TCCRI
Texas Conservative Coalition
Research Institute

FINAL
REPORT
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# HEALTHCARE & HUMAN SERVICES TASK FORCE

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# Texas Conservative Coalition Research Institute

*2021-2022 Health Care & Human Services Task Force*

Final Report

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# I. Introduction

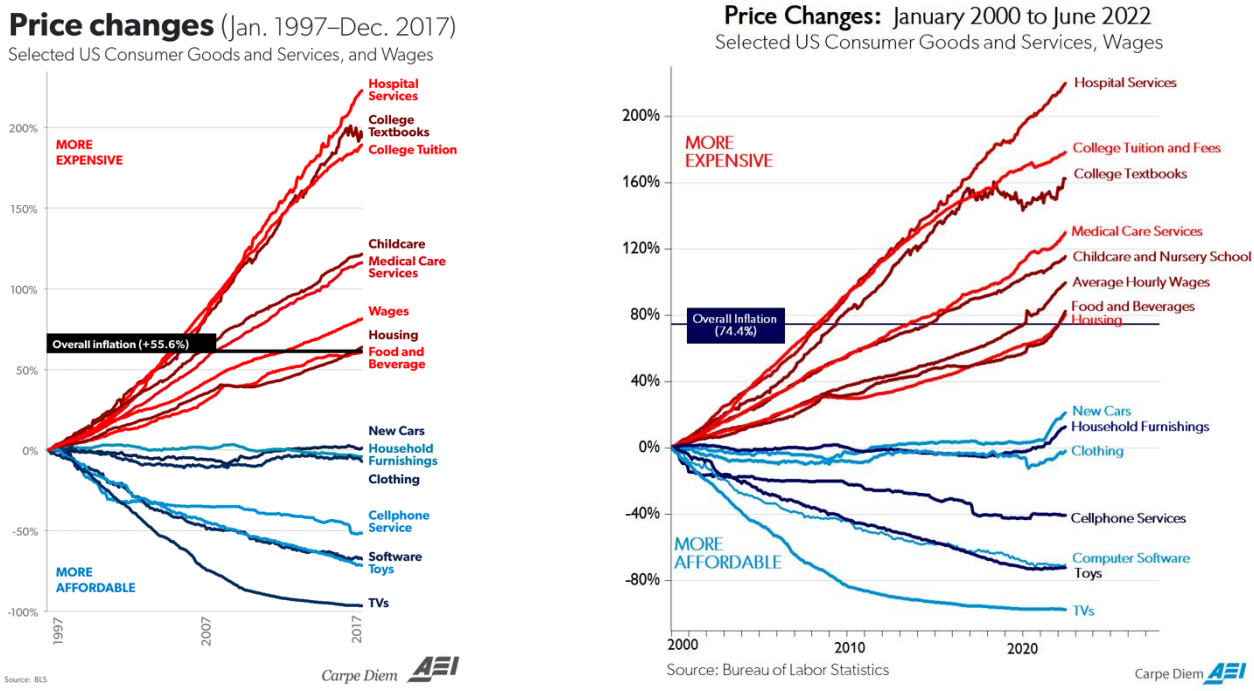
When Texas was approaching the last legislative session in 2021, our state, along with the rest of the world, was grappling with how to transition from a "pandemic mentality" to one of reasonable risk management. While COVID-19 wrought health and safety issues, economic catastrophe, and exploding welfare rolls, the resulting lockdowns also gave rise to some positive innovations, such as the increased use of telehealth, reduced occupational licensing hurdles, and a greater focus for many on overall health and wellness.

Significant change has continued over this past interim. While ever-present, COVID-19 has receded into a background narrative rather than the headline story; the Supreme Court made history with the overturning of *Roe v. Wade* earlier this summer; inflation in the United states reached its highest rate in 40 years;[1] and migrant crossings along the Texas border have consistently remained at near-record high numbers.[2]

Much has changed for the 88th Texas Legislature as well. State lawmakers find themselves in a remarkably different position than prior years. The effects of inflation, increased energy prices, and economic recovery from COVID lockdowns have left the state with an almost $33 billion budget surplus and a total of $188.23 billion for general spending, a situation Comptroller Glenn Hegar has described as "a truly once-in-a-lifetime" budget scenario.[3] Although a significant portion of these funds is subject to Texas' constitutional spending limit,[4] and Governor Abbott, Lieutenant Governor Patrick, and Speaker Phelan have already vowed to use some of the surplus to address property taxes, there will undoubtedly be intense debate as to how to allocate the seemingly overflowing coffers.

Unfortunately, the outlook and challenges facing healthcare issues have remained constant: 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. The Texas Conservative Coalition Institute's (TCCRI) task forces, like the rest of the nation, have been working to tackle them over the past several years. As such, 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.

As we have done in some previous years, we offer the American Enterprise Institute's (AEI) now famous "Chart of the Century," updated annually, to show how the costs in medical care and hospitals continue to trend upward, outpacing wages, housing, food, and now even childcare. Lest there be any confusion that such growth could be the result of inflation or the lingering effects of COVID-19, we juxtapose the most recent chart with the initial iteration of this series, first produced in 2018, which clearly depicts almost identical trends in medical and hospital costs.




*Source: American Enterprise Institute*[5,6]

Over the past several 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, including both the public and private sectors, all of the issues and challenges can be summarized into three primary needs: ***affordability***, ***accessibility***, and ***accountability***. Texans deserve to be able to *access* care and coverage at *affordable* prices in a manner that fosters both government and consumer *accountability*. Regardless of the consumer, payor, or provider, policy proposals must earnestly seek to address all of these issues and, not surprisingly, some of the issues covered in this report impact all three of these principles. Much like a tripod, if one leg of this platform is removed, the other two cannot successfully stand.

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 unfunded mandates 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 would require a literal act of Congress to reform, there are free market policies that state leaders can adopt in the 88th Legislative Session which would help to address the most critical issues facing healthcare today.

The "Affordability" 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 reign in its regulatory role. This portion focuses on reforms that the Legislature should consider in the private sector during the 88th Legislative Session to

help increase affordable high-quality coverage options - initiatives which TCCRI has championed for many years. These reforms include rolling back, and rejecting any new, benefit mandates; shielding ERISA plans from state mandates; providing for coverage options that are free of most state-mandated benefits; 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 "Accessibility" 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; allowing military physicians and nurses to maintain their licenses upon leaving active duty; examining how physician assistants and pharmacists can be better utilized to meet patient needs; allowing dental hygienists to administer local anesthesia under the delegation of a licensed dentist; and increasing access to telehealth and teledentistry services.

The "Accountability" section of this report is the most varied because it addresses policies that promote accountability of consumers, providers, payors, and the government. This segment begins with a discussion on how transparency begets competition, which fosters higher quality and lower costs. A transparent system empowers consumers, incentivizing them to hold providers and payors more accountable. 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; and ensuring price transparency requirements are uniformly applied to all providers and payors in the healthcare system.

This Report recognizes the ongoing challenges faced by the Teacher Retirement System of Texas, particularly the coverage of its retirees and their dependents. Here, TCCRI recommends examining the feasibility of allowing TRS-Care consumers to use funds the government would have spent to purchase their own lower-cost private health insurance products.

The final segment of the Accountability section of this report focuses on Texas Medicaid program, and the need for the 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 that focus on ensuring timely and accurate redeterminations of the estimated 2.5 million recipients on Medicaid due to the federal public health emergency (PHE) declaration, and maintaining the integrity of the current managed care program.

This final Task Force Report lays out the policy issues that the Healthcare and Human Services Task Force and TCCRI staff focused on over the past interim. 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 in the 88th Legislative Session.

# II. Affordability

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 the following 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.

## A. Government Mandates: Increased Costs and Decreased Consumer Choice

Unfunded government mandates within the health coverage marketplace may take several forms ranging from mandated contractural terms between two private entities to government price controls. However, two common forms of this practice include mandated benefits and any willing provider (AWP) laws. While they differ in their requirements, the results are the same: healthcare consumer are left with higher premiums and, often, decreased choice.

*Benefit Mandates*

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.[7] With the federal Affordable Care Act (ACA) already requiring that plans cover ten categories of "essential benefits,"[8] 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 also unquestionably a sympathetic population (all of these mandate bills have been filed in prior sessions with the former having passed into law, and just last session the Texas Conservative Coalition opposed dozens of bills that would have increased mandates on private carriers). 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.[9]

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.[10] 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.

*Any Willing Provider (AWP) 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.[11] 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. <u>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</u>.[12]

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.[13] Proponents of such laws argue that they "level the playing field," particularly for independent practitioners, and provide greater choice to consumers.[14] 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.[15] 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.[16]

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.'"[17]

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."[18]

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.[19]

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.

### 1. Policy Recommendation: Reject Unfunded Mandates

TCCRI has long supported rejection of unfunded government health care mandates in any form, be they benefit, price or rate controls, contractural, or administrative. The 88th 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.

### 2. Policy Recommendation: Require a Fiscal Impact Statement on Legislation Containing Health Coverage Mandates

In the 87th Legislative Session, HB 2600 (Paul, et. al.) would have required the Legislative Budget Board (LBB) to prepare a fiscal impact statement for any bill or joint resolution containing a health plan mandate, including new benefit, rate, contractural, or administrative requirements. Such information is critical, as the current fiscal note process captures only costs to the state budget. Therefore, unless a requirement applies to a state-funded plan, such as ERS or TRS, no costs are reported, regardless of the impact on Texas families and employers. Although the bill was jointly authored by members of both parties, passed unanimously from House State Affairs, and was placed on the General State Calendar, it was never ultimately heard on the House floor.

The 88th Legislature should pass the language in HB 2600 (87R) to ensure policymakers have access to this vital information. Such an analysis would allow lawmakers to better weigh the benefits of additional mandates on any type of coverage model against their true costs to Texas consumers and employers.

### 3. Policy Recommendation: Adopt Coverage Options Free of Additional Mandates

In the 85th Session, HB 4213 (Phillips) was filed and would have authorized health plans to offer catastrophic health benefit plans, free of any state-mandated health benefits. If passed, this legislation would have augmented SB 541 (78R) (Williams/ Sp: Taylor), which allowed employers and health maintenance organizations (HMOs) to offer plan options free of certain state mandates. Current law, as a result of SB 541, allows employers and plans to waive many state-specific mandates, but does still prescribe some benefits that must be covered, such as certain pre-existing conditions and serious behavioral health conditions,[20] and the list of mandates has grown since that legislation was passed as a result of additional federal and state mandates. HB 4213, as filed, would have amended the same section of the Insurance Code as SB 541 to include an additional option for a completely mandate-free catastrophic plan to group plans and individual consumers.

