



Center for Public Policy Priorities

National Health Reform: Overview and Issues for Texas

Texas Children's Mental Health Forum

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Health Reform's Big Picture

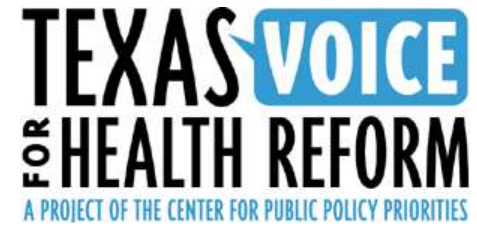
1. *For the first time:* a system making comprehensive care available to all* Americans, at a cost they can afford.
2. *For the first time:* health insurance marketplace requires insurers to compete based on good care and customer service, and not by avoiding covering people or denying them care they need.
3. Lays foundation for medical practice reforms based on effective health care, not just rewarding volume; this is **ESSENTIAL** to cost control and long-term deficit reduction.

* Lawfully present in U.S.

The Timeline

- A number of insurance industry reforms begin this year. Greatest impact is on those with high health costs.
- Also starts building the new systems needed to support covering large numbers of uninsured.
- The big expansion of coverage starts January 2014.

First-Year Reforms



New Benefits and Protections in Your Health Insurance Coverage

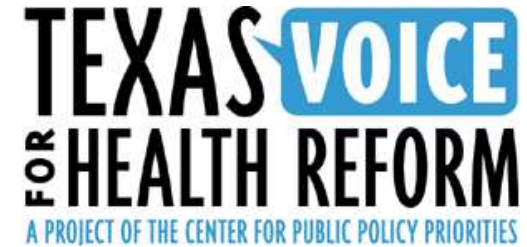
The following provisions take effect at policy renewal starting on September 23, 2010:

- No lifetime caps (All plans). Restrictions placed on annual limits in new plans.
- Prohibits denial of coverage for children based on pre-existing conditions and pre-existing condition waiting periods for kids. (All)
- Prohibits rescission—retroactive cancellation of coverage—except for fraud. (All)
- Dependent allowed on parent’s plan until 26th birthday (even if married). (All)
- Bans co-pays or other out-of-pocket expenses for preventive care. (New plans)
- No employer policies favoring higher-wage workers for coverage eligibility. (New)
- New independent review process for appeals. (New)
- Direct access to pediatricians and OBGYNs without referral. (New)
- Out-of-network emergency care covered at in-network cost-sharing rates. (New)

Ensuring Reasonable Rates

- 2010: HHS Secretary and states establish process for annual review of rate increases. (New state-regulated plans). Grants available to states.
- 2011: Requires insurers to devote 80-85% of premiums to medical benefits or provide rebates to consumers. (All state-regulated plans)

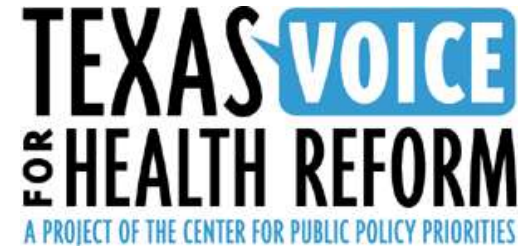
First-Year Reforms, cont'd



These provisions take effect within the first year:

- New nationwide interim high-risk pool coverage for uninsured individuals with pre-existing conditions (*July 2010*).
- Small employer tax credits available. Up to 35% of premium cost.
- New interim re-insurance for early retirees (age 55-64) (*June/July 2010*).
- Grants available to states to establish an Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman.
- Grants available to states to establish health insurance exchanges
- Begins new \$11 billion investment in Community Health Centers.
- New funding for training primary care docs, nurses, other professionals.
- Medicare improvements.

Making Medicare Stronger



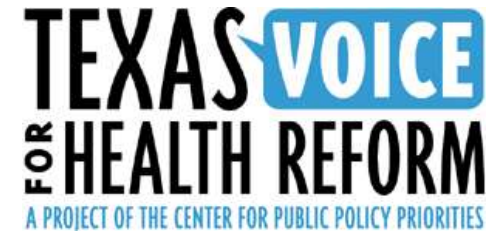
2010: Closing the Rx “Doughnut Hole”: Shrinks Doughnut Hole by \$250 in 2010 (rebate), 50% discount on brand-name drugs in the remaining gap; **closes doughnut hole entirely by 2020**

Jan. 2011: New preventive benefits: comprehensive annual check-up and other prevention benefits with no out-of-pocket costs.

Extends Solvency of Medicare Trust Fund by 10 years: Not by cutting current Medicare benefits or budgets, but “bending the curve” slowing growth in Medicare spending from 2010 to 2019.

Better Access to Community-Based Services and Supports: Medicare today does not cover community-based services to help seniors remain in their homes. Creates voluntary insurance program (CLASS) to provide community-based assistance services and support. *Starts 2011; 5 years to vest; first benefits 2016.*

Health Reform Basics



- Key coverage elements:
 - Build on current system: “grandfathering” leaves much current coverage potentially unchanged for years
 - **2014: Medicaid expansion:** cover all up to 133% FPL (\$14,404 for one; \$29,327 for 4).
 - **2014: Reform Private Health Insurance:** standardize benefits, can’t raise premiums if you get sick, limited premium increases based on age, no denial of coverage, no excluding pre-existing conditions, no annual or lifetime maximums..
 - **2014: New Health Insurance Exchanges** where private insurers’ options can be compared and purchased (like Amazon or Travelocity for insurance).
 - Includes non-profit plan option; All members of Congress get coverage thru Exchange;
 - Exchanges’ effectiveness depends on subsidies, market reforms, standardized benefits, individual mandate, negotiating powers.
 - **2014: Premium assistance** up to 400% of FPL (\$88,200 for family of 4)
 - **2014: Out-of-pocket subsidies and out-of-pocket caps,** too, to increase affordability reduce medical bankruptcy
 - **2014: Individual mandate** to have coverage (with major exemptions)
 - **2014: Some requirements for employers to contribute,** with exemption for all employers with 50 or fewer workers.

