TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Senate Health and Human Services Committee

Written Testimony from the Texas Medical Association
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Honorable Chair Kolkhorst and Members of the Committee,

Thank you for the opportunity to testify today on behalf of the Texas Medical Association (TMA), which is a private, voluntary non-profit association of more than 57,000 Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its vision is "Improving the health of all Texans." TMA's diverse physician members practice in all fields of medical specialization.

A Need for Change

As we all know and should address, Texas has a significant number of uninsured people with over 4.3 million individuals – including children and working adults – lacking health insurance. The complexity of enrollment and coverage criteria and high costs to patients associated with obtaining health insurance presents substantial barriers, especially for those without employer-based insurance.

As practicing physicians, we witness, daily, the difficult choices patients face when they cannot afford health care, such as skipping medications, screenings, or other essential medical services. Tragically, my colleagues and I see the severe consequences of delayed or neglected care, which can lead to financial distress from lost work, diminished quality of life, or worse, long-term disability and death. Therefore, TMA and Texas physicians are committed to increasing access to health care and helping ensure early intervention in patients' health needs.

So, how do we reduce costs while enhancing access, quality, and safety? The well-known saying in health system reform sums it up: Provide the right care, at the right time, in the right place, from the right person. For instance, children with routine ear infections should be able to see their pediatrician promptly instead of seeking care in more expensive emergency care settings. Similarly, any woman in labor should be able to find nearby, in-network maternity services.

This may seem straightforward, yet it is challenging to achieve due to overstretched safety nets, misaligned payments, workforce shortages, outdated models, and old data systems. To make matters worse, health care consolidation and vertical integration by insurers has reduced competition and exacerbated challenges experienced by both physicians and their patients. The ongoing disruptions caused by the Change Healthcare cyberattack on February 21, 2024, is a prime example of this.

The cyberattack on Change Healthcare – a health care technology company that is part of Optum and owned by UnitedHealth Group – directly impacted an estimated 80% of physicians and 94% of hospitals across the country. This in turn led to significant financial losses and disruptions in patient care. Smaller practices of 10 or fewer physicians were particularly hard-hit.

As of April 29 (more than two months after the incident), physicians report continuing issues with multiple operations, despite UnitedHealth Group's announcements of restored service:

- Sixty percent continue to face challenges in verifying patient eligibility;
- Seventy-five percent still face barriers with claim submission;
- Seventy-nine percent still cannot receive electronic remittance advice; and
- Eighty-five percent continue to experience disruptions in claim payments.[1]

While patients, physicians, providers, and policymakers alike are still reeling from the devastating nationwide incident, it cannot be ignored that vertical integration of the targeted entities, coupled with the use of exclusivity clauses in their contracts with physicians and other providers, magnified the breadth of the attack's consequences.

Despite these ongoing challenges, the last few years have shown remarkable adaptability in our health system and opportunities for innovation. For instance, the swift pivot to telemedicine during the pandemic allowed unprecedented access to care, despite its limited use before. In this case, a unique combination of regulatory flexibility, technological innovation, and consumer protections were in place to align delivery of quality care to patients in an affordable, convenient manner. However, the concern still stands that health plans do not adequately pay physicians for telemedicine services.

The Texas Department of Insurance (TDI) adopted emergency rules during the pandemic that required state-regulated health insurers and HMOs to pay an in-network physician for providing a covered health care service or procedure to a covered patient as a telemedicine medical service at least at the same rate that the issuer is responsible for paying that physician for the service or procedure in an in-person setting. This payment provision was an important component enabling the growth of telemedicine during the pandemic; however, the TDI rule is no longer in effect. Codifying such a requirement into Texas law would enable telemedicine's continued growth in Texas, thereby enabling it to better: (1) facilitate access to care (particularly in rural and underserved areas of the state); and (2) provide convenience to patients (potentially increasing patient compliance with treatment plans and follow-up care and avoiding unnecessary trips to the emergency room). This language also recognizes that physicians who offer both in-person and telemedicine services typically have higher overhead costs when they adopt the necessary technologies to add virtual care visits.

