Center *for* Public Policy Priorities

# Texas Health Reform and Texas: The View from Fall 2011

**October 27, 2011**
**Equal Voice Network**
**HFMA South Texas Fall Institute 2011**
**San Antonio, Texas**

Anne Dunkelberg, Assoc. Director, dunkelberg@cppp.org
Center for Public Policy Priorities
900 Lydia Street - Austin, Texas 78702
(512) 320-0222 – www.cppp.org



- **Course Description:** This session will focus on the basics of the 2010 Affordable Care Act, what has already taken effect; what Texas has & has NOT done to prepare for implementation, the state and national political context, and what to watch for in the months to come.
- **Learning Objectives:** After this session, the attendees will be able to (1) Describe basic coverage concepts of the ACA; (2) Understand what steps Texas has taken toward implementation and what changes have already taken effect; and (3) Understand the variables involved in determining how or whether the federal law will be fully implemented in 2014.

## Health Reform: The Big Picture

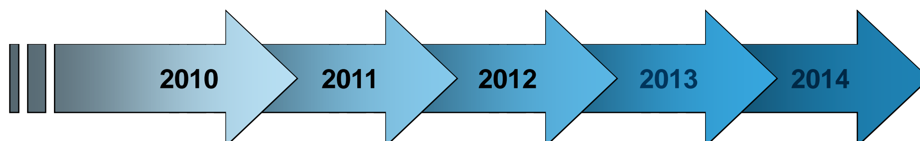
***Or, Why ACA is worth Keeping, In Spite of Flaws***

- Establishes a system for making comprehensive care available to all lawfully present Americans at an affordable price
- Competition in health insurance marketplace cannot be based on avoiding risk
- Lays a foundation for controlling costs and improving quality of care

3

## Affordable Care Act Timeline

- 2010: Early insurance market reforms begin.
- 2010-2014: Start building new systems needed to support covering large numbers of uninsured.
- 2014: Big expansion of coverage starts.




4

## *Early Texas Health Reform Gains*

**New Medicare Wellness Benefits.**

- Nearly 20.5 million Medicare enrollees got **a free Annual Wellness Visit or other preventive services** this year -- **with no deductible or cost sharing**, **including 1,445,888 people in Texas.**
  - For Example: Annual Wellness Visit; Mammograms and cervical cancer screenings; Cholesterol and other cardiovascular screenings; Colorectal and prostate cancer screenings, bone-mass measurement, diabetes screenings, Flu and pneumococcal vaccines, to name a few.
  - Already more than 4 million women have taken advantage of the free annual mammography benefit this year**, including 265,364 women in Texas.**

5

## *Early Texas Health Reform Gains*

**New Medicare Prescription Help**

- Nearly 1.8 million people with Medicare got **discounts on brand-name drugs in the Medicare Part D coverage gap** (the "donut hole“) between January and August of this year, **including 103,818 people in Texas.**
  - The total value of discounts to people with Medicare in the donut hole **in Texas is $58. 6 million through 8/2011, with an average savings of $565 per person.**
- Medicare Advantage and Part D drug plans are a better deal for the second year in a row.
- **In Texas, 91.1 percent of people have access to a Part D plan with a lower premium than they paid in 2011.**
  - In Part D coverage gap (donut hole) will continue to be able to get discounts on brand name drugs; deeper discounts every year until the gap is closed in 2020.
- Average Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, **and in Texas, 100 percent of people with Medicare have access to a Medicare Advantage plan that doesn’t charge a premium.**

6

## *Early Texas Health Reform Gains*

- The **Pre-existing Condition Insurance Plan** provides good coverage for people with pre-existing conditions who have been uninsured for six months or longer.
- **Young adults can stay on their parent's policy until their 26th birthday,** even if married or a full-time student, unless the child is already eligible to enroll in employer-sponsored coverage.
- **Insurers cannot deny coverage to a child based on the child's pre-existing condition.** This is helping kids get and keep group coverage and family policies. Texas Blue Cross and Blue Shield sells "child-only" plans, and the Texas Department of Insurance is developing rules to encourage more companies to sell coverage for kids.

