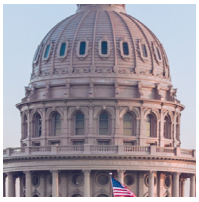

TEXAS PUBLIC POLICY FOUNDATION

Testimony

October 1, 2020

Testimony to the Texas House of Representatives Statewide Health Care Costs, Select Committee

by David Balat, Policy Director

My name is David Balat, and I am the director of the Right on Healthcare campaign with the Texas Public Policy Foundation.

I have testified before Congress and in various state legislatures regarding healthcare, health insurance, and putting patients first. I have also worked in the healthcare industry as a hospital executive and CEO for nearly 20 years.

Thank you for allowing me to take the time to address these incredibly important issues.

Licensure Reciprocity

Many Texans have difficulty getting healthcare—medical, dental, mental, and behavioral—when they need it. There is a shortage of medical professionals, both an insufficient number of medical professionals and maldistribution (meaning that they are not located where they are needed most).

Everyone wants to feel confident that their healthcare provider—whether it is a doctor, a nurse, or a radiologist—is qualified and competent. This is why Texas has licensing requirements for these professions. But are those licensing requirements excluding qualified providers?

One way for Texas to begin to address the shortage of healthcare professionals in the state is by making it easier and quicker for healthcare professionals licensed in another state to become licensed in Texas. If the burden to become a licensed professional in the state is reduced, more providers will be available to treat patients.

Here is one way. In 2019, Gov. Abbott signed a bill making it easier and less costly for military spouses with certain out-of-state licenses to become licensed more quickly in the state of Texas. The legislation included healthcare professionals, among others. Instead of requiring applying for a license to a state agency, the bill simply requires military spouses to notify the appropriate state agency of their intent to practice in the state. The state agency then verifies with the appropriate jurisdiction the individual is licensed in, sends a confirmation to the individual, who is then free to begin working in Texas. This legislation was a step in the right direction.

But it can be expanded. Also in 2019, Arizona became the first state to recognize most licenses from other states without requiring other states to reciprocate. Arizona did for all new residents what Texas did for military spouses—expediting the process and making it easier for new residents in the state to jump back in the labor market quickly after moving to the state.

Texas should follow Arizona's example and make it easier for all healthcare professionals with out-of-state licenses to become licensed in Texas.

Doctor-to-Patient Medication Program

The majority of Texans get a prescription from their physician then travel to a pharmacy to get it filled. Yet 45 states allow physicians to both prescribe and dispense medications to some extent, a practice known as *physician dispense*. Texas is behind the curve with no allowance for physician dispense in most of the state.

For doctors, physician dispense makes sense. They are better able to monitor whether their patient is following their advice. In 2018, nearly 30% of Americans did not take their prescriptions as recommended because of the cost. Nineteen percent did not fill their prescriptions, 18% took over-the-counter drugs instead, and 12% cut their pills in half or skipped doses due to cost.

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Physician dispense can improve medication adherence by making prescription-filling more convenient and providing patients the opportunity to take their first dose in their physician's office with the assistance or supervision of a doctor or nurse. Physician dispense will expand physicians' ability to provide care, improve patients' experience, and reduce the underuse of medications.

For patients, physician dispensing is both safe and convenient. And most importantly, in a recent study of Medicare Advantage patients trying the new system, 87% said that the model improved their ability to take their medication.

Currently, only some Texans can take advantage of physician dispense. Since 1999, Texas has allowed physician dispense in rural areas, so long as no pharmacies operate within 15 miles of the care facility. Texas physicians can also dispense free drug samples or dispense a maximum 72-hour supply of drugs to patients with "immediate needs," intended to ensure proper treatment until the patient can access a pharmacy.

As we have seen in previous sessions, efforts to expand physicians' ability to dispense drugs will likely be contested by pharmacy cooperatives in the state. Ultimately, it is important to recognize that physician dispense does not require patients to purchase their drugs at their physician's office but merely makes the option available to them, allowing them to shop for the best price and make tradeoffs between price and convenience.

Texas should allow physicians to dispense medications across the state of Texas in a manner that grants physicians maximum flexibility to perform this service. It is a safe and effective policy for Texans.

