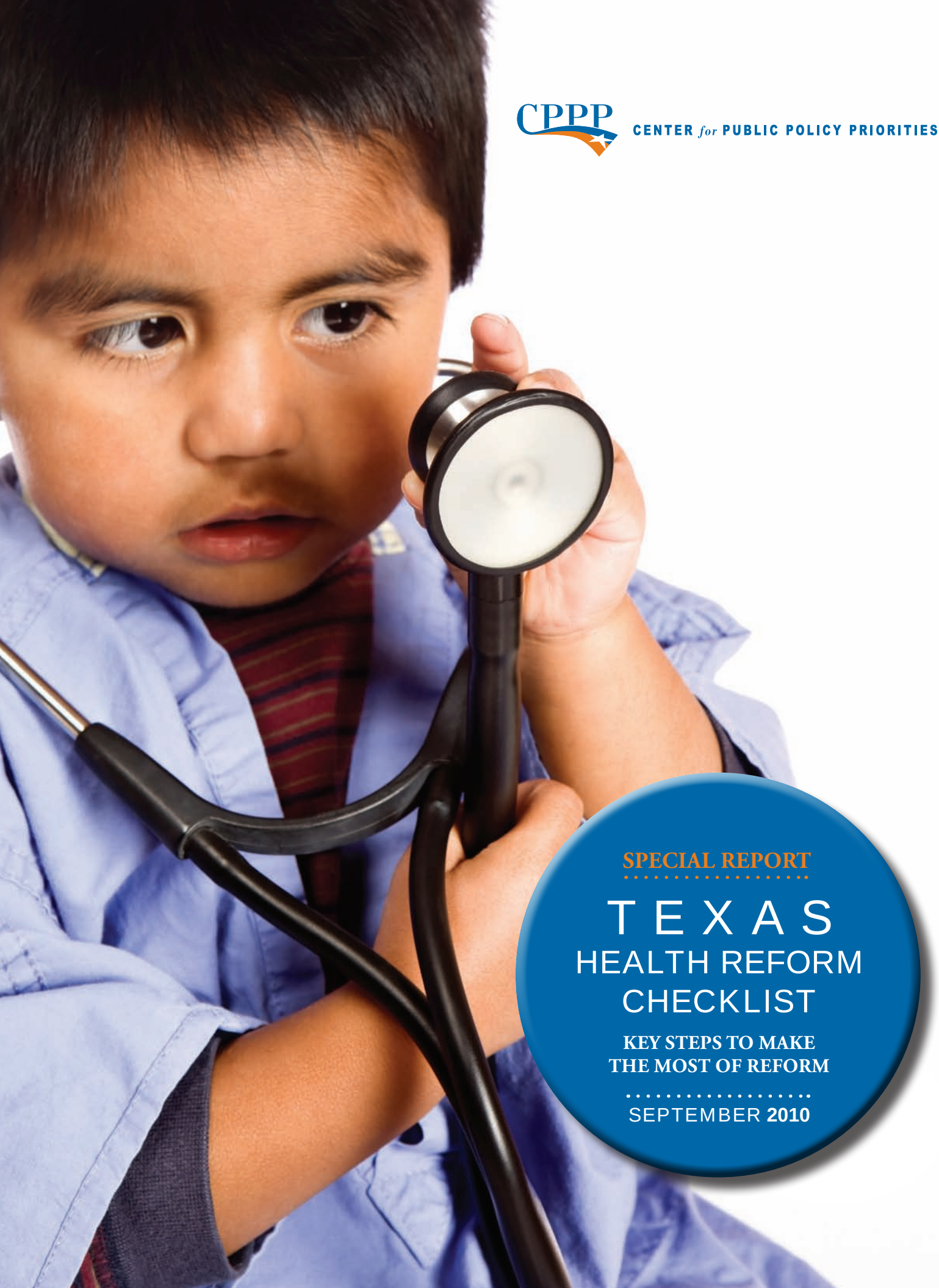

CPPP CENTER for PUBLIC POLICY PRIORITIES

SPECIAL REPORT

TEXAS HEALTH REFORM CHECKLIST

KEY STEPS TO MAKE THE MOST OF REFORM

SEPTEMBER **2010**

CPPP

For 25 years, the Center for Public Policy Priorities has been a nonpartisan, nonprofit policy institute committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. The center pursues this mission through independent research, policy analysis and development, public education, advocacy, coalition-building, and technical assistance.

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METHODIST HEALTHCARE MINISTRIES
OF SOUTH TEXAS, INC.
"Serving Humanity to Honor God"

Table of Contents

Introduction

The new national health reform law will change the health care landscape in Texas. Though Texans' opinions of the new health care reform law cover the full spectrum from approval to those who would have preferred a different approach, the new law is an important tool that states can use to achieve their own health policy goals, such as increasing coverage, improving transparency and quality, and controlling costs.

The new law provides substantial federal funding to support fundamental improvements in Texas' health care system, but leaves many of the key policy decisions and much of the heavy lifting to implement national health reform up to the states. Ultimately, decisions made at the state level—by the Texas Legislature and state agencies including the Health and Human Services Commission and the Texas Department of Insurance—will determine how successful Texas is at expanding health insurance coverage, improving quality, and controlling health care costs.

Texas is at a fork in the road. We can take a strategic approach in implementing the law with the goal of maximizing new policy changes and federal funding to create a high-performing health care system that delivers quality care to Texans and serves as a model to the nation. If we don't, we will squander an opportunity to make much-needed improvements in our health care system. The consequences of inaction will be unnecessary barriers to coverage, less-coordinated and lower-quality care, a less healthy population, and uncontrolled health care costs that take a toll on Texas' families, employers, and state budget.

This report provides an overview of health reform implementation in our state. It explains key health reform provisions, identifies imminent decisions that must be made at the state level, and explains what is at stake for Texas as we work on implementation.

Implementation in Texas

Every state will face challenges in implementing health reform: the scope and complexity of tasks required for implementation and the serious budget shortfalls facing most states, to name just two. Texas will face additional challenges. For one, the Legislature and state agencies must move forward with new responsibilities under federal law at the same time that key leadership in Texas is opposing health reform and working to overturn parts of the law. On top of that, past public policy and funding decisions place Texas in a weak starting position, with the highest uninsured rate in the nation (25 percent), the largest share of uninsured children (1.4 million), widespread health care provider shortages, and low per-capita state and local spending on health care.