Health Reform: A full circle solution



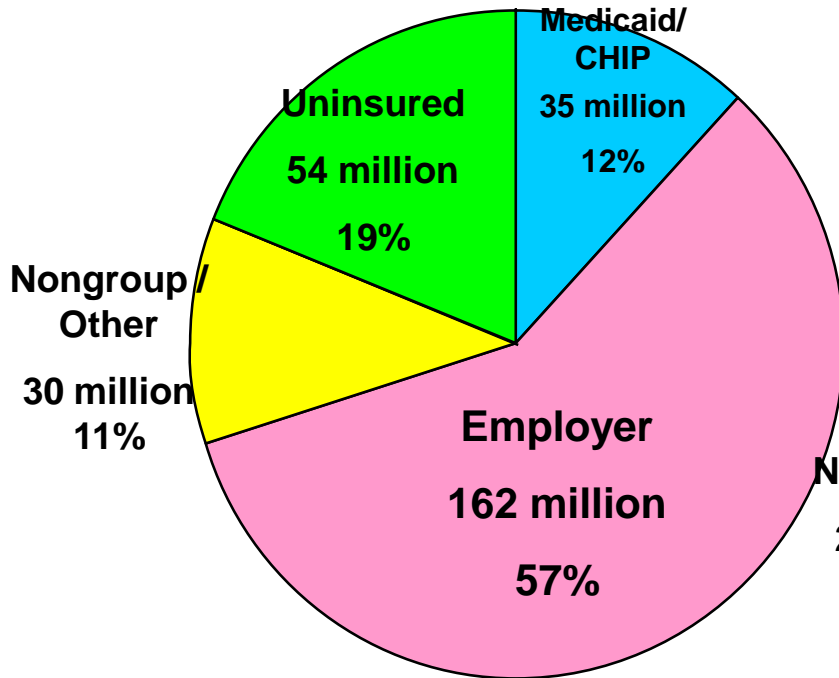
Affordable Coverage

- **Medicaid for very low-income adults:** cover all U.S. citizen adults up to 133% of the federal poverty level (< \$14,404 for one person; \$29,327 for a family of 4). Texas does not cover most parents or adults without children today, no matter how poor.
- **CHIP Program Preserved:** CHIP program extended to 2019, and CHIP block grant funded through end of FY 2015.
 - In 2014, all kids up to 133% FPL in Medicaid; above that in CHIP (brings some 6-18 yr-old kids into Medicaid)*
 - In 2015, 23 point increase in state CHIP match rate (i.e., to ~95% in TX)
- **MOE:**
 - States serving adults above 133% FPL may not reduce their income limits until 2014 when Exchange opens
 - States may not change CHILDREN'S income levels for Medicaid or CHIP through 2019.
 - Entire Medicaid funding at risk.
- **Sliding-scale premium assistance:** Uninsured above Medicaid limit and < 400% FPL (\$43,320 for a single person, \$88,200 for family of 4) can buy insurance through Exchange, protected from having to spend more than a set % of income on premium (ranging from 2% to 9.8%); also lower cost sharing and out-of-pocket caps.

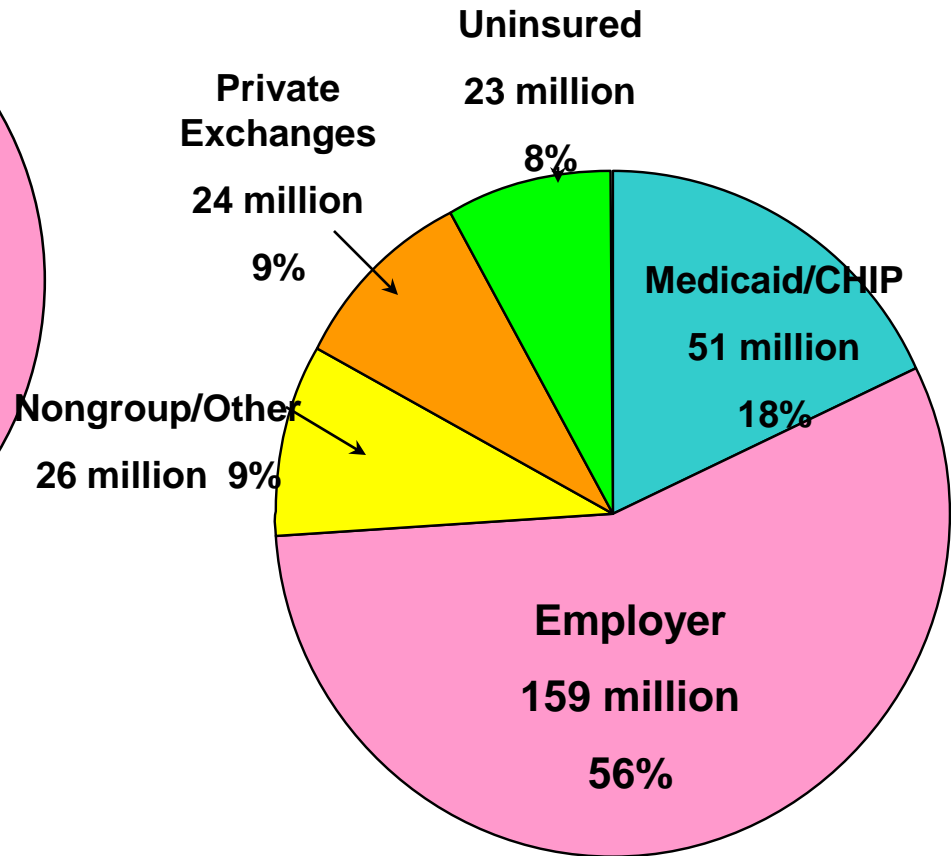
Mental Health Coverage Provisions

- Private market and Medicaid coverage expansions
- Private market reforms:
 - new, more affordable high risk pool
 - can't be turned down or charged more because of health status
 - No pre-existing condition waiting periods
 - no lifetime or annual limits
 - preventive care with no out-of-pocket costs
- All exchange plans would be required to offer a minimum benefit package, which must cover mental health and addiction services, rehabilitative services, Rx.
- Mental health parity extended to plans offered to small businesses and individuals.
- Adults newly eligible for Medicaid will get 'benchmark' benefits, but they must contain mental health and substance abuse benefit and federal mental health parity applies
- New Medicaid chronic care state plan option (2011): community mental health centers can be designated a health care home, and mental health professionals may be part of any health care home clinical team. For Medicaid enrollees with at least 2 chronic conditions or 1 serious mental health condition. 90/10 match for 2 years.
- Medicare: closing Part D doughnut hole.

CBO Projected Shifts in Insurance Coverage of Non-Elderly Populations Current Law and Final Health Care Reform Bill Year 2019 (U.S.)



Current Law - 2019



Under Reform - 2019

- The Nongroup & Other category includes Medicare. Bill provisions affect Nongroup coverages, which consists of those that purchase policies outside of group or employer coverage
 - Undocumented immigrants and people who are eligible for, but not enrolled in Medicaid are included in the uninsured category.

New State Roles; Medicaid/CHIP Eligibility and Enrollment Issues

- State Medicaid eligibility system
 - Must overcome current problems and prepare to accommodate growth
 - Must have smooth interface with Exchange system
 - Exchange has option to pay state to do income eligibility for insurance subsidies
 - Medicaid **MUST** offer online, in person, telephone and mail application options in 2014.
 - “No Wrong Door” coordination between Exchange and Medicaid required.

