Written Testimony in Support of HB 711
House Select Committee on Health Care Reform
March 23, 2023

Key Takeaways:

- HB 711 is the single most important thing the state can do to help empower employers to provide more affordable health care for their employees.
- Unhealthy markets have led to high prices, and employers need help in addressing the issue.
- HB 711 is a key part of a broader solution to make our health care markets healthy – informed, competitive, and engaged.

Background

Texas' healthcare markets are unhealthy, and are leading to high and rising health care prices, putting affordable care out of reach for more and more Texans each year. Over half of Texans *with insurance* have skipped or delayed care in the last year due to cost.[1]

In healthy markets, informed consumers are able to shop for care, comparing providers on both price and quality, and selecting them on the basis of their overall value. As medical providers compete for customers on these bases, basic economic theory tells us that prices will drop, and quality will improve. In order for Texas to achieve that vision, our markets need to be informed, competitive, and engaged.

Informed markets require customers to have access to information on both the price and quality of services. In Texas, we've made good progress on promoting price transparency – including large strides last session and in the interim thanks to the hard work of many members of this committee – but there are some improvements yet to be made.

Competitive markets require choices. When markets consolidate, they become less competitive. While many of Texas' markets have become so concentrated that there is little or no effective competition, many of Texas' largest markets still have some competition. Our efforts here need to focus on limiting further consolidation and concentration, and on mitigating the harmful impacts of what consolidation has already occurred.

Engaged markets require that both consumers and providers have the right incentives to act. For consumers, this means appropriate incentives to choose high-value care, and for providers, this means appropriate incentives to deliver high-value care. While each person

[1]https://www.episcopalhealth.org/wp-content/uploads/2022/05/Texas_Residents_Views_on_Health-Care-Access-Affordability-and-Health-Policy_2021_FINAL_FORMATTED_PUBLIC.pdf

will define value for themselves, as a general matter, value is a function of both price and quality.

HB 711 is a key part of our efforts to restore Healthy Markets to Texas' health care. It prohibits four specific anti-competitive contracting clauses that serve to limit both competition and engagement in our markets, preventing employers from taking advantage of the transparency revolution that is currently underway. To paraphrase Chairman Frank: Transparency, without more, just lets you know how badly you're getting [hosed]. HB 711 is the next step past transparency. While many of the problems with our health care industry can only be fixed through federal legislation, addressing anti-competitive behavior is the single most important thing the state can do to help Texas businesses lower the cost of health care for their employees.

Data & Research

Health Expenditures are High Because Prices are High

Employer sponsored insurance for a family costs, on average, over $20,000.[2] The economic literature is clear that the reason why we spend so much on health care is, in the words of seminal economist Uwe Reinhardt: "it's the prices, stupid."[3] The Health Care Cost Institute's annual reports[4] confirm this when they break down the relative impact of prices vs utilization on overall spending. Further research shows that the single biggest reason why prices are so high is market power.[5]

While prices in aggregate are high, there also exists a substantial amount of price variation. Price variation is when the same service is provided for a different price, sometimes within the same facility. In an infamous example reported in the New York Times, two friends who received a COVID-19 test on the same day at the same facility were charged amounts that varied by over $6,000.[6]

Two Friends in Texas Were Tested for Coronavirus. One Bill Was $199. The Other? $6,408.

There is Massive Price Variation in Texas Health Care Markets

Price variation also exists between facilities, and should, in theory, allow employers and insurers to design health benefit plans that encourage patients to go to facilities providing high quality care at lower prices. For example, Texas 2036' examination of hospital price transparency files shows that, among hospitals posting compliant files, the price of a Brain MRI in the Central Texas area can vary from a high price over $4600, to less than $500.[7]

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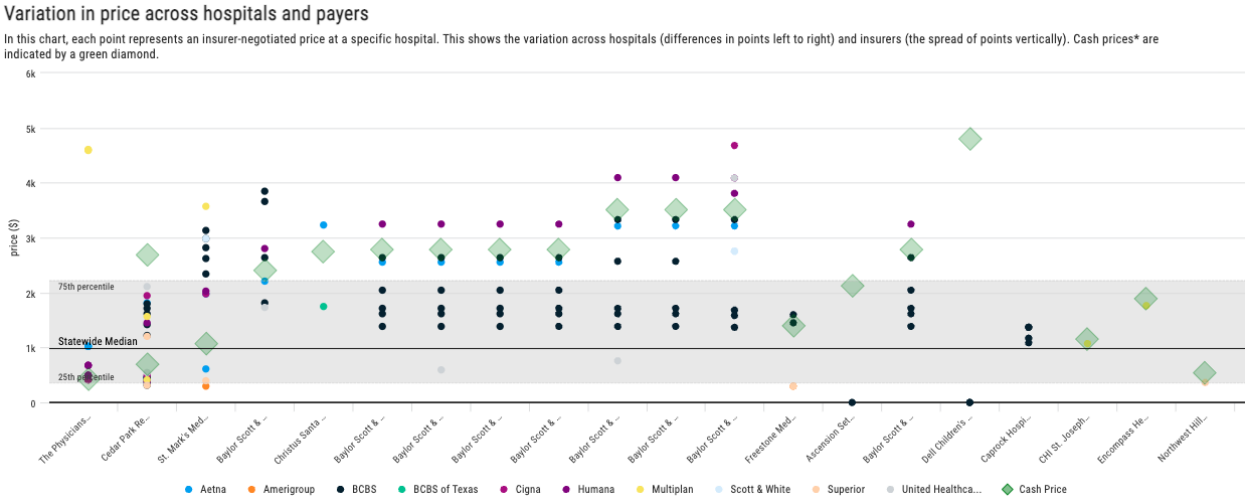
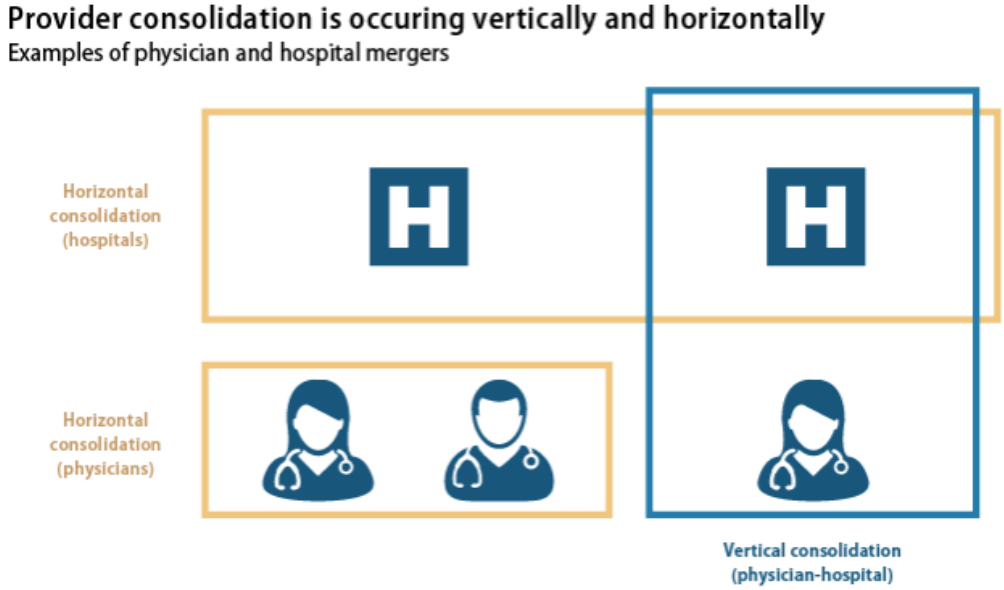
[2] https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/
[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144
[4] https://healthcostinstitute.org/images/pdfs/HCCI_2020_Health_Care_Cost_and_Utilization_Report.pdf
[5] https://isps.yale.edu/sites/default/files/publication/2015/12/cooper_2015_pricing_variation_manuscript_0.pdf
[6] https://www.nytimes.com/2020/06/29/upshot/coronavirus-tests-unpredictable-prices.html
[7] https://texas2036.org/health-price-transparency/