Additionally, payers should not unfairly favor health visits with telemedicine-only companies by offering waived copays or other imbalanced pricing incentives. Patients should be encouraged to first seek encounters with their established physician in order to promote continuity of care. While telemedicine will never fully replace an in-person visit where a physician can "lay hands on" a patient, it can serve as a useful tool in the toolbox of patient care.

On the other hand, the United States health care system is also fraught with examples of failed innovation. An example of innovation gone wrong is illustrated by the failures of managed care in the 1990s, which led to decreased quality of care and limited access to necessary services. Managed care organizations often prioritized cost savings, which led to underutilization of essential health services and restrictions on patient choices of physicians and health care providers. This approach resulted in negative health outcomes for patients, as the focus shifted from quality to cost containment. Failures like this highlight the importance of putting patients first.

Overall, our experiences have taught us that successful innovation seeks balance between ensuring timely access to appropriate, high-quality care and reducing regulatory inefficiencies

[1] See Follow-up survey results. (2024, April 29). American Medical Association.

and administrative waste. Consistent with its vision, TMA has a keen interest in:

- Supporting the development of health insurance plans that balance affordability with meaningful coverage;
- Advocating in favor of state and federal protections for people with preexisting conditions;
- Advocating in favor of health benefit plans' adherence to state-mandated consumer and physician protections, including network adequacy standards, prompt payment, mental health parity, independent review of utilization denials, and gold-carding requirements;
- Supporting requiring all alternative benefit plans to register with the Texas Department of Insurance to provide regulators, lawmakers, and the public insight as to their prevalence and utilization; and
- Pursuing legislation and regulation requiring health benefit plan issuers to provide consumers with sufficient information to make informed decisions regarding their health plan options.[2]

As such, we encourage applying this framework to the evaluation of any current or proposed innovations in the health insurance market.

Exploring Alternatives to Employer-Based Insurance

While employer-based insurance is the predominant vehicle for coverage, we certainly understand the need to explore viable alternatives that could provide more Texans with affordable health care coverage.

1. Direct Primary Care (DPC)

In 2015, Texas became the 13th state to enact Direct Primary Care (DPC) legislation with the passage of House Bill 1945. DPC is not insurance. Instead, DPC is a form of direct care that offers a model where patients pay a monthly retainer, membership fee, subscription fee or fee paid under a medical service agreement covering primary medical care services, which simplifies billing and potentially reduces overall health care costs. In contrast to traditional health care, which often involves complex insurance systems and administrative challenges, DPC operates on a straightforward model where patients pay a fee directly to their physician, eliminating the need for intermediaries.

DPC has specifically shown promising results, such as reduced hospital admissions and lower total health care spending. In one example, an evaluation showed DPC enrollees experienced 48% fewer emergency room visits and 41% fewer hospital admissions than a comparable population not enrolled in DPC.

However, DPC does have its limitations. While TMA supports direct contracting between patients and all physician specialties[3], DPC rarely covers specialist care, emergency/hospital visits, or prescription drugs. This lack of coverage poses a limitation for comprehensive health needs. Since individuals still need access to emergency or specialty care that primary care practices do not provide, along with coverage for significant health care expenses, employers often provide DPC as a complementary option alongside other insurance plans.

For substantial savings to be realized, a model incorporating DPC must also include more coverage for care not covered under a Direct Primary Care model.

[2] See TMA Policy 145.042 Framework for Evaluation Health Insurance Benefit Design.
[3] See TMA Policy 235.035 Health Care Freedom: Protection of Direct Contracting Between Patients and Physicians of All Specialties.

2. Value-Based Care (VBC)

Value-based care models focus on improving patient outcomes and can potentially lower health care costs by promoting quality over quantity of care. As opposed to the fee-for-service model more commonly seen in traditional insurance, value-based care is a health care delivery model in which physicians and providers, including hospitals, are paid based on performance metrics, such as patient health outcomes. The models are designed to focus on disease prevention, reducing the incidence and severity of chronic disease, and helping patients live healthier lives in an evidence-based way. Payments are tied to performance metrics rather than the volume of services provided.