Though HB 4213 did not proceed past the House committee stage, the 88th Legislature should make this a goal for this session and pass language similar to that in HB 4213. Although some catastrophic coverage options are available to purchase in the private market, removing the requirement for any mandates above those required in federal law could encourage other carriers to provide additional competitive offerings.

Catastrophic plans are often attractive coverage options for young, otherwise healthy individuals. According to an October 2020 report by United States Census Bureau, individuals age 26 have the highest uninsured rate of any age group, followed by peers in the later 20s.[21] This makes sense, as individuals in this age group are no longer eligible for coverage as dependents of covered parents (this ends at age 26 under the ACA), and many are likely facing the choice of whether or not to purchase insurance coverage for the first time. As one noted healthcare policy expert explains, "Healthy people tend to buy insurance based on price. Sick people, however, look at likely out-of-pocket costs for their illnesses and want broader networks."[22] So, while a catastrophic plan is not for everyone, it could provide a great value for someone who does not see the need to pay a large monthly premium for regular primary care and prescription drug coverage, but does recognize the value of a lower cost plan that would cover health emergencies.

Lawmakers should also support two bills that have been filed in the 88th Legislative Session: SB 605 (Springer) and its identical companion HB 1001 (Capriglione). These bills would increase consumer choice by allowing coverage options that are free of many of the exiting state-mandated benefits currently in place.

## 4. Policy Recommendation: Protect ERISA Plans from State Mandates

The Employee Retirement Income Security Act (ERISA) is a federal law that permits employers that operate across multiple states to operate health coverage plans under a standard set of requirements. Simply put, ERISA contains a very broad preemption clause allows large employers to administer health benefits more efficiently and cost-effectively without having to adhere to state-by-state mandates. A recent Texans for Lawsuit Reform (TLR) newsletter describes the law thusly:

> ERISA comprehensively regulates the administration of employee healthcare plans that provide "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death." It does not regulate the substantive content of such plans. Thus, each employer can choose for itself the costs and benefits that best fit its circumstances.[23]

Over the last few years, litigation has threatened ERISA's preemption clause, with some arguing that preemption needs to be curtailed in order to give states broader regulatory authority over these health plans.[24] TLR goes on to explain:

> Courts have determined that ERISA is a valid federal statute pursuant to the Commerce Clause of the Constitution and, thereby, is a law that can properly preempt conflicting state or local laws.
>
> The preemption rule in the ERISA statute expressly prohibits states and localities from forcing employers to create or amend an ERISA-sanctioned employee benefit plan, or from enacting statutes or ordinances controlling the administration of an employee benefit plan established under ERISA.
>
> ERISA preemption matters for two reasons. First, it allows companies that operate across state lines to establish uniform health plans for their entire workforces. Second, entrepreneurial plaintiff's lawyers seek to end ERISA preemption for their personal gain.[25]

Signaling the importance of maintaining these protections for Texas employers, the Texas Association of Business (TAB) has identified preserving ERISA as one of its 2023 Key Legislative Priorities "by opposing any attempt to erode the federal preemption of state law relating to employer health benefit plans."[26]

Texas lawmakers should ensure the state remains business-friendly by refraining from attempts to enact state mandates on ERISA plans. ERISA's preemption is vital to the availability of affordable coverage for both Texas employers and consumers.

## B. Alternative Coverage Options

*Texas Mutual & Farm Bureau*

During the last legislative session, lawmakers began exploring coverage options that could serve as alternatives to the heavily regulated, and therefore more expensive, traditional insurance marketplace. Two hallmark pieces of legislation were passed that laid the groundwork for alternative coverage options. The first, HB 3752 (Frank, et. al.), authorizes the Texas Mutual Insurance Company, which has historically handled workers' compensation coverage, to begin offering health coverage. Texas Mutual was created by the Legislature in 1991 to "offer a stable, competitive source of worker's compensation," and currently covers about 1.5 million employees through its 70,000 policyholders.[27] The company was established by the Texas Legislature and originally funded with state money; however, Texas Mutual repaid those funds and no longer receives state funding. Although Texas Mutual had never until this point been authorized to offer health coverage options outside of workers' compensation, its success in the latter makes this an innovative concept that could provide coverage options for Texas who have been priced out of individual plans, and could allow small employers to offer new overage to their employees.

The second bill, HB 3924 (Oliverson, et. al.), allows Texas Farm Bureau to also offer health coverage options to its members, following a precedent set by some other states with strong agricultural ties. Indiana, Iowa, Kentucky, and Tennessee currently offer mandate-free coverage offerings based on medically underwritten criteria.[28] Ohio and Georgia provide self-funded plans, and Nebraska offers guaranteed-issue short-term plans to its farm bureau members. While it does establish some guidelines, such as prohibiting a waiting period of longer than six months and requiring certain disclosures, HB 3924 provides flexibility in establishing and administering the Texas version of this plan so that our state's Farm Bureau may determine what best meets the needs of its members.

Both bills enjoyed broad bipartisan support from members across the state, demonstrating that the need to offer an array of choices to meet various consumer needs supersedes geographical boundaries and party lines.

*Association Health Plans & Multiple Employer Welfare Arrangements*

The current healthcare environment can seem overwhelming, especially in terms of what states can do to effect any positive change in the face of so much sclerotic federal policy. One option that some small employers can use to provide health coverage for themselves, and their employees, is association health plans, or AHPs. TDI explains that AHPs involve an "arrangement where businesses group together to provide their employees' health insurance, either on a fully insured or a self-funded basis," with the goal of "lower[ing] premiums using economies of scale and exemptions from some small-employer requirements."[29] Simply put, AHPs allow small business to join together and purchase coverage that is typically only available to larger employers, where risk is spread across a larger population. And, because

the plans are not subject to all of the ACA's mandates, their premiums are generally more affordable than Exchange plans.

One variation on current AHPs is known as a multiple employer welfare arrangement (MEWA). While AHPs are required to be administered by an employer, or a group acting as an employer, MEWAs are not subject to this restriction.[30] These plans are described as:

> …the basis for group health coverage offered through association health plans. As a MEWA, multiple employers can come together within an association to offer a health benefits plan (though, in theory, other benefits could be offered). In other words, the MEWA functions as a single health plan for multiple employers belonging to the association. The ability of employers to work together to sponsor a health plan as a single entity and aggregate total eligible employees allows smaller employers to gain access not only to more flexible large group health plan rules but also gain improved leverage in negotiations with insurance companies and healthcare providers.[31]

Although legislation to provide framework for MEWAs was filed last session, it did not ultimately pass to enrollment. Such arrangements could prove crucial in the array of coverage options for Texas employers, especially small business owners, and should be taken up again by the 88th Legislature.

Though they are generally governed by ERISA, MEWAs may also be subject to state regulations.[32] They offer critical opportunities for small business owners, which make up a significant share of the Texas employer pool, to offer the type of group health benefit coverage to their employees that would otherwise be unavailable.

Texas lawmakers should continue to foster an economy that welcomes AHPs so small businesses can fully utilize the options currently available and expand the use of these plans if and when the option presents itself. Texas is home to 2.8 million small businesses that provide jobs to almost 5 million Texans[33] who need and deserve affordable quality coverage free of intrusive, and expensive, government mandates.

### 1. Policy Recommendation: Reject Additional Regulations on AHPs and MEWAs

Texas currently allows both fully insured and self-funded AHP options with varying requirements depending on the specific type of plan.[34] State lawmakers must reject any attempts to saddle AHPs with any additional burdensome regulations that could further restrict such plans as a practical option for working Texans. Lawmakers should also foster the use of MEWAs but must abstain from any inclination to regulate these offerings like a traditional insurance product. Small business owners are the backbone of the Texas economy but are often left with little to no options when looking to offer affordable coverage to their employees. MEWAs permit small businesses to band together and harness their

collective resources when purchasing coverage, providing them with competitive leverage that would be otherwise unavailable.

### 2. Policy Recommendation: Continue to Offer and Improve Non-Traditional Coverage Options

Special attention should be given to how the new coverage authority provided to Texas Mutual and Texas Farm Bureau during the last legislative session could be improved or enhanced to maximize opportunity for these entities, and for Texans in need for affordable coverage and care. The key to the expanded use of such coverage options is to refrain from over-regulation. Alternative coverage models, including the Texas Mutual, Farm Bureau, and Association Health Plan options, are made affordable primarily because they are not subject to the full array of insurance mandates. Attempting to regulate these products as if they are traditional insurance models will prohibit the innovation and flexibility needed to offer these lower cost options to Texas consumers.

# III. Accessibility

Texas' provider shortage is longstanding and well-established. Although primary care and physician shortages offer some of the starkest statistics, similar data exists regarding lack of access to dental care in many parts of the state (especially rural areas),[35] as well as challenges accessing behavioral health and other specialty providers. The bottom line is that Texas has access to care issues for multiple provider types- these challenges are not strictly limited to those in primary care.

State leaders are aware of these issues and have taken action over the past several sessions, passing a number of laws to increase the availability of certain healthcare providers, including establishing new medical schools and residency slots; increasing access to telehealth and telemedicine platforms; and allowing greater licensing reciprocity with states participating in interstate licensure compacts. The Texas Legislature passed two important bills last session to help increase access to care. SB 993 (Hancock, et.al./ SP: Klick, et.al.) allows therapeutic optometrists to prescribe certain oral medications and independently diagnose, treat, and manage glaucoma,[36] permitting these providers to treat diseases for which they have been trained, without requiring delegation from, or consultation with, an ophthalmologist. And HB 1616 (Bonnen, et.al/ SP: Huffman, et. al.) authorized Texas to join the Interstate Medical Licensure Compact. This compact affords physicians in the state access to similar interstate compacts that the Texas Board of Nursing[37] and the Texas Behavioral Health Executive Council[38] already participate in, allowing providers under their respective purviews to more easily practice within participating states.

While these policies represent great strides in helping our growing state address quickly expanding demand, more can, and should, be done in the 88th Legislative Session.