7

## *Early Texas Health Reform Gains*

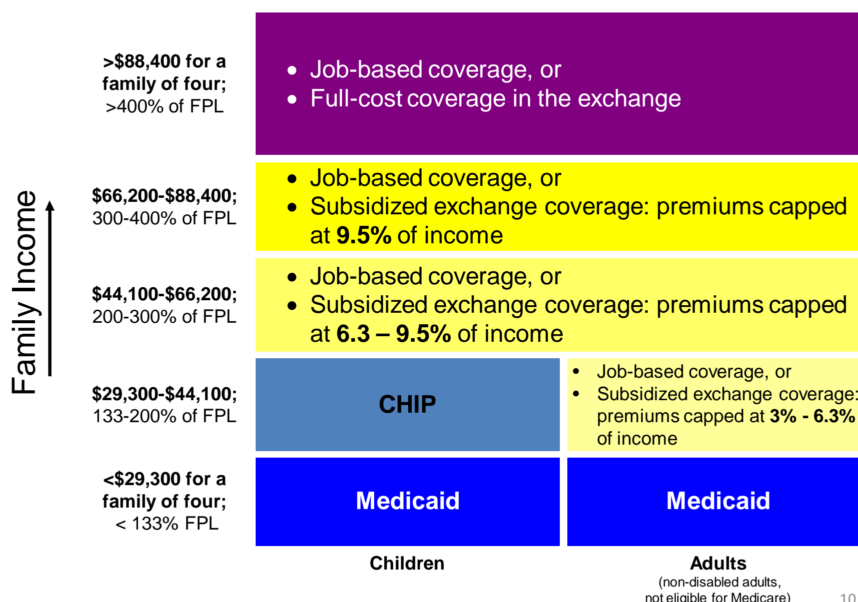
- **Many of Texas' biggest employers (private sector and public) are getting help lowering the cost of health care for their early retirees.** More than 200 large Texas corporations and state land local governments—including AT&T, American Airlines, Southwest Airlines, and Texas **Instruments—have received over $276 million in reinsurance support** to keep health coverage affordable for early retirees.
- **Tax credits of up to 35 percent of a small employer's cost of coverage** are available to help eligible small businesses afford insurance.
- **Year-to-year health plan rate hikes now are subject to review** at the state and federal levels to make sure they are reasonable.
- **Health Plans now report the share of every premium dollar that pays for health care.** The shares ("medical loss ratios") reported for 2010 by Texas' top 8 individual-market insurers who cover 90% of Texans in that market ranged from a low of 60.5% to a high of 87.8% (i.e., as little as 61 to as much as 88 cents on the premium dollar).

8

## 2014: Health Reform Building Blocks

- **Build on current system:** Vast majority of Americans still get coverage through their employer.
- **Medicaid expansion:** US citizens to 133% FPL ($14,404 individual; $29,327 for 4). (Increases primary care Medicaid fees to MediCARE level in 2013.)
- **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 4).
- **Sliding scale deductibles/co-pays 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 employees get sliding-scale help in exchange**, with exemption for all employers with 50 or fewer workers.

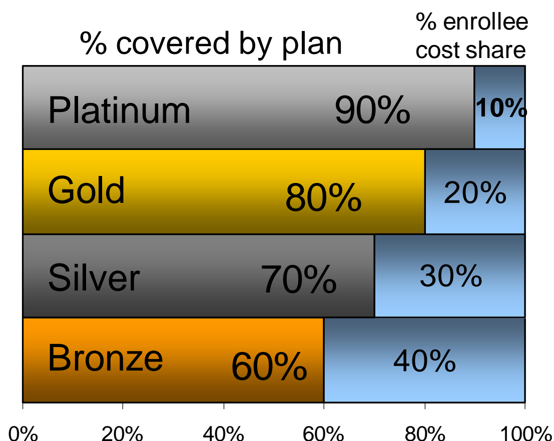
## Health Reform Coverage Options by Income



## Coverage Level Options in the Exchange

All plans will cover *essential benefits*, to be defined by HHS: hospital, ER, mental health, maternity, Rx, preventive care, chronic disease management and more.

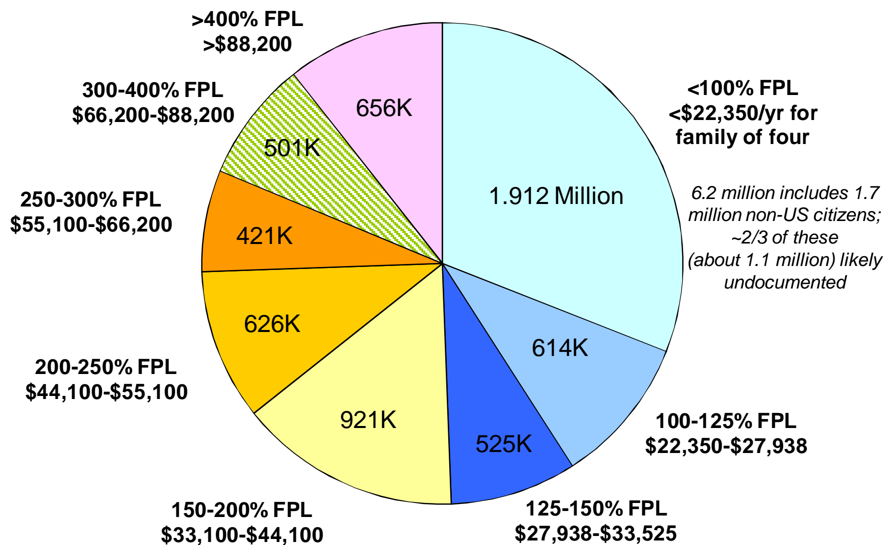
4 standard levels, *(plus a 5th catastrophic plan for people under age 30 or if no other coverage is affordable)*




Options vary by % of covered benefits paid by the plan on average vs % covered through out-of-pocket enrollee cost sharing

