

85th Legislative Session

CANDIDATE BRIEFING

**Texas Medical Association
Political Action Committee**
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Dear Candidate:

Congratulations on your decision to lend your skills, background, and commitment to improve the lives of Texans by running for public office.

The Texas Medical Association Political Action Committee (TEXPAC) is the political voice of more than 48,000 Texas physicians and medical students, and nearly 8,000 Texas Medical Association Alliance members. Organized 54 years ago, TEXPAC is one of the oldest and largest bipartisan PACs in the state and ranks first nationally among all state medical association PACs.

TEXPAC provides financial and campaign support to candidates running for state and federal offices who will stand up for patients and their physicians and the sacred patient-physician relationship. We need candidates today who will put Texas patients before Texas politics. We cannot continue to procrastinate, put off making difficult decisions, or focus on issues that do little to improve the health of Texans.

Legislators, physicians, hospital systems, insurance companies, and community leaders must create a more sustainable and efficient health care system. A viable Texas economy must ensure every Texan has access to affordable and quality care when he or she needs it. It's incumbent upon us to create and support that system.

You have the opportunity to make real, substantive changes in 2017. Texas physicians look forward to working with you to make that happen. These are the four items TEXPAC examines to determine the level and type of support we put behind endorsed candidates:

- A candidate's philosophy and positions on legislation affecting physicians' ability to care to their patients,
- Recommendations from local TMA physicians and alliance members,
- Demographics of the district, and
- The candidate's chances of winning the election.

Please review organized medicine's top legislative issues and questions. We look forward to visiting with you and learning firsthand what your position is on many of these topics, and your commitment to improving the health of Texans in your district.

Please contact the TEXPAC office at (800) 880-1300, ext. 1365, if you would like to learn more about our organization.

Sincerely,

Brad Holland, MD
Chair, TEXPAC Board of Directors
Waco

Robert Rogers, MD
Chair, Candidate Evaluation Committee
Fort Worth

Caring for Patients in a Time of Change

TMA's 2017 Legislative Priorities

Protect the trusted patient-physician relationship

The patient-physician relationship is unique in modern American life. Patients place their lives in their physicians' hands. Not only must they trust in their doctor's knowledge, experience, and skill, but also they must trust that their physician is acting in their best interest — neither motivated nor distracted by competing interests. In return, the physician is responsible for recommending and applying the most appropriate, science-based treatments for the patient's individual circumstances and medical conditions.

Protecting the patient-physician relationship lies at the heart of Texas' legal doctrine banning the corporate practice of medicine. Patients must be able to trust that the tests and treatments their physicians recommend are tailored to their individual medical needs and are shielded from improper lay influence. Each patient encounter must be governed by the ethics of the medical profession, the integration and application of advancing medical knowledge, and the partnership with the patient in making good decisions for that patient's health.

At TMA's urging, the 2011 Texas Legislature passed groundbreaking laws that protect patients and their physicians' ability to exercise independent medical judgment free from interference by a hospital administrator or corporate officer. At the same time, we preserved Texas' ban on the corporate practice of medicine with several carefully delineated expansions for physician employment. These included strong protections for physicians employed by or associated with hospital-controlled health care corporations, rural county hospital districts, large urban hospital districts, and the new delivery systems propelled by the Affordable Care Act.

Texas is the first state in the country to take the critical step of protecting physicians' clinical autonomy. The laws place responsibility for monitoring and enforcement with the Texas Medical Board (TMB), which is the agency responsible for upholding the standards of medical practice in the state. These laws remained firmly intact during the intervening legislative sessions. Moving forward, it's critical these laws are protected.

Medicine's Recommendations

- Support strong statutory provisions that protect independent medical judgment for physicians in all employment relationships.
- Strengthen state laws to ensure that corporate entities cannot dictate medical decisions to the detriment of patient care.
- Strengthen statutory provisions to protect physicians' due process rights and prohibit retaliation for patient advocacy in all employment relationships.
- Oppose legislation that allows the government to dictate care or that prevents physicians from having honest and candid conversations with their patients or from providing medically appropriate care.

