant PBMs is beginning to emerge, to the point that the large PBMs are being forced to respond.

Policy Recommendation 5

Monitor growth of emerging competitors in the PBM industry, but avoid extending PBM regulation in the ERISA context

Making Providers More Accessible

In 2015, Merritt Hawkins released an extensive report examining the adequacy of the state's physician workforce. The results were not encouraging, ranking Texas among the lowest ten states for the number of actively practicing physicians per 100,000 residents, with 2.2 million Texans residing in small counties that were served by only 2.5 percent of the state's entire physician workforce.[100] While this study is worth noting because it is Texas-focused, it is admittedly growing dated. Unfortunately, more recent studies show this trend is headed in the wrong direction.[101]

Later studies have again ranked Texas near the bottom of the nation in having an adequate number of physicians to meet demand, a problem that is compounded by the fact that a growing percentage of Texas doctors are nearing retirement age.[102] While the state has invested in new medical schools and residency slots, one academic, who is also a medical doctor, posited that even if every Texas medical school graduate stayed within the state to practice medicine, it still would not meet the state's demand.[103] DSHS projects that Texas will face a shortfall of over 10,330 physicians by 2032.[104] Today, only thirty of Texas' 254 counties do not have a primary care provider shortage, with the term "provider" in this context including both physician and non-physician professionals.[105]

The maps in Figures 2 and 3, based on data from the federal Health Resources & Services Administration (HRSA), show the extent of primary care shortages in Texas. Counties may be designated by HRSA as a "whole" or "partial" health professional shortage area (HPSA), with either the entire county experiencing a shortage (show in dark blue) or only a portion of the county (show in medium blue). Counties meeting HRSA's defined primary care access needs are shown in light blue.

The map in Figure 2 reflects HRSA's 2017 designations for the State of Texas, while the map in Figure 3 presents the most up-to-date version of this data, as of October 2024. Access challenges existed in 2017, but not nearly to the degree in which they do today. In 2017, fewer than half of the state's counties were considered "full" health professional shortage areas. Since then, most of these "partial" designations have become "whole county" shortage areas, and only 20 counties in the entire state are currently able to fully meet their residents' primary care needs. Out of the state's 254 counties, 214 currently are in HPSAs, and 10 more counties are partially It is clear that Texas is moving in the wrong direction on access to primary care, and immediate action is needed in the 89th Legislative Session.

Figure 2

Health Shortage Areas in 2017

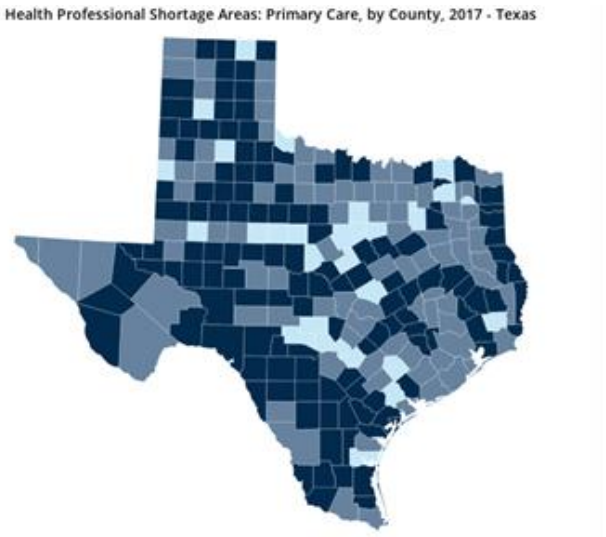
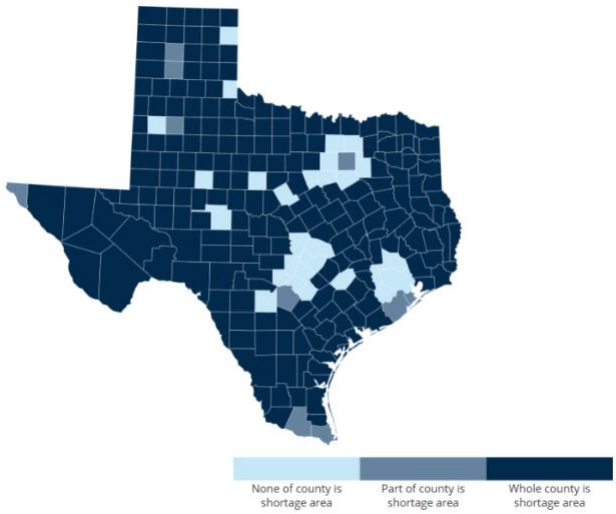


Figure 3

Health Shortage Areas in Oct. 2024



Source: Rural Health Information Hub[106]

Although many tout Medicaid expansion as the solution to addressing the state's access challenges, this myopic approach fails to understand the basic premise that coverage does not equal access to care. Even if government programs were expanded to cover every person in Texas, this imprudent and expensive approach would do nothing to ensure that anyone could actually be treated, irrespective of whether the government or a private sector plan was paying for the services. And, while TCCRI supports ensuring that private sector coverage is made more affordable for both Texas employers and families, the success of that coverage also hinges on an adequate provider base and the means to access the care.

Understanding these dynamics, Governor Abbott took swift and decisive action early in 2020 to make it easier for Texans to get the medical care they need by temporarily relaxing regulatory burdens for out-of-state health care providers in good standing to practice in Texas,[107] opening up the pipeline for qualified nursing students to enter the workforce,[108] and easing telehealth[109] and pharmacy[110] regulations. As TCCRI has discussed throughout the work of its Task Forces over the last few years, disasters often offer a unique opportunity to strip away politics and truly examine whether certain laws and regulations should be there in the first place. And nowhere was this opportunity greater than in addressing Texas' provider shortage. As a result of unprecedented wait times during the COVID-19 lockdowns, telehealth and telemedicine were adopted as a first-line, rather than alternative, treatment modality, and some of the arbitrary provider licensing restrictions that had stood for years were finally stripped away.

While those were some unintended positive consequences during a terrible time, these actions alone are not enough to meet Texas' growing access demands.

APRNs

One key solution to address this issue that is fully within the state's purview is expanding the ability of certain qualified providers to practice at the top of their licenses- meaning to fully exercise the education, training, and scope conferred by their current licensure- thereby allowing these providers to expand access to healthcare. While efforts to enact such policies have been pursued in past sessions, very few of them have been successful. This session, however, is a critical opportunity to embrace these reforms and entrust qualified providers to do the jobs for which they are trained and licensed.

In a 2023 report, the Cato Institute ranked Texas dead last among states in terms of "occupational freedom."[111] The state's treatment of advance practice registered nurses (APRNs) is an excellent example of why it ranked last in the country. Currently, APRNs in Texas may practice and see patients, but must do so under the delegation of a licensed physician. As such, APRNs generally may only contract with a health insurer if their delegating physician is also contracted with that plan, although there is some flexibility of this restriction in the Medicaid program.[112] Proponents of expanded APRN practice authority argue that the current system of regulations really amounts to a requirement that APRNs sign expensive delegation agreements with physicians, up to $120,000 per year in some cases, in order to see their patients and write prescriptions.[113]

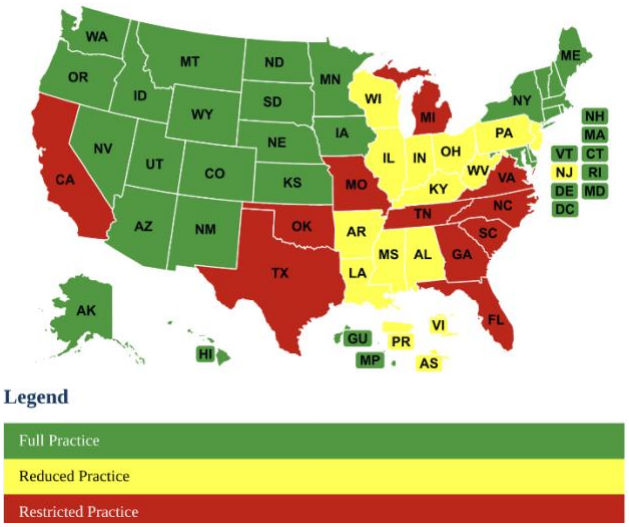
Easing restrictions on APRNs would be especially useful in a state like Texas that has many areas with a primary care shortage. As touched upon above, DSHS classifies 214 of the state's 254 counties as health professional shortage areas (HPSAs), with another 10

counties having a partial designation.[114] There is no reason for patients to go unserved in many areas of the state when qualified medical personnel are ready to assist them.

Texas is one of the 11 most restrictive states with respect to APRN practice.[115] As of 2019, 22 states and the District of Columbia, federal health care services, and all branches of the military[116] allowed APRNs to practice without physician delegation authority. The map in Figure 4, updated by the American Academy of Nurse Practitioners in October 2023,[117] provides an overview of the national landscape of how APRNs are able to practice across the nation, and clearly shows how Texas could lose to some surrounding states in recruiting these providers, with only one adjacent state, Oklahoma, restricting the practice of APRNs to the same degree as Texas (Oklahoma's legislature recently passed a bill easing restrictions on APRNs, but it was vetoed).

Figure 4

APRN Practice by State



Source: AANP[118]

In addition to addressing care issues and further illustrating the point that the pillars of affordability, accessibility, and accountability are inexorably linked, allowing ARPNs to practice at the top of their license results in a cost savings for consumers and taxpayers. While it is difficult to provide a cost savings estimate for private care, TCCRI has modeled potential savings through the increased use of APRNs in the Medicaid program in a prior paper. Because APRNs are reimbursed at a percentage of the cost of a regular physician visit, there is potential for cost savings if utilization shifts to greater use of APRNs. The analysis found, in comparing costs for evaluation and management (E&M) procedures in primary care between APRNs and physicians, there is a cost savings as utilization shifts from physicians reimbursed at rates higher than those of APRNs (in Texas Medicaid that reimbursement is 92 percent of the regular physician rate).

It is also important to note that analysis of longitudinal data patterns has shown that APRNs tend to refer for other services (i.e., lab, x-ray) similar to physicians. This has allowed researchers to conclude that there are minimal differences in referral patterns and use of ancillary services,[119] and no increase in overall Medicaid service utilization (claims, days of care), when patients are treated by APRNs.[120]

Multiple studies and simulations show overall cost-effectiveness and sometimes significant savings with no restrictions on APRN practice,[121] with net savings ranging from more than $700 million in Alabama over a 10-year period[122] to billions of dollars in Pennsylvania and California over a 10-year timeframe, considering the overall healthcare system.[123]

Policy Recommendation 6

Allow APRNs to practice independently and to perform the services for which they have been trained

The time has come to place Texas on par with most states and grant APRNs independent practice authority. The necessary legislation would not alter the scope of practice of these providers, meaning that an APRN would still have to operate under current requirements regarding education, training, and certification standards, and to continue to adhere to the Texas Nursing Practice Act and Board of Nursing (BON) rules.[124] The necessary legislation need only remove the requirement that APRNs practice under a delegation agreement with a licensed physician.

While the Texas Medical Association (TMA) has historically favored of what it calls a "team approach" with physicians and APRNs, it should be noted that

under current regulations APRNs are not required to be located in the same city as their delegating physicians, nor are the physicians required to see any patients treated by an APRN.[125] In addition, research supports the safety and efficacy of APRN care. An in-depth study looking at the role of APRNs in helping to fill primary care needs examined multiple studies on APRN safety and patient satisfaction, finding the following:

> Several studies consider the quality of care or clinical outcomes provided by NPs and the existing literature suggests that NPs provide a quality of care almost on par with physicians. A meta-analysis of NPs in primary care found that in studies, controlling for patient risk in a non-randomized way, patient satisfaction and resolution of pathological conditions were greater for NP patients and NPs were equal to physicians in the majority of variables in controlled studies.[126]

Although some opponents might argue that allowing this independent practice could place patient safety at risk because there is no physician oversight, this policy change would alter little in the actual manner in which APRNs care for their patients. Rather, this legislation removes a cumbersome and costly hurdle to practice and is a critical step towards increasing access to care in areas of the state where that care might not be otherwise available, while also providing the opportunity for cost savings both to the Medicaid program and private payers.

In July 2024, *Bloomberg Businessweek* released an article expressing concerns about the rapid expansion of nurse practitioner (NP) programs in the U.S. and potential implications for patient safety. With over 300,000 practicing NPs and a projected 45.7percent increase by 2032, the NP profession is growing significantly faster than that of physicians. According to the article, the number of schools offering advanced nursing degrees has tripled compared to medical schools, with 39,000 NP graduates in 2022 alone—a 50 percent increase since 2017. The article argues that the lack of standardized clinical training and the prevalence of direct-entry programs, which accept students without healthcare experience, may compromise the preparedness of new NPs, potentially leading to patient safety risks.[127]

In response to the *Bloomberg* article, the American Association of Nurse Practitioners (AANP) submitted a letter to the editor highlighting the contributions of NPs to the U.S. healthcare system and criticizing the *Bloomberg* article for highlighting exclusively negative information and neglecting all evidence to the contrary. The AANP underscored the rigorous training and accreditation standards to which NPs adhere, including clinical rotations and national certification exams. The rebuttal letter by the AANP also argued that NPs deliver care that is at least comparable to physicians according to academic and policy reports, including those by the National Academies of Science, Engineering, and Medicine, the American Enterprise Institute, and The Brookings Institution.[128]

Even if the claims presented in the Bloomberg article regarding inadequate training for nurses are accurate—such as some Registered Nurses (RNs) potentially completing their education through entirely online programs— the appropriate response should focus on enhancing the standards of training and accreditation, rather than abandoning or undermining the broader framework of nursing education. Addressing deficiencies in educational quality through rigorous oversight, curriculum improvements, and accreditation reforms can ensure that nursing professionals are well-prepared to meet the demands of their roles, thus safeguarding patient care and public health without discarding valuable aspects of the existing system.

Two studies indicate that APRNs are not sued at higher rates than primary care physicians, powerful evidence that APRNs offer comparable levels of care quality. For instance, one analysis examined malpractice claims against NPs and found that the types of allegations—such as those related to diagnosis and medication—were similar to those faced by primary care physicians. This study concluded that both NPs and physicians encounter comparable challenges that may lead to adverse events, implying that NPs provide a standard of care on par with their physician counterparts.[129] Additionally, a report by the American Academy of Physician Assistants analyzed malpractice trends and found that physician assistants (PAs) and NPs had proportionally fewer reported malpractice payments and adverse actions per

provider than physicians, further supporting the assertion that APRNs maintain a high standard of care.[130]

SB 1700 (Blanco, 88R) adopted a forward-thinking approach to improving healthcare access and workforce efficiency by allowing APRNs to practice independently. By addressing the utilization and scope of APRNs, the bill aligned with evidence suggesting that APRNs provide high-quality care comparable to primary care physicians, as demonstrated by malpractice trends and patient outcomes. Legislation like SB 1700 is crucial for enabling APRNs to practice at the top of their licenses, thereby enhancing healthcare delivery in underserved areas and reducing barriers to care for countless Texans. Although that bill did not proceed far in the legislative process, the bill author (joined by several co-authors) has filed a similar bill in Senate Bill 911 (89R, Blanco, et al.).

While concerns regarding patient safety and patient outcomes should be taken seriously by the legislature and should outweigh considerations such as cost of providing care, the balance of research does not indicate poorer patient care when delivered by APRNs as compared to physicians, the *Bloomberg* article to the contrary notwithstanding.

Expanded Pharmacist Authority

♦ *Pharmacy Vaccinations*

While pharmacists used to be associated strictly with filling prescriptions, over the years that role has evolved to include greater patient interaction and a larger responsibility as part of the patient care team. The most recent National Pharmacist Workforce Survey, released in 2019, found that approximately 90 percent of community pharmacists now administer vaccines (up from 15 percent in 2004); more than 80 percent assist in drug level monitoring and therapeutic drug interchange; 73 percent order laboratory tests; almost 70 percent provide medication therapy management services; and a majority also play a key part in dispensing and counseling on drugs to reverse the effects of opioid overdose.[131]

The delivery of immunizations is a key example of how pharmacists have increased access to a healthcare service with a proven benefit, not only to the individuals receiving the immunization, but to the wellbeing of the general population at large. However, pharmacists are uniquely placed to be better utilized to provide even more in-depth services. An article in *North Carolina Medical Journal* entitled "The Role of the Pharmacist in Health Care: Expanding and Evolving" explains:

> In addition to the expanding role of the pharmacist in the delivery of health care in a variety of practice settings, the community pharmacist has more opportunities to make a significant impact on the populations they serve. As the needs of society have changed in relation to the provision of health care, the pharmacist is positioned as one of the most accessible health professionals and his/her role has evolved to provide a variety of services for the health of both individuals and the community.[132]

A *Journal of Family Practice* article reports that greater collaboration between physicians and pharmacists has proven successful in better management of chronic diseases such as hypertension and diabetes, and suggests that similar benefits would likely extend to collaboration on other health conditions.[133] An additional study supported these findings, reporting that, "[c]ollaborative care between pharmacists and physicians has been recognized to improve pharmacotherapeutic outcomes and provide increased value and efficiency to the health care system," and has found applications for better disease management across an array of chronic conditions.[134]

Policy Recommendation 7

Expand pharmacists' ability to administer certain immunizations

House Bill 1105 (Price | Kolkhorst 88R) would have expanded immunizations and vaccine authority, though the bill died in conference committee during session. Current law directs the Board of Pharmacy to specify conditions under which a pharmacist may administer medication, including an immunization or vaccination, but stipulates that the conditions must ensure, among other things, that a licensed health provider authorized to administer the medication is not reasonably available; that failure to

administer the medication might result in significant delay or interruption of a critical phase of drug therapy; and that the pharmacist administers the immunization or vaccine under a physician's written protocol.[135]

This bill would have eased those restrictions, while still ensuring a pharmacist has received the necessary education and training to administer immunizations and vaccines and notifies a patient's primary care physician of any care provided. Lessening these restrictions could increase access to vaccines and immunizations, as pharmacies are more readily accessible in some parts of the state than other types of healthcare providers.

