



TCoC Reduction Through Legislative Policy



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Total costs of care reduction through legislative policy

December 8, 2022

Houston Business Coalition on Health

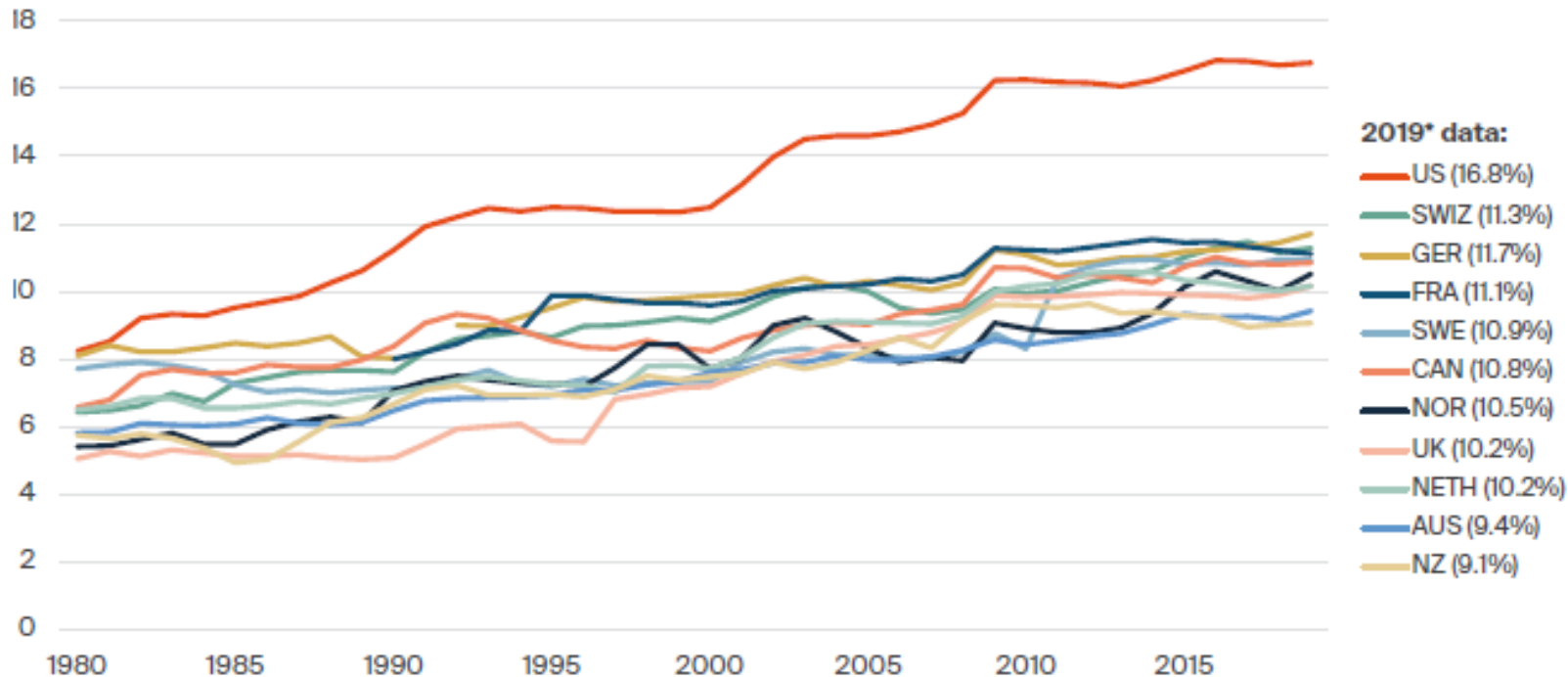
Session participants

- Peter Cram, Physician, Policy Researcher, UTMB
- Ted Barrall, Friedkin Group Director of Comp and Benefits
- Charles Miller, Texas 2036 Senior Policy Advisor
- Alan Gilbert, Purchaser Business Group on Health VP of Policy

