October 1, 2020

Re: Interim Charge I

The Honorable Greg Bonnen, MD, Chair
House Select Committee on Statewide Health Care Costs
Submitted via email to Samantha.Durand_HC@house.texas.gov and Brigitt.Hartin_HC@house.texas.gov

Dear Chairman Bonnen and Committee Members:

On behalf of the Texas Medical Association and the 14 undersigned specialty societies, who together represent more than 53,000 physicians and medical students, thank you for the opportunity to respond to the Select Committee on Statewide Health Care Costs' Request for Information regarding Interim Charge I: examine the primary drivers of increased health care costs in Texas.

In 2018, the United States spent 17% of gross domestic product (GDP) - $3.6 trillion – on health care,[1] translating to the highest per capita costs among all industrialized countries - $11,172 per person.[2] According to the most recent state-level data available (2014), Texas' per capita spending equals $6,998, compared with $5,982 in Utah, the lowest cost state, and $11,064 in Alaska, the highest cost.[3] Yet, studies show that higher spending has not resulted in better health care outcomes.

Prior to the pandemic, nationwide more than one in three adults reported they could not afford to pay their health plan deductible before obtaining health care services. Texas has the 5th highest rate of adults with unpaid medical bills.[4] Yet, our members know firsthand that delayed or foregone care can have tragic – even deadly -- consequences. If we are to fulfil our mission to improve the health of all Texans, we must also find ways to constrain health care costs.

Doing so is not for the faint-hearted. Like Sisyphus forever rolling a boulder up the hill, meaningfully reducing health care costs has proved elusive not only for the state but also for the nation as a whole, in part because of the complex interplay between multiple, dynamic and interconnected factors - excessive

administrative costs, consolidation of health care markets, fragmentation of the health care delivery system, erosion of primary care, health inequality, and rising rates of uninsured. COVID-19 has amplified many of these trends. Yet, it also has created a stronger imperative to address them.

So, where should Texas start? We recommend Texas pursue initiatives that will:

- Expand availability of meaningful health care coverage to the uninsured,
- Address social determinants of health,
- Eliminate inefficient and costly administrative waste,
- Strengthen Texas' public health infrastructure, and
- Strengthen the physician primary care network.

In the coming weeks, we will continue to explore other potential options for the Select Committee to consider. Despite the enormity of COVID-19's impact on patients, communities, and practices, it also has shown that physicians, hospitals, providers and the state have a deep well of imagination to quickly revamp stale and ossified health care delivery models and outdated regulatory regimes when faced with a crisis. We must harness that same energy to ensure Texans have access to meaningful, comprehensive, timely and affordable health care.

Should you have any questions about our comments, please contact Clayton Stewart, director, legislative affairs, at clayton.stewart@texmed.org or (512) 217-0744; Helen Kent Davis, associate vice president, governmental affairs at helen.davis@texmed.org or (512) 415-8048; or Kelly Walla, associate vice president and deputy general counsel at kelly.walla@texmed.org or (512) 799-4488; mailing address: 401 W. 15th St., Austin, TX 78701.

Thank you again for the opportunity to comment.

Sincerely,

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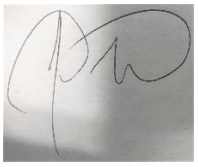

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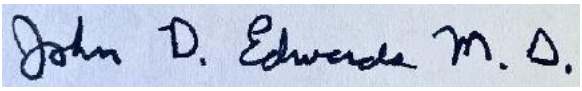

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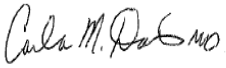

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Recommendations

1. Enact a comprehensive strategy to reduce Texas' rate of uninsured. Recently published data from the U.S. Census Bureau showed the percentage of Texans who lack health care coverage increased for the fourth year in a row, rising from 16% in 2016 to 18.4% today, for a total of 5.2 million uninsured Texans. Those figures do not include the estimated 1.6 million Texans who lost health insurance when they lost their jobs. While the job market has bounced back somewhat, and some of the newly uninsured might be able to obtain coverage elsewhere, **Texas can no longer ignore the profound human, social, and economic impact of having more than 20% of our people uninsured.**

