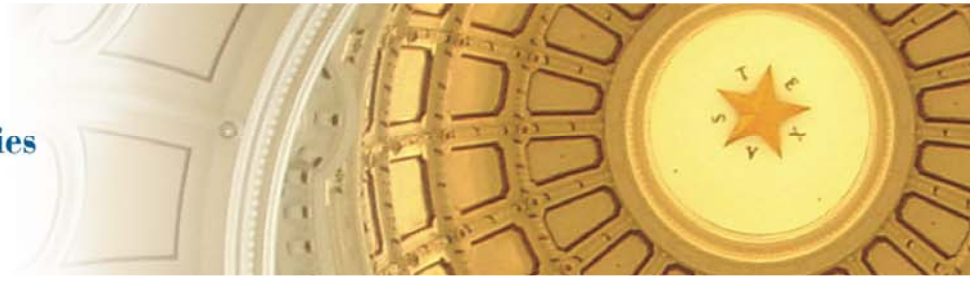




Center for Public Policy Priorities



Breast Cancer and Health Reform 101: Basics for Texas

6th Annual Breast Health Summit

Sponsored by: Pink Ribbons Project; The Rose; Houston Affiliate of Susan G. Komen for the Cure; St. Luke's Episcopal Health Charities; MD Anderson Cancer Center; American Cancer Society-Gulf Coast Region; Houston Endowment

Thursday, October 28, 2010

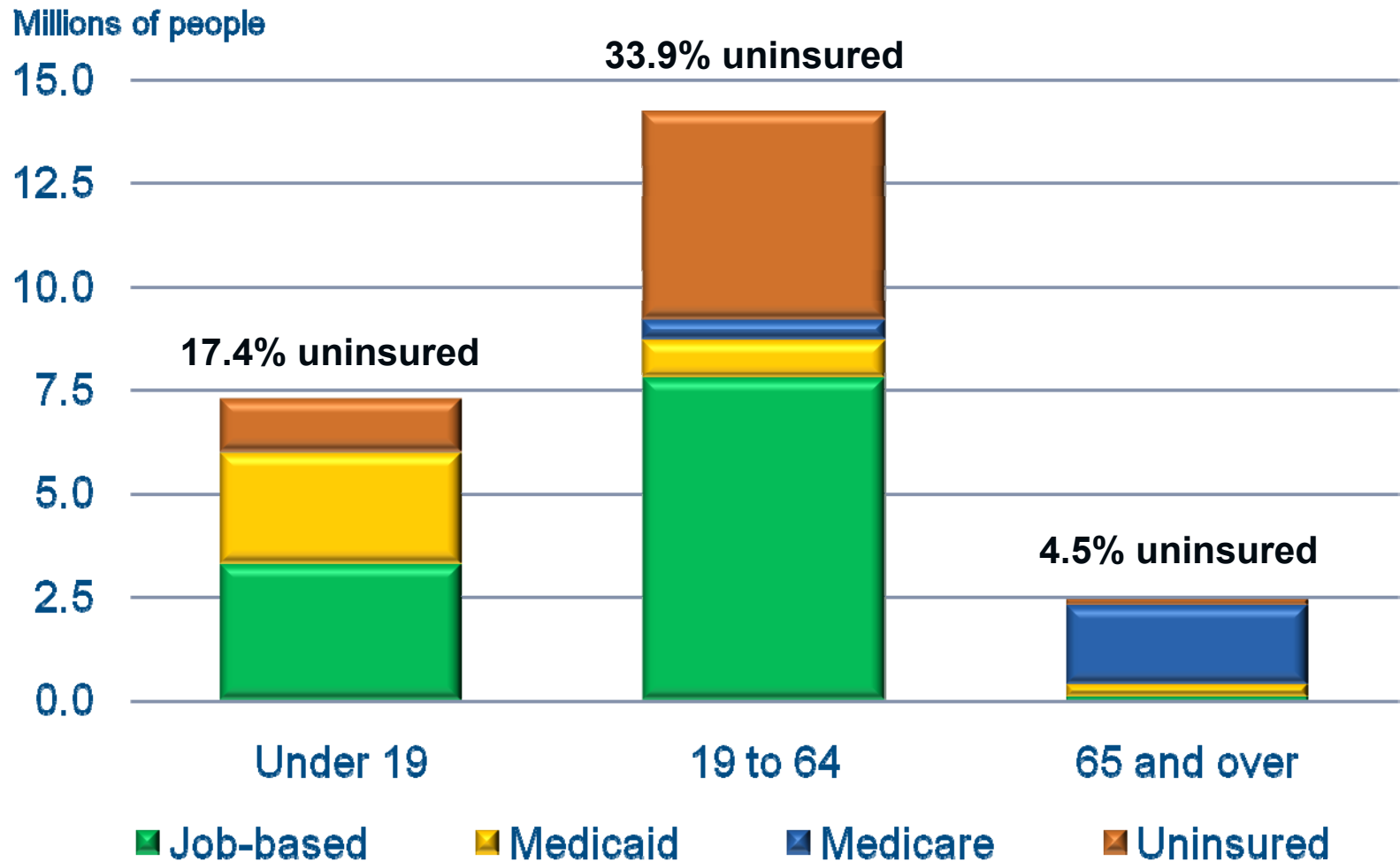
United Way of Greater Houston
50 Waugh Drive
Houston, Texas 77007

Anne Dunkelberg, Assoc. Director, dunkelberg@cphp.org
Center for Public Policy Priorities, 900 Lydia Street - Austin, Texas 78702
Phone (512) 320-0222 (X102) – www.cphp.org; www.texasvoiceforhealthreform.org

Insurance Coverage in Texas

Now and After Reform

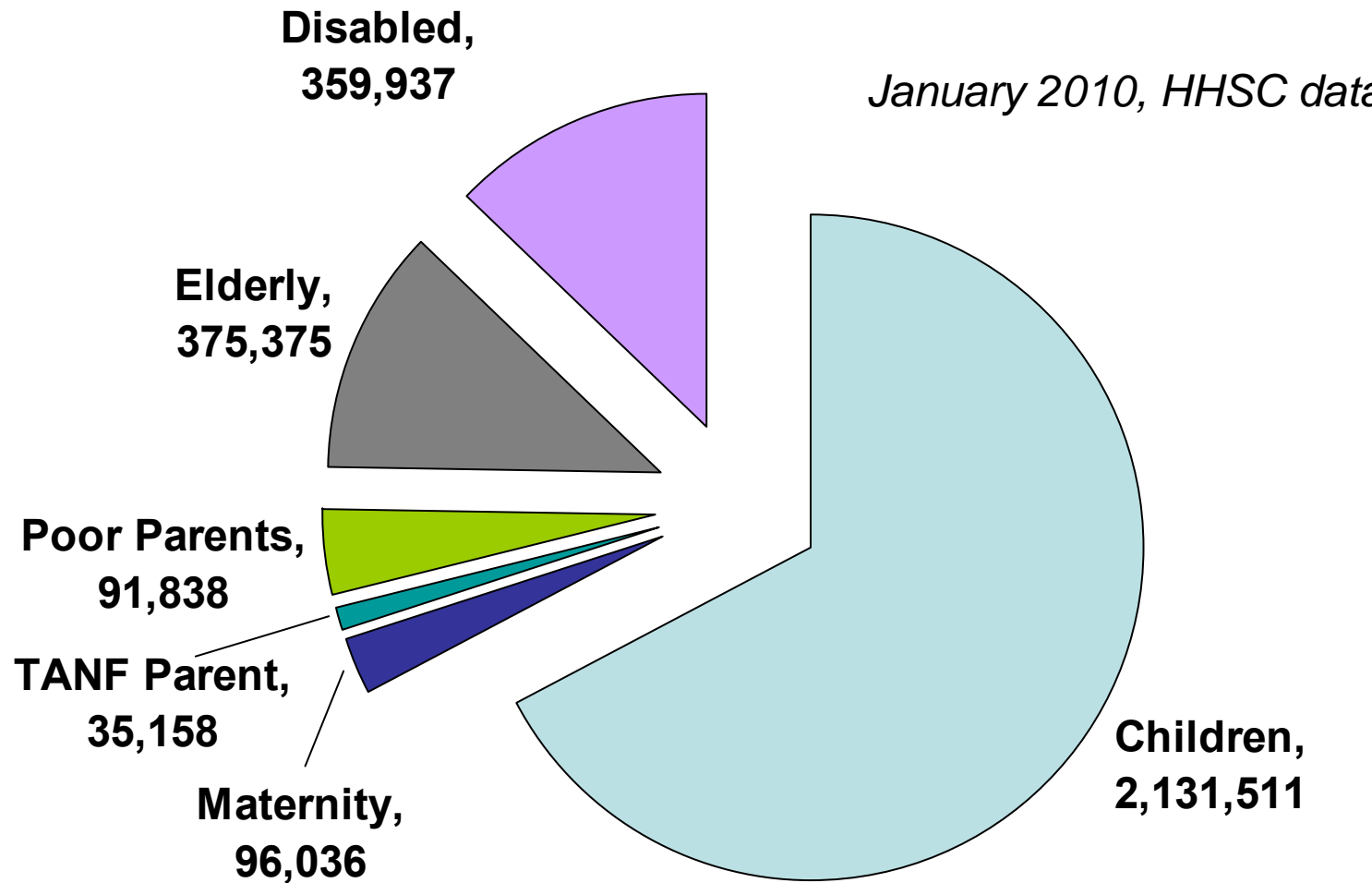
Working-Age Texans Are Most Likely to be Uninsured