11

## Texas Uninsured by Income Today… 89% of 6.2 million uninsured have incomes <400% FPL




12

Annual income limits given for a family of four, 2011 federal poverty level

*U.S. Census, 2010 CPS*

## Who Will Still be Uninsured?

**U.S. Citizens**

- Not subject to mandate; will not owe penalty
  - those with very low income
  - those who would pay more than 8% of income for most affordable exchange coverage
- Subject to mandate; will owe penalty
  - Some may choose not to buy coverage
  - Others may still find coverage unaffordable

**Undocumented:**

- not covered by the mandate
- no Medicaid/CHIP (not before, not now),
- no premium help, and cannot buy at full cost from exchange

**Legal Permanent Residents:**

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

13

## Will ACA be Upheld?

- Challenges filed by 26 states (some jointly) and the National Federation of Independent Business.
- Challenges are essentially to individual mandate, not entire Act
- So far, appeals court decisions are 2:1 in favor of upholding ACA
- Possible SCOTUS outcomes:
  - Uphold all of ACA
  - Repeal Individual mandate but leave rest of law standing
  - Repeal entire statute
- New wrinkle: tax law, called the Anti-Injunction Act, requires Americans to pay a tax before they can challenge it in court. Individual mandate. Mandate doesn't go into effect until 2014, and people who get tax penalty wouldn't pay until 2015– could delay SCOTUS ruling to 2017.
  - BUT: if the AIA applies here, that means the mandate is a tax, and thus mandate could be constitutional under the taxing power granted to Congress.
- Most likely outcome is Supreme Court decision this session, i.e., before next October.

14

## What We Hoped Texas Legislature would Accomplish in 2011 to Implement Health Reform……

1. **Build an Effective and Consumer-Friendly Health Insurance Exchange for 2014**
   - **Avoid Adverse Selection**
     - TIPA died in 1990s due to this
   - **Ensure Effective Governance**
     - No COI, independent of but coordinated with TDI and HHSC
   - **Be Consumer-Friendly**
     - Authority to set standards higher than fed minimums
     - Establish a REAL Navigator program to meet our diverse needs



## …..What We Hoped Texas Legislature would Accomplish in 2011 to Implement Health Reform

2. **Ensure TDI Has Needed Authority and Capacity**
   - **TDI can't enforce the new consumer protections in fed law, including excessive rate hikes, enroll dependents through age 26, no pre-existing for kids, etc.**
   - **Small employer group rates not even filed with TDI**
   - **Staff capacity needed for these activities**
3. **Build Systems to Ensure Efficient, Family-Friendly Enrollment**
   - Fed law requires "No Wrong Door" and online application between exchange and Medicaid. Need integration between 2 enrollment systems from Day 1 (90% fed match for Medicaid system builds IF they meet inter-operability standards.
   - **NO HHSC ENROLLMENT STAFF CUTS**

## And What Happened in 82nd….

- Under veto threat, no exchange bills passed.
  - Despite HB 636 by Zerwas, support from health plans, physicians, hospitals, business groups, and policy and conservative groups.
  - Some policy development work could be "recycled" if /when Exchange implementation moves.
  - With planning grant work, agencies not completely unprepared.
  - Proposed fed rules suggest states will have limited role in Exchange until they pass readiness review for full Exchange administration.
- No authority for TDI to enforce existing ACA protections (ex: no pre-ex for kids, dependent coverage to age 26).
  - TDI and HHSC have applied for and received about $4 million federal ACA funds: Consumer Assistance program at TDI, rate Review capacity-building at TDI, and Exchange Planning shared between HHSC and TDI
  - All were before session, before Presidential campaign, and under previous TDI Commissioner

17

## And What Happened in 82nd….

- Eligibility staff were not reduced in the 2012-2013 budget.
- ….but no staff increases to deal with increased enrollment were approved, either.
- HHSC implementing greatly expanded online systems for applications, renewals, updates and communication.
- 2 new 2011 laws help shape the effort to modernize, improve performance, and minimize staffing needs in the eligibility and enrollment system.
  - HB 2610 establishes training & certification program for CBOs, promotora/community health workers who partner with HHSC to provide application assistance. New HHSC advisory committee to improve community partnerships, increase use of online systems.
  - HB 2819 directs HHSC to improve client communications, make better use of technology, and reallocate staff to streamline eligibility process, and establish stronger performance measures to improve the performance of frontline staff.
- Clear legislative directive to continue modernization, increase use of CBOs, and new web-based capacity: staff workloads may be reduced helping HHSC keep up with the growing demand for services.

