Summary provided by TELICON

H. SELECT COMMITTEE ON HEALTH CARE REFORM – DAY ONE

AUSTIN (8/4/22, E2.010, 10:05 AM)

The House Select Committee on Healthcare Reform met today under the direction of Chair Sam Harless.

(10:05) Chair Harless called the hearing to order. Roll called. Chair Harless made opening comments and reviewed protocols for providing oral and written testimony. Chair Harless said the committee's goal was to improve access and affordability of healthcare for all Texans.including the uninsured and the underinsured. Chair Harless said they all had a loved one struggling with a complex medical condition and they were committed not to placing blame but to finding solutions. Chair Harless said his office had met with industry experts and committee members throughout the spring and the testimony would reflect much of that input.noting there would be specific input from the House Insurance Committee and stakeholders which often testified before it.

Rep. Rose made opening comments, noting she had a paralyzed vocal chord which was making it difficult to speak. Rep. Rose said she felt the conversation was overdue and expressed the desire to have honest testimony on the issue. Rep. Rose said, "I don't want to come down here for a dog and pony show." Rep. Rose said they'd made progress on making healthcare more accessible, but there were still a lot of Texans lacking access.

Overview Healthcare Costs in Texas (10:13) Dr. Marty Makary, self, testified. Dr. Makary provided his background, noted he was the healthcare advisor for HEB and said, "In healthcare, everyone is getting risk with the exception of one group: the American worker." Dr. Makary noted that rural healthcare providers were also not being compensated at the same rate as their counterparts in urban and suburban areas. Dr. Makary listed several procedures which he felt were over-utilized.providing data on each including c-sections being used for more than 30% of low-risk pregnancies by 40% of OBGYNs in the country when the average should be below 25%. Dr. Makary said Medicaid paid one of the highest co-pays for crowns in pediatric patients despite other less invasive options being available. Dr. Makary said some dentists put crowns on all pediatric patient front teeth because they were more adequately reimbursed for the procedure than for others despite the fact that the teeth would be falling out anyhow. Dr. Makary said he felt transparency was an important tool and noted that there was an autocorrection when cancer block reporting was instituted. Dr. Makary said a national provider databank was an important tool-though many states made it difficult to access the data and/or made the data so deidentified that it was useless. Dr. Makary said most of the data they were trying to access was not HIPAA protected and should be accessible as government owned data. Dr. Makary said, "We could keep throwing good money after bad," suggesting that a good portion of the federal funding which went to healthcare was in administrative costs. Dr. Makary said healthcare accounted for over half of federal spending between SSI, Medicaid/Medicare co-pays

and individual department healthcare programs including the DOD and Veterans Administration. Dr. Makary said people had the right to be upset that they were paying significant premiums without receiving coverage.paying the full cost of a clinic or hospital visit. Dr. Makary said, "The game is called 'spread pricing' and it now dominates healthcare." Dr. Makary said he felt price gouging and predatory billing now dominated the healthcare system-though many hospitals followed the spirit of the ACA by providing healthcare which should be provided at a primary provider. Dr. Makary said, "If I sell you a used car, I'll give you a 99% discount if I get to set the price." Dr. Makary said similar things were occurring in the pharmaceutical market-noting the state may be paying for those spreads via the use of PBMs-suggesting there were 7 different methods PBMs used to increase prices citing insulin costs and rebates as another examples.

(10:28) Dr. Makary said the largest benefit to those seeking financial gain from the healthcare market was the lack of competition and transparency. Dr. Makary said proprietary contracting was the most often utilized method of doing so-citing the Sutter Health lawsuit and Texas statute that created a non -competitive rule which steered patients to less cost effective options. Dr. Makary said peer-to-peer review was not the fundamental problem-noting that many got "trench mentality" from looking for other parts of the system to blame for the excessive costs.

Rep. Guerra said he agreed.

Rep. Oliverson thanked Dr. Makary for traveling to the state. Rep. Oliverson agreed pricing failures were primarily problematic because consumers could not be reasonably expected to know the cost prior to billing-noting that the car example was a good one. Rep. Oliverson asked if transparency was "the magic bullet." Dr. Makary said it was not a silver bullet, but it would help. providing the Surgery Center of Oklahoma as an example of where price transparency was beneficial to patients. Dr. Makary said, "Hospitals are geniuses at cost-shift accounting," suggesting that they were not barely getting by as their financials indicated, they were not serving 3 times more uninsured patients as a university hospital, and they were often employing significant administrative and contracting departments. Dr. Makary said many doctors had simply accepted that the patient, if they were buying a car, was paying different entities for different parts of the car and may have a bill for one part show up a year later. Dr. Makary said price bundling would be beneficial to patients-using radiological services for cancer patients as an example. Rep. Oliverson said he understood most doctors now worked for a hospital system, health plan or other healthcare network and were restricted to in-network referrals-noting that some of the bundling recommendations may drive vertical integration and be counterproductive in controlling for costs. Rep. Oliverson asked if he felt that consolidation was driving some of the cost inefficiencies. Dr. Makary said he felt that monopoly pricing was a problem and one solution was to have direct primary care costs-especially when the primary care provider was responsible for downstream costs if their preventative care was lacking. Rep. Oliverson asked how they could make PQRS/ PQRI metrics more useable. Dr. Makary said the Johns Hopkins metrics for intercity hospitals showed c-section rates below 20% and felt that the measurement prevented overutilization when compared with other area providers. Rep. Oliverson said he was concerned that the metrics may also lead to denial of care and asked how providers could avoid getting punished by providing for the most at-risk populations. Rep. Oliverson said, "I don't want to see quality weaponized." Rep. Oliverson asked if they should eliminate pharmaceutical rebates-noting the Trump Administration had proposed designating any rebate which wasn't provided to patients as "kick-backs" and bar the practice. Dr. Makary said he felt that was only one of the 7 problems and passing such a provision on its own would result in an increase of the other 6. Dr. Makary said he did agree they needed to address it, but they also needed to address the other 6.

(10:43) Rep. Frank said Dr. Makary's book was .one of the best books ever. and that his focus on the over-utilization of c-sections often indicated the doctors felt they had the solution for insurance, insurers felt they had the solution for PBMs, and so on. Rep. Frank said he'd like to see each area be more accountable in what they personally could do. Dr. Makary said, "The 100% c-section doctors give me heartburn," and he felt that there were many avenues to address the issue. Dr. Makary said providing data transparency would be one major method of providing accountability-noting the state had the data on Medicaid utilization of the procedure and they had about half of the data available for private providers. Dr.

Makary described low-value care as " popping a pill for every malady in America" and noted he'd personally requested a medication for his heartburn until he found the rare adverse events data-noting that when he.d found out about the data, he'd asked his doctor for an alternative which had been lifestyle changes. Dr. Makary said, " COVID has been a tsunami of low-value care," suggesting that boosters for younger populations and vaccination for those recently infected were not necessary as well as utilization of Paxlovid in low-risk populations. Dr. Makary said, "Don't has the pharmaceutical industry about natural immunity as an alternative to a booster."