## A. Medical Care

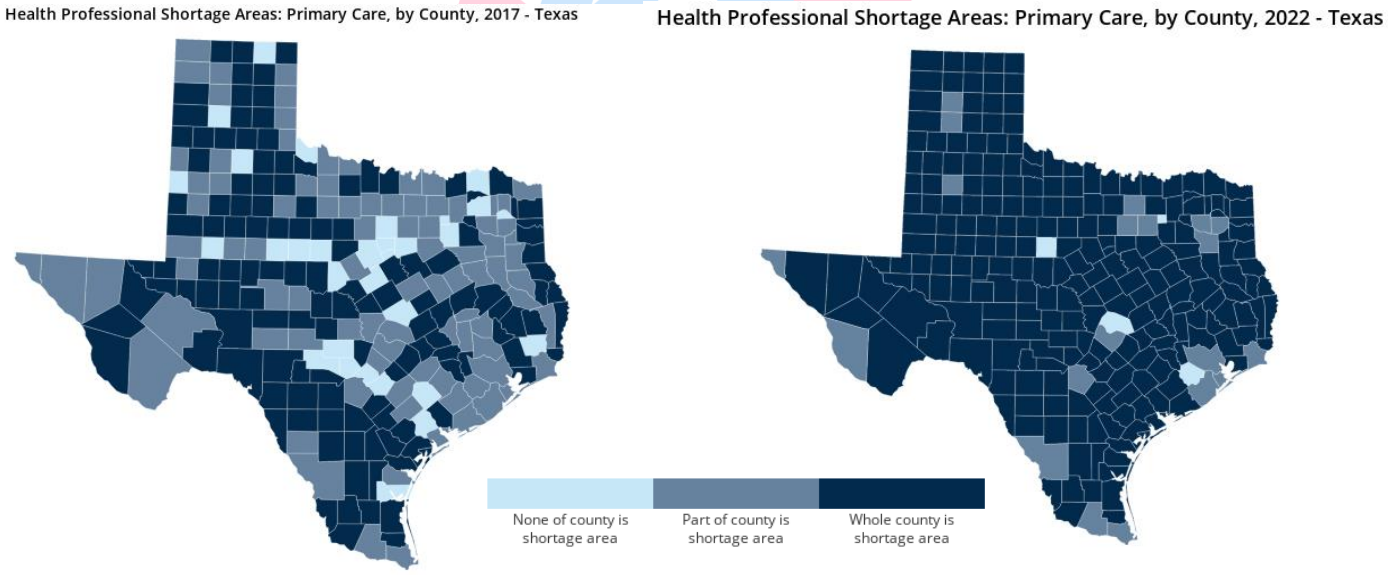
In 2015, Merritt Hawkins released an extensive report examining the adequacy of the state's physician workforce. The results were not encouraging, ranking Texas among the lowest ten states for the number of actively practicing physicians per 100,000 residents, with 2.2 million Texans residing in small counties that were served by only 2.5 percent of the state's entire physician workforce.[39] 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.[40]

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.[41] 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.[42] A Texas Department of State Health Services (DSHS) report found that by 2030 the additional need for primary care physicians across the state will have grown by 67 percent.[43] And it bears mention

that this research was conducted prior to the worldwide outbreak of the coronavirus, which only served to add additional stress to an already burdened healthcare system. Today, only four 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.[44]

The maps below, 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 on the left reflects HRSA's 2017 designations for the State of Texas, while the map on the right presents the most up-to-date version of this data for 2022. 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, almost all of these "partial" designations have become "whole county" shortage areas, and only four counties in the entire state are currently able to meet their residents' primary care needs. It is clear that Texas is moving in the wrong direction on access to primary care, and immediate action is needed in the 88th Legislative Session.




*Source: Rural Health Information Hub*[45]

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 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,[46] opening up the pipeline for qualified nursing students to enter the workforce,[47] and easing telehealth[48] and pharmacy[49] 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.

## 1. Allowing Providers to Practice at the Top of Their Licensees

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.

*Advanced Practice Registered Nurses*

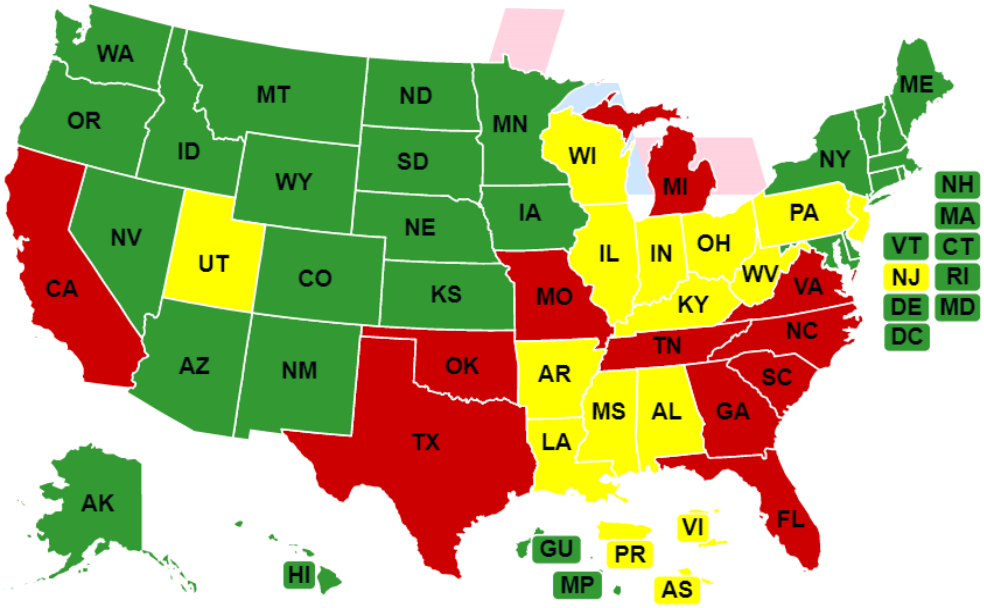
In past sessions, multiple bills have been several bills filed to permit Advanced Practice Registered Nurses (APRNs) to practice with independent authority, allowing these practitioners to fully exercise the medical licenses for which they are trained. Since their emergence in the 1960s to address access-to-care needs, ARPNs have become an integral part of the U.S. primary care system.[50] In 2022, there were more than 350,00 APRNs across the country, an increase of more than 200,000 since 2009, with about 90 percent of these professionals trained in primary care.[51]

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.[52]

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.[53] These expensive delegation requirements put Texas at a distinct disadvantage to neighboring states that don't require delegating physicians, such as New Mexico, which allows full practice, and Louisiana and Arkansas, which allow greater flexibility than our state.[54] Texas is one of only eleven states that restricts APRN practice, with 22 states and the District of Columbia, federal health care services, and all branches of the military[55] allowing APRNs to practice without physician delegation authority.[56,57]

The following map, updated by the American Academy of Nurse Practitioners in 2022,[58] provides an overview of the national landscape of how APRNs are able to practice across the nation, and clearly shows how this state 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.

**2023 Nurse Practitioner State Practice Environment**




**Full Practice:** State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

**Reduced Practice:** State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

**Restricted Practice:** State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

*Source: American Association of Nurse Practitioners*[59]

In addition to addressing access to 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 past 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,[60] and no increase in overall Medicaid service utilization (claims, days of care), when patients are treated by APRNs.[61]

Multiple studies and simulations show overall cost-effectiveness and sometimes significant savings with no restrictions on APRN practice,[62] with net savings ranging from more than $700 million in Alabama over a 10-year period[63] to billions of dollars in Pennsylvania and California over a 10-year timeframe, considering the overall healthcare system.[64,65] An examination of Texas Medicaid costs, looking at historical data from 2018 and 2019, showed that even a 25 percent shift from physicians to APRNs for primary care E&M services would have saved the state almost $7 million,[66] and those numbers would likely be significantly higher today.

*Armed Service Veteran Physicians and Nurses*

While APRNs can help fill the provider shortage gap, there is another subset of trained and qualified medical professionals whose ability to practice in Texas currently hinges upon active-duty military status. Under current law, physicians and nurses on active-duty military status are exempt from state licensure laws and able to fully practice, on the condition that the license is still valid and in good standing. That authority is revoked upon leaving active-duty service, even though nothing in the provider's education, training, or experience has changed. This is an arbitrary and unnecessary licensure impediment for Texas veterans and should be addressed.

HB 548 (Frank) and its identical companion SB 1909 (Blanco) from the 87th Regular Session would have allowed physicians and nurses to maintain a license to continue practicing medicine in certain underserved areas in Texas upon leaving active military service, on the condition that the license is still valid and in good standing.

*Pharmacists*

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.[67]

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.[68]

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.[69] 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.[70]

Some states have also embraced the "test and treat" model that allows pharmacists to administer certain 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.[71]

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.[72] 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.[73]

### 2. Policy Recommendation: Allow the Independent Practice of Advanced Practice Registered Nurses

The time has come to place Texas on par with most of our neighboring states and grant APRNs independent practice authority, as set forth in last session's HB 2029 (Klick) and SB 915 (Hancock). These bills would have made various changes to laws governing APRNs, most significantly allowing them to practice as independent practitioners. The legislation would not alter the scope of practice of these providers, meaning that an APRN would still have had 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.[74] However, the legislation would have removed the requirement that APRNs practice under a delegation agreement with a licensed physician and would have centralized the regulation of APRNs at the Texas Board of Nursing.

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.[75] 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.[76]

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.

### 3. Policy Recommendation: Allow Veteran Physicians and Nurses to Maintain Their Licenses

Lawmakers should adopt the language in HB 548 and SB 1909 from the 87th Session, permitting physicians and nurses to maintain their active licenses to practice medicine and nursing upon leaving active duty military. The Legislature should consider going one step further by removing the restriction that these providers may only practice in medically underserved or health professional shortage areas (although admittedly those restrictions still cover almost the entire state in today's provider shortage environment).

Adopting such legislation in the 88th Session would admittedly impact a relatively small number of providers but could increase access in the areas where they reside and could entice these veterans to remain in Texas if they are able to continue to practice their profession upon leaving military service.

### 4. Policy Recommendation: Allow Pharmacists to "Test and Treat" Certain Illnesses

Lawmakers should adopt language similar to that of HB 2049 (Howard) filed in the 87th Session, which would have expanded the ability of pharmacists to "test and treat" for the flu and strep. 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 visit, there could be cost savings to 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.

