TEXAS ACADEMY OF FAMILY PHYSICIANS

House Select Committee on Health Care Affordability

Testimony of Lane Aiena, MD, for the Texas Academy of Family Physicians

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Chairman Frank and Members of the Committee:

Thank you for the opportunity to testify today on healthcare affordability and on how Texas can preserve the ability of independent physicians to compete.

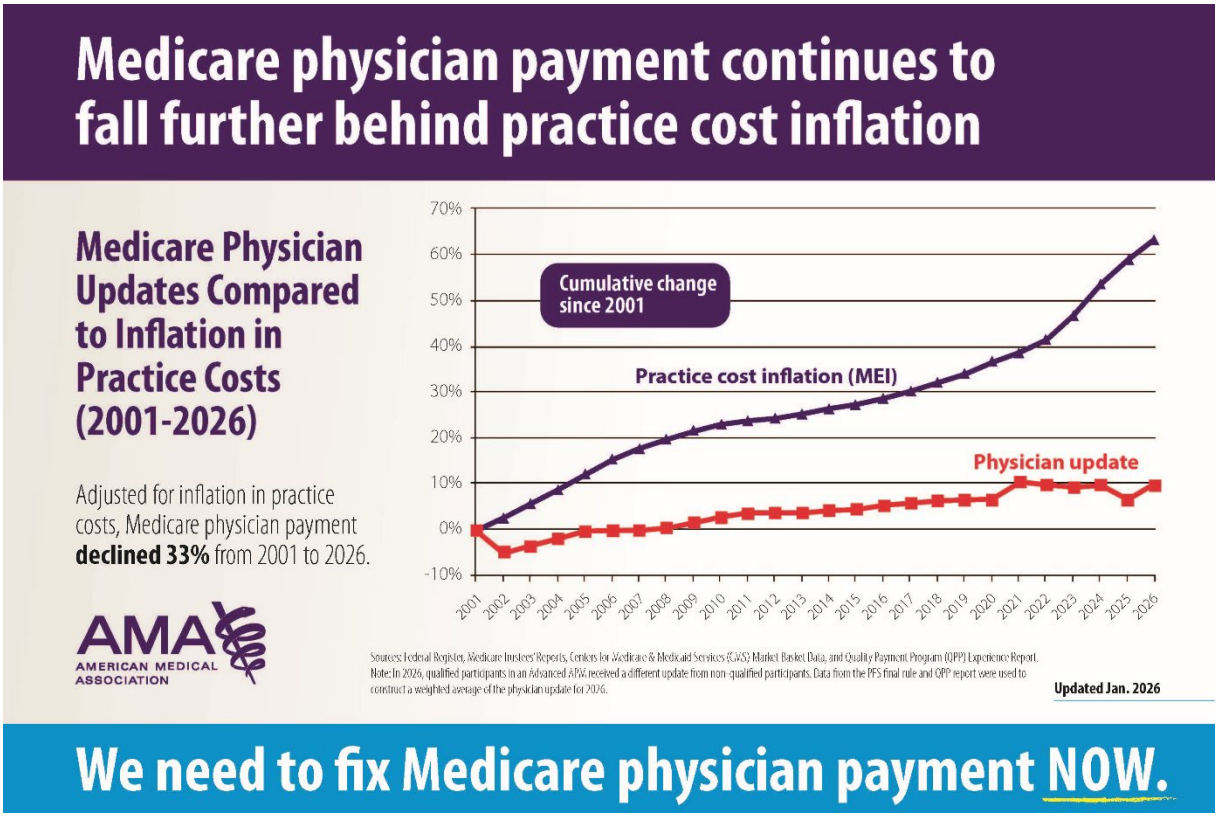
My name is Dr. Lane Aiena. I am a family physician in Huntsville. After residency in Conroe, my family and I moved to Walker County, where I joined a five-physician independent primary-care practice that now cares for more than 10,000 patients in the area.

I see our healthcare affordability problem every day — in exam rooms, in the hospital, at the drug store counter, in conversations with employers irate about their sky-high insurance premiums and with patients who are struggling to afford their care.

And I see something else, the steady erosion of independent physician practice.

The economics are getting harder.