New State Roles: Health Insurance

Greater Role for TDI in Regulation

- **2010:** Rates filed with TDI; TDI identifies unreasonable rates increases (but no authority to act on them)
 - **2010 Decision:** Apply for rate review grants. \$250 million from 2010-2014 with \$1-\$5 million to each state per year
- Enforce new insurance reforms
- Oversee dual regulatory systems with grandfathered and reformed markets.

New Opportunities for Consumer Assistance and Education

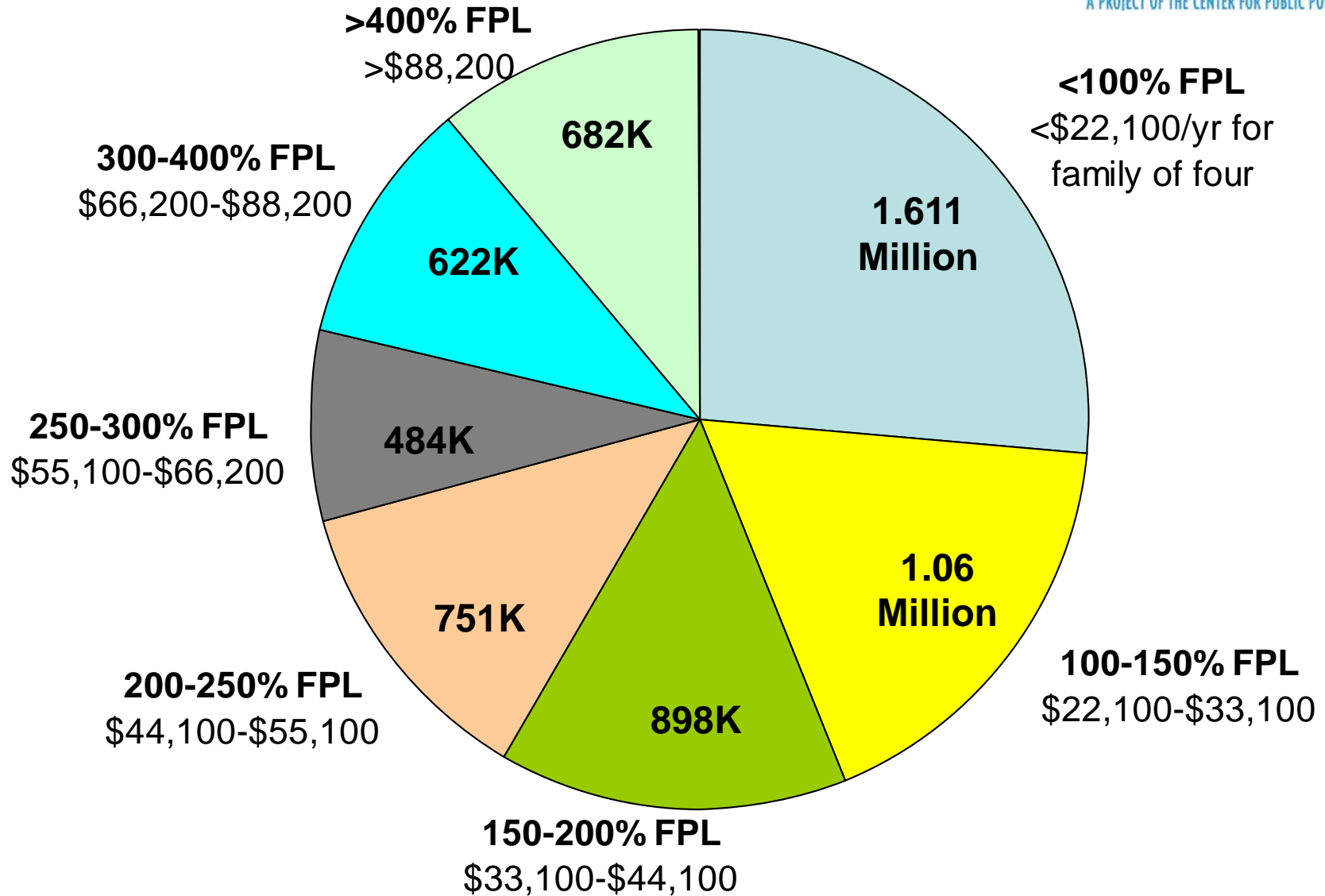
- **2010 Decision:** apply for grant to create an Office of Health Insurance Consumer Assistance or Consumer Ombudsman at TDI? OPIC? Other location? \$30 million in 2010 and as appropriated in following years.

Create and Run a Health Insurance Exchange

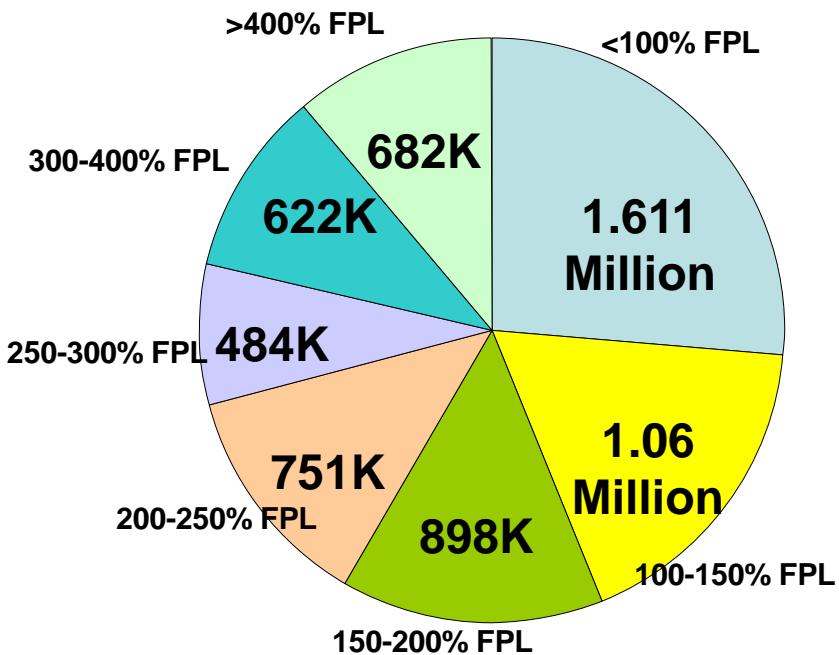
- Run by the state, or deferred to feds? Run by which state agency?
- Basic functions set in federal law, but many decisions on how to establish and operate the exchange will be made at the state level.

Texas Uninsured by Income Today...

6.1 million uninsured in 2008



How Would Texans Gain Coverage If Health Reform were Fully Implemented Today?



6.1 million
Uninsured 2008

Of the 6.1 Million Uninsured Texans today...