While lawmakers should continue to explore opportunities to maximize the role of pharmacists in the delivery of care where appropriate for patients, the policies in HB 1105 provide good starting points to better leverage pharmacists in the care continuum and should be adopted in the upcoming session.

- ***Test & Treat***

Accessing primary care in Texas is increasingly challenging due to a significant shortage of healthcare professionals, particularly in rural areas. As discussed above, Texas is projected to face a shortfall of over 10,330 physicians by 2032, with over 80 percent of Texas counties already designated as Health Professional Shortage Areas for primary care. This shortage leads to prolonged wait times, especially in rural communities, exacerbating barriers to care for time-sensitive conditions like influenza, strep throat, and COVID-19. The need for innovative solutions to improve affordable and timely access to care is urgent.

Pharmacists have emerged as critical healthcare providers, expanding their roles to include vaccine administration and diagnostic testing, particularly during the COVID-19 pandemic. Under the federal Public Readiness and Emergency Preparedness (PREP) Act, pharmacists provided essential services such as administering vaccines and conducting diagnostic tests. [136] This temporary authorization showcased the potential of pharmacists to fill gaps in care, particularly in underserved areas. Under the PREP Act, Texans could effectively access time-sensitive care for certain conditions. Pharmacists are often open for longer hours than primary care physicians' offices. Nearly half of all Americans— over 48 percent— live within one mile of a pharmacy. Moreover, 73 percent live within two miles of a pharmacy, 88.9 percent live within 5 miles, and 96 percent live within ten miles of a pharmacy.[137]

Some states have already embraced the "test and treat" model that allows pharmacists to administer Clinical Laboratory Improvement Amendments (CLIA)-waived tests, such as a rapid flu or strep throat test, and then administer the treatment for the condition without the need for a physician visit. Pharmacists in Texas may already perform rapid flu and strep tests under a physician delegation but are not currently allowed to prescribe and dispense applicable medications.[138]

States that have implemented test and treat programs has done so with varying degrees of autonomy that range from more tightly controlled collaborative practice agreements with physicians to broad authority for the pharmacy to treat and dispense medications.[139] Idaho and Florida appear to utilize more of a statewide protocol approach, while most other states that have such a policy (ID,IL, KY,MI, MN, MT, NE, NM, SD, TN, UT, VT, WA, WI) favor a collaborative practice model that allow physicians to delegate prescribing treatments pursuant to certain rapid diagnostic tests.[140]

The benefits of Test and Treat programs are clear. They reduce delays in care, improve health outcomes, and mitigate complications from untreated conditions. For example, untreated strep throat can lead to rheumatic fever, while delayed flu treatment may result in hospitalization. These programs also reduce reliance on costly emergency departments and urgent care centers, optimizing healthcare spending. By managing low-acuity cases in community settings, pharmacists improve accessibility and reduce financial strain on patients and the system. Finally, a point that deserves special emphasis is that test and treat has already been validated during the pandemic, during which the PREP Act expanded the services that pharmacists can perform.

Policy Recommendation 8

Allow pharmacists to "test and treat" certain illnesses

Lawmakers should adopt language similar to that of HB 2079 (Jetton) filed in the 88th Session, which would have expanded the ability of pharmacists to "test and treat" for the flu, strep, and COVID-19. The bill would still require written physician orders and delegation but would allow patients to receive confirmation and treatment of an illness without the need to schedule a physician visit and make a separate trip to the pharmacy for medication.

Such legislation could open access to care points in the state where a pharmacy may be more easily accessed than the nearest physician's office or hospital. And, depending upon the cost for administering the test compared to a doctor's visit, there could be cost savings for consumers and health insurers, both for the direct treatment and for the possible avoidance of expensive emergency care that might be required if certain conditions are left untreated.

More Physicians

The Legislature could also consider legislation similar to House Bill 2556 (Oliverson, 88R),[141] which would have created a new classification of medical practitioner: physician graduate. This would enable medical school graduates who did not match with a residency program to practice primary care medicine and would enter into a supervising practice agreement with a physician. According to a 2022 article, 6.7 percent of medical school graduates [142] would potentially qualify to practice medicine under this designation who would not be able to otherwise practice.

HB 2556 did not pass in the 88th Legislature. Given the state's shortage of primary care physicians and mental health professionals, the Legislature could consider introducing legislation modeled on HB 2556 to create additional pathways for mental health professionals to complete supervised clinical hours prior to licensing. The Legislature should consider ways to utilize an increased number of physician assistants, advanced practice registered nurses, and potentially new classifications of practitioners, such as a Physician Graduate, in order to mitigate the shortage of physicians.

Policy Recommendation 9

Expand the health workforce by utilizing alternative healthcare providers

Given the state's shortage of primary care physicians, the Legislature could consider legislation similar to HB 2556. The Legislature should consider ways to utilize an increased number of physician assistants, advanced practice registered nurses, and potentially new classifications of practitioners, such as a Physician Graduate, in order to mitigate the shortage of physicians.

Telehealth

Providing mental health services via telehealth is another way Texas can improve access to health care while potentially lowering the cost of care, and these services should be factored into network adequacy standards. While network adequacy standards— a structural mandate— are intended to ensure Texans do not have to travel too far to see a provider, these standards do not factor in the ability for patients to see a provider via telehealth. In the case of mental health, this is an unnecessary mandate, as the quality of care for mental and behavioral health services received via telehealth can result in equivalent or even better outcomes than in-person visits. A 2022 study assessed patient and clinician satisfaction with virtual behavioral health care during COVID-19 and compared outcomes to in-person treatment. Findings showed high patient and clinician satisfaction, increased preference for virtual formats over time, and higher completion, attendance, and treatment rates in virtual settings. These results suggest that telehealth behavioral health care can be as effective as, or better than, in-person care, highlighting its potential as a preferred long-term option.[143]

However, legislators should reject payment parity in telehealth, a mandate requiring health insurers to reimburse providers the same amount for services rendered in-person and online. In short, payment parity mandates negate a primary purpose of telehealth services: the cost savings generated by more efficient delivery.

Policy Recommendation 10

Allow telehealth services to be considered in terms of determining network adequacy in the context of mental health services, and reject payment parity in the context of telehealth

Given the efficacy of mental health and behavioral health services via telehealth, as compared to in-office visits, mental health services received via telehealth should be factored into equations determining network adequacy. The availability of these telehealth services should be considered regardless of the time and distance between the patient and the provider. This change would result in cost savings for mental health and behavioral health services. To ensure this change actually results in a cost savings, the Legislature should also reject any payment parity measures in the context of telehealth.

Tele-dentistry

Just like telemedicine enables physicians and other providers to provide medical care for patients in all geographical areas of the state, teledentistry provides similar opportunities for Texans in need of oral health care. A report by the Texas Health Institute found that, while some (mostly urban) areas of Texas enjoy good access to oral healthcare, rural and border regions have the highest concentration of oral health concerns.[144] The Abilene region, for instance, has four times more adults with "poor dental health" than Texas' highest ranking urban areas; the Abilene and Wichita Falls areas both contain some of the state's highest rates of oral cancer; and many rural and border regions experience "profound provider shortages."[145] This comports with data cited in the report, which ranks Texas 44th in rural access to dental care out of 47 states with rural counties.[146] And even though Texas has added more dentists to its healthcare workforce than any other state over the last several years, over 90 percent of practicing dentists are located in urban areas, leaving millions of Texas primarily residing in designated "dental health professional shortage areas."[147]

In addition to making more dentists available directly to patients, teledentistry could also increase the effectiveness of care provided by dental hygienists. Under current law, a dental hygienist with at least two years of experience may provide up to six months of services to a patient in the certain aforementioned settings (school-based health centers, nursing facilities, and community health centers) with the express written authorization of a supervising dentist.[148] At the six-month mark, the supervising dentist must then examine the patient before the hygienist may provide any additional services.[149]

Teledentistry could permit these patients to be examined by the dentist remotely, removing the need for these patients to travel and possibly interrupt their care. This technology could also increase opportunities for hygienists to remotely consult with supervising dentists on more complex cases and refer patients to a dentist more quickly when appropriate. Expanding the practice of teledentistry, in conjunction with hygienists administering local anesthesia, has the potential to bring regular and preventive oral healthcare to those areas of the state where dental-related healthcare problems are most severe.

In the 2021-2022 Healthcare and Human Services Task Force Report, TCCRI recommended the legislature allow dental hygienists to administer local anesthesia. The recommendation was carried out by HB 3824 (Klick; 88R), which was signed into law and became effective in September 2023. While the new statute is still in the process of being implemented, this is a successful step Texas has taken towards expanding access to care in this area and supports the increased access to teledentistry that remains a recommendation in this Report.

Policy Recommendation 11

Explore increased access to tele-dentistry

Like traditional medical telehealth, teledentistry offers the opportunity for Texans across the state to access dental care that might not otherwise be available or delayed until an acute, and potentially dangerous and expensive, complication occurs. Lawmakers should encourage the use of this modality, ensuring that statute permits a dentist to supervise a hygienist in a telehealth setting (not exclusively in a physical dental office), and provides a framework for dentists and

hygienists to establish a collaborative practice agreement for teledentistry services.

Furthering Competition

Increasing Transparency

A key factor in the dysfunction in the American health care system is the lack of price transparency. In contrast to consumers in other markets, consumers in the health care industry (which encompasses employers and individuals) cannot easily identify precisely what goods are being offered at what price. Without this transparency, the businesses offering the best value are not necessarily rewarded with consumers' dollars in the way they would be in other industries. It is not possible to have a well-functioning market when prices of goods and services are not known to consumers.

The federal government and Texas government are slowly making progress on this front. Since January 1, 2021, a federal rule has required hospitals to publicly list their charges for various procedures. While hospitals' compliance with this rule nationwide has been an issue, Senate Bill 1137 (87R; Kolkhorst) codified the federal rule into state law, with significant fines for noncompliance.

While transparency is lacking, there are a number of steps the state can take that will encourage competition and reward parties that seek out or provide high value healthcare.

♦ *APCD Funding*

House Bill 2090 (Burrows, et al.; 87R) created the Texas All Payor Claims Database (APCD). This program is part of a growing trend nationwide; as of January 1, 2023, 23 states had either a mandatory or voluntary APCD, with eight other states developing a mandatory database.[150]

With health, pharmacy, and dental claims information submitted by many insurers[1] and the state's Medicaid program, Texas' APCD will eventually store a wealth of data that researchers can analyze. Once functional, the Texas APCD will allow for the study of utilization, spending, prices, and enrollment across payors. The implications of the APCD are far-reaching. To cite just one example of its potential uses, the APCD can be used to develop benchmark prices for a given health service. Another example: as RAND has noted, "Price transparency information derived from APCDs may help purchasers, insurers, and third-party administrators to negotiate lower prices or to implement programs that steer patients towards lower-priced providers." Still another use would be to better evaluate the cost of proposed mandates, as discussed earlier in this report.

The APCD is maintained by the Center for Healthcare Data at The University of Texas Health Science Center at Houston ("the Center"). In its legislative appropriations request (LAR) for the 2026-2027 biennium, the Center requested a relatively modest $9 million,[151] but the Center has not been funded to date.

It is important to realize the scope of the APCD and the challenges it faces. When functional, it will receive monthly claims information that cover perhaps 60 percent of Texans. A database of that scope cannot be constructed to work perfectly in a matter of months. The Legislature should fund the APCD with the understanding that, while its potential to bring about greater transparency and efficiency in health care is tremendous, it will take at least several years for the system to realize its promise.

Policy Recommendation 12

Fund the APCD in accordance with the relevant Legislative Appropriations Request

The Texas APCD will allow for the study of utilization, spending, prices, and enrollment across payors. It can be used to develop benchmark prices for a given health service; may help purchasers, insurers, and third-party administrators to negotiate lower prices or to implement programs that steer patients towards lower-priced providers; and allows policymakers to better

[1] Self-funded plans are exempt from requirements to report to APCDs.

evaluate the cost of proposed mandates. This policy recommendation alone, if implemented, would greatly increase transparency in healthcare costs.

♦ *Facility Fees*

The increasingly widespread practice of imposing facility fees has gained the attention of healthcare policy experts over the last several years, with many experts calling for reforms of the practice or an outright ban on it. Over the period from 2004 to 2021, facility fees grew at a rate (531 percent) that was 4 times the rate of growth in professional fees (132 percent) for emergency department evaluation and management services.[152]

Hospitals have charged facility fees for many years.[153] The purpose of these fees was to help defray the overhead costs associated with a hospital that could offer services 24 hours a day (e.g., emergency services), even when its volume of patents could fluctuate considerably from day to day.[154] But the fees have attracted scrutiny in recent years because they are increasingly charged for patients visiting hospital outpatient [2] departments (HOPDs); as the name suggests, HOPDs are facilities owned by hospitals that provide outpatient treatment. They have become increasingly common in the medical world as hospitals consolidate in many local markets and purchase physician practices.[155]

Today, when patients visit a HOPD to receive medical care, they (or the responsible payor, such as an insurance company) are of course charged for the services they receive. In addition to being billed for services, they may also be billed a facility fee. This facility fee is often not covered by the patient's health insurance; for example, the patient may not have reached his or her deductible for the year. In such cases, the patient is responsible for payment of the portion of the fee (if any) that is not covered by health insurance.

Bills for facility fees could come as a shock to patients, particularly if they went to a physician-owned practice for years without ever being billed a facility fee, and then that practice was purchased by a hospital that opted to charge patients a facility fee for a visit. The frustration felt by patients is compounded by a lack of understanding in how the fee was calculated; facility fees for the same service can vary wildly from one location to the next. As an article in the journal *Health Affairs* noted, "these [facility] fees often appear unrelated to the level of care received."[156] Furthermore, facility fees are especially frustrating to patients who need consistent periodic treatment (e.g., chemotherapy), because they can be assessed a substantial facility fee for every visit.[157]

In some cases, the facility fee is more than the charge for medical services rendered.[158] For example, one Ohio man recounts being charged $348 to see an ear, nose, and throat specialist in 2023, along with a facility fee of $645.[159] In rare cases, these fees can reach thousands of dollars.[160] Due to a lack of quality data, it is unclear what the median or average facility fee is, but anecdotes of fees being several hundred dollars are common.

According to a March 2024 article in *The Wall Street Journal*, "Medicare advisers said last year the federal insurer likely overpaid for a sample of services by about $6 billion because of the [facility] fees in 2021."[161] Facility fees have become an issue of concern for legislators at both the federal and state levels. That same article cited a health insurance industry source for the claim that, in Ohio and Maine, facility fees are added to approximately 80 percent of the bills sent to each state's largest insurer for heart-disease screening.

Hospitals argue that facility fees being charged at HOPDs still serve the purpose of paying for some of the overhead costs incurred by the hospitals. The Texas Hospital Association (THA) states that, without facility fees:

- 85 percent of Texas hospitals would reduce staff;
- 80 percent of Texas hospitals would reduce services; and
- 69 percent of Texas hospitals would close outpatient clinics.[162]

[2] "Outpatient" generally refers to the class of patients that does not require an overnight stay in a hospital.

THA further argues that the amount of a facility fee is not fixed, but rather varies depending on "the intensity of the care the patient receives."[163]

As a general matter, it should be uncontroversial for a business to set the price for the services it renders. The basic right of a business to do that, and for consumers to walk away if they find the price objectionable, are fundamental to a free market. It is fair to ask, then, why hospitals charging facility fees for services provided at HOPDs is concerning from a policy perspective. The answer is that facility fees for services at HOPDs raise at least three concerns:

1. As noted above, they often come as a surprise to a patient, particularly those who had a history of visiting the facility for medical care before a hospital acquired it;

2. Some area may have a dominant hospital system, or a highly concentrated hospital market.[164] In such cases, a facility fee can be charged simply as an exercise of monopoly power, rather than a reflection of value added; and

3. In some cases, Medicare pays a higher rate for a service provided in a hospital setting than in another setting, such as a physician's office.[cxx] This not only disadvantages non-hospital practices against HOPDs,[3] but also feeds into the second concern, in that it provides an incentive for a hospital to acquire a physician practice and convert it to an HOPD. By doing so, the revenue generated by the facility (now an HOPD) can increase even if the type and volume of services rendered are unchanged.

About 15 states currently have laws regarding facility fees,[165] although in some states the law applies only in a narrow context. For example, Texas law requires freestanding emergency medical care facilities (FEMCFs) to provide disclosures of facility fees pre-treatment,[166] and bans such facilities from assessing facility fees for drive-thru services.[167] Policymakers have several options when it comes to additional legislation on facility fees, ranging from disclosure to billing transparency to bans.

State regulations on facility fees exhibit considerable variation, reflecting diverse legislative approaches to healthcare cost management and transparency. Some states have enacted prohibitions on facility fees for specific services. For instance, Connecticut has implemented strict regulations that prohibit off-campus hospital-owned facilities from charging facility fees for routine outpatient services, such as consultations and telehealth visits. Similarly, Maine requires healthcare providers to disclose facility fees upfront and post notices on their websites and at physical locations, clearly indicating whether a facility is hospital-owned and whether it charges facility fees.[168] Indiana enacted a law in 2023 prohibiting the charging of facility fees for outpatient services provided in off-campus locations, unless the services are provided in a hospital-based facility that is within 250 yards of the hospital's main campus. This measure aims to prevent unexpected facility fees for patients receiving care in outpatient settings.[169] In 2024, Maryland passed legislation requiring hospitals to provide patients with advance notice of facility fees, including an estimate of the cost. The law also mandates annual public reporting of the total facility fees collected, enhancing transparency and enabling consumers to make informed decisions.[170]

The most basic reform would be to require disclosure of any facility fee to patients prior to them receiving service, not just in the FEMCF context. Moreover, patients who have a history visiting a facility that subsequently becomes an HOPD should be notified that, due to the change in ownership, they may now be responsible for payment of facility fees that were not charged by the previous ownership. These patients are in particular need of disclosure because they understandably may not pay much attention to any general closure statement, given their history in visiting the facility without incurring any payment responsibility for a facility fee.