The data should be familiar

Exhibit 3. Health Care Spending as a Percentage of GDP, 1980-2019

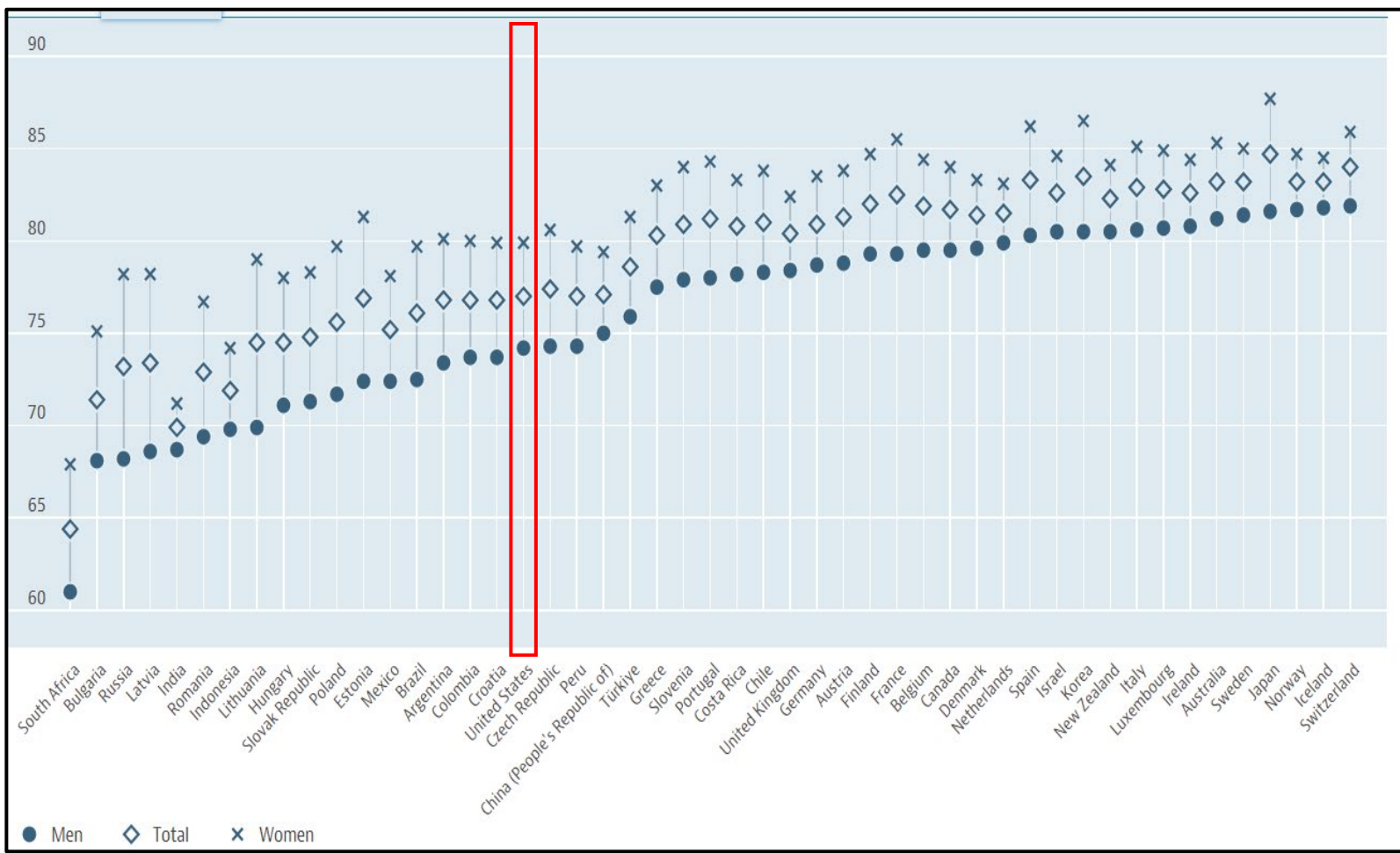
Percent (%) of GDP



Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP refers to gross domestic product.

* 2019 data are provisional or estimated for Australia, Canada, and New Zealand.

Data: OECD Health Data, July 2021.





The Friedkin Group

Automotive, Entertainment, Investments, Sports, Travel & Adventure

Automotive

- Gulf States Toyota
- Westlex, Ascent
- USAL
- Gulf States Financial Services

Benefits:

- 2,300 lives
- Self-funded medical plan with two TPAs
- Costs
 - Largest: Hospitalization
 - Fastest Growing: Pharmacy





Collective Action by Employers

Impact of rising costs

- Higher premiums
- Higher copays and deductibles
- Increased cost to the company