### 5. Policy Recommendation: Expand Pharmacists' Ability to Administer Certain Immunizations

HB 678 (Cortez, et. al.)/ SB 2136 (Blanco) would have expanded immunizations and vaccine authority. 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.[77]

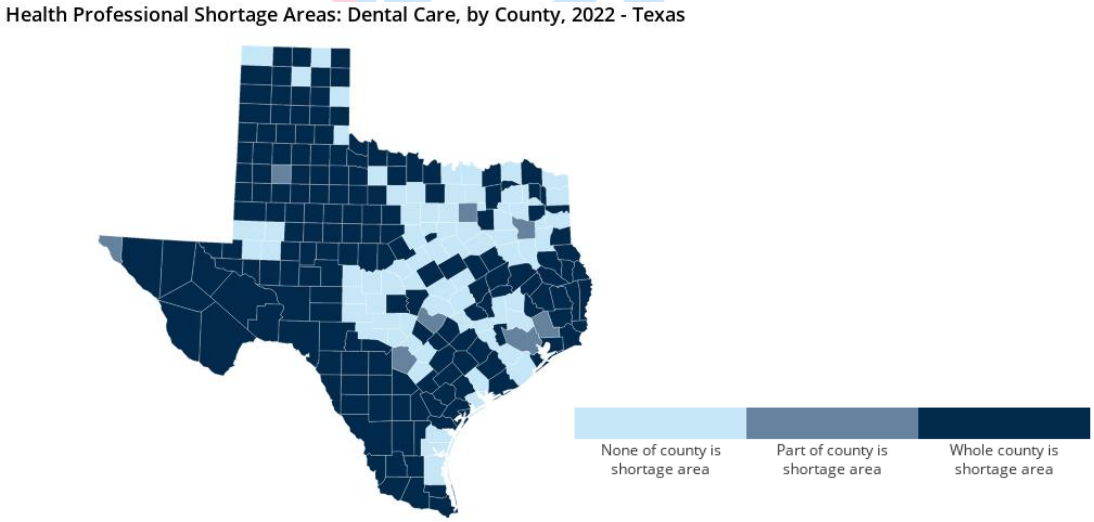
Both bills would have eased those restrictions, while still ensuring a pharmacist has received the necessary education and training to administer immunizations and vaccines and notifies a patient's primary care physician of any care provided. Lessening these restrictions could increase access to vaccines 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 both HB 2049 and HB 678 provide good starting points to better leverage pharmacists in the care continuum and should be adopted in the upcoming session.

## B. Dental Care

Another area where Texas lags behind other states in the use of ancillary providers to increase patient access is in dental care. While cosmetic dentistry and certain orthodontics are a luxury, there are both economic and wellness arguments behind obtaining regular, preventive oral care, such as cleanings. The cost savings of maintaining oral health could be significant, not only on the healthcare system, but in other sectors as well. The CDC reports that children miss about 34 million school hours annually due to unplanned emergency dental visits; the U.S. workforce experiences about $45 billion in lost productivity because of untreated dental diseases; and, in just one year, more than 2.2 million Americans visited costly emergency rooms for emergency dental care.[78]

Though access to dental care in Texas is not as dire as that in primary care, the map below clearly shows that the availability of dental care is largely centered around the state's urban areas. The vast majority of West, South, far North, and far East Texas are considered by and large dental health professional shortage areas.




*Source: Rural Health Information Hub*[79]

Two steps the state could take to remove barriers and increase access to general and preventive oral health visits are to allow dental hygienists to administer local anesthesia under the authority and delegation of a licensed dentist, and to increase the availability of oral care via teledentistry services.

*Allowing Hygienists to Administer Local Anesthesia*

Allowing dental hygienists who have been properly trained to administer local anesthesia (the numbing of teeth and gums) without having to wait for the dentist to come by and administer the medication, only to then allow the hygienist to proceed with his or her job, would increase the efficiency of the dental office, not to mention greater convenience for the patient. This could also increase access to routine oral care in some areas. Dental hygienists in Texas are able to practice independently to a limited degree in certain settings, with the goal of increasing access to oral health care. These settings include school-based health centers, nursing facilities, and community health centers. [80] The authority to administer local numbing could allow hygienists practicing in these settings to perform routine oral care that they might not otherwise be able to provide because it would be too uncomfortable for the patient without anesthesia.

Texas is one of only three states that states that does not permit dental hygienists to administer local anesthesia (implementation in two of the 47 states that allow this practice is currently in progress).[81] Other states began allowing hygienists to administer local anesthesia as early as 1971,[82] and a 2005 study on this topic by researchers from the Caruth School of Dental Hygiene, the Baylor College of Dentistry, and the Texas A&M University System Health Science Center "affirmed public safety, which should be helpful to states considering statutes to allow the administration of local anesthetics by dental hygienists."[83] While this study is admittedly dated, it is generally the standard of research cited in most articles and paper on this topic. This is not surprising; since the majority of other states have already adopted this policy, it is no longer under broad discussion as the safety and efficacy of this practice have been long established.

*Teledentistry*

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.[84] 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."[85] 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.[86] 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." [87]

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.[88] At the six-month mark, the supervising dentist must then examine the patient before the hygienist may provide any additional services.[89]

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 allowing hygienists to administer 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.

#### 1. Policy Recommendation: Allow Dental Hygienists to Administer Local Anesthesia

Texas has trailed its counterparts on better utilizing dental hygienists in the dental care continuum going back to the early 1970s. The vast majority of other states have employed this practice for decades with no quality or safety concerns of note, as they continue to use and expand this practice. Multiple bills have been filed over past legislative sessions attempting to enact this reform, the most recent being HB 2348 (Klick) in the 87th Session. Lawmakers should support this this scope of practice change in the 88th Session to ensure Texas remains competitive in its ability to attract qualified dental professionals and meet the state's access needs. The legislation does not mandate any practice, nor does it decrease a dentist's authority over his or her hygienists or patients. On the contrary, it would simply allow a licensed dentist, at his or her discretion, to permit a hygienist to administer a numbing agent if the hygienist has received specified training. The precedent and safety of this practice is well-established in almost every other state, and Texas should not delay adoption of this policy any longer.

#### 2. Policy Recommendation: Explore Increased Access to Teledentistry

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.

### C. Telehealth

Though the demand for telehealth and telemedicine visits had been increasing prior to the outbreak of COVID-19, mandatory lockdowns in many areas of the country, coupled with eased regulatory or administrative burdens during the pandemic, catapulted telehealth to the principal method in which providers saw many of their patients for several months. Today, telehealth remains a prime modality in which patients continue to access care, even when face-to-face visits may be readily available.

The increased use of telemedicine has particular promise in Texas where a smart phone or laptop could provide areas of the state with virtual visits to primary care providers or specialists located hundreds of miles away. In addition to some basic medical care and disease management, behavioral health is another area where a provider's reach could be greatly expanded by telehealth and is generally very well suited for telehealth visits.

During the 2020-21 interim, at the height of COVID-19 lockdowns, TCCRI's Healthcare & Human Services Task Force studied this issue, focusing on any changes Texas could enact to better utilize telehealth in safe, efficient, and cost-effective ways for patients and payors alike. The Task Force was joined by multiple experts on the topic of telehealth, including the John Locke Foundation which, in conjunction with the Brookings Institute, released a 2020 report centered on removing barriers to telemedicine in the age of COVID-19.[90] While there are acknowledged issues, such as a lack of broadband access in some areas- a challenge of which many in rural Texas are keenly aware- there are actions that state leaders can proactively undertake to increase the use of telehealth and telemedicine services. Issues highlighted in the original John Locke Foundation/ Brookings Institute report included:

- allowing the practice of telehealth across state lines;
- increasing the types of providers and sites that may offer telehealth services;
- establishing parameters that discourage opportunities for fraud, waste, and abuse;
- allowing greater innovation for payors to design benefits and coverage utilizing telehealth; and
- eliminating or rejecting payment parity mandates between telehealth and face-to-face care.

The findings of this report should come as no surprise to those who champion free-market principles - the key to success in improving the adoption of telehealth technology lies in shrinking government intrusion, including those laws that require payment parity with face-to-face visits.[91] Such mandates, while generally well-meaning, can actually have an adverse impact, creating higher costs and greater hesitance in widespread adoption.

The Brookings Institute produced a new report in 2022 that takes the current healthcare landscape into account. This paper, entitled *The Roadmap to Telehealth Efficacy: Care, Health, and Digital Equities*, again addresses the need for fewer government mandates, particularly around payment parity laws, explaining:

> As parity laws mandate same rates of reimbursements for telemedicine and in-person visits, the worry is that this may stagnate the abilities of physicians and patients to embrace a wider range of technologies and modalities for eligible services that could be more cost-efficient or stray from traditional practice models. As delivery of telehealth tends to be leaner, lower prices are in-line with highlighting telehealth's cost-effective nature.[92]

As always, the goal of any legislation aimed at increasing access to, or use of, telehealth should be to reduce burdensome regulations rather than adopt additional mandates.

### 1. Policy Recommendation: Examine and Adopt Policies to Encourage the Secure and Cost-Effective Use of Telehealth Technology

As lawmakers look to the continued use of telehealth and telemedicine as first-line treatment, the 88th Legislature should continue to expand and improve upon the important work it has already done. Focusing on broad guidelines that should exist in state law, and unnecessary restrictions that should be eliminated, will allow private sector market forces to drive quality and innovation while decreasing costs. Such policies will help establish a strong telehealth infrastructure that will serve the healthcare needs of Texans for years to come.

### 2. Policy Recommendation: Reject Payment Parity Laws

Equally critical to adopting broad guidelines that allow space for innovation and competition is rejecting mandates that stifle this freedom. While payment parity laws are offered with the goal of expanding the use of telehealth, these measures actually run counter to the objective. On this topic, researchers at John Locke and Brookings found:

> While state parity laws have been implemented with good intention to attempt a more uniform use and regulation of telehealth reimbursement, payment parity laws in practice may not produce the intended effects. The main problem with payment parity laws is that they are contradictory to telehealth's cost-effectiveness. If telehealth can help reduce costs of using the health-care system and reduce doctor visits, it is contradictory to mandate that a service provided through telehealth be paid for at the same rate as if it were provided in a doctor's office.[93]

Brookings' updated 2022 report upholds this finding and encourages both state and federal leaders to eschew payment parity laws in favor of maximum flexibility. Lawmakers should reject such payment parity mandates in the 88th Session and allow the free market to shape competitive reimbursement rates for telehealth services.

# IV. Accountability

The tenet of accountability is one of the most varied, as a successful free-market driven healthcare system requires accountability from all factions - consumers, payors, providers, and the government. In addition to polices that increase transparency and competition, this section also discusses government-funded programs that require accountability to Texas taxpayers.