Medicaid and Direct Primary Care

"Direct Primary Care" (DPC) is not really a new model for healthcare in Texas. Long before employer-based insurance (with the safety nets for the elderly and disabled, Medicare and Medicaid) became the standard, patients paid doctors for their care. There were no middlemen—only the patient and the provider, and they made the decisions.

DPC seems innovative now because we have moved so far away from that model. Government regulations combined with ever-more complex insurance standards have put third-party payers in charge of the decision making.

The current system frustrates not only patients, but also physicians. No healthcare provider wants to be second-guessed by a functionary behind a computer screen hundreds or thousands of miles from the examination room. No doctor wants to be limited to a maximum number of minutes of face time per patient, because human beings and their ailments are rarely so conveniently compartmentalized. And doctors and patients alike want the ability to follow up on treatments to ensure the best health outcomes possible.

DPC practices seek to resolve the flaws of our current healthcare system by providing transparent pricing and strengthening the doctor-patient relationship. Direct care has gained momentum in primary care, surgery, pharmaceuticals, and dentistry. Direct care functions differently in each setting, but the central idea is that third-party payers are not involved, and prices are known before the patient sees the medical professional.

It is really simple. Patients contract with DPC practices to receive a wide range of care at a convenient monthly price. Patients are allowed to see their provider as often as they like for preventative, wellness, and chronic care, and certain medical tests are included in the membership fee, depending on the membership agreement.

Typically, patients also have a high-deductible "catastrophic" insurance policy for things like hospitalization. But most of what the average family needs throughout the year will be covered by DPC—including some chronic illnesses, such as diabetes and heart disease, which can actually respond better to the kind of regular check-ins and solid relationships that DPC involves.

DPC is often confused with "concierge" care—the kind of high-end specialized care that the wealthy can access. It is not that. It shares some similarities, but it is for everyone. The usual monthly fee for a direct care patient is $77.

Many direct care providers connect with their patients through an app that allows for texts and email, eliminating the need for in-person appointments in many instances. Physicians can meet virtually with patients to diagnose illnesses and prescribe medication. According to a recent study, 82% of direct care practices have physician email access, and 76% allow patients to have 24-hour access to their direct care provider.

Employers looking to reduce healthcare costs for their employees can enroll their workers in direct primary care memberships in conjunction with a high-deductible policy, which can satisfy employees' needs as well as save money for the company. Companies that switch to membership agreements can see savings of 30-50% of their annual healthcare costs.

A 2020 Society of Actuaries report includes a case study that analyzed data from a single employer that offers a DPC benefit option and a traditional benefit option and compared cost outcomes during the same 2-year period between 912 members enrolled in DPC and 1,074 members enrolled in the traditional option. The following are key data points from the case study:

- DPC members had 19.90% lower claim costs for employers on an unadjusted basis and 12.64% lower claim costs on a risk-adjusted basis during the 2-year period.
- DPC members experienced approximately 40% fewer ER visits than those in traditional plans.
- DPC members experienced a 53.6% reduction in ER claims cost.
- DPC members experienced 25.54% lower hospital admissions on an unadjusted basis.

Currently, there are around 1,200 direct care practices in 48 states. States have the ability to regulate DPC as they see fit, and more than two thirds have crafted legislation to do so. Texas, like many other states, has codified that direct care does not fall under the category of insurance and should not be regulated as such.

Expanding the availability of direct care to rural Texans, Texans in busy metropolitan areas, and even Texans on Medicaid could be of great benefit. It can become another tool in developing better doctor-patient relationships and could be a good supplement for people who face healthcare plans with higher and higher deductibles.

Healthcare Price Transparency

It seems like every Texas family has opened that "surprise" bill from the doctor—the portion of a visit that insurance did not cover. Healthcare is unique; it is an industry that does not communicate its prices to its consumers until after services are rendered. People know the prices in advance for almost all goods and services they purchase—the items on the grocery store shelves, houses, or automobiles, for example.

But healthcare is different. Prices for the same or similar services and treatments can vary widely, both among regions, among facilities within a region, and even within a facility,

based on the payer. Patients feel they have limited knowledge about costs—and even less power over them.