- ~2.5 Million (adults and kids) would qualify for coverage, with help, from the new Exchange
- ~ over 600,000 more would qualify for Exchange coverage at full cost
- ~ 1.0 million U.S. citizen adults would qualify for Medicaid
- ~ 500,000 to 700,000 kids qualify for Medicaid or CHIP right now
- CBO predicts 1.5 to 1.8 million would remain uninsured
- ~ 2 Texans gain private coverage for each 1 gaining through Medicaid
- UNKNOWN: How quickly, what % of eligible persons enroll.

Who Remains Uninsured?

- **U.S. Citizens**

- VERY low income and those who would pay more than 8% of income for most affordable exchange coverage have no penalty (no mandate)
 - Some of these may remain uninsured, pay no penalty
- Some will be uninsured because they still can't afford their costs, and will pay a penalty;
- Others may choose not to be covered and pay the penalty
- Tax penalties are 1/6 of cost of coverage
- Unknown today: what share of low- & moderate-income Texans may stay uninsured?

- **Undocumented:**

- no Medicaid/CHIP (not before, not now),
- no premium help, and cannot buy at full cost from exchange
- best estimates say 40% of undocumented in U.S. TODAY have private coverage

- **Legal Permanent Residents:**

- Adults are excluded from Texas Medicaid under state law, but
- Can purchase from Exchange and qualify for help with premiums

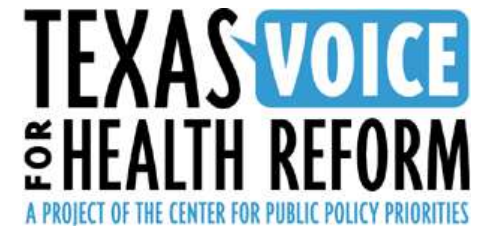
Fewer Uninsured, Reduced Demand for Safety Net Care: How Much, How Soon?

- + Medicaid expansion and Exchange coverage
- + \$11 billion for FQHCs
- Expansions don't start till 2014 and will take several years to ramp up.
- ~ 1 million of Texas' 6.1 million uninsured = undocumented
- Uncertainty re: adequacy of premium help: how many will remain uninsured?
- Inadequate provider base for ALL TEXANS, not just Medicaid: all capacity will be needed, and expanded capacity critical.

Caveats: (mis)perceptions that:

- Safety net funding/programs no longer needed
- Or, only needed for Undocumented, pressure to de-fund
- Temptation to dismantle safety net BEFORE reforms have reduced actual need to balance budgets.

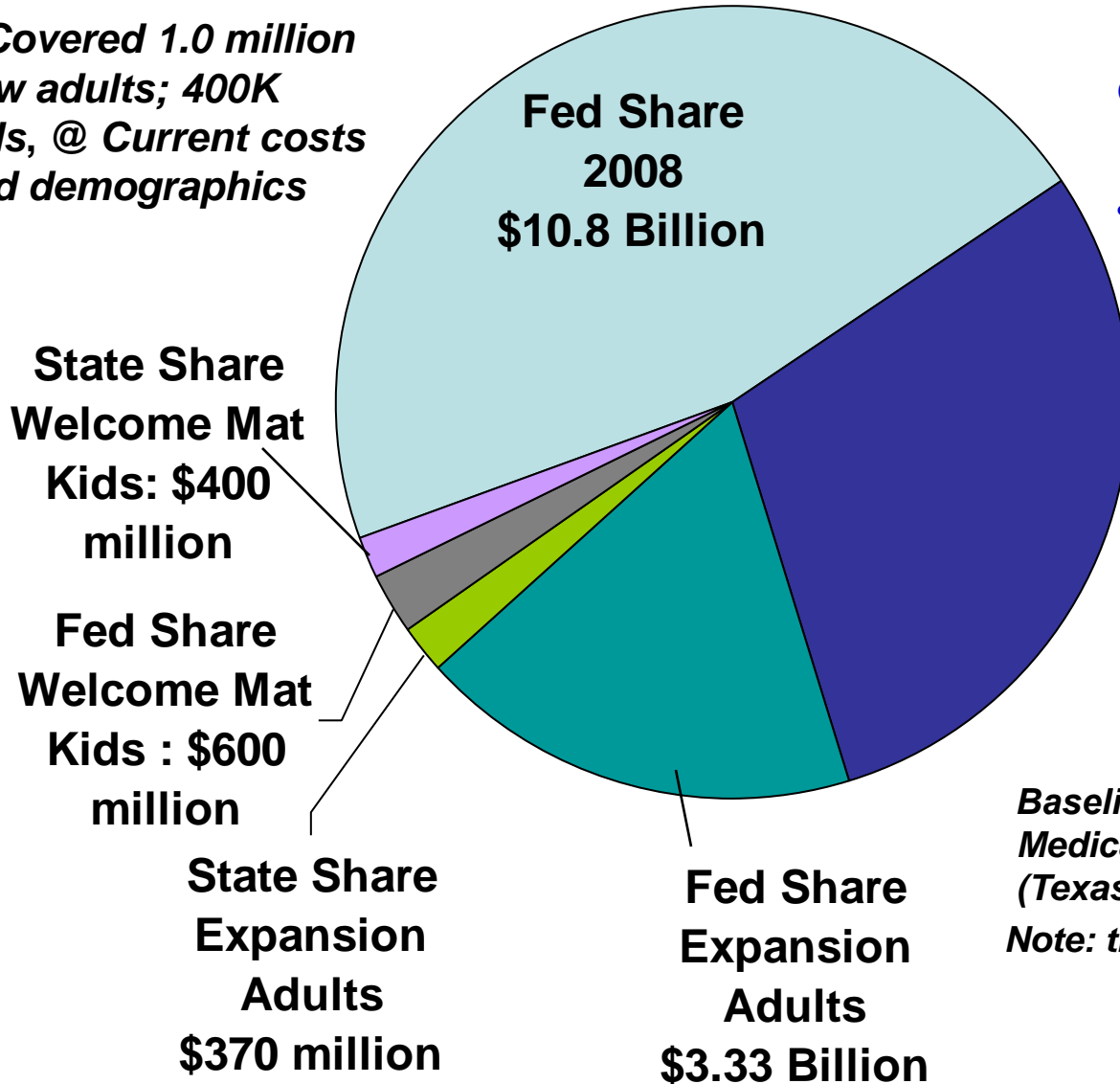
Benefits & Costs of Health Reform to State



- Medicaid expansion for adults: NO state budget costs until 2017 (federal govt. pays). In 2020, Texas get \$9 federal dollars for every \$1 state dollar.
- Based on other states' experiences, more currently-eligible Texas children will enroll in Medicaid; state must pay its standard Medicaid share of about 39% for these already-eligible uninsured Texas “welcome mat” children, **adding another significant cost to the state budget.**
- Medicaid will pay better primary care fees (Medicare levels) in 2013 and 2014, Feds pay 100% of but not thereafter. State concern: Unless Congress changes this, additional costs to state Medicaid budget – or rates get reduced again.
- Some providers' increased costs of covering their workers will show up passed through in Medicaid rates.
- HHSC “worst-case” preliminary cost estimate thru 2023 shows 6:1 ratio of federal dollars to state costs.
- Medicaid cost share --even if offset 6-to-1 with federal funds--must be funded in state budget to some degree as soon as 2014, and in context of a severe structural deficit in our state tax system and current leadership unfavorable to increasing revenue capacity, no matter what the benefits to the state.