Given this, Texas must start work on implementation now—leading up to and during the 2011 legislative session. The new law created some immediate changes and funding opportunities. But even for the longer-term changes, such as coverage expansions that start in 2014, Texas must begin planning now, coordinating across multiple state agencies, and developing the necessary infrastructure. To ensure successful implementation, the Texas Legislature must make important policy decisions and enact significant legislation in the 2011 session.

If we have strong state leadership and a firm commitment from policymakers and stakeholders, Texas can take advantage of the opportunities under health reform to create a better health care system for Texans. The following principles should guide Texas' work to implement reform:

Health Reform Timeline

2010-2013

- Several major insurance reforms begin: dependent coverage through age 26, no lifetime limits, no pre-existing condition denials for kids, premium increase oversight; minimum standards for share of premiums that plans must pay out for health care;
- Pre-existing condition insurance plan starts;
- Building/expanding systems needed to support covering large numbers of uninsured in 2014;
- Medicare starts closing Rx donut hole; adds preventive care with no out-of-pocket costs.

- **Every Texan deserves a choice of secure, affordable health insurance coverage.** Competition, regulation, consumer education and assistance, and financial help for low- and moderate-income families are all needed to expand access to coverage.
- **Every Texan deserves access to health care.** Beyond access to insurance coverage, Texans need timely access to high-quality care from an adequate system of doctors, other medical professionals, hospitals, clinics and safety-net providers.
- **The Texas health care system should be in the forefront nationally in the delivery of high-quality, efficient care.** Health reform provides multiple platforms for moving our health care system to greater accountability for improving outcomes, and away from merely rewarding high volumes of costly services.
- **Texas must develop a fair and sustainable way to address our health care funding needs.** An adequate system must meet Texans' needs and be able to keep up with Texas' growing population.
- **A healthy population is essential to a strong state economy and workforce.** We must improve prevention of chronic conditions, better coordinate care, and improve health outcomes. High-quality health systems and a healthy workforce are important parts of being a good place to do business.
- **Individuals have responsibility.** Health reform requires all but the very poorest to contribute financially to their health care. In return, implementation must assure that adequate systems are in place for health care delivery and health coverage that will protect families facing high health needs against financial ruin.

2014

- Expansion of Medicaid coverage to adults under 133% federal poverty level starts;
- Health exchanges begin offering coverage to small firms, uninsured, those who lack employer coverage, with sliding scale for those below 400% of federal poverty level.

2017

- First year Texas has costs for new adult Medicaid group (5% share).

2020

- Medicare Rx plan donut hole fully eliminated.
- Texas reaches maximum share of costs for new adult Medicaid (10%).

Health Reform Provisions

The health reforms passed by Congress do not radically restructure of our health care system, as some hoped and others feared. Instead, health reform builds on existing systems for health coverage and care in the United States that include a mix of public and private approaches with both federal and state responsibility. The health reform law makes three fundamental changes to our health care system:

- It establishes systems to ensure that all U.S. citizens and lawfully present residents who contribute a reasonable share of their income to health care are guaranteed access to good standard of care that's affordable even if their income changes.
- It changes the rules health insurance companies play by so that coverage is priced fairly for all and insurers can no longer compete by avoiding risk—denying or charging more to less healthy individuals—but must instead manage risk and compete for customers by offering good value.
- It lays a foundation for controlling costs—critical to long-term fiscal stability of our country—while improving the quality of care.

2014 Health Reform Building Blocks

- Builds on current system: Vast majority of Americans still get coverage through their employer.
- Medicaid expansion: US citizens to 133% FPL ($14,404 for an individual; $29,327 for a family of four). Increase primary care Medicaid reimbursement rates to Medicare levels in 2013 and 2014.
- Reform private health insurance: standard minimum benefits, can't charge more based on health status, limits on premium increases as people age, no denial of coverage, no excluding pre-existing conditions, no annual or lifetime maximums.
- New health insurance exchanges where private insurers' options can be compared and purchased. Open to people without job-based coverage and small employers, and all members of Congress will get coverage thru exchange.
- Sliding scale premium assistance in the exchange up to 400% of FPL ($88,200 for family of four).
- Sliding scale deductibles/copays and out-of-pocket caps in the exchange , to increase affordability & reduce medical bankruptcy.
- Individual mandate to have coverage (with major exemptions).
- Some requirements for employers to contribute if their full-time employees get sliding-scale help in exchange, with exemptions for all employers with 50 or fewer workers.
- Multiple programs to improve health care quality, effectiveness, and reduce cost inflation across Medicare, Medicaid, and private insurance.
- Multiple programs to grow the health care workforce and build more sites to access care, to accommodate more insured Americans

Health reform implementation will occur in stages over many years. Some reforms take place almost immediately, such as a new federal high risk pool, young adult access to a parent's insurance, and tax credits for small employers. Federal investments expanding the primary health care workforce are already underway and many pilot programs to improve the quality of care will start in the next few years. New health insurance exchanges, insurance market reforms, and a major expansion of coverage through Medicaid will start in 2014 when the individual mandate and employer responsibility provisions also take effect.

The following sections explain some of the key provisions in health reform; state action needed, if any; and the importance to Texas. Health reform provisions are grouped according to needed state action for implementation: those that require state action, those that present opportunities for state action, and those that take effect without state action. This information is summarized in the tables on pages 20-22.

Requires State Actions

Health Insurance Exchanges

Health reform establishes health insurance exchanges, new state-based mechanisms for purchasing health insurance coverage. Exchanges will create a more organized and competitive market available to individuals and families who do not have access to job-based insurance and small businesses by providing a central source of comparable information on health plan options and a standard enrollment process. Sliding-scale coverage for low- and moderate-income citizens will be available exclusively through the exchange. Undocumented immigrants cannot buy coverage in the exchange, even at full cost.

Federal grants will fund the planning, creation, and operation of state exchanges from 2010-2014. Starting in 2015, exchanges must be self-supporting. Funding options include an assessment on participating health plans or a surcharge on insurance premiums.

Health reform establishes some basic responsibilities of exchanges, but also leaves states with considerable discretion to decide the structure, governance, and functions of their exchange.