Source: CPPP Analysis of CPS Annual Social & Econ. Supplement

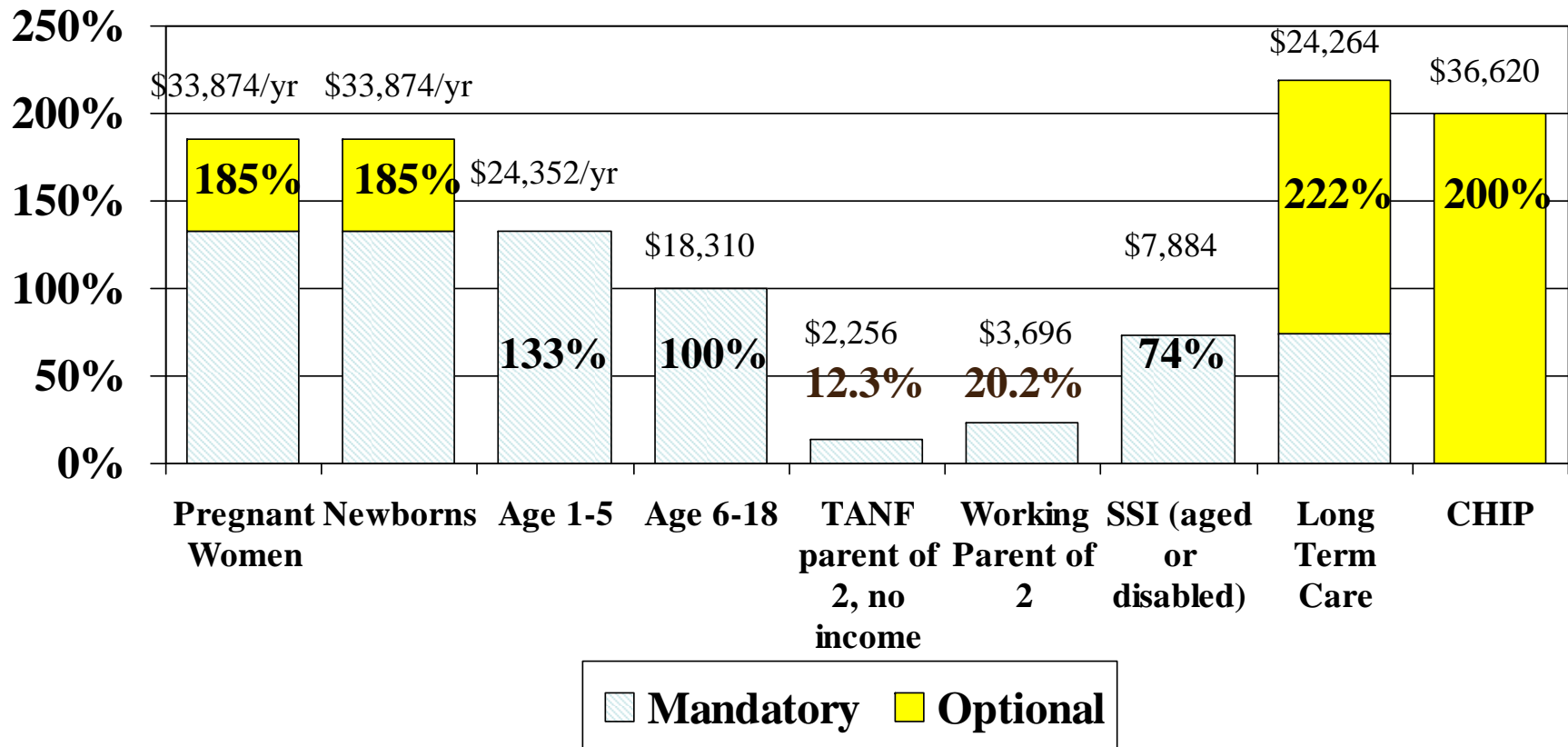
www.census.gov/hhes/www/cpstc/cps_table_creator.html

Texas Medicaid: Who it Helps



Total enrolled 1/1/2010: 3.2 million

Income Caps for Texas Medicaid and CHIP, 2010



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

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 people with high health care 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



Patient's Bill of Rights: New Protections for Health Insurance

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

For ALL policies:

- No more lifetime dollar caps
- No denial of coverage or waiting periods for kids with pre-existing conditions.
- No arbitrary cancellation of health coverage.
- Dependents allowed on parent's plan until 26th birthday (even if married).

For non-grandfathered (new) policies. Plans in existence as of March 23, 2010 are "grandfathered" and do not have to comply with these provisions:

- Restrictions placed on annual limits.
- No co-pays or other out-of-pocket expenses for preventive care.

Ensuring Reasonable Rates

- 2010: Federal and state government begin annual review of health insurance premium increases. (state-regulated plans) Grants available to states, & TX applied and received.
- 2011: Insurers must pay out 80-85 cents of each premium dollar for medical benefits -- or else provide rebates to consumers.

More First-Year Reforms



These provisions take effect within the first year:

- Pre-existing Condition Insurance Plan (PCIP) - temporary high risk pool for individuals with pre-existing conditions who have been uninsured for at least 6 months.
 - Info/applications at www.healthcare.gov
- Small employer tax credits available up to 35% of premium cost.
 - Info at www.irs.gov/newsroom/article/0,,id=223666,00.html
- Grants available to states: (1) to set up an Office of Health Insurance Consumer Assistance (2) to establish health insurance exchanges. TX applied and will get both!
- Begins new \$11 billion investment in Community Health Centers.
- New funding for training primary care docs, nurses, other professionals.

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: adds comprehensive annual check-up plus other prevention benefits, with no out-of-pocket costs.

Adds 12 more years to Medicare Trust Fund Solvency: Not by cutting current Medicare benefits or doctor fees, but slowing growth in Medicare spending from 2010 to 2019.

New Access to Community-Based Services and Supports: Medicare today does not cover community-based services to help seniors remain in their homes. A new voluntary insurance program (CLASS) will provide community-based assistance services and support. Starts in 2012 or 2013; 5 years to qualify for benefits.