Some commentators have expressed the belief that pre-treatment disclosure of facility fees would not necessarily deter many patients from proceeding with treatment, given that many patients prefer to deal with their existing provider and seek care to where their providers refer them.[171] Even granting this point, disclosure requirements would still provide a valuable benefit by greatly reducing the number of patients who are shocked to receive a bill for a facility fee.

Policy Recommendation 13

Require disclosure of facility fees of HOPDs

Require HOPDs that charge facility fees to disclose that to patients, and that the patient may be responsible for payment of all or a portion of such fee. Patients who visited an HOPD before it became an HOPD should receive additional notice, perhaps through mail.

Surprisingly, payors processing claims are not always certain where a given service was performed. As one source states: "Unfortunately, existing claims data often conceal the specific location where care was provided and the extent to which hospitals and health systems own and control different health care practices across a state. This makes it challenging for payers, policymakers, and researchers to effectively monitor and respond to outpatient facility fee charges." [172] Colorado has attempted to solve this problem by requiring every off-campus location of a hospital to acquire a unique National Provider Identifier (NPI), a 10-digit number issued to providers by the federal government. The Georgetown University Center on health Insurance Reforms states that, "When Colorado lawmakers debated the unique NPI requirement during the state's 2018 legislative session providers criticized the proposal as overly burdensome, but interviews suggest this concern was not borne out through implementation."[173] However, the Center also notes that, "One challenge Colorado has faced, however, is tracking the affiliations between different locations, all now represented by unique NPIs. A recently enacted law requires Colorado hospitals to report annually on their affiliations and acquisitions, which may help address this gap."[174]

Policy Recommendation 14

Consider requiring any facility for which a facility fee is charged to use a unique NPI

There is currently a dearth of data on facility fees in most states, including Texas. If policymakers wish to stop short of banning facility fees, but also wish to monitor the issue, billing transparency reforms like Colorado's may be useful. Stakeholder input on the possible challenges in implementing this policy recommendations could be particularly useful.

As discussed above, Connecticut has banned facility fees for certain services, and a few other states have limited them in narrower contexts (e.g., for telehealth services).[175] A ban on a business charging a price for a service- irrespective of the how weak the link is between the fee and the value of the service- is significant government intervention in a marketplace. Given the concerns about facilities discussed above, however, policymakers may wish to consider prohibiting the imposition of a facility fee for services that do not require the infrastructure of a hospital and can be performed just as well in a physician's office, such as basic preventative services. Similarly, a ban on facility fees for telehealth services makes some sense, as those services do not typically require even a physician's office.

Policy Recommendation 15

Regulate or ban telehealth facility fees

The Legislature can consider a ban on facility fees that are charged in connection with the provision of telehealth services and consider banning them for patient visits for preventative services. However, hospitals do incur significant regulatory costs; thus, the Legislature should be cautious about banning facility fees completely. Increased transparency would improve understanding of how these fees are being applied and generate data for future consideration of the role of these fees, if the Legislature later determines other changes are needed.

Aligning Economic Incentives

The purpose of competition and transparency in a marketplace is to allow consumers to choose the best value offered. Unfortunately, the current health care market in Texas contains some obstacles that interfere with the incentives that participants would naturally pursue in other markets. These obstacles are illustrated by two recent reforms that were considered by the Legislature but not enacted into law: HB 2414 (Frank; 88R) and HB 1073 (Hull; 88R).

HB 2414 would have allowed health insurers to provide incentives to enrollees to see certain physicians

or providers by offering modified deductibles, copayments, coinsurance, or other cost sharing provisions— essentially, allowing motivated consumers to shop for the best value. To guard against the possibility of insurers simply encouraging enrollees to visit the lowest-cost provider irrespective of quality or value, the bill provided that an insurer making use of these modified cost-sharing incentives has a fiduciary duty to the enrollee (or group contract holder) to act for the primary benefit of the enrollee (or group contract holder). A fiduciary duty is a high standard, and failure to comply with it exposes the party with the duty to legal liability.

HB 2414 would be a transformative bill. A key problem with the American health care system is that a large portion of the total dollars that are spent on a patient's health care do not come directly from the patient's pocket, but rather from the premiums paid by other enrollees in the applicable health plan. When patients spend their own money, they are much more likely to be judicious and to make the tradeoffs they make with every other shopping decision. If consumers have "skin in the game" the same way they do when they shop for groceries, cars, computers, and clothes (to name just a few products), market participants would have to compete more intensely for their dollars.

HB 1073 would have allowed health insurers to enter into contracts in which the economic incentives of providers are best aligned with those of patients. While the bill deals with different matters, it has a conceptual similarity to HB 2414 in emphasizing the proper alignment of incentives in the health care market. HB 1073 would have allowed (but not required) a preferred provider benefit plan or an exclusive provider benefit plan to contract for primary care using risk-sharing arrangements such as capitation agreements, a type of value-based payment arrangement. As one source has explained, "Value-based payment models ... are health care payment systems that reward medical providers for overall efficiency and patient outcomes, rather than paying them for each service they perform."[176]

Policy Recommendation 16

Provide additional opportunities for health insurers to enter into certain agreements

Legislation modeled on HB 2414 would allow health insurers to offer incentives to enrollees to choose providers that offer the best value. Similarly, legislation based on HB 1073 would permit health insurers to enter into risk- and value-based contracts with providers, such as capitation agreements.

- ***Vision Plans***

The issue of properly structuring incentives is also apparent in the field of managed vision care, an industry with a relatively high degree of concentration. EyeMed, for example, claims to have 72 million members.[177] According to the Centers for Disease Control and Prevention (CDC), VSP Vision Care reports that it covers one in four Americans.[178]

Senate Bill 684 (Taylor, 84R) generally prohibited MCPs from directly or indirectly controlling or attempting to control the professional judgement, manner of practice, or practice of an optometrist. More recently, the Legislature enacted House Bill 1696 (88R, Buckley). The bill author' statement of intent stated:

> Certain managed care plan issuers, including vision care plan issuers, compete directly with their own in-network providers in a variety of ways. Specifically, vision plan companies own brick-and-mortar optometry practices, e-commerce retail internet sites, eyeglass production laboratories, glasses frame brands, electronic medical records companies, and claim filing service companies. These companies may differentiate between in-network providers by attempting to steer patients to doctors at locations where their owned-products are being sold, and financially control doctors by incentivizing or disincentivizing plan benefits and reimbursements to prefer the products and services they own.[179]

The codified bill seeks to limit the influence MCPs have over participating optometrists and therapeutic optometrists (collectively referred to herein as "optometrists"). Its provisions do not apply to

ophthalmologists. It requires MCPs to (1) provide immediate electronic access to optometrists regarding plan coverage information; (2) publish complete plan information, with both in-network and out-of-network details; (3) allow optometrists to use any qualified third-party billing service; and (4) allow optometrists to receive reimbursement through an electronic funds transfer. It also prohibits the following:

- Using a contractual fee schedule that reimburses an optometrist differently from another on the basis of certain factors, such as the brand, supplier, or manufacturer of a product used by the optometrist;

- Incentivizing a plan enrollee to obtain covered or uncovered products or services at any particular participating optometrist, or at a retail establishment or any Internet or virtual provider affiliated with the MCP instead of a different participating optometrist;

- Identifying a participating provider over another based on factors such as discounts for non-covered goods or services, or the brand, source, manufacturer, or supplier of a medical or vision care product or service to the optometrist;

- Using a reimbursement fee schedule for a covered product or service that is different from the fee schedule applicable to another optometrist because of the practitioner's choice of (among other things) equipment, doctor alliance, optical laboratory, third-party billing service; or supplier of lenses, frames, or contacts;

- Encouraging an enrollee to obtain covered or uncovered goods or services at one participating optometrist over another participating optometrist, or at a retail establishment or internet retailer that is owned by or otherwise affiliated with the MCP over another such participating retailer; or

- Requiring the practitioner to provide a covered product or service at a loss.

The bill contained some reasonable provisions, such as requiring MCPs to reimburse optometrists in a manner that avoids unnecessary processing fees. However, in a state where managed care is embraced as a way to allow insurers to assume risk, the state should be cautious when it comes to inserting itself between MCPs, providers, and enrollees. As a general principle, MCPs should be able to inform their enrollees of practices and cost measures employed by any provider willing to provide the best value to the plan and therefore the enrollee.

Indeed, while vertical integration in any industry inherently carries the potential to inhibit patient choice and limit competition, it can also allow for economies of scale and efficiencies that translate into lower prices and better service for consumers. A key question in the wake of HB 1696 is: what if an MCP-affiliated provider or retailer really is offering the best value to enrollees? The fifth bullet point above (from the top) is quite broad, to the point that it would prohibit an MCP encouraging its enrollees to see an affiliated provider or retailer even when that is the case. It is important to ensure that companies offering the best value to consumers are rewarded; this provides companies with the proper incentive to constantly seek improvement in their offered goods and services. It also can encourage consumers to take more initiative in seeking out high-value providers.

How to best accomplish these goals can be challenging, particularly in an industry with considerable concentration. One approach the Legislature could consider is borrowing a concept similar to one in an unrelated bill, House Bill 711 (Frank, 88R). That bill, which passed into law, required in relevant part that, if health plans encourage enrollees to use certain providers, or divide their participating providers into tiers, they must do so for the primary benefit of the enrollee. HB 711 was an important reform that will enable plans to offer incentives to consumers to choose high-value care. This in turn will enable consumers to have more direction over how their health care dollars are spent, incenting providers to compete for their business.

Applying HB 711 to MCPs would require an MCP that encourages enrollees to obtain goods or services from the MCP's affiliates over other, unaffiliated in-network providers to do so in the interest of the enrollee. This approach might offer the "best of both worlds." It would leave in place the guardrails in HB 1696, but allow MCPs to encourage enrollees to see

affiliates that are offering the best value to consumers. The ultimate beneficiaries of such an approach would be consumers and high-value providers.

Policy Recommendation 17

Consider amending the codified provisions of HB 1696 to permit an MCP to encourage enrollees to visit a provider or retailer affiliated with the MCP, provided that, in doing so, the MCP acts for the primary benefit of the enrollee.

Policy Recommendation 18

Modify the codified provisions of HB 1696 to permit an MCP to encourage enrollees to visit a provider or retailer affiliated with the MCP, provided that, in doing so, the MCP must act with a fiduciary duty to the enrollee

- ***State Employee Healthcare Affordability***

One model that some payors have embraced to encourage consumers to engage in comparison shopping are "shared savings" programs. Research has shown that simply providing consumers with pricing tools does not necessarily result in behavior modification.[180] Those models that have achieved change in consumer behavior have included either rewards or disincentives paired with the ability to comparison shop.

The concept of shared savings models is relatively simple: A provider prescribes a medical service, such as an x-ray or MRI. The patient then calls a toll-free line or goes to a website operated by the insurer or employer to research options and prices and chooses the best location at the best value. After receiving the MRI at the location of his or her choice, the patient then receives some type of benefit (this may be a cash benefit in some models but could also be reduced out-of-pocket costs or other types of incentives) based upon the shared savings for choosing the best value care. These programs' successes hinge on the ability of consumers to access quick, accurate, and transparent cost comparisons, and to be rewarded in some way for smartly "shopping."

It should be noted that, in the private market, these models could be considered profit sharing. Lawmakers should ensure that no existing laws or regulations impede an employer or insurer's ability to implement this type of program if they choose, but should not mandate such arrangements in the private sector. These types of incentive plans can, and should, grow organically in the free market. This idea should, however, be explored *within* state government, where services are funded by taxpayer dollars.

Riders in the 2022-23 General Appropriations Act direct the Employees Retirement System (ERS) and the Teacher Retirement System of Texas (TRS) to incentivize enrollees to shop for lower cost care within their respective health plans through a "Right to Shop" program.[181] These riders were also adopted in the 2024-2025 General Appropriations Act (GAA)[182] and introduced in both the House and Senate versions of the 2026-2027 GAA.[183]

Policy Recommendation 19

Continue Consumer Incentive Programs in ERS and TRS, identifying and addressing any impediments

The ERS and TRS Right to Shop budget riders are a vital step in promoting transparency and competition within state-funded healthcare coverage and should certainly be continued. However, lawmakers should consider amending the current rider language to further direct ERS and TRS to identify any barriers to widespread and successful implementation of an enrollee incentive program, addressing any impediments that are within the agencies' purviews and notifying the Legislature of any that require statutory changes. Such initiatives contain real potential not only to educate and empower state employees to take ownership of their healthcare decisions, but also to save finite taxpayer resources.

Legislators should also consider variations on the incentive offered through Right to Shop if they are a better fit for the Texas ERS and TRS models. For instance, if cash rebates are legally or administratively cumbersome for the agencies to administer, the state might look at rebates in the form of premium or out-of-pocket discounts for enrollees who choose best value care.

- ***TRS beneficiaries Can Purchase Private Medicare Plans***

Government entities in some states have begun to turn to private insurance options for growing retiree costs, allowing enrollees to use money that would have gone to more expensive government-funded programs to purchase lower-cost care through private marketplaces.[184] The city of Memphis began exploring this idea in 2016 and by 2019 had dropped its obligation for retired employee health benefits by $300 million. As one city official explained, "The volatility we would have had by having retirees on our group insurance plan would have been much higher... Now we're able to better predict what our annual payments are."[185]

One of the greatest success stories of such a model is the Ohio Public Employees Retirement System (OPERS). Beginning in 2016, OPERS contracted with a vendor to create its own private Medicare exchange (different from an ACA exchange), also known as a Connector.[186] Under this system, Medicare-eligible retirees and their dependents are provided a monthly subsidy via a health reimbursement account (HRA) to cover premium and other qualified out-of-pocket costs, and are provided with benefit counselors to choose the best Medicare Advantage plan option based on the member's needs. According to a case study conducted by the administrator of Ohio's Medicare Connector, about 143,000 individuals transitioned to the Medicare marketplace and were able to find more personalized plan options at equal or lower cost than the state's original plan.[187] Prior to OPERS' transition to the Medicare Connector, the state's monthly premium cost for these plans was almost $400, compared to an average of less than $200 for a typical Medicare gap and Part D drug coverage plan. Since allowing eligible retirees to use an allocation to purchase more individualized coverage, OPERS has saved about $600 million annually and has reduced the system's postemployment benefits liabilities by $12 billion.[188] OPERS officials have also indicated that their data shows the program to be successful among members.[189] Recently, the OPERS Board of Trustees approved an increase in the HRA base allowance for Medicare retirees. Starting January 2025, the base allowance rose from $350 to $400 per month and is expected to remain at that level through 2030. This adjustment reflects OPERS' commitment to providing robust support for retirees' health care needs.[190]

Lawmakers should direct TRS to study the feasibility of allowing Medicare-eligible retirees and their dependents to use funds allocated to TRS-Care to purchase lower-cost supplemental Medicare coverage on the private market. House Bill 1461 (87R; Parker), which passed the House but failed to become law, would have directed TRS to conduct a study to evaluate the use of health reimbursement accounts in

conjunction with Medicare plans available through the individual marketplace for Medicare-eligible TRS-CARE enrollees.

Notably, each of the last three General Appropriations Acts (GAAs) included a rider relating to TRS (Rider 18), which stated:

> **Medicare Enrollment for Eligible Members of TRS-Care.** Out of funds appropriated above, TRS shall identify members of TRS-Care who are eligible for Social Security Disability or Medicare benefits, and provide information and assistance necessary for eligible members to enroll in the programs to help ensure the solvency of the TRS-Care fund.[191]

By making it a statutory directive rather than a rider, policymakers would ensure that its provisions are incorporated into every future budget, rather than being potentially subject to debate every session. TRS would be able to best fulfill its duties pursuant to these riders if a study similar to that envisioned by HB 1461 were first conducted. The 89th Legislature should enact legislation modeled on HB 1461.

- ***TRS-ActiveCare Sustainability***

The Teacher Retirement System of Texas (TRS) administers TRS-ActiveCare, a statewide health benefit program established in 2002. The program offers various plan options, including the Primary, Primary+, and High Deductible (HD) plans, each designed to cater to different healthcare needs and financial situations. TRS-ActiveCare is financed through a combination of participant premium payments and investment income.[192]

Before its establishment, many small districts struggled to provide affordable health insurance to their employees because their limited number of workers did not generate sufficient risk pools. In small risk pools, even one large claim can create significant financial strain on a program. A larger risk pool helps distribute costs more evenly across a diverse population, balancing high and low health care needs. Smaller districts lacked this advantage, often resulting in significantly higher premiums and reduced access to competitive health insurance plans. The implementation of TRS-ActiveCare sought to centralize and standardize health insurance coverage for public school employees, effectively pooling individuals across all participating districts into a single, larger risk group. This design allowed smaller districts to benefit from economies of scale, which helped stabilize and lower insurance costs. By consolidating resources and leveraging the bargaining power of a larger group, TRS-ActiveCare was able to negotiate better rates with insurance providers and offer more comprehensive plan options to employees.[193]

When the program was first implemented, school districts were divided into tiers based on their size. Thes smallest tier was required to join TRS-ActiveCare, and over the larger districts had the option to join. Once a district joined the program, however, it could not exit.