## A. Increased Quality and Competition Through Transparency

In today's era of Amazon and Google, consumers are conditioned to competitively shop for goods and services. A simple and quick internet search allows consumers to source what they need, from laundry detergent to customized business cards, compare offerings to find the best prices, and order what they need with virtually one click of a button. The marketplace has responded to this model by offering a bevy of merchants with competitive pricing, along with other benefits to consumers, such as fast and free shipping. This is the free market at its finest: consumer demand has fostered healthy market competition, ultimately driving down costs, and driving up quality.

American consumers have embraced this concept with vigor, with today's shoppers able to harness the power of the internet from their smartphones to compare prices on almost any good or service imaginable. However, despite healthcare being a major cost for most American households, comparison shopping for medical services has not organically translated into the healthcare marketplace.

According to data by the U.S. Bureau of Labor & Statistics, in 2021 (the most recent data available) average annual household spending on healthcare increased by 5.3 percent over 2020, which had seen a small decrease during COVID lockdowns.[94] While increases in food and gas prices grew significantly during this time, Americans spent about as much on healthcare as they did on education, apparel, and "miscellaneous expenses" (i.e., personal care products and services, alcohol and tobacco, and reading materials) combined.[95] Healthcare is a smaller percentage of household spending in 2021, but that is not because costs went down; it is only because inflation has driven the costs of other necessities up astronomically.

While most consumers do not order printer ink cartridges or laundry detergent without comparing prices, they would likely never consider comparison shopping for a common x-ray or magnetic resonance imaging (MRI) test, which generally cost considerably more. This begs the question: Why don't Americans comparison shop for their healthcare services, and what, if anything, can be done to promote this practice, with the end goal of bending the healthcare cost curve?

*Comparison Shopping for Healthcare Services*

The key difference between the healthcare marketplace and virtually all other areas of the consumer market is the ability to easily compare prices. Although multiple studies and polls have shown that

consumers would like to shop for the best value in healthcare,[96,97,98] the current system is not intrinsically built to encourage, or in many cases even facilitate, price comparison.

Research has found that healthcare consumers want a better value and that patients do not typically equate more expensive healthcare with better quality care.[99,100] Even more importantly, a study examining the relationship between cost and quality in hospital care found no real correlation between the two.[101] However, price comparison information must be made easier to both obtain and decipher if consumers are going to embrace comparison shopping in healthcare as they have done in other market areas.[102]

Price comparison shopping also has benefits beyond finding the lowest costs. Industry experts have found that once consumers start to engage in researching their healthcare options to find the best prices, they start to look at other comparisons too, such as quality metrics. Research by the Commonwealth Fund explains:

> Once patients start to look into health care prices, they may also become engaged in exploring the quality and safety of their care as well. "In our experience, when patients don't ask about prices, they don't ask about quality either," says Healthcare Blue Book's [CEO Jeffry] Rice. "When they start to become consumers [by comparing prices], they start to ask good questions about quality too."[103]

The importance of quality and health outcomes in this conversation cannot be overstated. The best value healthcare system is one that offers high-value quality care at competitive prices, and not one that lowers costs simply by lowering quality. Survey data shows that consumers want to access not only pricing information, but also quality and consumer satisfaction data.[104] Ensuring that consumers are educated and engaged on both quality and price is vital to transforming the healthcare system. Empowered consumers demand accountability from their healthcare systems, which in turn increases competition and quality while decreasing costs.

*Price Transparency Initiatives*

Although this concept has been slower to make its way to the healthcare space, both the private and public sectors have begun pursing various answers to the price transparency challenge over the past decade.

Some solutions have occurred organically, with private sector companies responding to the call for greater price transparency. One such company is the Healthcare Blue Book, which is based upon the idea of the *Kelley Blue Book* for cars and operates a subscription-based website that allows customers to compare "fair price" and quality for healthcare services. Similarly, the Healthcare Price Tool provides geographically searchable prices for hospitals, urgent care providers, physician groups, and more. Fair Health Consumer provides a "shoppable services" tool, as well as information to assist consumers in learning about surprise billing and what insurance benefits and provider costs mean for them. Health

insurance companies have also developed some of the most robust comparison tools thus far, allowing their enrollees to log into a website or app to calculate and compare their out-of-pocket expenses- even though many enrollees do not take advantage of these options.[105,106]

Price transparency has been at the forefront of government reforms as well. Texas began addressing transparency in the early 2000's with legislation giving consumers the right to healthcare price estimates and more recently addressing consumer protection from surprise medical billing. The Trump Administration helped to propel this debate to the national stage and championed the benefits of increasing competition through transparency with various initiatives to make healthcare cost data available to consumers for hospital, insurance,[107] and prescription drug benefits.[108]

On the heels of these federal rule changes, the 87th Legislature ensured that hospital price transparency requirements were codified in the state statute with the passage of SB 1137 (Kolkhorst, et.al./ SP: Oliverson, et al.). State lawmakers also passed HB 2090 (Burrows, et. al./ SP: Hancock) to establish the state's All-Payor Claims Database (APCD), which is tasked with collecting , processing, analyzing, and housing healthcare claims data (i.e., medical, dental, pharmaceutical) "for the purposes of increasing transparency of health care costs, reporting utilization and access, improving the affordability, availability and quality of health care and improving population health."[109]

While the aforementioned initiatives are critically important, policymakers and thought leaders must still contend with how best to encourage consumers to take advantage of information once it is made available.

*Shared Savings Programs*

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.[110] Those models that have achieved change in consumer behavior have included either rewards or disincentives paired with the ability to comparison shop.[111]

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. The crux of these programs' successes lies in the ability of consumers to access quick, accurate, and transparent cost comparisons.

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 so 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.[112] However, it is unclear if these programs have been implemented.

### 1. Policy Recommendation: Continue Consumer Incentive Programs in ERS and TRS, Identifying and Addressing any Impediments

The ERS and TRS Right to Shop budget riders were a vital first 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 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. Policy Recommendation 2, below, would ease the ability of the state and private insurance companies to offer these types of incentive models.

### 2. Policy Recommendation: Revise Regulations that Stifle Innovation

While state leaders should not mandate that private businesses implement any type of profit-sharing or incentive program, lawmakers should ensure that no existing laws or regulations prevent private businesses from employing innovative initiatives aimed at engaging consumers in better healthcare decisions.

One particular section of the *Texas Insurance Code* warrants further exploration and a possible revision to make certain that employers and insurers can implement Right to Shop-like programs if they so choose. The Texas Insurance Code § 541.056 is an anti-inducement statute and serves a valid purpose in preventing potentially unscrupulous practices in selling insurance policies. However, a portion of the existing code could be construed to prevent companies from utilizing incentive or shared-savings models. Subsection (a) reads, in part (emphasis added):

> ....it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to... directly or indirectly pay, give, or allow or offer to pay, give, or allow as inducement to enter into a life insurance contract, life annuity contract, or accident and health insurance contract ***a rebate of premiums payable on the contract, a special favor or advantage in the dividends or other benefits of the contract***, or a valuable consideration or inducement not specified in the contract...

Statute does provide for limited exceptions to these prohibitions, such as health-related services and premium adjustments for group insurance policies,[113] but does not appear to clearly allow for a shared-savings arrangement. In addition, the 80th Legislature passed HB 1847 (Hancock/ Sp: Averitt) to allow health plans to offer certain "noninsurance benefits" to enrollees and may include discount cards, financial planning, will preparation, and contributions for educational savings on behalf of a policy or certificate holder.[114]

While TDI did adopt administrative rules that allow the agency to examine and determine "reasonable relation" outside of the specific examples provided by law,[115] there is no mention or exception for a shared savings or incentive program. Because such models were not prevalent when this statue and associated rules were adopted, it makes sense that current law might not allow for such innovation. Since these programs are becoming more commonplace, the Legislature should consider amending current statute, and directing TDI to amend rules, to clarify that shared-savings or incentives programs (be they actual shared savings, or out-of-pocket cost reductions) do not violate anti-inducement or anti-rebate laws.

### 3. Policy Recommendation: Ensure Price Transparency is Uniformly Applied

Hospital and prescription drug pricing are often, and understandably, the center of discussions on the need for pricing transparency in the healthcare marketplace. Ambiguity in hospital charges versus actual costs, lack of clarity in which providers within a hospital's emergency department are "in-network," and questions around how much research and development costs are built into drug pricing have led many transparency initiatives to focus on these areas. However, transparency, and the competition it fosters, only work if they are uniformly applied to all facets of the healthcare system.

Too often in today's world of ever-increasing healthcare costs, various providers and entities are quick to point fingers and blame one another for skyrocketing costs. And, while there are some clear outliers that should be addressed, a lot of the confusion and helplessness consumers feel over trying to shop for the best value care could be addressed by ensuring that all areas of the healthcare marketplace are subject to the same price transparency standards. Hospitals and drug manufacturers are crucial to this

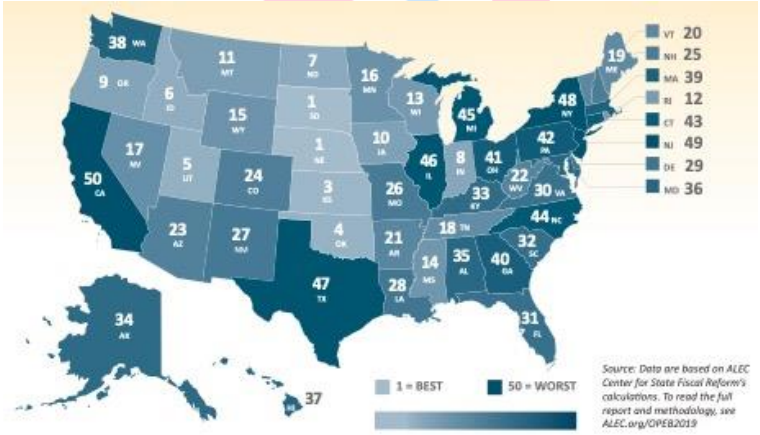
equation, but so too are physicians, anesthesiologists, radiologists, pharmacists, and so on, and Texas' APCD will be a crucial tool in addressing these challenges.