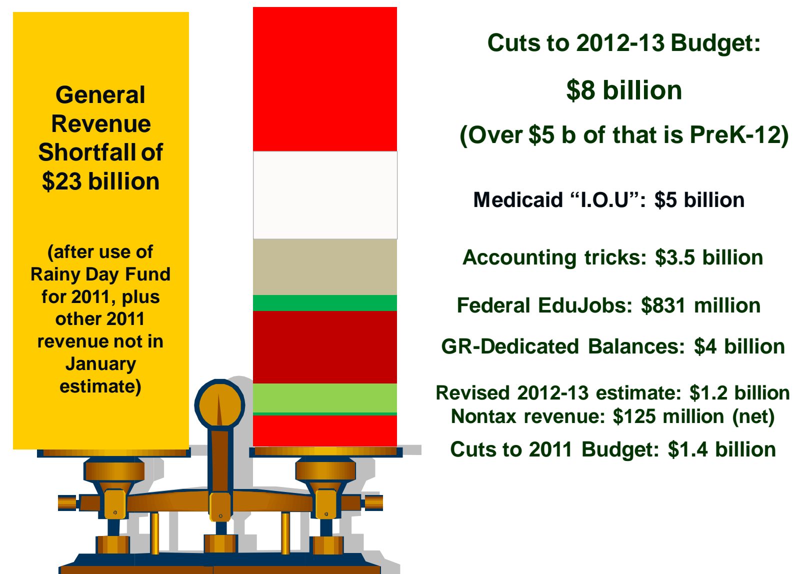
18

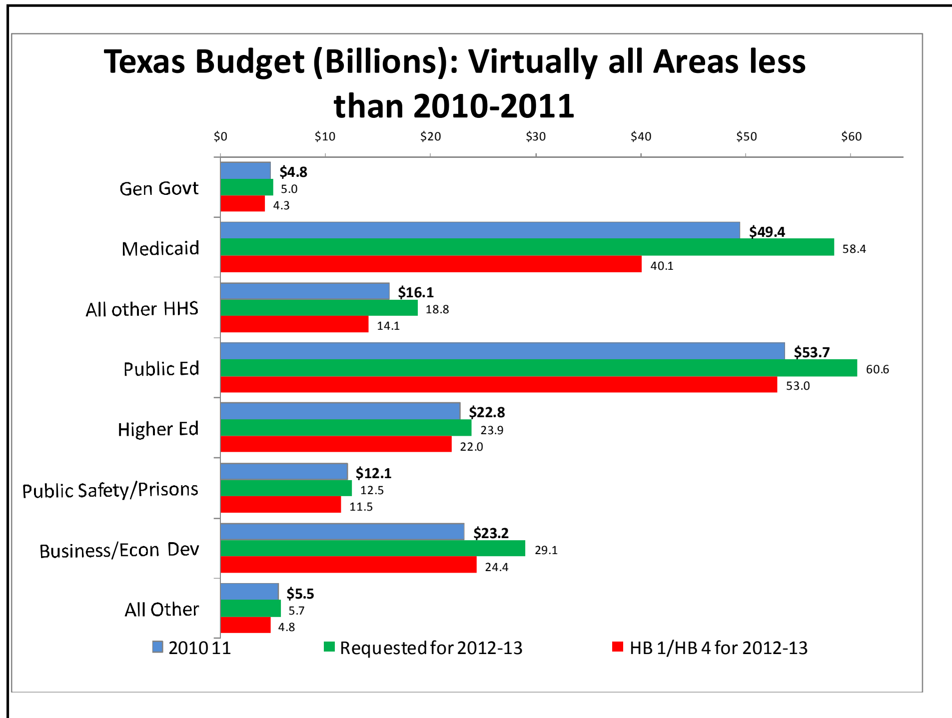
## 82nd Session Update: Other Private Coverage

- TDI Sunset bill (HB 1951) passed with 2 small but good amendments:
  - TDI can write "child-only" rules to increase availability
  - Improved notice to consumers of rate increases (was HB 2723)
- OPIC maintained as independent agency
- Exclusive provider organizations authorized (HB 1772)
- Healthy Texas Survives, as does sliding -scale help for Texas Health Insurance Pool

19

## "Balancing" the 2012-13 State Budget






## Health Care Cuts in Texas 2012-2013 Budget

### Medicaid:

- **$2 billion GR in specific cuts and "savings,"**
  - Provider rate/fee cuts (approx. $805 billion GR);
  - Other benefit and spending cuts (approx. $843 million GR); and
  - Managed care expansion spending reductions (approx. $385.7 million GR per HHSC #51)
- **~$5 billion in Medicaid Shortfall**
  - LBB says: a $4.4 billion GR "supplemental need" for Medicaid because the Legislature did not replace billions in federal stimulus aid (ARRA) that Texas used in 2010-2011 to fund Medicaid, but which ended in June 2011.
  - LBB adds to that another $700 million GR likely shortfall because of budget "rider"
  - Will these IOU costs be covered in 2013-- or become new, deeper cuts?
- **Texas Medicaid pays > $2 billion/mo. health & long term care bills,**
  - about $900 million/month is state dollars (GR); thus we are about 5 months short.
  - funds appropriated for Texas Medicaid program need to cover enough months bills to get us to Spring 2013, when the Legislature can appropriate more to fill the gap.