States may set up and operate an exchange, or choose to leave that role to the federal government. To open the exchange by January 1, 2014, and make other deadlines in the law, the Texas legislature will need to take action during the 2011 regular session (or a special session) to authorize a state agency or state-established nonprofit entity to create and operate an exchange.

Texas must decide whether to create one statewide exchange or multiple regional exchanges, and whether to operate two separate exchanges for individuals and small businesses. Texas must also design a governance structure for the exchange that has sufficient expertise, is free from conflicts of interest, and will be responsive to exchange customers and stakeholders.

A critical question Texas must address is whether the exchange should allow every health plan that meets minimum federal standards to participate (increasing choice for consumers), or selectively contract with health plans that provide the best premiums, customer satisfaction, and/or quality (increasing value for consumers).

Texas must also protect the exchange from "adverse selection"—to avoid having disproportionate enrollment by high-risk individuals in the exchange and migration of healthy enrollees to coverage in the non-exchange market—by ensuring that market rules both inside and outside of the exchange are the same.

Finally, the exchange will administer federally funded, sliding-scale premium and cost-sharing subsidies for low- and moderate-income enrollees. The Texas Comptroller estimates that Texans will receive more than $43 billion in federal subsidies from 2014-2019. Exchanges may choose to contract with state Medicaid agencies to process applications for premium and cost-sharing subsidies.

Exchanges are the cornerstone of private insurance market changes in health reform and will facilitate coverage for millions of low-income Americans who qualify for financial assistance. If Texas designs an exchange that acts simply as a web-based clearinghouse (a "Travelocity for health insurance"), we will miss an opportunity. Texas should design an exchange that acts as a catalyst to drive better value, efficiency, and quality in the health care system, much like large employers use their clout as health care purchasers to achieve these same goals.

Consumer Assistance

Health reform appropriates $30 million in grants in 2010 to help states set up and operate independent health insurance consumer assistance programs. Congress is authorized to make more funding available in years beyond 2010.

Such programs will help consumers understand coverage options and enroll, help consumers file complaints and appeals, and collect and report data on consumer complaints and problems. Though legal aid organizations help perform these functions for some very low-income Texans today, most Texas consumers who have or want private health insurance do not have access today to this type of independent consumer assistance.

Health Insurance Market Reforms

Health reform makes changes to health insurance market rules that are designed to expand access to affordable coverage. Provisions that prohibit lifetime limits; allow young adults to stay on a parent's policy until age 26; prohibit denials of coverage for children with pre-existing conditions; and strengthen appeals processes all take effect on September 23, 2010. In 2014, additional reforms take effect that prevent insurers from denying coverage or varying premiums based on health status and prohibit pre-existing condition exclusions. *The Legislature must bring Texas laws into compliance with these federal reforms. TDI will need to enforce the new market rules and provide consumer assistance and education related to new market reforms.*

Starting in 2010, the federal government and states will work together to review insurance premiums, identify unreasonable increases, and post for the public insurers' justifications for any increases officials find unreasonable. Exchanges will take a history of unreasonable rate increases into account when deciding whether to certify insurers for participation in the exchange starting in 2014. Health reform appropriates $250 million in grants to states for 2010-2014 to support the new rate review activities, and states can receive grants of up to $5 million annually. Texas has applied for and been awarded the first round of grant funding.

TDI engages in very little rate review today and will need these federal grants to build additional capacity to receive rate filings, review rates, and identify unreasonable rates. TDI today also lacks the authority held in most states to reject excessive rates proposed for individuals and small businesses. *The 2011 legislature should authorize this function to give teeth to TDI's new rate review activities.* The authority to block excessive rates will be even more important in 2014 when the individual mandate compels most consumers to purchase insurance.

Medicaid Expansion for Low-Income Adults

Medicaid today covers over 3 million Texans, primarily children in low-income families, and low-income seniors, individuals with disabilities, and pregnant women. Health reform expands Medicaid eligibility in 2014 to all U.S. citizens up to 133 percent of the federal poverty level ($14,400 for one person; $29,300 for a family of four). Today, Texas covers children in families at this income level, but does not cover most parents or adults without children. About 1 million of Texas' currently uninsured U.S. citizen adults would qualify for this coverage.

Texas has two primary roles in the Medicaid expansion: *(1) it must enroll eligible adults and administer their benefits; and (2) starting in 2017, it must pay part of the cost for those new adults.* The federal government will pay 100 percent of the costs of this new adult coverage for the first three years, 2014-2016. Texas will begin to pick up a 5 percent share starting in 2017, and topping out at 10 percent in 2020, meaning Texas will get nine federal dollars for every one dollar the state budget has to contribute.

The health reform law allows Texas to provide the newly eligible Medicaid adults either with the regular Medicaid benefits package or with a less comprehensive package, including one comparable to employer-sponsored health insurance: "benchmark" coverage. Benchmark packages must provide all the same "essential health benefits" that are required for people in exchange plans and in the individual or small group insurance market beginning in 2014, and meet other Medicaid requirements. Within these federal guidelines, Texas may define and administer the benchmark benefits.

Medicaid Eligibility Changes and Seamless Enrollment Systems

Health reform envisions an integrated eligibility and enrollment system between Medicaid, CHIP, and sliding-scale coverage in the exchange. States must use one common application form for all three programs, and accept applications in person, online, by phone, or by mail. All three programs will use the same federal income

tax-based definition for income eligibility. Reform also requires state eligibility and enrollment systems to use reliable third-party data matches when possible. For example, citizenship can be electronically verified with the Social Security Administration and income from IRS or state wage records. For Texas, major enrollment system changes needed include including accepting online applications and renewals, and using tax-based income definitions.

Changing family incomes will trigger coverage transitions between Medicaid, CHIP, and the exchange. *Texas must develop policies and systems that support a "no-wrong-door" approach to enrollment, including coordination among all relevant agencies, and the necessary infrastructure to trade information electronically. Without a strong focus on a no-wrong-door approach, Texans with incomes near the Medicaid threshold seeking coverage could get referred back and forth and fall through the cracks.*

Medicaid and CHIP Maintenance of Effort

States must maintain current eligibility levels for children in Medicaid and CHIP until 2019 and for adults in Medicaid until 2014, when the exchange is operational. States risk losing their full federal Medicaid funding if they cut back on eligibility. Texas received $16.4 billion in 2009 federal Medicaid funding, which helps finance coverage for over 2 million children, more than half of all births in Texas, and about 70 percent of all nursing home residents. Texas cannot cut Medicaid or CHIP eligibility to help close the looming budget shortfall. Pressure to make Medicaid cuts in other areas like provider reimbursement rates is likely.