Texas 2036 analysis of publicly posted hospital price transparency files for a Brain MRI among hospitals in Public Health Region 7.

The Impacts of Horizontal and Vertical Consolidation

Why does such massive price variation occur, even when some market segments aren't fully concentrated? The graphic below illustrates examples of the two types of consolidation. Because consolidation occurs both horizontally and vertically, if any provider market segment becomes concentrated, the harmful effects of that concentration can spill over into other types of providers, even if those providers have not yet become concentrated themselves.

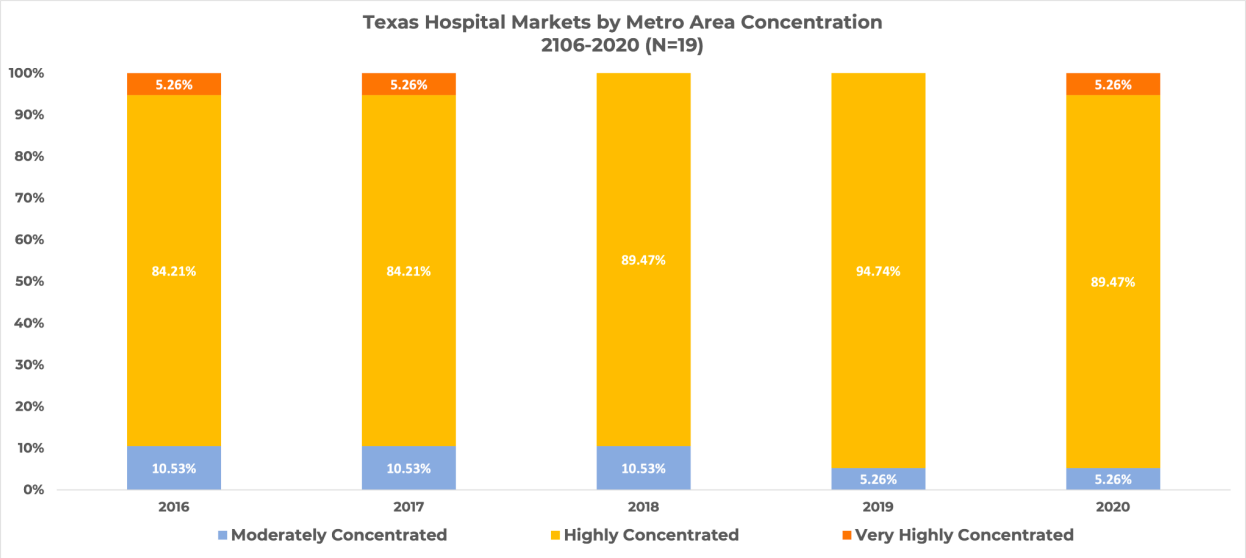


While this sounds confusing, perhaps an example can help illustrate the problem. Imagine a simple health care market that has three types of medical services: primary care, child birth, and surgery. The primary care and surgery markets are unconcentrated, but the child birth market is highly concentrated, with a dominant provider – let's call it Babies, Inc. To start, employers would be stuck paying whatever Babies, Inc. demands, but would be able to leverage competition in the primary care and surgery markets to keep prices low and quality

high. But now, imagine that Babies, Inc. acquires practices in the primary care (PCP, Inc.) and surgery (Surgery, Inc.) markets, raises their prices, and then tells employers that if they want their employees to continue to have access to Babies Inc, they will need to include the newly acquired, high-priced PCP, Inc. and Surgery, Inc. providers in their benefit plan. Not only that, but the employers won't be allowed to encourage their employees to go get primary and surgery services and providers with lower prices than PCP, Inc. and Surgery, Inc. Vertical consolidation – in combination with **anti-competitive contracting practices** – has now prevented our hypothetical markets for primary care and surgery (where there are choices) from being *engaged*, leading to higher prices even in market sectors that could be competitive.

Many Texas Markets are Already Highly Concentrated

While market concentration and consolidation are bad for markets, in many cases the genie is out of the bottle. By 2020, nearly 95% of Texas metro area hospital markets, for example, were "highly" or "very highly" concentrated according to a common market measure, with over 60% of our population living in at least a highly concentrated market area.[8]