Support the physician-led medical team model of care

Texas needs more physicians and other health care professionals working in all parts of the state, especially in rural and border Texas. But the real gains in improving access to and coordination of patient care will come largely from solidifying and expanding the use of physician-led teams. Team-based care capitalizes on the efficiencies of having the right professional providing the right services to the right patient at the right time ... but with overall direction and coordination in the hands of physicians.

In 2013, lawmakers emboldened this model by passing legislation that set up a more collaborative, delegated practice among physicians and advanced practice registered nurses (APRNs) or physician assistants (PAs). That law reinforces the importance of physician-led medical care teams, recognizes the skills all practitioners bring to patient care, and allows the delegating/supervising physician greater flexibility. At the same time, it recognizes that independent prescribing is the practice of medicine.

In the coming decade, integrating the talents of a diverse medical team under physician leadership will be a key challenge. Without physician direction, supervision, and management (or if the system evolves to accommodate teams led by practitioners with lesser training), medical care will trend toward even more fractured care, higher-than-necessary utilization, and creeping inefficiencies. This will lead to even higher costs, duplications of services, and lower-quality patient care. These inefficiencies in turn will hamper efforts to improve access to care.

Medicine's Recommendations

- Strongly oppose any efforts to expand scope of practice beyond what is safely permitted by nonphysician practitioners' education, training, and skills.
- Support only those changes to scope of practice laws that protect patient safety, are consistent with team care, are based on objective educational standards, and improve patient care services with appropriate regulatory oversight by TMB.

QUESTIONS

- Would you oppose any efforts by nonphysicians to practice beyond their education, training, and skills?
- Would you stand by agreed-to-legislation between physicians, APRNs, and PAs that was passed into law in 2013?
- Do you believe that nonphysician practitioners who seek legislation to allow them to perform a medical diagnosis and independently prescribe should be licensed and regulated by TMB?

QUESTIONS

- Would you support establishing competitive Medicaid rates for all physicians?
- Would you support reducing bureaucratic burdens and hassles, and making HMOs more accountable in the Medicaid program?

Improve access to care

Physicians are critical to Texas' health care system if it is to be cost-effective. Otherwise, the state's efforts to increase preventive care, improve medically necessary treatment for the chronically ill, and reduce inappropriate emergency department utilization will falter.

Of primary importance to physicians is ensuring our patients have access to effective, timely, and high-quality health care. That begins with ensuring low-income Texans on Medicaid have reliable access to primary care physicians and specialists in their communities.

Medicaid serves 4 million Texans, the vast majority of whom are children. Medicaid patients are people we all know or encounter every day, including hard working, low-income parents, people with disabilities, and seniors. Inadequate physician payment rates have forced many physician practices to limit their Medicaid and Children's Health Insurance Program (CHIP) participation or cease it altogether.

Texas is quickly headed towards a health care crisis if the legislature refuses to establish competitive Medicaid payment rates for all physicians. Without higher payments, physician Medicaid participation will continue to free fall. Physicians support Medicaid and want to participate. Yet, as owners of small businesses, facing ever more costly and demanding federal and state regulatory burdens, many just cannot afford to stay in the program that pays less than half their costs. Medicaid needs a facelift, and we want to work with the legislature to continue to identify commonsense changes that will benefit patients and the physician network while also improving patient outcomes and lowering costs. But we need to establish competitive Medicaid payment now to ensure vulnerable Texans have access to services they need to stay healthy and productive.

Physicians' practice costs — like any other business' operating costs — continue to march upward. For the past decade, covering practice costs has become more difficult, especially for physicians who care for patients covered by government insurance programs, such as Medicare and Medicaid. Medicare pays only 61 percent of physicians' average costs. Medicaid payments cover less than half of the average cost to provide services. Faced with losses on every service delivered, physician practices are often forced to limit services to Medicare and Medicaid patients if they cannot make up the losses elsewhere. In 2010 and 2011, the state cut physicians' already-meager payment rates another 2 percent. In January 2012, physicians who care for patients who rely on Medicare and Medicaid for their health care, known as "dual-eligible" patients, took another huge hit. Texas Medicaid stopped paying patients' Medicare deductible, which was \$140 — this year it's \$147. Medicaid also stopped paying the patient's coinsurance (due if Medicare's payment to the physician exceeded what Medicaid pays for the same service, which is usually the case). The coinsurance had been an 80/20 split, with Medicare paying 80 percent of the patient's doctor bill and in most cases, Medicaid paying the remaining 20 percent.

