Texas House of Representatives
House Committee on Insurance

Sept. 8, 2020

VIA ELECTRONIC MAIL to Sergio.Cavazos_HC@house.texas.gov

Sergio Cavazos
Committee Clerk
Texas House of Representatives
House Committee on Insurance

Re: House Insurance Committee Interim Charge Request for Information on Interim Charge No. 1

Dear Chairman Lucio and members of the House Committee on Insurance,

On behalf of our combined more than 53,000 Texas physician and medical student members, the Texas Medical Association (TMA) and the undersigned medical associations (collectively, the "Associations") respectfully submit this written testimony on various components of Interim Charge No. 1. For your convenience, please note that each separate bullet point/charge topic on which the Associations are commenting begins on a new page in this document and has a separate charge heading.

Charge

HB 2536, which requires certain reporting requirements for drug manufacturers, pharmacy benefit managers, and health insurers on certain pharmaceutical practices, including the pricing and availability of insulin. Examine its effect on drug pricing in the market and how to increase transparency in pricing associated with delivery of drugs, such as insulin, to the end user.

Association Comments

As the committee is aware, House Bill 2536 was an important measure designed to address a lack of transparency among certain actors in the supply chain as to the causes of pharmaceutical drug price increases. The bill requires drug pharmaceutical manufacturers, health benefit plan issuers, and pharmacy benefit managers (PBMs) to submit annual reports regarding certain pharmaceutical drug costs. It also requires the executive commissioner of the Texas Health and Human Services Commission and the commissioner of the Texas Department of Insurance to post related information on their respective websites.

The Texas Medical Association was "FOR" HB 2536 last session. Its recognized then (and continues to recognize now) its importance in increasing transparency related to drug pricing. TMA official House of Delegates policy expressly states, in part, that "The [TMA] will: … (2) study the issue of drug pricing, including whether large price increases impact patient access to critical medications; … and (6) support measures that increase price transparency for generic and brand-name prescription drugs."[1]

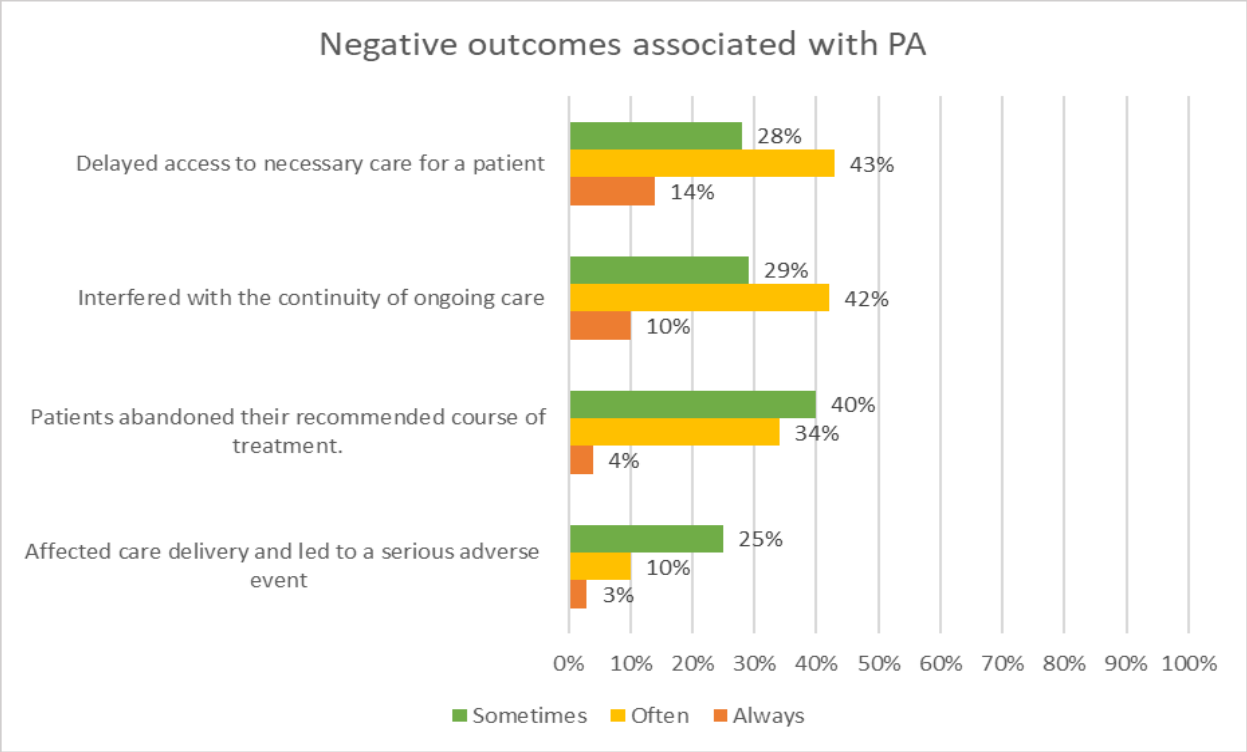
The Associations continue to have concerns regarding the impact of drug pricing on patients' access to care in Texas. Thus, we applaud the committee and the Texas Legislature for their efforts thus far with regard to HB 2536 and urge the committee to continue its efforts on this topic by examining methods of further strengthening the disclosure and reporting requirements imposed on PBMs, health benefit plan issuers, and pharmaceutical drug manufacturers under the law, such as by reducing the reporting threshold for drug price increases under Tex. Health & Safety Code §441.002(c).