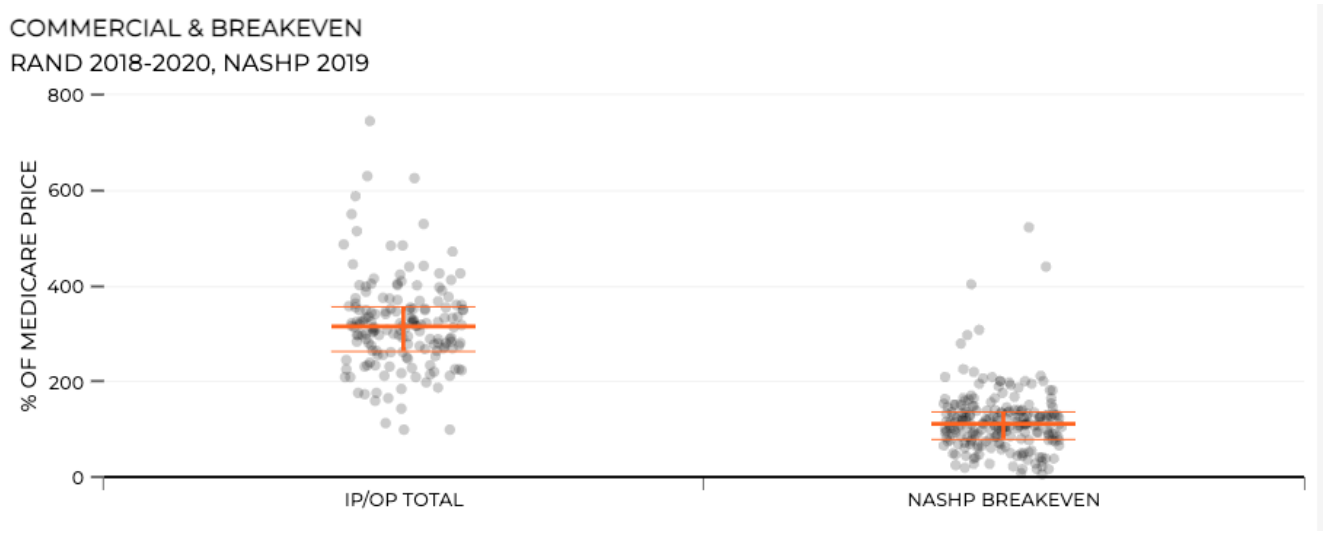


What Prices Employers Are Currently Paying

Recent studies and evaluations have given researchers and policymakers more insight into the prices employers are actually paying for medical services. And it isn't a pretty picture. Statewide, the median Texas hospital is receiving 315% of Medicare rates from commercial payers. 3/4th of Texas hospitals are receiving more than 264% of Medicare rates.[9]

These facts are reflected in the scatter plot below, and also include a comparison to the "NASHP Commercial Breakeven" point.

[8] https://texas2036.org/posts/concentration-competition-and-cost-how-are-the-hospital-markets-of-texas/
[9] https://texas2036.shinyapps.io/TEAHC/; https://tool.nashp.org



"Commercial breakeven" means the amount that each hospital would need to charge commercial payers as a % of Medicare to break even, taking into account all other sources of revenue and expenses, as the hospitals have reported using their own data. This isn't to suggest that the commercial rate should be the breakeven rate -- entities need to make a profit, have reserves, etc... The statewide median breakeven point is 110%, and 3/4 of hospitals have a breakeven point below 139%.[10]

What this means is that there is plenty of room for our Texas businesses to pay lower prices, while still allowing health systems to make a healthy profit. It confirms economic research that commercial prices largely reflect the extent of market concentration and market power, rather than amounts needed to help pay for uncompensated, undercompensated, and charity care.

Policy Recommendations

Given that many of our markets are already concentrated, we are left with the policy question of how to address that problem. Our recommendation is to first, stop the bleeding. HB 711 is a solution that will limit the harmful effects of already concentrated market segments from spilling over into market segments where competition can still exist.
To do so, HB 711 prohibits the following four types of clauses in contracts between medical providers and employers or insurers:

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[10] Appended to this testimony are summaries of our statewide markets, and local metro area markets in Austin, Corpus Christi, Dallas/Fort Worth, El Paso, Houston, and San Antonio. The data can be dense and confusing – I would be overjoyed to help walk anyone through an explanation of how to interpret these summaries.

1) Anti-Tiering – Removal of these clauses will empower employers to implement tiered network designs in their health benefit plans. In short, this means that employers would be able to do things like offer lower co-pays or cost-sharing requirements when employees use high-value providers.
2) Anti-Steering – Removal of these clauses will enable employers to incentivize their employees to use high-value providers through means other than tiered networks. Examples include offering free diapers for a year to employees that choose to deliver their child at a high-value hospital.
3) Gag – These clauses were recently made illegal under federal law, yet they may still persist in contracts. Removal of these clauses will enable decision makers at every level of health care purchasing to have access to more information to help them make an intelligent decision. For example, a pharmacist would be able to inform a customer that paying cash for a prescription may be much less expensive than their co-pay using their insurance card.
4) Most-Favored-Nation – Removal of these clauses will enable medical providers to offer care at prices lower than those negotiated with a market-dominant insurer. This can provide access to discounted rates for uninsured individuals and employers who wish to contract directly with the provider, as well as open up additional competition from other insurers in that market.

Importantly, HB 711 also imposes a fiduciary duty on insurance companies that would utilize Steering or Tiering mechanisms to do so only for the best interest of the patient. This crucial mechanism prevents insurers from engaging in self-dealing that would drive business to provider groups owned by or affiliated with the insurer when doing so would not be in the best interest of the patient. A fiduciary duty is among the strongest duties the law can impose.

Conclusion

HB 711 will not magically solve our unhealthy markets in Texas. But it will be a major step forward to empowering our businesses to get health care expenditures under control, allowing them the flexibility to provide their employees with greater access to affordable care, offer more competitive salaries in tight labor markets, and invest in further company growth. Our businesses have a duty to provide access to affordable, high quality health care for their employees. HB 711 will help enable them to fulfill that duty.

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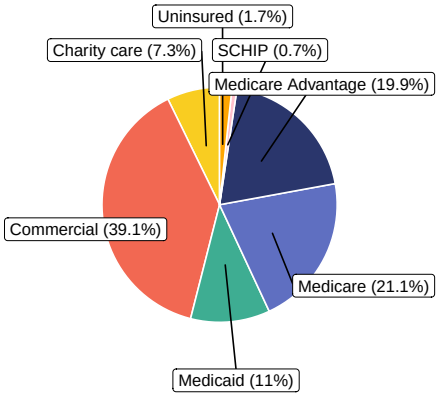
Area: All | Year: 2021 | Hospital Size: 0 − 1700 beds | Hospital System: All