22

## Medicaid and CHIP Rate Cuts in Texas 2012-2013 Budget

| Rate Cuts | 2010-2011 | 2012-2013 |
|---|---|---|
| Nursing Homes | 3% | 0% |
| ICF-MR (not SSLC) | 3% | 2% |
| HCS Waiver | 2% | 1% |
| NF-related Hospice | 2% | 1% |
| Other Community Waivers | 0% | $12.5 million GR cut in in admin for agencies |
| Medicaid & CHIP physician, dentist, orthodontist | 2% | 0% |
| Medicaid Hospital | 2% | 8% |
| Medicaid DME & Labs | 2% | 10.5% |
| Other Medicaid Providers | 2% | 5% |
| Other CHIP Providers | 2% | 8% |
| Medicaid Pediatric private duty nursing & home health | 2% | 0% |
| Medicaid Managed Care premiums reduced to "average acuity" | n/a | $169.3 million GR cut |

23

# Health Care and Texas 2012-2013 Budget

- Mental health funding held at 2010-2011 level:
  - no growth or inflation, but a reprieve from proposed $239 million cut
- Family Planning:
  - DSHS block grant FP $111+ million 2010-11 funding level
    - Budget for 2012-2013 $73.2 million LOWER
    - Leaves just $38 million, or a 66% reduction 2010-11 funds.
    - 150,000 fewer low-income women will receive birth control services, LBB estimates more than 20,500 additional unplanned pregnancies and Medicaid-paid births, and a projected $98 million increase in Medicaid delivery costs
  - Medicaid family planning program provides services to another 110,000-120,000 adult women (no teens); budget "rider" likely saves this program, but if Planned Parenthood excluded, would lose current base for 40% of clients.

24

## Other Health Budget Cuts

- At a time when growing provider base critical, Legislature made deep cuts in support for medical, nursing, and allied health training
- Across the board reductions for higher-need community care program clients at DSHS
- Medicare "Equalization"
- Possible additional cuts to "optional" benefits for Medicaid adults
- Early Childhood Intervention qualifications constricted

25

## 1115 waiver, SB 7

- Texas has been tentatively approved for 1115 waiver that will convert UPL funds to uncompensated care pool, with a phased-in component to reward service/payment/delivery reforms (e.g., reducing potentially preventable erros and readmissions)
- Advocates and providers joined to oppose 3-Rx limit porpsed by HHSC, and succeeded.
- SB7 (82-1) also sets in place laws and policies to promote clinical integration (a la ACOs) with protection for anti-trust issues.
- SB 7 also tells Texas to seek a glocal cap xix waiver with lower benefits, eligibility, higher cost sharing, AND to opt out of Medicaid, Medicare CHIP, all federal public and, mental health programs, and take a block grant instead that is exempt from all minimum standards.

26

# Expansions of Medicaid Texas Managed Care

## Contiguous County Expansion - September 1, 2011

- Expand existing STAR and STAR+PLUS service areas to more contiguous counties

**STAR**

- Add 28 new counties to the Bexar, El Paso, Harris, Nueces, and Travis service areas.
- Combine Harris and Harris Expansion service areas into one Harris Service Area.
- Form new service area called Jefferson.

**STAR+PLUS**

- Add counties to the Bexar, Harris, Nueces, and Travis service areas.
- Combine Harris and Harris Expansion service areas into the Harris Service Area.
- Form new service area called Jefferson.

# Expansions of Medicaid Texas Managed Care

## March 1, 2012 – STAR Expansion

- Expand STAR Medicaid to 10 South Texas counties (Hidalgo Service Area).
- **Replace** (end) the Primary Care Case Management Program (PCCM) with EPO/HMO program in all the remaining rural counties.
- "Carve the pharmacy benefit into" the services delivered by the Medicaid and CHIP HMOs.
- Develop statewide children's Medicaid dental HMOs.

## Expansion of Medicaid Managed Care: RGV and Texas-wide

**March 1, 2012 – STAR+PLUS Expansion**

- Expand into the El Paso, Lubbock, and Hidalgo service areas.
- No STAR+PLUS in the Medicaid rural service area.
- LTSS will be available to clients in this service area through other waiver programs.
- Carve-in inpatient hospital services (non-behavioral health).
- Carve-in prescription drugs.

## Sweeping Changes Proposed in DC (1)

**Medicare**

- U.S. House Budget Committee Chairman Paul Ryan's budget resolution—approved by the U.S. House but not the Senate—
  - would convert Medicare to a voucher program in which Medicare will pay less for care, but seniors would have to pay twice as much out of pocket to get the same coverage.
  - would also end today's sliding-scale help for very low income Medicare beneficiaries, & replace with new program that would leave average senior in poverty (less than $10,890/yr.) with $4,700 in annual out-of-pocket costs—43% of their income.

**Medicaid**

- Ryan budget plan would turn Texas Medicaid into a block grant that would:
  - By 2030, cut Medicaid funding in half,
  - Would lock in today's Texas Medicaid spending per enrollee at $600 below the national average, and
  - end our current protection of increased federal support in disasters and recessions.