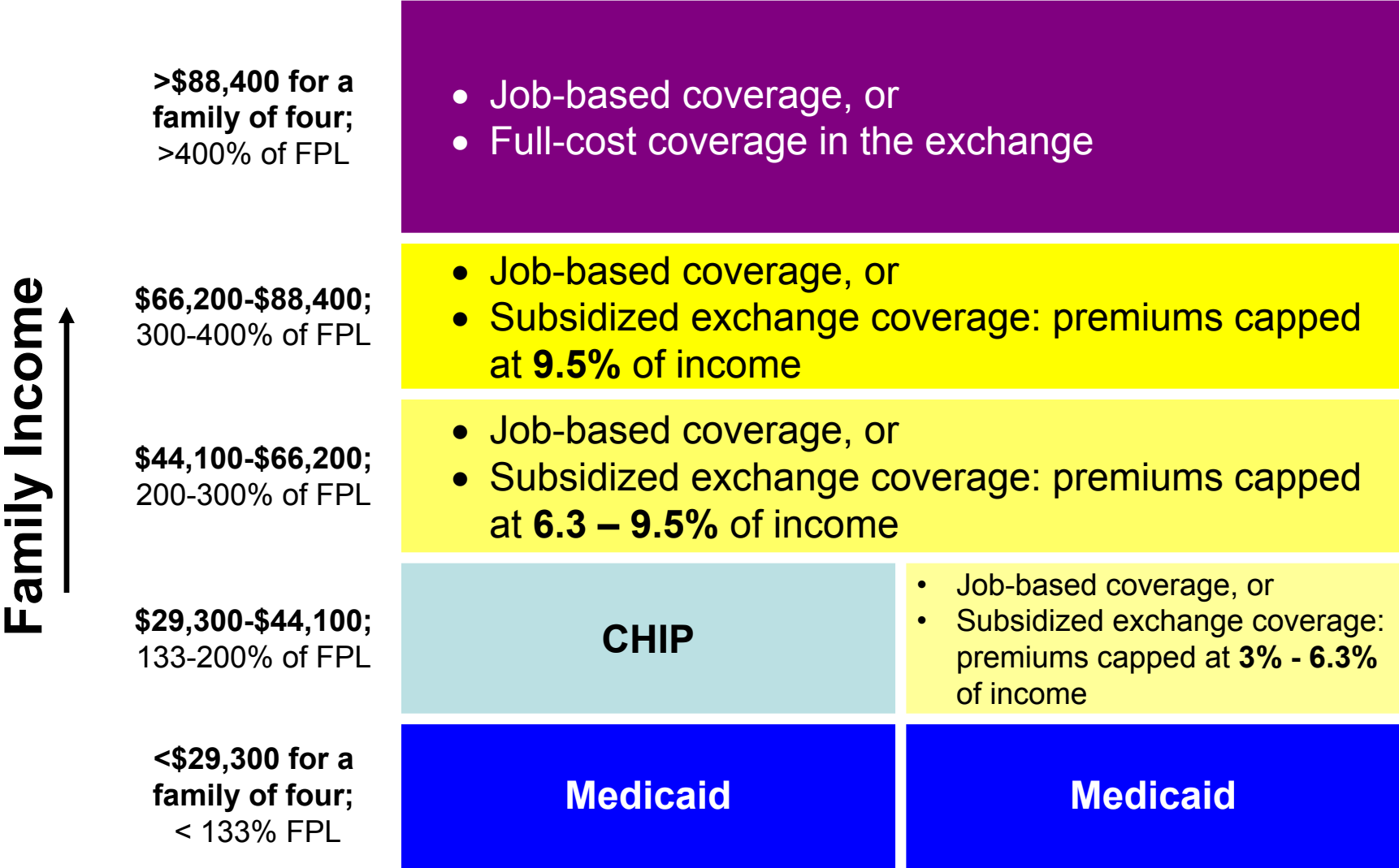
The Truth behind the Myths:

- *“SGR” Medicare Rate Cuts passed by Congress in 1997 have NOTHING to do with health reform, but DO need to be Fixed!*
- *Medicare Advantage: 20-25% of Beneficiaries HMOs are getting 14% more \$\$ than for the other 75-80% Seniors. MUST be fixed.*
 - *More than \$1,100 for each beneficiary in Advantage. These overpayments also drive up premiums for beneficiaries in traditional Medicare by \$86 per year for a couple.*

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 exemptions for all employers with 50 or fewer workers.

Health Reform Coverage Options by Income



Children

Adults

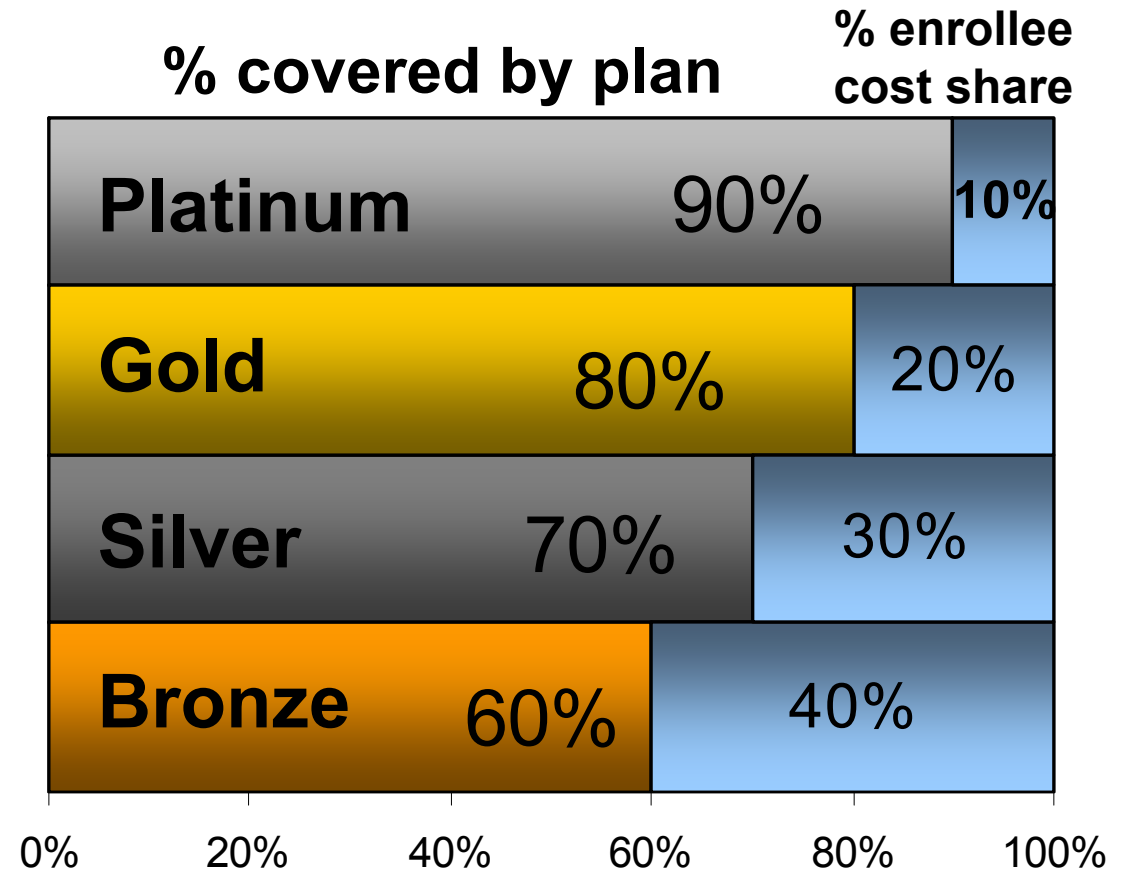
(non-disabled adults, not eligible for Medicare)

Family income based on 2009 federal poverty income levels for a family of four

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.