Payer Mix

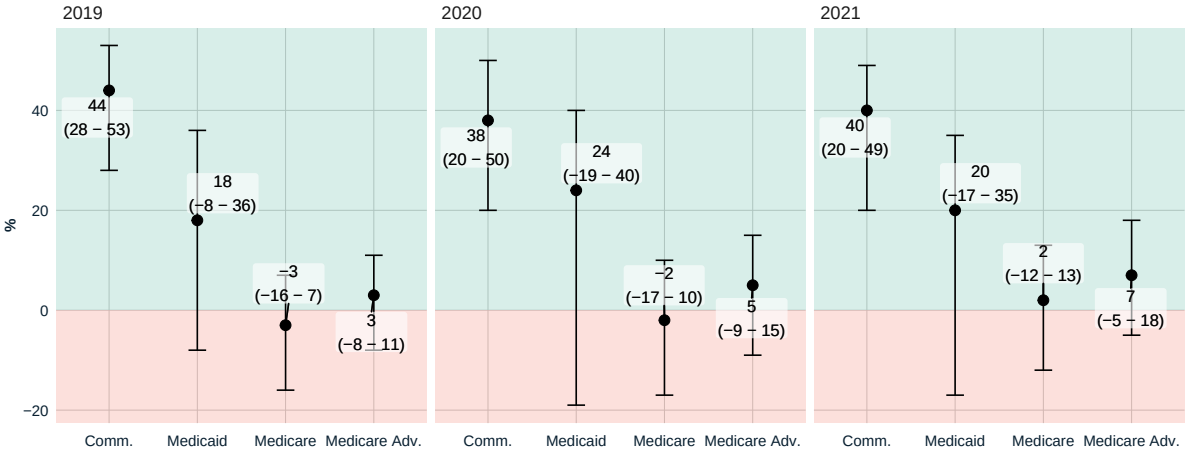
As a percentage of total charges

2021



Payer	2019	2020	2021
Charity care	7.9	8.4	7.3
Commercial	37.0	37.8	39.1
Medicaid	11.5	11.4	11.0
Medicare	25.0	23.4	21.1
Medicare Advantage	16.1	17.4	19.9
SCHIP	0.8	0.6	0.7
Uninsured	2.4	2.2	1.7

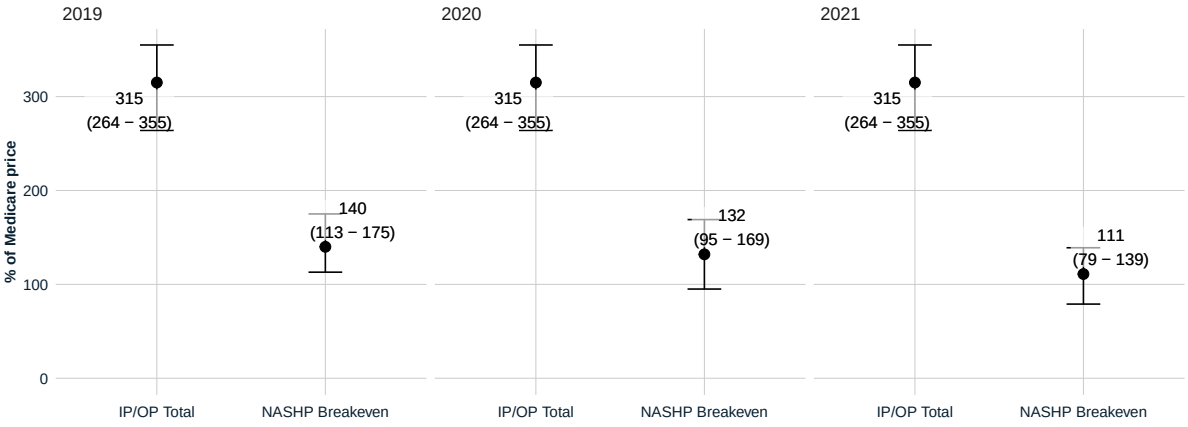
Operating Profit Margin



The point and the top number in the label represent the median value for the selected hospitals. The error bars and numbers in parentheses represent the interquartile range.

Commercial & Breakeven

RAND 2018−2020, NASHP 2019



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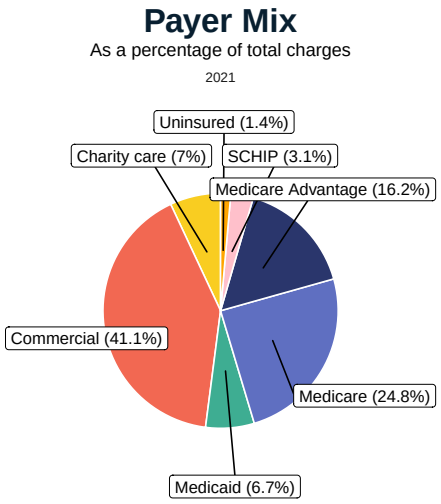
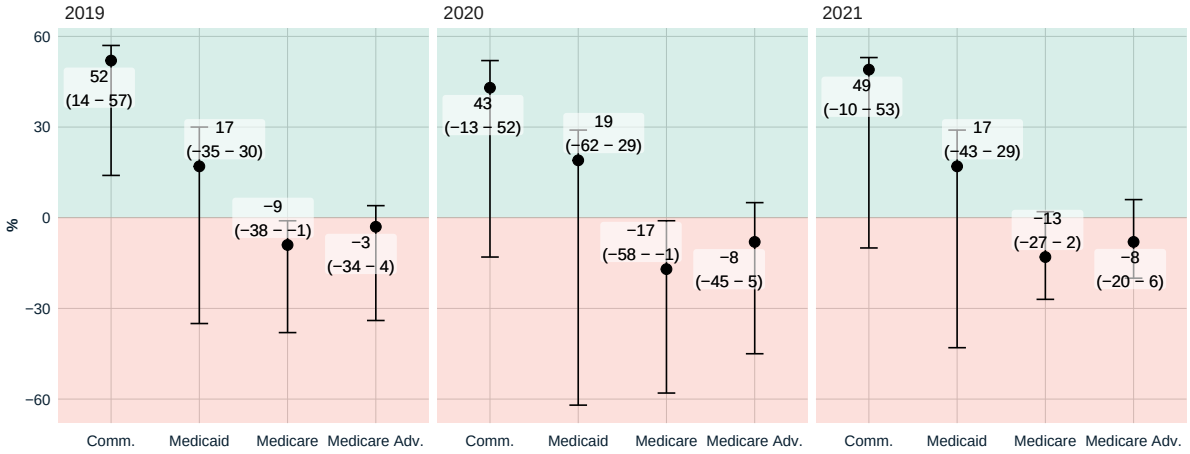
Area: Austin−Round Rock−Georgetown, TX | Year: 2021 | Hospital Size: 0 − beds | Hospital System: All



