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Via electronic submission to:
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House Select Committee on Statewide Health Care Costs
Rep. Greg Bonnen, Chair

PUBLIC COMMENT LETTER

Re: Response to House Select Committee on Statewide Health Care Costs: Interim Charge #1

Dear Honorable Members of the House Select Committee on Statewide Health Care Costs:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide responses to the House Select Committee on Statewide Health Care Costs' formal request for information on Interim Charge #1: *Examine the primary drivers of increased health care costs in Texas.*

Texas hospitals have been at the forefront of reducing the cost of health care. The industry has seen much change over the past decade, through the passage of the Affordable Care Act, a movement to quality-based payment policies and adjusting to the state's rollout of managed care throughout the vast majority of the Texas Medicaid system. However, adjusting to these changes has not been without its challenges. While these systems create oversight related to spending, fraud, waste and abuse, providers do report an increase in the cost of administrative paperwork in order to meet these metrics—particularly related to burdensome requests for records in order to obtain payment for services rendered.

Texas hospitals have a legal obligation to screen and stabilize the emergency conditions of all patients who come into their emergency departments, regardless of their ability to pay, making the financial outlook difficult for many hospital systems that serve a large uncompensated or low-compensated population.

All of these obstacles are amplified by the COVID-19 pandemic, a time in which hospitals, like every other sector of the economy, saw lost revenue as they paused non-emergent procedures.

Current Health Care Financing Strategies

The Medicaid program is critical to the stability of the health care safety net, on which millions of Texans rely. Texas hospitals are grateful that Medicaid and CHIP benefits and eligibility levels, public health services, behavioral health care and other services for vulnerable Texans are not subject to the agency cuts requested by state leadership and the subsequent legislative appropriations instructions. We ask that you continue to protect access to those services, including by protecting critical payments to the providers that deliver them. This includes

hospitals' base rates in addition to existing investments in trauma, rural and safety-net hospitals. THA supports continued funding of these critical payments to protect access to care and reduce the reliance on supplemental payments. Uncertainty in Medicaid rates or lower Medicaid rates leads to more uncompensated care and more underpayments that drive-up the cost of health care for Texas, as a whole.

The Uncertain Future of Supplemental Payment Programs

Two-thirds of Texas hospitals' Medicaid payments are provided through supplemental payment programs outside of the base payments for providing care to Medicaid enrollees. Together, the Uncompensated Care and Delivery System Reform Incentive Payment programs under Texas' 1115 Waiver, the Disproportionate Share Hospital Program and the Uniform Hospital Rate Increase Program total over $10 billion in annual payments to hospitals for providing care to low-income and uninsured individuals. However, hospitals face unprecedented levels of uncertainty regarding the future of these programs and how they are financed.

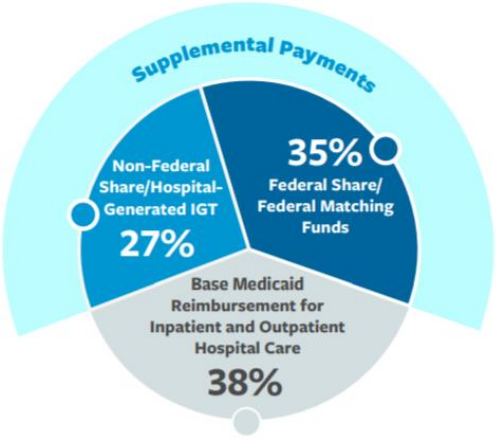
The Medicaid DSH Program provides nearly $1.9 billion to approximately 185 Texas hospitals to offset some of the costs hospitals incur for providing health care to low-income and uninsured Texans. The Affordable Care Act scheduled reductions to these hospital payments in anticipation of a reduction in the number of residents without health insurance and the amount of UC hospitals provide. Texas, however, has seen the number of uninsured residents increase, becoming the state with the largest number of residents without health insurance. This makes the DSH program crucial to Texas hospitals. These scheduled Medicaid DSH cuts so far have been successfully delayed, but, absent Congressional action, will take effect Dec. 1. The impact to Texas hospitals of these scheduled cuts is estimated to be $440 million in fiscal year 2021 and $880 million in subsequent years through FY 2025.