Further, the Associations ask the committee to study another area affecting patient access to needed pharmaceuticals, namely prior authorizations (PAs) of prescription drugs. We believe providing some relief to patients and physicians with regard to onerous PA requirements for prescription drugs, which unnecessarily delay or impede access to medically necessary prescription drugs, would be complementary of the legislature's efforts in HB 2536.

[1] *See* TMA House of Delegates Policy 95.041 Ensuring Patient Access to Affordable Prescriptions.

PAs (i.e., health plan cost-containment processes whereby health plans or administrators review proposed treatments or services prior to provision in order to assess their medical necessity or appropriateness) are often imposed in an excessive and administratively burdensome fashion that may delay access to medically necessary care and negatively affect continuity of patient care.

The following graph demonstrates negative outcomes associated with prior authorizations, according to TMA's 2020 Biennial Physician Survey data:



According to the same survey data, Texas physicians reported that over the past five years there has been an increase in the number of PAs required for prescription medications (85%) and medical services (80%). Consistent with these data, we are continuing to hear anecdotally from Texas physicians that health plans are imposing onerous PA requirements on everything from generic drugs to pharmaceutical cancer treatments.

Given the negative impact that PAs are having on patient care (i.e., negative impact on continuity of care, delayed care, and abandonment of care), the Associations strongly recommend that the committee consider some important reforms in this area. Among the prescription drug PA reforms recommended by the Associations are the following, which were included in the Consensus Statement on Improving the Prior Authorization Process document:

- "Encourage review of medical services and prescription drugs requiring [PA] on at least an annual basis, with the input of contracted health care providers and/or provider organizations;" and

- "Support continuity of care for medical services and prescription medications for patients on appropriate, chronic, stable therapy through minimizing repetitive [PA] requirements."[2]

The Associations also recommend that the committee consider more broadly reforms related to PA for prescription drugs and all other forms of medical care, including:

- Requiring health benefit plan issuers to "gold card" certain physicians from PA processes (i.e., creating an automatic approval or exemption, on a physician-by-physician basis, that waives prior authorization requirements if a specific procedure/service is ultimately approved for that physician the vast majority – i.e., 80% – of the time);
- Requiring TDI to perform audits of health plan compliance with statutory PA timelines for approvals and denials; and
- Requiring peer-to-peer discussions under Tex. Ins. Code §4201.206 (b) to be with a Texas-licensed physician who is of the same or similar specialty as the physician.

Finally, another related prescription drug issue for the committee to consider is a potential increase in the methods of "brown bagging" and "white bagging" related to cancer care. "White bagging," is the practice of requiring that a drug be purchased through a specialty pharmacy and shipped directly to the physician, rather than to the pharmacy of choice of the physician. In cancer treatment, this can negatively impact patient care as it limits the flexibility needed when administering cancer drugs. Each patient is unique and may need adjustments to the course of treatment even on the day of the patient's appointment.