"It is both mistaken and dangerous to assume that the persistence of a sizable uninsured population in the U.S. harms only those who are uninsured."[5] Numerous studies show that high rates of uninsured patients contribute to higher health care costs because physicians and hospitals must offset uncompensated care costs by passing them along to employers, privately insured patients, and taxpayers whenever possible. Yet, for physicians and hospitals practicing in underserved communities, the ability to pass along these higher costs is limited, resulting in closures or limited services. Moreover, high rates of uninsured hurt the health and economic well-being of communities. According to the Institute of Medicine (IOM), high rates of uninsured increase disease burden and disability within a community, impacting worker – and employer – productivity and harming the community's ability to recruit and

retain health care professionals as well as employers. Moreover, estimates show that by extending Medicaid, the state could save $110 million in net general revenue (GR) during the next biennium by offsetting certain GR-only healthcare expenditures.[6]

We support:

- Extending Medicaid coverage to low-income, uninsured working-age adults;
- Establishing a state-administered reinsurance program to reduce premiums for people enrolled in marketplace plans;
- Providing 12-month comprehensive coverage for women who lose Medicaid 60 days postpartum; and
- Establishing 12-month continuous coverage for children enrolled in Medicaid, the same benefit provided to children enrolled in the Children's Health Insurance Program.

2. Support measures to reduce social drivers of health. Improving access to comprehensive health care coverage must be paired with addressing the nonmedical factors that also affect health, commonly known as social determinants of health (SDOH) -- the places where people live, work, and play.

Research indicates that non-medical factors contribute as much as 80% of a person's health outcomes compared to 20% for medical services. Across Texas and the nation, physicians, hospitals, payers and community organizations are working together to address these factors, such as unsafe housing or food insecurity**. In one recent study, researchers found that by connecting low-income patients to social services, health care costs could be reduced by as much as 10%.**[7] For example, addressing food insecurity is a cost-effective intervention to reduce unnecessary emergency department and inpatient hospital admissions. Yet, according to the Commonwealth Fund, the U.S. spends the least on social services as a percent of GDP compared with other industrialized countries.

SDOH have been fuel to the pandemic. Susceptibility to chronic disease is closely tied to socioeconomic status, and as unemployment and uninsured rates increase, there is less access to health services and early treatment for preventable disease. While the strategies used to address social determinants of health will vary locally, Texas nonetheless needs a statewide commitment to addressing them, including:

- Directing the health plans administered by the Employees Retirement System of Texas (ERS), Teacher Retirement System of Texas (TRS), and Medicaid to promote and reimburse for SDOH screening and interventions conducted by physicians and other health care providers.
- Ensuring that health plans risk-adjust quality payment models and performance assessments to reflect the higher utilization and costs of caring for patients who experience negative SDOH; and
- Promoting and rewarding innovative, community-driven initiatives that connect medical and nonmedical systems to synergistically address underlying SDOH at the local level.

3. Reduce waste. As defined by the Institute of Medicine (IOM), "waste" encompasses six domains: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity. **"Reducing waste is by far the largest, most humane, and smartest opportunity for evolving an affordable health care system."**[8] Researchers estimate waste (excluding administrative costs), accounts for 25% of total health care spending. Factoring in administrative costs, researchers estimate that *excess* billing and insurance-related costs amount to $245 billion in current dollars, translating to an additional $2,497 per year per person.[9]

Of particular concern is the unwarranted proliferation of prior authorizations (PAs). PA is the process whereby a plan qualifies payment for a service by first reviewing a physician's proposed treatment, service, or prescription prior to the provision of care. When used judiciously, PAs have a legitimate patient safety and cost-containment purpose, allowing plans to assess whether a service meets medical necessity criteria or to determine if a prescribed drug or treatment is potentially contraindicated. However, in recent years, some plans have turned PAs into a cost-containment cudgel, excessively imposing them to delay or deter medically necessary care to save money.