Illustration: How Adult Expansion Could Change Texas Medicaid Budget

If Covered 1.0 million new adults; 400K kids, @ Current costs and demographics



- State share of new adult costs small relative to federal share (9:1)
- State share of welcome mat kids costs could be comparable due to less favorable match

Baseline "Now" = Projected Texas Medicaid Services Spending, 2008 (Texas HHSC)

Note: this does NOT model increased admin costs.

Medicaid in 2012-2013 TX Budget

- **NO health reform expansion costs, but admin costs at TDI & HHSC**
- **Revenue shortfall numbers make it obvious: without more revenue, there WILL be deep cuts.**
- In 2003, Provider Rates were the largest category of HHS (Article II) cut. After partial restorations, the total projected reduction in Medicaid and CHIP rates was about \$599 million.
- **Federal law Medicaid and CHIP maintenance of effort requirements mean provider rates are the largest program area that states can cut.** Health reform MOEs: no eligibility cuts for Medicaid adults until Exchange opens in 2014; no cuts for children in Medicaid and CHIP through 2019.
- **“Optional” adult benefits may also be cut**
 - 2003 Lawmakers rejected certain cuts: cutting off community care and nursing home care; eliminating Rx coverage for aged, disabled, and adult clients
 - They DID eliminate services of LPCs, SWs, psychologists, LMFTs, podiatrists, and chiropractors; and adult eyeglasses and hearing aids. (Restored in 2005)

LBB's Best Case Scenario

Assuming revenue growth matches growth in expenses

	Current Budget	2012-13 Budget
General Revenue	\$75.0 billion	\$75.0 billion
ARRA (instead of GR)	\$6.4 billion	\$0
Cash on hand	\$2.7 billion	\$0
Property Tax Relief Fund carryover	\$3.0 billion	\$0
Permanent School Fund	\$0	\$1.2 billion
TOTAL GR BUDGET	\$87.0 billion	\$76.2 billion
GAP		\$10.8 billion

Health Reform Implementation Timeline

Effective in 90 days	Takes Effect in 2010	Implement in 2014	Later Implementation
<ul style="list-style-type: none"> • Nationwide interim high-risk pool coverage for individuals with pre-existing conditions • Interim reinsurance for employers providing early-retiree health benefits 	<p><i>As of September 23</i></p> <ul style="list-style-type: none"> • Prohibit lifetime benefit caps • Prohibit pre-existing condition exclusions for children • More primary care training \$\$ • Ban Co-pays and other Out-of-Pocket expenses for preventive care and immunizations, incl. Medicare • No more “Rescissions” • Dependent coverage to 26th birthday <p><i>In 2010</i></p> <ul style="list-style-type: none"> • Start closing Medicare Rx Donut Hole; new Medicare prevention benefits • Grants to states to for consumer assistance • Expand access to Community Health Centers • Tax credits for small firms • Rate review medical loss ratios 	<p>MAJOR COVERAGE & REFORMS BEGIN</p> <ul style="list-style-type: none"> • Creation of Health Insurance Exchanges • Medicaid Eligibility up to 133 % FPL • Sliding-scale premium assistance up to 400 % FPL • Out-of-Pocket subsidies (to reduce out-of-pocket costs) • Out-of-Pocket caps for ALL persons with high medical expenses • Ban annual benefit limits in all plans • Individual Mandate • Employer Responsibility 	<ul style="list-style-type: none"> • January 2016: first benefits for community supports under CLASS Act • 2016: compacts for interstate insurance sales. • 2018: High-cost health plan excise tax begins