Rep. Walle said they'd recently considered model legislation for the all-payer claims database and asked if it would be helpful. Dr. Makary said it would be significantly helpful if there was data that was useable enough at the NPI level. Rep. Walle asked what "NPI" was. Dr. Makary said it was the national provider identification number which allowed the provider to compare their own data. Dr. Makary said they needed information that was identifiable enough to do profiling at which level the data would speak for itself. Rep. Walle asked if there was a state that could be used as an example. Dr. Makary said CA had a great system when it came to c-section utilization; NH, FL, and MN had decent databases; and, beyond that, some states collected adequate data, but it was not accessible. Rep. Walle asked if the data would allow for market adjustment. Dr. Makary said one of the problems TX faced was the use of PBMs for their Medicaid, ERS and TRS programs. Dr. Makary said some PBMs would charge a flat fee for each prescription, they may have significant markups and they should ask a doctor from OH for his information on spread pricing.

Rep. Rose asked if he had recommendations beyond what he.s provided to Rep. Guerra. Dr. Makary said there was a lot of group-think present during the pandemic-noting that many felt that schools should be open because of the low- risk to the youth and that they may have overestimated the effects of transmission to family members. Dr. Makary said he felt like school closures had left to a much larger mental health crisis and that the ban on visitation of dying family members should be considered "a human rights violation." Dr. Makary said he had never though Ivermectin would work as a treatment for COVID, but did not believe anyone should lose their license for prescribing it.

Rep. Capriglione asked for examples of what the problems were that other parts of the industry identified for parts they didn't function in. Dr. Makary provided examples and said that they all had solutions, but none were looking inward as to how they could improve care. Dr. Makary cited Vanderbilt and Children's Hospital of Pennsylvania as bad actors. Rep. Capriglione asked if he'd used "many" as opposed to "most" or "a plurality" because he felt that hospitals were the primary bad actors. Dr. Makary said he felt lax price control policies and transparency often increased prices at all providers. Rep. Capriglione said he'd recently taken his father for a knee replacement and described high cost facility amenities like marble floors. Rep. Capriglione said he was satisfied with the treatment, but he'd also seen a cockroach on the floor which he felt was a contributing factor to patients feeling they were paying a lot and getting less than they'd paid for.

(11:01) Rep. Capriglione said he was trying to figure out where the funding was going and how to address it-especially given the cost compared to other countries. Dr. Makary said he felt that they needed to have site neutral payments-noting it would help bring down the cost of Medicaid which was projected to .crush state budgets. in coming years. Dr. Makary said they should also consider barring low-value care from Medicaid as a primary form of healthcare and identify populations which were high utilizers. Rep. Capriglione said he'd been looking at their data which provided information on the number of patients which were on Medicaid and which were on private providers-noting that he felt that was data which should be available to the public.

Rep. Harrison and Dr. Makary discussed use of PQRI.

Rep. Bonnen asked how they could get consumers to be more sensitive to the market.in the same manner as they were when purchasing amenities. Rep. Bonnen discussed ERISA plan utilizers he treated from all over the US and suggested that until there was adequate price data they could not bring down costs. Rep. Bonnen suggested that vertical integration was a problem and said, "We're in the era of corporate medicine." Dr. Makary said there wasn't one stakeholder at fault, but

their research indicated providers felt 21% of healthcare provided was not necessary. Dr. Makary said he felt that represented a large opportunity as did healthcare blue book which provided information to patients on quality data that helped them choose providers with easy to understand information based on a number of metrics including "price toxicity." Rep. Bonnen said, "I'm not sure what the direct answer was in all of that." Rep. Bonnen said he felt leverage on pricing was what they needed-that they should be able to expect health insurance providers to want better access to preventative care and more quality life outcomes; but, as a practitioner, he felt they were not. Rep. Bonnen said he felt that many providers were leaving practice because they were being required to provide care at ¼-1/3 the price it actually cost and the insurers were "hiding behind ERISA." Rep. Bonnen said he felt employers often complained about premium cost for the plans for their employees, but he didn't feel they wanted to do anything about it.

(11:18) Dr. Makary said theft could have "thousands of hours" on the discussion-noting that Rep. Bonnen as a neurosurgeon would be able to have adequate input-but they should focus on what could be done from a state policy perspective. Rep. Bonnen said Texas had already codified the proposed rules put forward by the Trump Administration.noting the Biden Administration supported the same rules which was one rare example of agreement between the two. Rep. Bonnen said they were now at the point of how to drive compliance with the statutes they.d passed without driving people out of the industry. Dr. Makary recommended they eliminate facilities fees.

Dr. Crown, self, testified. Dr. Crown provided his background. Dr. Crown said they were paying $11 thousand per year per person on healthcare whereas Canadians spent $7,500-noting that average lifespan was 1-3 years shorter in the US, fewer people had access to primary and preventative care, child and maternal mortality was higher, and quality of life metrics were below that of their northern neighbors-metrics which held true when comparing to EU countries and the UK. Dr. Crown said lack of access to preventative care often led people to contracting chronic conditions which would result in loss of employment and becoming one of the 5 million uninsured Texans, adding, "If that doesn't keep you up at night, I don't know what will." Dr. Crown said healthcare was currently tied to economic performance, but wage stagnation was also an issue. Dr. Crown said as employers, wages may be stagnant when adjusted for inflation, but benefits per employee was going up which was eating up an employer's ability to provide raises to direct compensation. Dr. Crown said insurance companies had been trying to lower costs including the phasing-out of fee-for-service as well as emphasis on preventative care. Dr. Crown said they now had technology which would assist in allowing price- transparency to actually provide for a market correction once all the systems were online. Dr. Crown discussed the matter further.

(11:36) Dr. Crown cited an example of a university system with significantly lower costs at its centers and said that, while market disruption was painful, it was often a necessity. Dr. Crown said he was concerned about consolidation which could be seen as dystopian. Dr. Crown said price transparency with useable data that was accessible would provide the highest value care to the most providers.

Rep. Frank said he felt that competition was vital to bringing down costs. Dr. Crown said he was hopeful about competition, but that there was a lot of literature indicating it had not worked as intended. Dr. Crown said he was still hopeful that it could bring down costs.noting that NYC had many low-cost, high-quality options. Rep. Frank said he felt that price transparency had not been allowed to work-there was not enough competitive pricing to allow for it to work.

