FINAL REPORT
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TCCRI
Texas Conservative Coalition Research Institute

HEALTH CARE & HUMAN SERVICES TASK FORCE

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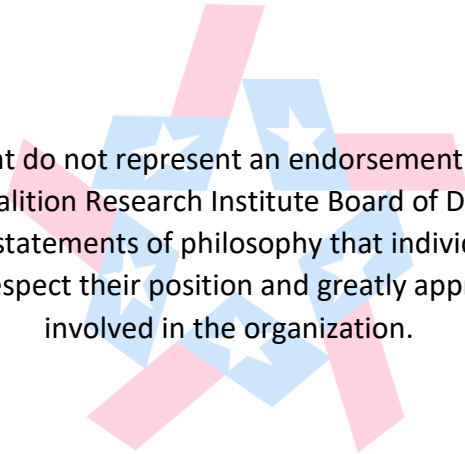

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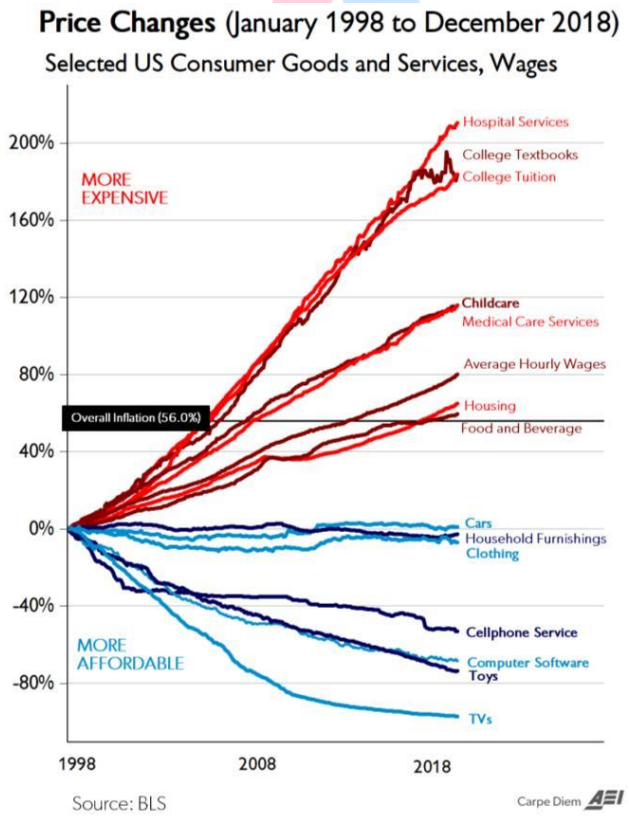
I. Introduction

Healthcare is one of the most personal issues that we as human beings face and, as such, is an issue that ignites fiery political and philosophical debates. From the degree to which the government or a third-party entity should be inserted in between you and your doctor, to birth and complex end-of-life care decisions, it touches every facet of our society regardless of gender, race, ethnicity, or socioeconomic status. And, although individuals may have very different experiences within the healthcare system depending upon geography, fitness level, and myriad other factors, one shared experience that has affected virtually every American is its ever-increasing costs.

The purpose of the following chart, developed by the American Enterprise Institute, was to depict price changes in US consumer goods and wages over the past 20 years. And while it is very helpful on that front, it also paints a disturbing image of America's healthcare cost trends, with "medical care services" on par with childcare and outpacing hourly wages, housing, and sustenance, while the growth in the cost "hospital services" outranks every single category on the chart.



Source: American Enterprise Institute[1]

This rate of escalation simply isn't sustainable and, based on current trends, is not headed toward any kind of course correction. The total cost of healthcare in the U.S. reached $3.3 trillion in 2016[2] and,

according to the federal Centers for Medicare and Medicaid Services (CMS), is projected to grow to an astounding $5.7 trillion by 2026.[3] A multitude of factors have contributed to this meteoric rise- some are positive, such as longer life expectancies- while others, such as rising costs of prescription drugs, larger segments of the population with chronic conditions such as diabetes and heart disease, and intrusive government mandates- are not.

The challenges facing our healthcare system did not happen overnight, nor will they be solved that way, but the enormity of this task cannot be delayed any longer. While there are no "quick fixes" to these seemingly insurmountable issues, there are reforms that state leaders can adopt. To that end, the Texas Conservative Coalition Research Institute's (TCCRI) Task Force on Health and Human Services met multiple times over the last 18 months to explore policy solutions focused on two key principles: lower healthcare costs and raise patient outcomes. Over the course of the past interim, TCCRI staff met with the Task Force's legislative co-chairs, legislative staff, and interested private sector stakeholders to discuss crucial public policy issues within the Task Force's purview.

The "Healthcare Reform" section of this Report delves into the latest Affordable Care Act (ACA) ruling from December 2018 which, if it stands, would strike the law down in its entirety. This section also discusses reforms that the Legislature should consider in both the private and public health care sectors in the 86th Legislation Session as this lawsuit continues to work its way through the legal system- policy initiatives which TCCRI has continued to champion for many years. Within the private sector, these reforms include rolling back, and rejecting any new, unfunded mandates; passing an option for a catastrophic coverage plan free of state-mandated benefits; and rejecting additional regulations on association health plans (AHPs). The public sector discussion focuses on the Medicaid program and changes that are within the jurisdiction of state leadership, such as pursuing a block grant waiver from the federal government, structuring Medicaid to function more like private insurance, injecting greater personal accountability into the taxpayer funded program, staying the course on the state's current use of Medicaid managed care, and continuing the move to outcomes-based payments within the managed care system.

The "Price Transparency" section of this Report is largely adapted from the white paper TCCRI released late last year on the advantages of a more transparent healthcare system. Specifically, the Task Force recommends that the Legislature pilot a model known as *Right to Shop* in the Texas Employees Retirement System (ERS). More broadly, the legislature must ensure that any transparency initiatives apply to all facets of the healthcare system, and not target only certain providers or entities.

With respect to the "Teacher Retirement System" (TRS) section, this Report recognizes the ongoing challenges faced by TRS, particularly in the Medicare coverage of its retirees and their dependents. Here, TCCRI recommends studying an idea that has merits in almost any publicly-funded system- examine 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.

In the “Increasing Access to Care” section, this report explores Texas’ well-documented physician shortage and discusses non-physician providers that can help fill access to care needs in both the medical and dental fields. Policy recommendations include allowing the independent practice of advanced practice registered nurses, exploring how physician assistants and pharmacists can be better utilized to meet patient need, allowing dental hygienists to administer local anesthesia under the delegation of a licensed dentist, and increasing access to teledentistry services.

The “Opiates” section looks at data related to opiate-related prescriptions and deaths specific to Texas, steps the state has taken to curb inappropriate prescription drug use, and examines electronic prescribing of controlled substances.

This final Task Force Report lays out the public policy issues that the 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 all should be strongly considered in 2019 when the Texas Legislature meets for the 86th Legislative Session.

II. Healthcare Reform

A. Exploring the New Affordable Care Act Ruling

Just before Christmas 2018, Affordable Care Act (ACA) opponents received an early, and somewhat unexpected, gift when a federal judge in Fort Worth, Texas struck down the law in its entirety, siding with Texas and nineteen other state plaintiffs in a lawsuit that was originally written off by detractors.[4] Supporters of the troubled law immediately vowed to appeal the decision, and the decision inevitably will work its way to the Supreme Court (SCOTUS) over the coming months and perhaps even years. Yet this ruling gave conservatives an opportunity to do something they have not dared since 2009: imagine a world in which the healthcare system can be reformed outside of the mandates of the ACA.

In his ruling, Judge Reed O'Connor focuses on whether the ACA can stand without the individual mandate to purchase health insurance coverage. Although SCOTUS originally upheld the individual mandate in 2012's *NFIB v. Sebelius* case, the Court based its decision on Congress' constitutional taxing authority, holding that the ACA's mandate penalty was, in effect, a tax.[5] Using the same logic, the *Texas v. United States* lawsuit alleges that the mandate became unconstitutional when its associated penalty was zeroed out by Congress in the Tax Cuts and Jobs Act of 2017,[6] thereby effectively repealing the mandate. Siding with the plaintiffs, Judge O'Conner did declare the mandate unconstitutional and went on to examine its relationship with the remainder of the law. He writes:

> Finally, Congress stated many times unequivocally—through enacted text signed by the President—that the Individual Mandate is "essential" to the ACA. And this essentiality, the ACA's text makes clear, means the mandate must work "together with the other provisions" for the Act to function as intended. All nine Justices to review the ACA acknowledged this text and Congress's manifest intent to establish the Individual Mandate as the ACA's "essential" provision. The current and previous Administrations have recognized that, too. Because rewriting the ACA without its "essential" feature is beyond the power of an Article III court, the Court thus adheres to Congress's textually expressed intent and binding Supreme Court precedent to find the Individual Mandate is inseverable from the ACA's remaining provisions.[7]

Based on this deemed inseverability of the individual mandate from the remainder of the law, and the trial court's consequent finding that the mandate is now unconstitutional, this decision strikes down the entire ACA.

To be clear, the ACA as we know it is wobbling, but still standing. Although Judge O'Connor's ruling invalidated the law in its entirety, he did not enjoin it. This is likely because he knew appeals would be filed, and the ACA has so entwined itself throughout the healthcare system that he did not want to further destabilize an already fragile system as this case works its way through the courts.

While this lawsuit is unquestionably a win for conservatives, it also represents somewhat of a double-edged sword for states, presenting simultaneously an opportunity and a challenge. The opportunity is obvious- Texas can, and should, immediately start developing plans to return to pre-ACA private sector insurance and Medicaid regulations, rolling back unfunded mandates and Medicaid eligibility changes that have caused skyrocketing caseloads. If the decision is upheld, and the entire law falls, Texas should be ready to seamlessly resume full control of its health insurance market and return to running our Medicaid program in accordance with Texas laws that were superseded by the ACA.

However, the challenge is that states must not become so consumed with relying on this lawsuit's success that they fail to move forward with reforms within the current environment. Because the Texas Legislature only meets biennially, the 86th Legislature is uniquely situated to take advantage of working with a federal administration that is eager to grant states broad authority to waive off of federal laws and regulations pertaining to both private insurance and the Medicaid program. So, while state leaders should move forward with plans for the ACA should it disappear, they must also, and perhaps counter-intuitively, move forward with enacting reforms to make the best of the existing situation and maximize flexibility should the law ultimately stand.

B. Private Sector Insurance

The detrimental impact of the Affordable Care Act on the nation's health insurance market would be difficult to overstate. Well-documented skyrocketing costs for individuals and families,[8] coupled with decreasing plan choices as multiple insurers decline to offer ACA Exchange plans,[9] have left many Texans in the position of choosing health insurance coverage or putting that money towards other necessities. To be clear- this law is a federal problem and these issues can only be completely resolved by Congress repealing this troubled law. While the aforementioned *Texas v. United States* lawsuit is cause for optimism, state leaders should continue to look at opportunities to make the healthcare marketplace more tenable for consumer and insurers within the federal status quo.

Two areas that deserve examination and possible action by the Legislature in the current session are unfunded government mandates on health insurance plans, and opportunities to increase coverage through the use of association health plans.