For detailed timeline, see www.kff.org

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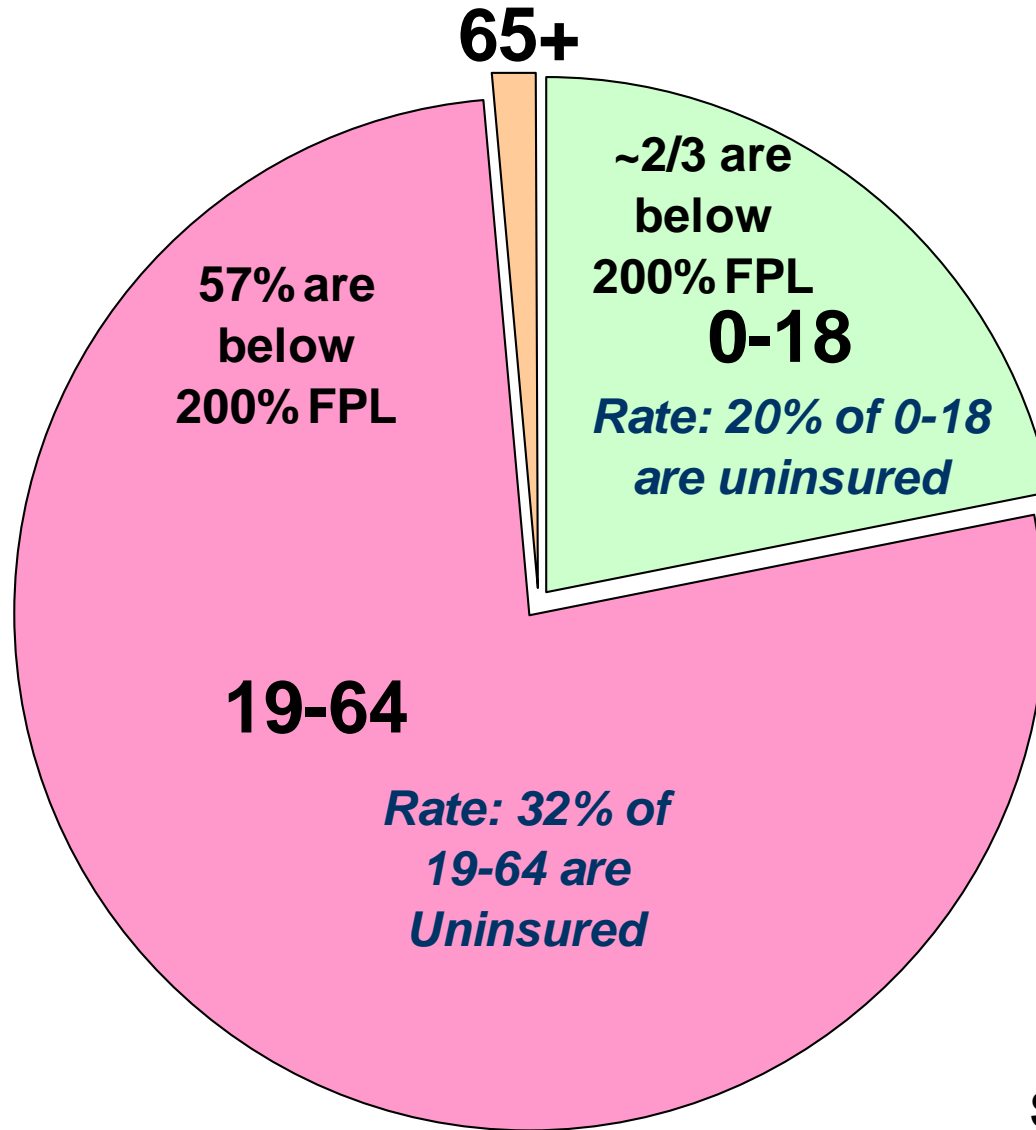
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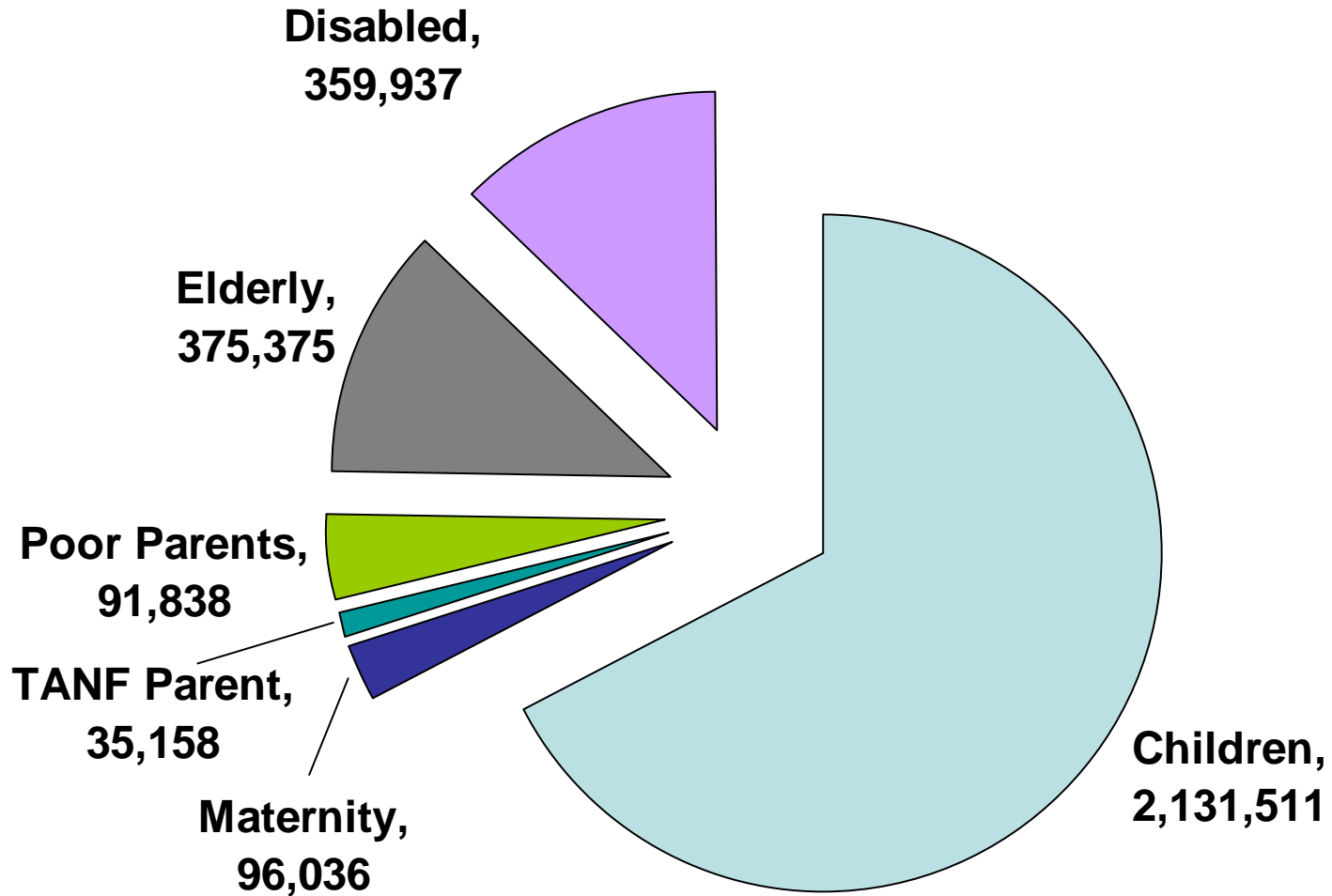
Uninsured Texans by Age Group, 2008