Opportunities for State Action

Health Care Payment and Delivery System Reforms

Health reform contains many tools to help transform our health care system from one that often delivers fragmented, inconsistent care to one promotes high-quality, coordinated care. A key tool is testing innovative payment systems, starting with Medicare that reward quality of care and good outcomes as opposed to the current fee-for-service system that pays based on volume of services. States can participate in testing out new models in several ways.

- Health reform creates a new Center for Medicare and Medicaid Innovation to test delivery and payment arrangements designed to improve quality and slow the growth in costs in Medicare, Medicaid, and CHIP. The Center is appropriated $10 billion to fund demonstrations and can expand effective models nationwide.
- Several provisions support the expansion of patient-centered "medical homes," including a new Medicaid state option to provide care to chronically ill enrollees in a medical home model. Up to $25 million in planning grants will be available to states starting in 2011, and for two years, the federal government will cover 90 percent of medical home services.
- In 2013, Medicare will start a five-year demonstration to test "bundled payments"—a comprehensive payment for an "episode of care," that covers services starting three days prior to a hospitalization through outpatient care received for 30 days afterwards. The single payment shared between all

providers should increase incentives and teamwork to coordinate care and thus reduce preventable and costly hospital readmissions. Health reform also authorizes similar Medicaid bundled payment pilots in eight states.

- Starting in 2012, Medicare will reimburse Accountable Care Organizations (ACOs): teams of physicians and hospitals that work together to manage and coordinate patients' care. ACOs that meet quality standards and reduce costs will be able to share in part of the savings to Medicare. Medicaid and CHIP will also test pediatric ACOs starting in 2012.
- Beginning in 2012, Medicare will reduce payments to hospital with excess preventable readmissions. In 2013, Medicare will begin to vary payments to hospitals based on performance on quality measures. In 2011, Medicaid will stop paying for hospital-acquired conditions, and in 2015, Medicare will reduce payments to hospitals with high rates of hospital-acquired infections.

Texas can maximize cost control and quality improvement opportunities by pursuing participation in Medicaid demonstration programs, and by incorporating effective Medicare pay-for-performance reforms into Medicaid, state employee coverage, and private coverage offered in the exchange.

Health Care Workforce

Health reform makes substantial investments in building workforce capacity, especially in primary care.

- Reform establishes a National Health Care Workforce Commission to size up current and future health care workforce supply and demand, recommend a national workforce strategy to Congress, and make workforce development grants to states. Reform redistributes graduate medical education slots, giving priority to primary care. It also expands the primary care workforce (including physicians, nurses, and other health care professions) by funding scholarships and loan repayment, professional training, workforce diversity initiatives, and programs to recruit doctors in rural and medically underserved areas.
- Texas Medicaid pays physicians about 73 percent of Medicare rates on average, making timely access to providers in Medicaid a challenge. Health reform will provide full federal funding to boost Medicaid primary care rates up to Medicare levels for 2013 and 2014. Congress will have to take further action to determine what will happen with those rates from 2015 forward.
- Health reform significantly increases access to primary care in underserved areas with an $11 billion investment from 2011-2015 in community health centers, which will allow centers to double the number of patients they serve, and another $1.5 billion to the National Health Service Corps.

Texas does not have an adequate supply of health care professionals to meet the needs of Texans—insured or uninsured—today. Health reform creates multiple opportunities that the state, institutions of higher education, and health centers should take advantage of to prepare to better meet Texas' future health care needs.

Prevention and Wellness Initiatives

Health reform makes significant investments in federal, state, and local prevention and public health initiatives. It also increases access to prevention and wellness services and information to help individuals stay healthier.

- The law creates the National Prevention, Health Promotion, and Public Health Council tasked with coordinating federal prevention activities and developing a national strategy to improve the nation's health. Health reform appropriates $7 billion for 2010-2015 and $2 billion annually in 2016 and beyond to the Prevention and Public Health Investment Fund for prevention and public health activities at the federal, state, and local levels. Reform authorizes numerous programs, grants, and demonstrations aimed at promoting healthy behaviors, reducing chronic illness and health disparities, and encouraging participation in wellness programs in employer health plans, Medicaid, and Medicare.
- Health reform increases people's access to preventive health services. New private health insurance plans and Medicare must offer certain proven preventive care services with no out-of-pocket cost sharing. States that offer similar coverage in Medicaid will receive a one percentage point increase in their federal share for those services. Health reform also provides full federal funding to boost Medicaid primary care rates up to Medicare rates in 2013 and 2014.

Should Texas choose to fully pursue new prevention and wellness opportunities through health reform, the state could make meaningful progress toward the goal of improving the health of Texans.

Long Term Care

Health reform offers new tools to states to expand home and community-based care in Medicaid and establishes a new, voluntary long-term care insurance program.

- The new Community First Choice option in Medicaid will allow low-income individuals with disabilities who would generally receive care in a nursing home to instead receive community-based services and supports. States that implement this Medicaid option will get an extra 6 percentage point federal match boost for program costs. The option is available to states starting October 2011. States also have a new option to provide community care without a special waiver, and a new State Balancing Incentive Program will offer enhanced federal match to eligible states to increase the share of community-based long-term care services.
- Health reform extends the Money Follows the Person Medicaid demonstration program through 2016 with an additional $1.7 billion in funding. The program helps qualified Medicaid enrollees move from nursing homes into community-based care.

- Health reform establishes the Community Living Assistance Services and Supports (CLASS) program, a new voluntary, long-term care insurance program operated by the federal government. The program will help enrollees pay for non-medical support services at home or in assisted living or nursing home facilities. This program could represent a major shift in how long-term care is financed in the U.S. Participants will be eligible for benefits after paying premiums for at least five years. Premiums, which will be set to fully cover program costs, will vary by age at enrollment, but will remain constant after a person enrolls. Benefit level options will be available with a minimum benefit of $50 per day. The program will likely begin operations in 2012 or 2013.