Since 2012, Texas' 1115 Medicaid Transformation Waiver has provided Texas hospitals and other health care providers with vital funding to transform the delivery system and to offset the costs of providing care to the uninsured. While never intended to be permanent, DSRIP nonetheless has been a vital part of the hospital safety net, providing primary, school-based, behavioral health and other health care services to Texans who otherwise would not have received these services. Funding for DSRIP projects has begun phasing out, dropping from $3.1 billion a year to $0 by 2022. THA has joined other hospital and health care provider groups to request that the Texas Health and Human Services Commission ask the Centers for Medicare & Medicaid Services to extend the DSRIP program for at least one more year. With the ongoing COVID-19 pandemic, now is not the time to require the development of new programs nor the loss of essential DSRIP funding. With the current waiver set to expire Sept. 30, 2022, state leaders and providers will need to determine the best path forward to ensure sustainability of our health care safety net.

In addition to pending DSH cuts and the expiration of the 1115 waiver, HHSC has launched a workgroup to make significant changes to UHRIP. Since its inception and subsequent statewide implementation, UHRIP has been an important tool in ensuring access to care and improving stability for Texas' safety-net hospitals. THA appreciates HHSC's interest in improving the program and the collaborative approach the agency is taking with this effort. However, the UHRIP redesign adds another element of uncertainty in terms of availability of funding going forward.

As with all Medicaid payments, a state contribution is required to draw down federal dollars for these supplemental payment programs. Texas hospitals themselves provide that state contribution through various financing mechanisms.

Texas Hospitals' Estimated Medicaid Reimbursement and Supplemental Payments ($13.862 Billion All Funds, FY 2016)



In November 2019, CMS proposed the Medicaid Fiscal Accountability Rule, which could severely limit the state's ability to leverage these financing mechanisms to draw down federal Medicaid funding. Although the CMS removed MFAR from its regulatory agenda, the rule itself has not been withdrawn. Texas hospitals remain concerned that it could reemerge.

Texas Needs a Plan to Increase Coverage

Leading the nation in the number of uninsured residents, Texas remains one of 13 states choosing not to increase access to coverage under the Affordable Care Act. We know that people who lack insurance coverage have worse access to preventative health care, leading to poor health outcomes and chronic disease that goes unmanaged. These barriers to care increase Texans' reliance on clinically inappropriate care settings, such as hospital emergency departments, to address health conditions that would be better managed in lower acuity settings. Even before COVID-19, Texas had both the largest uninsured population (5 million) and the highest uninsured rate (18%). COVID-19-related job-losses have pushed Texas' unemployment rate to 12.8%, the worst on record and up from 3.5%in January and February. For many Texans, losing a job or having hours cut also means losing job-based health insurance. Before COVID-19, 13 million Texans had job-based health insurance. As job losses mount, so will the number of uninsured Texans.

Two recent reports—one from the Kaiser Family Foundation and another from the Urban Institute—have started to shed light on the scope of health insurance losses in Texas:

- 1.6 million Texans have already lost job-based health insurance because of a job loss in the family between March 1 and May 2, according toKFF.

- The Urban Institute projects that if Texas hits a 20%unemployment rate, 2.3 million more Texans will lose job-based insurance. At 25%unemployment, 3 million Texans will lose job-based insurance.

Regardless of the future of the 1115 waiver, Texas needs a comprehensive plan to increase health care coverage to Texans. Overall, one of the biggest drivers in the health care system lies in the level of uncompensated care in the system. In addition, the supplemental payment system, which is intended to offset those costs, has seen much uncertainty, driving up the costs for those with insurance and the state as a whole.