Rep. Guerra said he benefited from having access to an ERS health plan, but he 'd heard the most complaints from his surgeons and primary care providers that managed care was the largest contributors to cost-noting that the MCOs often required a person to receive a hosts of test results from their PCP before duplicating those tests by a surgeon after referral. Rep. Guerra said it was his impression, "Managed care has been a nightmare." Rep. Guerra said there was supposed to be coordination, but it appeared the coordination was not occurring and that it was only driving up costs. Dr. Crown said there always needed to be oversight for healthcare, but it was his impression that managed care had not provided savings, adding, "Your points are extremely well taken." Rep. Guerra said they needed to re-examine whether they should use managed care. Dr. Crown said they had looked at the industry-noting that c-section, spine surgery and

cardiovascular device implantation rates were 3 times that of Canada. Dr. Crown said he also did not believe jettisoning managed care was an option because they would then be in the position of "whatever number is okay." Rep. Guerra said he felt there was no discussions between the PCPs, specialists and MCOs to look at rates or costs. Dr. Crown said he felt the same way, but he also understood the next generation of MCOs may improve, adding, "I know that.s kind of a unicorn."

Rep. Oliverson said they'd passed price transparency measures through the No Surprises Act, transparency in hospital billing and transparency in primary care billing had already been passed-noting the state's act extended to radiology and other medical imaging costs. Rep. Oliverson cited other legislation passed at the state level. Dr. Crown discussed grant funding and noted the ability for him to purchase things on his phone. Dr. Crown said they could use an app to find car information when purchasing a car.

(11:52) Rep. Oliverson said, "One of the things I live about coming to university towns like Austin is that I can imagine one of the kids walking around will build the next Google." Rep. Oliverson said he could imagine a student building an app for healthcare in their dorm room and, while an app couldn't fix everything, it would help. Dr. Crown said they needed to look at fiduciary responsibility and medical privacy as components because, while price transparency was important, they also needed to maintain personal privacy at the same level-noting that they may not get a commensurate amount of price transparency for the medical privacy given up. Rep. Oliverson said he was "perplexed" when it came to the ability to purchase any other service with cost comparisons available, but not healthcare.

Rep. Bucy said Dr. Crown.s picture was fairly bleak with 12% of Americans lacking healthcare either out of the choice not to purchase it or the inability to access quality care. Rep. Bucy asked what effect on pricing the 5 million uninsured Texans had. Dr. Crown said there was cost shifting.charging those with insurance more so they could afford to provide care for the 18% of their patients who were uninsured. Dr. Crown said cost shifting worked if everyone did their fair share.if all hospitals were seeing a similar amount of uninsured patients and cost shifting with similar models. Dr. Crown said that was not the case.sometimes because of geography which the providers couldn't do anything about and sometimes because uninsured patients were dissuaded by some providers and other hospitals were welcoming to the same patients. Dr. Crown said it only took one hospital avoiding the cost of uninsured patients to disrupt the market for all other providers in a service area. Dr. Crown said, "It's not great to be uninsured," citing the comparison with Canada. Rep. Bucy asked if higher costs were associated with the large number of uninsured people. Dr. Crown said they often needed to look at how people became uninsured which researchers showed was a combination of bad luck, geography, income and ability to access employer provided care. Rep. Bucy asked what the solutions were. Dr. Crown described how the Canadian healthcare system worked.noting it wasn't high level care, but it was accessible preventative care as an option.

Rep. Harrison said he understood that Dr. Crown was skeptical of the role of competition, but Medicare Part D and MA plans showed competition worked. Dr. Crown said he was still cheering on the potential for competition to lower prices and price transparency was key to doing so-but it was .getting lonelier and lonelier. to be a doctor who didn't favor single payer.

Rep. Bonnen said they needed to consider whether it wasn't working or whether they had not actually brought it about.

(12:07) Dr. Crown said he agreed that they hadn't adequately brought it about because they had not provided transparency. Dr. Crown said they'd been wondering whether it could work and how that would work.suggesting, "The Texas experiment could work." Rep. Bonnen asked of MCOs, "Is the dog wagging the tail or is the tail wagging the dog." Rep. Bonnen suggested that employers were fearful of compliance when it came to choosing a managed care option. Dr. Crown said it didn't appear to be a system that was working for employers or patients. Rep. Bonnen asked how they could make it work-including diversifying the market. Dr. Crown said he believed other witnesses could better speak to that.

Chair Harless asked members to be expeditious because they had people waiting to provide oral testimony.

Rep. Harrison said he felt that whether a person liked or did not like Medicare Part D, it was an efficient way to provide the care in the US market.

Price Transparency Compliance (12:15) Chris Severn, CEO - Turquoise Health, testified. Mr. Severn shared his screen with the members and said now that there was an incentive for entrepreneurs to enter into the market and provided information on the emergence of the company which was enabled by the new legislation on transparency. Mr. Severn asserted the lack of price control which could be provided by competition was hindered by the lack of transparency on negotiated rates. Mr. Severn said the three laws cited by Rep. Oliverson provided large opportunities for price transparency which allowed a company like his to allow for patients and employers-especially entrepreneurial employers-to better navigate the industry. Mr. Severn said his company was .fairly obsessed. with hospital price transparency menus (which included negotiated rates) despite the disappointing number of complying providers in the first month, but the picture was rosier after 18 months with 4,500 hospitals of 6 thousand providing useable data. Mr. Severn said several "hold out health systems" had "come around" in the past few months. Mr. Severn said the other data source they were excited to have was the negotiated prices coming from insurance companies which went well beyond hospital data-including ASCs, PCPs, tele- healthcare providers, etc. Mr. Severn provided examples of how having price transparency from multiple provider types would allow patients to receive specialist consultation from doctors who provided care in multiple settings at the most financially advantageous time to do so. Mr. Severn said a lot of people didn't have the ability to price compare because the data was difficult for lay people to use, but engineers like himself and his employees could do that foundational work to make the data useable. Mr. Severn provided information on how the company culled and translated the data into a useable format. Mr. Severn noted the cost of the engineering expertise to create the app and required the attraction of venture capital to ensure they could provide the resulting product at an affordable price to any user.

(12:30) Mr. Severn discussed compliance and usability. Mr. Severn asserted that if there were no barriers to entry into the healthcare market and all the data was available, then prices would come down-noting it may take some education of individual purchasers and employers who provided healthcare coverage to their employees. Mr. Severn said it appeared that the price equity was based most off the ability to employ a good negotiation team rather than quality of care provided. Mr. Severn said of the information available to employers, "We've taken this massive data set and made it more like Google," using the price of a colonoscopy in TX as an example which would allow employers to determine whether a plan was providing a service for the purchase price. Mr. Severn discussed factors which made purchasing healthcare was "not like purchasing off a menu at a restaurant."

Rep. Oliverson said, "You warm my heart a little bit," as he felt that the advent of Turquoise was what they expected to occur when they passed the legislation. Rep. Oliverson asked what they could do to standardize the data and make it more easily accessible. Mr. Severn said he'd been involved on a federal panel on the issue of standardizing the files of data and it was ongoing-he felt from his last interaction that they had a good draft standard, adding, "I don't know what happens next." Rep. Oliverson said he agreed they should wait for the draft from the federal government to come out to avoid creating a duplicate workload on another standardized form for the state.