How has healthcare resisted the market pressures other industries face? First, most people are not directly spending their own money, so they lack incentives to shop for services that suit them. With employer-sponsored health insurance, premiums are aggregated, and employers and insurers are in key decision-making roles. This isolates individual employees and consumers from the marginal financial cost of their healthcare decisions.

Second, markets are largely noncompetitive, increasingly dominated by large, integrated hospital systems consisting of inpatient facilities, outpatient facilities, and physician practices.

Finally, people rely very heavily on doctors for referrals. Since doctors are increasingly part of these consolidated hospital systems, they generally refer patients for services within the system regardless of price. All these features diminish price competition in healthcare.

Of course, some healthcare markets are more transparent—for services such as LASIK eye surgery and cosmetic procedures, for example. In these markets, prices tend to be transparent with robust competition among providers. Under these conditions, the result is generally what is found in other markets: prices drop over time, while quality improves.

The Surgery Center of Oklahoma, for example, posts prices on a consumer-friendly website. Over the 11 years it has posted these prices, it has changed them four times—lowering them each time.

What can be done to bring down costs—and frustrations—in Texas? We can make the healthcare industry, and in particular prices, more transparent.

There are four key ways in which price transparency can help make our healthcare system better:

1. Consumers and patients will be better informed.
2. Better-informed employers will be able to help workers shop for value.
3. Employers will be more empowered to monitor insurer effectiveness and to eliminate counterproductive middlemen.
4. And high-cost providers will feel pressure to find ways to lower their prices.

These elements together will create a more competitive market among providers. When price becomes a bigger part of the referral system, Texans will be able to make their choices with more of the information they need.

What can you do as lawmakers?

A step in the right direction for the state of Texas would be to require any third-party administrator of state employees' health plans to provide all claims data to the state. As an employer, the state of Texas has a vested interest in understanding what value it is receiving for the health coverage it provides to employees.

While price transparency efforts are not sufficient by themselves to reform America's healthcare system, it is a first step to help all parties involved rein in healthcare costs.

Medical Cost Sharing as an Alternative

A new and innovative model for healthcare in the U.S. is medical cost sharing. Medical cost-sharing plans are an alternative to traditional health insurance. Instead of operating with a network of providers, these organizations facilitate the sharing of medical costs among

members, who pay a monthly amount which is shared to cover healthcare costs of other members.

These monthly amounts are usually smaller than traditional health insurance because the coverage is not as far-reaching. Generally, members will pay the majority of smaller costs out of pocket, and larger costs will be submitted for sharing. The members retain ultimate responsibility for paying their medical fees, because the organization is not contractually obligated to cover specific costs like an insurance company would be and does not always cover as many items as traditional insurance.

Medical cost-sharing organizations are similar to faith-based health care sharing ministries, but there are some key differences. Medical cost sharing will have an appeal beyond a specific religious group. Some sharing ministries prohibit behavior that goes against their statements of belief, such as smoking, drinking, and extramarital sex, and they do not cover medical costs related to such activities. Medical cost sharing would not impose these limitations.

What can the Texas Legislature do to make this innovative option available to Texas families?

Medical cost sharing should be defined explicitly in Texas law as not being health insurance and thus exempted from insurance regulatory law. Medical cost-sharing plans do not operate as insurance companies and should not be regulated as such. This will allow them to operate more freely, bringing more low-cost options to the health coverage market and helping both individual Texans and small businesses.

The ACA significantly limited the amount of choice consumers have in the healthcare system. Medical cost-sharing plans are one more choice we can give to Texans.

Telemedicine

Something many Texas families have learned during the COVID-19 pandemic is that not every doctor visit needs to be in person. Telemedicine (also called telehealth) has really taken off in Texas, driven by stay-at-home orders and the temporary lifting of restrictions on the practice.

But much room for growth remains. Aside from those restrictions (which should be abolished permanently), there are other barriers in place. These include payment parity laws, lack of broadband access for some individuals, limitations on audio-only consultation, coverage from insurance plans, requirements for seeing a doctor in person before a telehealth appointment and interstate licensing (to name a few).

One barrier to wider usage of telehealth coverage is parity laws. Parity laws require insurance reimbursement for telehealth services at the same level as for in-person health services. Thirty-two states have parity laws applying to private insurance companies.