Transparency of the Cost of Health Care Services

There are a number of significant initiatives undertaken by the state and federal governments, the private sector and the Texas Hospital Association to increase transparency of the cost of health care services.

Protection from Surprise Medical Bills: Texas is a leader in health care price transparency. Unexpected health care costs are one of the most adverse effects of a lack of cost transparency and the State of Texas has taken robust steps to reduce incidents of high unexpected medical bills. Last session, THA supported Senate Bill 1264, 86th Texas Legislature, arguably the most comprehensive ban on surprise billing legislation in the country. The legislation was the product of much negotiation, which lead to a solution that both helps prevent surprise bills for consumers and strikes a fair balance between providers and insurers.

Federal Price Transparency Rules: In addition to largely eliminating surprise medical bills in Texas, hospitals are required under federal law to make public a list of their standard charges. Current federal law requires hospitals to publish their standard charges online. In addition, under a new federal rule, effective Jan. 1, 2021, hospitals are required to post their negotiated rates with commercial payors and Medicare Advantage plans. In addition, the rule requires hospitals to publish in a consumer-friendly format, 300 shoppable services, with information that displays a patient's expected out-of-pocket costs for nonurgent health care services that can be scheduled in advance.

Texas PricePoint: THA launched the Texas PricePoint website (www.txpricepoint.org/) in 2007 to meet a need in the state for consumer-friendly hospital charge information. PricePoint uses publicly available data submitted by hospitals to the Texas Department of State Health Services to provide, at THA's expense, basic demographic, quality and inpatient charge information on Texas hospitals and to encourage consumers to ask their insurance plan and/or hospital for additional information and resources. Most hospitals are required to report their inpatient and limited outpatient discharge information to the Texas Health Care Information Collection within DSHS. THA collects and reports this data for many of its member hospitals. The information submitted to the state includes billed charges, diagnosis codes, and procedure codes.

Cost Estimates: Senate Bill 1731, 80th Texas Legislature, requires health plans, providers and hospitals to provide cost estimates to individuals who are uninsured or who are seeking out-of-network care. Patients choosing elective, inpatient services or nonemergency outpatient surgery may request an estimate of charges and payments, due within 10 days. Extending the charge estimate to emergency care would violate state and federal law—EMTALA—that requires hospitals to provide emergency treatment and stabilization to anyone who needs it, regardless of ability to pay.

FAIR Health: FAIR Health, the result of a 2009 settlement with 12 health insurers in New York, is an independent repository of claims data provided by procedure code or by episode of care. Charges and reimbursement rates are provided on both an in-network and out-of-network basis. FAIR Health also provides cost estimates. FAIR Health organizes claims by a geographic area ("geozip"), usually based on the first three numbers of a zip code. FAIR Health groups charges into percentiles, from lowest to highest. For example, if a provider's price is in the 80th percentile for a certain service, 80%of the fees billed by other providers for the same service were that amount or lower.

The Need for Increased Network Adequacy: Adequate and accurate health benefit plan networks are paramount to preventing surprise medical bills from occurring in the first place and keeping the cost of health care down. Often, provider directories list providers as participating providers in a health benefit plan at the time a consumer selects the plan. However, after the consumer becomes an enrollee, but prior to the expiration of the enrollee's contract, the provider may become out of network. To ensure that consumers get the benefit of their bargain, if a provider is listed as "in-network" at the time a consumer selects a plan, but later becomes "out-of-network," THA recommends a legislative solution for the health benefit plan issuer to pay the provider's charges at the in-network rate and to limit the enrollees responsibility to in-network cost sharing. Some exceptions would be necessary to prevent inequity, such as exceptions for lapse in a provider's licensure and unilateral termination of a contract with a health benefit plan issuer by a provider.

Thank you for your consideration of these comments. We look forward to working with you on strategies to lower health care costs for all Texans.

Respectfully submitted,

Cameron Duncan
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Texas Hospital Association