These cuts affected about 320,000 dual-eligible patients in Texas, who are the oldest, sickest and frailest, and who rely on regular physician care and prescription medications. Doctors kept seeing these patients even though Texas Medicaid was not paying the patients' deductibles nor fully paying the 20-percent coinsurance. Many doctors were forced to tap savings, obtain loans, cut staff, retire early, or move away. Some patients lost their doctor altogether. State leaders did reinstate the Medicare deductible but not the coinsurance. That cut is still in place.

State leaders must realize that cutting physicians' payments is not an effective tool for controlling health care costs, and often exacerbates the cost of care.

It's more cost effective to provide care early when diseases can better managed and controlled.

Medicine's Recommendations

- Ensure Texans of all income levels have access to preventive, routine, and emergent care.
- Ensure competitive Medicaid and CHIP payments for physicians.
- Restore Medicare Part B coinsurance payments for dual-eligible patients.
- Support increased funding for cost-effective, community-based mental health care and substance abuse.
- Stop seeking to punish physicians for the woes of the state's substance abuse crisis.

QUESTIONS

- Would you support adequately funding TMB by dedicating a greater portion of the physician licensure fee to TMB operations, thus allowing the board to be more efficient and responsive to the public and physicians it serves?
- Would you oppose measures to increase physician licensure fees to fund TMB operations or other state budget initiatives?
- Would you oppose efforts that would prohibit the board from disciplining for “nontherapeutic prescribing” or from enforcing standards of care?
- Would you oppose measures that reduce the board’s ability to investigate and act on legitimate complaints?
- Would you oppose efforts to erode physician rights in caring for patients in end-of-life cases?

Protect and promote a fair civil justice system

In 2003, the Texas Legislature passed sweeping liability reforms to combat health care lawsuit abuse, reverse skyrocketing professional liability insurance premiums, and ensure Texans’ access to high-quality medical care. The centerpiece of those reforms was a \$750,000 stacked cap on noneconomic damages assessed against physicians and health care facilities (hospital system, nursing home, and such) in a liability judgment. There is no cap on economic damages. Texas voters then approved Proposition 12, a constitutional amendment that ratified the legislature’s authority to impose these important reforms.

The reforms have worked. They’ve lived up to their promise. Sick and injured Texans have more physicians to deliver the care they need, particularly in high-risk specialties like emergency medicine, obstetrics, neurosurgery, and pediatric intensive care. Physicians also have benefited from much lower liability insurance rates and fewer nonmeritorious lawsuit filings.

While Texas leads the nation in medical liability reform legislation, some would like to see the law weakened and/or destroyed. Ever since 2003, adversaries have tried to discredit the reforms with aggressive media outreach and misleading research. Each session, bills are introduced that would lift the caps on noneconomic damages and protections for emergency services.

Another issue that often surfaces during the session is increasing physician licensure fees. Right now physicians pay \$1,002 every two years for licensure, generating \$65 million in revenue. These funds originally were to help fund TMB. However, only about one-third, or \$22 million, goes to TMB. The rest goes into general revenue. Instead of increasing the fee, a larger portion of the monies already collected should go to TMB for more efficient administration. While the numbers of licensed physicians continues to grow by more than 4,000 per year, TMB’s appropriation has been pretty flat over the last several funding cycles.

Last session minor changes were made to the Texas Advance Directives Act. Previously, there have been attempts at drastic alterations that, if passed, would have set a dangerous precedent for the legislature to mandate physician services and treatments that could be medically inappropriate, outside the standard of care, or unethical. Because medicine is an art and no human can dictate the final stages of disease, physicians need clear pathways to resolve conflict with surrogates of our sickest patients, especially in their final days when additional care may be futile and/or conflict with a physician’s morals and ethics.