(12:46) Marilyn Bartlett, Senior Policy Fellow - NASHP, testified. Ms. Bartlett said she'd provide information on reference based pricing in MT which she'd assisted in providing to the state health plan which was so costly that controlling the cost was a contingency for being able to provide raises to state employees. Ms. Bartlett said the data she was providing was from 2015 and 2016 which showed that Medicare was fairly constant compared to other health plans. Ms. Bartlett said she always looked at cost-plus which included ancillary costs like room stay.noting that they always saw a discount off the charge master, but also for all other private plans. Ms. Bartlett said they'd decided to use price referencing with their reference price being Medicare given how much data was used, how large it was and how constant their pricing was. Ms. Bartlett said they did have to follow provisions prohibiting balanced billing and steerage which meant it would cost a bit

more, but it would make things more accessible and control for overall costs. Ms. Bartlett said she did have to work through a third party for contracting under the state's statute-noting that of their 9 responses from their RFP, no large health plans had applied. Ms. Bartlett discussed the data they were requesting and said they found only 13% of their spend was with critical access hospitals which had surprised them. Ms. Bartlett said they'd created blended contract rates for in-patient/out-patient stay and even calculated what it would take for each hospital to at least break even and found current rates significantly above that necessary. Ms. Bartlett said they found that doctors were being undercompensated and found that they would have more control over future trends if they were able to reimburse doctors at 165% of Medicare rates. Ms. Bartlett said reference based pricing had resulted in many providers offering new options, but her calculations still showed more savings under reference pricing which allowed them to pay for other things-noting she'd gained the support of MFPE. Ms. Bartlett said all employees had been able to access expanded care coverage while also receiving raises.providing specific programs enabled by the program.

(1:01) Ms. Bartlett noted an independent actuary had found that over the 3 years of implementation, they'd been able to save the state $49.6 million. Ms. Bartlett said the savings had been much larger than the use of health plan costs which allowed them to have the revenue to combat wildfires in 2017-2018 as well as premium holidays. Ms. Bartlett said in 2021 they'd been able to recapture $27 million and provide another premium holiday given that they were over reserves. Ms. Bartlett said there was no spread pricing and rebates were prohibited from going to PBMs. Ms. Bartlett said they were able to improve their health centers and create Healthcare Blue Book to allow for employees to appeal preclearance determinations adequately as well as retaining their data so they didn't have to rely on others for their data. Ms. Bartlett said they were using Excel and were able to work with Rice University to assist in creating a similar data sharing form for national hospitals. Ms. Bartlett provided additional information on data collection and analysis which indicated that Texas hospitals could break even should they charge 135% of the Medicare negotiated rate-the national average was 127%.

Rep. Harrison said he felt that reference pricing had great potential and asked what feedback they had and what hurdles they had. Ms. Bartlett provided information on stakeholder groups she'd approached which began with the Montana Association of Healthcare Purchasers where she got significant pushback from contractors who purchased care for larger employers, health plans and risk-averse employers, but the results had been convincing and the model had been used by the counties to combat similar opposition.

Rep. Bonnen said the state was larger in population with more providers and state employees.asking what the primary barriers were to scaling the option. Ms. Bartlett said she would start by taking the claims and putting them through Medicare Repricer and then compare it to what a hospital needed to charge to break even to start discussions on agreeable data.noting that none of the private entities would do that work. Ms. Bartlett said they then worked with hospitals which were providing below the curve pricing with high quality ratings in Billings, Helena and Missoula as the first entities they partnered with. Ms. Bartlett said they'd also gotten the governor.s budget director, finance committee leadership at the state legislature and state employees union on board.

(1:19) Ms. Bartlett said she believed the state would be surprised at who would come to the table if they had that data on their side-offering her assistance in developing a strategy. Rep. Bonnen said it had been his experience that if the offered the option, other plans and purchasers would follow suit.

Rep. Frank asked how they got employee buy-in. Ms. Bartlett said part of the bill was that they could not get raises without health plan costs being contained. Rep. Frank said he felt they should be able to give members a raise when they were able to spend state money more efficiently.

Chair Harless noted that they needed to move to another panel due to travel plans.

Efficacy of Texas Medicaid and Healthcare Insurance Excessive Healthcare Costs (1:26) A rheumatoid specialist testified virtually regarding pharmaceutical costs.

(1:51) Antonio Ciaccia, President - 3 Axis Advisors/CEO - 46 Brooklyn Research, testified. Mr. Ciaccia provided information on his background. Mr. Ciaccia said, "PBMs and pharmacists are very much Hatfields and McCoys," providing examples. Mr. Ciaccia said they'd used CMS data which allowed them to access averages for obtaining pharmacies and formulary information from Medicaid programs in a similar manner as Turquoise did. Mr. Ciaccia said they found that costs to the state compared to cost of the medication had a large gap and data from other states showed similar trends-though there were also major differences in average prices between states. Mr. Ciaccia said they'd compiled all the data similar to what Turquoise had done and made it available for free to everyone through 46Brooklyn.com and then launched 3 Access Advisors to consult for state health plans and Medicaid programs. Mr. Ciaccia discussed how vertical integration was driving prices up and said that while there were many players in the field, the largest players were publicly traded and therefore had a fiduciary duty to their shareholders compared to states which had a fiduciary duty to their taxpayers. Mr. Ciaccia said the reason PBMs came about was because of how obscure the price of a medication was at any point in the process and control for costs; but overtime they developed business interests to allow for higher drug prices.describing it as the archetypal firefighter who was also an arsonist. Mr. Ciaccia provided information on how list prices were set.noting that they were not set to be competitive.

(2:07) Mr. Chahca described list prices as "fake prices" and provided information on how list price was adjusted by multiple adders.

Rep. Frank asked what the incentive was for pharmaceutical companies to not lower their prices. Mr. Ciaccia said PBMs and insurers had more leverage the larger they were and they often looked at the size of discount they could get rather than the net cost they could get. Mr. Ciaccia said there were often three categories of pharmacies: one group which was well under reimbursement and struggling, ones which had a decent amount and used higher charges on certain medications to fill the 10% which was not covered by reimbursements, and those which were putting high increases on all pharmaceuticals to allow for a discount to be provided later (noting the two prices on GoodRX.com for certain entities). Rep. Frank asked why the industry is so different from all others. Mr. Ciaccia said the consumer was essentially cut out of the negotiation because they didn't have any leverage. Mr. Ciaccia provided information on the various points in the supply chain which allowed for various entities within that supply chain which allowed for advantage to be taken.noting that they found in one year a $200 million difference in pricing on what the state was being charged and what they were paying PBMs which indicated that they were pocketing the profits. Mr. Ciaccia said it was his understanding that Texas had outlawed the practice-Ohio had instead fired all those who were price gouging and used existing waste, fraud and abuse statute to prosecute at least one entity. Mr. Ciaccia said "spread pricing" was a general practice of buying low, selling high and pocketing the difference. Mr. Ciaccia said for Medicaid, that messed with the data MCOs were required to provide the state and pharmacies had indicated that outlawing the practice had been "a miracle." Mr. Ciaccia said they then saw PBMs overpay the pharmacies and claw back overpayments to pad how much they were receiving.