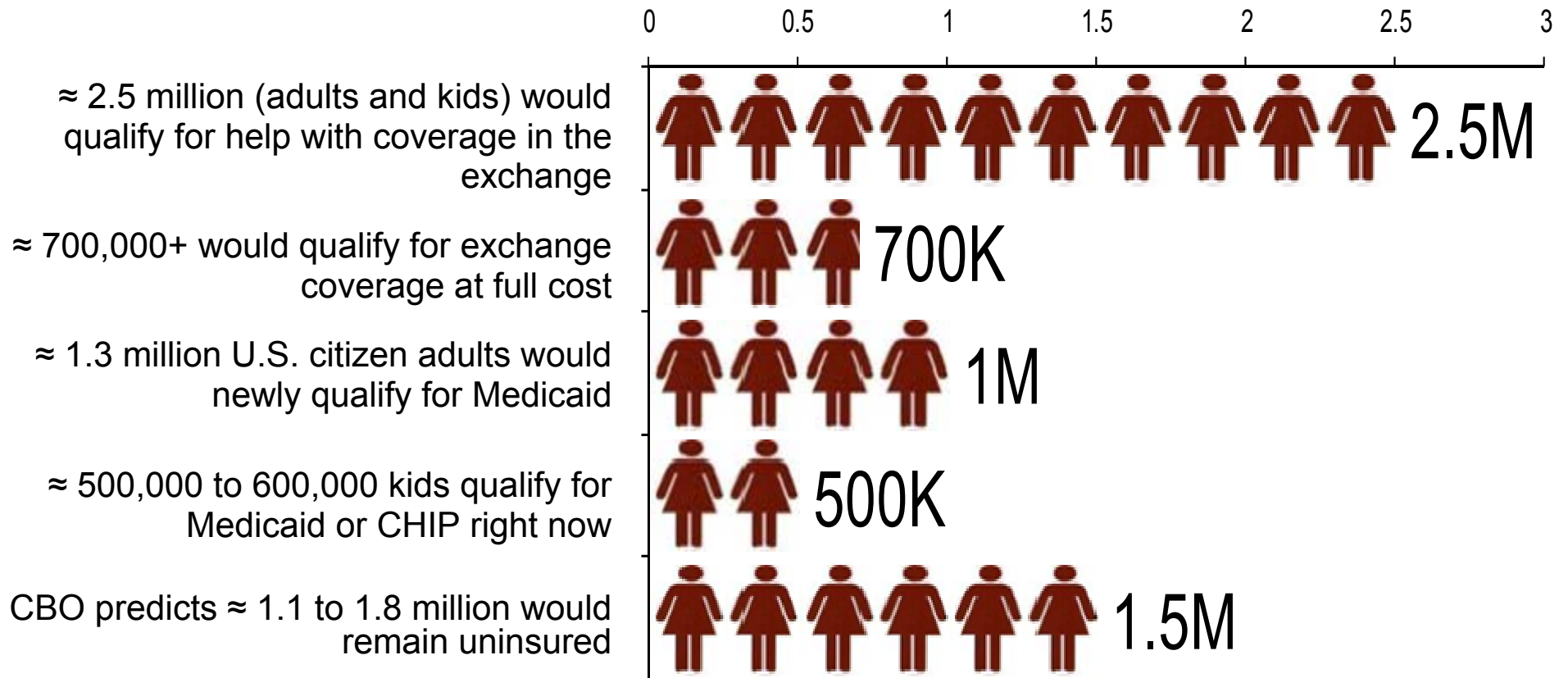
4 standard levels, (*plus a 5th catastrophic plan for people under age 30 or no other coverage is affordable*)



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

Which Texans would Gain Coverage If Reform were Fully Implemented Today?

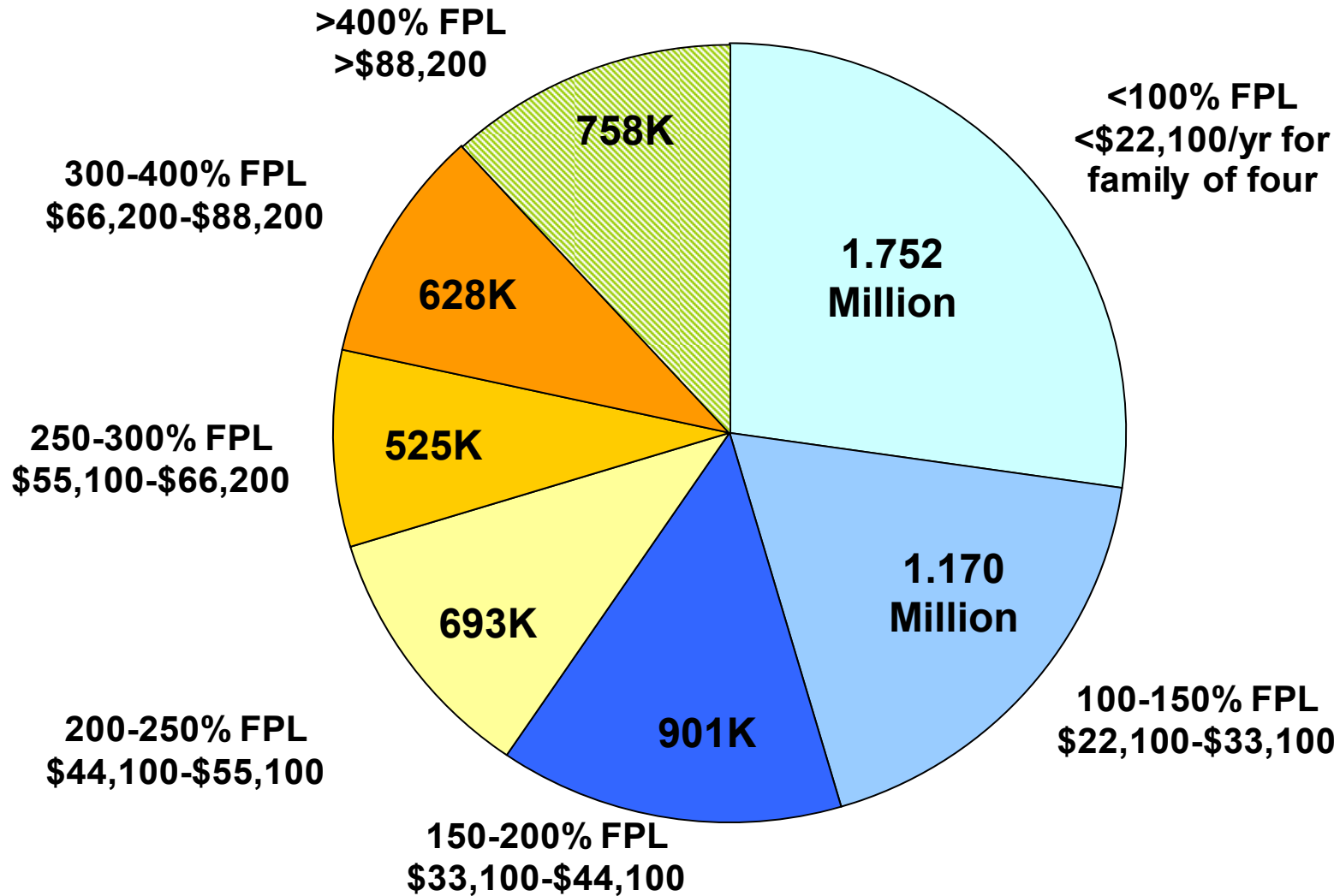
Of the 6.4 Million Uninsured Texans today...



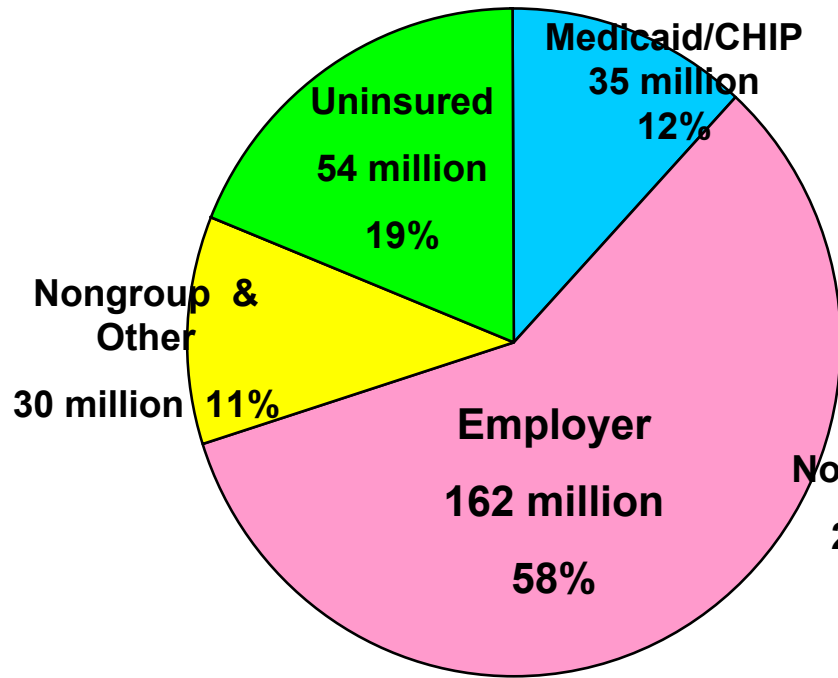
≈ 2 Texans gain private exchange coverage for each 1 gaining through Medicaid

Texas Uninsured by Income Today...