Over time, rising healthcare costs led some districts to seek alternatives, utilizing the Districts of Innovation (DOI) loophole to offer both ActiveCare and local health plans, creating a competitive dynamic between the two. This arrangement, however, introduced the problem of adverse selection; essentially, meaning individuals make choices based on their individual needs, often to the detriment of the insurance system. Healthy employees tend to select lower-cost, lower-benefit plans, while employees with chronic health conditions or significant medical needs are more likely to choose higher-cost plans with better benefits. This imbalance disrupts the financial equilibrium necessary for health insurance plans, which rely on a mix of low-risk and high-risk participants to remain sustainable. When healthy individuals disproportionately leave a plan, the remaining high-cost participants drive premiums upward, exacerbating affordability issues.[194]

The evolution of TRS-ActiveCare illustrates the risks of adverse selection. ActiveCare 3, once comparable to state employee plans in benefits, became unsustainable as healthier participants migrated to less expensive options, leaving the plan burdened with high-cost enrollees. Premiums rose sharply, participation declined, and the plan was ultimately discontinued. The DOI loophole replicates this dynamic, as districts offering cheaper local plans create a similar split among participants. Adverse selection may lead to higher costs and reduced viability for TRS-ActiveCare, threatening its ability to fulfill its original mission. SB 1444 (Taylor | Bonnen, 87R) ultimately

prohibited districts from offering competing plans, though it did allow districts to withdraw from TRS-ActiveCare and offer an alternative plan.[195] If a district so withdraws, it is "locked out' and cannot rejoin TRS-ActiveCare for five years, and if it does eventually rejoin, it similarly cannot exit for five years.

A critical challenge confronting TRS-ActiveCare is its affordability and sustainability, especially for employees covering dependents. The state and a school district are required to contribute $75 and $150, respectively, per member per month. These amounts are unchanged from when TRS-ActiveCare was created over two decades ago, despite significant increases in healthcare costs over the past two decades. This stagnation has resulted in employees shouldering a larger portion of their health insurance premiums. For instance, in the 2023-24 plan year, the total monthly premium for TRS-ActiveCare Primary coverage for an employee and their children ranged from $618 to $786, depending on the region. After accounting for the minimum employer contribution, employees were responsible for paying between $393 and $561 monthly, which constitutes a substantial percentage of their salaries.[196]

This financial burden is exacerbated by regional disparities in healthcare costs, leading to significant variations in premiums across different Education Service Center (ESC) regions. TRS-ActiveCare employs a regional rating system, meaning that premiums are adjusted based on the cost of healthcare in each area. Consequently, employees in higher-cost regions face higher premiums, further straining their financial resources. Moreover, the uniformity of the employer contribution does not account for these regional cost differences, resulting in inequities among employees in various districts. While some employers choose to contribute more than the mandated minimum, this practice is not consistent across all districts, leading to disparities in the financial burden borne by employees. This situation undermines the program's objective of providing equitable and accessible healthcare benefits to all public school employees in Texas.[197]

TRS has received substantial state funding to mitigate rising premiums for TRS-ActiveCare participants. For instance, in the 2022-23 plan year, state leadership committed an additional $435 million in federal funds to prevent anticipated premium increases of approximately 9.5 percent statewide. This intervention ensured that no TRS-ActiveCare participants experienced a base premium increase during that period. [198] For the 2024-2025 biennium, the state appropriated $588.5 million in general revenue to prevent ActiveCare annual premium increases from exceeding 10 percent.[199] Crucially, school districts that have opted not to participate in TRS-ActiveCare do not receive any of these infused funds.

While these infusions of funds to TRS-ActiveCare have provided immediate relief to some district employees, concerns have been raised about their long-term implications. By artificially suppressing premiums, such funding may inadvertently discourage competition among insurance providers and obscure the true costs of the program. Health plans that could offer districts a better deal than TRS-ActiveCare on a level playing field may not be able to do so when the latter is receiving large subsidies. Moreover, subsidizing TRS-ActiveCare gives currently non-participating school districts an incentive to join the program, thereby exacerbating its funding challenges and perhaps leading to calls for even greater subsidies.

The allocation of funds primarily for short-term premium suppression has been criticized for not tackling fundamental issues within the program. While the recurring infusion of funds provided temporary relief, it did not address the underlying structural issues within the program. [200] Indeed, TRS requested an additional $450 million from the 2026-2027 GAA.[201]

To avoid a situation in which the state must continue to inject hundreds of millions of dollars into a program to sustain it, the Legislature should instead consider the following actions to address the structural problems of the ActiveCare plans:

- **Increase Contributions:** Adjust state and district contributions to $375 per employee per month, potentially reducing per-member costs by 10 percent and stabilizing finances.
- **Accountability and Reform:**
  - Redirect any infused funds to support long-term structural improvements and reserve-building.

- Negotiate better provider rates to reduce healthcare costs.
- Enhance transparency and financial accountability within the program.

- **Transfer Oversight to the Texas Department of Insurance (TDI)**: Use TDI's expertise to improve governance, align with industry standards, and integrate the program into the broader insurance market.

While the Legislature can adopt any or all of the above options to provide greater stability to the TRS-ActiveCare program, the state should at minimum adopt equitable funding for all districts. Equitable funding will foster competition and support free-market principles within the healthcare system for public education employees. Currently, districts that opt out of TRS-ActiveCare and pursue private insurance alternatives are effectively penalized for doing so. By providing equitable funding to these districts, the state can ensure a level playing field, allowing all districts to choose the best plan for their employees. Increased competition can drive efficiency, improve service quality, and incentivize cost-saving measures, ultimately benefiting both educators and taxpayers. Aligning funding structures with free-market principles would enhance transparency and accountability while reducing reliance on state subsidies for a single program, creating a more dynamic and competitive healthcare market for Texas school employees.

Policy Recommendation 20

Provide equitable funding to districts that opt for private insurance

♦ *Cash-Pay Rebate Savings*

As health-care premiums are expected to increase yet again in 2025, potentially double-digit increases for some plans, Texans may seek alternative options for major planned procedures. There is growing evidence that prices negotiated between hospitals or providers and insurance plans may be higher than cash-pay prices available for uninsured individuals.[202] While this is good news for individuals without insurance, the Legislature should consider a pilot program for state employees to take advantage of these savings.

The Surgery Center of Oklahoma (SCO) provides a prime example of how state employees could capitalize on this program. SCO is an accredited, physician-owned, multispecialty surgical facility in Oklahoma City that advertises its transparent pricing model. Established in 1997, SCO publishes all-inclusive prices for every surgery it offers, including the cost of the surgeon, anesthesiology, use of the facility, and follow-up care fees. This pricing model primarily caters to patients with high-deductible plans, those with no insurance, or patients seeking financial clarity. SCO has only raised its prices once, to adjust for inflation, and maintains some of the nation's lowest infection rates (0.00% in 2021 compared to the 2.6% national average). The facility provides care for multiple specialties, including orthopedics, neurosurgery, and gynecology.[203]

Under this potential pilot program, a state employee could acquire an estimate for the cost to TRS or ERS for a planned, covered surgical procedure. In this example, the pilot program could consider either the lowest possible cost of the procedure or the median cost of the procedure, depending on the inclination of the Legislature. Given the transparency of pricing at facilities like SCO, the patient could determine if paying cash for this procedure would be more cost-effective than having the procedure performed in Texas by an in-network or approved provider. In the event the cash-pay price is lower, TRS or ERS would still cover the cost of the procedure according to the employee's policy, cover travel and lodging expenses necessary for the procedure, and then share the remaining savings with the employee.

While this would be a new program for the state, innovative approaches to healthcare, such as this pilot program, are already being utilized by large companies in the U.S., such as Walmart.[204] Most Walmart team members who have been employed for at least twelve months will qualify for the Centers of Excellence (COE) program through Walmart's insurance program. The COE program allows employees to utilize the best healthcare facilities in the country at no cost to the employee, for most of Walmart's health plans. For major procedures, Walmart will cover the cost of care for an employee to see a specialist, including travel and lodging costs for the employee and

companion.[205] Walmart determined that this policy saved the company over $30,000 on just one employee when a specialist determined the employee did not actually need spinal surgery, but was instead diagnosed with Parkinson's Disease. After receiving treatment, the patient's symptoms subsided and he was able to return to work.[206] Employers such as Lowe's, McKesson, GE, and Boeing are also bypassing insurance plans and contracting directly with health systems around the country.[207] As one of the largest employers in the U.S., Walmart spends billions of dollars each year on healthcare. Innovative initiatives like the COE program are saving the company money while also providing higher quality healthcare for its employees.

Policy Recommendation 21

Establish a pilot program that shares cost-savings with state employees who utilize less expensive cash-pay health care providers

While Texas may not directly contract with healthcare providers to provide certain services for employees, Texas could nevertheless implement a pilot program authorizing employees to seek out less expensive cash-pay options for planned procedures. By splitting the savings with employees, the state would encourage employees to help the state reduce its healthcare spending.

Public Health Sector

The General Appropriations Act (GAA) for the 2024-2025 biennium appropriated $75.4 billion to the Health and Human Services Commission (HHSC) for Medicaid client services, which amounts to 23.5 percent of the $321.2 billion appropriated in total (all figures are All Funds).[208] The state has often increased Medicaid appropriations for a biennium with a supplemental appropriations bill in the second fiscal year of that biennium; for example, Senate Bill 30, the supplemental appropriations bill enacted by the 88th Legislature for the 2022-2023 biennium, appropriated $2.5 billion in state funds and $4.7 billion in federal funds to HHSC for Medicaid client services.[209] Thus, total spending on Medicaid client services in the current biennium will likely exceed $75.4 billion. Moreover, the $75.4 billion figure does not consider the appropriations for administering the Medicaid program.

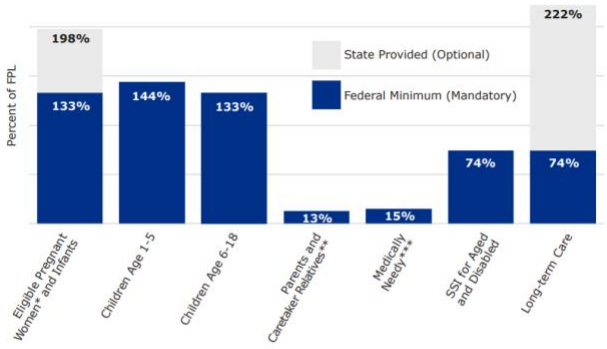
Because Medicaid is an entitlement with open-ended funding, and is largely governed by federal laws and regulations, the state has limited control in curbing Medicaid population growth and costs. In February 2020, immediately before the outbreak of the COVID-19 pandemic in the United States, the Texas Medicaid program served approximately 3.9 million low-income, elderly, and/or individuals with disabilities.[210] Typically, Medicaid enrollment is updated monthly, a process which includes disenrolling people who no longer meet the eligibility requirements for Medicaid. During the federally-declared public health emergency (PHE) attributable to the pandemic, however, federal rules effectively overrode the normal eligibility requirements for Medicaid by restricting disenrollment of people from Medicaid who were enrolled in the program when the pandemic started.[211] [3] This caused the number of enrollees in Texas to swell to almost 6 million at one point during the pandemic.[212] Once the PHE expired in 2023, the federal rules restricting the disenrollment of Medicaid enrollees also terminated, which eventually led to the state's Medicaid rolls dropping to more closely resemble the levels they were at on the eve of the pandemic. As of September 2024, the number of Medicaid enrollees in the state was over 4.1 million.[213]

Based on the most recent edition of the Texas Medicaid and CHIP Reference Guide (the "Pink Book"), published in late 2024, Medicaid provides coverage for 53 percent of all births in Texas, and covers 56 percent of all nursing facility residents.[214]

Even though the Texas Medicaid program is one of the nation's largest,[215] its coverage is largely limited to the mandatory populations for which the federal government requires coverage. Table 1, taken from the Pink Book, shows the population groups covered by selected programs in the state's Medicaid system (FPL refers to the "federal poverty level"), and which are mandatory versus optional.

Figure 5

Texas Medicaid Income Eligibility Levels for Selected Programs as a Percent of the FPL, March 2024:



*Through 12 months postpartum.
**For Parents and Caretaker Relatives, maximum monthly income limit in SFY24 was $230 for a family of three, or about 13 percent of the FPL.
***For Medically Needy pregnant and postpartum women and children, the maximum monthly income limit in SFY24 was $275 for a family of three, or about 15 percent of the FPL.

Source: HHSC[216] (asterisked statements immediately above appear in the source material).

[3] Technically, states could disenroll enrollees in accordance with their normal eligibility rules, but the cost of such action would have been a significant loss of federal funding.

Medicaid Managed Care Overview

The Texas Health and Human Services Commission (HHSC) is tasked with administering the state's managed care (MC) program. Under MC, HHSC contracts with private managed care organizations (MCOs), paying them a capitated fee in exchange for the MCO arranging for providers to deliver medical care to beneficiaries. As of April 2024, approximately 97 percent of the Texans covered by Medicaid or CHIP (Children's Health Insurance Program) were in the MC program, with the remaining 3 percent under a fee-for-service model.[217]

The state's MC program is further divided into the five following MC programs, the first four of which fall under the state's Medicaid system:

- STAR, which covers children and pregnant and post-partum women. This program covers the vast majority of MC enrollees;
- STAR+PLUS, which covers adults with disabilities and qualifying persons 65 and older;
- STAR Kids, which covers children with disabilities;
- STAR Health, which covers foster children; and
- CHIP is different than the others in that it is for children whose families make too much to qualify for Medicaid but still need government assistance. CHIP beneficiaries account for about 5 percent of MC enrollment.

While STAR+PLUS and STAR Kids have small enrollments relative to STAR, their per-enrollee costs are much higher than STAR's due to the disabilities their enrollees usually have.

The state's investment in the MC program is enormous; in FY 2023, it spent $38.7 billion on MC on Medicaid MC alone.[218] [219] The General Appropriations Act (GAA) for the 2024-2025 biennium (HB 1, 88R) appropriated a total of $321 billion in All Funds. Although that bill does not contain a line item for MC spending, it appropriated approximately $75 billion for Medicaid client services and $1.7 billion for CHIP client services (the category of "client services" excludes some spending, such as certain administrative spending). Because the overwhelming majority of Texans receiving services under Medicaid do so through the MC program, it can safely be inferred that MC accounts for a large portion of the spending on Medicaid client services.[4] In addition, the Legislature frequently appropriates additional funds for Medicaid client services in a supplemental appropriations bill in the second year of the biennium. For example, as noted above, the supplemental appropriations bill Senate Bill 30 (88R, 2023) appropriated more than $7.2 billion in All Funds for Medicaid client services for the remainder of the 2022-23 biennium. Such supplemental appropriations must be considered with the GAA in determining total spending on Medicaid in general and MC specifically.

In any case, the key point is that the state makes a huge investment in MC. Given the magnitude of this spending, the state has a compelling interest in ensuring that the MCOs with which it contracts do the best job possible in overseeing the delivery of care to their enrollees.

MCO Contracting

Texas law sets forth guidelines for agencies to follow in the procurement process. "For a purchase of goods and services . . . each state agency, including the comptroller, shall purchase goods and services that provide the best value for the state.[220] Unsurprisingly, statute makes clear that price is generally a component of best value;[221] however, HHSC's MC contract awards are an exception in that price does not factor into the competitive bidding process. Statute lists other factors that an agency can consider, including quality and reliability of the goods and services and indicators of

[4] For FY 2022, the Kaiser Family Foundation estimates that funds for Medicaid MCOs comprised 65 percent of all Medicaid spending in Texas. However, that number likely understates matters because the denominator includes items such as Disproportionate Share Hospital (DSH) payments. Available here.

probable vendor performance, including a vendor's past performance.[222]

It should be noted that there are a number of contracting preferences in statutes which are of questionable value. As TCCRI pointed out over a decade ago, these preferences constitute "a fairly voluminous set of provisions, all of which have a purpose, all of which have a constituency, and almost none of which have any apparent discernible effect on the better operation of state government."[223]

HHSC is given greater discretion that most other agencies in its procurement.[224] Statute provides that HHSC "may consider all relevant factors in determining the best value." The quality and reliability of the vendor's goods and services and indicators or probable vendor performance, such as past performance, are relevant factors (just as they are in other agency procurements).[225] HHSC follows statute and develops best value criteria for their procurements and, tying scoring directly to quality as defined in statute at Texas Government Code 536.052(a) and (b). In its request for bids, HHSC is generally required to specify the factors (other than price, if applicable) that the agency will consider in determining best value.[226]

HHSC awards contracts for the MC programs discussed above on a staggered basis (although STAR and CHIP contracts are awarded jointly), with the term of each contract generally being six years, with the possibility of up to six additional years through extensions.[227]

On March 7, 2024, HHSC issued a notice of intent to award STAR (and CHIP) MCO contracts.[228] When HHSC solicits bids for an MC program, it issues a request for proposals (RFP). Interested MCOs respond with written answers to the technical questions set forth in the RFP. In addition, interested MCOs must complete an oral examination before HHSC regarding how the MCO will serve its Medicaid enrollees if is awarded the contract. MCOs' responses to the RFP are graded by HHSC, and these rankings are used to award contracts, though it is important to note that MCOs do not compete on the cost of the care they provide. The purpose of the questions and presentation is to allow HHSC to determine the MCOs' capabilities for arranging and coordinating health care delivery for its members. The highest possible scores for written answers and the oral examination are 1,800 and 200 points, respectively, making 2,000 points the highest overall score. Each individual question is awarded a grade of 0-5 points, a score which is determined through "consensus scoring," i.e., as a result of multiple HHSC employees' agreement.

As TCCRI discussed in a 2018 paper,[229] a 2015 study prepared by the Milliman Group on behalf of the Texas Association of Health Plans estimated that over the six-year period of state fiscal years 2010-2015, Medicaid managed care resulted in savings of $3.8 billion All Funds (including $2 billion in general revenue) to the state.[230] Moreover, patient satisfaction (or the satisfaction of caregivers for patients who are minors) according to surveys is generally at or above national averages, although some improvement in the CHIP survey responses is needed.[231] HHSC deserves significant credit for overseeing the expansion of MC in the state.