(2:24) Rep. Oliverson said they were coming back to the issue of whether to have a state formulary or allow MCOs to set their own in the coming legislative session. Rep. Oliverson asked if the phenomenon was specific to managed care. Mr. Ciaccia said there were risks to all models and the difference would be with able degrees. of transparency to adequately audit the cost, and look at what hands on the plans decided to be when it came to prescription drug pricing as well as what guardrails the state statute provided. Rep. Oliverson asked how accountability could be enforced. Mr. Ciaccia said they should staff up the agency providing oversight. Rep. Oliverson asked what was different in OH than in TX. Mr. Ciaccia said OH was in transition to "clean up the aggregate mess" which included moving to a single formulary, firing all the PBMs, and now having one PBM to handle all the pharmaceuticals. Rep. Oliverson said the agency would likely say they were understaffed and undercompensated already and asked how big the agency should be to oversee the program. Mr. Ciaccia said it was not realistic to expect a few pharmacists and accountants to be able to control the behavior of

Fortune 50 companies. Mr. Ciaccia said, "I have learned that 'distrust and verify' is the best method of action in this space." Mr. Ciaccia said they had actually hired two companies.a new entrant PBM rather than a legacy company and an actuary that had specific expertise in drug pricing to hold that new entrant accountable. Rep. Oliverson and Mr. Ciaccia discussed the matter further.

Rep. Walle and Mr. Ciaccia discussed insulin pricing. Mr. Ciaccia described insulin as "the canary in the coalmine" when it came to pharmaceutical pricing. Mr. Ciaccia said he.d found in OH that many of the MCOs only allowed for the brand name options to be covered compared to the significantly lower generic products due to commercial plan sponsors.

(2:41) Rep. Harrison asserted when he was at CMS that the rebate rule had reversed certain trends, but he was seeing the reversal of that under the current administration. Rep. Harrison asked if there was a state level corollary which could "scratch that itch" as well. Mr. Ciaccia said going direct was an option for the state and also imposing itemization from plan sponsors to the state with significant enforcement in the statute.

Options to Expand Access to Comprehensive Healthcare Low-Income & At-Risk Populations (2:45) A representative from Rand testified on how to expand access and control for costs to low-income and at-risk populations as well as studies recently published by the organization regarding healthcare costs more generally.

(2:58) Rep. Capriglione noted the price swings on certain lab blood tests in El Paso which Rand had tweeted out-noting that there were similar price swings for COVID tests. Rep. Capriglione asked why the insurance companies would be okay with that. The Rand representative said it did not make sense and it made less sense considering that it was a $1 trillion market. The Rand representative said it was likely driven by the fact that the premium payer when it was an employer often did not access that data. Rep. Capriglione asked why the employer would not shop around. The Rand representative said they often looked at the known high costs like hospitalization co-pays, but not for more common procedures like blood tests. Rep. Capriglione asked if plans had a fiduciary responsibility to the state when used for Medicaid. The Rand representative said the lack of transparency often was a factor, but vertical integration also was. Rep. Capriglione asked if a CFO should be looking at healthcare costs. The Rand representative said they should because it was usually the 2nd largest cost for employers. Rep. Capriglione asked if Medicare pricing was the benchmark. The Rand representative said generally they weren't suggesting it should be the goal or what employers should base their purchases on, but it did have a certain degree of transparency and universality which created a common denominator. The Rand representative said they should also look to comparable rates to be less than twice as much as Medicare, but not close to commensurate. Rep. Capriglione asked what they could do. The Rand representative suggested improving their APCD disclosures. Rep. Capriglione and The Rand representative discussed the trend of physicians being employed by hospital systems and HMOs. Rep. Capriglione asked if physicians were paid more for working for a hospital system. The Rand representative said they usually were paid about half a percent left, but they may benefit from not having to pay for administration and cost negotiations from a private practice. Rep. Capriglione asked what the incentive was if they were getting a small cut. The Rand representative said the adders were usually higher like facilities fees. The Rand representative said if they wanted to incent more primary care in a clinical setting, they may want to create a state formulary so that the private practices did not have to negotiate their own rates.

Rep. Oliverson said he felt that a statewide formulary may limit autonomy on the part of the provider.the same may be true for larger hospital systems. Rep. Oliverson asked how they could protect clinical autonomy. The Rand representative recommended strong oversight and controlling for referrals. Rep. Oliverson said, "I agree, but corporate medicine destroys that for all time. " Rep. Oliverson said he wanted to ensure his constituents as a lawmaker that he was doing everything in his power to ensure the Hippocratic Oath was the key driver.

(3:15) Rep. Frank asked about the additional cost for a procedure at a hospital for a facility fee and noted that it did not improve patient care or protect against patient referrals. Rep. Frank asked if referral kickbacks were illegal for all

providers. The Rand representative said he understood it was illegal when providing for Medicare and Medicaid patients. Rep. Frank said he wanted to double check that. The Rand representative said there were often indirect incentives where there weren't direct incentives.

Lee Spangler, ED - Texas All Payor Claims Database, testified. Mr. Spangler said the TX APCD was established by House Bill 2090 (87-R) and thanked the members for their work in its passage. Mr. Spangler said they had data from September 2019 forward and were negotiating with some providers to add historical claims prior to that-noting that they would eventually have monthly reporting data, but they were ensuring that the data they were receiving could be validated. Mr. Spangler said the database would include data from all recipients of state revenue which went beyond those regulated by TDI. Mr. Spangler said they'd have claims from 60% of covered Texans in the database. noting they were working to get ERISA plans to also voluntarily submit data. Mr. Spangler said their data was available to all researchers and met CMS data sharing along with 34 other entities in the country. Mr. Spangler provided data points required by statute and those which had to be provided through a public portal.

(3:29) Mr. Spangler said when they looked at all the data, Houston exceeded all other areas in cost and was the only area exceeding the state average. Mr. Spangler said admissions related to adolescent self-harm indicated an increasing trend, but there was also a significant drop off at the end of the school year which tracked when schools closed early due to the pandemic-noting that the definition required either ER treatment or in-patient treatment for self-harm. Mr. Spangler said Medicaid showed higher ER utilization, much of the costs were driven by older populations in the program and that facilities fees were a significant cost driver. Mr. Spangler said they were readying for their third meeting with their advisory group to construct legislative recommendations and would be looking to have the program fully implemented by the first quarter of 2023.