Medicine’s Recommendations

- Protect the 2003 health care liability reforms, including caps on noneconomic damages and protections for emergency services.
- Oppose any effort that would dilute Texas’ medical liability reforms, liability safe harbors, or misguided proposals that would weaken TMB.
- Oppose any attempts to limit the use of “Do Not Resuscitate” orders that are consistent with accepted standards of medical treatment and science. Physicians must abide by the ethical standard “First do no harm.”
- Oppose attempts to increase physician liability and seek to escalate conflict in end-of-life care.
- Oppose attempts to legalize physician-assisted suicide or “euthanasia.”

Provide access to quality care via telemedicine

TMA has long supported telemedicine and believes that harnessing advancing technologies to deliver quality care holds great promise for both patients and physicians in the coming years. At the same time, these services should adhere to accepted standards of care and best practices for both diagnosing and prescribing. TMB rules, which TMA supports, require both a medical history and physical exam — generally through a face-to-face meeting — before prescribing dangerous drugs or controlled substances.

Various service models have sprung up in the past few years, some as cash businesses but increasingly as part of employee benefit plans. In fact, many of the models and protocols for telemedicine have been pioneered by Texas medical schools, most notably The University of Texas Medical Branch at Galveston and Texas Tech University Health Sciences Center School of Medicine.

Telemedicine in Texas takes on various forms, but the key to its use is the ability to access and use multiple modes of communication and data collection — audio, video, and, in certain situations such as the diagnosis of new conditions, the presence of a licensed patient presenter who is available to assist in the physical examination. Telemedicine has become quite established for specialty consultations, follow-up primary care, monitoring of chronic conditions, and the like in both rural and urban areas.

In contrast, telephone-only services operate in the absence of an established patient-physician relationship. These services have been described by some as more akin to Internet prescribing. Increasingly, these services are attempting to present as telemedicine and/or telehealth services.

The 84th Texas Legislature (2015) considered several telemedicine bills. Two, which TMA supported, passed. One establishes a school-based telemedicine service using the school nurse as the patient presenter and authorizes payment for physicians and providers. Another authorizes payment for home telemonitoring services under the Texas Medicaid program for persons with certain chronic conditions.

Moving to the 2017 session of the Texas Legislature, TMA continues to express support of the TMB rules on telemedicine and will look at proposals to expand the types of service available to patients through telemedicine and the payment for these services.

Related to this, TMA continues to support the concept that medicine is practiced where the patient is being treated, not where the physician is located. This is a state licensure issue. But this principle runs counter to a national agenda that would override state licensure laws and allow physicians licensed in one state to care for patients via telemedicine in any other state — beyond the regulation of the patient's state's licensing board.

Among the major challenges ahead is to provide a useful regulatory framework that works to the benefit of patients and their physicians, that holds physician services to accepted standards of care — regardless of whether those services are provided in person or via telemedicine — and that values and pays for these services appropriately. This regulatory footprint needs to be broad enough to ensure patient safety and adherence to quality standards but focused enough to allow the adoption of emerging technologies and innovations.

QUESTIONS

- Should telephone-only services, operating outside of established patient-physician relationships and failing to comply with TMB rules, be allowed to operate in Texas?
- Should physicians be held to one standard of care — regardless of whether those service are provided in person or via telemedicine?
- Should a Texas medical license be required of physicians to care for patients in Texas when that care is provided through telemedicine services?
- Should insurance plans pay for telemedicine services and telemonitoring on the same basis as they pay for medical services provided in person?

QUESTIONS

- Would you support a requirement on insurers to identify and label clearly and conspicuously any health insurance product marketed that limits access to certain physicians or health care providers through their use of narrow or limited networks?
- Would you support legislation that allows the use of VCC payments by insurers only when a physician has proactively selected or “opted-in” for that method of payment?
- Would you support the continuation of the ability of physicians to bill and collect from patients the amounts not paid by the insurer due to nonpayment or underpayment for out-of-network services by the insurer?