"Brown bagging" poses a larger threat to patients in need of critical treatment. Under this requirement, the drug, again, is required to be purchased through a specialty pharmacy, but the drug must be shipped directly to the patient. This creates the potential for disastrous problems, such as incorrect and improper storage of drugs that can be very sensitive to varying conditions. For example, a box containing a cancer treatment left on the front porch in the Texas sun is likely to be damaged. Additionally, cancer treatments, specifically, are extremely expensive, and to have the drugs ruined due to poor shipment or storage results in more expense, often to the patient, as well as delays to truly needed care. Aside from the patient safety concerns and potential care delays, these practices can also lead to a shift in cost-sharing to patient as they can be transitioned to an out-patient benefit versus an in-patient benefit.

The Associations recommend that the committee study the impact of "white bagging" and "brown bagging" on patients in Texas and methods of addressing any negative impact of these practices on patient care.

Furthermore, the Associations note that the use of copay accumulators is placing more cost burden on patients seeking medications with the help of rebates. Copay accumulators prevent the rebated amount for a drug to count towards a patient's deductible, further extending the patient's out-of-pocket expense. By requiring that rebates are not factored into a patient's deductible, and rather allowing the full patient responsibility be taken into account, plans are leaving the financial burden of health care to the patient rather than to the health benefit plan issuer. The Associations recommend that the committee also study this practice.

The Associations thank the committee for its time and consideration of our written testimony.

[2] Consensus Statement on Improving the Prior Authorization Process by American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, American Medical Association, and Medical Group Management Association.

Charge

SB 1264, which prohibits balance billing (surprise billing) and creates an arbitration system to settle balance bills. Monitor the implementation of the mediation and arbitration programs, including the establishment of a portal on the TDI website through which requests for mediation and arbitration may be submitted. Determine whether the appropriate state agencies are enforcing the prohibition on balance billing. Review the Department's rules implementing the legislation's exception for non-emergency "elective" services to determine whether the rules limit the exception to out-of-network services that a patient has actively elected after receiving a complete written disclosure. Monitor or follow up on TDI's process for selecting the benchmarking database and determine whether the database chosen provides the most accurate available and its sources are transparent. Evaluate the fiscal impact of the legislation on the Employees Retirement System of Texas and the Teacher Retirement System of Texas.

Association Comments

As the committee is aware, the Associations supported Senate Bill 1264, as passed into law, due to our commitment to helping patients address surprise out-of-network balance bills. As a result, we, much like other stakeholders involved with this bill, have eagerly awaited data from the Texas Department of Insurance (TDI) regarding the bill's implementation. On July 29, TDI issued its preliminary report based upon its first six months of data. Among the findings in that preliminary report are the following:

- As of June 30, 2020, TDI had received more than 9,000 requests for dispute resolution under the new process.
- [TDI] received 19 consumer complaints about balance billing in the first six months of 2020, down from 546 for the same period in 2019.
- Provider complaints have decreased more than 70% this year. Before SB 1264, consumers could request mediation for certain surprise bills, but the only recourse available through TDI for providers seeking to resolve billing disputes was to file a complaint.
- Through June, the majority of requests for arbitration were resolved during the 30-day informal negotiation period provided by the law. These disputes did not require an arbitrator to wade in.[3]

Much of the above-referenced preliminary data is very encouraging (e.g., indicating that physician and provider complaints have decreased more than 70%, that the process is being utilized, and that most cases are resolved in arbitration without the need for arbitrator involvement). As TDI acknowledges, however, these data are limited since it is only for a six-month period.

Further, the data may have been impacted by the COVID-19 pandemic and its associated bans on elective procedures; thus, we continue to await further data to evaluate the impact of SB 1264 in Texas more fully. As TDI noted when it issued its preliminary report, the agency is in the process of collecting more information from health plans and licensing boards to inform the report required by SB 1264, which is due by Dec. 1. We look forward to reviewing the results of that report.

[3] TDI email titled "Early report on new balance billing protections," issued on July 29, 2020.

Enforcement of SB 1264 and Fiscal Impact on ERS and TRS

In response to the specific questions asked in the SB 1264 report, we note that many of the questions are directed to the state agencies and/or the Employees Retirement System of Texas (ERS) and the Teacher Retirement System of Texas (TRS). Thus, we do not have additional data to provide on those points. In terms of the charge relating to "determin[ing] whether the appropriate state agencies are enforcing the prohibition on balance billing," we would expect the committee to go directly to those agencies. We note that SB 1264 has a bifurcated enforcement mechanism – the health care licensing/certifying agencies enforce the law with regard to physicians and health care providers within their respective jurisdictions, and TDI enforces the law with regard to health plan issuers in its jurisdiction. Thus, obtaining data from each of the agencies regulating affected physicians and health providers, along with TDI, will be important to properly evaluate that component of the interim charge.