The True Costs of Government Mandates

Unfunded government mandates generally take two forms in terms of health insurance coverage-mandated benefits and any willing provider (AWP) laws. While mandates are often designed to provide a benefit to a relatively small number of the insured population, every insured person contributes to the cost of each one through increased premiums. Although some mandates may appear harmless enough, increasing premiums perhaps only one percent, it is critical to bear in mind that each one percent can cost individuals and families a total of $230 million a year.[10]

Benefit Mandates

A significant amount of the consternation around the ACA was due to its substantial benefit mandates, designated by the law as essential health benefits (EHBs), and for playing a role in putting the commercial market into a state of crisis. Most people, regardless of their stance on the issue of mandated benefits, agree that they drive up the cost of healthcare coverage, capable of causing an increase in monthly premiums between one and five percent *per benefit*.[11] Examples of the ACA's "essential benefits" include maternity care, mental health and substance abuse disorder care, and oral and vision care coverage for children.[12]

Often times, benefit mandates are difficult to deny because they target sympathetic populations, such as mandated cochlear implants for child deafness, and/or they seem innocuous because they are limited to conditions that only impact a small number of the population, such as treatment coverage for certain conditions related to craniofacial abnormalities, which is also unquestionably a sympathetic population (both mandate bills were filed in the 85th Legislative Session with the former having passed into law). However, authorities on health policy warn against falling into this trap because these mandates have a cumulative effect. One policy expert explains:

> In general, it's politically palatable for lawmakers on both sides of the political aisle to pass benefit mandate after benefit mandate. This legislation shields them from being called out for explicit tax increases, and the per member per month (PMPM) cost of each imposed on policyholders is miniscule...
>
> The insignificant cost of each standalone bill also makes mandate legislation politically feasible for special interests and other medical providers to get their way, which explains why there are now 2,200 mandates nationwide – up from almost zero in the 1970s. But the issue becomes problematic when multiple bills are introduced simultaneously.[13]

According to data reported by Texas Association of Health Plans (TAHP), benefit mandates in the aggregate can increase the cost of healthcare by anywhere from 10 to 50 percent.[14] And between 1996-2011 new benefit mandates alone were found to have been responsible for 23 percent of total premium costs.[15] The Texas Department of Insurance provides a helpful and detailed chart of the state's mandated health benefits as of September 1, 2017.[16] While the majority of these benefits are federally required, not all are. Of particular note is the state-only mandate for certain group plans to cover in vitro fertilization.[17] While fertility is, again, a sympathetic issue, this mandate can have exponential ongoing costs, not only in the treatments themselves, but also in high-risk pregnancies and multiple births (i.e. twins/ triplets), which carry an increased risk of premature delivery.[18]

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.[19] 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 opportunity to negotiate lower prices and, most importantly, adopt standards that may restrict lower-quality providers from joining their networks. This applies to medical and pharmacy benefits.

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

> Many networks are highly exclusive. The greater a network's exclusivity, the more customers a member pharmacy can expect. The prospect of a large number of customers creates intense competition for exclusive networks; this competition leads pharmacies bidding for network membership to offer higher discounts in order to join the network. It is well understood that cost savings resulting from this exclusivity are generally passed on to consumers in the form of lower premiums, lower out-of-pocket costs, and better services.[20]

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.[21] Proponents of such laws argue that they "level the playing field," particularly for independent practitioners, and provide greater choice to consumers.[22] 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.[23] One analyst described it thusly: "The preponderance of evidence and economic logic would counsel emphatic rejection of new or even existing AWP … laws." Succinctly put,

> 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.[24]

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.'"[25]

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."[26]

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

Opportunities to Increase Coverage Options through Association Health Plans

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. Understanding this dilemma, and given Congress' inability to enact any true healthcare reforms, President Trump began looking at what his administration could do through executive authority to give states some opportunities to increase coverage options. In October 2017, the President signed an Executive Order[27] to increase greater choice and competition in healthcare coverage options through several means, including allowing the purchase of association health insurance plans (AHPs) across state lines, and increasing access to AHPs in general. The purpose of this Order was to provide coverage options to the millions of Americans who do not have access to employer-sponsored insurance, and cannot afford individual plans through Affordable Care Act Exchanges.

The function of AHPs is to allow small business owners to join together and purchase the type of group coverage options that are typically only available to large employers, when risk is spread across a larger population. And, because these plans are not subject to all of the ACA's mandates, their premiums are generally more affordable than Exchange plans. Prior to the Executive Order, AHPs were limited to small employers with a "commonality of interest." The Executive Order asked federal agencies to increase coverage options in accordance with the President's directive and, over the summer the Department of Labor (DOL) rolled out its final draft of the new regulations, with the first portion of the rule becoming effective January 1, 2019.

The DOL's final regulations did not impact existing AHPs, but they do allow for a greater number of associations and businesses within certain trades to form AHPs based on either a common business/ trade ***or*** a common geography.[28] These new associations may be formed by common industries nationwide, or could apply to all employees within a designated geographic area.[29] The new rule also allows sole proprietors and their families to join AHPs, an option that was not available to self-employed Americans prior to this change.[30]

The reactions to these reforms have been varied. Almost immediately, 11 states and the District of Columbia sued DOL over the rule changes. While the American Medical Association and various Democrat lawmakers submitted comments in support of the lawsuit, the U.S. Chamber of Commerce; Attorney General Paxton; the Attorneys General in Louisiana, Georgia, and Nebraska; and a coalition representing more than one million small employers filed briefs supporting the DOL change.[31]

As the lawsuit continues to progress, states have begun preparing for the expanded use of AHPs with mixed reactions. California, Connecticut, Pennsylvania, and Vermont have already taken pre-emptive action to limit the use and availability of AHPs through burdensome regulations, with California's new law outright prohibiting sole proprietors from taking advantage of these plans.[32] On the other side of the equation, though, is Iowa, which proactively passed legislation in April 2018 allowing for the expanded use of AHPs, in anticipation of DOJ's final rule.[33] AHPs have also already begun to form in some other states, including Nevada and Wisconsin.[34]

1. Policy Recommendation: Reject Unfunded Mandates

TCCRI has long supported rejection of unfunded government health care mandates in any form, and this should be defended irrespective of whether the ACA is in effect. In the 86th Legislative Session, state lawmakers should look to unwind any mandates that are not currently required by federal law, and continue to reject all proposed mandates. 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 would only lead to negative outcomes for Texas healthcare consumers. In addition to the anti-competitive environment and rising healthcare costs that would result from this bill, this move would set a dangerous precedent of allowing government to dictate to private businesses who they must contract with. Even benefits that are very limited and only apply to a small percentage of enrollees must 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: Pass a Mandate-Free Catastrophic Coverage Option

In the 85th Session, HB 4213 (Phillips) was filed, and would have authorized health plans to offer a catastrophic health benefit plan, free of any state-mandated health benefits. If passed, this legislation would have augmented SB 541 (83R) (Williams/ Sp: Taylor), which allows 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.[35] It is also important to remember that when SB 541 was passed in 2003,

it was done so in a pre-ACA world and largely geared towards group health plan offerings. HB 4213, as filed last session, would amend 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 last session, the 86th Legislature should make this a goal for this session using the following language to amend Chapter 1507 of the Texas Insurance Code (taken from HB 4213):

> SUBCHAPTER C. CATASTROPHIC PLANS
>
> Sec. 1507.100. CATASTROPHIC HEALTH BENEFIT PLANS. Notwithstanding Subchapters A and B or any existing requirement, a health carrier or health maintenance organization may offer a catastrophic health benefit plan that does not include state-mandated health benefits as described by 1507.003(a) and 1507.053(a).

A catastrophic plan option could be an attractive coverage option for young, otherwise healthy individuals. According to the United States Census Bureau, individuals 26-34 years old have the lowest healthcare coverage rates of any age group nationwide.[36] 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."[37] 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.

3. Policy Recommendation: Reject Additional Regulations on Association Health Plans

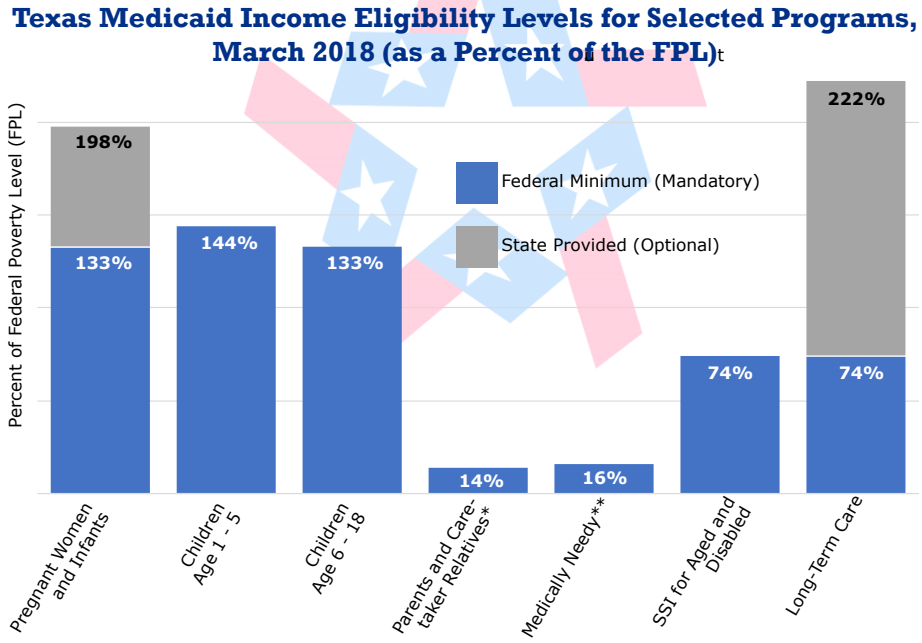
The 86th Legislative Session is the first time the Texas Legislature has convened since DOL finalized its new rule on association health plans. And with the first provisions of the rule just having taken effect on January 1st, there could be attempts to overly regulate these plans and defeat the entire purpose of the President's Executive Order. State lawmakers must reject any attempts to saddle AHPs with burdensome regulations, and allow eligible Texans the opportunity to participate in these expanded coverage options.

C. Medicaid

Background

At just over 28% of the entire state budget, and with a total FY 2018-2019 biennial appropriation of $61.8 billion all funds (AF), the Medicaid program is one of the single largest cost drivers for the State of Texas.[38] 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 State Fiscal Year (SFY) 2017, Texas Medicaid served just over 4 million low-income, elderly, and individuals with disabilities.[39] The program funds about 53% of all births in Texas, and covers 62% of all nursing facility residents.[40]

It should be noted that, even though our state has one of the nation's largest Medicaid programs,[41] Texas largely covers only mandatory populations required by the federal government. The table below shows the population groups that are covered by Texas' program, and which are mandatory versus optional.



This figure reflects eligibility levels as of March 2018. In 2014, the Affordable Care Act (ACA) required states to adjust income limits for pregnant women, children, and parents and caretaker relatives to account for Modified Adjusted Gross Income (MAGI) changes.

*For Parents and Caretaker Relatives, maximum monthly income limit in SFY 2018 was $230 for a family of three, which is approximately 14 percent of the FPL. **For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2018 was $275 for a family of three, which is approximately 16 percent of the FPL.