Key goals of VBC include:

- **Improved Patient Outcomes**: The model focuses on better health outcomes and patient satisfaction. Emphasizes managing health proactively to prevent hospitalizations and reduce urgent care visits through better chronic disease management and primary care.
- **Cost Efficiency**: Promotes cost efficiency by favoring generic and proven treatments and by carefully managing hospital stays and specialist referrals. Potentially reduces health care costs by utilizing a broad range of health care professionals to enhance care coordination and patient management.
- **Increased Patient Satisfaction**: Provides a more personalized approach to health care, which can improve patient experience.
- **Encourages Health Care Innovation**: Promotes innovative care models and technologies that can improve care delivery and quality.

While VBC innovations are prevalent in government programs (i.e., Medicaid and Medicare), growth in the state-regulated commercial market has not progressed as quickly due to the novel issues inherent to VBC models. For instance, because VBC models often involve some degree of physicians bearing risk, it is often viewed by regulators as the "business of insurance" unless explicitly exempted through legislation; this is a barrier in Texas, for which legislation was introduced in the 88th Legislative Session. However, there are variances in opinions among physicians generally and of different specialties as to the need and/or desirability of such legislation. For these reasons, TMA adopted a neutral position on this previous legislation and continues to evaluate ways to address the concerns of all physicians.

Disparate impacts on various stakeholders throughout the health care system are another issue to consider when implementing VBC. One such impact stems from the fact that practices cannot transition to VBC overnight. It involves significant adjustments in practice operations, including new technologies and patient care coordinators, in addition to the advice of consultants and legal counsel, all of which can be resource intensive. The high cost of transitioning to VBC can be a disadvantage to smaller, independent practices who are already struggling to stay financially viable against larger competitors. This could ultimately lead to less choice for patients.

Other concerns stem from the largely theoretical existence of VBC in the commercial market and a fear of the unintended consequences of the widespread adoption of VBC models without sufficient guardrails to balance freedom of contracting with patient safety.

Examples of these concerns expressed as questions:

1) How do we ensure financial incentives do not adversely influence clinical decisions?
2) How do you guarantee timely access to specialty care?
3) Can we guarantee that patient satisfaction and outcome metrics are appropriate and given primacy when evaluating the performance of physicians?

4) How do we accurately account for high-risk patients and non-clinical drivers of health such as poverty, lack of housing, food insecurities, and more, which significantly impact patient outcomes – the key driver of this delivery model?

As with any successful health care payment model, sufficient guardrails are essential to help balance the inherent tensions between cost savings and high-quality, patient-centered care.

3. Innovation Waivers

Section 1332 of the Affordable Care Act (ACA) provides states with the opportunity to apply for "State Innovation Waivers" (also known as 1332 waivers). State plans operating under 1332 waivers must:

1) Be as comprehensive and affordable as those provided by the ACA;
2) Cover a comparable number of residents as the ACA would;
3) Not increase the federal deficit; and
4) Be approved by the Secretary of Health and Human Services and of the Treasury after a period of public notice as well as state and federal comment periods.

The waivers are intended to give states the flexibility to experiment with different health coverage models to meet the state's unique needs while meeting minimum standards for coverage and access. The rigorous and transparent approval process is directed at ensuring these standards are met.

However, some have suggested applying a similar approach to the private market. These commercial "innovation waivers" would apply a regulatory sandbox approach to the state-regulated health insurance market. While this type of sandbox testing may be a popular approach to rolling out new regulatory schemes in other industries (like the fintech sector), the health care industry is different in that it is directly linked to the health and well-being of patients in our state. These waivers would allow health plans to be exempt from regulations that serve to protect patients' health, safety, and financial well-being. To be frank, while this experimental approach may be acceptable for exploring the viability of financial services innovations, it could be disastrous for the health and safety of many Texans.

We are particularly concerned that these health insurance "innovation waivers" could result in a false promise of comprehensive health care coverage. Employers and individuals purchase health insurance with the expectation that it will be there when they need it. Offering products without a responsible minimum level of coverage threatens to increase the rate of avoidable hospitalizations, thereby driving up health care spending. It could also erode health care literacy and trust in our health care system by creating an unreliable patchwork of plans with different regulations.