Monitoring TDI's Selection of the SB 1264 Benchmarking Database

Next, with regard to the benchmarking database utilized under SB 1264, the Associations continue to strongly support TDI's selection of FairHealth as the benchmarking database under Tex. Ins. Code §1467.006. TDI requires payers to submit data to the TDI-selected database (i.e., FairHealth) as part of the implementation of SB 1264. By including specific language regarding TDI's selection of a nonconflicted database in SB 1264, the Texas Legislature expressed its desire for the state to use an independent third party to collect and analyze claim data. FairHealth is an appropriate selection for this purpose.

FairHealth was created after New York sued UnitedHealthcare for creating a database that New York alleged had systematically set out-of-network physician payments well below the value of the care provided. After 15 years of allegedly using the Ingenix database to artificially lower physician payments and increase profits for itself and other payers, UnitedHealthcare was required to stop using its own database and start using an independent third party to determine market rates for out-of-network payments. Today, physicians still fight payers for appropriate payments for the care they deliver. Thus, it is imperative that an independent organization such as FairHealth is used to collect claims data for the benchmarking data points specified in SB 1264.

FairHealth was created to give everyone a "fair" and transparent view of claims data and is the largest database of privately billed health claims. In addition to the federal government, more than 20 states have asked FairHealth for assistance. Because the FairHealth database is so widely used, FairHealth is able to validate the data and address outliers. This also allows it to use various statistical models to aggregate and benchmark the data. For all the foregoing reasons, the Associations support continued use of this database.

Potential Methods to Increase Access to SB 1264's Independent Dispute Resolution Processes

Next, as the committee considers any potential changes to SB 1264 recommended by stakeholders, we again note that current TDI data on SB 1264 is very limited at this time. Thus, our current comments are focused on increasing access to and utilization of the independent dispute resolution (IDR) processes created by the legislation, rather than on any of the substantive components of the IDR processes. In particular, the Associations recommend two changes designed to enhance access to the SB 1264 arbitration process.

1. *Amend SB 1264 to Raise the Statutory Bundling Cap for Arbitrating Multiple Claims in One Proceeding*

First, the Associations recommend increasing the bundling cap for arbitrating multiple claims in one arbitration proceeding. Currently, Texas law provides that the TDI commissioner must adopt rules providing for requirements for bundling multiple claims for submission to arbitration in one proceeding. Specifically, the law states that the rules must provide that (1) the total amount in controversy for multiple claims in one proceeding may not exceed $5,000, and (2) the multiple claims in one proceeding must be limited to the same out-of-network physician or provider. See Tex. Ins. Code Sec. 1467.084(e)(1).

The Associations strongly recommend increasing the $5,000 amount-in-controversy statutory limit on bundling claims in order to (1) increase access to the arbitration process (particularly for claims with smaller amounts in controversy); (2) address inefficiencies in the arbitration process; (3) reduce the cost of the arbitration process (which is subject to a flat fee that is split evenly between the parties, currently ranging from $270 to $3,200); and (4) reduce the administrative burden for all parties involved, including TDI.

Given the limited data currently available, the Associations have not yet identified a specific recommended dollar amount for the bundling. We are awaiting an opportunity to review TDI data that will be presented to the Texas Legislature in December; however, we do know there is a need for an increase in this threshold. Access to arbitration is imperative for physicians to have an opportunity to seek adequate payment, as intended under SB 1264, when physicians are prohibited from balance billing enrollees. This is particularly true as the preliminary TDI data indicate that average health plan initial payments are very low compared with average settlement amounts/arbitration decision amounts. Thus, the Associations urge the committee to support an increase to the bundling cap.