Over the last decade, HHSC has had some missteps in the MC contracting process. After a series of cancelled procurements, HHSC engaged national firms Ernst & Young and Mercer to conduct comprehensive assessments of its managed care procurement process and identify recommendations for improvements.[232] The agency then overhauled its processes and has since conducted two successful procurements that resulted in contracts going live for STAR Health and STAR+PLUS, in 2023 and 2024, respectively, and tentative awards for STAR and CHIP in 2024.[233]. While almost every RFP results in varying numbers of protests, the outcry regarding the most recent RFP was greater given the number of involved plans and number of potential covered Medicaid recipients.

The new STAR and CHIP contracts would result in a change in the health plan of 1.8 million Texans. Some of the plans that lost contracts filed a suit to halt the implementation of the contracts. On October 4, 2024, Travis County District Judge Laurie Eiserloh issued an injunction delaying the implementation of the contracts until November 2024.[234] Judge Eiserloh ruled that the temporary restraining order was necessary as the state's proposed changes would "impose significant harm and confusion on millions of Texas' STAR & CHIP members."[235] HHSC appealed this order but subsequently agreed with other parties to abate the appeal until early July 2025, shortly after the close of the regular legislative session.[236]

Reform Options for Medicaid Contracting

In the current regular legislative session, members will have the opportunity to review and amend existing statutes surrounding HHSC's process for awarding MCO contracts. States have significant flexibility in how they administer MCO procurements, though most states use competitive procurements and expect MCOs to compete not on price, but rather on innovations and program delivery (including integrated care, value-based payments, population health efforts). These procurements are also among the largest state contracts;[237] for example, the STAR and CHIP awards currently on hold in Texas total $116 billion.[238] There are three primary pathways states are using or considering for awarding MCO contracts:

- The "ranking option";
- "Application state" or "file and compete"; and
- The "incumbent option."

States have considerable flexibility in designing their Medicaid managed care programs, although they are subject to many federal rules (e.g., federal law requires there to be at least two MCOs in each service area in the state). The options for Medicaid contract procurement outlined in this report are based on models utilized in other states. However, the three broad categories described above are somewhat loosely delineated as each state implements a unique model. Some states utilize a central procurement office to conduct all procurements, while other states delegate some purchasing authority to the state's Medicaid agency. As one source has wryly noted, "If you have seen one state's Medicaid contracting process, you have seen one state's Medicaid contracting process."[239] For a full breakdown of the current procurement methodologies in each state and their respective laws governing Medicaid contracting, refer to the Georgetown University Center's complete "Legislation for all states with MCOs."[240]

♦ *The Ranking Option*

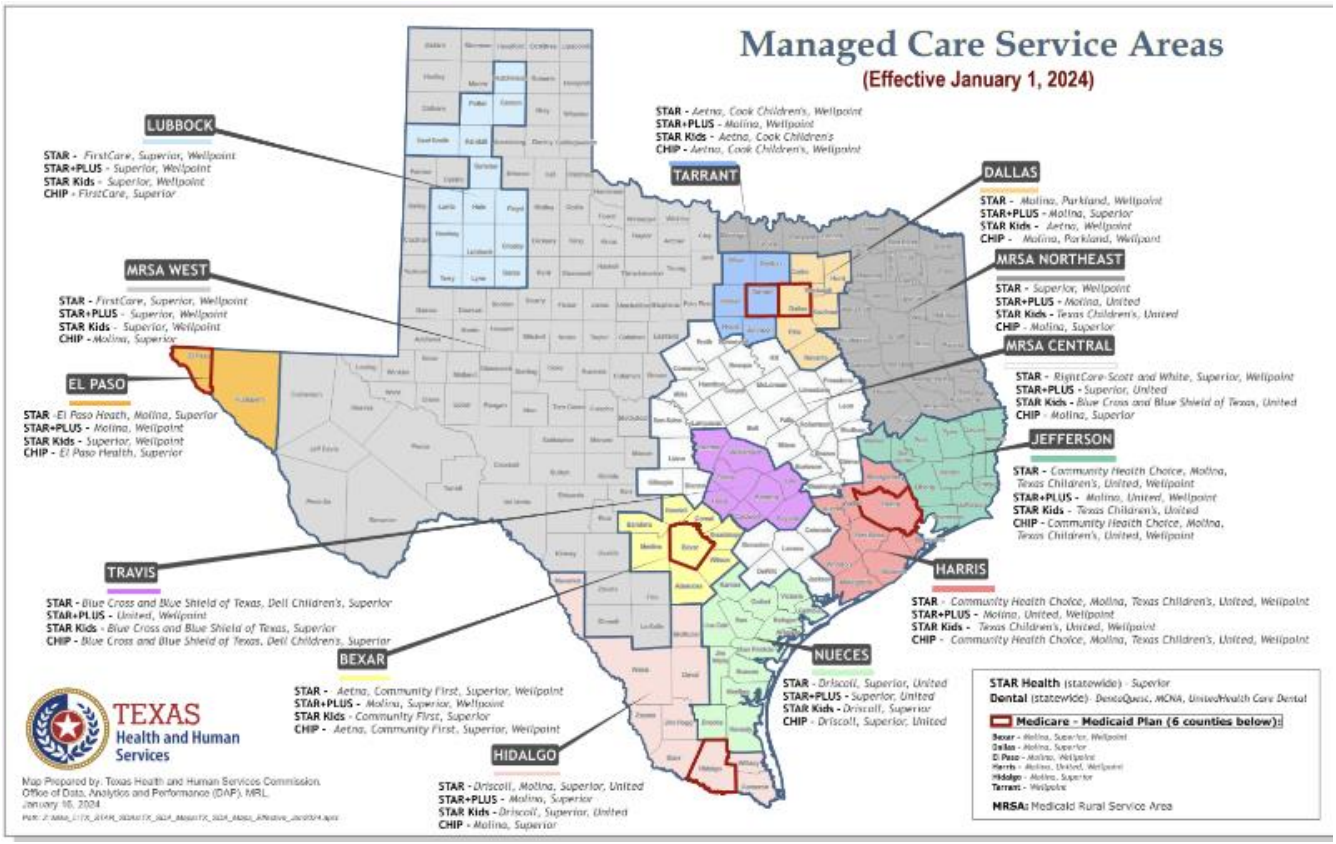
Texas primarily utilizes the ranking option to award MCO contracts (but see the discussion on mandatory contracts below). In this procurement method, HHSC employs a structured evaluation process to ensure that contracts are awarded to MCOs capable of delivering quality healthcare services to Medicaid recipients. This lengthy process involves multiple stages, including planning, solicitation, evaluation, and contract award, with an overarching emphasis on transparency, competition, and alignment with certain prioritized healthcare objectives. In recent years, these healthcare objectives have included maternal health outcomes and case management.

The MCO procurement process begins with HHSC conducting a thorough assessment of the healthcare needs across the state's 13 Service Delivery Areas (SDAs: see the map below). These assessments consider factors such as population demographics, healthcare utilization trends, and feedback from stakeholders, including Medicaid recipients and healthcare providers. The goal is to determine the number and type of MCOs needed to deliver services in each SDA effectively. Based on this analysis, HHSC develops an RFP, which outlines the scope of services, performance expectations, and evaluation criteria for prospective MCOs. The RFP also specifies the contract duration, reporting requirements, and compliance mandates, ensuring that MCOs understand their obligations. Key components include quality measures, network adequacy standards, and financial accountability mechanisms.[241]

The figure below shows the various MCOs operating in the state's SDAs as of January 1, 2024. If the STAR and CHIP awards currently on hold are finalized, the information in the figure below will change.

Figure 6

Managed Care Services Areas in Texas



Source: HHSC[242]

In order to receive a Medicaid contract, a health plan must be licensed as an HMO by the Texas Department of Insurance (TDI). As part of the RFP process, HHSC then requires MCOs to certify that they will meet financial stability and network adequacy standards, should they be awarded a contract. This includes evidence of sufficient numbers of primary care physicians, specialists, hospitals, and behavioral health providers that are verified prior to a contract going live.

The ranking option requires MCOs to bid on a contract for which HHSC is seeking bidders. The MCOs will submit documentation, answer interview questions, and otherwise demonstrate their ability to execute the contract. MCOs are ranked according to how they perform in this process and contracts are awarded to the highest performing MCOs. As noted above, contracts are typically awarded for six years, with provisions for extensions for up to another six years.

In this methodology, MCOs prioritize their preferred service delivery areas (SDAs) for which they are seeking a contract. MCOs list the 13 SDAs in order of preference within their RFP submissions. This ranking is then considered alongside the MCO's evaluation score and the number of MCOs specified per SDA in the RFP. HHSC reviews these preferences in conjunction with mandatory contract awards to determine the assignment of MCOs to SDAs. This approach aims to align MCO capabilities and strategic interests with regional healthcare needs, thereby promoting efficient service delivery.[243]

Once evaluations are complete, the HHSC scores the MCO's based on their bids. Importantly, MCOs receive a single statewide score, regardless of the SDAs they may currently serve. This is significant because each SDA and its enrollee population have unique traits that can result in lower (or higher) scores attained by a plan in another SDA, all else being equal. The MCO with the highest overall score is awarded a number of contracts based on their priority list of

SDAs. The next highest scoring MCO then receives awards based on its priority list of SDAs.

Beginning in 2024, HHSC limited the total number of SDAs in which a plan could receive an award. Under the current rules, a plan cannot operate in more than a specified number of SDAs for a single product, such as STAR or STAR Kids (STAR Health is an exception and is one statewide contract). While this cap on the number of plans in a single SDA may have been implemented to limit the state's risk should a plan become insolvent, caution should be exercised when limiting access to government contracts in this way.

The RFP process is inherently complex, requiring MCOs to navigate detailed requirements and submit comprehensive proposals that address multiple evaluation criteria. These criteria include network adequacy, cost containment, quality assurance, and administrative capacity.[244] While such rigor helps ensure that only qualified MCOs are selected, it also creates significant barriers, particularly for smaller organizations. Critics argue that the complexity of the RFP process places undue administrative and financial burdens on bidders, diverting resources away from core healthcare delivery functions, which is why the state only procures these contracts every six or twelve years.

The transition of Medicaid contracts from one MCO to another as a result of the procurement process has the potential to lead to service disruptions, particularly for vulnerable populations, according to Judge Eiserloh's statement on the recent hold on MC awards. However, it is important to note that all Medicaid benefits are federally and state mandated, including the coverage of the same prescription drugs across all plans, and that recent MC transitions involving more complex populations have occurred without significant disruption. Health plans must also offer the same benefits and services at the same amount, scope and duration as in a fee-for-service setting, and must offer all medically necessary services, as required under federal law.

To the extent that these types of disruptions may take place, they could include interruptions in care, difficulties in accessing providers, and confusion among Medicaid recipients regarding their coverage. Such disruptions could be especially problematic for individuals with chronic conditions, who rely on consistent care coordination and established provider relationships. Additionally, transitions often result in administrative challenges, such as delays in credentialing providers and transferring medical records. However, it should also be noted that the recent STAR+PLUS transition, which includes many medically complex enrollees, encountered no significant issues. To mitigate these risks, HHSC has implemented measures like mandatory transition plans and oversight during the contract "handover" period. One such continuity measure is the requirement for a new MCO to honor a prior authorization for a drug or treatment for six months after beginning coverage of care in a new SDA.[245]

But the most fundamental question regarding a procurement system is whether high procurement scores accurately identify the best plans to provide care in a given SDA. Undoubtedly, there is considerable value in HHSC seeing MCOs' responses to written questions and later their oral presentations. The entire bidding process is essentially HHSC interviewing MCOs to determine their potential for strong performance. But intuitively, actual performance by an MCO- particularly recent performance- should be weighed heavily in the awards process, and much of this is built into the written responses that an MCO provides to the agency. Interviewing is an attempt to determine what future performance will be, but the importance of an interview should be lessened if the applicant has already demonstrated that it has performed strongly, especially in the same SDA and with respect to the same MC program (e.g., STAR or STAR Kids), unless there are new requirements outlined in the RFP.

The quality of services and the past performance of vendors are factors for HHSC to consider in its procurements; however, HHSC also must maintain a process in which non-incumbent plans (e.g., new entrants to the state) can still bid on an RFP. Incumbent plans will have a track record in the applicable SDA. With respect to non-incumbent plans, HHSC could expect them to be able to highlight data from another state and explain why it is comparable and should be considered.

A notable aspect relating to the procurement process is that HHSC already receives and maintains a massive amount of data on the Texas Medicaid program.[246] As part of this data collection and usage, HHSC issues

annual report cards for MCOs assessing the patient experience and the quality of care provided to patients. These report cards are issued to an MCO for each MC program in each SDA in which it participates, so an MCO generally has multiple report cards. In addition, separate report cards for an MCO with a STAR contract are issued for STAR (Children) and STAR (Adults).

STAR/CHIP report cards for 2022 were released in March 2024, the same month that HHSC released its notice of intent to award for new STAR/CHIP contracts. Given that timeline, it is interesting to compare MCOs' recent past performance *as measured by the report cards* with the tentative award of contracts. However, it should be noted that these report cards are a single point in time assessment of performance that include only a relatively small subset of the overall total metrics that are used by the agency to assist new enrollees to select a plan.

These report cards provide MCO members with a summary of data on the health plans in their region so they can choose the best health plan for them. When a member declines to choose a health plan, HHSC will select one for them. It is interesting to note that under these circumstances, HHSC does not select the plan with the highest scoring report card in that SDA, but rather uses an incentive program called value-based enrollment (VBE) to automatically enroll the member into a health plan using a calculation that incorporates the quality control metrics of the plans in that SDA. HHSC tracks over 140 individual quality control metrics to ensure Medicaid-eligible patients receive a high-quality of care, consistent with standards set by CMS.[247] Higher-scoring plans on a subset of these measures receive a higher percentage of these automatic enrollments.[248]

If the Legislature chooses to maintain the ranking option for MCO contracting, priorities should include a greater emphasis on past performance, and consolidating HHSC's data on plans' performance into metrics that are consistently used in evaluating plans.

- ***Application State or File & Compete***

Some states utilize a process known as "file and compete" (also called "application state") in Medicaid contracting. Under these models, MCOs would be able to offer Medicaid or CHIP services without undergoing an arduous procurement process, so long as they meet minimum requirements under state and federal law. A 2023 report commissioned by the New York State Legislature detailed how New York has engaged in such an approach by permitting any qualified plan to enter the market and compete for members. This approach allowed MCOs to operate under state contracts without undergoing a standardized bidding procedure.[249]

While the file and compete method of Medicaid contracting is perhaps the most open and competitive of the approaches to Medicaid procurement, the New York report expressed concerns about transparency, accountability, and potential inefficiencies associated with the approach. MCOs of varying sizes were implementing aggressive marketing tactics to attempt to enroll new members in their health plan. For example, sales teams for the health plans would stand on subway platforms and hand flyers to individuals walking by, encouraging them to apply for Medicaid and enroll in their specific plan. This emphasis by plans on marketing caused individuals who might not have otherwise applied for Medicaid to then file for Medicaid with the state, an occurrence known as the "woodwork effect,"[250] in addition to plans utilizing resources on client acquisition and not on providing care.

Critics of file and compete generally highlight concerns around market adequacy and stability for Medicaid members. Profit margins tend to be small in Medicaid and therefore sustainability for plans is more likely to come from a larger patient base. For this reason, plans are more likely to flock to urban areas with a larger patient base than to rural areas. This holds true to an even greater extent for plans that serve more complex populations with higher costs. The critics also note that, while free market principles ideally guide policy, Medicaid is an open-ended entitlement program in which federal law requires the states to provide services to eligible individuals.

The New York report recommended increased use of competitive procurement processes to ensure better oversight, cost-effectiveness, and alignment with program goals.[251] New York Governor Kathy Hochul's Executive Budget for 2022-23 included a proposal requiring MCOs to participate in a state procurement process to administer Medicaid in New York.[252]

South Carolina provides an example of another file and compete state, although that state's model has generated less controversy than that of New York. The South Carolina Department of Health and Human Services (SCDHHS) oversees the Medicaid contracts for the state. Interested organizations must obtain a certificate of authority from the South Carolina Department of Insurance before engaging with SCDHHS. Once certified, MCOs are required to submit a comprehensive provider network at least 90 days prior to their intended start date, ensuring statewide coverage and service adequacy. Additionally, MCOs must successfully complete an external quality review.[253]

South Carolina authorizes certain plans to participate in Medicaid contracting in the state and then requires all plans to compete and accept patients statewide.[254] New plans can enter the market at any time, after receiving a certificate of authority and establishing network adequacy. However, South Carolina's Department of Health and Human Services filed a state plan amendment (SPA) with CMS in December 2024, seeking to move to a model that combines a certification approach with file and compete in order to limit total plans operating in the Healthy Connections program to four.[255] This underscores the important balance that state Medicaid agencies must strike when designing procurement and service delivery models.

It is worth noting that some file and compete states are also states that have expanded Medicaid, meaning their patient population is generally going to be different than that of Texas. Some file and compete states have mitigated a number of the concerns with a large number of plans by implementing stricter certification before entering the market to ensure the plans will be able to operate successfully in the environment, combining urban and rural areas in a single SDA, or by conducting an RFP for complex populations and only implementing file and compete for Medicaid expansion populations. [256] Some states have also required a plan to serve in a specific SDA or have grouped more profitable SDAs with less profitable SDAs. While this an option for Medicaid agencies to ensure patients in rural areas do not have less attractive options than their urban and suburban counterparts, there is also an inherent concern in requiring a plan to serve an area the plan does not wish to serve as it may lack expertise with respect to that population or may not see a path towards profitability.