Only 23 states have full parity laws, however. Full parity requires an insurer to cover telehealth services on the same basis as in-person services, which means the insurers often must add more health services to their coverage. The other nine states have partial parity laws, which only require insurance companies to cover telehealth services which would have been covered in an in-person visit. This means the insurers do not have to incorporate more coverage.

Parity laws are a two-edged sword. Proponents of parity laws argue that they provide a strong incentive for physicians to provide telehealth resources. If more physicians offer telehealth options, this will benefit patients—particularly low-income or rural patients who have difficulty getting to appointments—and give them more options for treatment.

At the same time, parity laws set a precedent for the state to mandate what coverage private insurance companies must provide. Also, when reimbursement for telehealth is required on the same basis as for in-person treatment, the potential for cost savings by using telehealth are lost, because providers would have a great incentive to charge more for the service. And finally, by enforcing full parity, the actual cost of care would be obscured further. Price transparency is a big part of what keeps telehealth costs low.

Another issue that restricts the use of telehealth is the lack of broadband access in the rural areas which comprise much of Texas. Broadband access is essential for supporting the video technology required for telehealth under current regulations. According to the Texas Comptroller's Office, only 69% of rural Texans have access to high-speed internet. Yet people in rural areas are one of the main demographics telehealth aims to reach.

Medicare and Medicaid, for instance, both require that telehealth provide interactive telecommunication systems which allow for audio and video permitting two-way, real-time communications. Not everyone's internet access can handle that.

Fortunately, during the COVID-19 crisis, the CARES Act provided for several waivers of regular restrictions on telehealth, one of which was that requirement for Medicare and Medicaid. The waiver allows "telephone evaluation and management services, and behavioral health counseling and educational services" to be conducted using audio-only communications.

This temporary waiver (which, again, should be made permanent) provides a blueprint for how to mitigate the broadband access issue for telehealth. Allowing audio-only communications for reasonable areas of telehealth where physical examination is not as important could be a way to allow patients in rural areas to access some aspects of telehealth, despite not having video technology support.

Medical licensing is managed by the individual states, which presents an obstacle for providers trying to provide telehealth services across state lines. This is because telehealth providers are required to be licensed in all the states in which they provide care, the same as in-person providers. Getting a medical license in every state can be a challenge.

There are a few proposed solutions to the interstate licensing challenge: special telehealth licenses, consultation exceptions, and reciprocity and endorsement.

The least complicated licensing approach is licensure by reciprocity or by endorsement. With reciprocity, states agree to accept the medical licenses of other states that meet their qualifications. With endorsement, an out-of-state physician has an expedited process to obtain a medical license in another state, based on the requirements of the state in which the physician was initially licensed.

One of the largest issues for telehealth is whether or not it is covered by insurance policies, because if people cannot have it covered by their health plan they will likely not utilize this service. In Texas, insurance companies are not allowed to exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided through a face-to-face consultation. This ensures that, at the least, providers who wish to offer some of their services virtually will not lose patients who do not have this covered by insurance.

The use of telemedicine has been growing rapidly, and the COVID-19 pandemic accelerated this trend. But even more Texans could benefit from this service, and lawmakers can help ensure that barriers to care are removed.

ABOUT THE AUTHOR

David Balat is the policy director of the Right on Healthcare initiative at the Foundation. He has broad experience across the healthcare spectrum with special expertise in healthcare finance. He is a former congressional candidate in Texas's 2nd Congressional District and a seasoned hospital executive with more than 20 years of healthcare industry leadership and executive management experience.

Balat has earned the privilege of being invited to testify before the U.S. House Committee on Oversight and Reform in Washington, D.C., and before various House committees in the Texas state Legislature. He is a published op-ed columnist in *The Hill, Real Clear Politics*, and other news outlets and an active speaker and commentator on matters of health policy. He speaks at national conferences and advises on healthcare policy to both state and federal lawmakers.

Balat often volunteers to help families navigate their bills and how to understand their benefits. He serves as a board member for a nonprofit focused on educating legislators and the community about important matters pertaining to healthcare freedom.

Balat is a first generation American and the first in his family to graduate from college. He received his B.S. from the University of Houston and joint master's degrees in business administration and hospital administration from the University of Houston – Clear Lake.

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