As the committee knows, enrollees have been taken out of the arbitration process under SB 1264. However, increased access to the arbitration process by physicians through a heightened bundling cap should benefit patients, as well as physicians, for multiple reasons. Specifically, increased bundling and arbitration access will:

- Enhance the economic viability of physician practices, thereby enhancing access to care and reducing the need for small practice consolidation (economic viability is always an issue for small practices, but these challenges are even more acute at the present time as practices face new issues associated with the COVID-19 pandemic);
- Encourage health plans to develop robust networks (which again benefit the enrollees of those plans); and
- Decrease the burden on TDI in processing requests, allowing the agency to perform other regulatory duties that protect consumers.

2. Amend SB 1264 to Authorize the TDI Commissioner to Set a Maximum Arbitrator Fee by Rule

As another measure to increase access to the arbitration process established under SB 1264, the Associations recommend that the committee consider amending SB 1264 to grant the TDI commissioner express statutory authority to set by rule a maximum reasonable arbitrator fee.

Currently, Texas Insurance Code §1467.082 provides, among other things, that the commissioner "shall adopt rules, forms, and procedures necessary for the implementation and administration of the of the arbitration program … ." This statutory language is broadly drafted; however, TDI has stated it does not believe it currently has authority to establish a maximum arbitrator fee.

The Associations, therefore, recommend that the legislature grant TDI this authority. Reasonable arbitrator fees are critical to ensuring access to the SB 1264 independent dispute resolution processes, particularly

since (1) the physician and the health plan are statutorily required to split the arbitrator fee evenly, and (2) if the parties cannot agree to an arbitrator, one is assigned by TDI.

The current list of arbitrators on TDI's website reflects a wide range of flat arbitrator fees (from $270 to $5,000). It is unclear why the range is so wide when the basic 10 factors to be considered in arbitration are limited by the statutory language of SB 1264 and the review is a streamlined, documentation-based review. Notably, at least 18 of the 103 arbitrators (more than 17% of arbitrators) currently on TDI's list have a fixed fee of $350 or less, which is similar to historic IDR rates assessed for New York's IDR process.

As we have stated previously, the Associations strongly recommend that New York's fees serve as a model for setting reasonable fees for Texas' arbitration process. In New York, it is our understanding that the typical fees for its surprise billing IDR process have been as follows:[4]

	IMEDECS	IPRO	MCMC
Full Review	$ 325.00	$ 225.00	$ 300.00
Negotiation/Settlement	$ 250.00	$ 150.00	$ 175.00
Application Processing/ Rejection as ineligible	$ 150.00	$ 95.00	$ 100.00
Hardship Waiver	$ -	$ -	$ -

We understand that Texas' surprise billing law is not identical to New York's law; however, similar arbitrator fees are achievable in Texas, given (1) the limited, document-based review envisioned by both laws and (2) the fact that numerous arbitrators in Texas have, of their own volition, listed rates in a range similar to New York's standard fees.

By setting a maximum arbitrator fee by rule, TDI will be able to inject some predictability and affordability into the arbitration process and will allow the process to be more accessible to physicians and affected providers. We are concerned that some of the fees currently charged by arbitrators are so high that (1) physicians and providers are deterred from seeking arbitration, and (2) even if a physician or provider seeks arbitration and wins during the arbitration, he or she may walk away with a net loss (particularly for small claims). This severely undercuts the utility of the arbitration process and the fairness of SB 1264. Thus, we urge the committee to examine this issue further.

Once again, the Associations thank the committee for its time and consideration of our testimony. We look forward to working with the committee as it examines the impact of SB 1264.

[4] Note that this information may have changed. This is the latest information that we had on the fees, which we received in 2019.

Charge

SB 1852, which requires certain disclosures for insurers that offer short-term limited duration plans. Study whether similar consumer disclosures and other safeguards are needed for non-traditional health coverage products marketed to individuals or small employers in Texas. Identify any gaps that leave consumers without needed information or consumer protections, including network adequacy and protections from surprise medical bills.

Association Comments

Over the past several years, the number of Texans participating in nontraditional health coverage arrangements has steadily grown, due in large part to rising health insurance costs for both employers and individuals. Examples of nontraditional products include health sharing ministries, disease-specific plans, fixed indemnity plans, and association health plans, among others.