Payer	2019	2020	2021
Charity care	7.5	8.2	7.0
Commercial	41.1	40.7	41.1
Medicaid	6.3	6.9	6.7
Medicare	28.7	26.6	24.8
Medicare Advantage	12.6	14.5	16.2
SCHIP	2.4	2.2	3.1
Uninsured	1.7	1.3	1.4

Operating Profit Margin



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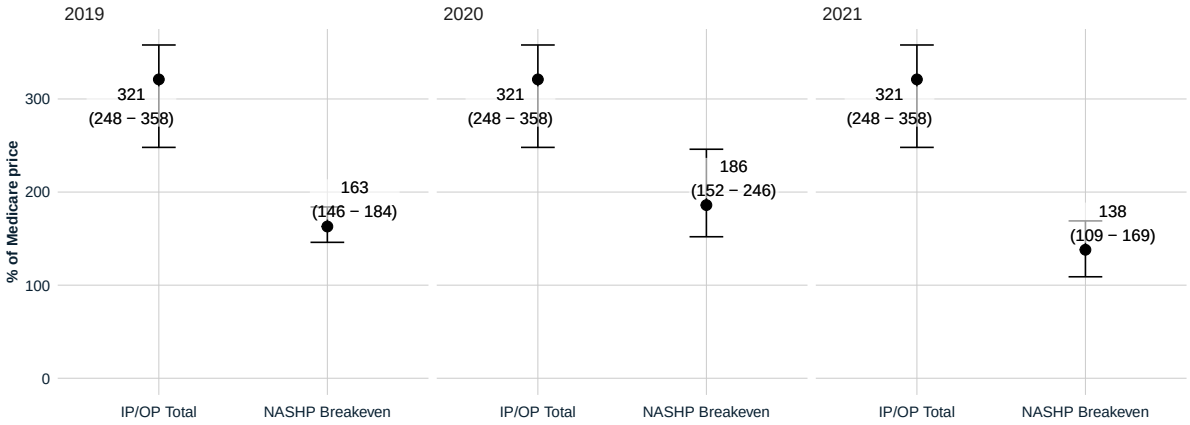
Commercial & Breakeven

RAND 2018−2020, NASHP 2019



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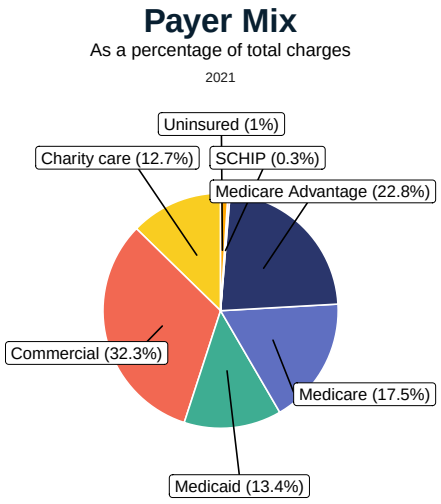
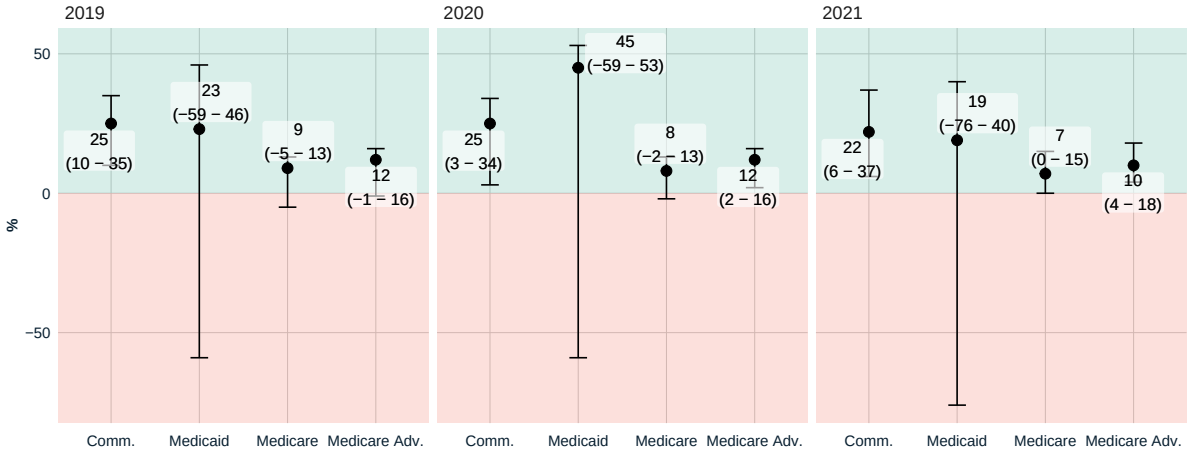
Area: Corpus Christi, TX | Year: 2021 | Hospital Size: 0 − 1700 beds | Hospital System: All



Payer	2019	2020	2021
Charity care	14.0	13.0	12.7
Commercial	29.8	31.6	32.3
Medicaid	13.6	13.1	13.4
Medicare	20.5	19.2	17.5
Medicare Advantage	20.4	21.1	22.8
SCHIP	0.3	0.4	0.3
Uninsured	1.8	1.6	1.0

Operating Profit Margin



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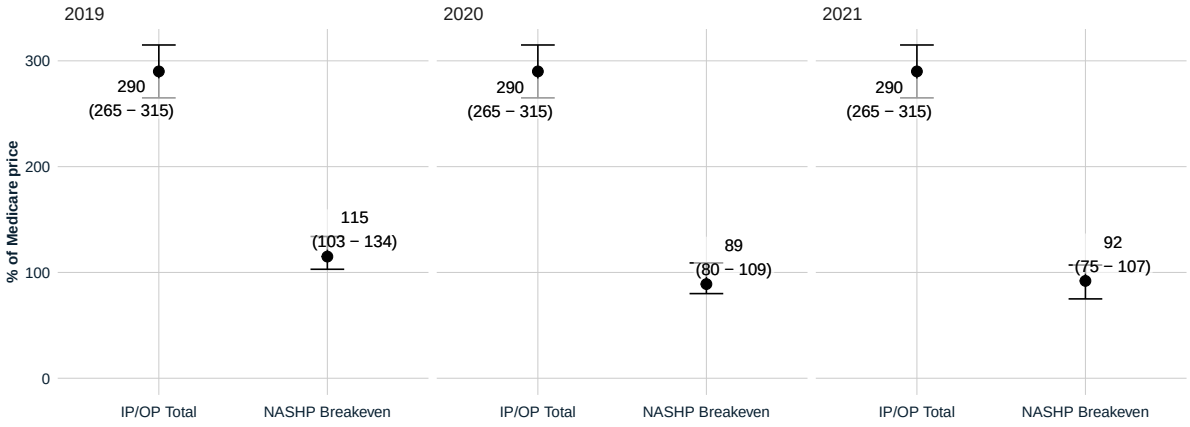
Commercial & Breakeven