According to TMA's 2020 Biennial Physician Survey, 28% of physicians reported that PAs sometimes delayed access to care while another 43% said often. In the same survey, 85% of respondents reported that within the past five years there has been an increase in the number of PAs required for prescription medications and 80% said so for medical services. However, **PAs themselves are not free. Research indicates that it costs physicians $10.92 to $12 per claim[10] to obtain one.** Additionally, according to a March 2020 report from the Hamilton Project, among surgical practices, staff spend some "25 hours per week adjudicating 37 prior authorization requests. If staff time costs $20 per hour, this is about $14 per claim." **These costs do not account for the administrative costs incurred by the health plans or missed time and work borne by patients.**

However, there is broad agreement among stakeholders that the PA process needs fundamental reform. Two years ago, national organizations representing physicians, hospitals and health plans released the Consensus Statement on Improving the Prior Authorization Process. TMA strongly recommends that the committee codify these common-sense reforms, including:

- Require plans to conduct an annual review of all prior authorization requirements to determine whether the PA is clinically justified and cost effective. The review should include input from contracted physicians, health care providers and/or medical and provider organizations.
- Support continuity of care for medical services and prescription medications for patients on appropriate, chronic, stable therapy through minimizing repetitive PA requirements.
- Require health benefit plan issuers to "gold card" certain physicians from PA processes (i.e., creating an automatic approval or exemption, on a physician-by-physician basis, that waives prior authorization requirements if a specific procedure/service is ultimately approved for that physician the vast majority – i.e., 80% – of the time);
- Require the Texas Department of Insurance to perform audits of health plan compliance with statutory PA timelines for approvals and denials; and
- Require peer-to-peer discussions to be conducted with a Texas-licensed physician who is of the same or similar specialty as the physician.

Additionally, **Texas should consider requiring state-regulated plans to pay for the administrative costs associated with PAs**, **thus incentivizing plans to apply PA requirements more sensibly.[11]** Besides administrative costs, IOM also defined "waste" to include overtreatment or low-value care. To address this type of inefficiency, in 2012, the *Choosing Wisely* campaign initiated a system to

> [P]romote conversations between clinicians and patients by helping patients choose care that is:
> - Supported by evidence
> - Not duplicative of other tests or procedures already received
> - Free from harm
> - Truly necessary

Examples of *Choosing Wisely* initiatives, which originate with national medical specialty organizations, include educating patients about the impact of antibiotic overuse and whether certain screening or imaging tests are clinically necessary. TMA and more than 70 national medical specialty societies endorse the campaign, but more could be done to promote it. We recommend that ERS, TRS, and the Health and Human Services Commission collaborate with TMA and specialty societies to better promote it among plan enrollees.

4. Invest in Public Health. In addition to the impact COVID-19 has had on health disparities, the pandemic has drastically strained Texas' already limited public health resources and illustrated where Texas' emergency preparedness needs strengthening and attention for future action. Lack of personal

protective equipment (PPE) has been a debilitating factor, with up to 78% of Texas physicians having an insufficient supply in April 2020.[12]

This shortage has highlighted the inextricable link between Texas' emergency response systems and essential medical services. Investments in PPE procurement, supply maintenance, and appropriate staffing are key to ensuring physicians have access to the PPE they need to safely care for their patients.
A strong infrastructure for effective surveillance, reporting, and response requires a skilled public health workforce. A statewide electronic case reporting (eCR) system also needs to be further implemented, updated, and streamlined for use across sectors and throughout all levels of public health systems. In addition, electronic lab reporting system vendors must prioritize the efficiency, functionality, and interoperability of their eCR systems.

5. Increase utilization of high value primary care services and intervention. Compared with other industrialized nations, the U.S. spends only one-third to one-half on primary care as a percent of total health care dollars. Yet, there is a strong relationship between greater primary care utilization and lower health care costs, including decreased use of preventable inpatient hospital and emergency department (ED) services. Multiple studies show that in communities with higher primary care physician capacity, patients experience lower health care costs, higher satisfaction, and better health outcomes.

A strong primary care system is like the tide that raises all boats. For the physician subspecialty network, having a robust primary care physician network supports their practices by allowing them to treat and manage the most complex patients, often in collaboration with primary care physicians. At the outset of the pandemic when many primary care practices struggled to obtain Personal Protective Equipment (PPE) and temporarily stopped seeing patients in-person, emergency departments experienced firsthand how the lack of primary care could exacerbate staffing shortages and overcrowding.