Some of these models may be subject to state regulation, while others may not. However, what they all have in common is that consumers may not understand that they are not intended to provide or replace comprehensive health insurance, potentially leaving consumers partially or fully uninsured when they seek health care in addition to leaving them financially exposed for unexpected and devastating medical bills. According to the Texas Department of Insurance, these plans:

- May not cover all injuries or illnesses, including preexisting and chronic conditions;
- May have waiting periods to join, pay less for each service, and limit their total yearly payments; and
- Don't allow consumers to get federal help – such as tax credits and cost-sharing reductions – to lower their premiums and out-of-pocket costs.

Based on current trends, nontraditional health coverage products will proliferate in coming years. As such, it is imperative that state lawmakers not only require detailed, upfront, written disclosures for individuals purchasing these products but also direct TDI to conduct research to better understand what types of nontraditional plans operate in Texas and the number of Texans enrolled in them.

Regarding disclosure, there is no need to reinvent the wheel. The current TDI alternative health plan educational material and health plan shopping guide provide consumers what they need to know. However, few purchasers will consult the TDI website before purchase. Furthermore, many Texans lack reliable broadband and/or technology needed to access to the agency's electronic educational resources. Thus, the Associations strongly support requiring *all* alternative health plans to provide this information to consumers in writing *before* purchase.

Additionally, to better understand a rapidly changing market, we recommend that TDI be directed to research and report to the legislature on the following:

- What types of nontraditional health plans operate in Texas, and how many Texans are enrolled in these products?
- Which alternative health plans underwritten or sold in Texas are subject to state regulation?
- How many complaints has TDI received on nontraditional health coverage products, categorized by plan name, type of plan, and complaint category?
- Are nontraditional health plans subject to existing consumer protections, including prompt pay laws, state surprise billing protections, and network adequacy protections, among others?

Once again, the Associations thank the committee for its time and consideration of our written testimony.

Charge

SB 1940, which extends to August 31, 2021, TDI's authority to revise and administer the temporary health insurance risk pool to the extent federal funds are available. Study ways to foster a competitive market and reduce the uninsured rate, including by exploring flexibility available through federal waivers. Study the impact to health care systems if the Affordable Care Act is ruled unconstitutional, including identifying which mandates, consumer protections, and subsidies will be lost and which have equivalents in state law.

1) **Study ways to foster a competitive market and reduce the uninsured rate, including by exploring flexibility available through federal waivers**.

Association Comments

Prior to the pandemic, Texas held the dubious distinction of being the uninsured capital of the country, with nearly one in five Texans lacking health care coverage. Alarmingly, that number is rapidly growing. As a result of job losses tied to COVID-19's economic upheaval, 13% of Texans were unemployed in June,[5] resulting in close to 1.6 million people losing job-based health insurance. Of these, approximately half will find alternative coverage while the remainder will become uninsured.[6] Women and people of color have been disproportionately impacted.

High rates of uninsured contribute not only to poorer and sicker individuals and families but also to poorer and sicker communities. An estimated 35% of Texans aged 18 and older – the backbone of the state's workforce – have chronic medical conditions.[7] Yet most uninsured Texans are low-income, working-age adults. Without meaningful health care coverage, a large swath of Texas' workforce, including many of the very people on whom Texans depend to provide essential services during the pandemic and beyond – grocery store clerks, bus drivers, janitors, and even health care workers – cannot access the health care they need to stay healthy and productive. Additionally, according to a 2019 study by the Texas Alliance for Health Care, the uninsured also have lower lifetime earnings, impacting the ability of Texas families to become more financially secure and prosperous.

Moreover, high rates of uninsured threaten the ability of rural and underserved communities to sustain their hospitals and physician networks. Over the past decade, states with the highest number of uninsured, including Texas, have experienced more rural hospital closures than states that have acted to extend coverage to more people.

Texas can no longer ignore the profound economic, social, and human impact of having more than 5 million uninsured residents. The Associations urge the committee to support a multipronged approach to meaningfully reduce this number by pursuing federal 1332 and Medicaid 1115 waivers. Under the Affordable Care Act (ACA), states have tremendous flexibility to craft health care coverage initiatives best suited to their needs. Under Section 1332 of the law, states can seek waivers "to experiment with … strategies to provide residents with health coverage that delivers at least the same level of protections guaranteed under the ACA."[8] However, 1332 waivers on their own are not enough. These waivers cannot be used to implement Medicaid changes or extend coverage to low-income working adults as authorized

---

[5] Texas Workforce Commission, June 2020.

[6] The Urban Institute. How the COVID-19 Recession Could Affect Health Insurance Coverage, May 2020.