6.4 million uninsured in 2009

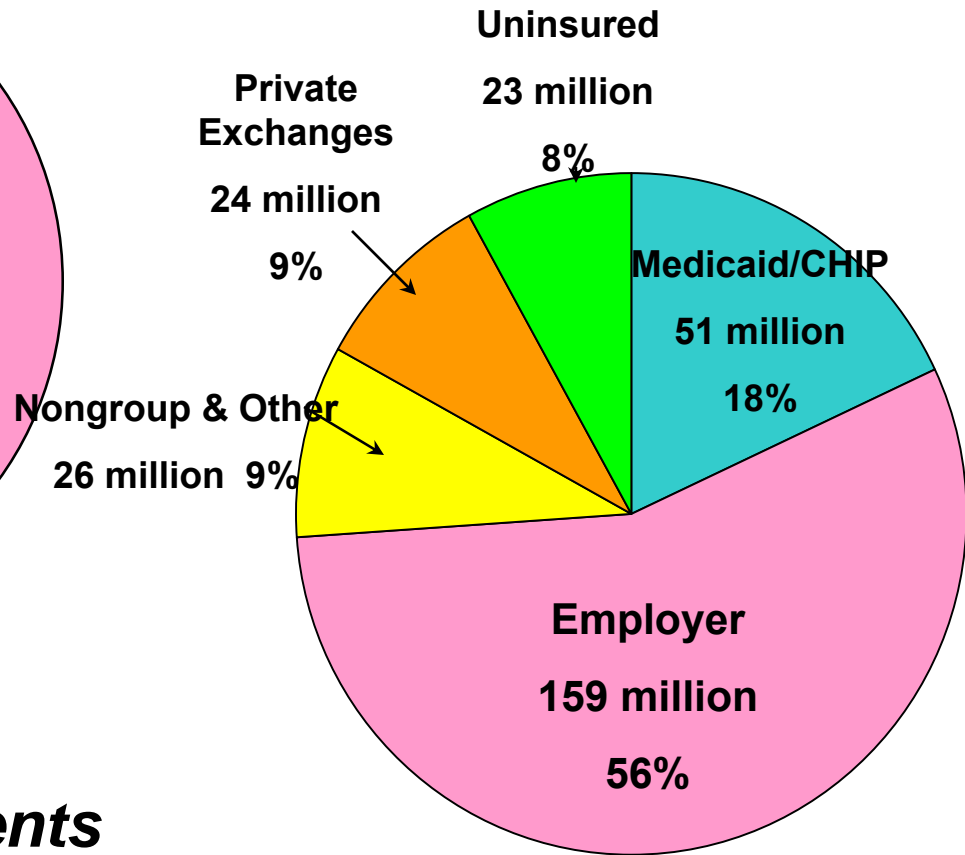


Americans' Insurance Coverage in 2019: If Nothing Changed compared to Health Reform Law



Without Reform - 2019

***282 Million U.S. Residents
Under Age 65***



Under Reform - 2019

Source: The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, <http://www.cbo.gov/doc.cfm?index=11379> .

Who Will Still be Uninsured?

- **CBO projects 92% of under 65; or 95% of < 65 excluding undocumented will be covered in 2019.**
- **U.S. Citizens**
 - Those with VERY low income, and those who would pay more than 8% of income for most affordable exchange coverage will have no penalty (no mandate)
 - Some of these may remain uninsured, and pay no penalty
 - Tax penalties are about 1/6 of cost of coverage
 - 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
 - **Unknown today: what % 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

Examples of Family Costs:

Premiums, Out-of-pocket help, and Out-of-pocket Caps

<u>Family of 4 Income, with Coverage through Exchange, 2014 and later</u>	<u>Maximum Yearly Premiums</u>	Average % of health costs covered by plan (“Actuarial Value”)	Cap on Uncovered spending (<u>not</u> including premiums)	Upper Limit on TOTAL Family Spending (% of income)
150% FPL: \$33,075	\$880	94%	\$3,967	\$4,847 (15%)
250% FPL: \$55,125	\$4,465	73%	\$5,950	\$10,415 (19%)
350% FPL: \$77,175	\$7,332	70%	\$7,973	\$15,305 (20%)
450% FPL: \$99,225 (No Financial Assistance)	None	Buyer’s Choice; 60-90%	\$11,900	n/a

Implementation in Texas

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

Factors +/-:

- + 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' 6.4 million uninsured = undocumented
- Uncertainty re: adequacy of premium help: how many will remain uninsured? (CBO:
- Inadequate provider base for ALL TEXANS, not just Medicaid: all capacity will be needed, and expanded capacity critical.

Caveats: Advocates must correct misperceptions that:

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

New State Roles

- **State Medicaid eligibility system must grow, improve performance**
- **Create and Run a Health Insurance Exchange**
- **Greater Role for TDI in Regulation**
- **New Opportunities for Consumer Assistance and Education**
- **Needed: Aggressive Initiative to Expand Health Care Workforce**
- ***Challenge: Texas needs real investments in these systems, but leadership is planning cuts***

State Budget Effects



Now

- From now until 2014, the only costs to state budget are from increasing Health and Human Services Commission and Department of Insurance capacity to handle new duties (no coverage costs)
- Early estimates of HHSC and TDI costs for the next state budget (2012-2013):
 - TDI asks for \$11.4 million , (57 FTEs in 2012, 40 in 2013). Feds may pay for \$5 million of this IF TDI requests the \$.
 - HHSC asks for \$101 million related ONLY to decreasing Rx rebates, but also asks for \$122.6 million for eligibility system staffing and improvements, over 1,500 eligibility staff. This is CRITICAL for reform implementation.
 - MORE is coming; both agencies will have new estimates before end of year.

Later

- Federal government will pay 100% cost of new Medicaid adults from 2014-2016; the state starts paying 5% in 2017, topping out at 10% share in 2020.
- States expect to also see increased Medicaid and CHIP enrollment by uninsured kids who are already eligible today once all the expansions of 2014 begin, so costs for children's coverage will go up in the existing Medicaid program, too.

Texas Comptroller's Estimates

New report released June 4; based on CBO estimates (divided across states according to population) for many items.

<http://www.cpa.state.tx.us/specialrpt/healthFed/>

- Includes THHSC estimate for Medicaid 2010-2019:
 - State costs will increase **\$5.8 B**
 - Federal funds for Texas will grow **\$76.3 B**
- Texas will gain **\$43.5 B** in sliding-scale Exchange help to buy private coverage.
- Small firms will get **\$1.9B** in tax credits for providing coverage
- Businesses will pay **\$9.3 B** penalties; Individuals **\$2.2 B** penalties
- Texas will gain at least **\$1.3 B** in new premium tax revenues
- **Take-Up rates: CBO assumes ~57%; KFF/Urban Institute 75%; HHSC 91-94%!**

Recap: Health Reform and Breast Cancer

Today-2013:

- **Greater Access to Prevention and Screening:** July 2010 federal regulations all new plans issued by private health insurers to cover preventive services, including annual screening mammography for women age 40 and older, with no cost sharing or co-pays in health plans issued after September 23, 2010. Starting 1/2011, no-cost mammography for all women on Medicare.
- **New Options & Protections for “Uninsurable”:** PCIP option available; No denial of care for kids up to age 19 with pre-existing conditions; keeping kids on family plan until 26th birthday; health insurers barred from dropping people from coverage when they get sick for bogus reasons.
- **No Lifetime, and Reduced Annual Caps**
- Shrinking the “doughnut hole” in Medicare Part D (incl. 50% off on brand-name drugs 2011) helps survivors & those in treatment.

2014 & Forward:

- Medicaid expansion improves low-income women’s ongoing access to prevention & detection
- No denial of care, no one charged more for coverage based on health status/history, no gender, employer size, or industry rate variation.
- Preventive care coverage required for 100% of the health insurance market.
- People whose income drops due to reduced capacity for work can still get coverage, with sliding scale help below 400% FPL

....More on Health Reform & Breast Cancer

- **Komen:** *“government must maintain the safety net screening services funded by the Centers for Disease Control and Prevention, states and non-profits, until all women have access to these new cancer screening benefits and we are assured women know how and when to access them.”*
- **US Preventive Care Task Force lesson:** Eternal vigilance is the price not only of liberty, but also of American Democracy, health reform, and appropriate public health policy.
 - Cannot leave any of this discussion and policy development to elected officials or to academics.
 - Obligation as citizens to be willing to learn and understand more about OUR government – it is not someone else’s job.
 - Yes, we WILL stay busy!