Source: Texas Health & Human Services Commission[42]

Even though Texas rightly refused to expand its Medicaid program under the ACA, enrollment has grown since the law's enactment due to other eligibility changes mandated by the ACA and CMS rule changes under the Obama administration. These federally required mandates include:

- Twelve-month eligibility certification: Under the ACA, Medicaid recipients receive a 12-month Medicaid eligibility certification.[43] Texas previously required Medicaid recipients to re-enroll and provide proof of Medicaid eligibility every six months. The state is allowed to request limited information from certain enrollees during the eligibility period and may take action (i.e. disenrollment) if information is obtained showing that the enrollee no longer meets income eligibility requirements.
- Prohibition of assets testing: Prior to the Affordable Care Act, Texas applied an assets test to Medicaid enrollees; all Medicaid and CHIP assets testing is prohibited under the ACA.[44]
- Hospital Presumptive Eligibility: the ACA contains a provision that statutorily ***requires*** states to allow hospitals to conduct Medicaid presumptive eligibility screening.[45]
- Medicaid coverage of former foster care youth to age 26:[46] prior to the ACA Texas provided Medicaid coverage to this population through age 21, or age 23 if the individual provided proof of enrollment in higher education.
- Transition from CHIP to Medicaid: The ACA required that all children up to 133% of the FPL be enrolled in Medicaid.[47] Prior to the ACA Texas covered children ages 6-18 above 100% of the FPL in CHIP, which has a more generous federal match rate than Medicaid and requires cost sharing. Due to this change all CHIP enrollees 133% FPL and below were required to be transitioned to Medicaid.

Although Texas had no control over exploding caseloads post-ACA, this does not mean that states are left completely powerless to bend Medicaid's ever-growing cost curve. 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 and direct 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.

Medicaid Managed Care

During the last interim, TCCRI published a two-paper series exploring the Medicaid managed care program in depth. The first paper, released in December 2017, looked at the history and overall value of the Medicaid managed care program, while the second paper conducted an in-depth review of the program's cost-effectiveness. This subsection is largely adapted from those papers.

Prior to the 1990s, Texas Medicaid enrollees received their health care services in what is known as a fee-for-service (FFS) system. In FFS, providers are paid per claim directly by the state. While enrollees

can access any Medicaid provider in FFS, there is no coordination of care or benefits, which often leads to Medicaid enrollees receiving duplicative or unnecessary services and results in an overall lack of successful management of chronic conditions like asthma and diabetes.

In 1991 the Texas Legislature passed House Bill 7 (72S1), establishing the state's first Medicaid managed care pilot programs, with the goal of seeking innovative methods for providing higher-quality lower-cost health care to the Medicaid population.[48] The first pilot, known as LoneSTAR (State of Texas Access Reform, later shortened to just STAR), was originally implemented in the Travis County and Gulf Coast regions for acute care clients in the early 1990's.[49] Encouraged by the program's success, the Legislature began growing this model, and, by the end of the decade, STAR had expanded to most of the state's major metropolitan areas; the program had also begun serving some long-term services and supports (LTSS) enrollees in the STAR+PLUS program which, for the first time, integrated acute and LTSS care for the state's most complex and high-cost members.[50]

Texas, like other states at the time, originally turned to managed care as an innovative method for controlling skyrocketing Medicaid costs.[51] However, the managed care model also yielded innumerable 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.[52]

Building upon these accomplishments, the Legislature continued to steadily expand the Medicaid managed care model over the years, both in terms of geography and in the types of clients served, due in equal part to its success in achieving cost savings and improving client outcomes. Today the program operates in all of Texas' 254 counties and serves over 90% of the Medicaid population.[53]

HHSC contracts with these Medicaid managed care organizations (MCOs) and pays them a capitated per member per month (PMPM) premium to ensure that Medicaid recipients receive all necessary and appropriate services, and plans are at risk for facilitating the provision of an enrollee's services within the PMPM rate. In addition to assuming full financial risk for these enrollees, MCOs must also maintain provider networks that ensure their members' access to all types of care, e.g. physician, hospital, pharmacy, therapy, etc.[54] Unlike FFS, managed care plans must also meet specific access standards, such as how far members must travel to see a provider and how long it takes to get an appointment.[55]

In the current Medicaid managed care program, enrollees are served through one of the following programs:

- *STAR*- provides primary, acute, and behavioral care and prescription drug coverage for low-income pregnant women, children, and certain parents of children enrolled in Medicaid.
- *STAR+PLUS*- integrates primary care, behavioral health services, prescription drug benefits, and LTSS services for enrollees aged 65 or older or other adults with disabilities; a portion of this program also serves individuals in home or community-based settings as an alternative to institutional settings, such as nursing facilities.
- *STAR Kids*- similar to STAR+PLUS, this program integrates acute and LTSS services for children and young adults with disabilities.
- *STAR Health*- operates on a statewide basis to provide children and youth in foster care with comprehensive medical and behavioral health services.
- *Children's Medicaid Dental Services Program*- the state contracts separately with dental maintenance organizations (DMOs) to administer dental benefits for children who do not reside in a health care facility or are not in the STAR Health program (these clients receive dental services through their primary delivery models).[56]

Since its implementation, the Medicaid managed care program has demonstrated proven benefits, both in terms of cost savings and improved client outcomes. In addition to the budget certainty provided to the state as a result of MCOs assuming financial risk, and improved access to care standards, Medicaid managed care enrollees also tend to experience better health outcomes than if they were served through a traditional FFS model.

The state's independent External Quality Review Organization (EQRO) reports continue to show that the state's Medicaid managed care plans perform well in terms of patient satisfaction and meet or exceed national standards in enrollees' satisfaction both with their health plans, and with the care they receive.[57] A 2016 study by the University of Texas School of Public Health entitled *Texas Medicaid Performance Study* also found that under managed care, access to, and quality of, care for Medicaid enrollees is not only superior to the FFS system, but also on par with, and in some cases better than, private coverage.[58] Health plans are also able provide what are known as value-added benefits to Medicaid clients. These are services that cannot be provided in a FFS system, because they are not covered Medicaid benefits. The MCO uses its own money to provide such services with the understanding that it will improve the health care of its enrollees, and thereby ultimately reduce costs. Examples of value-added benefits include: allergy-free mattress and pillow covers for enrollees with asthma; birth preparation classes for pregnant women; limited preventive dental care for adults; and diet/ weight-management and nutrition programs for enrollees with obesity-related diabetes or other health complications.[59]

In addition to the aforementioned access to care and quality standards that MCOs must adhere to, Texas also employs one of, if not the most, robust Medicaid managed care oversight regimens in the nation. As part of its inclusive supervision, HHSC monitors all aspects of an MCOs business and operations, including the plan's fiscal soundness and staff turnover; HHSC also assesses contractual remedies, including corrective action plans and liquidated damages, when appropriate.[60] The state

places a cap on the amount of money that MCOs may use towards administrative expenses, places a percentage of a health plan's premium at risk to ensure certain client quality metrics are met, and enforces a strict limit on the amount of profit these plans can make from Medicaid and CHIP business.[61] Any profit that exceeds this threshold is recovered by the state through an experience rebate process.[62] The combination of a profit cap and quality measures adds an additional layer of client protection by disincentivizing plans from taking any action that might adversely impact an enrollee's outcome in an attempt to increase profit margins. The state's EQRO also assesses and reports on care provided by MCOs including patient access to providers, quality of care, and overall enrollee experience.[63]

To help analyze available data and the cost-effectiveness of the Texas Medicaid managed care model, TCCRI engaged the services of Carruth & Associates, an independent entity headed by the former Chief Financial Officer of HHSC. Key findings of the March 2018 Carruth & Associates report include:

- When Medicaid caseloads grew by 93 percent between fiscal years (FY) 2002-2016, PMPM Medicaid costs increased only by a total of 17 percent, or just over one percent per year on average. Though overall Medicaid costs have continued to grow, this is primarily due to caseload increases, which are driven by federal policy, such as the relaxation of Medicaid eligibility standards under the ACA. Other factors have also contributed to costs increases. For instance, the *Frew v. Hawkins* lawsuit, which led to significant provider rate increases in 2008,[64] increased both the overall Medicaid budget and per-person costs. However, despite the influence of these outside cost drivers, managed care has consistently been able to hold the PMPM cost trend at a steady continuum.

- Both historical cost trend analysis and forecasted studies have demonstrated the cost-effectiveness of the Texas Medicaid managed care program. Two studies using similar methods, one conducted by HHSC in 2012, and one by Milliman on behalf of the Texas Association of Health Plans in 2015, arrived at comparable outcomes in validating Medicaid managed care cost savings.

    - In July 2012, HHSC submitted the *Medicaid Managed Care Expansion Cost Savings Report* to the Legislature in compliance with House Bill 1, Article II Rider 51 (82R). This report, ***looking only at managed care expansion in the 2012-2013 biennium, determined a $650 million all funds (AF) savings; it did not consider the impact of any prior managed care initiatives.***

      A 2015 study prepared by the Milliman Group on behalf of the Texas Association of Health Plans estimated ***that over the six-year period of state fiscal years 2010-2015, Medicaid managed care resulted in nearly $4 billion in all funds, and $2 billion in general revenue savings to the state.***[65]

> While these studies differed some in the magnitude of savings based on different timeframes and some differing assumptions, they arrived at similar conclusions and validated managed care cost savings.[66]

HHSC also just released a new report by Deloitte (mandated by the 2018-2019 GAA, Article II, HHSC Rider 60) that provides a comprehensive assessment of the Medicaid managed care system. This report provides a range of estimates for the amount of money saved by the Medicaid managed care system from ***FYs 2009-2017, and estimated a savings of $5.3 billion on the low end to $13.9 billion on the high end.***[67]

There is no question that managed care has been an invaluable tool in providing the state with innovative cost savings and payment models. Nonetheless, state reforms are limited in what they can achieve because Medicaid policy is so federally driven. However, for the first time in recent history, the federal government appears poised to grant states almost unprecedented levels of flexibility in administering their programs.

New Opportunities for Medicaid Reform

Not surprisingly, CMS leadership under the Obama administration was loath to allow states to pursue any waivers that would curb Medicaid's skyrocketing caseload and costs, or to introduce personal accountability measures into the program, such as cost sharing for most of Texas' covered populations. The Trump administration, however, is moving in the opposite direction, by approving 1115 demonstration waivers allowing states to possibly have the first opportunity in decades to start getting runaway Medicaid spending under control. Major waiver themes include greater cost-sharing, work requirements, and elimination of some retroactive eligibility standards.[68] And, just earlier this month, *Politico* reported that multiple sources within the administration (unofficially) confirmed they are working on a plan to allow states to block grant the Medicaid program.[69]

Over the years there has been much discussion of a Medicaid block grant and how that could afford funding predictability to the federal government and maximum program flexibility, with the ultimate goals of higher quality care and lower costs, to the states. A block grant is often hailed as the ultimate Medicaid reform. However, a detailed plan as to what this would entail has never been presented. A block grant, in its purest form, is a set "block" of money given to the state by the federal government to fund a program over a period of time. States are generally still required to fund a certain match or maintenance of effort (MOE) to earn the block grant funding.