Texas can take advantage of these new tools and help more Texans with disabilities and seniors to live as independently as possible in their homes and communities. Most new Medicaid-based options will require the state to share in the costs, which will create a hurdle for their adoption.

Essential Benefits Package

Starting in 2014, all plans sold in the individual and small employer markets that are not "grandfathered" (i.e., were not in existence as of March 23, 2010) must cover "essential benefits," a comprehensive, standard floor for benefits that will be defined by the U.S. Secretary of Health and Human Services (HHS). At a minimum, it will include hospital and emergency care, preventive care, chronic disease management, prescription drugs, mental health and substance abuse treatment, and maternity and newborn care.

Plans will be sold in five levels of coverage—platinum, gold, silver, bronze, and catastrophic—that vary by the share of costs covered by the plan (as opposed to enrollee cost sharing like deductibles and copays). For example, the platinum level will pay for 90 percent of covered benefits and the bronze level will pay for 60 percent. All plans sold in the exchange will cap annual out-of-pocket cost sharing at $5,950 for individuals and $11,900 for families above four times the poverty level, and set lower caps on a sliding scale for lower-income enrollees.

Today, both state and federal laws require certain individual "mandated benefits," such as mammography and mental health parity, but neither defines a comprehensive minimum standard of coverage. Health reform allows for plans to have significant enrollee cost sharing and high deductibles, but through essential benefits, it ensures that covered medical services will be sufficient to keep people healthy and treat them if they get sick.

If a state law requires mandated benefits in plans that go beyond the new essential benefits, the state must pay the extra cost of the additional benefit for exchange enrollees.

After the federal government defines essential benefits, Texas will need to evaluate which, if any, state mandated benefits exceed the new federal standard.

Takes Effect Without State Action

Individual Responsibility

Starting in 2014, individuals with affordable coverage options must have health insurance or pay a tax penalty. People exempt from the individual mandate penalty include:

- Individuals with incomes below the tax filing threshold (near the poverty line),
- Individuals for whom the lowest-price exchange plan costs more than 8 percent of family income;
- Those excused due to additional financial hardship standards;
- Religious objectors;
- Undocumented immigrants (who are also ineligible for Medicaid, CHIP and premium assistance); and
- Those with a gap in coverage of less than three months.

The tax penalty for failing to maintain coverage phases in from 2014-2016. By 2016, for those who are not exempt, the maximum penalty will be $695/year for each uninsured adult (half of that for children) up to a per-family maximum of $2,085 a year, or 2.5 percent of family income. The Texas Comptroller estimates that Texans will pay about $2 billion in penalties from 2014-2019.

Today, insurers use pre-existing condition waiting periods and exclusions to discourage people from waiting to buy coverage until they need care, and insurers keep more healthy people than sick people in the insurance pool by denying coverage or charging much more to those who are sick. Once these practices end in 2014, the individual mandate will be necessary to ensure that people do not wait to buy insurance after they get sick, which would cause premiums to rise dramatically.

State-based exchanges will certify who is exempt from the individual mandate, but otherwise, the federal government will be responsible for administering the new requirement through the federal income tax system.

Employer Responsibility

Employers will see many changes under health reform. They face new requirements, like the "free rider" penalty and standards for job-based coverage (no lifetime limits, for example). They'll also receive new benefits, like small business tax credits for insurance and federal funding to help pay for high-cost early retirees on employers' plan.

There is no across-the-board requirement for employers to offer health insurance. Small businesses (50 or fewer full-time equivalent employees) have no obligation to provide coverage, face no penalties if they don't, and can buy as part of a large pool through the exchange in 2014. Small businesses with 25 or fewer full-time equivalent employees and average annual wages less than $50,000 can qualify for federal small business tax credits for up to 35 percent of premiums starting in 2010, with the maximum tax credits increasing to 50 percent for two additional years

in 2014. The Texas Comptroller estimates that Texas small businesses will receive nearly $2 billion in tax credits.

Larger employers (more than 50 full-time equivalents) are subject to a new "free-rider" penalty starting in 2014 if any of their full-time employees receive a taxpayer funded sliding-scale subsidy in the exchange.

- If a large employer *does not* offer coverage and a full-time employee (30 or more hours per week) gets a subsidy in the exchange, the penalty is $2,000 a year for each full-time employee, excluding the first 30 employees.
- If a large employer *does* offer coverage, but a full-time employee gets a subsidy in the exchange (possible if that employee's job-based coverage would cost more than 9.5 percent of family income), the penalty is $3,000 a year per employee getting subsidized coverage, with a maximum of $2,000 per full-time employee, minus the first 30.

In either case, the cost of the penalty will be a fraction of the employer's cost of providing coverage. Today in Texas, 94 percent of all private firms with 50 or more employees report that they offer insurance.

Health reform also provides $5 billion in funding to help employers offset costs to maintain health coverage to early retirees (ages 55-64) from June 2010 to 2014. Funding to help pay high-cost claims from early retirees will be made available directly to qualified employers, which includes public employers.

ERS and TRS, the Texas agencies that administer state employee and teacher health benefits, and many other Texas employers that offer retiree coverage have already qualified to receive this funding.

Pre-existing Condition Insurance Plan

Health reform appropriates $5 billion ($493 million to Texas) to create the Pre-existing Condition Insurance Plan, new high-risk pool coverage for uninsured individuals with pre-existing conditions. Coverage is available from August 2010 until 2014, when health reform will prohibit health insurers from denying coverage or charging higher premiums based on pre-existing conditions. States had the option to directly administer the new program or defer to the federal government. The Texas governor opted to let the federal government run Texas' program. Plan information is at www.pciplan.com.

Medicare Benefit Improvements

Starting in January 2011, Medicare will add coverage of a comprehensive annual checkup and provide that checkup and other evidence-based preventive services with no out-of-pocket costs to enrollees. Health reform also closes the Medicare prescription drug "doughnut hole," a gap in coverage. Today, Medicare helps pay for the first $2,830 in annual prescription drugs, before enrollees fall into the doughnut

hole, and must pay 100 percent of all drug costs until reaching $6,440 in total drug costs, when Medicare coverage pays again. In 2010, enrollees who reach the doughnut hole will receive a $250 rebate check. In 2011, brand name drugs will be discounted 50 percent in the doughnut hole. Every year thereafter, the gap is closed a bit more and will be phased out entirely by 2020.