Medicare, Medicaid, and commercial insurance payments have not kept pace with inflation, while the costs of staff, technology, supplies, and compliance continue to rise. At the same time, prior authorization, documentation, and other administrative requirements keep taking more time and money.



And we're competing against increasingly large health systems, insurers and corporate healthcare organizations that have something a small practice doesn't have — scale and bargaining power.

We have the same rising costs. We just don't have hundreds of physicians across which to spread those costs, or the leverage to negotiate better rates with insurers and vendors.

So, for many independent physicians, selling their practice is not a clinical decision. It's a financial survival decision.

That's important because independent physicians are not the affordability problem we're trying to solve. They're part of the solution.

Independent practices give patients another choice. They're often deeply connected to their communities, responsive to local needs, and able to make decisions without any implicit regard for the needs of the health system or the layers of overhead that can come with corporate ownership.

And, importantly, they provide competition.

I'm not asking the Legislature to pick winners or losers or protect independent practices. What I am asking is for the Legislature to level the playing field and allow physicians, hospitals, insurers, and others to compete on what should really matter — quality, access, service, and value — rather than size and bargaining power.

Mr. Chairman, healthcare costs and inflation have many causes, and Texas cannot solve all of them. We don't control Medicare. We cannot make major Medicaid changes without federal approval. And we have limited authority over self-insured employer plans governed by ERISA.

But that doesn't mean Texas is powerless. There are things we can do. I would encourage the Committee to focus on several policy principles:

First, Texans need better information about what healthcare actually costs.

Texas has an enormous volume of healthcare data, but it still lacks sufficiently accessible, actionable information to show where prices are highest, where spending is rising, and whether that growth reflects improved care, greater utilization, or increasing market power.

The Texas All-Payer Claims Database can help close that gap. Properly used, it can identify price variation for comparable services, high-cost outliers, regional differences, referral patterns, and the effects of provider and insurer consolidation. For full disclosure, I serve on the APCD Stakeholder Advisory Committee.

But data collection alone is not enough.

Texas should establish a Healthcare Affordability Office within the Comptroller's office to translate APCD data into practical, public-facing tools. The office could produce public scorecards, regional spending benchmarks, price comparisons, and regular reports on cost and quality variation for common services and procedures. Its purpose should be straightforward: give employers, patients, policymakers, and clinicians usable information — not merely more data.

Colorado offers a useful model. Its All-Payer Claims Database, administered by the Center for Improving Value in Healthcare (CIVHC), provides a public dashboard that allows users to compare prices and, where available, quality measures across major

categories of elective care. These include cardiology, behavioral health, maternity and obstetrical services, laboratory testing, imaging, and physical therapy.

Including quality information is critical. Without it, patients may understandably assume that a lower-priced provider delivers lower-quality care and avoid comparison shopping altogether. Yet price and quality do not always move together; higher prices do not necessarily mean better outcomes, and lower prices do not necessarily signal inferior care. Presenting both measures together would help Texans make more confident, informed choices.

Accessible cost-and-quality information would also strengthen independent physician practices like mine. Small practices generally do not have the analytic resources, contracting leverage, or market intelligence needed to determine what patients are likely to pay across referral options. With reliable information at the point of referral, physicians could better counsel patients about clinically appropriate, high-value options — and help families avoid unnecessary financial surprises.

Second, support and fund healthcare navigators.

If we expect patients to act as healthcare consumers, we must give them the support and tools to become informed ones.

Texas has taken meaningful steps toward price transparency. Patients can request estimates, review coverage information, and in some cases compare the cost of services. But the existence of information is not the same as information people can readily understand and use.

Healthcare decisions are inherently complex. Patients may be trying to interpret unfamiliar medical terms, determine whether providers are in-network, compare deductibles and coinsurance, anticipate facility fees, or understand whether a lower-priced option is clinically appropriate. That complexity often discourages people from comparison shopping — even when doing so could substantially reduce their out-of-pocket costs.

Texas should invest in independent healthcare navigators who can help patients make informed decisions when selecting healthcare services and health insurance coverage. A trained navigator could provide neutral, personalized assistance without steering patients toward a particular insurer, provider, or health system.