Opportunities for employers to act collectively

Legislation to address hospital price transparency

- Texas Employers for Affordable Healthcare



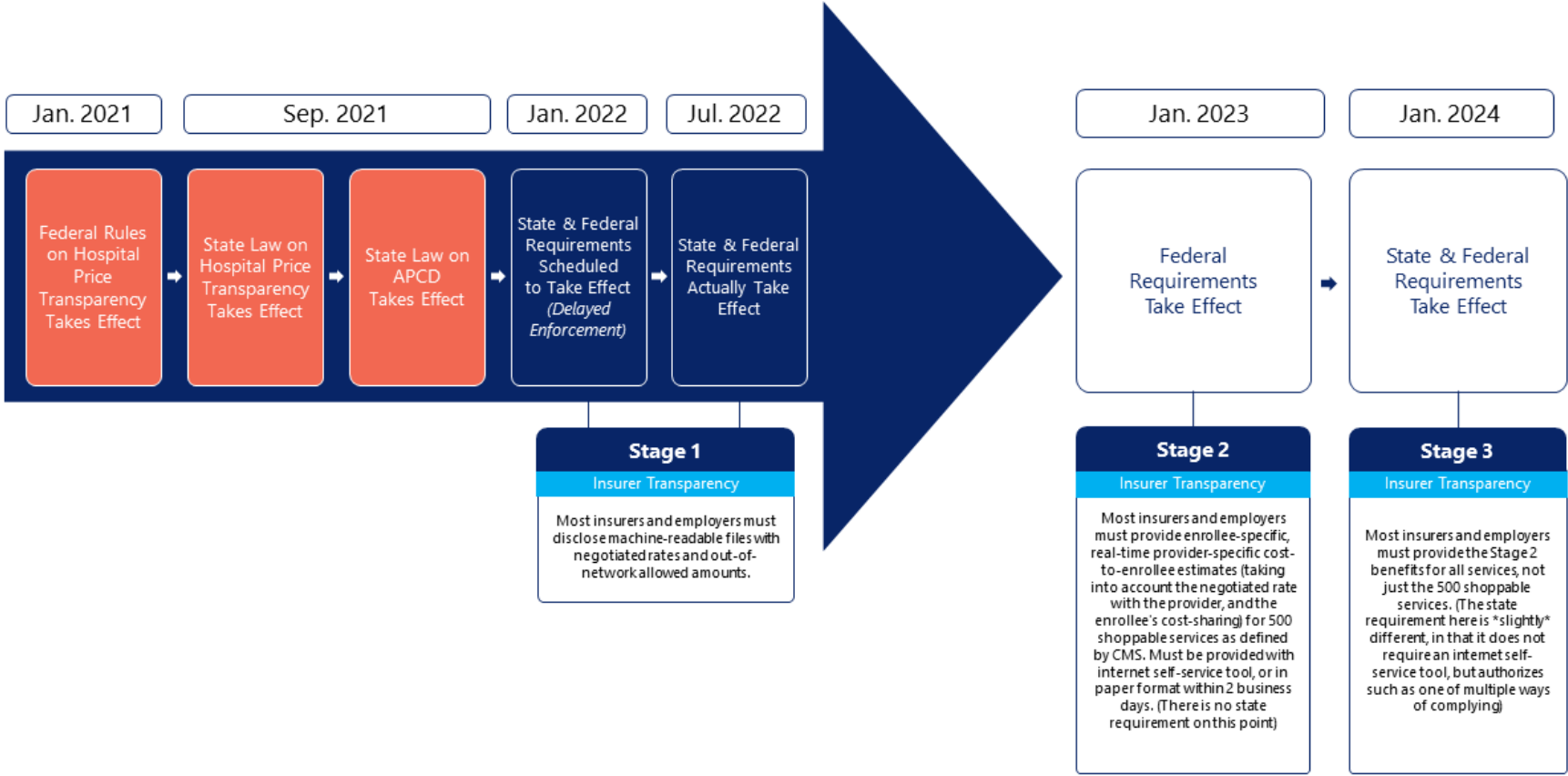


TEXAS 2036

Reducing Employer Health Care Costs: State Legislation

Month XX, 2022





Health Price Transparency Timeline





Potential Legislation

- a. Anti-Competitive Contracting
- b. Site-Neutral Payments / Facility Fees
- c. APCD Improvements
- d. ERS/TRS Benefit Design Changes