Top Five Priorities for Texas to Make the Most of Health Reform

Like every state, Texas has critical and systemic issues that limit the performance of our health care system today, and which must be addressed if Texas is to fully realize the promise of health reform. The following section identifies five of these most critical issues facing Texas.

1 Create a Consumer-Friendly Health Insurance Market

The Texas health insurance market fails many consumers today. Despite having more insurance companies doing business in Texas than most states, the market leaves one in four Texans uninsured, and Texas lags well behind the nation in coverage through job-based insurance. Texas must use the new tools in health reform to reshape the health insurance market into one that empowers and provides value to the purchasers of health insurance.

Texas should take advantage of federal grants to bolster effective consumer assistance functions in the state, by expanding capacity at state agencies or partnering with community-based organizations. Consumer assistance will help consumers understand their rights and responsibilities, enroll in coverage, appeal insurer decisions, and identify systemic issues facing consumers.

Competition cannot produce a healthy market if consumers lack good information to make informed decisions. The health insurance exchange gives states a platform from which to provide clear, comparative information about health plan price, benefits, value ratings, and customer satisfaction. But information is only powerful if consumers can easily access and understand it. Texas must ensure clear information is provided to consumers to enhance competition in the marketplace.

Decisions Texas will make in designing the structure and functions of the exchange will determine its level of success. Texas must guard against adverse selection, or disproportionate enrollment in the exchange by less healthy, more expensive individuals and businesses. An attempt in the 1990s to run an exchange-like entity for Texas small businesses failed due to adverse selection. The exchange must enroll a large and diverse pool of individuals and businesses, and the legislature must align state laws that govern the market outside of the exchange with federal standards for the market inside of the exchange to ensure a level playing field.

Texas should also give the exchange tools to drive value in the market. The exchange can serve as a market catalyst by limiting participation to those health plans that provide the best value in terms of affordable premiums, quality, and consumer satisfaction and negotiating to get the best value on behalf of exchange enrollees.

Health reform offers states the needed tools to bring transparency to the market, spur competition, empower consumers, and increase value. Whether and how Texas uses these tools will determine the degree to which the Texas market continues the status quo or evolves into a market that serves consumers, increases efficiencies, improves quality, and holds down costs.

2 Build a Health Care Workforce and Infrastructure for 21st Century Texas

Texans in many urban and rural communities alike already experience difficulty getting the kind of care they need, when they need it. If our systems are lacking today, with one in four Texans lacking health coverage, we can clearly expect that our health workforce has to grow to handle the significant increase in insured Texans that will begin in 2014. Health professionals are not trained overnight, so our state must start working right away to plan and build the health workforce and the delivery sites our growing population needs.

Problems accessing physicians today are not limited to public insurance programs like Medicaid and Medicare. Privately-insured Texans often find that doctors in their health plan are not taking new patients, and such shortages affect both primary and specialty care. Texas' uninsured fall across a wide income range whose demographics suggest that about twice as many uninsured Texans will gain private insurance coverage in the first years after 2014 as will gain Medicaid or CHIP. This means Texans in every walk of life will be affected by provider shortages if our state does not begin work in earnest today to prepare for the increased needs.

Though provider access problems are not limited to public insurance programs, they are clearly worst there—and fees are controlled by the Legislature and Congress. Texas Medicaid does not make regular updates in fees. Doctors went over 15 years with no increase before the last updates in 2007. Surveys confirm a steep decline in Texas doctors accepting Medicaid, where fees average 73 percent of what Medicare would pay. Rate cuts planned for the 2011 budget year and even deeper cuts proposed for the next two-year budget will only worsen the Medicaid access problems at a time when Texas needs to be building physician participation in Medicaid. Medicare rates are set by the U.S. Congress, and while they are far more adequate than in Medicaid, there are long-term issues that Congress must address so that seniors can truly access their new preventive care benefits.

Optimal planning for a Texas health system that can provide timely access to care must look across the entire spectrum of health professionals, and should take into account the evolving best practices nationwide in scope of practice regulations that make the most of the training of every class of provider while protecting standards of care.

Legislative planning and actions must also recognize the reality that significant—and not easily predicted—numbers of Texas residents will remain uninsured under the coverage expansion launching in 2014. Of the 6.1 million estimated uninsured in Texas in 2008, congressional health reform modeling predicts that 1.2 to 1.8 million would remain uninsured in 2019. This group will include U.S. citizens who remain uninsured, as many will be exempt from individual mandate penalties while others will choose a penalty over the higher cost of buying coverage. Today, roughly one in six uninsured Texans is estimated to be an undocumented resident. This group will remain disproportionately uninsured under reform unless federal immigration laws change to create new opportunities for this population.

Because significant numbers of Texans will remain uninsured in the years to come, and because even Texans with coverage will face access barriers due to provider shortages, it is imperative that lawmakers not undermine or prematurely dismantle critical health care safety net systems in Texas. In tough budget times, it will be tempting to redirect safety net funding before the needs of the uninsured have actually been met by a new system, or before uncompensated care demands on public providers have been reduced.

Texas has the opportunity to use the new platform of health reform to improve on weaknesses in our current system while building the resources needed to provide a decent standard of care for millions more Texans in the years ahead. Failure to plan and invest today—or to protect the systems still needed to serve the neediest—will be detrimental to the health and safety of Texans, as well as our desirability as a state to live and do business in.

3 Build Modern, Efficient Enrollment Systems for Medicaid and the Exchange

The speed with which uninsured Texans in 2014 forward gain either private exchange insurance or new Medicaid coverage for adults will depend in no small part on the efficiency of the systems in place to enroll them. Health reform requires states to have strong links between the two systems to ensure a "no wrong door" policy where Texans can apply to either system and be enrolled into the right coverage without

any further application steps. States can also choose to have the Medicaid eligibility system calculate who is eligible for help with premiums and out-of-pocket costs in the new insurance exchange, rather than setting up a new separate system for the exchange. A choice to integrate the two processes could help streamline access, but only if the Texas Medicaid enrollment system has the capacity it needs for high performance.