The idea of a Medicaid block grant is not a novel one. President Ronald Reagan first proposed a Medicaid block grant in 1981.[70] In 1995 Speaker Newt Gingrich proposed a different version of a Medicaid block grant, known as *Medigrant*. Under the *Medigrant* program each state's funding need would have been separately calculated based on an array of issues such as the state's historical spending, the number of low-income residents in the state, case mix, etc.[71] Though this proposal passed both the House and Senate, President Bill Clinton ultimately vetoed the measure.[72] And, in early 2003 President George W. Bush laid out a high-level version of a Medicaid

block grant that appeared to operate more like the current TANF program.[73] Though President Bush called on the National Governor's Association (NGA) to develop specifics, the NGA failed to achieve bipartisan support for a block grant plan and the proposal was not pursued.[74]

This new direction, if it comes to fruition, would be the first opportunity to put a block grant in place for Medicaid, a funding mechanism that has been successful in the traditional welfare program, also known as Temporary Assistance for Needy Families (TANF).[75] However, it is crucial to bear in mind that a block grant is funding mechanism and does not, in and of itself, inherently convey sweeping policy reforms. While supporters of block grants accurately point out that under them "states would be able to spend the money smarter with fewer federal strings attached,"[76] states must go into these negotiations with strong plans for policy reforms.

1. Policy Recommendation: Pursue a Waiver to Increase State Flexibility

Lawmakers should direct the Texas Health and Human Services Commission (HHSC) to pursue either a new Section 1115 demonstration waiver, or an amendment to the state's current 1115 waiver, to enact the Medicaid and Children's Health Insurance Program (CHIP) reforms set forth in HB 3634 (85R) (G.Bonnen). These reforms are aimed at inserting greater personal accountability into the Medicaid program and treating the program more like a private-sector insurance product. Specifically, this bill directed HHSC to seek the flexibility to:

- operate the Medicaid program under a federal block grant funding system based on population and cost growth trends;
- reinstate the Medicaid eligibility criteria that existed prior to passage of the ACA: this would include reinstating prior income limits, assets testing, and eliminating the ACA's across-the-board five percent income disregard and modified adjustment gross income (MAGI) methodology;
- reinstate the CHIP eligibility requirements that were in place prior the passage of HB 109 (80R), which largely eliminated assets testing and crowd-out provisions for CHIP applicants, in addition to rolling back the aforementioned ACA eligibility mandates;
- implement six-month eligibility certification period for both programs;
- like traditional insurance programs, prohibit Medicaid managed care members from switching to different plans during the 6-month enrollment period without cause;
- enact Medicaid cost-sharing requirements that coincide with those already in place in CHIP;
- authorize the imposition of missed appointment fees in Medicaid and CHIP;
- require adult Medicaid recipients to sign a personal responsibility agreement (PRA) similar to the PRA required for TANF recipients;
- require Medicaid and CHIP enrollees to participate in a health insurance premium payment reimbursement program, which would use Medicaid or CHIP dollars to purchase private coverage, if employer-sponsored coverage is available and that coverage meets established benchmarks;

- authorize HHSC to establish a system to allow employers to pay all or part of the employee premium and be reimbursed by the State;
- ensure that HHSC has broad-based authority to test new and innovative Medicaid payment and delivery models, such as direct primary care and bundled payments, without the need to seek additional waivers or federal authorizations in order to stand up such pilot programs.

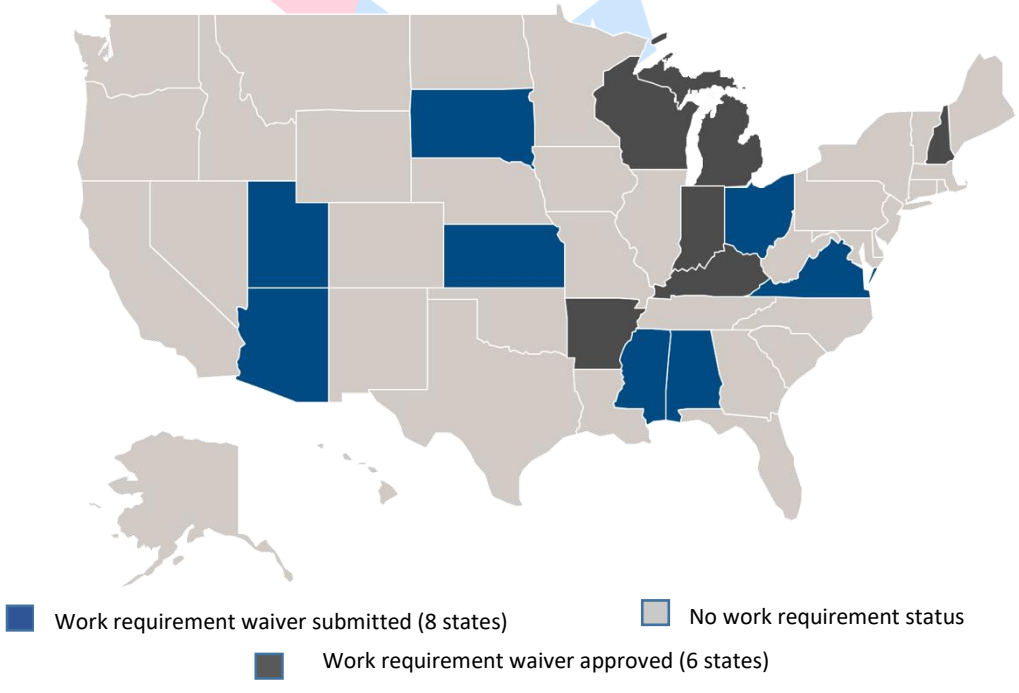
In directing HHSC to pursue this new waiver or waiver amendment, lawmakers should ensure the bill sets forth timelines for when the waiver must be submitted so that Texas takes advantage of working with a more flexible and willing federal government.

2. Policy Recommendation: Examine the Feasibility of Work Requirements

One provision that was not included in HB 3634, but that has since received greater focus nationwide, is work requirements for able-bodied adult Medicaid recipients. At the time the bill was filed in 2017, Medicaid work requirements had never been allowed. However, the Trump administration has now approved them in six states, and waivers have been requested by an additional eight. The map below shows the current status of Medicaid work requirement waivers by state.

Medicaid Work Requirement Waivers by State

As of January 24, 2019



Source: The Commonwealth Fund[77]

Requiring able-bodied adults to work in order to receive a fully subsidized government benefit, like the requirements in TANF and the Supplemental Nutrition Assistance Program (SNAP), has the dual advantage of both ensuring a measure of personal accountability in the Medicaid program, and possibly helping move that individual up the income scale and ultimately to self-sufficiency. It should be noted that all of the states where work requirements have been approved, with the exception of Wisconsin, have expanded Medicaid under the ACA.[78] Texas does not cover any adult non-disabled expansion populations; the only able-bodied adults within Texas Medicaid are those mandated by federal law-parents and caretaker relatives of children on Medicaid up to 14% FPL (as depicted in the Medicaid eligibility table above). And, any of this population also enrolled in SNAP and/or TANF must meet those work requirements.

No official numbers have been released as to exactly how many Texas Medicaid recipients would be subject to work requirements. However, during a TCCRI Health and Human Services Task Force meeting on this subject over the interim, HHSC agency representatives discussed preliminary data indicating that there are likely around 25,000 able-bodied adult Medicaid recipients who are not already subject to work requirements under SNAP or TANF (although it should be noted that some of these individuals could be subject to a work requirement exemption similar to those in SNAP and TANF).

TCCRI believes that a good economic policy is the best healthcare policy, and equipping individuals and families living in poverty with the skills and opportunities to be self-sufficient is the only long-term sustainable goal for getting Medicaid caseload and spending under control. Although final numbers are not yet available, if the state determines that there is a population of able-bodied adults who are receiving Medicaid benefits and not otherwise subject to work requirements under a concurrent program, Medicaid work requirements should be included as part of the larger waiver request. This reform should be pursued, even if the population is relatively small and would not result in a cost-savings to the state. Unlike a traditional shorter-term cost savings measure, the purpose of this policy is to produce a longer-term culture change and help move recipients into self-sufficiency, breaking the poverty cycle for these recipients and their families. For abled-bodied adult Medicaid populations that largely overlap with SNAP and TANF, the State could also look at a waiver provision to sanction Medicaid benefits along with other SNAP and/or TANF benefits if work requirements are not met.

3. Policy Recommendation: Stay the Course on Medicaid Managed Care

During the last interim, the *Dallas Morning News* ran a series of articles highlighting certain families and Medicaid enrollees who were unhappy with the Medicaid managed care program. While these individuals need to be heard, and the managed care program certainly has room for improvement and issues that should be addressed, this series of articles took some liberties in extrapolating the challenges of a very small percentage of the Medicaid population to the larger program. Thus, many readers were erroneously left with the impression that there are alarming systemic problems within Medicaid managed care. This led to a number of interim legislative hearings based on these articles that soon expanded from focusing on the initial cases highlighted by the paper (largely based on the tragic case of

a child with complex medical conditions) to an overall referendum on managed care, including a good deal of testimony from providers and other advocates who generally oppose managed care in any form.

It is almost certain that these articles and discussions from the ensuing interim hearings could lead to Medicaid managed care-related legislation during the 86th Legislative Session. Some legitimate issues were raised during these hearings, such as a lack of coordination of benefits between commercial insurance and Medicaid for children covered by both programs; gaps within the appeals and fair hearings process; and needed improvements in the provider enrollment process. Lawmakers should ensure that any such legislation focuses on addressing these and other valid issues to make Texas' Medicaid program that most efficient and highest quality in the nation, both for clients and the state, while staying the course on Medicaid managed care. Lawmakers must, on the other hand, eschew any so-called "reforms" that seek to limit the effectiveness of MCOs, such as placing populations back into FFS (which the state likely no longer has the existing infrastructure to support), prohibiting plans from restricting their networks to the best value providers, and forcing plans to operate with such identical mandates that the state loses the unique innovation that each plan can offer based on their independent private sector experiences.

4. Policy Recommendation: Continue the Transition to Outcomes-Based Payments Within Medicaid Managed Care

One area in which the Medicaid managed care model has given particular rise to innovative quality initiatives is the move towards outcomes-based payments. While the fee-for-service system reimbursed based on *input* (i.e. the quantity or volume of services provided), these new payment models focus more on *output* (i.e. access to care, patient outcomes and reduction in unnecessary ER use). Two programs within Texas Medicaid managed care are centered around these goals. The Medical Pay-for-Quality (P4Q) program, in which Texas has been a leader, impacts how Medicaid MCOs are reimbursed by the State. This program:

> …creates incentives and disincentives for managed care organizations based on their performance on certain quality measures. Health plans that excel on meeting the at-risk measures and bonus measures may be eligible for additional funds while health plans that don't meet their at-risk measures can lose up to 3 percent of their capitation rate.[79]

Quality measures vary by population but are based on standards such as well-child visits; prenatal and postpartum care; potentially preventable events (i.e. emergency room visits/ hospital readmissions); diabetes care measures; and the percentage of enrollees who provide their plans with the highest satisfaction ratings.[80]

The second initiative, known as Value-Based Contracting or Value-Based Purchasing (VBP), impacts payment and shared-savings opportunities between MCOs and contracted providers within their networks. HHSC requires Medicaid health plans to "develop alternative payment models between them

and their health care providers to encourage innovation, quality improvement and increased efficiency," with the goal of focusing on "quality of care and not on volume."[81] Examples of VBP arrangements are a shared savings model for a provider group that reduces ER use or hospitalizations for patients with chronic medical conditions (i.e. asthma) or bonus payments to nursing facilities that meet certain quality metrics.[82] According to its 2017 *Value-Based Purchasing Roadmap*, HHSC reports that VBP "has the strong potential to accelerate improvement in healthcare outcomes and increase efficiency."[83]

Though Texas has a strong foundation in the move to Medicaid outcomes-based payments, thanks in large part to its mature and robust Medicaid managed care program, the State should continue to move towards these non-traditional payment arrangements. Placing the responsibility for better health outcomes with both payers and providers ensures that everyone involved is invested in not just patient utilization of care, but in making sure that patient is actually improving based on that care.