## B. TRS

The Teacher Retirement System of Texas (TRS) manages the retirement and related benefits of the state's active and retired teachers. The system currently serves approximately 1.9 million individuals,[116] and is expected to pay out more than $16 billion annually in retirement and healthcare benefits during the upcoming FY 2024-25 biennium.[117] As part of its responsibilities, TRS operates healthcare benefits for this population through two programs: TRS-Care covers about 222,000 retired public education employees and their dependents, while TRS-Active Care covers an estimated 444,000 active educators and their dependents.[118]

Both the retirement and healthcare portions of the TRS pension fund have faced challenges with unfunded liability balances at times. The reforms of Senate Bill 12 (86; Huffman, et al.) set the retirement portion on a sustainable path forward. On the other hand, TRS-Care, despite some signs of progress, remains a concern. This issue is not unique to Texas, or even specifically to TRS. Although retirement benefits are the costlier, and generally the higher profile items in public pension funds, the American Legislative Exchange Council (ALEC) explains that "state governments offer public employees Other Post-Employment Benefits (OPEB), including health insurance, life insurance, Medicare Supplemental Insurance and more."[119] State OPEB liabilities have continued to grow and, as of 2019, totaled about $1 trillion nationwide, with Texas ranking 47th, outperforming only New York, New Jersey, and California in the amount of its state unfunded OPEB liability.[120]

**Total Unfunded OPEB Liabilities by State- 2019**



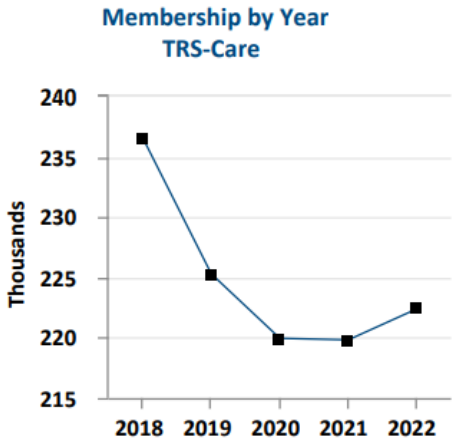

*Source: American Legislative Exchange Council*[121]

*Recent Solvency Issues for TRS-Care and a Possible Trend Reversal*

Although the challenges facing TRS-Care had been building for some time, they reached a fever pitch during the 85th Legislative Session when lawmakers scrambled to avoid a significant shortfall by pouring

an additional $484 million into the system for the FY 2018-2019 biennium and pairing that increase with higher enrollee out-of-pocket costs and elimination of the $0 premium plan option.[122] After state leaders continued to hear from retired educators about problems in the system and increased costs, they appropriated an additional $212 million during the 85th 1st Called Special Session.[123]

Yet, despite these attempted stop-gap measures, the average retiree contribution still increased by about 50 percent in 2018, causing about 36,000 retired educators and their dependents to voluntarily leave TRS-Care to pursue less expensive Medicare plans on their own.[124] In comparison, the number of enrollees leaving the system in prior years was about 1,500 or fewer.[125] The chart below, taken from TRS' 2022 Popular Financial Report, shows how TRS-Care enrollment declined from 2018 to 2020.




However, as the chart shows, there are signs that this declining trend has reversed, with year-over-year enrollment being virtually unchanged in 2021 and then ticking up slightly in 2022.

Unfortunately, even with then-decreasing enrollment, the funding needs of TRS-Care continued into the 86th Session with the Legislature ultimately appropriating an additional $263.6 million GR funds for the 2020-21 biennium to maintain FY 2019 premium and benefit levels.[126] The 86th Legislature took additional steps to address the program's fiscal condition, passing SB 1682 (Huffman/ SP: Bonnen, Greg), which required TRS to establish a contingency reserve capable of funding an average of 60 days' worth of average projected TRS-Care claims and administrative costs.

These actions appear to have curtailed the significant losses TRS-Care had been experiencing. In TRS' recent Legislative Appropriations Request (LAR) for the upcoming FYs 2024-25 biennium, the agency notes that, while its request includes an additional $73.8 million in GR base spending for TRS-Care due to projected enrollment growth, it does not expect there to be a need for any additional funding beyond that for the program, explaining:

> TRS does not anticipate that supplemental funding will be needed to maintain TRS-Care benefits at current levels through the 2024-25 biennium. This is a result of the additional

> $236.3 million appropriated by the 86th Legislature to TRS-Care above statutorily required amounts and the re-procurement of major health administrator contracts, which is generating an estimated $754 million in savings across both TRS-Care and TRS-ActiveCare in the next three to five years.[127]

Notably, nearly identical language appeared in TRS's LAR for the 2022-23 biennium. Nevertheless, to combat the effect of the COVID-19 pandemic, Senate Bill 8 (87S3; Nelson) appropriated $286.3 million for COVID-19-related claims in TRS-Care and TRS-ActiveCare, although this appropriation was federal income rather than GR and was made in the context of a (presumably rare) worldwide pandemic.

While the tide has hopefully been stemmed, there remains some concern that TRS-Care periodically requires influxes of cash. This merits examination of innovative policy solutions to place TRS-Care on a solid path towards continued stability and solvency.

1. Policy Recommendation: Study the Feasibility and Cost-Effectiveness of Allowing TRS-Care Enrollees to Purchase Private Medicare Plans. To that end, enact Rider 18 into statute, and pass legislation modeled on House Bill 1461 (87R; Parker).

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.[128] The City of Memphis, Tennessee, began exploring this idea in 2016 and, as of reporting in early 2019, had since dropped its obligation for retired employee health benefits by $300 million.[129] 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."[130]

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.[131] 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.[132] 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.[133] 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.[134] 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.[135]

OPERS officials have also indicated that their data shows the program to be a successful among members.[136]

Although TRS-Care appears to be headed towards a course correction, it is worth examining whether additional alternatives could help ensure that the program remains on this course. 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 the last two 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.[137]

Both the House and the Senate drafts of the GAA for the 2024-25 biennium (House Bill 1 and Senate Bill 1, respectively; 88R) contain this rider. 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 Rider 18 if a study similar to that envisioned by HB 1461 were first conducted. The 88th Legislature should enact legislation modeled on HB 1461.

## C. Medicaid

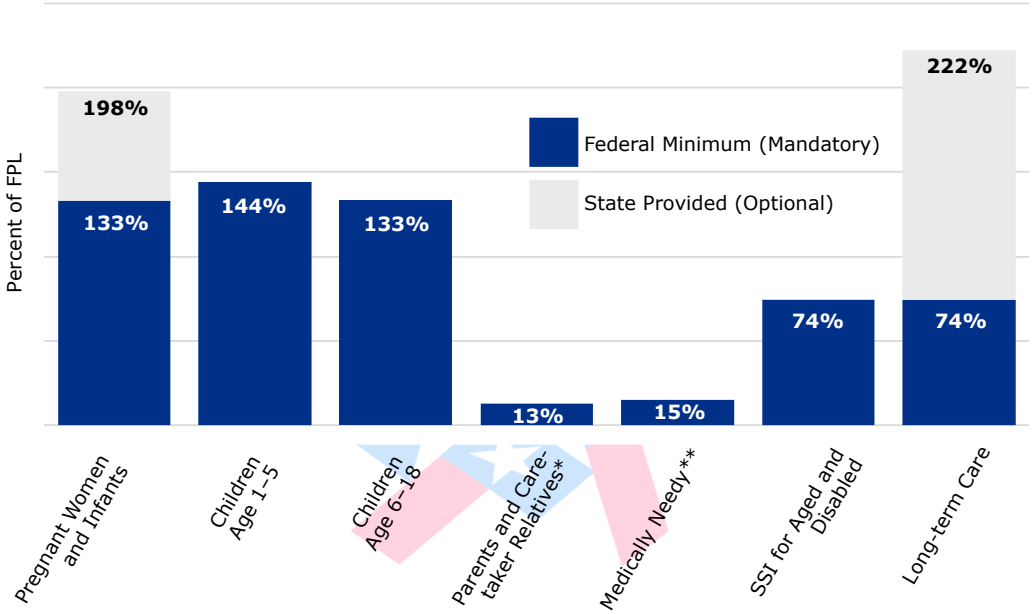
Nowhere is the principle of accountability more important than for governments entrusted with billions of taxpayer dollars, and the Texas Medicaid program is no exception. Comprising more than a quarter of the entire state budget in the 2022-23 biennium, and with a total biennial appropriation of $68.7 billion All Funds (AF), the Medicaid program is one of the single largest cost drivers for the State of Texas.[138] And, because the program is an entitlement with open-ended funding, and is largely ruled by federal laws and regulations, the state has limited control in curbing Medicaid population growth and costs.

In 2022 Medicaid rolls continued to grow monthly with November enrollment numbers, the latest month available on the Health and Human Services Commission's statistics site, topping out at more than 5.7 million recipients.[139] Although enrollment data had begun trending slightly downward prior to 2020, those numbers quickly reversed and have continued to shatter historical records due to the economic effects of the COVID-19 pandemic and the maintenance of effort requirements for receiving

the public health emergency (PHE) enhanced federal match. The program covers about 51 percent of all births, about 47% of all children (along with the Children's Health Insurance Program), and 58 percent of all nursing facility residents in Texas.[140]

It should be noted that, even though our state has one of the nation's largest Medicaid programs, Texas largely covers only mandatory populations required by the federal government.[141] The graph below shows the population groups that are covered by Texas' program, and which are mandatory versus optional.

**Texas Medicaid Income Eligibility Levels for Selected Programs, March 2022 (as a Percent of the FPL)**




*For Parents and Caretaker Relatives, maximum monthly income limit in SFY22 was $230 for a family of three, or about 13 percent of the FPL.
**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY22 was $275 for a family of three, or about 15 percent of the FPL.

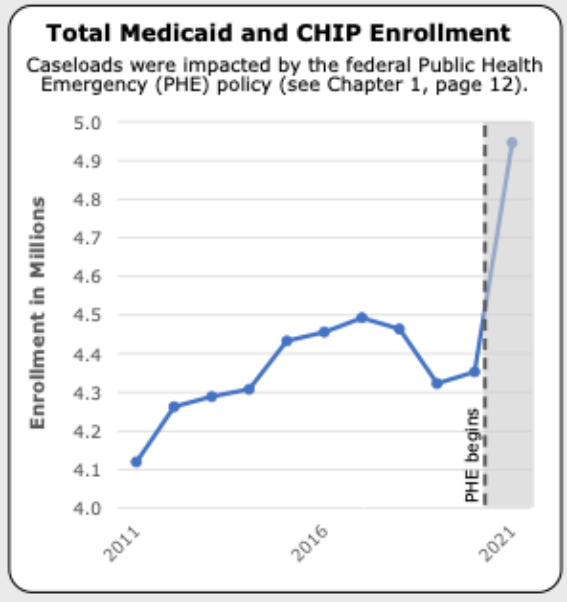
*Source: Texas Health & Human Services Commission*[142]

The Medicaid program is jointly funded by both the federal and state governments, with the state maintaining responsibility for the program's day-to-day operations. In Texas, about 60 percent of the program's funding comes from the federal government, while the state pays about 40 percent.[143] And, although states are given some flexibility within their Medicaid programs, the federal government sets policies that states must follow or obtain federal permission to alter. For instance, the federal government establishes mandatory populations that each state *must* cover (e.g., pregnant women and children at certain income levels, determined by reference to the Federal Poverty Level, or FPL) in order to participate in the Medicaid program, and it provides a list of optional populations states may *choose* to cover (e.g., traditional populations at higher income levels, childless adults at certain income levels).