30

## Sweeping Changes Proposed in DC (2)

**CHIP Cut or Abolished, Too**

- U.S. House Energy and Commerce Subcmte. on Health voted 5/2011 to repeal the federal stability protections (A.K.A. "maintenance-of-effort rules" or MOE) now keeping states from cutting Medicaid and CHIP coverage.
- CBO calculates that if MOE repealed, by 2013 states will drop Medicaid and CHIP coverage for about 400,000 people, about two-thirds of them children. CBO projects that three-quarters or 300,000 of those children and adults would become uninsured, and only a quarter would gain job-based coverage.
- Because the House/Ryan plan would repeal the ACA, it would also eliminate the CHIP program, because CHIP's funding and authorization are part of the health reform law.

31

## Sweeping Changes Proposed in DC (3)

**Spending Caps Alone Can Cut Medicare and Medicaid Just as Deeply**

- Several other proposals for hard caps on spending—whether for total federal spending, for Social Security, Medicare, and Medicaid, or just for federal health spending—**all have been calculated to cut Medicare and Medicaid just as deeply or even deeper than the Ryan plan.**
- These cap proposals and Balanced Budget Amendment (BBA) proposals are being pushed hard in the ongoing Congressional debate over deficit and debt reduction measures.

**Balanced Budget Proposals: Even deeper cuts**

- House Judiciary version of balanced budget amendment would bar federal spending from exceeding 18% of GDP in any year.
- Under Ryan budget, federal Medicaid funding in 2030 would be 49 percent lower;
- CBO says CBO says Ryan budget federal spending would be 20¼ percent of GDP in 2022 and 20¾ percent of GDP in 2030- or TOO HIGH for the BBA 18% **cap—so under BBA far deeper cuts would be needed.**

32

## More Deficit Reduction Facts:

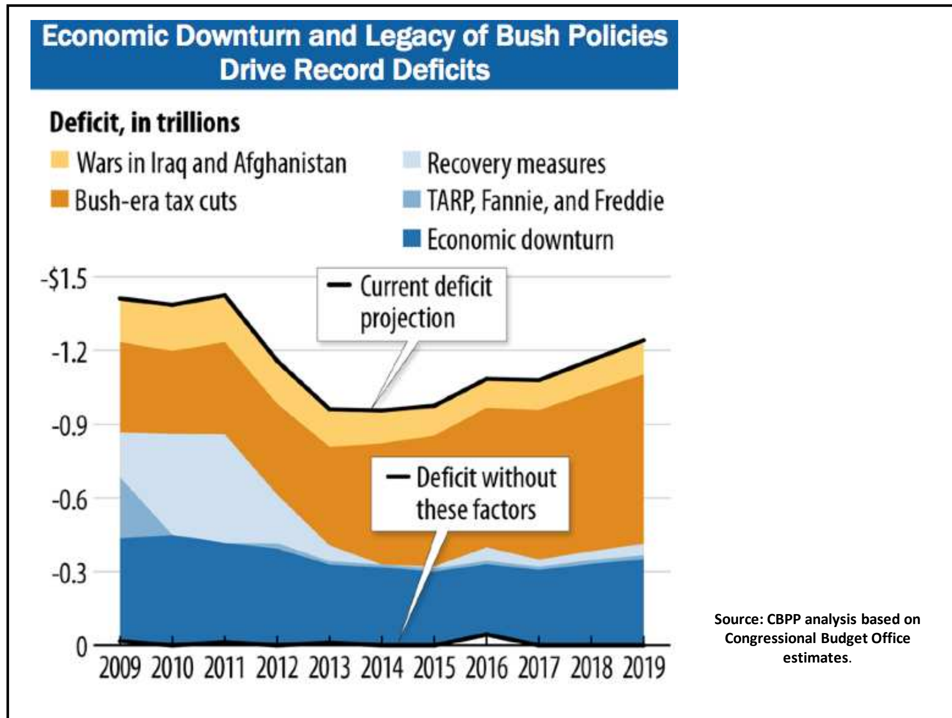
- The House/Ryan budget plan takes two-thirds of its spending cuts from low-income programs, and then uses those cuts to offset the cost of making the Bush tax cuts permanent and prevent defense cuts, <u>not</u> to reduce the deficit.
- **Medicaid is NOT uniquely troubled by rising care costs:**
  - the CBO reports that growth rates for Medicare, Medicaid, and "All Other" U.S. health spending have out-stripped GDP growth consistently since 1975.
  - Medicare logged the highest cost growth in excess of GDP, and
  - Medicaid "tied" with All Other health spending over that entire period, despite having grown at a much slower rate than the rest of the system since 1990.
- Don't ask the poorest Americans to carry most of the load. Any "debt triggers" that would impose across-the-board cuts to keep federal spending growth under control must protect essential services for the poor including Medicaid.
- Americans agree: **Latest polls show a large majority of Americans oppose major cuts to Medicare and block-granting Medicaid to reduce federal deficits.**
  - **59 percent of Americans oppose any Medicare cuts at all;**
  - **53 percent of Americans oppose any Medicaid cuts at all, and**
  - **60 percent oppose making Medicaid a block grant.**