III. Price Transparency

(Note: The following section is adapted from a TCCRI White Paper released in November 2018.)

In today's era of *Amazon*, *Costco*, and *Google*, consumers are conditioned to competitively shop for goods and services. The concept is simple. Consumers want lower prices, so they shop for the best value and, metaphorically speaking, vote with their feet by taking their business to the retailer with the best pricing. Merchants, in turn, respond to this demand by lowering costs to vie for a greater share of the market. This is the free market at its finest: consumer demand fosters healthy market competition that ultimately drives down costs for everyone.

American shoppers have embraced this concept with vigor. A 2017 survey found that, of the top four business challenges facing retailers, three concern pricing strategies, with "[i]ncreased price transparency- the impact of comparative price shopping" snagging the number one spot.[84] And retailer pre-occupation in this area certainly seems to be well-founded, with the same survey finding that consumers' largest concern with pricing is whether they can get the product elsewhere at a better cost.[85]

Today's shoppers are able to harness the power of the internet, often from the convenience of their smart phones, to obtain the best value on everything from toothpaste to automotive tires, and almost everything in between- with *almost* being the operative word. Although the concept of comparison shopping has indeed permeated almost every facet of American consumerism, this notion has, curiously enough, not organically translated into the healthcare marketplace.

Even though *the average American spends more of his or her annual gross income on healthcare expenses than on education and apparel and services combined*,[86] the same individuals who comb the internet to locate the best prices on home goods or clothing often do not give a second thought to shopping around for the best price on a common x-ray or magnetic resonance imaging (MRI) test, which generally cost considerably more.

This raises 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,[87] the current system is not intrinsically built to encourage, or in many cases even facilitate, price comparison. One poll of registered voters

showed that 88% of respondents said that they generally shop for the best value in other areas.[88] However, over half of respondents reported that they have trouble getting any estimated costs prior to care, and even when the bill does arrive it is difficult to decipher.[89]

Research has found that healthcare consumers want a better value and that, even for relatively serious care, "people are willing to trade off hospital prestige or distance to their house in order to save money."[90] Another study looking at healthcare consumers practices found that patients do not typically equate more expensive healthcare with better quality care.[91] 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. According to research by The Commonwealth Fund:

> Ultimately, this kind of health care consumerism might be part of a generational shift. "Young people—who use their phones to choose restaurants and buy airplane tickets—might be predisposed to use price transparency tools," says Brent Parton, director of health policy and programs at SHOUTAmerica, a nonprofit aimed at engaging young people in health care system reform. But, he says, price information must be made available at "teachable moments," such as when people are seeking out routine or planned services, and must be integrated into their health care experiences (e.g., through mobile apps or as part of physician visits). "Health care data is not following us as much as it should be; the onus can't be on the consumer to dig it up," Parton says.[92]

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. The Commonwealth Fund's research continues:

> 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."[93]

The importance of including 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. Ensuring that consumers are educated and engaged on both the quality and pricing fronts is vital to transforming the nation's healthcare system.

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 pursuing various answers to the price transparency challenge over the past decade, with the most intense activity springing up relatively recently.

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 website open to anyone with "fair prices" for medical services.[94] Other similar options exist as well. 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.[95]

The federal and state governments have also begun engaging in transparency policy reforms. One analysis found that state legislatures have started to slowly pursue more pricing transparency laws, with more than 70 such bills filed in both 2016 and 2017, and 15 and 21 pieces of legislation ultimately passing in each year, respectively.[96] These initiatives include one in California that requires an alert and justification to insurers before a manufacturer raises a drug price; a patient bill of rights in Florida that entitles consumers to more information on potential treatment costs; and several aimed at making hospital pricing more transparent.[97]

Texas has also pursued its share of price transparency laws going back several years. In 2007 the 80th Legislature passed SB 1731 (Duncan, SP: Isett, et al), which gives consumers the right to health care price estimates, and requires the Texas Department of Insurance (TDI) to collect and publish information on the average costs of certain healthcare services.[98] TDI has parlayed this requirement into its own price transparency tool, TexasHealthcareCosts.org.[99] And just last session the 85th Legislature enacted SB 507 (Hancock, SP: Frullo) to more aggressively address the issues of hidden charges and balanced billing,[100] for which the State of Texas had an existing mediation process.[101]

In addition, the federal government has taken on this issue, with the Trump Administration championing the benefits of increasing competition within the healthcare marketplace through transparency with the White House's MyHealthEData.[102] In August, CMS finalized a new rule that will require hospitals to publish a list of standard charges online, and to update these charges annually.[103] This new regulation went into effect January 1st. This push was also extended to include prescription drugs, with CMS releasing a draft rule late last year requiring pharmaceutical manufacturers to disclose the wholesale price of prescription Medicare and Medicaid drugs in any television ads.[104] That rule has not yet been finalized.

While all of 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 and engage in price and quality comparisons.

Price Transparency Must be 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 it is 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, such as the widespread patient confusion associated with free-standing emergency centers, 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 it must also include physicians, anesthesiologists, radiologists, pharmacists, and so on.

1. Right to Shop: A Test Case in Price Transparency

One model, known as Right to Shop, has specifically taken on this issue, and has enjoyed some early success. Right to Shop can serve as a test case for how price transparency and consumer engagement has impacted total healthcare costs.

Prices vary widely in health care due to a variety of factors. The same x-ray on the same kind of machine can fluctuate in price from a few hundred to thousands of dollars if the x-rays are performed in different locations.[105] Surgery by the same doctor but in different facilities (i.e. a hospital vs. an ambulatory surgical center (ASC)) can also vary greatly.[106] However, most consumers often do not think to shop around for the best price on a diagnostic imaging test and, even if they wanted to, it can be difficult to find the actual price of the test or procedure. Most information that can be obtained by consumers will quote the insured's out-of-pocket expenses. And, while this is a vital piece of the equation, this information does not capture the total cost to the healthcare system. For instance, a patient may pay only a slighter higher co-pay or deductible for choosing to have an arthroscopic knee procedure in a hospital rather than an ASC, but the cost to the healthcare system could be thousands more.

The Right to Shop model is predicated on the basis of educating consumers about the total cost of their care, not just the out-of-pocket portion, and rewarding them for choosing highest value care.

The concept is simple: A provider prescribes a medical service, such as an 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 then chooses the best location at the best value. After receiving the MRI at the location of his or her choice, the patient then receives a cash benefit based upon the shared savings for choosing the best

value care. The crux of this program's success lies in the ability of consumers to access quick, accurate, and transparent cost comparisons.

Source: Foundation for Government Accountability[107]

Private companies that have implemented these programs have seen positive changes. One employer with 47,000 workers reported a savings of $1.7 million over a nine-month period, after paying employees about $218,000 in rewards incentives.[108] And program participants find that shopping pays off. One employee found an $18,000 price difference for a weight loss surgery performed by the same physician, depending on the facility in which it was performed.[109] During the last session HB 307 (Burrows) was filed to enact this type of incentive program in Texas, but it did not ultimately pass.

It should be noted that, in the private market, a right-to-shop policy could be considered profit sharing, which is not something the state should mandate. 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. These types of incentive plans can, and should, grow more organically in the free market. This idea could, however, be explored *within* state government where services are funded by taxpayer dollars, such as the Employees Retirement System (ERS) and the Teacher Retirement System of Texas (TRS).

2. Policy Recommendation: Pass Right to Shop in ERS and TRS

The state of New Hampshire has operated an incentive-based program for its state employees for a little over three years. So far, almost 90 percent of enrollees have shopped at least once, with two out of three shopping every year and receiving an incentive payment.[110] Average savings have been around $670 each time a service or procedure is shopped.[111] The state has saved over $12 million, and paid over $1 million in incentives so far.[112] Fairly new programs have also been implemented in Kansas, Kentucky, and Massachusetts.

There could also be 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 consider rebates in the form of premium or out-of-pocket discounts for enrollees who choose best value care. Policy Recommendation 3, below, would ease the ability of the state and private insurance companies to offer these types of incentive models.

3. Policy Recommendation: Revise Regulations that Stifle Innovation

While state leaders should not mandate that private businesses implement any type of profit-sharing, 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. State statute defines this type of benefit as being "reasonably related to the type of policy or certificate issued" and provides the following examples:

(1) discount cards for health care programs, vision care programs, dental care programs, prescriptions, physical fitness programs or facilities, or other similar programs;

(2) financial planning, will preparation, or similar services; and

(3) contributions for educational savings on behalf of a policyholder 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 Right to Shop- type program. Because shared-savings 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 models are becoming more commonplace, the Legislature should amend current statute, and direct TDI to amend rules, to clarify that shared-savings programs (be they actual shared savings, or out-of-pocket cost reductions), as set forth in a model similar to the Right to Shop concept, do not violate anti-inducement or anti-rebate laws.

4. Policy Recommendation: Require FSECs to Report the Same Data as Traditional Hospitals

In Texas, free-standing emergency centers (FSECs) offer many of the services of a traditional ER that is attached to a hospital, and generally include similar fees, but are often confusing to consumers. According to the analysis on HB 3276 (85R) (Oliverson, SP: L. Taylor), a bipartisan bill aimed at increasing transparency around FSECs:

> Throughout the state, FECs [free-standing emergency centers] are rapidly popping up in residential areas. Though these facilities tend to have the same look and feel of urgent care centers, many consumers are unaware that these facilities are often out of network and can charge patients multiple times more for the same services, resulting in surprise medical bills.[116]

The confusion around FSECs is two-fold. First, patients walking into one of these facilities might assume there are seeking care at an urgent care center, which cannot bill for emergency room fees and are typically less expensive. Second, while an actual facility might be in network, the different providers that treat a patient may still be out-of-network. Over the past several years, various news reports have featured healthcare consumers, many with insurance, who receive large surprise bills for care they obtained in an FSEC.[117]

TCCRI supports the right of private businesses to operate competitively within the law and free market principles. However, consumers must have access to adequate information to make well-informed decisions, and some FSEC practices appear to fall short of this standard. While the Texas Legislature has taken steps to address these issues and help patients avoid surprise medical bills, a report released by AARP late last year found that some of the challenges surrounding FSEC costs may not yet be resolved. The following results were reported in December 2018:

> A recent AARP "secret shopper" survey of 213 freestanding ER facilities in Texas found less than half were able to answer a simple "yes" or "no" question about health plan coverage over the phone, and 77% of facilities say they "take" or "accept" insurance on their website when they are actually out of network for any major health plan.
>
> The report also found 60% of freestanding ERs used language suggesting they were part of an insurer's network when they were, in reality, out-of-network for all health plans.[118]

While FSECs bill themselves as full-service ERs, this description can be misleading. Some key distinguishing factors of these independent facilities is that they are not recognized or reimbursed by Medicaid and Medicare; ambulances do not take patients to any free-standing centers; they are often found in zip codes with more privately insured individuals; and none of these FSECs are recognized as trauma centers like many of their more traditional counterparts.[119] While these differences might naturally lead to the conclusion that the cost of care in FSECs would be lower, research actually found the opposite to be true. A 2015 analysis of insurance claims found that Texas patients "paid on average $763 in out-of-pocket costs at private FSEDs [free-standing emergency departments] compared to $749 at hospital-based emergency departments and $63 at urgent care centers."[120]

In addition to enhanced enforcement of the measures already passed by the Texas Legislature, free-standing ERs should be required to provide the same discharge data to the state that traditional ERs are required to report. Currently, the Department of State Health Services (DSHS) is required to collect emergency department discharge data from hospitals and ASCs.[121] This allows the state to compare both cost and quality data across all payers and can ultimately help better inform policy makers on how best to curb inappropriate ER use. However, FSECs are not subject to this reporting because they do not fall under hospital or ASC licensure requirements. While TCCRI does not advocate for unnecessary licensing or reporting requirements, collecting uniform data from any facility acting as an emergency department would allow state leaders to better determine if additional reforms are needed.