The same is true for program benefits. The state must seek approval from the federal government to make any substantive program changes, including populations covered, benefits provided, and even certification of premiums paid to managed care plans.

*Public Health Emergency & Medicaid Enrollment*

The federal Families First Coronavirus Response Act (FFCRA) provided enhanced funding for state Medicaid programs. To qualify for the enhanced funding, states must maintain continuous Medicaid coverage for most enrollees deemed eligible on or after March 18, 2020, until the end of the PHE declaration, which is still in place today.[144] Under this law, it is possible that some recipients have continued to receive Medicaid benefit for almost three years after they no longer qualified for the program.




The figure on the right, produced by HHSC, shows the impact of the PHE declaration on Medicaid enrollment.[145]

While the federal government provided enhanced funding to assist states with increased caseloads, Texas reached its "tipping point" during May/June 2022 in which the increased costs of the additional caseload outpaced any additional funds the state had received.[146]

The federal omnibus spending bill, passed in December 2022, ends the continuous coverage requirement on March 31, 2023, meaning that Medicaid eligibility redeterminations will soon be taking place for the first time since March 2020. The federal Centers for Medicare and Medicaid Services (CMS) has established some guidelines for these eligibility reviews, including:

- The state must conduct redeterminations over a 12-month period;
- Redeterminations may begin up to 60 days before any disenrollments take effect (any disenrollment may not take effect until the first of the month after the month the PHE ends- April 1, 2023); and
- States must conduct full redeterminations in accordance with federal regulations and allow recipients a minimum of 30 days to respond to renewal packet or requests for additional information[147]

Additional details should soon be forthcoming on how HHSC will execute these redeterminations, but a presentation to the House Appropriations Committee in September 2022 indicates that the agency plans to conduct eligibility actions on about 2.5 million recipients.[148] Enrollees will be divided into three separate cohorts, beginning with those most likely to no longer be eligible for Medicaid (i.e., women

who gave birth and can transition to Healthy Texas Women; adults who have aged out of the program), and ending with a third cohort of individuals most likely to remain eligible for the program.[149]

*An Introduction to Medicaid Managed Care*

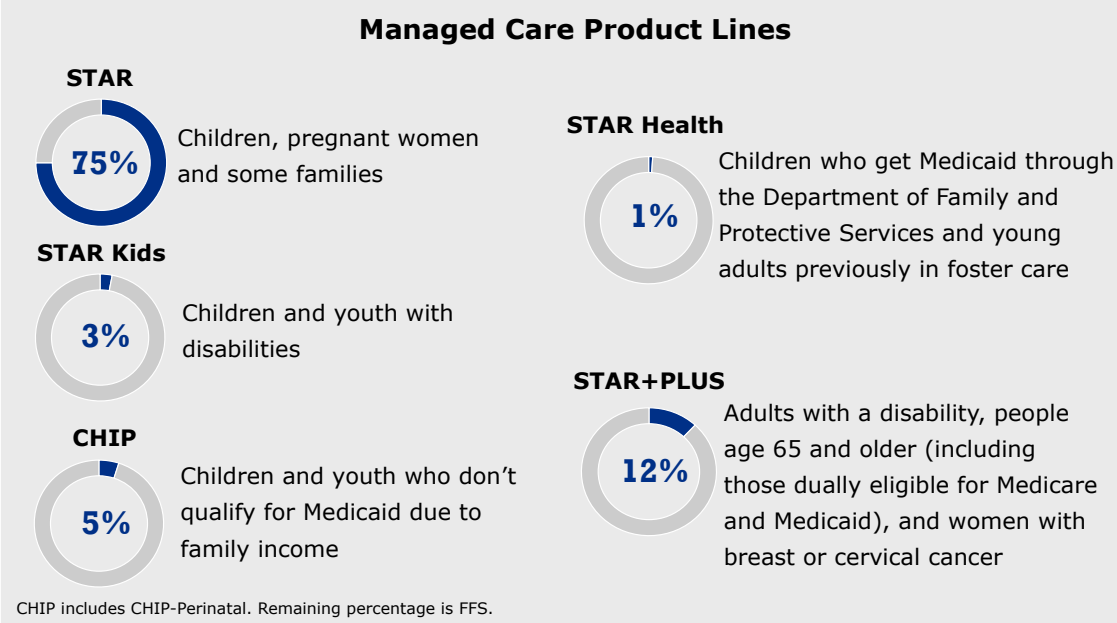
Although states can experience some degree of frustration with sclerotic federal regulations, this does not mean that state leaders are left with no options to improve Medicaid efficiencies and contain costs. One of the most effective means of providing high-quality affordable health care coverage is through managed care. Health plans are generally able to provide better care by helping coordinate care, directing enrollees to more preventive, lower-cost settings, and by utilizing the providers within their networks. By only contracting with certain providers, health plans, just like those in the private sector, have the opportunity to negotiate lower prices and, most importantly, adopt standards that may restrict lower-quality providers from joining their networks. Texas has long embraced this concept as an early adopter of the Medicaid managed care model.

Prior to the 1990's, enrollees in Texas Medicaid received their services through a fee-for-service system, where providers are paid directly by the state for each claim. While enrollees can access any Medicaid provider in FFS, there is little or no coordination of care or benefits, often leading to unnecessary or duplicative services. This results in an overall lack of successful management of, and poor health outcomes for, people with chronic conditions like asthma or diabetes and those who require both acute and long-term services and supports (LTSS).

With the passage of HB 7 (72S1) in 1991, the Texas Legislature established the state's first Medicaid managed care pilot program, and in the past 30 years managed care has grown to become the primary service delivery system, particularly with the statewide implementation of care beginning in 2012 under the 1115 Texas Transformation waiver.

Texas, like other states at the time, originally turned to managed care as an innovative method for controlling skyrocketing Medicaid costs.[150] However, the managed care model also yielded myriad client benefits. Beginning in 1999, HHSC conducted a 15-month review of the state's current Medicaid managed care programs with the input of various stakeholders to assess the model's effectiveness and outcomes. The analysis concluded that "…implementation of managed care improved access to providers, produced program savings, and resulted in program accountability and quality improvement standards and measurement not found in the traditional fee-for-service (FFS) Medicaid program."[151]

Today Medicaid managed care operates statewide and serves 97 percent of the entire Texas Medicaid population through Medicaid managed care organizations (MCOs).[152] HHSC contracts with these plans and pays them a capitated per member per month (PMPM) premium to ensure that Medicaid recipients receive all necessary and appropriate services. The following graphic, available in HHSC's 2022 Medicaid and CHIP Reference Guide, illustrates the various managed care programs, who they serve, and the percentage of each program as a total of the Medicaid population.




*Source: Texas Health and Human Services Commission*[153]

Health plans are at risk for facilitating the provision of all of an enrollee's services within the negotiated PMPM rate and have relatively wide latitude in implementing prior authorizations (PAs) for certain services, negotiating provider rates, and managing enrollee care. The exception to this rule, however, is the Medicaid prescription drug benefit (discussed in greater detail in the *Medicaid Prescription Drug Benefit* section).

*The Value of Managed Care*

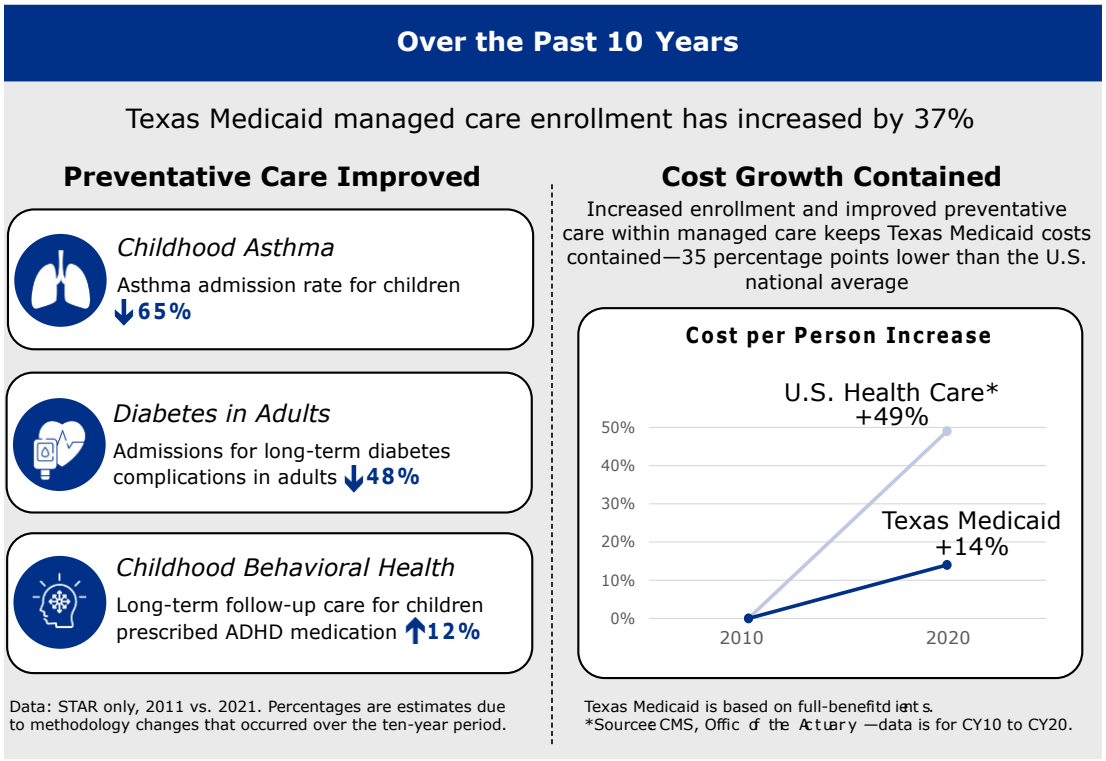
Over the past 30+ years, managed care has unquestionably established itself as an essential component of the Texas Medicaid program, improving health outcomes, containing costs, and offering unique benefits to enrollees, state leaders, and taxpayers that would never have been possible under other service delivery models, such as fee-for-service.