- ***The Incumbent Option***

Under the "incumbent" option, MCOs stay in a service area for which they are already performing a contract unless they provide poor service to enrollees according to the quality control metrics established by the governing agency. Periodically, the applicable state agency evaluates the service area to determine if the service area has the market and the potential to be better served by the admission of additional MCOs into the service area.

West Virginia is an example of a state employing the incumbent option. West Virginia's Medicaid program operates under a managed care model, primarily through the Mountain Health Trust (MHT) program. The West Virginia Department of Health and Human Resources (DHHR), specifically the Bureau for Medical Services (BMS), oversees the procurement and contracting processes for MCOs. Historically, West Virginia has utilized a competitive procurement process to select MCOs for its Medicaid program. For instance, in 2020, the state issued an RFP for the MHT program, inviting health plans to submit proposals to provide managed care services. The state awarded contracts to three health plans, with the contract period beginning that same year.[257] All plans offer services to all regions of the state.

Legislative changes influenced the procurement approach to include incumbency protections for plans. In March 2023, the West Virginia House of Delegates passed Senate Bill 476, which exempts managed care contracts from standard purchasing requirements. This legislation allows the BMS to bypass the traditional RFP process and enable plans to become grandfathered in the state market.[258] In 2024, the state held an RFP and added a fourth plan to the list of plans grandfathered into the state network.[259] Proponents argue that this change opens the market to more health insurance providers, potentially driving quality improvements.

Under the incumbent option, service areas and the patients in them have the option to maintain relationships with networks and providers they know, while there is the potential for adding competition that would benefit the service area. This option also

provides an incentive for incumbent plans to make long-term investments into the service area in ways that will reduce the cost of care in the long-term, as the plans know they are likely to remain in the service area for an extended period of time.

The success of such a system would hinge on HHSC's robust oversight model that is used to review quality metrics provided by the plans and to implement performance improvement requirements for the plans. In addition, the concern that a plan under the incumbency model would have less of an incentive to perform better over time would be mitigated at least partially by MCO members themselves, who have the ability to switch to a different MCO.

- ***Mandatory Contracts***

Mandatory contracts are a component of the discussion on MCO procurement, but not a stand-alone option for procurement. In 1997, the Legislature passed HB 2913 (75R) into law, requiring the state to award managed care contracts to MCOs owned and operated by public hospital systems. This bill is codified at Section 533.004 of the Government Code, which provides that, in providing health care services through Medicaid managed care to recipients in a health care service region, HHSC must contract with an MCO that meets certain requirements. These requirements include, most typically, that the MCO be (1) wholly owned and operated by a hospital district, or (2) created by a nonprofit corporation that has the obligation to provide care to indigent patients. In January 2023, HSHC issued a notice of intent to award contracts for the STAR+PLUS program, which included three mandatory contracts out of the seven plans receiving contracts, though the number of mandatory contracts is not fixed and is dependent upon each RFP.[260] The STAR/CHIP awards currently on hold similarly awarded a number of mandatory contracts.

If the group of MCOs bidding for an MC program contract in an SDA includes a certain type of MCO affiliated with a hospital district or a nonprofit corporation, HHSC must award one of the contracts for that SDA to that MCO, irrespective of how high or low the MCO scored on the 2,000-point scale. Thus, it is possible for a health plan with mandatory contracting rights to secure a contract award in the applicable SDA even if it is the lowest-scoring plan on the 2,000-point scale in the entire applicant pool, which has in fact happened in past RFPs.[5] It is fair to ask whether communities are truly being best served by an MCO that perform more poorly than its competitors, at least as measured by procurement scoring.

Advocates for retaining mandatory contracts also raise concerns that non-community health plans may one day choose not to participate in SDAs covered by community plans. In this case, it might benefit the Medicaid recipients in that SDA to have long-term relationships with the community plans, even if they provide lower-quality care than their competitors. However, community plans currently cover some of the most populous (and therefore presumably some of the most desirable) SDAs in Texas. There is no real concern about plans abandoning these SDAs in the foreseeable future.

Policy Recommendation 22

Eliminate mandatory contracting

Eliminating mandatory contracting would require the Legislature to pass a bill similar to that of HB 2401 (Oliverson, 88R)/SB 651 (Perry, 88R). The introduced version of that bill provided an unequivocal repeal of the state's mandatory contracting statute. That statute, adopted almost 30 years ago when there were basic questions about how well Medicaid managed care would work in Texas, is outdated in today's world, where Medicaid managed care is a mature industry with a proven track record. The statute does little to ensure quality of care for members and its approach is anathema to the conservative principles of free enterprise and competition. To the extent that state contracting processes are able to reflect these principles in the Medicaid contracting process, they should do so. If community plans are truly offering high quality care, and the procurement process is appropriately weighing past performance, smaller

[5] Section 533.005 of the Government Code does provide a very minimal requirement for any health plan awarded an MC contract; HHSC must certify that the plan is "reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law."

plans should be able to compete against their larger counterparts.

♦ *Additional Policy Considerations*

The fate of MCO procurement in Texas is currently on hold pending action by the Legislature in the 89th Legislative Session. If the Legislature chooses not to overhaul the procurement process or disturb the awards announced in 2024, the issue will revert to the courts for an indeterminate amount of time. To ensure that procurement is more legislatively driven rather than judicially driven, the Legislature could adopt a comprehensive vision for Medicaid procurement. Then, it would have to determine whether those changes should be purely prospective, or also retroactive to the awards currently in abatement. Rescinding a procurement via legislative action could, however, potentially set a negative precedent for other contract awards by the state if it is perceived that the Legislature could become involved and override the award.

Any of the Medicaid contracting options outlined above can incorporate competitive, free-market principles to a meaningful extent. Below are a series of policy considerations the Legislature could address as part of selecting a Medicaid procurement model.

The following policy considerations apply to all procurement options:

- HHSC should more heavily weigh past performance by plans in awarding contracts, and provide transparency in how that weighing occurs.

- HHSC should perform a rigorous certification of plans before bidding, not simply asking plans to check a box asserting financial solvency and network adequacy, though MCs must be licensed by TDI and therefore pass capital reserve requirements to operate.[261] This upfront analysis would be particularly helpful if a file and compete model were adopted.

- The agency should consolidate the detailed data it has on plans' performance into a score that is used consistently used as the default for plan evaluation. It would also be necessary to utilize national metrics, such as those developed by the National Committee for Quality Assurance (NCQA), to account for the performance of non-incumbents outside Texas.

- The Legislature should clarify that HHSC can implement a cap on the number of plans within a single SDA if needed under the chosen procurement model, but should not cap the number of SDAs in which a particular plan can operate; and

- The Legislature should maintain the current regulations governing marketing by MCOs.

The following policy consideration applies to the ranking procurement option:

- HHSC should give plans unique scores for each SDA (unless plans are bidding on a statewide contract) given the unique nature of each SDA in Texas.

The following policy consideration applies to the file and compete procurement option:

- HHSC should group SDAs such that plans are incentivized to compete for business in more than just the most populous areas (e.g., Harris County).

The following policy consideration applies to the incumbent procurement option:

- Provide periodic sunset-type review of incumbent plans by HHSC and/or the Legislature with advice from an external, nationally-recognized reviewer. Such a review should include feedback from MCO members, consumers, and other stakeholders.

SHARS Funding

Another Medicaid area that experienced significant changes in 2024 was the School Health and Related Services (SHARS) funding program. A final ruling by the U.S. Office of Inspector General (OIG) in 2023[262] resulted in significant changes to the program,

including increased administrative burdens for schools and a roughly 50 percent cut to funding available to them.[263]

Congress passed the Education for All Handicapped Children Act (EHA) in 1975 to protect the rights of children with disabilities and to support school districts and local governments in providing education for all children, including those with disabilities. This law was reauthorized in 1990 and renamed the Individuals with Disabilities Education Act (IDEA).[264] These laws outline minimum standards to ensure all students with disabilities have access to a free and appropriate public education (FAPE). IDEA includes requirements that students receive education in the least restrictive environment, and that students receive all services they need to succeed in public school, as outlined in the student's individualized education program (IEP).[265]

When services that are required by a student's IEP are medical in nature, as opposed to educational in nature, the school providing the service may qualify for Medicaid funding under the SHARS program, if the student is eligible for Medicaid. SHARS oversight is a joint operation by the Texas Education Agency (TEA) and HHSC.[266] Services covered by SHARS can include nursing services, personal care services, physician services, speech therapy, specialized transportation, counseling, and more.[267] Participation in SHARS is not mandatory and school districts or parents can decline to participate, but schools that do not participate are not exempted from the requirement to provide a free and appropriate public education to all students.

In 2010, the U.S. OIG conducted an audit of the SHARS program in Texas. This study resulted in a report that emphasized data collected in a Random Moment Time Study (RMTS).[268] An RMTS is a statistically valid sampling that can be used by states to determine how much staff time is spent performing work activities that are reimbursable under Medicaid, as opposed to educationally oriented activities. Schools utilize a formula and methodology as outlined by CMS to contact personnel and request information about their activities at specific moments in time during working hours. These moments are then used to calculate the number of moments staff are using on Medicaid reimbursable activities.[269] The 2010 OIG report found a significant number of educational expenses were miscoded by school districts as Medicaid eligible expenses. The state received $18,925,853 in unallowable Medicaid reimbursements for FY 2011 and has been directed to return it.[270]

Texas HHSC appealed the OIG ruling through 2024, when the agency exhausted opportunities for appeal. Upon the conclusion of the final appeal, the OIG recommendation for codification of certain moments in time as educational and not as Medicaid reimbursable moments was adopted as final and ongoing. Medicaid reimbursable moments dropped from approximately 43 percent to approximately 20 percent.[271] This change will result in an ongoing cut in SHARS funding by approximately 50 percent for all school districts.

Some sources estimate this change could result in a cut of more than $600 million in federal funds for special education per year.[272] This cut merely adds to the deficit in federal funds that has plagued special education since the passage of IDEA. This federal law, which now results in onerous documentation requirements for teachers and school districts, also authorized federal funding for 40 percent of the services it requires. Since the law was enacted, the most the federal government has ever contributed was 18 percent. Current funding is less than 13 percent.[273] Some school districts are now requesting the Texas legislature make up for these lost federal funds by increasing special education funding in general revenue.[274]

It is worth noting that a bill that would have increased funding for Special Education Services by over $1.5 billion for the biennium was widely opposed by school districts and groups such as the Texas Association of School Boards[275] during the 88th legislative session because the bill also contained a provision establishing an Education Savings Account, effectively a voucher program, for students with disabilities. House Bill 3781 (88R, Jetton) would have updated the funding formula for special education services by providing funding to schools based on the services the schools were providing. Schools currently receive services based on what type of learning environment the students are located in when they receive services. HB 3781 would have brought alignment to funding of the education services received by students with disabilities by establishing a funding formula linking funding to education services, as opposed to the current link between funding and classroom type. The Legislature should consider this type of legislation to operate in

tandem with the new SHARS program requirements to align funding for the medical services these students receive.[276]

As CMS and the OIG require Texas to more properly identify and code education versus medical services for students with disabilities, Texas schools that wish to receive SHARS funding will be required to code medical services appropriately. The Legislature should consider legislation such as HB 3781 that would also require educational services to be coded more accurately. While this bill was drafted to provide $1.5 billion for special education services over the biennium, the legislation can be drafted so the allocation for each level of services is subject to an appropriation.

Policy Recommendation 23

Align special education service funding with the services the student receives

Appropriately parsing out medical and educational services for students with disabilities not only allows for more accurate funding for these students but also creates a better dataset for these students and services in the state and makes funding these services more predictable. Students who are eligible for Medicaid services are required to receive those services, and the state is required to reimburse Medicaid providers for services they provide. While the state appropriates these funds in the budget, if costs exceed what was appropriated, the state must increase the funds available to providers retroactively. This is done in the supplemental budget that is passed each regular session.

Education services generally do not operate the same way. While school districts are still required to provide a free and appropriate public education for students with disabilities, they are generally expected to find discretion within their existing budgets to accomplish this. For example, in SB 30 (88R, Huffman), the supplemental appropriations bill for the 88th Legislative Session, the only funding provided for special education was $74.6 million to offset the federal funds being withheld by the U.S. Department of education.[277] These funds are withheld as a result of the state's "failure to maintain adequate state financial support for special education," [278] which occurs when the state reduces the amount appropriated for special education services from one biennium to the next.[279]

The state's current financial concerns regarding special education and SHARS funding should serve as a cautionary tale to the state when considering accepting large regulatory burdens from the federal government, in exchange for the promise of federal funds. While IDEA's premise—ensuring that students with disabilities receive a free and appropriate public education[280]– is a positive one, it has evolved into an expensive bureaucratic problem for states who implement the law differently.[281] Since it is a federal law, the states are unable to update the law to accommodate changes in special education and Congress has not made any significant changes to IDEA in the last twenty years.[282] Congress has also never fulfilled its agreement to fund 40 percent of the costs associated with IDEA, leaving instead a significant financial burden on the states.

The federal government's failure to appropriately fund special education, despite the growing burdens to comply with federal law, should give the Texas Legislature yet another reason to decline to expand Medicaid. While there were greater financial incentives available to encourage states to expand Medicaid during the Public Health Emergency caused by the COVID-19 pandemic, funded by the American Rescue Plan, [283] these incentives only became permanent for states that expanded Medicaid during that period.[284]Texas should assume the bureaucratic burdens will grow with time and when the federal subsidies dwindle, Texas will be required to find ways to fund this entitlement program through general revenue while maintaining a balanced budget, a limitation that Congress does not face.

Medicaid Expansion

Lessons should be learned from the ACA's maintenance of eligibility (MOE) mandate. When the ACA became law in 2010, it required states to continue serving anyone eligible for Medicaid and CHIP at that time under their respective state policies for a number of years (adult coverage had to extend until exchanges were fully functional and children until September 30, 2019).[285] That resulted in states losing the ability to restrict any eligibility requirements, including optional populations. State lawmakers must consider the long-

term consequences of expanding Medicaid, including the possibility that future federal law could lock the state into these eligibility criteria or other criteria that would greatly expand case load.

Texas covers eligible pregnant women under Medicaid up to 198 percent of the federal poverty level (FPL).[286] Although federal law requires states to cover this population up to 133 percent of the FPL, Texas chooses to cover pregnant women between 134 percent and 198 percent of the FPL as an optional Medicaid population.[287] The Texas Medicaid program currently pays for 53 percent of all births in this state, [288] and children born to these women are automatically enrolled in Medicaid through the month of their first birthday.[289] With the passage of HB 12 (Rose) in the 88th Legislative Session, the continuous eligibility period for post-partum women has been extended to cover the twelve months following the end of the pregnancy.[290]

Medicaid is an entitlement program meaning that funding is open-ended at both the state and federal levels. **Once additional individuals are made eligible, the state loses much of its ability to rein in costs and program growth**. Expansion advocates often rally behind the call of maximizing federal funding while completely ignoring the fact that increased costs will be borne by the taxpayer at both the state and federal levels and failing to acknowledge that these taxpayers are one and the same. The federal government cannot afford the future cost of its current entitlement programs without adding further to the nation's $35.5 trillion debt ($28.3 trillion is held by the public, with the rest consisting of intra-governmental holdings[291] [6]), and Texas should not add the burden of an entitlement expansion to its state budget. It should be pointed out that debt held by the U.S. public has exploded in recent years, more than doubling since 2013.[292]

As TCCRI has continuously stated: **Texas should oppose Medicaid expansion**. As noted above in the portion of this Task Force Report dealing with private sector issues, when Medicaid was enacted in 1965, its primary purpose was to act as a safety net for the needy who could not work and obtain coverage on their own (i.e. children and individuals with disabilities).[293] Over time, it has become the insurer of first resort for the low income, including individuals who could reasonably be expected to secure employment and either purchase coverage or get it through their employers, and, in this case, even those who qualify for government-sponsored insurance subsidies.

Policy Recommendation 24

Oppose any type of Medicaid expansion

IDD Direct Support Staff Funding

More than half a million people with intellectual and developmental disabilities and related conditions (IDD) live in Texas. People with IDD often need assistance with learning, mobility, language, and self-care. Of the IDD population, about 15,000 people reside in either community-based intermediate care facilities for individuals with an intellectual disability or related condition (community-based ICFs/IID) or Home and Community-Based Services group homes ("HCS group homes"), and many thousands more are currently on interest lists hoping their name will soon rise to the top of the list. These 15,000 residents qualify for IDD-linked benefits under the state's Medicaid program, which requires that they have only limited income and assets and display a certain level of need for care.

Direct support professionals (DSPs) at IDD community-based group homes are the people who work with the residents on a daily basis and ensure they are receiving the care they need. The wage rate for DSPs is set by the state at $10.60 per hour, although providers can vary the specific wages paid to workers. If an IDD community-based provider pays above the wage rate set by the state, it does so at a loss, because the state's Medicaid program will not reimburse providers at a higher rate even if they spend more. Moreover, the work of DSPs is often stressful given the medical and behavioral challenges much of the IDD

[6] Figures are as of September 30, 2024, the close of the 2024 federal fiscal year.

population faces, and benefits such as health insurance coverage and access to a 401(k) plan are not common.

This $10.60 base wage is not competitive with the pay for many entry-level jobs across the state, such as those at restaurants and grocery stores, many of which pay $15 or even $20 an hour, plus benefits. Strikingly, the $10.60 base wage is not even competitive within the same industry; the base wage for DSPs who serve residents with IDD in state-supported living centers (SSLCs) is currently $19.16 per hour. Moreover, as state employees, their health insurance coverage is paid entirely by the state.