IV. Teacher Retirement System

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 1.5 million individuals,[122] and is expected to pay out just over $26 billion in retirement and healthcare benefits in upcoming the FY 2020-21 biennium.[123] As part of its responsibilities, TRS operates healthcare benefits for this population through two programs: TRS-Care covers 236,000 retired public education employees and their dependents, while TRS-Active Care covers an estimated 492,000 active educators and their dependents.[124]

While both the retirement and healthcare portions of the TRS pension fund have been challenged with growing unfunded liability balances over the past several years, TRS-Care has become of particular concern. This issue is not unique to Texas, or even specifically to TRS. According to a recent report by S&P Global Ratings, "[i]n just two years...unfunded retiree health-care liabilities across the 50 states increased by $100 billion to now just under $700 billion," due to the fact that "retirees are living longer and medical costs are rising faster than the rate of inflation."[125]

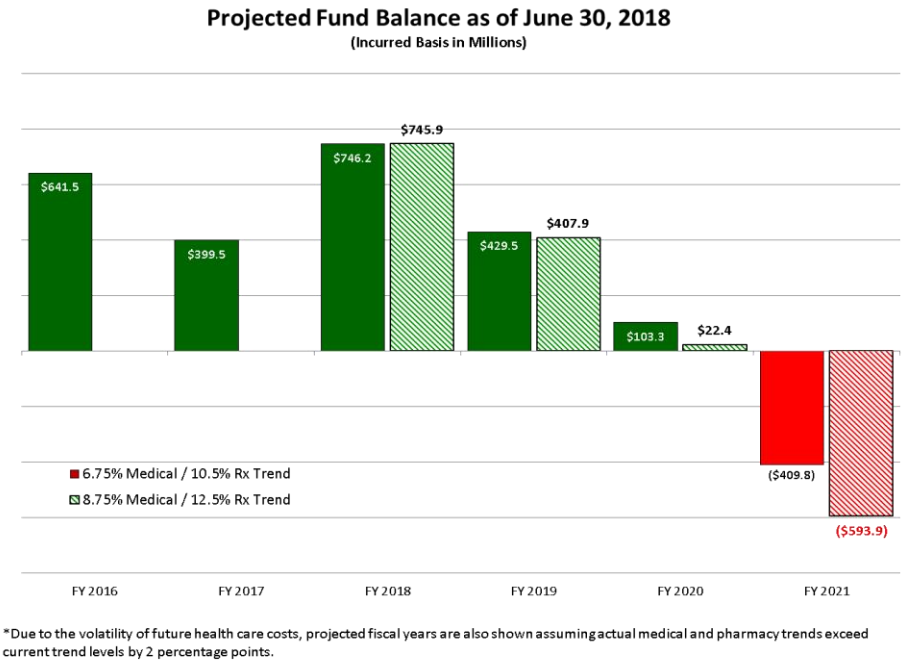
Ongoing Solvency Issues for TRS-Care

Although the challenges facing TRS-Care have 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.[126] After state leaders continued to hear from retired educators about problems in the system and increased costs, they appropriated an additional $212 million during last summer's Special Session.[127]

Yet, despite these attempted stop-gap measures, the average retiree contribution still increased by about 50% 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.[128] In comparison, the number of enrollees leaving the system in prior years was about 1,500 or fewer.[129]

Unfortunately, the funding needs of TRS-Care are continuing into the 86th Session with the agency requesting an exceptional item totaling $409.8 million for the coming FY 2020-2021 biennium.[130] The table below depicts the state of the TRS-Care fund balance from FY 2016 projected through FY 2021, with TRS stating in its LAR that they "currently project that an additional $400-600 million in funding, over the current base request, is needed to maintain the same level of benefits and premiums during the FY 2020-21 biennium."[131]

TRS-Care Balance Projection



*Due to the volatility of future health care costs, projected fiscal years are also shown assuming actual medical and pharmacy trends exceed current trend levels by 2 percentage points.

Source: Teacher Retirement System of Texas[132]

The continuing trend makes it clear that more aggressive and innovative policy solutions must be pursued if there if TRS-Care is going to experience stability and solvency in the near future.

1. Policy Recommendation: Study the Feasibility and Cost-Effectiveness of Allowing TRS-Care Enrollees to Purchase Private Medicare Plans

Government entities in other states are starting 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.[133] The City of Memphis, Tennessee, began exploring this idea in 2016 and has since dropped its obligation for retired employee health benefits by $300 million.[134] 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."[135]

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.[136] 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, from a wide array of choices, the best individual Medicare health plan based on the member's needs.[137] According to a case study conducted by the administrator of Ohio's Medicare

Connector, about 143,000 individuals transitioned to the Medicare marketplace, and the vast majority were able to find more personalized plan options at equal to, or in many cases, lower costs than the state's original plan.[138] 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 individual Medicare Supplement and Part D drug coverage plan.[139] 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.[140]

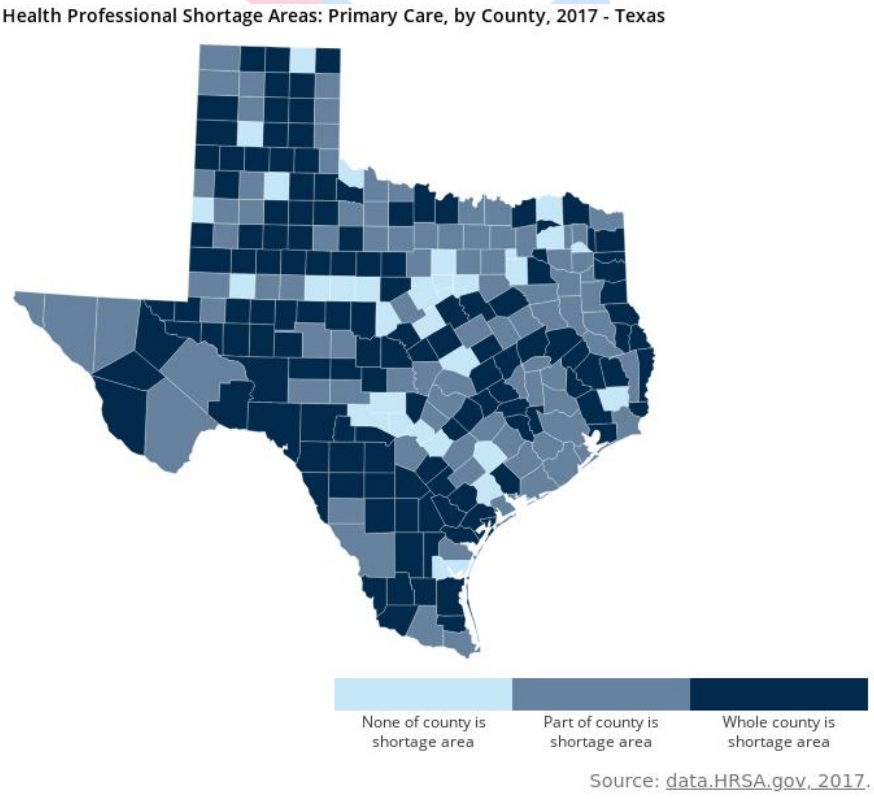
Based on the reports of the more than 30,000 retirees and dependents who have left TRS-Care over the last 18 months, it is appears evident that better value alternatives exist. And the success experienced by Ohio's public employee retirement is justification to conduct an in-depth study to see if TRS-Care might enjoy similar savings. Texas 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.

V. Increasing Access to Care

A. Medical Care

Texas has a well-documented and indisputable physician shortage. A 2015 Merritt-Hawkins study focused on the physician workforce needs of Texas found that 35 Texas counties had no practicing physician and 80 had five or fewer.[141] 57 percent of Texas's practicing physicians operate in the urban counties of Dallas, Tarrant, Travis, and Bexar,[142] and 2.2 million Texans live in small counties that are served by only 2.5 percent of the physician workforce.[143] The study concluded that more than 12,000 additional physicians were needed for Texas to meet the national average of 226 physicians per 100,000 residents.[144] A more recent nationwide study by the American Association of Medical Colleges ranked Texas 47th out of 50th in having an adequate number of physicians to meet patient need.[145] And, compounding this problem is the fact that almost 30% of Texas physicians are over 60.[146] While the state has invested in new medical schools and residency slots, one academic 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.[147]

The map below, based on 2017 data from the federal Health Resources & Services Administration (HRSA), shows the extent of primary care shortages in Texas, with the vast majority of the state's 254 counties designated by HRSA as either a partial or whole "health professional shortage area."



Source: Rural Health Information Hub[148]

One key solution to address this issue that is within the state's purview is expanding the ability of certain qualified non-physician providers to practice independently, thereby allowing these providers to expand access to healthcare.