A key takeaway from a past TCCRI research paper entitled *Evaluating the Cost-Effectiveness of Medicaid Managed Care* was that, as managed care has become the primary service delivery system in Texas, a significant component of the value is in consistently generating savings, preventing "cost creep," and continually managing utilization.

It is critical to point out that, the longer the state is in the managed care model, the more challenging it becomes to draw an apples-to-apples comparison of what costs would have run under a FFS system. In Texas, Medicaid managed care achieves cost savings by negotiating rates with a preferred network of providers, by ensuring that clients receive appropriate levels of care, by improving enrollees' health outcomes so they become less expensive over time (this is particularly true of the long-term services and support (LTSS) population), and by assuming financial risk. All of these variables have now been

baked into the Medicaid program's cost and budget projections for several years. Thus, it becomes extremely difficult to attempt to determine what expenditures would have been without these cost and quality controls in place. Despite these challenges, there continues to be clear evidence that managed care provides far superior value than other service delivery models.

The below graphic, also available in HHSC's Medicaid and CHIP Reference Guide, illustrates the impact managed care has had on the Texas Medicaid program over the last decade. As managed care enrollment has increased by almost 40 percent, preventive care has improved, and per person health care costs have been contained at a rate that is about 35 points below the national average.[154]




*Source: Texas Health & Human Services Commission*[155]

*Maintaining the Infrastructure of the Managed Care Model*

The managed care program provides an optimal environment in which to test innovative payment and delivery models. But it is crucial to maintain the fundamental structure of the program to continue to achieve improved outcomes and cost containment strategies. Initiatives such as prior authorizations (PA), utilization review (UR), case management, and service coordination, when appropriately applied, are all key to the success of the model. While some may see these practices as arbitrary or punitive, that is not the case. Take for instance PAs, which require approval from a payer before an expensive or potentially complicated service or prescription drug will be reimbursed. These services or medications often require a PA, not to discourage the benefit from being provided, but to ensure the patient has not

recently undergone the same test or 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. As the payer, MCOs are often the only entity able to see the entirety of an enrollee's medical history and, in that role, are uniquely positioned to identify costly redundancies and potentially unsafe interactions.

It is important that managed care companies retain flexibility around these key components of the model. The foundation and success of managed care lies in its ability to facilitate whole-person care. To effectively provide this level of coordination, plans must have access and ability to work across a member's needs including medical, pharmacy, therapy, home care, etc. Any attempts to remove or "carve out" services or populations from managed care will weaken the entire system, including the state's ability to maintain budget certainty.

*Medicaid Prescription Drug Benefit*

Individuals enrolled in Medicaid and CHIP receive prescription, and some over-the-counter, drugs as part of their program benefits. Since the implementation of Texas' Medicaid managed care program, HHSC has continued to play a central role in the administration of prescription drug services. In March 2012, Texas successfully implemented one of the largest Medicaid managed care rollouts in history, extending care models statewide and carving in prescription drugs and nursing home care. Up until that point, these services had continued to be paid through the FFS system, even though virtually all other aspects of enrollee care were under Medicaid managed care.

Although the state has been fully committed to the managed care model, state leaders made the decision to retain control of the Medicaid drug formulary, rather than ceding it to managed care plans. This was primarily due to the state's successful administration of its preferred drug list (PDL) and the negotiation and collection of supplemental rebates that prescription drug manufacturers must pay the state to be included on the PDL. While the *formulary* stipulates which drugs are covered by the state's Medicaid program, the *PDL* is a subset of the formulary and contains prescription drugs that are "preferred" and, therefore, covered without a prior authorization (PA).

Health plans are responsible for administering this benefit through their subcontracted pharmacy benefit managers (PBMs), but must adhere to the state's drug formulary, clinical edits, and PA guidelines, though they do have some discretion in employing additional state-approved care management strategies.[156] Current statute requires that health plans adhere to the state formulary until August 31, 2023.[157] It should be noted that, while plans are required to adhere to the state's formulary and guidelines, they remain responsible for all other aspects of the prescription drug benefit, including building and maintaining provider networks, claims adjudication, and taking on the financial risk of the benefit.

Health plans are also required to accept any willing pharmacy provider. This is unlike the commercial market, where each health plan develops and controls its own provider network, drug formulary, and clinical standards. The state's Drug Utilization Review (DUR) Board is responsible for reviewing various classes of drugs and recommending to HHSC which medications should be on the state's Medicaid preferred drug list (PDL).[158] Federal law requires that drug companies pay a rebate (shared between the federal and state governments) to have their drugs on the Medicaid PDL, and Texas negotiates an additional supplemental rebate on top of that.[159] Prescription drug spending is responsible for about 13 percent of state's total Medicaid expenditures,[160] a percentage that has appeared to hold relatively stable over the past several years.

During the last three sessions, there have been numerous attempts to alter the current Medicaid prescription drug program with efforts ranging from establishing prescriptive rate setting mandates in statute to even fully carving the prescription drug benefit out of managed care and back into FFS. Such attempts pose a significant risk to the success of the Medicaid managed care program, which focuses on whole-person coordination and care. Removing a critical piece of this equation jeopardizes not only the budget certainty that managed care affords Texas taxpayers, but also, more importantly, the care and health outcomes of some of Texas' most vulnerable populations.

A 2018 analysis commissioned to examine the possible impact of carving Louisiana's prescription drug benefit out of managed care offers an important warning for Texas. While the report found that Louisiana would incur a substantial cost by carving the benefit back into FFS, the report included reference information that is of even greater significance to Texas. One particular section examined 13 states spanning 2011-2017. Nine of these states, including Texas, had prescription drugs in the FFS model in FY 2011, which they subsequently carved into managed care, while the "control group" remained in a FFS model the entire time. The "managed care" states saw an increase of 0.9% in per-prescription drug costs from FY 2011-2017, while the "control group" states experienced a 16% increase.[161]

While the cost savings provide clear and sufficient evidence of the need to maintain the current Medicaid prescription drug model, any discussion cannot omit the most important aspect of this equation, which is the patient. One of the key advantages of a managed care model is facilitation of patient care. The administration of the prescription drug benefit by MCOs allows these plans to have real-time access to prescription information, which is critical in coordinating and managing care for enrollees- particularly those with chronic disease that are managed pharmacologically (e.g., chronic obstructive pulmonary disease (COPD), asthma, heart disease). Access to this information also allows plans to flag patients who may be "doctor shopping" for controlled substances or filling multiple prescriptions with potentially dangerous counteractions, unaware of the potentially harmful consequences of mixing some drugs.

While the state can contract with a claims administrator to process and pay these claims, health plans have the expertise and ability to flag potentially dangerous contraindications and to reach out to patients, working with their practitioners when appropriate, to reduce the chances of dangerous

prescriptions interactions. In addition, health plans can also ensure that enrollees who need lifesaving medications are regularly filling their prescriptions.

Much of the consternation in the discussion on whether to carve-out Medicaid prescription drug benefits has been around PBMs. However, Texas places specific requirements in its contract with health plans that prohibit some of the practices that PBMs may employ in the commercial market, such as spread pricing and negotiation of additional rebates.[162] The practice of spread pricing in general appears to be of particular concern to stakeholders and advocates. The HHSC contract and monitoring tools address this issue specifically, and these steps have proven effective. A 2019 audit of a major PBM conducted by HHSC's Office of Inspector General (OIG) confirmed no evidence of spread pricing in the Medicaid prescription drug benefit.[163] In 2019 the Kentucky Cabinet for Health and Family Services issued a report entitled, "Medicaid Pharmacy Pricing: Opening the Black Box." As part of its analysis, the agency looked at initiatives in other state Medicaid programs and had the following to say about Texas:

> In 2014, Texas became one of the first states to closely regulate PBMs. Using a managed care system, all MCO-PBM contracts are uniform subcontracts to the state and MCOs are held responsible for all duties performed by the PBM. In order to keep costs low for the state, regulations prohibit PBMs from using spread pricing, receiving additional rebates from manufacturers, and using unauthorized clinical edits. Texas use of a Uniform Managed Care Contract dictates the role and operations of each of their 20 MCOs and 6 PBMs.[164]

### 1. Policy Recommendation: Ensure Timely and Efficient PHE Redeterminations

HHSC estimates that it has extended coverage for as many as 2.7 million enrollees due to the continuous Medicaid coverage provisions of the FFCRA (disenrollments have continued for recipients who are deceased, moved out of state, or voluntarily withdrew from the program).[165,166] It is frustrating to know that there is likely a significant cohort of individuals continuing to receive Medicaid benefits who are not eligible for the program, and the immediate reaction to this is to conduct redeterminations, and disenroll those deemed ineligible, as quickly as possible. While this is a reasonable response, state leaders should ensure that HHSC has appropriate time and resources to conduct these redeterminations. Given that Texas has an integrated eligibility system, and the same staff help determine eligibility for multiple programs (i.e., Medicaid, CHIP, SNAP, TANF), the state may need at least additional temporary resources to complete these redeterminations in a manner that is both timely and accurate.

### 2. Policy Recommendation: Stay the Course on Medicaid Managed Care

Staying the course on Medicaid managed care, including the carve-in of any remaining services, and the rejection of any attempts to carve out populations or benefits, is the most responsible, and accountable, decision for the state. While there is always room for improvements to be made and efficiencies to be gained, Texas has demonstrated that its Medicaid managed care program is built on a solid foundation

that ensures cost-effective quality care for recipients and budget certainty for taxpayers, and should be maintained.

### 3. Policy Recommendation: Maintain the Prescription Drug Benefit in Managed Care

The cornerstone of the managed care model is coordination of whole person care. The prescription drug benefit is a critical component of this coordination, particularly for enrollees with expensive chronic health conditions who need drug therapy for adequate disease management. Carving this benefit out of managed care would be taking a step backwards, not only in retreating to an outdated FFS model, but also in terms of patient care. This carve-out is not worth the risk of Texas taxpayer dollars or the health and wellbeing of the low-income and vulnerable populations covered by Medicaid and CHIP.

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