A cornerstone of conservative policymaking is recognizing that people respond to economic incentives. Accordingly, it should be no surprise that IDD community-based group homes are experiencing severe staffing shortages as DSPs (and people who might have previously pursued a DSP job opportunity) flock to higher paying, less stressful jobs. The Legislature attempted to address the issue by increasing the base pay from $9.53 to the current $10.60, effective September 2023, but staff vacancy rates at IDD community-based group homes have increased slightly since that time. Providers have sounded the alarm, and the Health and Human Services Commission (HHSC) has heard recommendations from an advisory council focused on the IDD service delivery system that any attempts to solve the workforce shortage must address inadequate pay for DSPs working in IDD community-based group homes.

IDD community-based providers report declining quality of care as exhausted and shorthanded staff attempt to support their clients with IDD, to the point that administrative employees are being assigned to direct care duties. Some providers are simply not able to accept referrals due to their staffing shortages. From January 2023 through February 2024, 50 community-based ICFs/IID and 179 HCS group homes closed, and those numbers will continue to rise as providers overcome temporary obstacles to closing group homes, such as terminating lease commitments and identifying buyers.

The staffing shortages at IDD community-based group homes and the related closures have serious implications for the IDD population that resides in them. Inexperienced and/or exhausted workers are more likely to make mistakes, and staff turnover is disruptive to IDD clients even under the best of circumstances. People with IDD who do not receive the care they need may seek admission to more expensive SSLCs, or they may eventually require intensive medical care such as hospitalization or admission to a nursing facility. In any of these scenarios, increased costs to the state and its health care system will result. The increased demand on SSLCs is already reflected in data reported by HHSC in early July 2024, covering the months of September 2023 – May 2024. According to this data, SSLCs are already serving approximately 50 to 60 more people each month than projected in the average monthly enrollment performance measure set by the Legislative Budget Board in the General Appropriations Act for the 2024-2025 biennium. But even more importantly, some of the most vulnerable people in the state will not receive the care that safety net programs such as Medicaid were intended to provide.

TCCRI has long opposed the expansion of Medicaid as the insurer of first resort for low-income but healthy, able-bodied people, a trend that is apparent in other states. The state's default policy should be to encourage people to seek health insurance coverage through their employers, and as a corollary, to create an environment in which employer-sponsored health insurance coverage is affordable. People with IDD who qualify for Medicaid in Texas, however, are a population that Medicaid was originally intended to cover, given that population's special needs, limited financial resources, and limited ability to obtain full-time employment.

The state has entered a crisis with respect to the staffing shortages at IDD community-based group homes.

Policy Recommendation 25

Appropriate funding in the Supplemental Budget that equalizes the pay of DSPs at IDD community-based group homes with DSPs in SSLCs

Waiting to address this issue until FY 2026 is inadvisable. This pay increase would require a significant investment by the state- approximately $255 million in revenue for the 2026-2027 biennium. But the funds required to make this critical adjustment

should be available given the current biennium is expected to end with a healthy budget surplus of an estimated $23.8 billion. Any appropriation for DSP compensation should be contingent on the appropriated funds being used for that purpose, with any provider who fails to comply with established accountability measures being subject to recoupment.

Policy Recommendation 26

Direct HHSC to improve its data collection regarding IDD community-based group homes

This change would allow HHSC and the public to better evaluate the quality and capacity of these settings and make more informed decisions. Additionally, collecting data on facility closures, vacancies, and employee retention would allow policymakers both to measure the effects of their policies and to detect concerning issues before they become critical problems.

Mental Health

Texas has taken significant steps to improve access to mental health care in recent years. This includes one-time funding investments and systematic reforms. In just the 88th Legislative Session, the Texas Legislature approved a record $11.68 billion in behavioral health funding. This investment represents a 30 percent increase from the 87th legislative session and "one of the largest increases in behavioral health funding by any state legislature in history."[294]

Despite these legislative steps and historic investments in mental and behavioral health, there remain concerns that access to mental healthcare in Texas continues to fall short. By some metrics, Texas is ranked as the worst state in the nation for mental health, and not for the first time.[295] A recent analysis of data from the Centers for Disease Control and Prevention (CDC) by the Kaiser Family Foundation (KFF) found Texas outpaces the national average in some negative mental health outcomes, including rates of children without insurance and suicide rates.[296]

While there are certainly concerns about the state of mental health in Texas, there is both a lag in data accumulation and expenditure of appropriated funds. House Bill 1, the budget bill from the 88th Legislative Session that provided a historic investment in mental health services, was not signed into law until mid-June of 2023. Agencies then had to disburse funds, issue Requests for Proposals and review responses, new positions had to be filled, and some programs were completely innovative and therefore also required rulemaking.

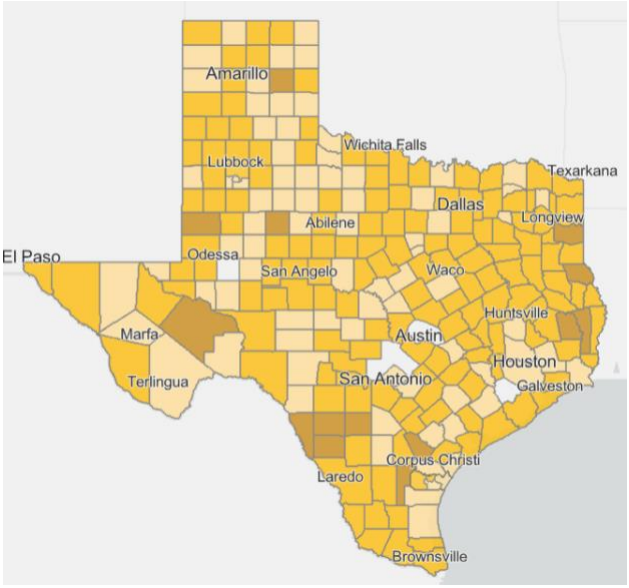
Because the state is still in the process of disbursing additional funds, it is too soon to say Texas is doing too little, though there is a cautionary tale about the lag time between the Legislature's determination to act and those actions taking effect, particularly when implemented in a system as complex as health care and on a state-wide scale. The Texas legislature should also view with skepticism claims that Texas is not spending enough money on this issue.

Leaders in Texas continue to raise concerns about the mental health provider workforce. On September 10, 2024, Department of Family Services Commissioner Stephanie Muth testified before the House Appropriations Committee that the agency has concerns regarding accessing sufficient mental health care professionals' services, to the extent that the agency may not be able to provide the services required by law to children in the foster care system.[297]

Of further concern, out of 254 counties in Texas, 246 are experiencing a Mental Health Professional Shortage, and two more counties are experiencing a partial Health Professional Shortage Area (HPSA) designation.

Figure 7

MPSA Shortages in Counties



Source: Department of State Health Services[298]

When individuals cannot otherwise get access to a provider, they will sometimes reach a critical need and be forced to seek care in an emergency department. Strategic efforts also seek to reduce the number of individuals who enter emergency departments for mental health concerns. Emergency departments are hospital facilities that are open 24 hours a day, 7 days a week and provide unscheduled services to patients who require immediate care.[299] A federal statute (the Emergency Medical Treatment & Labor Act, or EMTALA) requires emergency departments to assess, and then stabilize or transfer all patients. While these should theoretically be short visits in the emergency departments, patients can wait extended periods before receiving a referral to another provider.[300]

Relying on emergency departments increases costs, extends wait times, and ultimately risks compromised patient care. Groups including the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association encourage investments in mental health services to prevent people with mental health concerns from reaching the emergency room.[301]

48-Hour Detention

Under Chapter 573, Health and Safety Code, Texas' emergency detention (EDO) statute, a person with a mental illness who is at substantial risk of serious harm to themselves or to others, may be detained either by a peace officer[302] or through an application for a warrant for an emergency detention through the court system.[303] A peace officer may detain an individual and escort them to a location where they can receive emergency medical care, potentially including a psychiatric hospital.

However, a person who has been detained will often first need emergency medical assistance if they have attempted to injure themselves or ingested something toxic. These individuals will need to be medically stabilized before they are able to receive psychiatric assistance. A peace officer is not always able to remain with the person who has been detained, but physicians and health care providers have no legal authority to hold a patient who meets the emergency criteria set forth above as they are not peace officers. While medical professionals can apply for a warrant from a judge, there can be delays between the time the person is admitted to a hospital and when a judge signs a warrant for an emergency detention, particularly if the judge must sign the warrant in person. A person being detained under and EDO may generally only be detained for 48 hours, or slightly longer on weekends and holidays, barring a judge granting a longer detention.

Within these parameters, the 254 counties in Texas each have a unique interpretation of the statutes regarding EDOs. Some counties argue the EDOs must be signed by a judge in person, precluding electronic submission or signature. Some counties will only sign EDOs during business hours. As a result, a peace officer might have to remain with the person detained, and a hospital treating a patient risks a potential violation of the patient's rights, regardless of the care that patient may need. Some counties require a unique warrant to detain an individual in a standard emergency department and an additional unique warrant for each transfer to a new facility after the person is stabilized, including transfer to a psychiatric facility. Some counties permit first responders other than peace officers to transfer these patients to psychiatric facilities while some counties prohibit this practice.

There is also inconsistent application in the notice that an individual receives when they are placed under an emergency detention order. Peace officers are not required to read Miranda Rights to these individuals.

There is often no notification given to an individual of his or her rights, either by peace officers or the facility where the individual is ultimately held.

Peace officer-initiated warrantless detentions are an effective tool but may not always be suited for detentions that must be initiated in a hospital emergency department under exigent circumstances. Such circumstances can include, for example, an incident after hours or on weekends, or when a peace officer is unavailable to come to the hospital to initiate the warrantless process.

Senate Bill 362, 86th (2019) Legislature, directed the Texas Supreme Court to (1) adopt rules to streamline and promote the efficiency of court processes under Chapter 573, Health and Safety Code (the Texas emergency detention statute); and (2) adopt rules or implement other measures to create consistency and increase access to the judicial branch for mental health issues. This charge led to the creation of the Senate Bill 362 Task Force by the Judicial Commission on Mental Health. The Task Force's earliest efforts focused on the emergency detention warrant process.

In the 88th Legislative Session, some clarifications were made to the EDO process, though each county may continue interpret elements of the statute differently. To better facilitate statewide expedited acceptance of electronic EDOs, the Office of Court Administration was directed to develop and implement a process for an applicant for emergency detention to electronically present the application to a judge.[304]

```
(a)  (h-3) The Office of Court
     Administration of the Texas
     Judicial System shall develop and
     implement a process for an
     applicant for emergency detention
     to electronically present the
     application under Subsection (h)
     and for a judge or magistrate to
     electronically transmit a warrant
     under Subsection (h-1).
```

However, OCA did not receive direct funding for this statutory direction, despite receiving $295 million in the GAA[305], including $77 million for information and technology purposes. Therefore, the OCA did not develop this process.

Policy Recommendation 27

Create a line item with OCA's bill pattern directing them to implement a process under which an application for emergency detention can be electronically submitted and any resulting warrant can be electronically transmitted

Given that the actual cost of the software for this system should be relatively low, the GAA for the 2026-2027 biennium should be able to offer this direction.

Policy Recommendation 28

Clarify Section 573 to ensure a peace officer can execute a warrantless detention order for a patient who is currently located in a hospital

This policy recommendation would be a small cleanup of a statute to ensure peach officers can expeditiously navigate the legal system and ensure a patient receives mental health resources in a timely manner.

- ***Patient Transfer Platform***

In addition to the statutory questions surrounding EDOs, peace officers often face practical difficulty in finding a location where they can take a patient for psychiatric care. Unless an individual requires medical stabilization, a standard ED is not the correct venue for care for them as EDs are not typically equipped to provide mental health care, although some standard EDs also share space with psychiatric hospitals or have dedicated psychiatric beds. Peace officers can be faced with calling various psychiatric hospitals and attempting to ascertain if each facility has a bed available for the patient.

First responders in Texas have largely adopted a more integrated system for finding a facility and transmitting patient information regarding physical emergencies. Texas should adopt a similar platform to direct mental health emergencies. During the COVID-19 pandemic, DSHS implemented a platform in which hospitals could voluntarily participate, in order to better address

patient-transfer needs. This platform assists with matching available beds and patients across the state and enables hospitals to see a patient transfer request instantly across the entire state. This is vastly more efficient than the traditional method of hospitals making calls to determine where beds might be available.[306]

Policy Recommendation 29

Implement a patient transfer platform for mental health emergencies

This could again be a voluntary use platform to ensure the state does not adopt an unfunded mandate for hospitals or first responders. Usage of such a platform would reduce the time and resources needed to transfer patients experiencing a mental health crisis to the facility where they could receive services.

Best Interest of the Child

Background of the Standard

The "best interest of the child" is the standard used when the state removes a child from the care of their parent or legal guardian for suspicion of abuse or neglect. The state can eventually request a temporary or permanent change to the conservatorship of the child, but must first give parents and guardians the opportunity to participate in parenting, substance abuse, and/or other classes that would enable the family to remain intact. While the best interest of the child standard is designed to ensure agencies and courts prioritize the needs of the child over the rights of adults, it does not necessarily provide sufficient direction to an agency that must also comply with state law that requires the prioritization of family unity and reunification.

Federal law requires the Texas Department of Family and Protective Services (DFPS) to request termination of parental rights if a child has been in foster care for 15 of the last 22 months, barring some exceptions[307]. A judge must then refer to this standard to determine the temporary, and eventually permanent, placement of the child. While DFPS can make recommendations, judges ultimately make the determination on whether to alter a parent or guardian's rights.

There have been changes in understanding of what constitutes the best interest of a child over time. In recent years, there has been greater emphasis placed on reunification than on removing the child from parental or kinship care. It is the stated primary goal of DFPS to keep a child with their guardian in the same home when possible.[308] Maintaining the familial bond and proving increased wrap-around services for the family has been considered in the best interest of the child, particularly when the purpose behind the removal was related to neglect as opposed to willful abuse. A parent can be a seriously flawed caregiver and still have a bond with a child that is tremendously important to the child.

While TCCRI supports the state's shift towards familial unification, and the requirement to provide prevention services that enable the whole family to thrive and remain together, this should always be implemented under the condition that a child will be safe in the home.

Post-Dobbs Foster Care Rates

As of June 2024, abortion rates in Texas hovered around 5 abortions per year; however, this remarkably low figure does not include abortions induced in ways contrary to state law and not reported. Prior to the passage of legislation banning elective abortions, the average monthly rate was closer to 4,400, which equates to approximately 52,800 annually. However, in 2023, approximately 35,000 Texans traveled out of state (mostly to New Mexico) to get an abortion. In addition, more individuals utilized medication to induce an abortion.[309]

A Johns Hopkins study showed infant deaths increased by nearly 13 percent after Texas banned abortions after six weeks (as compared to 2 percent nationwide).[310]

A Harvard Medical School study found an 11 percent increase in children entering the foster care system in states where the mother underwent the first trimester of her pregnancy in a state with restrictions on abortion. A disproportionately high number of those entering the foster care system were racial minorities, came from economically disadvantaged families. "In this cohort study of 4,179,701 children placed into the US foster care system between 2000 and 2020, restricted abortion access was associated with an 11

percent increase in foster care entry. These findings were statistically significant for foster care entries of Black children and children of racial and ethnic minority groups compared with White children."[311]

While the repeal of Dobbs was a victory for pro-life advocates everywhere, it demonstrably means there will continue to be an increase in children entering the foster care system in Texas. The Legislature should ensure there is continuous attention paid to the agencies caring for the children who are the responsibility of the state.