33
33

## Debt Ceiling Deal & Health and Social Programs

The deal to raise ceiling by $2.1 trillion

- Binding Caps on "discretionary" programs: defense, education, national parks, the FBI, the EPA, low-income housing assistance, medical research, etc.
- Congress must vote this fall on BBA to U.S. Constitution;
- Joint Select Committee must report by December 2 of this year, legislation to reduce projected deficits by an additional $1.5 trillion through 2021
  - NO RESTRICTIONS on what this cmte can cut, and the CAN raise revenues
- IF cmte fails (does not report the required legislation, if Congress defeats the legislation, if the President vetoes the legislation and the veto is sustained, or to the extent the legislation is enacted but reduces deficits by less than $1.2 trillion), then automatic cuts known as "sequestration."
- Sequestration would not start until 2013, though.
- Sequestration would take $55 B/year from defense, and another $55B/yr from other programs,
  - including up to 2% per year from MEDICARE
  - BUT NO CUTS to Medicaid, CHIP, SS, SSI, SNAP, EITC, child nutrition, veterans, or fed employee retirement.
  - THUS: biggest threats to low-& moderate income will come from the "Super-Committee" plan, as opposed to the triggered "sequestration" cuts.




Source: CBPP analysis based on Congressional Budget Office estimates.

# Use of This Presentation

The Center *for* Public Policy Priorities encourages you to reproduce and distribute these slides, which were developed for use in making public presentations.

If you reproduce these slides, please give appropriate credit to CPPP.

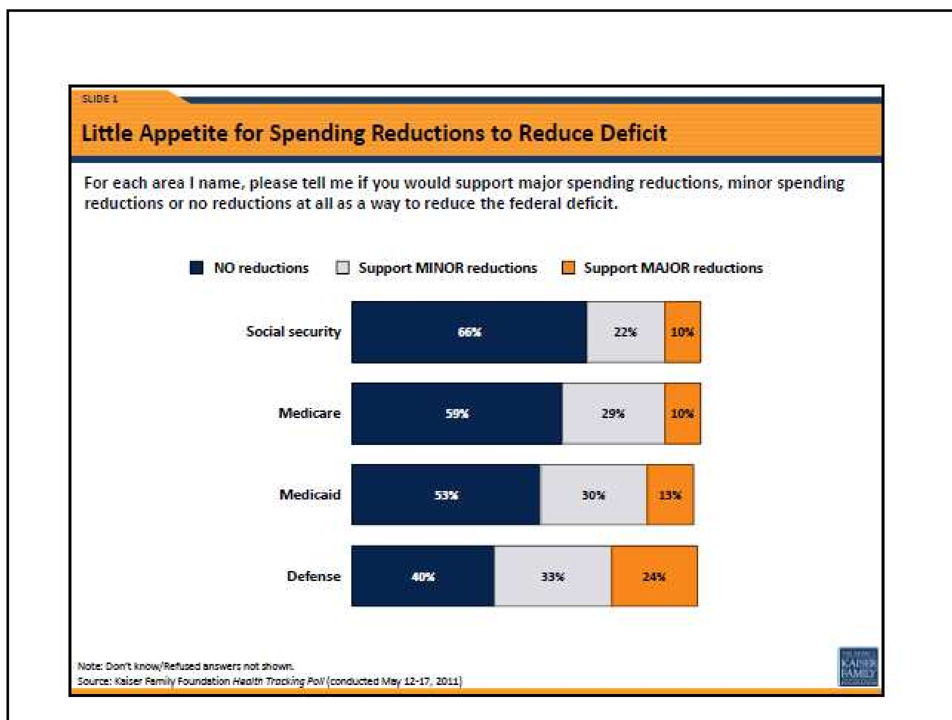
The data presented here may become outdated.

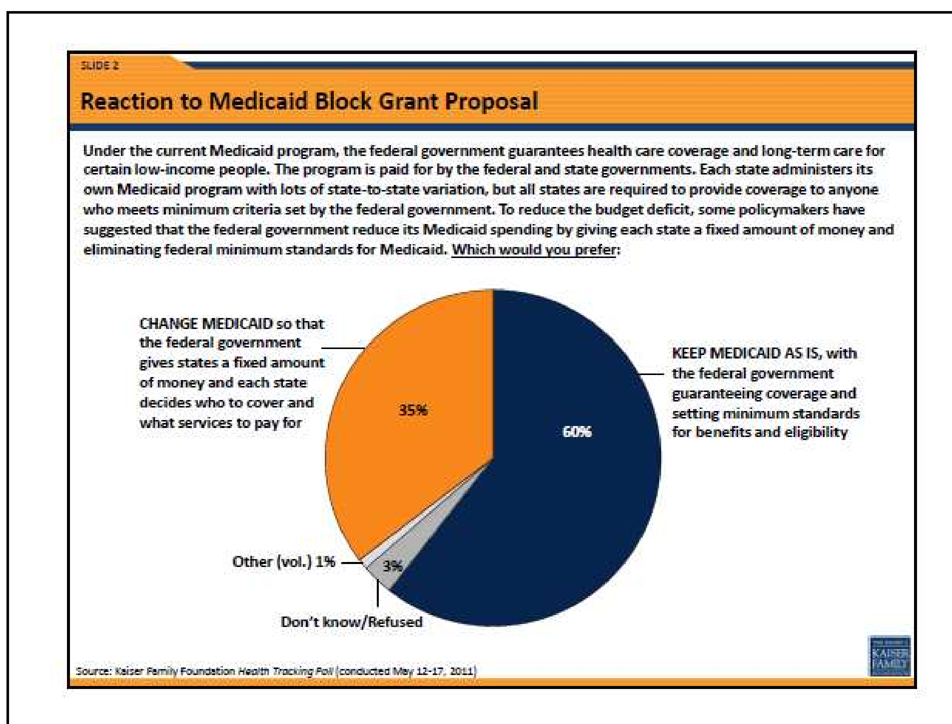
**For the most recent information or to sign up for our free E-Mail Updates, visit www.cppp.org.**