Source: U.S. Census

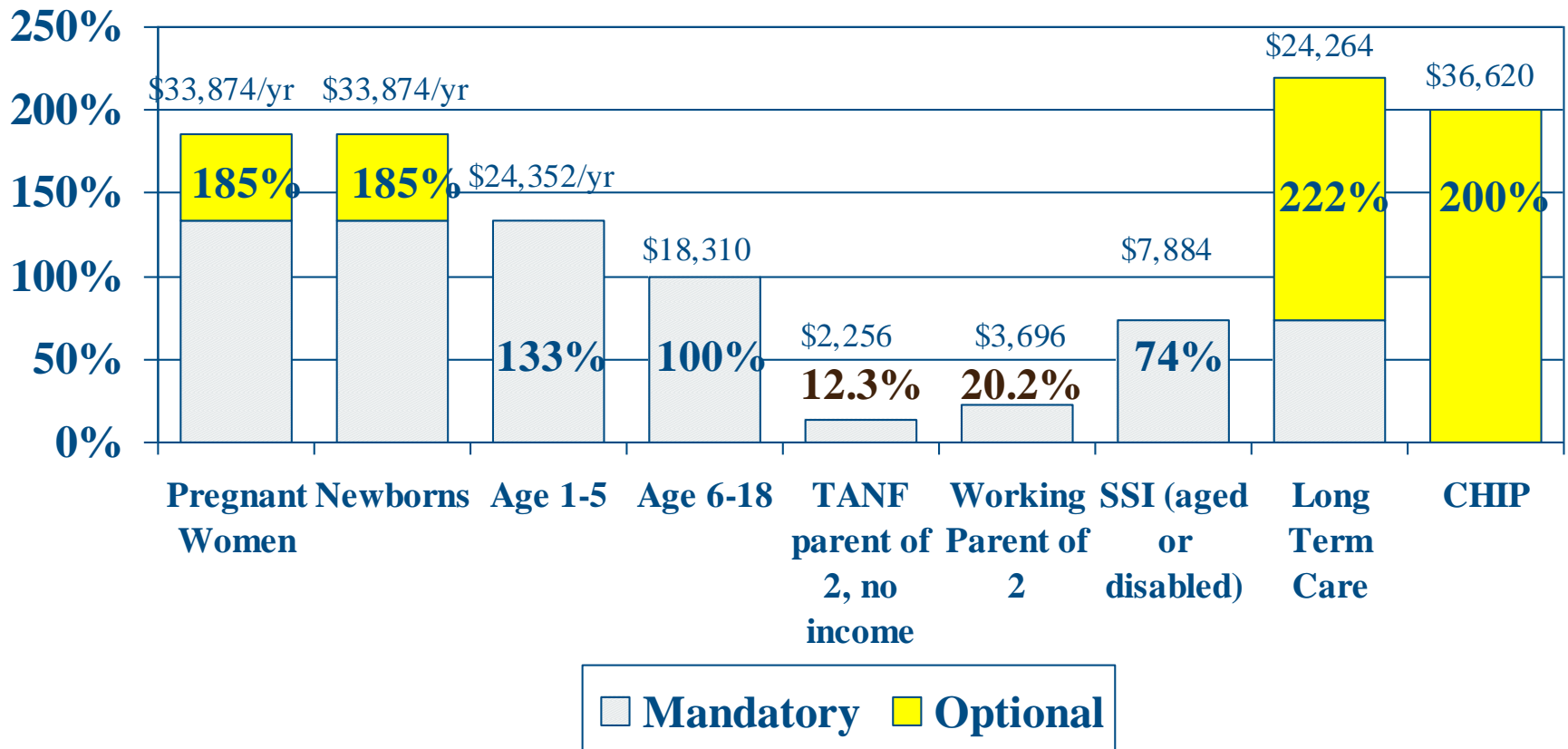
Texas Medicaid: Who it Helps

January 2010, HHSC data.



Total enrolled 1/1/2010: 3.2 million

Income Caps for Texas Medicaid and CHIP, 2009

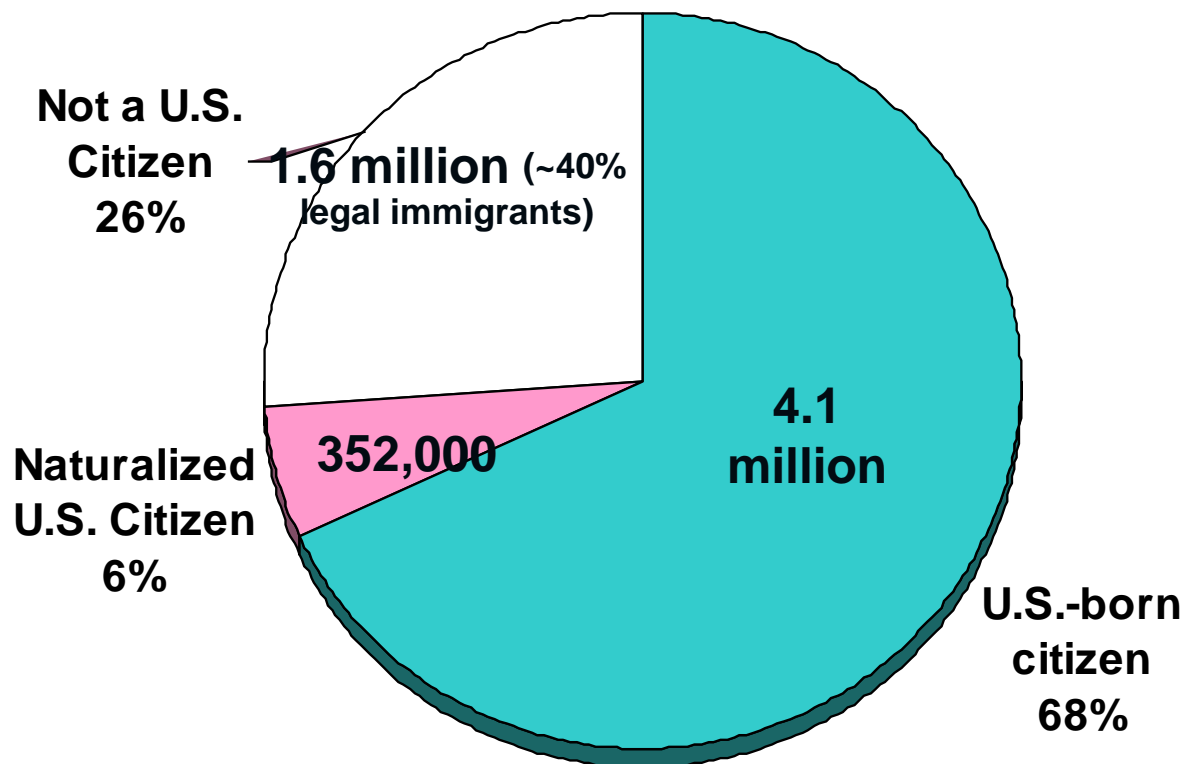


Income Limit as Percentage of Federal Poverty Income
Annual Income is for a family of 3,
except Individual Incomes shown for SSI and Long Term Care


Most Uninsured Texans are U.S. Citizens

(6.1 million Uninsured in 2008)

Uninsured by Citizenship Status, 2007-08 Average



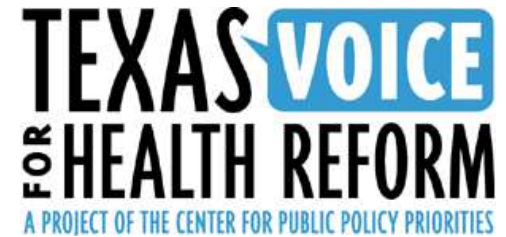
Premium Help: Max % of Family Income for Premiums in Exchange

Income for a Family of Four		Max % Income for Premiums
From:	To:	
\$22,000 (100% FPL)	\$29,000 (133% FPL)	2.0-3.0% 
\$29,000	\$33,000 (150% FPL)	3.0-4.0%
\$33,000	\$44,000 (200% FPL)	4.0-6.3%
\$44,000	\$55,000 (250% FPL)	6.3-8.1%
\$55,000	\$66,000 (300% FPL)	8.1-9.5%
\$66,000	\$77,000 (350% FPL)	9.5%
\$77,000	\$88,000 (400% FPL)	9.5%