Navigators could help Texans:

- Understand and use information comparing costs and quality among healthcare facilities, physicians, other providers, and health plans so they can make better-informed decisions about where to obtain care.
- Evaluate whether a health plan will meet both their medical and financial needs by reviewing covered and noncovered services, provider networks, deductibles, copayments, coinsurance, expected out-of-pocket expenses, and total cost-sharing — not simply the monthly premium.
- Complete health coverage applications accurately and understand the documentation required to enroll.
- Identify whether a referral, prior authorization, or other plan requirement could affect access to a preferred clinician or service.
- Prepare questions to ask at a physician's office, hospital, imaging center, insurer, or pharmacy before scheduling nonemergency care.
- Recognize when an estimate may exclude important costs, such as professional fees, facility charges, anesthesia, laboratory work, or follow-up care.

The goal is not to shift responsibility for a fragmented and opaque system onto patients. It is to make the system more navigable while patients retain meaningful choice. Price transparency works best when patients can pair clear cost information with trusted guidance about quality, coverage, and the clinical appropriateness of their options.

Third, Texas should reduce and standardize administrative requirements wherever possible.

Administrative complexity imposes real costs throughout the healthcare system. Every unnecessary form, duplicative credentialing request, nonstandard quality measure, and avoidable prior-authorization review consumes time that could otherwise be devoted to patient care. Those costs are ultimately borne by patients, physicians, employers, and health plans.

For an independent practice, the impact is especially direct. Every hour my staff spends navigating administrative requirements is an hour they are not spending helping a patient schedule care, resolve a prescription issue, coordinate a referral, or answer a clinical question.

A large health system can absorb these demands by hiring dedicated departments for credentialing, prior authorization, billing, compliance, and reporting. A five-physician practice cannot. When administrative demands increase, an independent practice is left with difficult choices: hire another employee and raise overhead, see fewer patients, or conclude that remaining independent is no longer sustainable.

Reducing unnecessary bureaucracy is therefore not simply a physician-practice issue. It is an access-to-care issue. Streamlining administrative requirements would allow small practices to devote more capacity to patient care — an especially important goal in a state facing shortages of primary care clinicians.

Lawmakers should consider practical reforms that reduce duplication while preserving appropriate oversight, patient protections, and plan accountability.

- **Create a single credentialing pathway.** Texas already uses a standardized credentialing application, and many plans use the CAQH Provider Data Portal. Yet physicians can still face duplicative submissions, different portals, repeated document uploads, inconsistent timing requirements, and payer-specific requests for substantially similar information. Texas should evaluate whether all health plans can use a single statewide credentialing platform, modeled on the approach used in Medicaid managed care, with one provider-maintained record accessible to participating plans. Blue Cross and Blue Shield of Texas, for example, directs many professional providers to use CAQH for initial credentialing and recredentialing, illustrating that a shared platform is feasible. The policy opportunity is to make the process more consistent across payers.

- **Limit duplicative credentialing requests.** Plans should be required to accept core information already verified through a standardized process unless they can identify a specific, legitimate reason for additional documentation. Examples of avoidable duplication can include repeatedly submitting copies of medical licenses, DEA registrations, malpractice coverage, board-certification records, work history, ownership disclosures, hospital affiliations, and attestations that have not changed since the prior submission.

- **Evaluate a carefully designed credentialing-by-proxy pilot.** Texas could examine whether, with appropriate consent, verification standards, security protections, and audit authority, a physician credentialed by one participating Texas health plan could allow another plan to rely on defined portions of that verification. Credentialing by proxy is already an established approach in the

telemedicine setting, where one institution may rely on credentialing information verified by another rather than repeat the entire process from the beginning. The NAMSS — American Telemedicine Association guide describes it as an efficient pathway for credentialing telemedicine practitioners. A Texas pilot should begin with common primary-care credentialing elements and retain each plan's authority to impose genuinely plan-specific network standards.

- **Standardize quality reporting and documentation.** Physicians are often asked to report similar clinical information in different formats, on different schedules, and through separate payer portals. Texas should encourage or require alignment around a limited, clinically meaningful set of quality measures, common definitions, and interoperable reporting methods. For example, a primary care practice should not have to calculate and submit measures for blood pressure control, diabetes control, preventive screening, or follow-up after hospitalization differently for every health plan when the underlying clinical information is drawn from the same electronic health record.