RAND 2018−2020, NASHP 2019



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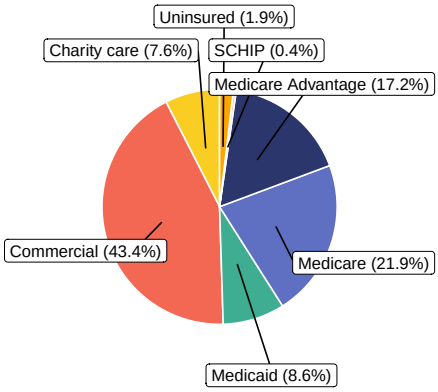
Area: Dallas−Fort Worth−Arlington, TX | Year: 2021 | Hospital Size: 0 − 1700 beds | Hospital System: All

Payer Mix

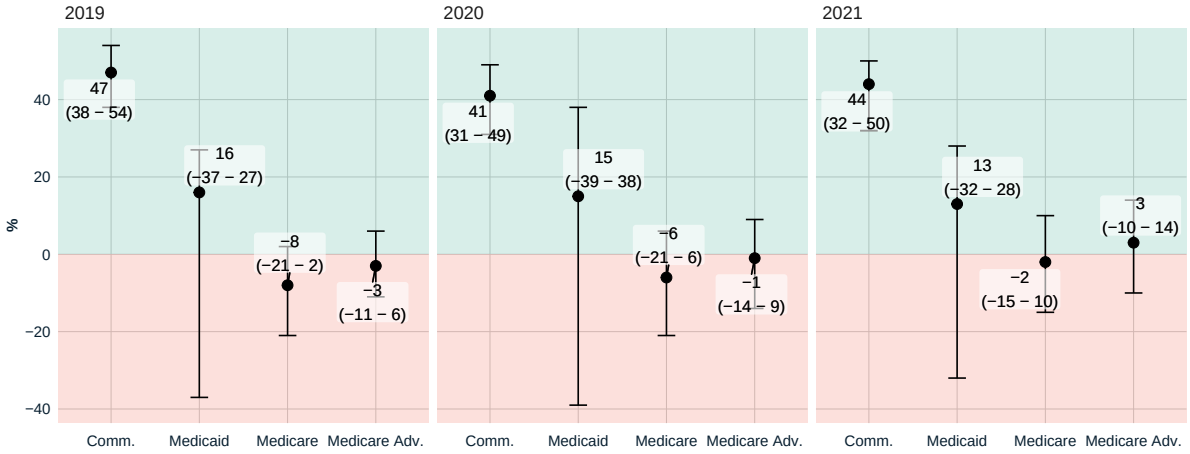
As a percentage of total charges

2021



Payer	2019	2020	2021
Charity care	7.9	8.6	7.6
Commercial	40.7	42.4	43.4
Medicaid	9.3	8.7	8.6
Medicare	25.6	24.1	21.9
Medicare Advantage	14.3	14.2	17.2
SCHIP	0.3	0.4	0.4
Uninsured	2.7	2.6	1.9

Operating Profit Margin



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Commercial & Breakeven

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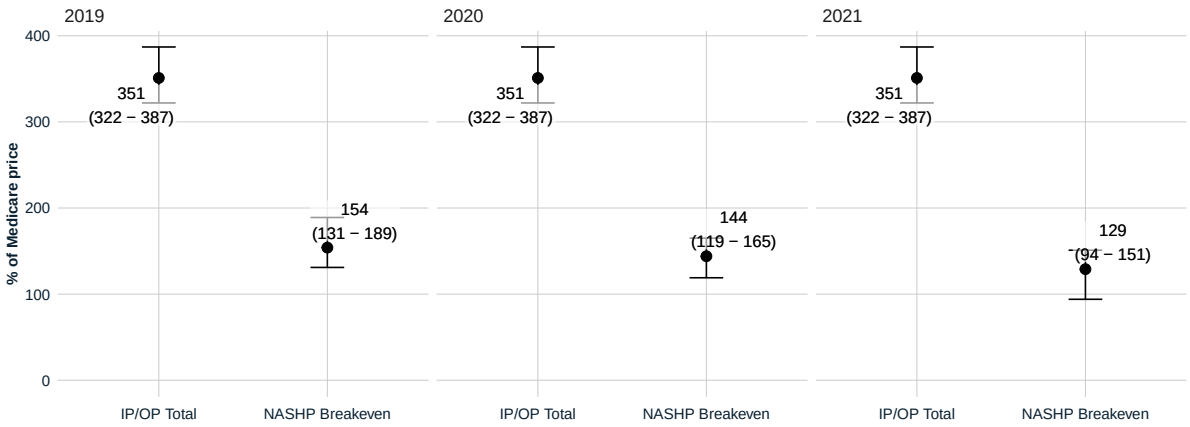