How Reform will look for:
RN with 2 Kinds of Cancer



Nancy K., 30-year Nurse now on Disability

- Has breast and neuroendocrine cancer, both stage 4
- Qualified for SSDI, but no Medicare for 29 months!
- Unable to work, denied health insurance. As former Certified Nurse Case Manager, knew how to research all options but qualified for no assistance.
- Finally negotiated partial charity care from a local hospital

Under Reform in 2010:

- Nancy could get coverage from new temporary high-risk pool in all 50 states. It will not be cheap, but premiums will be about half of current Texas high-risk pool price.

in 2014:

- She'll be able to get coverage immediately from the exchange, and will not be denied or charged more because of their health condition. She'll also pay premiums and out-of-pocket costs on a sliding scale according to the size of her disability income.

Source: Consumers Union

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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How Reform will look for:
Twenty-Something Single



Ashley L., age 24, single.

- Ambulance driver, does summer Forest Service fire-fighting work
- Uninsured now, earns \$24,375 per year (225% FPL)
- No health problems today

Under Reform NOW:

- Her parents can add her to their Employer Plan at the employer's next renewal date.

Under Reform in 2014:

- She would pay \$150/month for insurance (\$1,800/year, about 7% of her gross income) in the exchange; or
- Pay a tax fine: 1% of income in 2014, phasing up to 2.5% (\$695) in 2016.
- Has choice (because under age 30) to buy catastrophic plan with high deductible, lower premiums
- The real Ashley says she is not thrilled, but thinks she'll buy the coverage and not pay the fine.

Source: www.thefiscaltimes.com

How Reform will look for:

Senior with Medicare and Big “Doughnut-Hole” Costs

Barbara D., age 75, retired

- Monthly Social Security just under \$800, small IRA supplements
- Has Alzheimer’s and age-related health needs
- Her medications cost \$6,142/year; 95% are brand-name drugs
- Under Medicare NOW she first pays a \$310 deductible. Then Medicare pays \$1,890 and she pays \$630 until her drug costs total \$2,830.
- Barbara must pay the next \$3,610 in medications out of her pocket before Medicare resumes any coverage.
- She also has co-pays and \$38/month premiums.

Under Reform in 2011:

- Her medication costs will be cut by \$1,573: ↓\$250 rebate; plus 50% discount on brand-name drugs in the “doughnut hole”
- Her drug costs share will drop every year, and if she is lucky enough to live to 2020, her medication costs would drop from \$4,468 to \$1,486.
- She’ll get free annual check-ups and recommended preventive care starting in 2011.

How Reform will look for:
**Middle Class Family with
2 Children**



Michael and Kiersten B.

- Ages 38 and 34, married, No current health problems
- Two children, ages 1 and 4 years
- Michael is a scientist at State University; Kiersten has been home with the children but recently started doing part-time, self-employed work and hopes to slowly expand that. They earn about \$60,000 (~272% FPL) a year.
- Covered through the State University via United Health Care, they pay \$528 monthly and State U. contributes \$658 monthly (their share of insurance cost is \$6,336 yearly).

Under Reform in 2014:

- Because they spend over 9.5% of their income on their share of health insurance, they could choose to buy coverage instead in the exchange with premiums capped at \$5,700 per year.
- Michael is unhappy that he now pays more for his family's insurance than for their mortgage, but he and Kiersten are not sure whether they will switch in 2014 to get the \$636 annual savings.

How Reform will look for:
**Newly Laid-off Dad, Self-Employed
Mom, 3 Kids**



Deb & Allen N., age 43, & 47, married

- 3 children under 19
- Deb started her own small printing business.
- Allen was laid off from IT job where he earned \$58,000.
- For now, must rely on her modest income plus his unemployment, about \$32,500 (<\$2,700 monthly, ~125% FPL).
- Their children qualify for Medicaid/CHIP, but Deb & Allen are uninsured.

Under Reform in 2014:

- If their income did not improve, Deb & Allen could be covered by Medicaid until it did.
- If their income grows but still no job-based insurance, they could get good coverage through the exchange, with premiums and out-of-pocket cost help.
- If they hire employees, they could qualify for a tax credit to help provide insurance benefits, but would not be required to (because 50 or fewer employees).
- If Allen rejoins the IT industry, he could be covered under employer plan again.

Source: www.thefiscaltimes.com

How Reform will look for:

Self-employed with High Income

Dan N., successful comedian

- Age 28, single, no children
- Earns about \$300,000 yearly in New York and L.A.
- Pays \$99 a month for coverage through the Screen Actors Guild
- No current health problems


Under Reform in 2014:

- Dan can keep his SAG health insurance.
- Because of his high income, he'll be subject to a new tax on singles over \$200,000 and couples over \$250,000, amounting to an increase of about \$900 in his income tax bill.
- Dan, who volunteered to tell his story, says he thinks his tax increase is a good idea, to make sure everyone in society—not just the fortunate—has access to good affordable health care.

Source: www.thefiscaltimes.com

In-depth Look: Addressing Affordability

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%; (\$37 to \$73/month)
\$29,000	\$33,000 (150% FPL)	3.0-4.0% (< \$110/month)
\$33,000	\$44,000 (200% FPL)	4.0-6.3% (< \$231/month)
\$44,000	\$55,000 (250% FPL)	6.3-8.1% (< \$371/month)
\$55,000	\$66,000 (300% FPL)	8.1-9.5% (< \$522/month)
\$66,000	\$77,000 (350% FPL)	9.5% (< \$610/month)
\$77,000	\$88,000 (400% FPL)	9.5% (< \$695/month)

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%	\$1,983/indiv. \$3,967/family
\$33,000	\$44,000 (200% FPL)	85%	
\$44,000	\$55,000 (250% FPL)	73%	\$2,975/indiv. \$5,950/family
\$55,000	\$66,000 (300% FPL)	70%	
\$66,000	\$77,000 (350% FPL)	70%	\$3,987/indiv. \$7,973/family
\$77,000	\$88,000 (400% FPL)	70%	

Examples of Family Costs:

Premiums, Out-of-pocket help, and Out-of-pocket Caps

<u>Family of 4 Income, with Coverage through Exchange, 2014 and later</u>	<u>Maximum Yearly Premiums</u>	Average % of health costs covered by plan (“Actuarial Value”)	Cap on Uncovered spending (<u>not</u> including premiums)	Upper Limit on TOTAL Family Spending (% of income)
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250% FPL: \$55,125	\$4,465	73%	\$5,950	\$10,415 (19%)
350% FPL: \$77,175	\$7,332	70%	\$7,973	\$15,305 (20%)
450% FPL: \$99,225 (No Financial Assistance)	None	Buyer’s Choice; 60-90%	\$11,900	n/a

In-depth Look: Covering Kids

Focus on Children

- States can't cut eligibility for children's Medicaid or CHIP between now and 2019 (or lose all federal Medicaid funding, about \$18 billion a year in Texas)
- CHIP continues through 2019, and feds will begin paying about 95% of Texas CHIP costs starting in October 2015.
- CHIP block grant \$\$ must be reauthorized by Congress for period after 9/30/2015.
- Now: children of state and school employees can get CHIP IF:
 - premiums and cost-sharing exceed 5% of family income and
 - if state premium contributions have not declined below 1997 levels (adjusted for inflation).
- In 2014, Children below 133% FPL in CHIP (ages 6-19 from 100-133% FPL) will move into Medicaid; kids 133-200% will be in CHIP.
- If a state runs out of FEDERAL CHIP funds 2014 or later, states can enroll kids in Exchange coverage instead, but only in plans the US HHS Secretary has certified provide both benefits & cost-sharing protections comparable to CHIP.
- Many children above CHIP incomes will gain coverage through exchange; undocumented children are not helped.