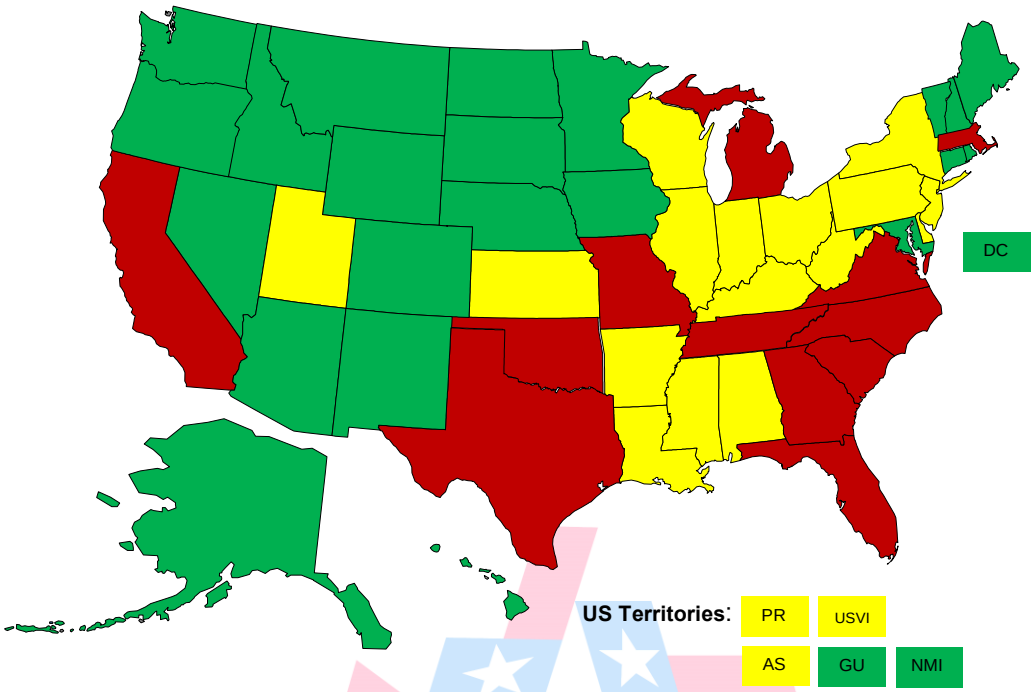
1. Using of Non-Physician Providers to Increase Access to Care

Last session, several bills were filed to expand the scope of practice authority for Advanced Practice Registered Nurses (APRNs). 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. The Legislature did take an important step in helping Medicaid enrollees better access APRN care by passing SB 654 (85R) (Seliger/ SP: Smithee). While SB 654 does not grant an APRN any additional scope of practice authority, it does allow APRNs to contract directly with Medicaid managed care plans and see Medicaid patients, regardless of whether or not the delegating physician is in that plan's network.

Some additional bills filed in the 85th Session would have taken additional steps to increase access to care. The original version of SB 654's companion bill, HB 1225 (Smithee), would have allowed APRNs to contract not only with Medicaid health plans, but also with commercial HMOs and preferred provider benefit plans regardless of whether the APRN's delegating physician was in network. While this would have been preferable to the status quo, HB 1415 (Klick) and its companion, SB 681 (Hancock), would have placed Texas on par with a significant number of other states by allowing APRNs to practice without physician delegation authority.

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.[149] According to the author of a Texas bill that would have allowed this independent practice (HB 1415- 85R), these expensive delegation requirements put Texas at a distinct disadvantage to neighboring states that don't require delegating physicians, such as New Mexico.[150] The following map provides an overview of the national landscape of how APRNs are able to practice across the nation, and clearly shows how Texas could lose to surrounding states in recruiting these providers.

2018 Nurse Practitioner State Practice Environment



Full Practice
State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications and controlled substances—under the exclusive licensure authority of the of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine and National Council of State Boards of Nursing.

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

Restricted Practice
State practice and licensure law restricts the ability of a nurse practitioner 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[151]

Physician Assistants

Currently in Texas, PAs, like APRNs, are required to practice under the supervisory authority of a physician.[152] However, also like APRNs, this does not mean that physicians must be present where PA services are being provided. According to an article in *Nurse Journal*:

> In all but a few states, PAs are required by law to work under some form of collaborative agreement with an MD, but very little of what they do day-to-day actually requires any direct physician oversight. In this sense, virtually all PAs spend most of their time working

> autonomously. PAs can even operate independent PA-led clinics where physician involvement may be limited to little more than a couple on-site visits per month.[153]

The article goes on to describe the training and patient care approach of PAs and APRNs, explaining that, while the amount of education and number of classroom and clinical training hours are similar (PAs actually require more in some instances), APRNs are typically trained more in a preventive/ wellness approach to primary care (with an option to specialize in certain populations), while PAs generally take a more physician-based approach of specializing in a certain medical specialty or disease pathology.[154]

Pharmacists

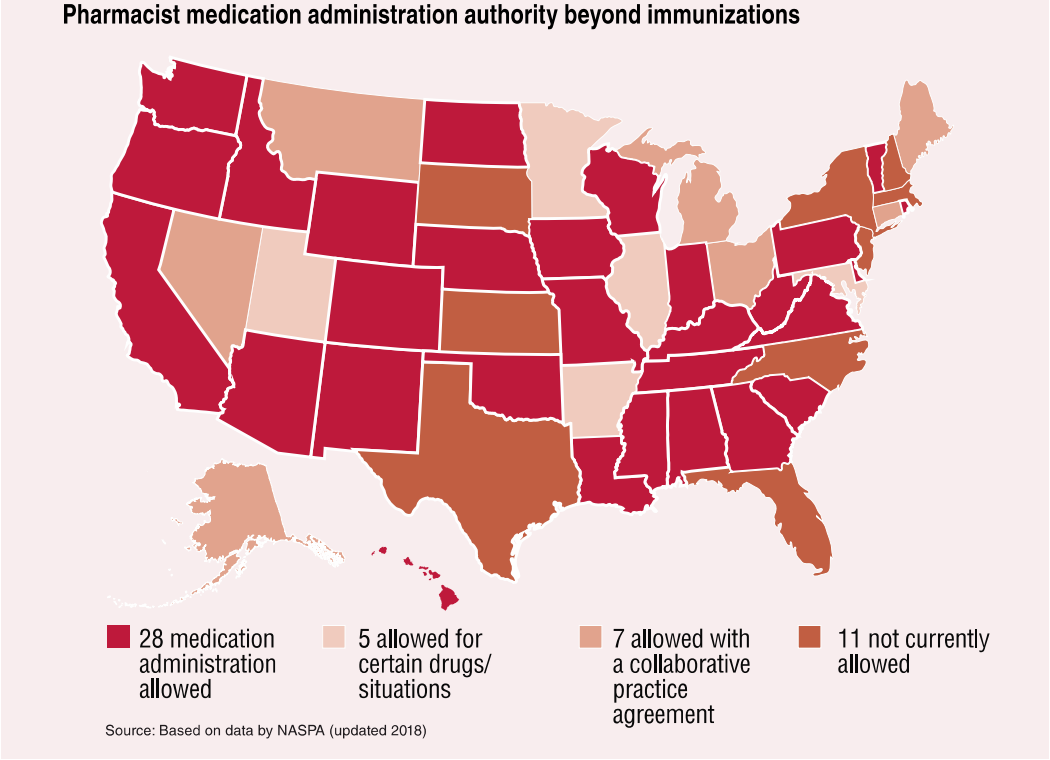
While pharmacists have traditionally been associated strictly with filling prescriptions, over the years that role has evolved to greater patient interaction and a larger responsibility as part of the patient care team. Data from the National Pharmacist Workforce Survey found that, in 2014, "60 percent of pharmacists provided medication therapy management and 53 percent performed immunizations. Ten years earlier, only 13 percent of pharmacists provided medication management and just 15 percent administered vaccinations."[155] 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. According to a 2017 article in the *North Carolina Medical Journal* entitled "The Role of the Pharmacist in Health Care: Expanding and Evolving":

> 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.[156]

Given the fact that medication misuse, be it over- or under-utilization, is responsible for about $300 billion in costs in the U.S. each year,[157] and that in any given month patients may have more regular interaction with a pharmacist than other provider types, it only makes sense that a pharmacist's role would grow into one that encompasses preventive and disease management care through medication therapy management (MTM). By actively helping to ensure that patients are using medications appropriately, pharmacists can play a vital role not only in reducing hospital admissions and readmissions for conditions that can be managed by proper medication usage, but they can also contribute to combatting the nation's opioid crisis.[158] A 2017 article in the *Journal of Family Practice* reported that greater collaboration between physicians and pharmacists has already proven successful in better management of chronic diseases such as hypertension and diabetes, and the study goes on to suggest that similar benefits would likely extend to collaboration on other health conditions.[159]

Payers have begun recognizing the shift in better utilizing pharmacist by extending value-based contracting (i.e. pay-for-performance) arrangements to pharmacists. Medicare has embraced this trend in its Part D Enhanced Medication Therapy Management Model, which "tests whether providing Part D sponsors with additional payment incentives and regulatory flexibilities promotes enhancements in the MTM program, leading to improved therapeutic outcomes, while reducing net Medicare expenditures."[160] The model appears promising thus far- initial results released in November 2018 show that pilot participants spent approximately $325 million less than originally estimated through more robust medication management.[161]

Most states allow pharmacists some degree of authority to administer injectable drugs beyond vaccines and immunizations. According to the American Pharmacists Association (APhA), the following non-immunization medications are appropriate for pharmacists to administer: antipsychotics, anticoagulants, immunological agents, erythropoietics/hematopoietics, androgen, calcium regulators, vitamin B12, naltrexone, and certain antineoplastic agents.[162] As shown in the map below, while the majority of states allow pharmacists to administer non-immunization drugs to some degree, Texas is one of the more restrictive states in this regard.



Source: Pharmacy Today[163]

One example where pharmacists have been able to increase patient adherence and outcomes is in administering long-acting injectable mental health drugs.[164] Research presented at the APhA Stakeholder Conference on Improving Patient Access to Injectable Medications found that "[p]atients who receive their long-acting antipsychotic medications at an alternative injection center, typically a pharmacy, and remined in the program for more than 6 months were 4.5-fold more likely to be adherent to their medication than those within the program who did not select the medication administration offering."[165]

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

While the passage of SB 654 in the 85th Legislative Session is a positive start in better utilizing APRNs, the 86th Legislature should continue to build upon this foundation and pass the legislation allowing the independent practice of advance practice registered nurses, as set forth in last session's HB 1415 and SB 681.

These bills would have made various changes to laws governing APRNs, most significantly allowing them to practice as independent practitioners. The bills would not have altered 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.[166] 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 BON (APRNs are currently regulated by both the BON and Texas Medical Board).

While the Texas Medical Association (TMA) has historically favored 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.[167] So, 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.

3. Policy Recommendation: Examine Other Providers Able to Help Fill Access to Care Needs

There is a clear precedent established in other states to allow the independent practice of APRNs, but the Legislature should also explore how physician assistants and pharmacists could be better utilized to deliver care. The need within Texas is certainly present and will only continue to grow as the population increases.

Physician Assistants

Given that PAs have similar, and in some cases more, required education and practice hours as APRN, it may well be appropriate to allow PAs greater autonomy in their areas of practice specialty. For example, one policy option short of independent practice authority would be to at least revise the relationship between PAs and physicians to be less supervisory and more collaborative in nature.

Pharmacists

State lawmakers should ensure that state laws and regulations are not overly restrictive in allowing pharmacists to play a larger role in preventive and primary care, both through increased MTM and in delivering certain injectable medications that can keep patients out of the hospital and potentially prevent a mental health crisis in both privately and publicly funded programs. Current laws appear to be a detriment in allowing Texas to take advantage of innovative new delivery models for certain injectable drugs, and the Legislature should seek to rectify this in the 86th Session. Also, as the Medicaid program continues to move more towards value-based contracting, state leaders should explore opportunities to involve pharmacists in more of these arrangements, especially given the success of Medicare's pilot program.