[7] Kaiser Family Foundation. How Many Adults Are at Risk for Serious of Serious Illness If Infected with Coronavirus? Undated Data, April 23, 2020.

[8] *Id*. New Rules for Section 1332 Waivers - Changes and Implications, Dec. 10, 2018.

by the law.[9] However, if paired with a Medicaid 1115 waiver, Texas could draw down federal funds to extend health care coverage to this population – an estimated 1.5 million Texans.

Together, both waivers could substantially improve health care coverage.

Fourteen states have received federal approval for a Section 1332 waiver that allows them to establish state-administered reinsurance programs funded jointly with federal and state dollars.[10] Under these waivers, states use the funds to reduce health insurance premiums for individuals purchasing coverage via the marketplace but who are in eligible for subsidies. According to Avalere, in the first year of operation, state-run reinsurance programs authorized by 1332 waivers reduced individual market premiums by an average of 19.9%.[11]

The Associations support pursuit of such a reinsurance-focused 1332 waiver not only because of its potential to help lower the costs of marketplace premiums but also because this type of 1332 waiver is the most likely to be quickly approved by the Centers for Medicare & Medicaid Services.

Additionally, as the committee evaluates these waivers, the Associations recommend that it carefully consider the following principles, which were developed in recent months by an informal workgroup of health care providers and consumer advocates striving to identify opportunities to advance high-quality, meaningful health care coverage for fellow Texans.

Section 1332 waivers should:

- Be the part one component of a broader strategy to establish comprehensive health care coverage for uninsured Texans, and include efforts to extend Medicaid eligibility for certain low-income adults;
- Adhere to statutory guardrails that ensure coverage under the waiver will be affordable and comprehensive and will cover the same number or more Texans as are covered today;
- Use reinsurance to reduce the price of full-cost premiums while making the Texas individual insurance market more stable and competitive;[12]
- Support clear and unbiased information on health plan options for consumers, as well as enrollment assistance;
- Be designed in conjunction with diverse stakeholders with ample opportunity for public input; and
- Be data driven.

2) Study the impact to health care systems if the Affordable Care Act is ruled unconstitutional, including identifying which mandates, consumer protections, and subsidies will be lost and which have equivalents in state law

Comment. Since the passage of the ACA, TMA's position has been "keep what works, fix what's broken." Like any law, there are elements that work and those that do not. Yet, despite its flaws, without question Texans have benefited from the ACA's enactment. Key patient protections within the law include:

- Preventing health insurers from denying coverage to Texans with preexisting conditions; in Texas' largest metropolitan-statistical areas, the percent of working age adults with preexisting conditions ranges from 23% in Austin-Round Rock to 31% in Wichita Falls;[13]

[9] Center of Budget and Policy Priorities, Frequently Asked Questions about ACA Section 1332 Waivers and Medicaid, September 2019.
[10] State Health Insurance Assistance Center. State-Based Reinsurance Programs via 1332 State Innovation Waivers.
[11] Avalere. State-Run Reinsurance Programs Reduce ACA Premiums by 16.9% on Average, Oct. 19, 2019.
[12] Kaiser Family Foundation. Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act, Jan. 3, 2020
[13] *Id.* Mapping Pre-existing Conditions across the U.S., Aug. 28, 2018.

- Eliminating cost-sharing for vital preventive health care services, including prenatal care, well-child visits, immunizations, and cancer screenings;
- Allowing adult children up to age 26 to stay covered via their parent's insurance;
- Establishing essential health benefits, including coverage for maternity care, prescription drugs, and mental health and substance use disorders;
- Prohibiting annual and lifetime limits;
- Extending Medicaid coverage for low-income working adults, with 90% of costs paid by the federal government[14] compared with 60% paid for existing Medicaid enrollees; and
- Providing subsidized, private-sector health care coverage to more than 1 million Texans.

As of October 2019, 13 states have enacted laws to replace some features of the ACA.[15] Yet, according to the Kaiser Family Foundation, *the ACA's reforms affect nearly everyone in some way, and a court decision that invalidated the ACA would have complex and far-reaching impacts throughout the health care system.* In Texas, such a decision would impact millions of people, not only by eliminating health care coverage – or the promise of it – but also by stripping people of important patient protections that cannot easily be replaced on a state-by-state basis.