Help physicians continue to provide jobs and quality care by resolving health insurance issues

Physicians are small, midsize, and large employers. Solo practices often run on a shoestring, with only a nurse and one or two staff; group practices use a larger support staff for medical and administrative functions. Regardless of practice size, physicians are important businesses and employers who make significant contributions to state and local economies. Physicians’ practices must remain viable to continue providing jobs and quality patient care in rural and urban Texas.

Health plans have increased their use of “narrow networks” of physicians and providers as a cost containment strategy to offset their risk for high-cost patients with chronic and preexisting conditions. It has been said that narrow networks have become the new form of medical underwriting by insurers. Conversely, these plans have proven popular with consumers and employers because they carry lower premiums. Yet, consumers have little information to guide them on the tradeoff between lower premiums and network size when shopping among the various plans offered either by their employer or in the individual marketplace. These narrow networks leave consumers vulnerable to the financial burden of out-of-network care. Surveys by various policy institutes suggest that many consumers who select narrow network plans on the basis of lower premiums are unaware of the network size of the plan they selected. By requiring health insurers to disclose network limitations, consumers can make better decisions when purchasing health insurance coverage. Consumers must clearly understand what their health insurance covers. It saves time and money.

The use of paper checks by health plans to pay for services is dwindling, and insurers have opted for other electronic payment methods. Physicians and health care providers certainly appreciate administrative simplification efforts by insurers, including those that allow payments for services to be delivered in a timely and efficient manner. Unfortunately, virtual credit card (VCC) payment increases costs and has unintended consequences for physicians and health care providers because VCCs often come with unexpected hidden costs.

Insurers and their contracted vendors are increasingly using VCCs to pay physicians, hospitals, and providers for health care services. VCC payments are the high-cost alternatives to lower-cost electronic direct deposit payments (automated clearing house-electronic funds transfer) or to paper checks. Just like credit card payments, VCC payments are subject to interchange and transaction fees. However, those VCC interchange fees can run as high as 5 percent. For example: Accepting a VCC payment for a contracted fee of \$5,000 would require physician to pay a \$250 interchange fee and not receive the full contract amount. Essentially, the physician is paying to get paid!

Just like any other business, physician practices must consider all of their costs when determining their prices/charges. Their charges must be adequate to cover all operating costs and to provide an allowance for losses such as charity care and bad debt. These losses also include nonpayment and underpayment by insurers for out-of-network services. Unlike other businesses, physicians don’t always get to select the customers to whom they will provide services, especially when on-call for the hospital or for work in the emergency department. Nor do they always get to decide what their payment will be, especially if they are out of network for certain patients. Some states have passed legislation that prohibits out-of-network physicians from collecting from the patient the difference between what the insurer paid and what the physician charged for the service.

A physician's charge for a service applies to every payer, no matter if it is a commercial or government payer. It applies to every patient, no matter if insured or uninsured. What varies significantly is what the physician actually receives as payment in return for his or her services. No other business in the marketplace has to depend on a middleman or third-party payer for payment to the extent physicians do. Most businesses can go directly to the customer, client, or vendor for payment for the services provided.

Medicine's Recommendations

- Require insurers to identify and label clearly and conspicuously any insurance product they market that limits access to certain physicians or health care providers through the use of narrow or limited networks.
- Prohibit insurers and health plan administrators from paying claims to a physician via the use of VCCs unless the physician has proactively and voluntarily "opted-in" to accept that form of payment.
- Support the ability of physicians to bill their patients and collect monies owed for services not covered by insurers.

Don't Tax Sickness

Saving lives should not be taxed like other services. Health care is not a traditional business activity and should not be subject to a traditional business activity tax.

Recognizing the unique nature of health care when they rewrote the state's business tax in 2006, legislators included deductions for the free and underpaid care physicians provide to Medicaid, Medicare, CHIP, workers' compensation, military, and charity care patients. Because physicians have contractual and ethical obligations to care for patients, often without regard to their own financial interests, their losses on unpaid and underpaid services are unavoidable and substantial. Those losses merit recognition.