B. Dental Care

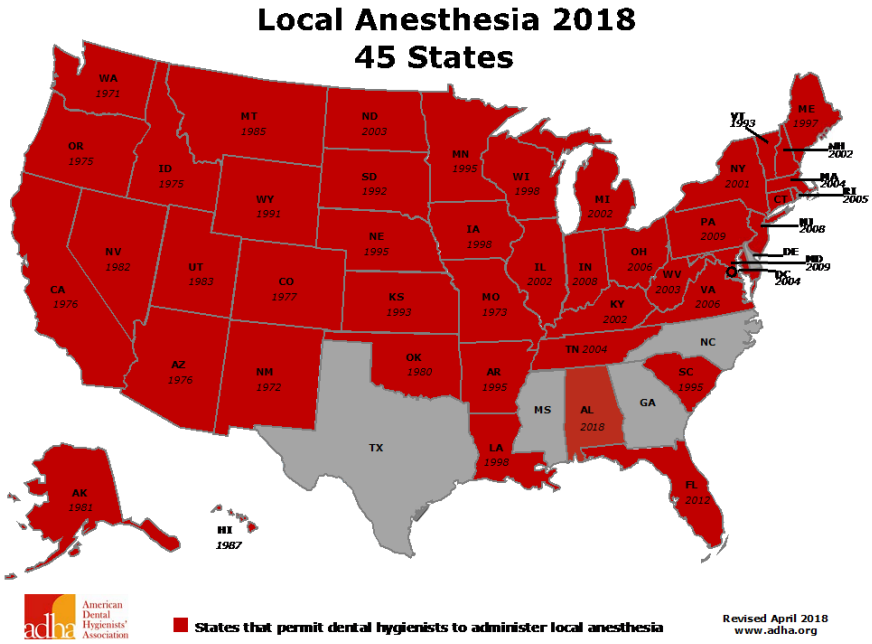
Another area where Texas lags behind other states in the use of ancillary providers to increase patient access is in dental care. While cosmetic dentistry and certain orthodontics are a luxury, there are both economic and wellness arguments behind obtaining regular, preventive oral care, such as cleanings. The cost savings of maintaining oral health to the healthcare system could be significant, for instance, if more pregnant women received regular oral care; if dental problems were identified and addressed early on before severe dental pain drives patients to emergency rooms (one estimate puts the number of preventable dental-related ER visits at 800,000 per year);[168] and if patients with diabetes better managed oral care.[169] 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, could free up more time for the dentists and hygienists alike, not to mention increase 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. [170] 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.

As depicted in the map below, Texas is one of only five states that currently does not allow this practice to some degree.[171] Other states began allowing hygienists to administer local anesthesia as early as 1971,[172] 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."[173] While this study is admittedly dated, it is generally the standard of research cited in most articles and paper on this topic, likely because, since the majority of other states have already adopted this policy, it is no longer under broad discussion.



Source: American Dental Hygienists' Association[174]

Teledentistry

Last session, the 85th Legislature took an historic step in increasing access to care by passing SB 1107 (Schwertner/ Sp: Price), which opened up direct consumer telemedicine services in this state, creating new access to care options for Texans in rural and other medically underserved areas. Although this type of telemedicine is still relatively new in Texas, as agency rules were promulgated just a little more than a year ago, the bill proved its worth almost immediately with Houston officials saying that telehealth helped maintain critical care services during the aftermath of Hurricane Harvey, and contributed to cost savings by ensuring no interruption of services.[175]

Just like telemedicine enables physicians and other providers to provide medical care for patients in all geographical areas of the state, teledentistry can do the same for Texans in need of oral health care. A 2018 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.[176] 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."[177] 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.[178] And even though Texas has added more dentists to its healthcare workforce than any other state over the last several years, all but seven percent of practicing dentists are located in urban areas, leaving more than four million Texans living in designated "dental health professional shortage areas." [179]

Teledentistry provides a unique opportunity for dentists, hygienists, and other oral healthcare professionals to consult with, and provide care to, patients all over the state. 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.[180] At the six-month mark, the supervising dentist must then examine the patient before the hygienist may provide any additional services.[181]

Allowing teledentistry in the state of Texas would 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. Opening up 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

Legislation filed last session (SB 430- Rodriguez/Burton and HB 1201- S. Thompson/Rainey/Flynn) would have amended the actions that a dentist may delegate to a hygienist by adding the administration of local anesthesia to that list. This legislation has already been refiled (SB 510/ Rodriguez) in the 86th Legislative Session, and lawmakers should support this effort. The bill does not mandate any practice, nor does it decrease a dentist's authority over his or her hygienists or patients. On the contrary, this 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.

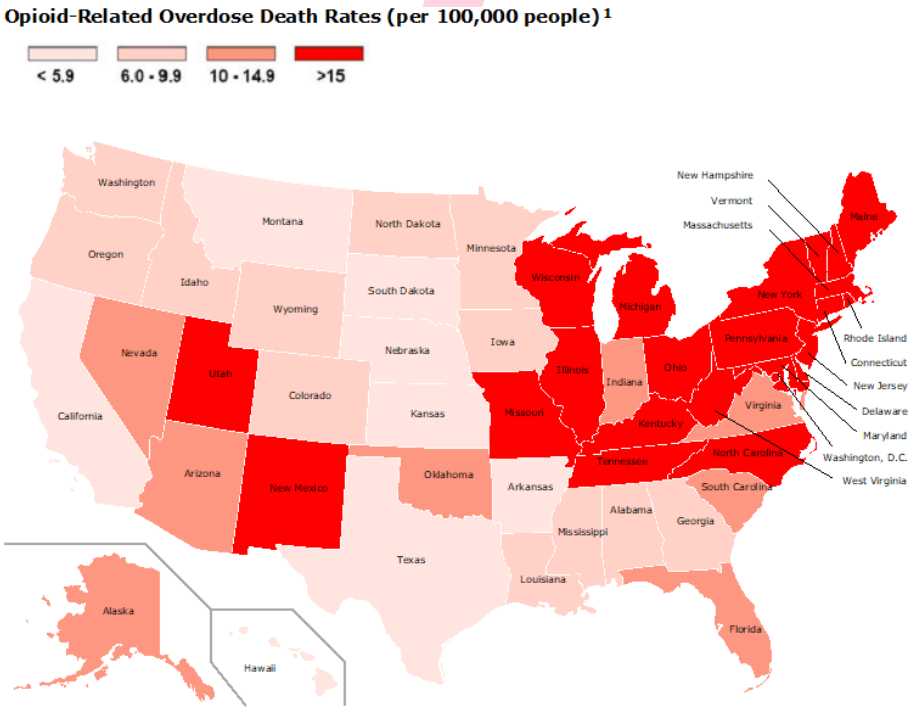
2. Policy Recommendation: Add Teledentistry to the Services Available Under Texas' Current Telehealth Law

Lawmakers should amend the state's telemedicine and telehealth statutes to include teledentistry, and recognize dentists and dental hygienists to provide care via telehealth technology, using the same "store and forward" modalities provided for under current law. The legislation should allow a dentist to supervise a hygienist in a telehealth setting (not exclusively in a physical dental office), and provide a framework for dentists and hygienists to establish a collaborative practice agreement for teledentistry services.

VI. Opioids

While no corner of the United States has been spared from the opioid epidemic sweeping the nation, Texas has fared significantly better than many other states, including some of our most immediate neighbors. Historical data looking at opioid-related deaths from 2000- 2016 found that Texas ranked "significantly lower than [national] U.S. [rates]" in instances of natural, semi-synthetic, and synthetic opioid-related deaths (i.e. all forms of opioids).[182] And, according to the National Institute on Drug Abuse, a division of the National Institutes of Health, Texas ranks near the bottom of all states in both the numbers of per capita opioid-related deaths and in opioid prescriptions, which is perhaps a better measure of proactively addressing the opioid crisis.[183] This is not to say that Texas has been immune from this issue. The Texas Department of State Health Services (DSHS) reports there were 1,174 opioid-related deaths in Texas in 2015 (the most recent year available on the agency's website).[184]

The map below provides an updated national picture of how opioid-related deaths have impacted the country, with the northeast clearly hardest hit by the epidemic.



Source: National Institute on Drug Abuse- Revised February 2018[185]

In looking at how Texas has managed to escape the fate of other states in opioid-related deaths, and to explore any opportunities to ensure that our current trends continue, it is worth looking at safeguards the state already has in place.

Texas passed the first iteration of its Prescription Monitoring Program (PMP) in 1982, and over the years it has grown both in scope and sophistication. Currently housed at the Texas State Board of Pharmacy, the PMP "is an electronic database used to collect and monitor prescription data for all Schedule II, III, IV, and V controlled substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. The PMP also provides a venue for monitoring patient prescription history for practitioners and the ordering of Schedule II Texas Official Prescription Forms."[186] Simply put, the PMP houses a patient's prescription drug history, regardless of who pays for the prescription (i.e. insurance vs. private pay), where the prescription is written, or where that prescription is ultimately filled. Over the years the PMP has evolved from a system that allowed prescribers and pharmacists to passively query a patient's prescription history to a tool that is now used more proactively.

The 85th Legislature made changes to how PMP data is utilized by both prescribers and pharmacists. Effective September 1, 2017, pharmacists were required to report the dispensing of all controlled substances (which include opiates) to the PMP within one day (the former requirement allowed seven days).[187] Beginning September 1, 2019, any prescriber will be required to check a patient's history prior to writing a prescription for certain controlled substances (including opiates), and pharmacists will be required to check that patient's history prior to dispensing any of those prescriptions.[188] The goal of these cumulative efforts is to further prevent drug-seeking behavior and thwart any attempts at opiate misuse or diversion by preventing those prescriptions from ever being written.

While the PMP cannot claim full credit for Texas' relatively low number of opioid-related deaths and prescriptions, it is very likely that the state's early efforts to track controlled substances and engage prescribers and pharmacists in the dispensing of Schedule II medications helped to prevent misuse to some degree.

Electronic Prescribing of Controlled Substances

In the 86th Session, lawmakers will undoubtedly look for policy solutions to build upon Texas' current efforts, and one idea that is being discussed at the national level is requiring electronic prescribing for controlled substances (EPCS). EPCS is currently allowed, but is not mandated. And although e-prescribing has become the "standard" for non-controlled substances, data indicates that the majority of prescribers still write out hard-copy prescriptions for controlled substances.[189] This could be due to the fact that EPCS technology requires additional safeguards and authentications and providers may encounter additional costs for upgrading to these more sophisticated systems.[190] In Texas, while almost 96% of pharmacies are ECPS-enabled, only about 28% of prescribers are set up to electronically prescribe controlled substances.[191]

Supporters of EPCS point out the policy's various advantages. Some of these, such as increasing provider accuracy, supporting better provider workflow efficiency, and enhancing the security of controlled substance prescriptions,[192] would enhance Texas' current efforts to curb inappropriate prescription drug use. However, it should be noted that other touted advantages, such as preventing

doctor shopping and allowing providers insight into a patient's prescription drug history,[193] are already available through the PMP.

In closing, EPCS could be an important tool to help Texas continue its fight against opiate misuse. However, state leaders should examine why such a low percentage of prescribers have chosen to adopt electronic prescribing for controlled substances, especially since data seems to indicate that the majority of these physicians use e-prescribing for other prescriptions.[194] Lawmakers must then determine whether any steps can be taken at the state level to increase the use of EPCS among Texas physicians, and whether the public health benefit to mandating EPCS outweighs any costs or hardships associated with its implementation.

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