As with any sophisticated industry, our legislative and regulatory framework should encourage responsible innovation. In health care, our responsibility is the health of the patient and the decision to seek quality care should never be impacted by concerns over coverage.

4. Multiple Employer Welfare Arrangements (MEWAs)

Multiple Employer Welfare Arrangements (MEWAs) are health care benefit plans established by multiple employers, typically from unrelated businesses or industries, to provide health and welfare benefits to their employees.

Where MEWAs historically have fallen short is their lack of regulation and financial solvency. The National Association of Insurance Commissioners (NAIC) has described these plans as having "a colorful and troubling history" and being "notoriously prone to insolvencies."

Additionally, according to the NAIC, "While the promise of [these plans] has always been to give small employers access to low cost health coverage on terms similar to those available to large employers, that promise has never been the reality." In some cases, MEWAs have been shown to increase premiums for individuals and small businesses that need comprehensive coverage.

The 88th Legislature passed House Bill 290 to align state and federal regulations of MEWAs. While final rules have not been adopted at the time of this writing, this legislation may create a regulatory framework that promotes the expansion of MEWAs while enhancing consumer protection, regulatory oversight, and compliance with federal and state laws. The implementation of HB 290 should be monitored to ensure these products deliver on their promises to patients.

5. Health Care Sharing Ministries (HCSMs)

Health care sharing ministries (HCSMs) are organizations that facilitate sharing of health care costs among members who are of a similar faith. Although they may appear to be similar to health insurance, they are not insurance companies and do not guarantee payment of medical bills.

HCSMs are not regulated like health insurance companies, which means they don't have to follow the same rules regarding coverage guarantees and financial reserves. HCSMs also may have limitations on what they cover. For example, they might exclude pre-existing conditions or specific types of procedures that do not align with their religious beliefs. Since HCSMs are not obligated to cover any medical bills, members take on the risk that their medical expenses might not be shared. The decision-making process and coverage specifics are governed by the ministry's own guidelines, which can be less transparent than those of traditional insurers.

While health care sharing ministries offer an alternative to traditional health insurance for people who are comfortable with their faith-based stance and are willing to accept the associated risks, regulation of these products is lacking. These products are not required to have any minimum level of consumer protection or coverage, which – despite their limited availability to voluntary members of the ministry – raises concerns about their role in addressing the state's coverage needs. Moreover, there have been several high-profile examples of HCSMs becoming insolvent, leaving individual members in financial ruin due to unpaid medical debt.

6. Short-Term, Limited Duration Insurance (STLDI)

STLDI plans are intended as temporary coverage solutions but have often been used as substitutes for comprehensive coverage. TMA has expressed concerns regarding these plans due to their lack of essential health benefits, preexisting condition exclusions, and the potential for consumer confusion with more comprehensive ACA-compliant plans. TMA supports regulations that limit the duration of STLDI plans to ensure they are used appropriately as short-term "bridges" between comprehensive coverage, rather than comprehensive coverage in their own right.

7. State-Based Marketplace

Under the ACA, any state may withdraw from the federally run health insurance marketplace (the Marketplace) and establish an exchange of its own. Legislation has been previously filed to do exactly this and establish a state-based marketplace in Texas. In response to this legislation, TMA and a coalition of health care-related organizations have proposed a set of principles and goals (reflected in the attached letter) to be considered by the legislature if it were to move forward in creating a state-based marketplace and/or pursuing a 1332 waiver.

We respectfully urge the committee to consider these principles when evaluating the proposal to create a state-based exchange.

As the committee evaluates proposals to implement or expand alternatives to employer-based insurance, we respectfully implore that the following recommendations be taken into consideration.

Recommendations on Exploring Alternatives

1) Ensure any alternative benefit plans include necessary protections and coverage, such as:
    - Protection for people with preexisting conditions.
    - Meaningful coverage, including minimum health benefits.
    - Adherence to consumer and provider protections, including network adequacy standards, prompt payment, mental health parity, independent review of utilization denials, and gold-carding requirements.
    - Transparency and robust disclosure to consumers and physicians regarding any limitations of the plan.
2) Ensure that any proposal to expand value-based care into state-regulated PPO/EPO products appropriately considers the impact on physicians of all specialties and practice sizes and that participation in value-based case is truly voluntary.
3) Improve state efforts to inform consumers about available health insurance options and the implications of each. Develop a state-managed care portal to help consumers compare insurance options effectively.