Out-of-Pocket Costs: Share of Health Costs Covered under Exchange Plans

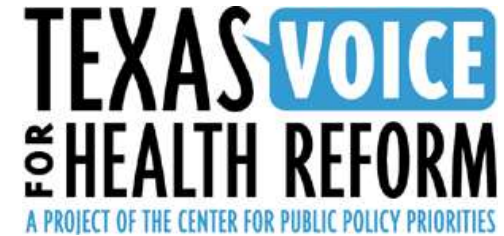
Income for a Family of Four		Avg. Share of Costs Covered	Out of Pocket MAX as % of income (not incl. premiums)
From:	To:		
\$29,000	\$33,000 (150% FPL)	94%	1/3 of HSA: \$1,983/indiv. \$3,967/family
\$33,000	\$44,000 (200% FPL)	85%	
\$44,000	\$55,000 (250% FPL)	73%	1/2 of HSA: \$2,975/indiv. \$5,950/family
\$55,000	\$66,000 (300% FPL)	70%	
\$66,000	\$77,000 (350% FPL)	70%	2/3 of HSA: \$3,987/indiv. \$7,973/family
\$77,000	\$88,000 (400% FPL)	70%	

Medicaid DSH



- Given Texas' relatively large share of both uninsured U.S. citizens and undocumented residents (the latter ineligible for Medicaid, CHIP, or premium subsidies), Texas is likely to continue to have one of the highest uninsured rates relative to other states.
- Reduce national Medicaid DSH allotments by \$0.4 billion in 2014; \$0.6 billion in 2015; and \$1.8 billion in 2017, \$5 billion in 2018; \$5.6 billion in 2019; \$4 billion in 2020.
- ***Worst case:*** *If cuts are allocated in proportion to a state's share of the total federal DSH funding, then Texas' share would be reduced by \$35 million in 2014, \$52 million in 2015, \$156 million in 2016, \$434 million in 2017; \$487 million in 2018; and \$348 million in 2019.*
- Because DSH cuts are targeted to states with the lowest uninsured rates, Texas should expect smaller cuts than this.
- DSH revenue today is small relative to hospitals' uncompensated care burden; substantial gains in coverage—e.g., covering a million adults in Medicaid--would increase patient revenues for most hospitals by a much larger amount than the current capped DSH pot (~\$1.5 billion All Funds).
- UPL future is unclear; ongoing issue of gap between Medicaid rates and costs.

Individual Responsibility



- **Keeping coverage affordable** requires spreading risk over large pool that includes healthy people; individual responsibility to get insurance makes this possible.
- **Individual mandate:** Starting 2014, most U.S. citizens and legal residents will be required to obtain coverage meeting minimum standards for themselves and for their dependents.
- **Who Is Exempt?** No penalty for these:
 - (1) uninsured if lowest-price Exchange plan costs > 8% of family income;
 - (2) anyone with income below the **tax filing threshold (\$9,350 indiv./\$18,700 couple in 2009)**
 - (3) excused for financial hardship (to be defined);
 - (4) religious objectors;
 - (5) Native Americans;
 - (6) undocumented immigrants (also ineligible for Medicaid or premium help);
 - (7) incarcerated persons; and
 - (8) those with a gap in coverage of less than 3 months.

Individual Responsibility

- Penalty concept: create incentive to take responsibility; funds collected also help support safety net that uninsured will rely on when sick or injured.

How it Works. *Unless exempt:*

- federal income tax penalty is based on # uninsured in a family.
- but family max is greater of: 3X individual penalty, or 2.5% of family income, when fully phased in.
- penalties phase in from 2014 to 2016: \$95/1% in 2014, \$325/2% in 2015; \$695/2.5% 2016.
- from 2016 on \$695 for adults and \$375 for children under age 18.
- maximum of \$2,085 per family or 2.5% of income.
- Annual inflation updates to penalty amounts after 2016.

Individual Responsibility

Penalties for the uninsured are a fraction of the cost of getting insurance.

- average annual cost of a family group insurance premium in Texas today about \$13,000, so:
- the maximum family penalty of \$2,085 would be **less than one-sixth of the cost of insuring a family.**

Employer Responsibility

*Employer-sponsored insurance is the foundation for coverage today.
Employer responsibility provisions encourage employers to maintain existing coverage.*

- Strictly speaking, the law does not require employers to offer coverage.
- But does require larger employers to contribute financially if their employees get subsidized coverage in the Exchange.
- Penalties are a fraction of the cost of coverage.
- **Small employers (50 or fewer full-time workers) have no obligation to provide coverage, and are exempt from penalties** if they choose not to offer coverage and their workers get help in the Exchange.

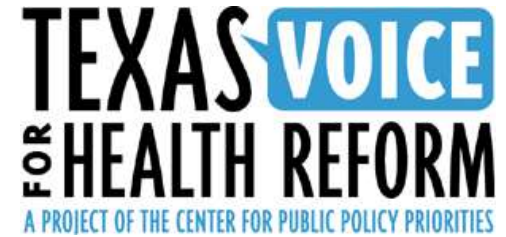
Employer Responsibility

Penalties for firms with more than 50 full-time workers:

Penalty Situation	Assessment
<p>If <u>NO</u> coverage offered <i>and</i> at least 1 full-time employee get subsidized coverage in the Exchange.</p>	<p>Annual assessment of \$2,000 per full-time worker, excluding the first 30 workers from the penalty calculation.</p> <p>\$2,000 penalty is ~23% of employer's cost for family coverage*</p>
<p>If coverage is offered, but at least 1 full-time worker gets subsidized coverage in the Exchange (allowed if worker's premium share exceeds 9.8% of family income).</p>	<p>The lesser of \$3,000 per subsidized employee OR \$2,000 for each full-time employee.</p>

*On average, Texas employers today pay 68% of the cost of family coverage, or \$8,840 of a \$13,000 family premium.

Other Significant Medicaid Changes



- **Asset limits abolished** for all but aged and disabled Medicaid (“MEPD” in TX), effective **2014**
- **Expansion adults** will get a benchmark benefit plan,
- **New gross income standard** (MAGI) with 5% “standard deduction”,
- Medicaid until 26th birthday for all **youth formerly in foster care** for 6 mo. + (2014)
- **CHIP allowed for state employee kids** if premium/cost share exceeds 5% of income, based on July 1997 out-of-pocket costs (updated for inflation); i.e., state cannot increase family costs to take advantage.
- **Cost reduction**: states will get higher rebates for Medicaid Rx
- **New Options:**
 - New medical home benefit for enrollees with 2+ chronic conditions (2 years 90% match)
 - State Plan optional HCS benefit (not waiver) up to 3X SSI, tied to “higher need”
 - Community First Choice option, enhanced match rate (interaction with optional HCS not clear yet)