 <p>All-or-nothing contracting</p>	 <p>Anti-tiering or Anti-steering Clauses</p>	 <p>Most-Favored Nation (MFN) clauses</p>	 <p>Gag Clauses</p>
<p>Health systems leverage the status of their “must-have” providers and require plans to contract with all providers in the system or none of them. This forces insurers to face a difficult choice - include <u>all of</u> the systems’ providers (even if they are low-value or high-cost) or lose them all.</p>	<p>Dominant systems may require a health plan to place all physicians, hospitals, and other facilities associated with a hospital system in the most favorable tier of providers (<u>i.e.</u> anti-tiering) or at the lowest cost-sharing rate to avoid steering patients away from that network (<u>i.e.</u> anti-steering). These clauses undercut a plan’s ability to direct patients to high-value providers.</p>	<p>Typically used by a dominant insurer in combination with a dominant health system, MFN clauses are contractual agreements in which a health system agrees not to offer lower prices to any other insurer. For a dominant insurer, this ensures they are getting the best price and that no rival insurer can negotiate to offer a novel product at lower rates. MFNs may also allow insurers and providers to collude to raise prices.</p>	<p>Gag clauses may prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party. The lack of transparency from gag clauses and the mistaken notion that prices are trade secrets undermines price transparency tools for consumers and decreases plan sponsors’ ability to push back on rising prices.</p>

Spotlight: Anti-Competitive Contracting



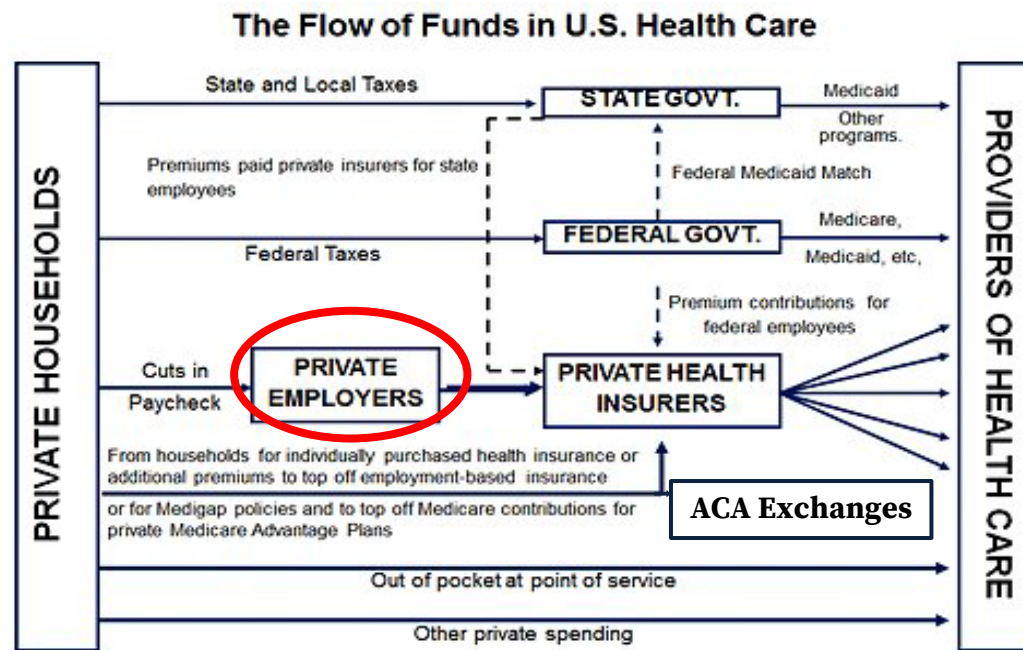
Take Action Now

Large employers have tried to change and failed. Now, it's time for the Legislators to act and they need to hear from Texans like you. Sign up now to be notified when you can take action.

What Can You Do?

Visit www.txeahc.org and sign up!

Role and Problems Employers are Trying to Solve in the Healthcare Ecosystem



Source: Uwe Reinhardt, "The Money Flow From Households to Health Care Providers". New York Times Economix blogs. Sept. 20, 2011.
<https://economix.blogs.nytimes.com/2011/09/30/the-money-flow-from-households-to-health-care-providers/>