In-depth Look: Individual Responsibility

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.**

In-depth Look: Employer Responsibility

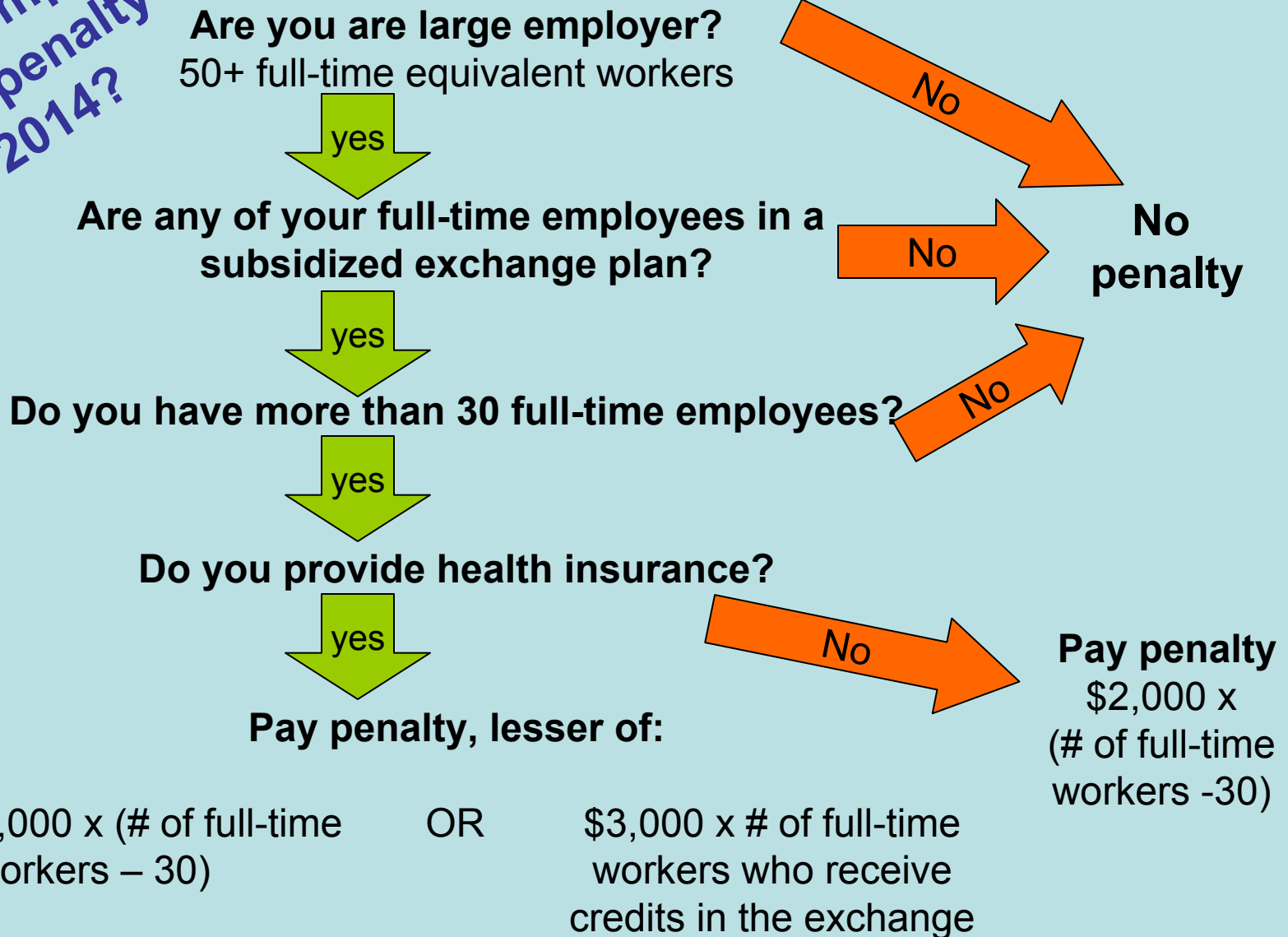
Employer Responsibility



*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.

Will an employer face a penalty in 2014?



Are you a large employer?

Large employer = 50+ full time *equivalent* employees

Full time = 30+ hours/week on average

Example employer = 38 FT; 20 PT working 24 hr/wk each.

How to count employees to determine if you are a large employer

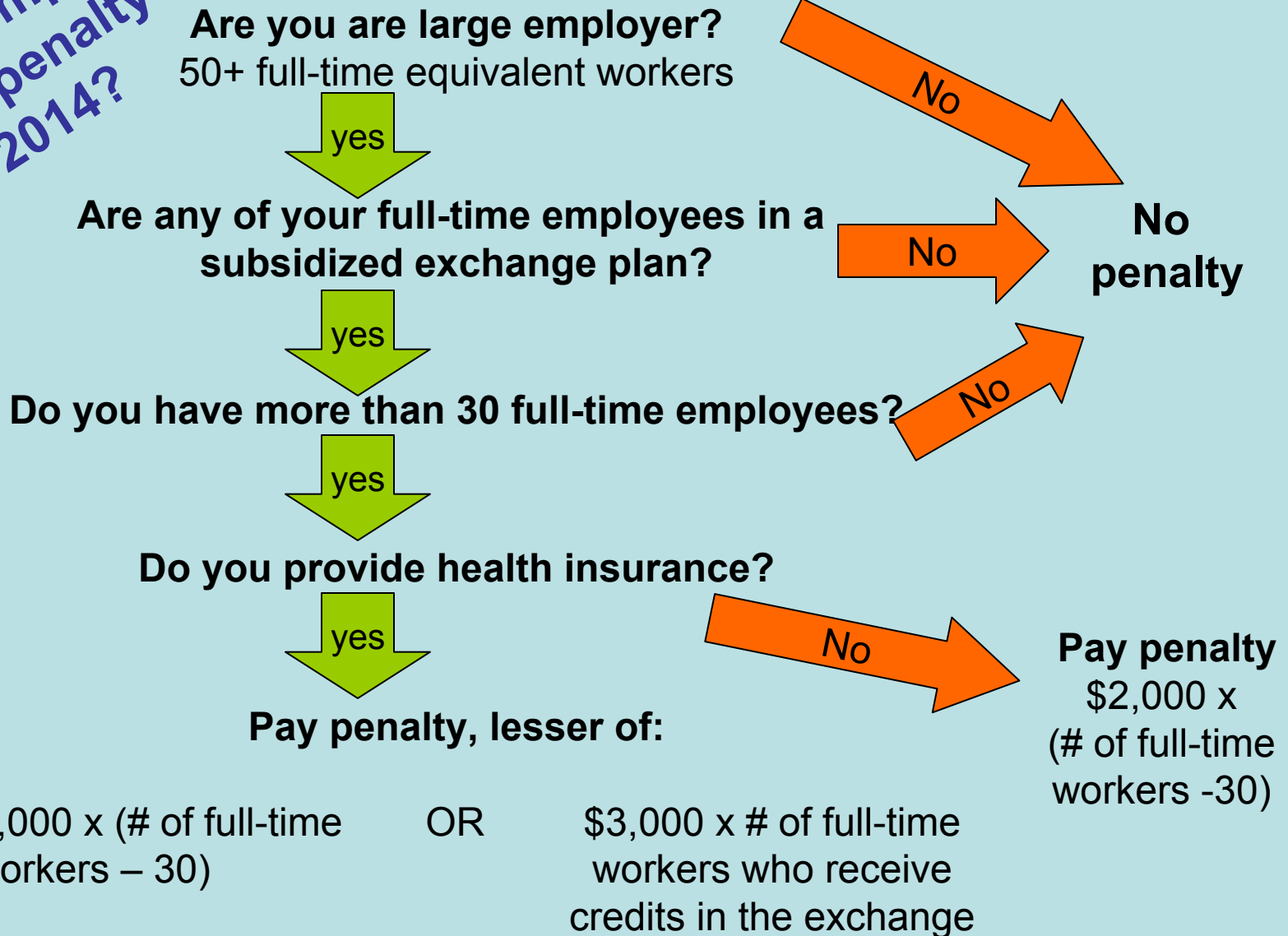
Employee Type	How to Count	Example Employer
Full-time (30+ hrs/ week)	Count as one employee each	= 38
Part-time (<30 hrs/wk)	Prorate. Take total hours worked by part-time employees in month divided by 120	(20 employees x 96 hours) / 120 = 16
Seasonal	Don't count if work <120 days/ yr	0

54 FT equivalents 47
= large employer

Are any of your FT employees in a subsidized exchange plan?

- In general, employees are NOT eligible for subsidies in the exchange if they are offered job-based insurance or are eligible for Medicaid
 - Exceptions, in cases where job-based coverage:
 - Is unaffordable; if employee's premium share is $> 9.5\%$ of household income ([several questions remain here](#)) and family income is $< 400\%$ FPL
- OR
- Has $< 60\%$ “actuarial value”
 - AV = share of covered benefits the plan pays on average
 - Employees pay remainder of covered benefits through copays, coinsurance, and deductibles.
 - Typical job-based PPO: 80%-88%

Will an employer face a penalty in 2014?