Rep. Oliverson thanked Mr. Spangler for agreeing to lead the project and asked how he could access the data if he were a healthcare researcher. Mr. Spangler said they would apply for it at the agency-which required affiliation with a healthcare 501(c)(3), a higher education institution or a healthcare entity. Mr. Spangler said the research couldn't be conducted for purposes of commerce and submit to IRB processes if human subjects were a part of the research outside the data. Mr. Spangler said they were provided a virtual environment through which to access the data by team members specifically certified to do so.and the data could not be exported. Rep. Oliverson and Mr. Spangler discussed how to ensure the data being provided was free from corporate bias and did not allow for an entity to preclude publication of data if they did not like the results of research.

Rep. Walle asked if there were any other belts and suspenders against the data being used in a nefarious way. Mr. Spangler said the statute generally tasked them with being stewards of the data and it would not benefit anyone involved in the entity overseeing the data for the information being used for nefarious purposes.

(3:43) Rep. Walle asked if there was any pushback from those being asked to provide the data. Mr. Spangler said they were working well with TDI and insurers, but many had significant questions about how to use the universal form-none had specifically pushed back on providing the data more generally. Rep. Walle asked if there was anything else they needed. Mr. Spangler said they needed to fully fund the program-noting that the estimated funding had not been included in the GAA from his understanding.

Maureen Hensley-Quinn, Senior Program Director - NASHP, testified. Ms. Hensley -Quinn said they created a cost comparison tool which Ms. Bartlett had discussed earlier and it was another tool for states to use in controlling for costs. Ms. Hensley-Quinn said Texas data indicated that hospital profit medians were higher than the national average and provided breakout information based on capacity-noting that 95% of beds in the state were parts of larger systems. Ms. Hensley-Quinn said, while the state had many more hospital systems in competition with each other, they left little room for private hospitals which showed higher than national average profits on the part of hospital systems. Ms. Hensley-

Quinn noted that currently there were requirements that all services be included in a contract with a system when an insurer may only need one service to meet network adequacy requirements. Ms. Hensley-Quinn said some systems required they be considered as top tier providers for all services which also drove up costs and there were some gag rules in contracts when it came to pricing. Ms. Hensley-Quinn said they'd also developed language to prohibit the use of facilities fees.

(3:58) David Balat, Director of Right on Healthcare - TPPF, testified. Mr. Balat provided his background and said he felt one perspective had not been touched on. Mr. Balat discussed the expansion of CMS costs in the country which accounted for nearly 20% of GDP with $1.3 billion going to hospital care alone. Mr. Balat said cost increases were also associated with non-competitive markets due to hospital closures. Mr. Balat quoted one of the representatives about non-competitive markets leading to a person knowing "you're getting hosed." Mr. Balat said there had been a lot of work to provide price transparency and incent preventative care.noting that his analysis showed a lot of variation between pricing for procedures provided at the same facility and also between the procedure under the same insurer at different facilities. Mr. Balat provided information on disparities for ACSs and the bundled pricing variation. Mr. Balat asserted that lack of price transparency not only limited information accessible to competitors, but also to the communities in their service areas. Mr. Balat said they should focus on price transparency for scheduled services as emergency services were not usually circumstances where price comparison was beneficial, but was an area where he could provide information showing ranges differing in the 10s of thousands of dollars.

Rep. Oliverson said he felt Mr. Balat and Texas 2036 had significantly improved their healthcare statute and noted that he did not exactly believe that price transparency was a panacea.noting that the Oklahoma Surgery Center was providing good data, but it didn't show a whole lot insofar as UC. Mr. Balat said he didn't believe they had UC as a surgery center. Rep. Oliverson asked if they could do something about padding when it came to spreading out the costs and how .charity care. was accounted for under their other revenue streams.noting the majority of those procedures were not covered under EMTALA. Mr. Balat said he.d provided data on both hospitals and surgery centers-noting his recommendation was not that facilities of different sizes should have event pricing, but they should have bundled prices up front-noting obstetric services as one where there was generally a lot of surprise costs that weren't state up front and not normally conducted in an ACS. Rep. Oliverson noted that things like hip and knee replacements were now being provided at ACSs at a lower cost due to improvement in technology when they used to be procedures which required multi-day hospital stays. Mr. Balat noted that retailers often built all their costs into their prices rather than having each piece billed for separately.

Rep. Bonnen and Mr. Balat discussed the use of vendors to check the quality and cost efficiency. Rep. Bonnen asked how they could increase utilization of such organizations. Mr. Balat said they should be able to increase that kind of utilization and he hoped it would become more popular. Rep. Bonnen said it wasn't just when it came to individuals unless it was a person paying for their own plan-it was also for employers. Rep. Bonnen said he wasn't sure whether it was having difficulty gaining traction due to competition with larger plans.

(4:14) Rep. Frank said he believed part of the reason was that employers didn' TTY have much of a way to know-noting his company would be discussing plans to adopt for the coming year the following day and he had more information by virtue of being a legislator so he could better navigate the incentives being provided.

Rep. Bonnen noted that often the options were being provided but in a manner designed to deter engagement. Mr. Balat discussed the challenges in providing direct cost prices. Rep. Bonnen said he felt that was separate from an employer offering a plan they paid for and an ERISA plan as options for their employees.

Rep. Harrison and Mr. Balat discussed changes seen since the passage of the option for employers to offer employees either a plan they paid the premium on or the salary commensurate with that which allowed them to access plans which were of a commensurate cost.

Rep. Lujan asked if any of the WV reforms requiring rebates to be passed onto patients were recommended for TX. Mr. Balat said they had seen it work well in getting patients to get the lowest net price despite warnings that it would lead to increases in costs.

Chris Slezak, Texas Employers for Affordable Healthcare, testified. Mr. Slezak provided information on his background. Mr. Slezak said equity was important to employers because retention and recruitment were among their highest concerns.noting that providing the most equitable and efficient healthcare allowed employers to provide for wage growth and employees to use more of their income on other things. Mr. Slezak said there had been a 250% increase on the cost of hospital services in the past 20 years which had negative impacts on individuals, employers and communities. Mr. Slezak said the new Rand data showed hospital care in Texas was an average of 252% that of Medicare from 172 providers-providing breakout information for those at 300%, over 200% and under 200%. Mr. Slezak said the result of staying on trend had been the advent of high deductible health plans which increased costs to individuals, decreased life outcomes and impacted the ability of communities and families to prioritize other spending-noting it even impacted the stability of other areas of the economy which required consumers to have expendable income and resulted in a shrinking middle class.

(4:31) Mr. Slezak provided information on the impacts of family quality of life by increased costs to healthcare and said financial toxicity led to clinical toxicity-often leading to people deferring care or seeking unproven alternatives and citing the Kaiser Family Foundation bill of the month which cited the son of a mid-level energy industry worker who'd seen complications from seeking treatment for a shoulder injury in Mexico. Mr. Slezak suggested that ACSs may be charging facilities fees to attract qualified staff. Mr. Slezak provided data for costs for flagship hospitals at each of Houston.s 4 hospital systems for 4 different payer types. Mr. Slezak said their analysis indicated hospitals they'd analyzed data from were charging 100% more than their break even costs. Mr. Slezak said employers had been unable to act as good fiduciaries because they did not have a seat at the table when it came to healthcare costs.