No other profession is required by law to give away its products or services for free. Federal law requires physicians to provide care to patients in emergency settings without regard to ability to pay. Texas physicians deliver almost \$2 billion per year in a hidden tax via unpaid charity care.

Medicaid and CHIP payments to Texas physicians cover less than half the cost of providing care. Each Texas physician, on average, provides almost \$83,000 per year in undercompensated care to Medicaid and CHIP patients (even more in some specialties, and in rural Texas and along the border). Tax increases add to the cost of caring for these patients, forcing more physicians to find ways to limit participation in these government programs.

Texas physicians pay their fair share in business and personal taxes. They also pay such additional state taxes as a licensing fee, a patient protection fee, and a state website fee. These fees are in addition to the sales taxes physicians pay on the supplies and equipment they use to care for patients, and the property taxes they pay on all business property and equipment. Additionally, because rates are set by Medicare, and insurers rarely negotiate their payment rates, physicians have little opportunity to offset these costs.

Texas should not place additional taxes on caring for the sick.

Medicine's Recommendations

- Support tax law provisions that acknowledge physicians' unique role in caring for all patients — this includes physicians who provide charity care.
- Ensure that any tax legislation that affects health care does not harm patient care or access.

Reduce red tape and regulations

We need legislative solutions to cut through the red tape, regulations, and other unproductive elements that do nothing to improve quality and everything to interfere with doctors' ability to practice medicine efficiently and effectively.

New compliance requirements from the state and federal government are bombarding physician practices seemingly every day. Unfunded mandates and hidden regulatory burdens threaten the viability of practices and patients' access to care. The average cost to staff and run a practice now exceeds \$500,000 per physician, and that's before the physician gets paid a dime. These excessive administrative expenses add to the escalating cost of medical care that are borne by patients, employers, and taxpayers.

The cost to operate a physician's office continues to climb unabated. Excessive regulations also hurt local economies, which receive nearly \$1 million in wages and benefits for each physician in practice. Physician offices employ support staff and often work with nonphysician providers, increasing the total number of employees in the industry to well above the count of physicians alone. In 2012, Texas office-based physicians supported 522,000 jobs. On average, each office-based physician supported 10.8 jobs, including his or her own.

Texas should not burden practices with additional regulatory costs that provide no benefit to patients or their health care.

Medicine's Recommendations

- Oppose measures creating additional government mandates that cause red tape and hassles that don't contribute to or add value to patient care, such as onerous billing procedures and inconsistencies across Medicaid HMOs, and government agency regulations and penalties that disrupt medical practices.
- Support legislation that creates user-friendly databases that could help physicians' practices streamline and enhance routine patient intake.
- Provide protection to physicians forced by federal mandates to participate in health information exchanges so they are not held liable for mistakes made by others.

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Texas Medical Association Political Action Committee (TEXPAC) is a bi-partisan political action committee of TMA and affiliated with the American Medical Association Political Action Committee (AMPAC) for congressional contribution purposes only. Its goal is to support and elect pro-medicine candidates on both the federal and state level. Voluntary contributions by individuals to TEXPAC should be written on personal checks. Funds attributed to individuals or professional association (PAs) that would exceed legal contribution limits will be placed in the TEXPAC administrative account to support political education activities. Contributions are not limited to the suggested amounts. TEXPAC will not favor or disadvantage anyone based on the amounts or failure to make contributions. Contributions are subject to the prohibitions and limitations of the Federal Election Campaign Act.

Contributions or gifts to TEXPAC or any CMS PAC are not deductible as charitable contributions or business expenses for Federal income tax purposes. Only contributions to the TMA Foundation, any CMS foundation and The Physicians Benevolent Fund are deductible as charitable contributions for Federal income tax purposes.

Federal law requires us to use our best efforts to collect and report the name, mailing address, occupation, and name of employer of individuals whose contributions exceed \$200 in a calendar year. To satisfy this regulation, please include your occupation and employer information in the space provided. Contributions from a practice business account must disclose the name of the practice and the allocation of contributions for each contributing owner. Should you have any questions, please call TEXPAC at (512) 370-1361.