Alarmingly, studies published prior to the pandemic found that patients' use of preventive and primary care had dropped precipitously – 24.2% between 2008 and 2016.[13] Unfortunately, the pandemic has fueled this trend. In March, patient volume at primary care practices plunged, resulting in a concomitant drop in revenue. While most practices quickly established telemedicine as an alternative mode of care, telemedicine did not replace patient volume, which remains flat or down. According to a recent national poll of primary care practices that included Texas physicians, "The vast majority of primary care practices have not returned to pre-pandemic status" in terms of patient visits, revenue, or staffing. Yet, primary care practices are the frontline to combat not only COVID-19 but also flu.

COVID-19 may prove to be an "extinction level event" for primary care physician practices without more help from the state. Otherwise, practices have few options, including closure or selling to private equity entities, all of which will have long-term repercussions for health care costs. As such, we support the following:

- Rapid deployment of risk-adjusted, prospective payment initiatives for interested physicians contracted with ERS, TRS and/or Medicaid. This approach will achieve our two-pronged goals of providing physicians financial security while also advancing Texas' long-term goals to promote value-based payment initiatives.
- Investment of dollars to reward and sustain primary-care-centered, innovative, cost-effective, value-based delivery models that will maximize the state's efforts to improve patient health outcomes and address Texas' critical health care challenges, including improving maternal and child health, increasing the availability of mental health and substance use disorder treatment, and strengthening rural, border, and underserved physician networks.
- Establishment of "statewide, multi-stakeholder, consensus based… approach to strengthening our primary care systems," as called for in the Texas Primary Care Consortium's Call to Action, which TMA and more than 40 other organizations endorsed.
- Restoring the $8.45 million funding reduction to the Physician Loan Repayment Program to help attract and retain more primary care physicians in Texas' Health Professional Shortage Areas.

- Providing $1 million to fund the State Rural Training Track Grant Program, which lawmakers created in 2019 to provide grants to medical schools to develop rural physician training tracks, a blend of urban and rural clinical experiences to train residents to practice in rural areas. However, no funds were allocated. A robust body of research shows that physicians who train in rural areas are more likely to practice there.

Lastly, COVID-19 has had an outsized impact on the health care economy. Significant care has been delayed thereby negatively impacting patients and the financial stability of physician practices and hospitals. While inpatient COVID-19 care is reportedly very expensive, those costs have not yet materialized with commercial payer earnings. For example, Anthem's 2020 second quarter (Q2) operating gains more than doubled year over year.[14] UnitedHealthcare's 2020 Q2 earnings almost doubled over the same period the prior year.[15] Payers helped patients by waiving patient costs associated COVID-19 and some, such as Anthem, deployed assistance to physicians and food banks.[16] Yet, these payers significantly increased their earnings.

While payers are expected to set premium rates according to their expected costs for the future period, COVID-19 must affect these forecasts. Because patients delayed care in 2020, there likely will be pent-up demand for care in 2021, though rising numbers of uninsured will likely impact this trend. Enduring COVID-related complications and COVID vaccine costs could also increase costs. As we advised the House Committee on Insurance, TMA strongly urges the Select Committee to scrutinize premiums to ensure all Texans have affordable health care coverage and the health insurance markets have adequate networks of participating physicians and health care providers.

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[1] National Health Expenditure Survey, Office of the Actuary, Centers for Medicare and Medicaid Services
[2] *Id.*
[3] Health Care Spending Per Capita by State, Kaiser Family Foundation
[4] FINRA Investor Education Foundation, National Financial Capability Study, 2018
[5] A Shared Destiny: Community Effects of Uninsurance (2003), National Academies of Sciences, Engineering and Medicine.
[6] State Budget Impact of Providing Health Insurance to Low-Income Adults with 90%, analysis by Randy Fritz, John R. Pitts and John R. Pitts, Jr. for the Episcopal Health Foundation, September 14, 2020
[7] Expenditure Reductions Associated with a Social Service Referral Program, Population Health Management, Nov. 2018
8 **Reducing Waste: The "Humane" Path to Affordable Health Care**, Institute for Healthcare Improvement
[9] https://www.hamiltonproject.org/assets/files/Cutler_PP_LO.pdf
[10] *Id.*
[11] *Id.*
[12] April 2020 TMA COVID-19 PPE Needs Survey of Texas Physicians
[13] *Annals of Internal Medicine*
[14] *See* Anthem's Q2 report, July 2020.
[15] *See* UnitedHealth Group's Q2 performance report, July 2020.
[16] *Id.* at FN 13.