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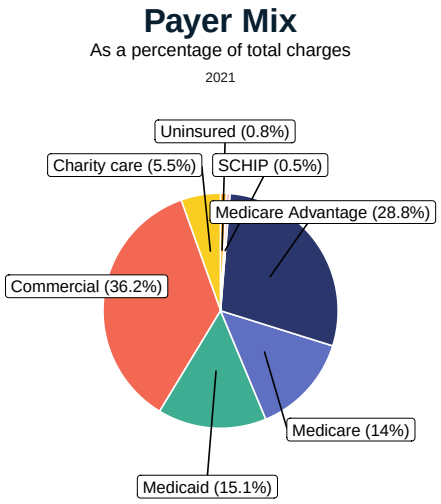
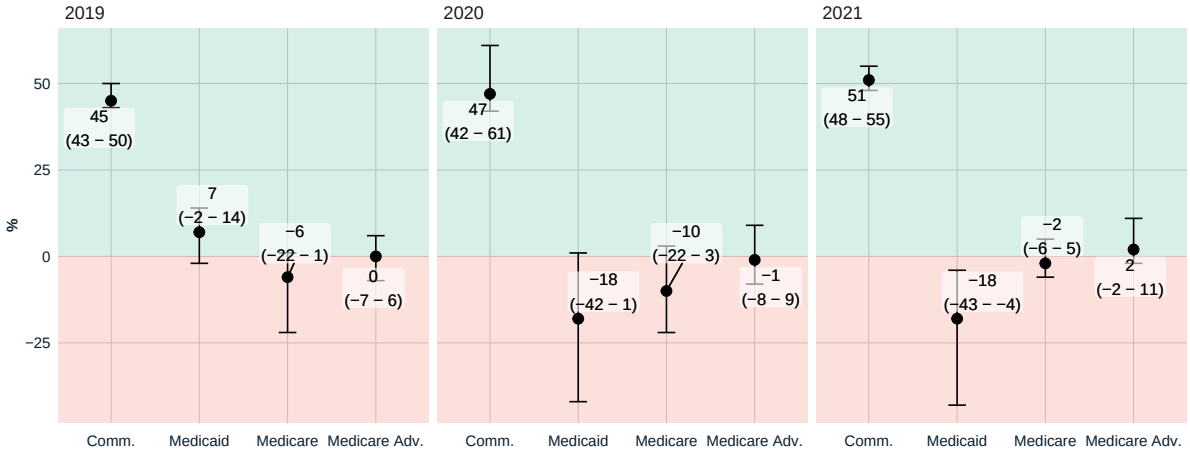
Area: El Paso, TX | Year: 2021 | Hospital Size: 0 − 1700 beds | Hospital Syste All



Payer	2019	2020	2021
Charity care	6.9	6.7	5.5
Commercial	34.3	35.2	36.2
Medicaid	16.3	15.6	15.1
Medicare	17.3	15.3	14.0
Medicare Advantage	24.3	26.7	28.8
SCHIP	0.5	0.5	0.5
Uninsured	1.4	1.2	0.8

Operating Profit Margin



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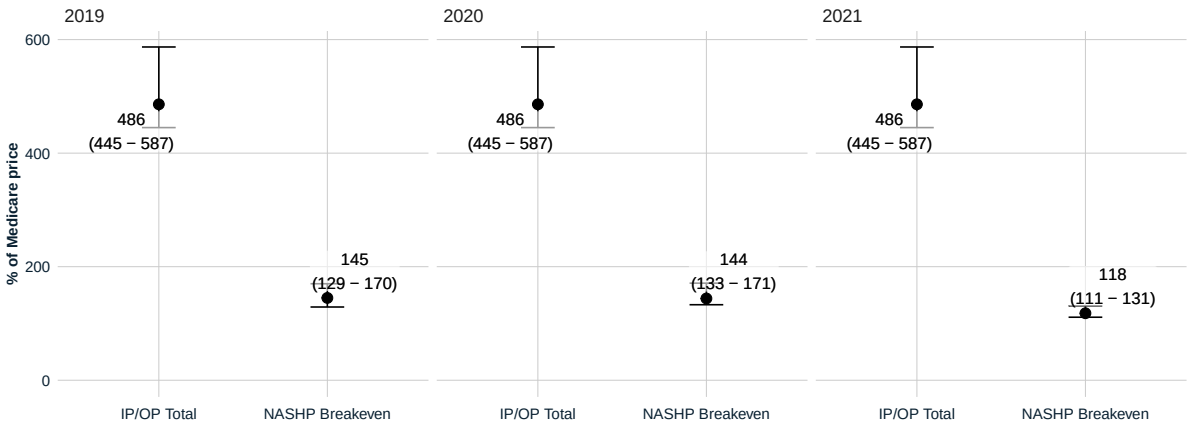
Commercial & Breakeven

RAND 2018−2020, NASHP 2019



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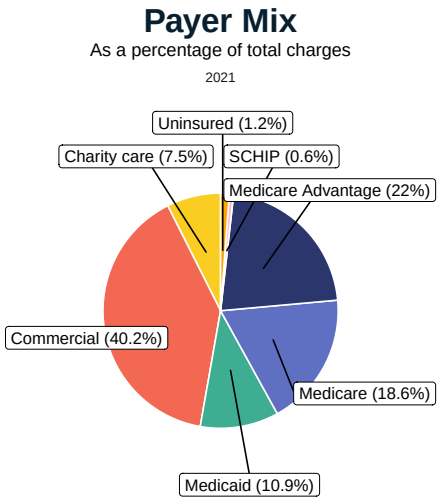
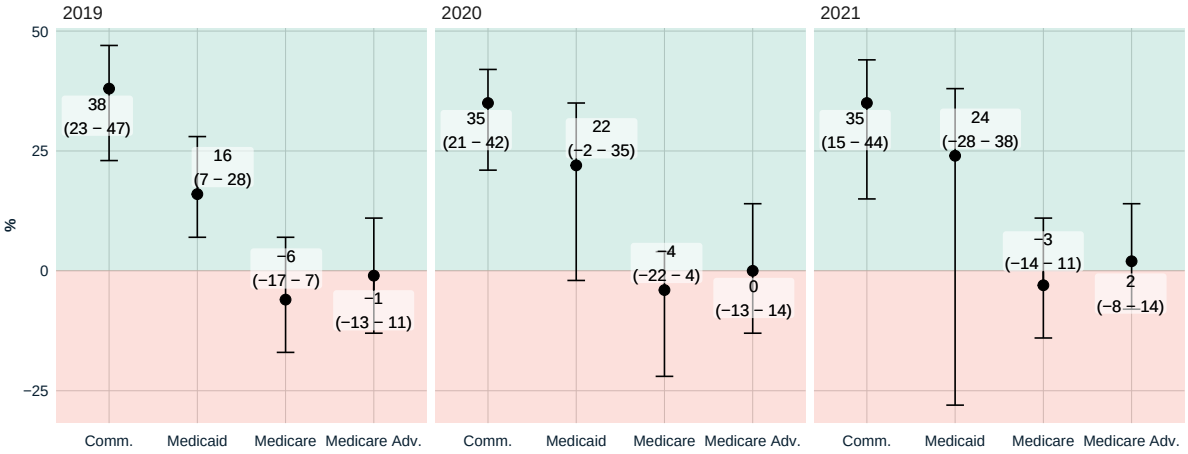
Area: Houston−The Woodlands−Sugar Land, TX | Year: 2021 | Hospital Size: 1700 beds | Hospital System: All