Prior to the ACA, most states, including Texas, took multiples steps both to reduce the number of uninsured and to make coverage more affordable and available.[16] However, success proved elusive to all.[17] For example, Texas attempted to help people with preexisting conditions by establishing a high-risk pool. However, enrollment never exceeded more than about 30,000 people because of cost-prohibitive premiums, high-deductibles, and a 12-month waiting period. In 2011, the pool reached 2.6% of the nongroup market.[18] To establish an affordable, meaningful high-risk pool in the wake of any ACA repeal, state lawmakers would need to invest substantial new dollars in addition to eliminating policies that keep people with preexisting conditions from getting and keeping coverage.

Additionally, the Texas Department of Insurance regulates less than half of the current health insurance market. Without a federal health reform strategy, many Texans with employer-sponsored coverage would not be subject to any new state-level reforms that might replace protections under the ACA. Moreover, it would be cost prohibitive for the state to replace ACA marketplace subsidies as well as any future federal Medicaid dollars. A 2019 analysis by the Urban Institute found that full ACA repeal could result in Texas' uninsured rate growing to 37% among nonelderly Texans.[19]

Once again, the Associations thank the committee for its time and consideration of our testimony.

Sincerely,

Diana L. Fite, MD
President, Texas Medical Association

---

[14] In 2012, the Supreme Court ruling on the ACA made Medicaid expansion voluntary. The law allows states to extend Medicaid eligibility to 138% of the federal poverty level for working adults and parents ($29,973 for a family of three in 2020). As of August 2020, 39 states have adopted it.

[15] The Commonwealth Fund. Can States Fill the Gap if the Federal Government Overturns Preexisting-Condition Protections?, Oct. 29, 2019.

[16] Texas Medical Association. Texas Health Opportunity Pool and Medicaid Reforms, Senate Bill 10, 2007.

[17] PricewaterhouseCoopers. Challenges of partial Reform - Lessons from State Efforts to Reform the Individual and Small Group Markets before the ACA, February 2017.

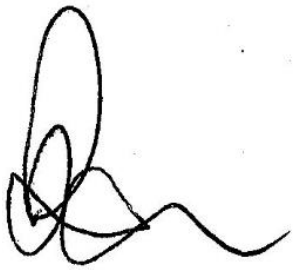
[18] Kaiser Family Foundation. High-Risk Pools for Uninsurable Individuals, Feb. 22, 2017.

[19] The Urban Institute State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA, March 2019.

Jeff Lee, MD
President, Texas Society for Gastroenterology and Endoscopy

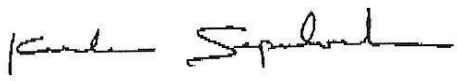
Tammy Camp, MD
President, Texas Pediatric Society

Ken Kaminksi, MD
President, Texas Orthopaedic Association.



Evan Pivalizza, MD
President, Texas Society of Anesthesiologists

Robert Hancock, DO, FACEP
President, Texas College of Emergency Physicians



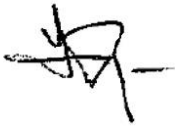
Karla Sepulveda, MD, FACR
President, Texas Radiological Society

Brandon Lewis, DO
President, Texas Osteopathic Medical Association

Ken Shaffer, MD, FACC
President, Texas Chapter of the American College of Cardiology

O. Lenaine Westney, MD
President, Texas Urological Society

Amanda LaViolette, MD, MPH, FACP
President, Texas Chapter of the American College of Physicians Services



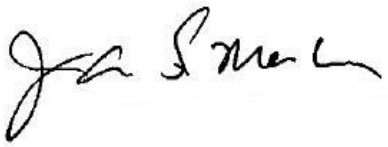
Luis Rios, MD
President, Texas Society of Plastic Surgeons

Brian Bruel, MD
President, Texas Pain Society

C. Tony Dunn, MD, FACOG
President, American College of Obstetricians and Gynecologists District XI (Texas)

Mark Mazow, MD
President, Texas Ophthalmological Association

Waleed El-Feky, MD
President, Texas Neurological Society



James Malter, MD
President, Texas Society of Pathologists

Submitted by:

Clayton Stewart
401 W. 15th St.
Austin, TX 78701
Email: clayton.stewart@texmed.org
Phone: (512) 370-1365