No matter which choice Texas makes, expanding and modernizing Texas' Medicaid enrollment system in advance of 2014 will be a key to the success of health reform. Of 6.1 million uninsured Texans in 2008, over 1 million were U.S. citizen adults with incomes that would qualify them for Medicaid in 2014, and another 600,000 to 700,000 uninsured children who qualify for Medicaid or CHIP today but are not enrolled. Though all the eligible uninsured will not enroll immediately in 2014 (e.g., Texas CHIP took a full 24 months to reach peak enrollment) the system must be prepared to handle an increase from the current 3.1 million Medicaid enrollees to numbers approaching 5 million in the first years of expansion. Of course, should the state elect to use that same system to handle exchange enrollment, capacity must be even greater.

The Texas Medicaid (and other public benefits) enrollment system has undergone a performance crisis since 2006 from which it has only recently begun to recover. In the worst months, fewer than half of applications were processed in the 45 days required by law, and more than a third of applicants waited more than 90 days to have eligibility determined. Since September 2009, HHSC has gained nearly 850 eligibility staff, which along with system and training improvements has brought the percentage of cases processed timely up to 94.1 percent in July 2010, compared to 75.4 percent in September 2009.

At this juncture, it is critical that the Medicaid enrollment system continue to modernize, improve, and expand capacity to prepare for the 2014 Medicaid expansion. This will not be achieved unless we sustain and build upon these staffing and system improvements between now and 2014.

Health reform provides states with the opportunity to offer good, affordable coverage options for all lawfully present residents. Enrollment systems that delay or discourage coverage are a pitfall Texas must avoid, so that reform can deliver on its promise for both low-income and middle-class communities.

4 Update Texas' Revenue System to Fund New State Roles and Coverage

In order for Texans to benefit as much as possible from health reform, our state must invest in the near term in building capacity for new and expanded state roles: insurance regulation, consumer assistance, health insurance exchange, workforce development, and Medicaid enrollment. Federal funding will be significant for some of these near-term costs, but some state effort will be required as well to get prepared between now and 2014. With a serious state revenue shortfall facing the 2011 legislative session, achieving the preparations and investment needed will be profoundly challenging and demand strong leadership.

In the longer term, the state will need to begin planning for a modest share of the costs of Medicaid coverage expansions under reform. Overall, coverage expansions in reform are a great deal for Texas. The state will pay nothing for private insurance subsidies for millions of moderate-income Texans in the exchange, projected by the Texas Comptroller to be worth over $43 billion between 2014 and 2019. States will get the first three years of Medicaid expansion for adults without a state cost, and will phase up to a maximum share of just 10 percent (compared to 38 percent for today's Texas Medicaid enrollees) in 2020. Texas' share of reform's Medicaid expansion for adults will not start until 2017, but to the extent that more already-eligible children enroll alongside the newly-eligible adults—the "welcome mat" effect—the state also must prepare to pay our standard Medicaid share for higher participation by children as soon as 2014.

Even pessimistic estimates of state budget impact show the federal Medicaid funds coming to Texas outnumbering the state's costs by more than six to one, and some project nearly twice that benefit. In addition, as coverage expansions from 2014 forward reduce direct service and charity care spending, some state budget costs for services like community mental health care and trauma systems will be reduced, offsetting more of the state's new Medicaid costs. Regardless of the potential fiscal and social gains, leadership will be required to begin planning for the future revenue needs today, not waiting until 2017 and declaring a crisis.

Health reform's coverage expansion and Medicaid funding phase-in schedules afford Texas the opportunity to plan and prepare today for adequate revenues to meet our capacity-building needs now and our modest share of coverage expansion costs over time. We can avoid the pitfall of inaction today resulting in failure to reap the coverage gains offered and an avoidable revenue "crisis" in 2017 by taking steps to prepare in the 2011 session of the Texas Legislature.

5

Improve Quality and Slow Growth in Costs

Health reform provides many new tools to states to improve the quality and efficiency of the health care system. Health reform targets health care delivery and payment reform first in Medicare, and in doing so, will provide states with information on what reforms successfully improve the quality of care and outcomes while holding down costs.

Texas should be at the forefront as states, institutions of higher education, and providers pursue pilot programs and demonstrations aimed at improving health outcomes, improving care coordination, reducing hospital readmissions, reducing medical errors, increasing provider accountability, increasing the cost-effectiveness of care, and encouraging prevention and wellness.

Based on the evidence and experience from pilots, Texas policy makers should make informed decisions about how to spread innovative and successful payment and delivery reform. Texas can align the substantial purchasing power of Medicaid, CHIP, public employees, and the exchange to more effectively encourage proven delivery and payment reforms that improve Texas' health care system.

The current growth in health care costs is unsustainable over time for governments, employers, and families. National health reform can greatly expand coverage while reducing the federal deficit, in part because it includes many different approaches aimed at improving the quality of care while holding down costs. Texas can and should build on the foundation created by health reform to improve the health care system for all Texans and to put the Medicaid, CHIP, and public employee health care costs in our state budget on a more sustainable path.

Conclusion

National health reform provides Texas extraordinary opportunities to improve our health care system, and in many areas, considerable state discretion in how reform is implemented. Texas should take a strategic approach in the 2011 legislative session to begin implementing reform in a way that maximizes federal funds, expands coverage, and improves quality of care. Beyond merely implementing the letter of the law or meeting minimum standards, Texas should think broadly about using health reform as a tool to make necessary improvements to our health care system for the benefit of all Texans.