Payer	2019	2020	2021
Charity care	8.1	8.4	7.5
Commercial	38.7	38.5	40.2
Medicaid	11.1	11.2	10.9
Medicare	22.2	20.7	18.6
Medicare Advantage	18.2	19.9	22.0
SCHIP	0.6	0.6	0.6
Uninsured	1.6	1.5	1.2

Operating Profit Margin



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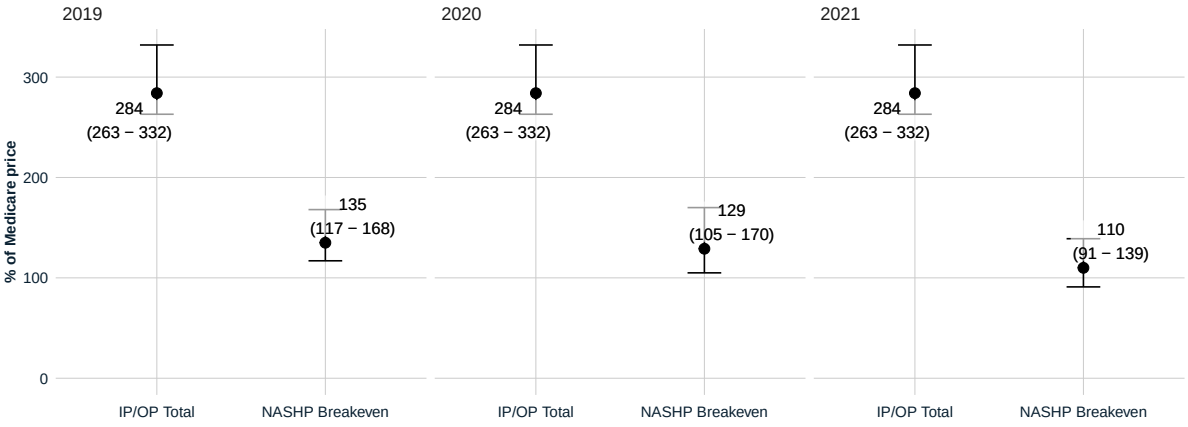

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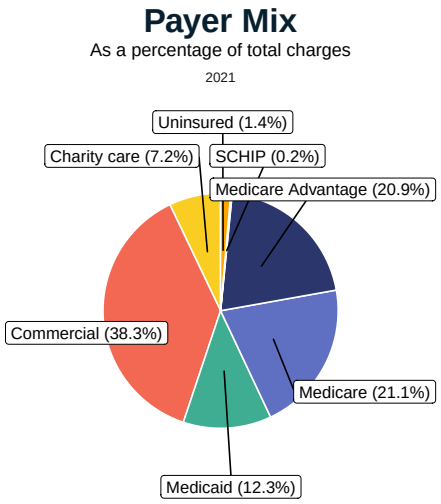
Area: San Antonio−New Braunfels, TX | Year: 2021 | Hospital Size: 0 − 1700 | Hospital System: All



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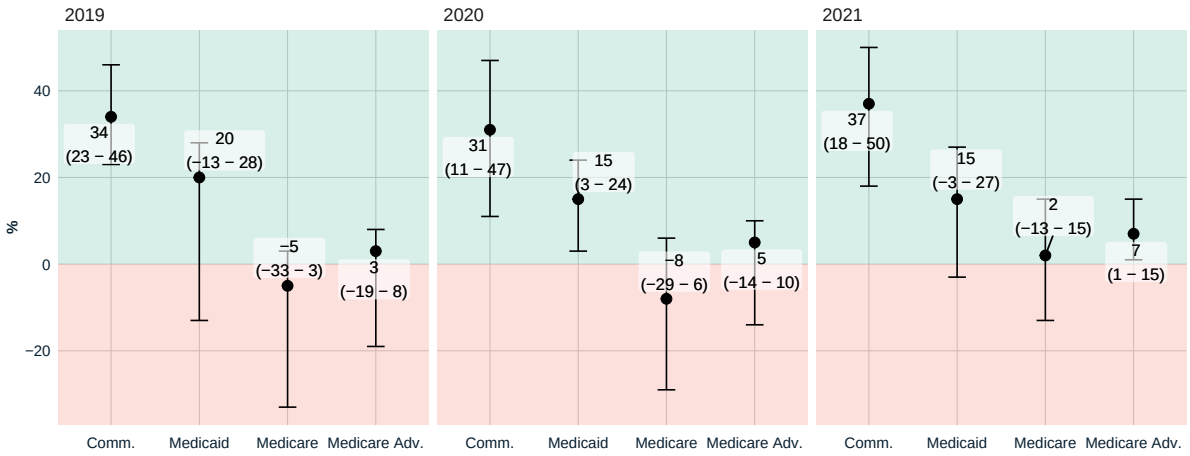
SCHIP	0.1	0.1	0.2
Uninsured	2.3	1.9	1.4

Operating Profit Margin



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Commercial & Breakeven

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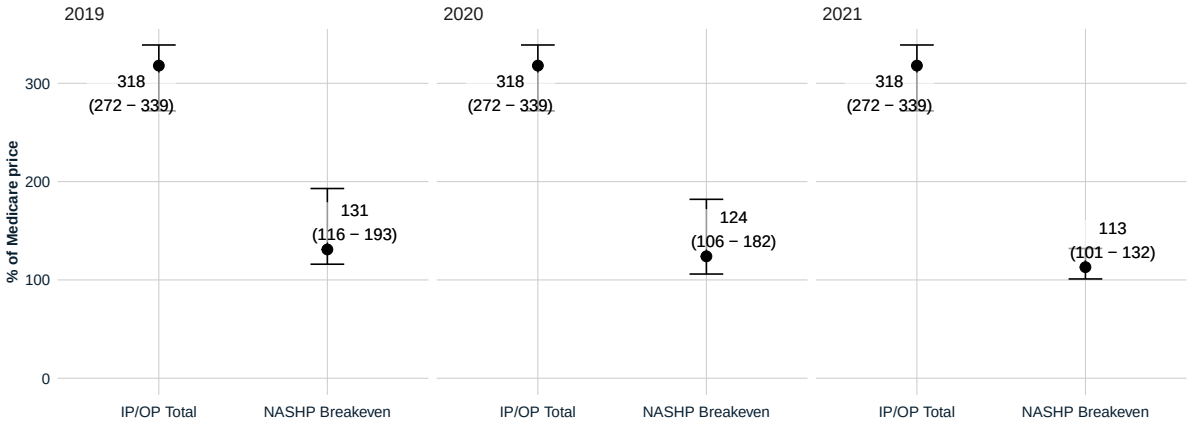

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