Rep. Bonnen asked what he meant by there being a lack of good faith effort on the part of the hospitals. Mr. Slezak said they'd approached the systems with the data from Rice and NASHP, but had not been able to do so. Rep. Bonnen asked if large employers wanted to negotiate rates with hospitals. Mr. Slezak said they did. Rep. Bonnen said he'd been begging them to take a seat at the table since 2006. Mr. Slezak said they had not been, but they also did not have the data previously to indicate the plans were getting them the best rates and then were unable to get the plans to the table which was why they wanted to negotiate with hospitals. Mr. Slezak discussed his vision further.

(4:47) Rep. Bonnen said he felt they could have had much more impact 10 years prior, but it wasn't too late. Mr. Slezak said it had been difficult to get competing companies to "play in the same sandbox", but the data availability had significantly changed things.

Rep. Frank said he understood the frustration was the inability to get contract transparency between insurers and hospital systems when purchasing a plan. Rep. Bonnen said he felt some of the larger companies were sophisticated enough and had enough resources to ask for justifications; but, instead, often advised one of the larger plans to their subsidiaries and subcontracts who weren't as well resourced. Mr. Slezak said change was likely not going to come from "jumbo employers", but from the small and midsized employers doing so collectively with governmental purchasers. Mr. Slezak said a conversation with one of the top three company executives in the country indicated that they did not want to have the blowback of taking the lead. Rep. Frank said they had to see the benefit as the employees. money rather than padding the bottom line on the backs of employees.

Rep. Oliverson described himself, Rep. Frank and Rep. Bonnen as "either the Three Musketeers or Three Stooges." Rep. Oliverson said he felt there was a failure to negotiate between two of the most profitable sectors: health systems and health insurance companies. Rep. Oliverson asked if Fortune 500 companies were asking the legislature to restrict the ability for the two behemoths to negotiate-noting that it was normally the insurers who were imposing gag clauses restricting himself and Rep. Bonnen from disclosing their salaries. Rep. Oliverson asked if they were asking for more regulation of a marketplace. Mr. Slezak noted that while they had difficulty getting large employers to join their coalition, most people were employed by smaller employers. Rep. Oliverson asked why they couldn't negotiate more with the health plans. Mr. Slezak said it appeared they were uninterested in coming to the table which was why they were asking for the ability to negotiate directly with the health systems.

Rep. Rose asked, "Have you heard the phase 'if you're not at the table, you're on the menu'?" Mr. Slezak said he felt that was applicable.

(4:59) Charles Miller, Texas 2036, testified. Mr. Miller said there was a lack of data for his argument, but that was his point. Mr. Miller said that they needed to allow for price transparency to allow employers to best negotiate plans for their employees rather than leaving it up to plans and provider systems. Mr. Miller said the goal of transparency needed to be coupled with incentives to use it; and, while price transparency was making progress, they needed access to data on outcomes and quality of care. Mr. Miller said he agreed with Rep. Bonnen that employers had been offered a seat at the table in the past, but it would be a mistake not to take advantage of them now asking to be involved due to failures to engage in the past. Mr. Miller said hospitals were mostly compliant with price transparency data, but they needed prices for all services provided to ensure they were fully compliant. Mr. Miller said 60% of hospitals had useable files they could access-noting that some only provided prices for some plans and some only provided access to their price master lists which were those which they said were "made up prices. Mr. Miller said some had links that didn't work. Mr. Miller said with regard to insurer transparency data, providing reasons why. Mr. Miller said quality transparency would also result in utilization of preventive care because it would demonstrate to premium payers the long-term cost-benefit to accessing such care. Mr. Miller said they were concerned that there was always either a health plan or health system which leveraged their positions to increase costs which were at the expense of patients and employers. Mr. Miller said a lack of specialty facilities was an example of where having limited options for certain care plans to have network adequacy was an area where health systems were driving up the costs. Mr. Miller said previously Berkshire Hathaway and Amazon had attempted to fix the problems, but were not large enough to drive that change. Mr. Miller said he understood there was a difference having the small and mid-sized employers at the table as well as having the technology available to help employers and patients better navigate the system.

(5:13) Chair Harless asked what his opinion was on the CO 1332 waiver and state based exchange. Mr. Miller provided information on the 1332 waiver in the ACA and said CO had used it to dictate that all plans available on the healthcare marketplace in the state had to provide a certain low-cost plan that covered the same amount with a set premium reduction for plan members each year. Mr. Miller said they were using a light touch for rate-setting which had the stick of the state telling them how to lower the costs if they didn.TTY find a way to do so themselves. Mr. Miller said the state based exchange had been based off the fact that the fees on health plans for operating the state exchanges were in excess of the cost for doing so. Mr. Miller said those which operated their own exchanges kept the rest of their fees-noting that CO had used their savings for a UC care pool though that may not be the best option for the state.

Rep. Oliverson said they struggled with finding affordable health plan options for small employers and asked if they could use the state based exchange savings to provide a state care pool subsidized with the savings to make it more affordable.

Dr. Robert Van Boven, slef, testified. Dr. Van Boven said they could not limit themselves to one option for controlling for costs-suggesting that they treat brand name and generic medications with different solutions. Dr. Van Boven said they were also seeing people paying higher co-pays for medications than they would pay out of pocket without their insurance.

Dr. Van Boven recommended they adjust the law to account for vertical integration. Dr. Van Boven said they weren't able to get how much was being kept by PBMs or other middlemen and they should not pass legislation before getting that information. Dr. Van Boven said 80% of the market was being controlled by 3 PBMs which were vertically integrated with specialty pharmacies so their indication that pharmacies were seeing the benefit of rebates often was the product of the pharmacies they owned receiving those benefits.

(5:31) Dr. Van Boven noted that estimates for certain costs from CBO for the ACA had been inflated-noting that Optum had created a program to pass on all rebates to customers which saved plan members on average $130 and did not increase costs.noting the pilot was only for insulin. Dr. Van Boven said if patients were allowed to pay the lowest net price of insulin, they'd be paying $4.80 per refill as opposed to $21. Dr. Van Boven provided additional information on the reasons found for plans to drive patients to brand name drugs, use specialty pharmacies, or over-pay pharmacists and then instituting clawbacks.

Debbie Garza, Texas Pharmacy Association, testified. Ms. Garza provided information on net costs which were significantly lower than the list price. noting a medication which was listed at $535 when it was only $88 net cost. Ms. Garza discussed the expanded use of "specialty drugs" which was not defined by the FDA which resulted in each PBM having their own lists and restricted those to pharmacies they owned-noting that they were normally the highest cost medications. Ms. Garza cited legislation to try to curb the use of specialty pharmacies, but there were still difficulties accessing the data to enforce those bills.