Challenges and Barriers in the Texas Health Insurance Market

While alternatives to health insurance may one day prove effective in improving our health care system, the transition will take time and have challenges of its own. In the meantime, we must continue to emphasize the need to reform the existing health insurance regime.

Navigating the health insurance market presents a multitude of challenges and barriers that often create unnecessary complications and burdens for both physicians and patients. One of the most pervasive issues is the inadequacy of networks and provider directories. Many health insurance plans offer limited choices of physicians and health care providers, and their directories are often outdated or inaccurate. This can lead to patients unknowingly receiving care from out-of-network physicians or providers, resulting in unexpected higher costs, and complicated continuity of care.

Another significant hurdle is the inconsistency in insurance policies and formularies. Insurance providers frequently change formularies and policies, with little to no transparency or notice to patients or physicians. This inconsistency can severely disrupt treatment plans, forcing physicians to spend valuable time navigating bureaucratic procedures instead of focusing on patient care. For example, Blue Cross Blue Shield and Aetna both recently announced policy changes stating that they will no longer provide additional payment for physical status modifiers. These modifiers classify the level of complexity of anesthesia care for patients based on a clinical determination that various health factors may add to the time or risk of the procedure. These policy changes threaten patient access by limiting the availability of care for patients with comorbidities.

The use of prior authorization requirements adds another layer of complexity. These systems,

which require physicians to obtain approval from insurance companies before prescribing treatments or medications, can delay patient care and lead to serious adverse effects. Recent investigations by ProPublica and *The New York Times* have highlighted how these burdensome requirements can significantly harm patient outcomes, lack transparency, and infringe on physician medical judgment.

Furthermore, the health insurance market is plagued by conflicting transparency requirements. While there are federal and state mandates aimed at making health care costs more transparent, these regulations often clash or are implemented inconsistently. This confusion can prevent patients and physicians from obtaining clear and accurate information about treatment costs, complicating financial planning and potentially leading to unexpected medical bills.

Lastly, issues surrounding Medicaid enrollment and disenrollment represent a critical barrier to health care access. The process is often cumbersome and lacks the flexibility needed to accommodate changes in patients' circumstances. The need for significant reforms in Medicaid enrollment practices is evident, as current challenges can lead to eligible individuals being unjustly disenrolled or experiencing lapses in coverage, which in turn affects their access to timely medical care and potentially undermines the state's significant investment in the care of this vulnerable population.

Addressing these challenges requires a concerted effort from all stakeholders in the health care industry, including policymakers, physicians, insurance companies, and health care providers, to ensure that the system works more effectively and equitably for everyone involved.

Recommendations for Addressing Challenges and Barriers in the Insurance Market

1) Enhance the enforcement of network adequacy standards and provider directories by TDI and the Office of Public Insurance Counsel.
2) Enact reforms to current prior authorization laws to protect patient health and safety as well as physician medical judgment.
3) Prohibit the following practices by insurers which affect competition and patient freedom of choice/access to care: patient steering and use of all-products clauses.
4) Extend and simplify enrollment processes for public programs like CHIP and Medicaid. Enact express lane eligibility legislation.
5) Address telemedicine payment parity.

Conclusion

The Texas Medical Association remains steadfast in its mission to improve the health of all Texans by advocating for meaningful changes in health care policies. Our testimony today underscores the critical challenges facing our health care system – from the devastating impacts of cyberattacks on health care infrastructure to the pressing need to expand access and reduce costs. By addressing these challenges head-on and embracing equitable and effective health reforms, we can ensure that all Texans have access to high-quality health care, irrespective of their socioeconomic status or geographical location. Thank you once again for the opportunity to share these insights. We look forward to working with the committee to constructively constrain health care costs while improving access, quality, and safety.

Should you have any questions, please contact Ben Wright, TMA director of public affairs, at Ben.Wright@texmed.org.

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