- **Reduce low-value prior authorization.** Prior authorization should be reserved for services where it demonstrably improves safety, appropriateness, or value — not used as a routine barrier for well-established, evidence-based care. Policymakers could require plans to exempt clinicians or practices with consistent approval histories from prior authorization for specified services, establish faster decisions for routine requests, and require authorization approvals to remain valid when a patient's coverage changes within the same plan year.

The principle is simple: administrative standards should protect patients and ensure accountability, but they should not force independent practices to divert scarce staff time away from patient care. A fairer, more standardized system would lower overhead, preserve physician independence, and expand the capacity of community practices to care for Texans.

Fourth, require payment neutrality for comparable outpatient services.

Texas should pursue site-neutral payment policies that prevent materially higher reimbursement for comparable routine outpatient services simply because the service is delivered in a hospital-owned facility rather than an independent physician practice.

For patients, ownership should not determine the price of care. Yet when an independent physician practice is acquired by a hospital system, the same physician

may continue seeing the same patients, in the same building, providing the same service — while the service is suddenly billed at a higher hospital-affiliated rate. Patients can face higher deductibles, coinsurance, and total out-of-pocket costs without receiving anything meaningfully different.

This is particularly important for routine outpatient services such as imaging, laboratory testing, infusions, and certain procedures that can be safely and appropriately provided in either a physician office or a hospital-affiliated outpatient setting. If the clinical service is comparable, Texas should not allow the corporate ownership of the site to become a justification for a materially higher price.

This is not an argument that hospitals and physician practices should be paid identically for every service. Hospitals perform functions that independent practices generally do not: emergency and trauma readiness, inpatient capacity, complex and high-acuity care, teaching, and other essential community services. Those functions deserve appropriate support.

But those legitimate costs should not automatically justify higher reimbursement for routine, nonemergency outpatient care that can be safely delivered in a physician office. Texas should distinguish between paying appropriately for the unique functions of hospitals and paying more simply because a routine service has moved onto a hospital's balance sheet.

The issue is also bigger than the price of an individual service. **Site-of-service differentials can create a financial incentive for consolidation.**

When a hospital system can receive substantially more reimbursement for a service simply by acquiring the practice that provides it, the payment system can effectively reward the acquisition itself. That additional revenue can help large systems support higher administrative overhead, subsidize other operations, finance further acquisitions, and offer compensation packages that independent practices cannot match.

That creates a structural disadvantage for independent physicians — even when they provide the same high-quality care at a lower underlying cost.

The effect is particularly important for the next generation of physicians. A young physician may value the autonomy, continuity, and community connection of independent practice. But if the system pays substantially more once that practice becomes hospital-owned, the hospital can use that additional revenue to offer higher

guaranteed compensation, signing bonuses, benefits, technology, and administrative support.

The result is a market that can reward ownership rather than efficiency.

Over time, that can accelerate consolidation: fewer independent practices, fewer meaningful competitors, less patient choice, and greater dependence on dominant health systems. The consequences are especially serious in communities where an independent practice is the only realistic alternative to the dominant hospital system.

Texas should therefore consider a targeted site-neutrality policy for a defined set of routine, nonemergency outpatient services that can safely and appropriately be provided in multiple settings.

The policy should be carefully designed to protect access and recognize legitimate differences in the role of hospitals. That could include service-specific implementation, reasonable exemptions, phased implementation, and protections for rural and qualifying safety-net hospitals. Texas could also consider directing a portion of any savings toward maintaining essential services in communities where hospitals face genuine financial or access challenges.

The objective should not be indiscriminate payment cuts. It should be to eliminate a distortion that allows the same routine service to command a materially higher price simply because a hospital owns the practice.

If Texas wants a more affordable and competitive healthcare system, it should stop rewarding consolidation when consolidation does not produce additional value. Texans should pay for the care they receive — not pay more because the building is owned by a hospital system.

Fifth, Texas should use its own purchasing power.