State Action Required

Provision	Federal funding	Timing	State Role(s)	+ Benefit of Action for Texas – Consequence of Inaction
Health insurance exchanges	Grants to states to plan, set up, and operate an exchange from 2010-2015.	Grants 2010-2014 Operation starts 2014	Apply for grants; determine structure, functions, and governance and operate exchange; or defer to federal government.	+ Key tool to expand private coverage, increase competition, and improve the price and quality of coverage. – Without the correct design decisions, exchanges could be too complex, encourage adverse selection, or fail to drive value in the market, making coverage LESS affordable for Texans.
Consumer assistance functions	$30 million to states	Grants and operations begin in 2010	Apply for federal grant; administer consumer assistance program.	+ Will provide education and assistance to consumers so they can better understand, purchase, and use health insurance. – Lack of resource to help consumers understand new choices, overcome barriers to coverage.
Health insurance market reforms	$250 million for rate review grants to states	Rate review grants 2010-2014 Most reforms take effect in September 2010 or January 2014	Pass conforming laws; enforce new market reforms; apply for rate review grants; begin rate review function.	+ Will increase access to good coverage at reasonable rates for all Texans, regardless of health status. Federal regulators may enforce reforms if states fail to. – Weak state reform/regulation may leave Texans with poorer access to good, affordable coverage compared to other states.
Medicaid expansion to adults up to 133% FPL	100% of costs for 3 years, phasing down to 90% of coverage costs for newly eligible in 2020	Effective January 1, 2014	Implement new coverage as of January 1, 2014. Set benefit package for newly eligible population.	+ Near term, 1 million currently uninsured adults living in or near poverty would become eligible for Medicaid; reducing charity care for local governments. – State loses all Federal Medicaid funding (over $17 billion per year).
Medicaid eligibility system standards and “no-wrong-door” required with Exchange	Standard Medicaid administrative match	Effective January 1, 2014	Expand and update enrollment policies and systems; Coordinate between agencies; Decide if Medicaid or exchange will determine eligibility for exchange sliding-scale help.	+ Newly-eligible and already-eligible for Medicaid, CHIP, exchange gain coverage without errors or delays; low-income families do not fall through the cracks when income changes move them between programs. – Texans remain uninsured despite eligibility for coverage; Texans go without care they need or get charity care that could have been covered.
Medicaid and CHIP maintenance of effort	n/a	2010-2019	Continue Medicaid and CHIP eligibility levels.	+ State budget shortfalls will not result in the loss of coverage for Texas children or adults. – May concentrate Medicaid budget cuts in provider rates, exacerbating access issues.

State Opportunity

Provision	Federal funding	Timing	State Role(s)	+ Benefit of Action for Texas – Consequence of Inaction
Delivery and payment reforms • Center for Medicare and Medicaid Innovation • Bundled payments • Medical homes • Accountable care orgs.	Funds for many different grants and pilots available to states, institutions of higher education, health care providers, etc.	2011-2019	Implement Medicaid options; pursue grants and pilot programs; expand successful models into Medicaid, public employee coverage and exchange.	+ Create a more effective, efficient health care system by improving quality of care while holding down growth in costs. – Without a focus on quality and cost, care will continue to be fragmented and costs will maintain an unsustainable path.
Investments in workforce and capacity • Funding for health care provider training, loans • Medicaid primary care rates • FQHC investments	Funds for many different workforce grants/programs; federal funding for boost in Medicaid rates; $11 billion for FQHCs	Funding for providers starts 2010 Medicaid primary care rate boosts in 2013-2014 FQHC investments 2011-2015	Analyze workforce capacity and needs; pursue federal funding; and invest state funds to build capacity.	+ Help for the state, institutions of higher education, health centers, etc. to begin to address existing health care workforce shortages to better meet Texas' future health care needs. – Lack of planning, investment undermines promise of reform as Texans across state cannot access primary and specialty care promptly.
Prevention and wellness • Prevention and Public Health Investment Fund • Coverage of prevention	$15 billion 2010-2019	Changes to preventive services coverage 2010-2011	Pursue prevention grants and pilots; implement Medicaid preventive care option.	+ Investments in prevention and public health initiatives at the federal, state, and local levels increase access to prevention and wellness services, information to help individuals stay healthier. – Lost opportunities to improve health outcomes and healthy behaviors for Texans.
Long term care • New Medicaid options • CLASS (community care insurance)	Increases in federal Medicaid match rate and other funding for Medicaid. (CLASS funded exclusively by premiums.)	Community First Choice option effective 2011 CLASS starts 2012-13	Implement new Medicaid long term care options.	+ Opportunities to improve access to community supports in and out of Medicaid; new CLASS program will reduce demand for Medicaid long-term care over time. – Many Texans with disabilities remain wait-listed for community care services.
Essential benefit package	n/a	2014	Must determine if any current Texas mandated benefits exceed essential benefits.	+ Creates a comprehensive standard of coverage for individuals and small businesses. – Failure to harmonize Texas mandates with essential benefits would create avoidable state-budget costs.

Takes Effect Without State Action

Provision	Federal funding	Timing	State Role(s)	+ Benefit for Texas – Challenge for Texas
Individual responsibility	Significant funding to help low- and moderate-income families afford coverage and satisfy the coverage mandate	Takes effect January 1, 2014	State-based exchange will certify exemptions from mandates.	+ Individual mandate supports the goal of expanding coverage and will keep premiums from rising substantially in 2014 when insurers can no longer turn Texans down for coverage, or charge more based on pre-existing conditions. – Good, affordable, easy to access coverage is critical for mandate to benefit Texas consumers.
Employer provisions: • Free rider penalties • Small business tax credit • Help for coverage to early retirees	$2 billion to Texas for small business tax credits 2014-2019 $5 billion for early retiree coverage	Penalties take effect in 2014 Tax credits and help for early retiree coverage begin in 2010	State can apply for funds to help with cover high-cost claims of early retirees in public employee and teacher coverage.	+ Together, provisions preserve and support the existing foundation of job-based coverage by requiring large employers to pitch in if their full-time employees get tax-funded sliding-scale coverage; and extending tax credits to small employers. – Employers with more than 50 FTE workers who do NOT provide coverage will have to adapt their business model or pay penalties.
Temporary Pre-existing Condition Insurance Program	$493 million for Texans	August 2010-2013	n/a	+ Provides a more affordable coverage option for uninsured Texans with pre-existing conditions. – Because no sliding–scale help included, some low-income medically uninsurable Texans still cannot afford coverage.
Medicare benefits • annual checkups; free preventive care • closes doughnut hole	n/a	New preventive benefits in 2011 Doughnut hole closure phases in from 2010-2019	n/a	+ Improve access to preventive care and prescription drugs in Medicare. – Seniors will still make significant contribution for Rx due to premiums, deductibles and coinsurance.

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CENTER *for* PUBLIC POLICY PRIORITIES

MISSION

The Center for Public Policy Priorities is a nonpartisan, nonprofit policy institute committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. The center pursues its mission through independent research, policy analysis and development, public education, advocacy, coalition building, and technical assistance. We pursue this mission to achieve our vision for Texas.

VISION

We envision a prosperous Texas where economic and social opportunity is available in fair measure to all.

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