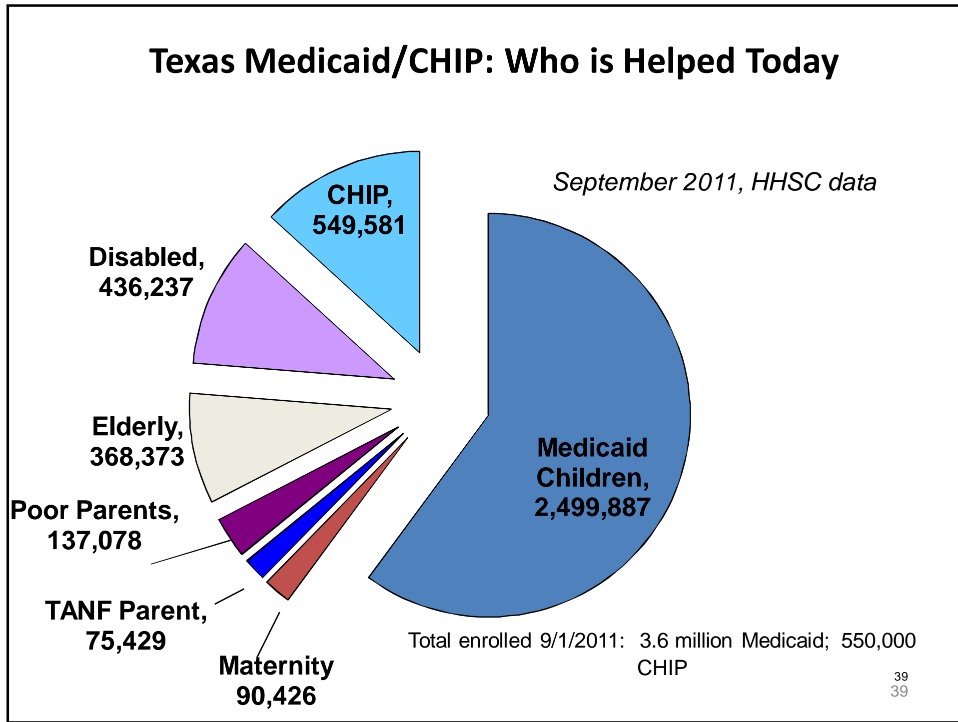
© CPPP

**Center for Public Policy Priorities**
**900 Lydia Street**
**Austin, TX 78702**
**P 512/320-0222 F 512/320-0227**

36


SLIDE 1
Little Appetite for Spending Reductions to Reduce Deficit
For each area I name, please tell me if you would support major spending reductions, minor spending reductions or no reductions at all as a way to reduce the federal deficit.
NO reductions
Support MINOR reductions
Support MAJOR reductions
Social security
66%
22%
10%
Medicare
59%
29%
10%
Medicaid
53%
30%
13%
Defense
40%
33%
24%
Note: Don't know/Refused answers not shown.
Source: Kaiser Family Foundation Health Tracking Poll (conducted May 12-17, 2011)


SLIDE 2
Reaction to Medicaid Block Grant Proposal
Under the current Medicaid program, the federal government guarantees health care coverage and long-term care for certain low-income people. The program is paid for by the federal and state governments. Each state administers its own Medicaid program with lots of state-to-state variation, but all states are required to provide coverage to anyone who meets minimum criteria set by the federal government. To reduce the budget deficit, some policymakers have suggested that the federal government reduce its Medicaid spending by giving each state a fixed amount of money and eliminating federal minimum standards for Medicaid. Which would you prefer:
CHANGE MEDICAID so that the federal government gives states a fixed amount of money and each state decides who to cover and what services to pay for
35%
60%
KEEP MEDICAID AS IS, with the federal government guaranteeing coverage and setting minimum standards for benefits and eligibility
Other (vol.) 1%
3%
Don't know/Refused
Source: Kaiser Family Foundation Health Tracking Poll (conducted May 12-17, 2011)


Texas Medicaid/CHIP: Who is Helped Today
September 2011, HHSC data
CHIP, 549,581
Disabled, 436,237
Elderly, 368,373
Poor Parents, 137,078
TANF Parent, 75,429
Maternity 90,426
Medicaid Children, 2,499,887
Total enrolled 9/1/2011: 3.6 million Medicaid; 550,000 CHIP
39
39