(5:50) Ms. Garza noted that in Texas 20% of zip codes relied on independent pharmacists as the sole provider of pharmaceuticals, they had been key to addressing the pandemic in various manners, and were sometimes the only healthcare provider in certain communities.

Rep. Harless asked if she favored the PREP Act and allowing pharmacies to immunize children. Ms. Garza said she did.

Rep. Frank discussed the claim differences on insurance policies for PBMs and asked, if the pharmacy was not getting the rebate, whether the rebate went to the PBM or the insurer. Ms. Garza said they didn't know what the full cost of the reimbursement was. Rep. Frank asked why the bill didn't curb spread in the private market. Ms. Garza said it was prohibited for public plans, not private ones. Rep. Frank said he felt lying was not allowed. Dr. Van Boven said they were seeing some lack of transparency from the PBMs as they were middle-men who weren't under the same reporting requirements as plans or pharmacies.

Rep. Harrison asked for information on immunizations at pharmacies and the impact of the new laws regarding PBM transparency. Ms. Garza said they had not seen large numbers of adverse events related to immunizations provided at pharmacies and were happy to be able to assist in combatting the pandemic. Ms. Garza said the DIR prohibitions (claw backs) had assisted in the managed care contracts for Texas Medicaid patients, and some progress on TDI regulated plans; but were seeing many changing the terms they were using for the practice change outside of that. Ms. Garza recommended they look at their new options under the Rutledge v. PCMA ruling.

(6:05) Lee Purvis, Director of Healthcare Costs & Access - AARP, testified. Ms. Purvis said they were interested in the issue because they'd seen prices go up to 7 figures per year and many of their members were living on fixed incomes with limited resources. Ms. Purvis said some products were growing at double the rate of inflation and the drugs they monitored had exceeded inflation every year since 2006-noting that older adults were particularly vulnerable given that they were usually taking 4-5 prescriptions for multiple chronic conditions and many members were desperate for help. Ms. Purvis said higher costs created higher premiums for other plan members as a portion of their cost shares and increase taxes paid to cover Medicare and Medicaid costs. Ms. Purvis said they.d found that the industry offered average for the cost of bringing a drug to market were not verifiable once more data was available and did not result in cost reductions

once generics were available after the cost recovery patent period. Ms. Purvis said, "The reality is that drug companies and drug companies alone are responsible for setting drug prices." Ms. Purvis said the public generally agreed that cost controls needed to be imposed regardless of political party identification. Ms. Purvis said the prices did not reflect the cost of innovation given that the majority of patents were going to repurposing existing medications.

Melodie Shrader, VP for State Affairs - PCMA, testified. Ms. Shrader asserted that PBMs had been mischaracterized, spread pricing was already banned for Medicaid pricing, and the legislation passed the previous session had curbed the use of clawbacks and specialty pharmacies. Ms. Shrader said there were about 70 PBMs operating and they were now managing a much more complex benefit and supply chain than when they'd initially been created-noting that the services they provided would still be needed even if they were eliminated. Ms. Shrader said they were the only entity in the RX supply chain which had the purpose of controlling costs. Ms. Shrader said, "I'm not going to apologize if my neighbor may need a medication and only have access because of their health plan.s PBM." Ms. Shrader said PSAOs were different from PBMs and were negotiating a contract like any other. Ms. Shrader asserted that they operated on a 2% profit-though the majority of members were for-profit and they were proud of that.

(6:31) Rep. Oliverson said 97.7% of rebates were being withheld by either the insurance plans or the PBMs and asked what they should do to make sure more of the rebates were going to employers and consumers-noting that the argument that retaining them would lower premiums rang hollow because premiums continued to increase. Ms. Shrader asserted 90% of the rebates were taken up by the health plans. Rep. Oliverson said he was not okay with them trying to split off the PBMs from the health plans when the 80% of the market was taken up by 3 health plans who were vertically integrated with their PBM. Ms. Shrader said it would reduce their premiums. Rep. Oliverson asked if she was saying that premiums in Texas would have gone up $4.3 billion without that use of rebates. Ms. Shrader said it would.

Rep. Frank asked how they could be price transparent if most health plan purchasers were unaware of the rebates. Ms. Shrader said they benefited from lower premiums. Rep. Frank asked how they could know that if they didn't know what the rebate was. Ms. Shrader said it was IP and she couldn't speak to the specifics.

Rep. Harrison asked them for more information on where they fit into the system. Ms. Shrader said they were there to control for costs and there was little correlation between rebates and price.

(6:44) Sharon Lamberton, Deputy VP for State Government Advocacy - PhRMA, testified. Ms. Lamberton said medications were only 14% of healthcare spend nationwide and was the only treatment with an ROI because it kept people from needing in-patient care. Ms. Lamberton said medication costs were actually in line with inflation or below it outside of brand name medications and noted that MAT utilization would improve costs. Ms. Lamberton said they were seeing increased costs for medications due to pharmacies increasing patient co-pays, requiring separate deductibles for pharmaceutical coverage, and needed rebate reform. Ms. Lamberton recommended extending the statewide formulary, requiring a given portion of the rebates to be passed on to patients to decrease out of pocket costs (noting that WV had not seen premium increases when they passed a similar mandate).

Dr. Cliff Porter, Texas Direct Medical Care, testified. Dr. Porter asserted they were "being held hostage against ourselves." Dr. Porter said he.d opted out of Medicare which had made it easier for him to provide care to Medicare patients under direct expense while Medicare still covered referrals and prescription costs. Dr. Porter noted co-pay increases for medications like Metformin, Diflucan and Epi-Pens which had significant markups.

Rep. Oliverson and Dr. Porter discussed clinical autonomy and options for patients to have more choice.

(7:05) Blake Hudson, Director of Public Affairs - TAHP, testified. Mr. Hudson discussed issues they were seeing as cost drivers on pharmaceutical spend. Mr. Hudson said they found that over 80% of hospital medications were marked up by at

least 100% over the cost and cancer specialty hospitals were marking up an average of 631%. Mr. Hudson said House Bill 1919 required companies not steer to affiliated pharmacies even if they could save the patient money. Mr. Hudson proposed elimination of rebates and prohibitions on kickbacks instead.

Rep. Capriglione said the only significant outlier on commercial spend was CA given that they had about half the spend per person. Mr. Hudson asserted that CA was spending significantly more on Medicaid. Rep. Capriglione asked what a good explanation was for the increase costs for pharmaceuticals. Mr. Hudson said they didn't have one.

Rep. Oliverson said they were trying to put the onus for oversight of House Bill 1919 at the agency which regulated a plan-HHSC or TDI-but, after 2 years of it not being implemented, they put it under DSHS since they had authority over manufacturers.

(7:20) Chair Harless adjourned the committee until 9 am on 8/5/22.

- 30 -