In Huntsville, many of my patients are state employees, educators, retirees, or family members covered through state-related health plans. So, the decisions made here in Austin are not abstract to me. They directly affect whether my patients can afford care and whether practices like mine can continue providing it.

Texas should use its purchasing power to test a better way of paying for care.

One model I believe is worth looking at is the bipartisan Patients First Act, a comprehensive, bipartisan bill introduced in the U.S. House in July, designed to

overhaul the Medicare physician payment system, stabilize independent medical practices, and decrease administrative burdens.

The idea is pretty simple: instead of paying primary care physicians only for individual visits and procedures, provide a predictable per-member, per-month payment for taking responsibility for the patient's primary care.

That matters because primary care doesn't happen only when the patient is sitting in the exam room.

It happens when we coordinate with a specialist. When we manage a patient's diabetes or hypertension between visits. When we call a patient who is struggling. When we review medications. When we answer a question that keeps someone from going to the emergency room.

Those things have value, but our current payment system often doesn't pay for them.

The Patients First model recognizes that. It provides a predictable payment that can support office visits, care management, behavioral health integration, and communication with patients outside the traditional office visit. It also removes patient cost-sharing for those services, making it easier for patients to stay connected to their primary-care physician.

And importantly, this isn't simply giving physicians more money with no accountability.

The payment should come with clear expectations for access, quality and total cost of care.

- Did patients have better access?
- Did quality improve?
- Did we reduce unnecessary emergency-room visits and hospitalizations?
- Did total spending go down?

Let's measure it. Texas could pilot this approach in its own employee and educator health plans, particularly with independent primary-care practices. We could test it alongside other strategies like direct primary care, lower-cost sites of care, bundled payments, and value-based arrangements.

Then let the results guide us. If it works, expand it. If it doesn't, change it or stop it.

Finally, we have to invest in primary care.

As a family physician, I believe one of the most important things Texas can do to improve affordability is strengthen primary care — the part of the system patients are encouraged to use first.

Primary care clinicians handle about half of ambulatory physician visits, yet primary care receives only a small share of total healthcare spending. That is a poor match for the role primary care plays in preventing costly complications and helping patients navigate an increasingly complex system.

Much of primary care's most valuable work is not captured in a billable office visit: managing diabetes and hypertension before they become emergencies; coordinating with specialists; reviewing medications after a hospital stay; answering an after-hours question that prevents an unnecessary emergency-room visit; and helping patients overcome barriers such as transportation, food insecurity, or inability to afford a prescription.

Texas spends far more when those efforts fail. Hospital care accounts for nearly one-third of total U.S. health spending. Adults with chronic disease who have a usual source of primary care have lower odds of emergency-department use and hospitalization. If Texas wants fewer preventable complications, emergency visits, and hospitalizations, it must make primary care financially sustainable before patients get sick enough to require more expensive care.

Texas should test payment models similar to the Patients First Act, providing predictable monthly support to independent primary-care practices in exchange for accountability for access, quality, patient experience, and total cost of care. The Patients First Act framework allows payment approaches that include fee-for-service and risk-sharing arrangements.

Those payments should support care that fee-for-service often overlooks: chronic-disease management, care coordination, hospital follow-up, same-day and after-hours access, and proactive outreach to patients at risk of avoidable complications.

Finally, Texas should help small practices participate in value-based care. Large systems have the staff, technology, data, and contracting infrastructure to take on these models; independent practices often do not. Shared analytics, care-management resources, standardized reporting, contracting support, and affordable technology would allow smaller practices to compete on value rather than size.

The principle is simple: Texas should pay primary care not only for the visits it provides, but for the costly problems it helps patients avoid.

Mr. Chairman, I don't think anyone is happy with our current health care system. We may sometimes wish we could blow it up and start over, but that isn't a realistic option. If we do these six things, we can increase competition and make healthcare more affordable without sacrificing independence, quality or access.

- Make cost and quality information usable.
- Fund independent healthcare navigators.
- Reduce and standardize administrative requirements.
- Stop paying more for comparable routine care simply because of ownership.
- Use the state's purchasing power to test better ways of paying for care.
- Make primary care financially sustainable.

Thank you again for the opportunity to provide testimony. I'm happy to answer any questions.