Adoption Process

DFPS utilizes the Child Protective Investigations (CPI) program to investigate reports of child abuse and neglect. State law requires CPI to investigate any reports and requires anyone who has reason to believe a child is being abused to report those concerns to DFPS. CPI can also provide services to children and families in their homes and can place children in foster care when needed.[312]

Once a report is made, it must be investigated. A CPI caseworker will conduct a recorded interview of the child, contact the person accused of neglecting or abusing the child, run criminal background checks on any individual in the home or any individual who may have abused or neglected the child. The caseworker also has the option to visit the home, interview other children in the home, visually inspect the child, ask for medical records for the child or adults who may have neglected or abused the child, and take the child to interviews and examinations.[313]

CPI can refer the family to services such as counseling, day care, evaluation, treatment, and parenting training. These services are designed to help address any safety issues or concerns found during the investigation. In the course of the investigation, which takes an average of 45 days, the caseworker seeks to determine if the child is safe, if abuse or neglect occurred, and if there is risk of future abuse or neglect.[314]

A caseworker can determine whether a child is unsafe in the home if there are significant safety threats AND the family appears unwilling to utilize resources to address the risk factors. However, a caseworker can close a case if the family appears willing and able to use the family resources.[315]

As outlined in Chapter 262 of the Texas Family Code,[316] CPI must make all reasonable efforts to prevent a removal, including working with the parent to provide a safe environment. If a child must be removed, CPI will work to find a family or alternative placement option to prevent a child entering foster care.[317]

If a caseworker, in conjunction with a supervisor, concludes a child is unsafe, the caseworker may offer services to the family, refer the case for family-based safety services, or file a petition to initiate a process to protect the child. Court actions could include removing the child from the home and possible termination of parental rights.[318]

If DFPS and the parent or guardian cannot resolve the issues that created an unsafe environment for the child(ren), then the court may terminate the parents' rights and place the child with another family permanently. Another family will complete comprehensive paperwork, background checks, training, and more in order to be able to foster or adopt. In many cases, the children will have already lived with the family as part of kinship care or foster care. The adoptive family can then petition to adopt. If approved by a judge, DFPS is dismissed from the case and the adopted child(ren) has the same legal and inheritance rights as naturally born children.[319] [320]

Generally, DFPS is not significantly involved in private adoptions. Private adoptions are typically limited to newborns and occur when a birth parent works with an adoption agency to place a child into an adoptive family. International adoptions can include children of all ages and details vary depending on the nation of origin of the child being adopted.[321] In both cases, adoptive families must complete extensive paperwork, background checks, and interviews in order to adopt a child. Private and international adoption also tend to be significantly more expensive than adopting through the foster care system. Adoptions from foster care can cost less than a few thousand dollars, whereas a private adoption can cost more than $60,000.[322]

Fentanyl in Child Welfare

One factor encountered by CPI caseworkers is drug use. National and local data suggest that up to 80 percent of adults associated with an abuse or neglect investigation have a substance abuse problem

contributing to the abuse or neglect of the children.[323] Between 2015 and 2017, "51 percent of all child fatalities in Texas involved a caregiver who was actively using or under the influence of substances at the time of the child's death."[324] Unfortunately these numbers do not likely tell the full story as substance abuse is frequently underreported and difficult to track.[325]

While any substance abuse can threaten the safety or well-being of a child, fentanyl is a particular concern due to its lethality and growing prevalence. The Drug Enforcement Administration (DEA) advises that fentanyl is a Schedule II drug similar to morphine, but approximately 100 times more potent.[326] While there are regulated, prescription versions of fentanyl, there is also a market for illicit forms of fentanyl. However, producing illicit fentanyl is "not an exact science," and the DEA warns the public that fentanyl is often mixed with other drugs because of its low cost and potency. The DEA has found counterfeit drugs, such as heroin, cocaine, and methamphetamines, that also contained .02 to 5.1 milligrams of fentanyl. For context, two milligrams of fentanyl – equal to 10 to 15 grains of table salt- is considered a lethal dose for an adult.[327] Depending on the size of the child, a smaller dose could still be a lethal dose. Forty-two percent of pills tested contained this amount. Drug traffickers typically distribute fentanyl by the kilogram.[328]

According to the Centers for Disease Control and Prevention (CDC), fentanyl is up to 50 times stronger than heroin and responsible for nearly 70 percent of overdose deaths in the United States. Fentanyl is often added to other drugs because it makes them cheaper, more powerful, and more addictive. However, it also makes them more dangerous. Even lethal amounts of fentanyl are undetectable by sight, taste, and smell.[329]

Fentanyl can contaminate food, water, or be released into the air as an aerosol. It can be absorbed by the body via inhalation, oral exposure, ingestion, or via skin contact. Peak effects of fentanyl occur between several minutes and two hours after ingestion or exposure. Fentanyl can delay respiratory function, result in respiratory arrest, cause hypoxia, slow the heart rate, cause accumulation of fluid in the lungs, cause a coma, or result in death. The CDC also notes absorption through the skin increases as the temperature of the skin rises.[330]

CPI caseworkers are trained to observe families, interpret drug test results (when conducted), and review interview information and past casework notes. When observing families, caseworkers are looking for changes in behavior, sleeping patterns, financial or relationship problems that could be explained by substance use. Caseworkers are trained to look for signs of impairment by the parent or legal guardian, identify the child's level of vulnerability, and assess the environment for physical evidence of current or past substance abuse.

Caseworkers can request drug testing, but this is only done when the caseworker identifies a factor that indicates substance abuse. A caseworker will require a drug test with 48 hours of a child safety threat that the caseworker believes is related to substance abuse. The graphic below shows the drugs that are currently tested on different types of drug screens and drug tests. Oral fluid testing can occur multiple times per week, while urinalysis testing occurs no more than once per week. A court order, or newly discovered child safety concern, can result in more frequent testing. Hair strand testing, the only type of testing permitted in children, can occur no more frequently than every 105 days, outside of a court ordering more frequent testing.

Figure 8

Drug Detection Period by Drug Screen & Drug Test Type

Drug Screen and Drug Test Type	Detection Period	Drugs Detected
Instant Read Oral Swab Screen[i] Lab Confirmed Oral Swab Test	24-36 hours maximum	**Marijuana, Cocaine, PCP, Amphetamines, Methamphetamines, and Non-Synthetic Opioids**
Urinalysis Test[ii]	3-5 days	**Marijuana, Cocaine, PCP, Amphetamines, Methamphetamines, Opioids, Benzodiazepines, Methadone, Barbiturates, Methaqualone, Propoxyphene**
Head Hair Strand Test[iii]	Over the last 90 days	**Marijuana, Cocaine, PCP, Amphetamine, Methamphetamine, Non-Synthetic Opioids**
Body Hair Strand Test	Over the last year	
Nail Test	**Over the past 6-12 months**	

Source: Department of Family and Protective Services[331]

Children can be tested for drugs when there are concerns about possible environmental contamination in the home or living environment. This contamination can occur from drug use, handling, or manufacture. When environmental contamination is suspected, the caseworker will seek immediate care by a health care professional. If recommended by the health care professional, the minor is drug tested.[332]

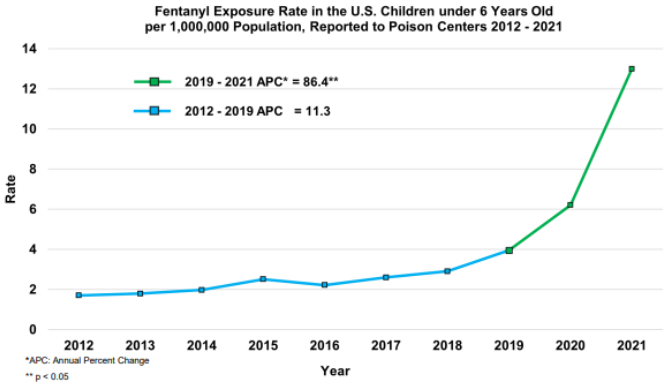
Infant exposure to substance abuse is addressed according to different policies on a case-by-case basis. Caseworkers consider frequency of drug use, time frame of the use, and the impact on the child. Healthcare professionals can assist in developing a plan of safe care by connecting the parent(s) to resources prior to the involvement of DFPS.[333]

The agency has existing procedures for incidences where adults refuse a drug test. The refusal is documented, and the agency has the option to pursue a court order to require a drug test. For cases already under court jurisdiction, the caseworker notifies the judge and attorneys about the parent or caregiver's refusal to test.[334]

A child is not automatically removed from a home if it is determined that there is substance abuse in the home. A caseworker will work with a supervisor to assess if the child is able to self-protect and how dangerous the environment is for the child. The agency is required by state law to keep the child with the parent or care giver in the home if possible. The caseworker will seek to determine the underlying causes of the substance abuse, such as domestic violence, mental health concerns, or lack of a support network, and attempt to connect the family with community resources and agency resources to keep the child with the parent in the home.[335]

Active drug use in the home and noncompliance with DFPS recommendations *could* result in the agency seeking judicial oversight and possible conservatorship removal, though each case is unique and the caseworker and supervisor's assessment factor into safety plans. However, active drug use in the home will not trigger the same intervention if the family is compliant with DFPS directives, though caseworkers are still instructed to ensure the child's immediate safety.[336]

While these processes are consistent with state law, there are increasing reports of children being harmed or killed from exposure to fentanyl in the home. For instance, a North Texas man faces criminal charges in connection with the fentanyl poisoning death of his 2-year-old daughter in February 2024.[337] A Los Angeles woman faces murder charges in connection with the death of her twins in July 2024. Preliminary investigations suggest the 3-year-old boys had ingested or been exposed to an unknown substance containing fentanyl. [338] Between 2020 and 2021, the fentanyl exposure rate doubled among U.S. children under six years old.[339]



Source: University of New Mexico[340]

The unique lethality and difficulty in detecting fentanyl need to be considered when balancing the statutory

requirement to pursue the preservation of the family unit with the safety of the child. The Legislature may need to consider the unique and alarming threat posed by fentanyl when evaluating what constitutes the best interest of the child.

Policy Recommendation 30

Establish a statutory exception for maintaining family unity while fentanyl is a risk in a child's living environment

Texas statute currently requires DFPS to keep a child with a parent or guardian if possible. This currently includes a standard where a child can remain with a parent or guardian even when the guardian is abusing substances in the home as long as the adults are compliant with DFPS requirements, which could include referrals to community resources.

This standard has potentially harmful implications for the child if fentanyl is determined to be a factor in the household because of the particular lethality of fentanyl. Even a small dose of the drug can pose a lethal and immediate risk to a child. The Legislature should consider if a statutory change is needed to ensure a child is in a safe living environment if fentanyl is a factor in the environment.

Given fentanyl's addictive nature, there is also a possibility that an adult with substance abuse involving fentanyl, whether or not they are aware of the fentanyl abuse, may make it more difficult to comply with DFPS requirements to seek resources. If this is the case, even an adult who wishes to comply with DFPS requirements might have a longer or more challenging treatment path before the living environment is truly free from fentanyl. This consideration is another reason for the Legislature to decide whether a statutory change is needed to ensure that a child has a safe living environment while a parent or guardian pursues compliance with DFPS requirements.

Agency Monitoring

Ideally, a placement resulting in the "best interest of the child" incorporates a child's emotional and mental health and opportunities for education and self-actualization. These considerations, however, mean little if a child is in danger of severe harm and even death.

DFPS conducts comprehensive background checks on parents and caregivers of children in state care to ensure their safety and well-being. These checks involve reviewing criminal history records, including both name-based and fingerprint-based searches through the Texas Department of Public Safety (DPS) and the Federal Bureau of Investigation (FBI) databases.[341] DFPS also examines the Central Registry, a web-based portal providing child abuse checks, for any history of child abuse or neglect in Texas or in other states.[342] The agency also mandates that individuals report any new criminal incidents within five business days.[343] However, background checks conducted by the agency are at specific points in time and do not involve continuous monitoring of criminal history. Therefore, an individual might pass a background check when it is initially conducted but later commit a crime, with the agency failing to learn of the crime.

The adoption of continuous monitoring practices could further strengthen the agency's efforts to protect vulnerable populations. Continuous monitoring involves real-time alerts and ongoing checks beyond initial pre-employment screenings. This approach provides private sector employers with immediate notifications of any legal activities or changes in an individual's background, enhancing workplace safety and compliance.[344] In the past, the Texas Department of Public Safety utilized continuous monitoring for individuals with a license to carry a handgun, so there is some precedent for a state agency to adopt such a policy.[345]

Policy Recommendation 31

Adopt continuous background monitoring

DFPS could perform continuous monitoring of adults in proximity to children while they are in care. Once a child is adopted, or DFPS is otherwise formally removed from the case, the agency would cease monitoring activities.[346] It is worth nothing that continuous monitoring of all individuals involved in the lives of children in care could result in a significant fiscal note for the agency.

The agency could also take steps to clarify certain procedures around the investigation of potential abuse and provide greater oversight to private organizations facilitating child adoptions. For example, one of the rights ascribed to children in foster care is the right to visit and have regular contact with family, unless a court order or case plan does not allow it.[347] Parents whose rights have not been terminated have a right to visit their child. The frequency, location, and timing are determined with the caseworker unless a court order has laid out a plan. Rules for phone calls are outlined in the family's visitation plan, but the best interest of the child will supersede.[348] The agency should adopt a standard cap to the number of visits that parents can have with their child (which can still be frequent) and limit how many individuals can attend these visits. While it is appropriate for caseworkers to maintain discretion in waiving these limits in the best interest of the child, it would be beneficial to implement additional guidelines around these visits to support stability and normalcy for the child and temporary caregivers.

Policy Recommendation 32

Adopt limits around family visitation

When a woman or family is considering placing an unborn infant up for adoption, they may not sign the paperwork until 48 hours after the birth of the child. The decision to place a baby up for adoption only becomes final when a parent(s) signs the paperwork, though a birth family can be chosen before that. [349] However, some organizations facilitating child placement, including child-placing agencies and matchmaking services, are inaccurately relaying to birth and/or adoptive families that these documents can be signed earlier.

While birth or adoptive families can signal their intent to place an unborn child for adoption or adopt an unborn child, respectively, and their intent to do so with a specific family, they should not be misled into believing this intent constitutes placing a child for adoption or adopting a child. Organizations representing these contracts as binding should be subject to financial penalties, and if there is evidence that such erroneous statements were made with the intent to deceive, criminal penalties are appropriate.

Policy Recommendation 33

Adopt statutory clarification that organizations may not present pre-birth contracts as adoption paperwork, including penalties for violations

It is also worth noting that not all child-placing agencies are licensed by the state, though they must still meet minimum statutory guidelines. Some sources advocate against working with adoption facilitators, as they are unlicensed and unregulated. As compared to a law center, which will utilize an attorney to work on the legal aspect of adoption but does not match birth mothers with families,[350] an adoption facilitator will provide matching services but cannot assist with the legal components of adoption.[351] The Legislature should review options for maintaining minimum standards by individuals presenting themselves as credible adoption facilitators. In at least one case, an adoption facilitator was charged with identifying potentially pregnant incarcerated women and paying them while they were in jail with the understanding that they would place their children up for adoption upon birth.[352]

The Penal Code (Sec. 25.09) makes it a misdemeanor for a person to advertise for placement of a child in public media, other than a licensed child-placing agency.[353] While some sources[354] argue it is illegal to work with an adoption facilitator, it seems the illegality only derives from advertising, so potentially a "matchmaker" can exist, though they cannot advertise.

Any person involved in the adoption process (including matchmakers and adoption facilitators) should have to post conspicuous notice that they are not licensed by the state, if in fact they are not. Violators should face significant penalties. This step would create a minimum threshold to inform pregnant women that not all adoption facilitators are necessarily operating with practices that have been endorsed by the state.

Policy Recommendation 34

Adopt disclosure requirements for unlicensed adoption facilitators

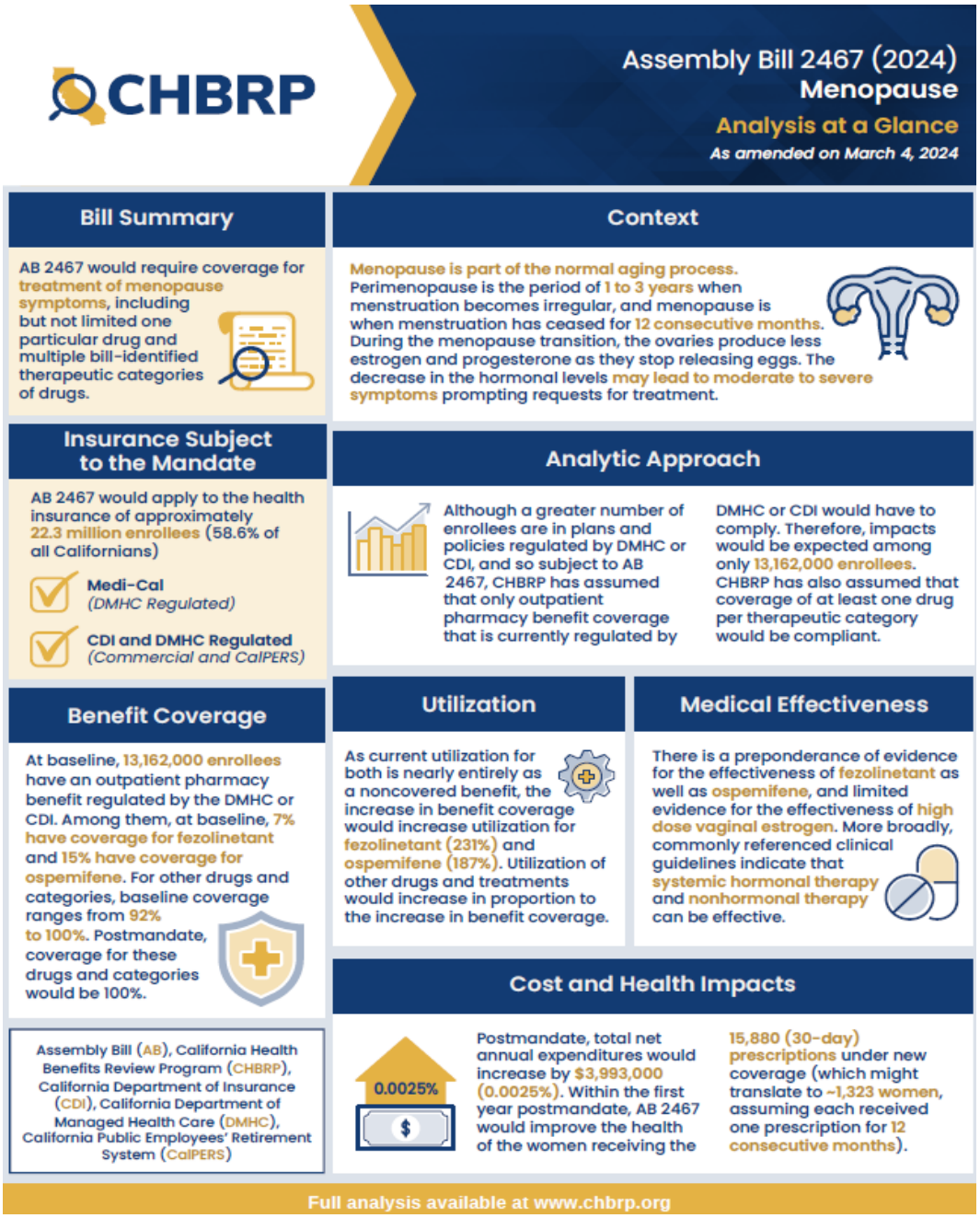
Licensed child-placing agencies are sometimes single source continuum contractors (SSCCs) with DFPS. SSCCs provide child placement, case management, and other support services to children and families.[355] As licensed facilities, SSCCs submit more data than unlicensed groups to DFPS for quality control purposes. All individuals who receive services from SSCCs should receive a survey after their experience with the agency. These surveys should be submitted to DFPS for additional review and monitoring of the SSCCs, and the result should be heavily weighed when DFPS determines whether it should renew its contract with an SSCC.

Policy Recommendation 35

Direct DFPS to solicit surveys from individuals who receive services from SSCCs

Appendices

I - CHBRP Analysis of AB 2467



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