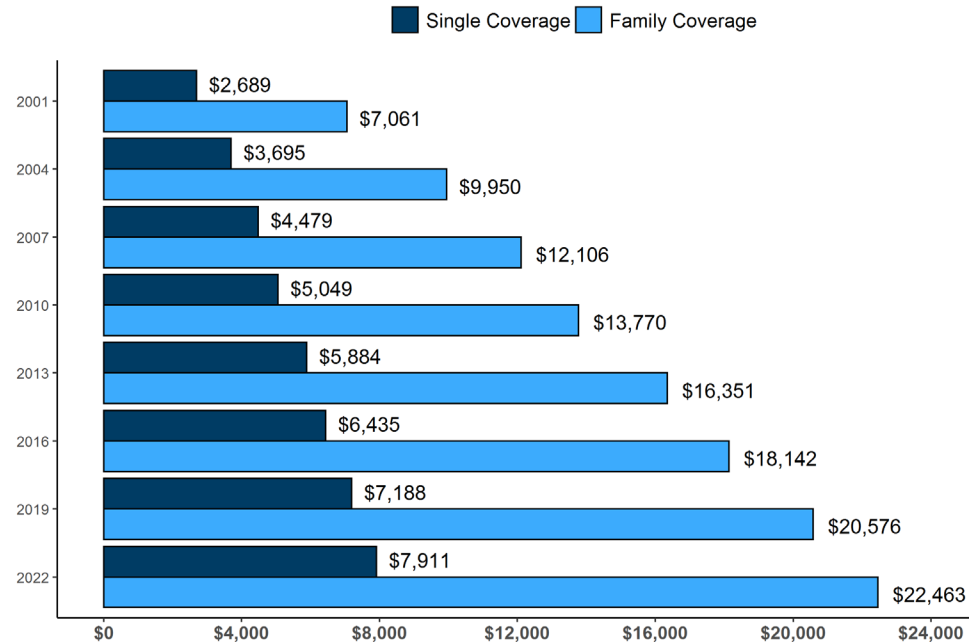
This is NOT private employers' day jobs ...yet they are facing:

- Unacceptably high and growing **costs**
- Inexplicably variable and mediocre **quality** of care
- Enormous **waste** in the health care system
- Serious inequities in health care and outcomes

Both sides of the value equation going the wrong way.

Relentless Increase in Costs

Average Annual Premiums for Single and Family Coverage, 2001-2022

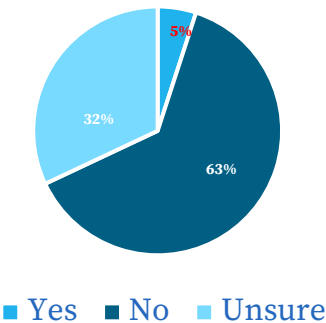


SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001-2017

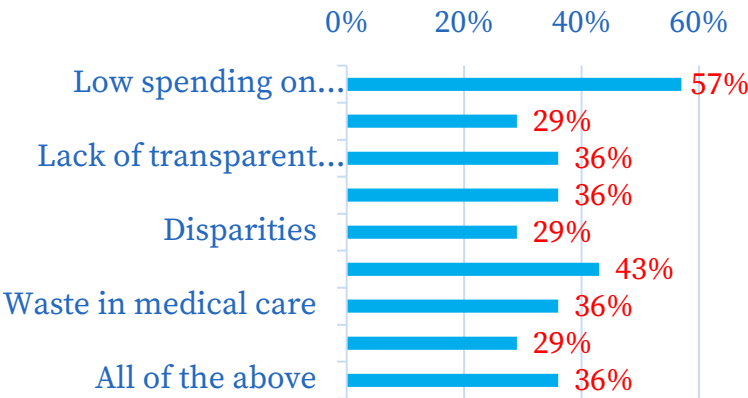


- **Prices rising** 5-10% year-over-year
- **Increased consolidation** allowing for monopolistic business practices
- Hospitals buying up smaller hospitals and underpaid primary care providers to **further control referral patterns and increase prices**
- PBMs **manipulating formularies and including hidden fees** in their contracts that increase costs by millions for employers
- Hospitals and doctors **fighting surprise billing legislation and regulations** with multiple lawsuits
- PBMs, insurers and health systems **refusing to give their self-insured employers access to their own data**
- Hospitals **making it difficult to access price data**, if they comply with the law at all (many haven't)
- Hospitals **refusing to engage** in arrangements with employers that would lower their cost
- Hospitals, physicians and health plans **refusing to use standardized metrics** so performance can be evaluated by customers

For the money you spend on health benefits and services, do you believe your employees'/members' health is improving?



If you answered no, why are you not getting what you want from your health spending?



PBGH uses a multipronged approach to get results for our members. We enable the **INNOVATIVE PURCHASING** of **QUALITY** health care.



Care Redesign



Direct Contracting



Strengthening Mental Health



Reducing Pharmacy Costs



Payment Reform



Measuring What Matters



Influencing Policy