In-depth Look: Small Employer Tax Credits

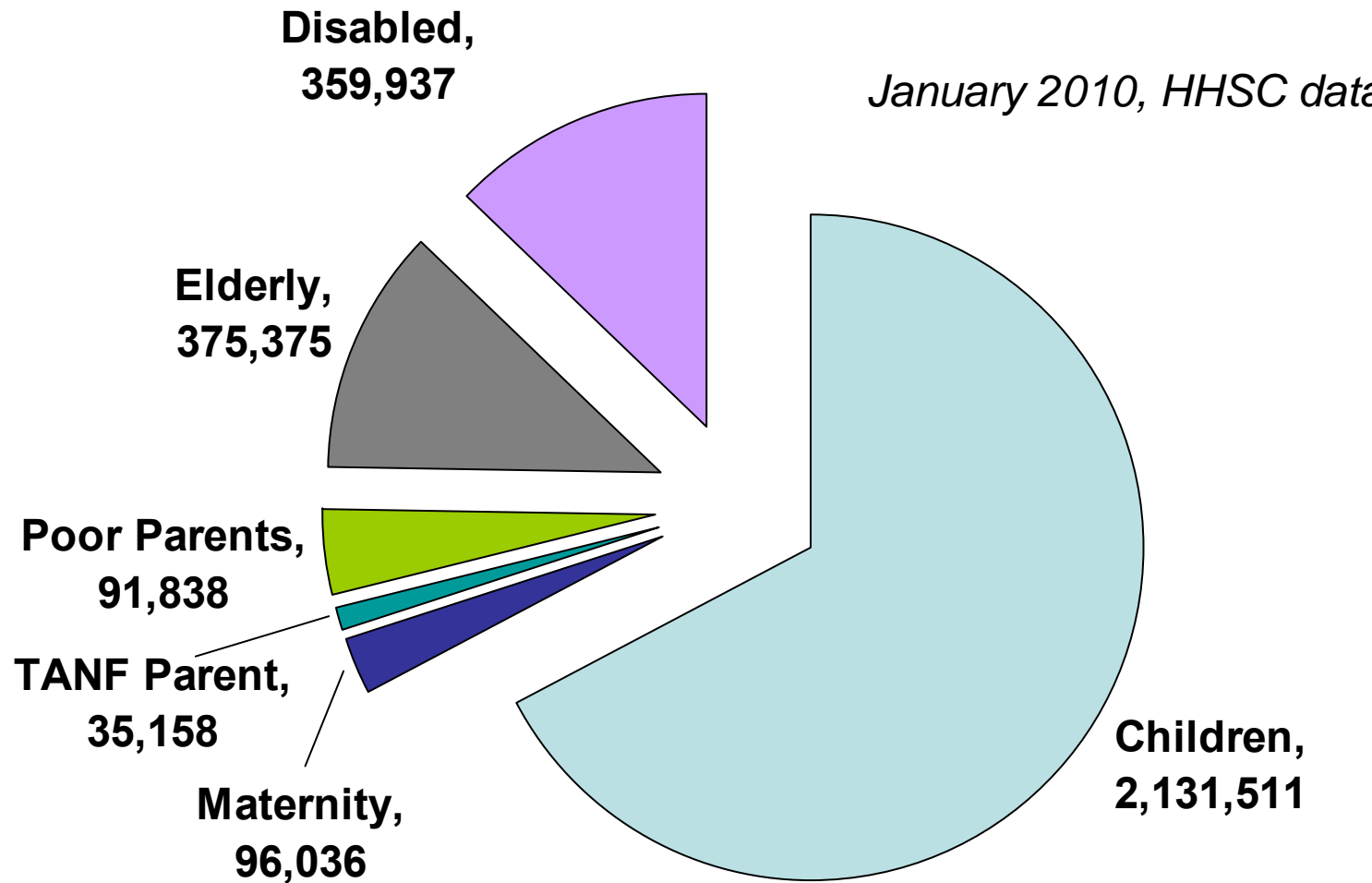
Tax Credits for Small Businesses



- Only one-in-three small businesses in Texas offers health insurance today.
- Cost is the primary reason they cannot provide coverage.
- Health reform provides tax credits to small businesses to help them afford coverage starting in 2010.
 - Eligibility: Small firms with 25 or fewer full-time equivalent employees, average annual wages under \$50,000, and employer covers 50% of the premium cost.
 - Phase I, 2010-2013: Max credit of 35% of employer's cost for businesses, and 25% for nonprofits.
 - Phase II, 2014 and on: Max credit of 50% of employer's cost for coverage through the Exchange, and 35% credit for nonprofits. Available for two years.
 - Max credit is available to small employers with 10 or fewer employees and average wages under \$25,000, with phase out as size and wages increase.

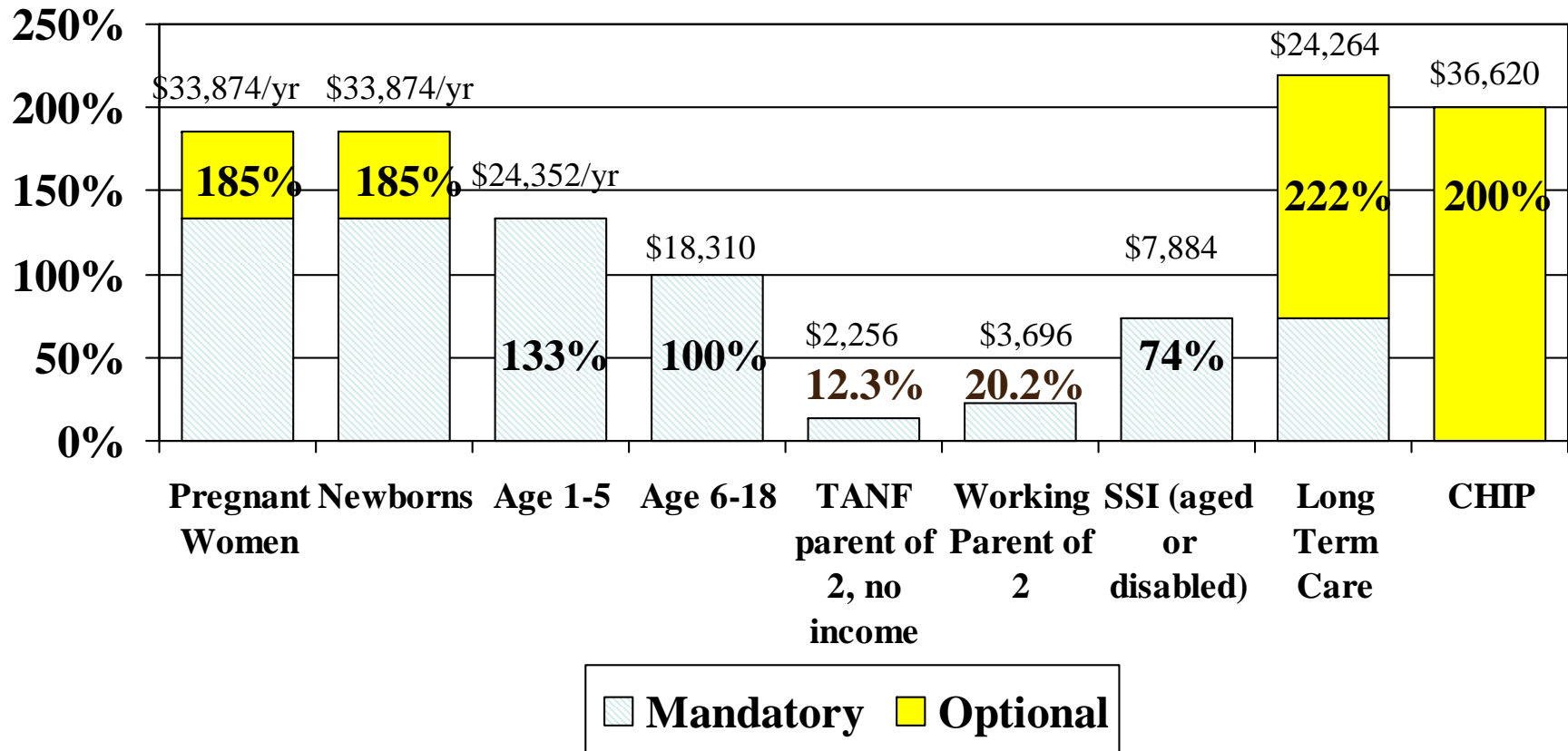
In-depth Look: Medicaid Changes and the State Budget

Texas Medicaid: Who it Helps



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

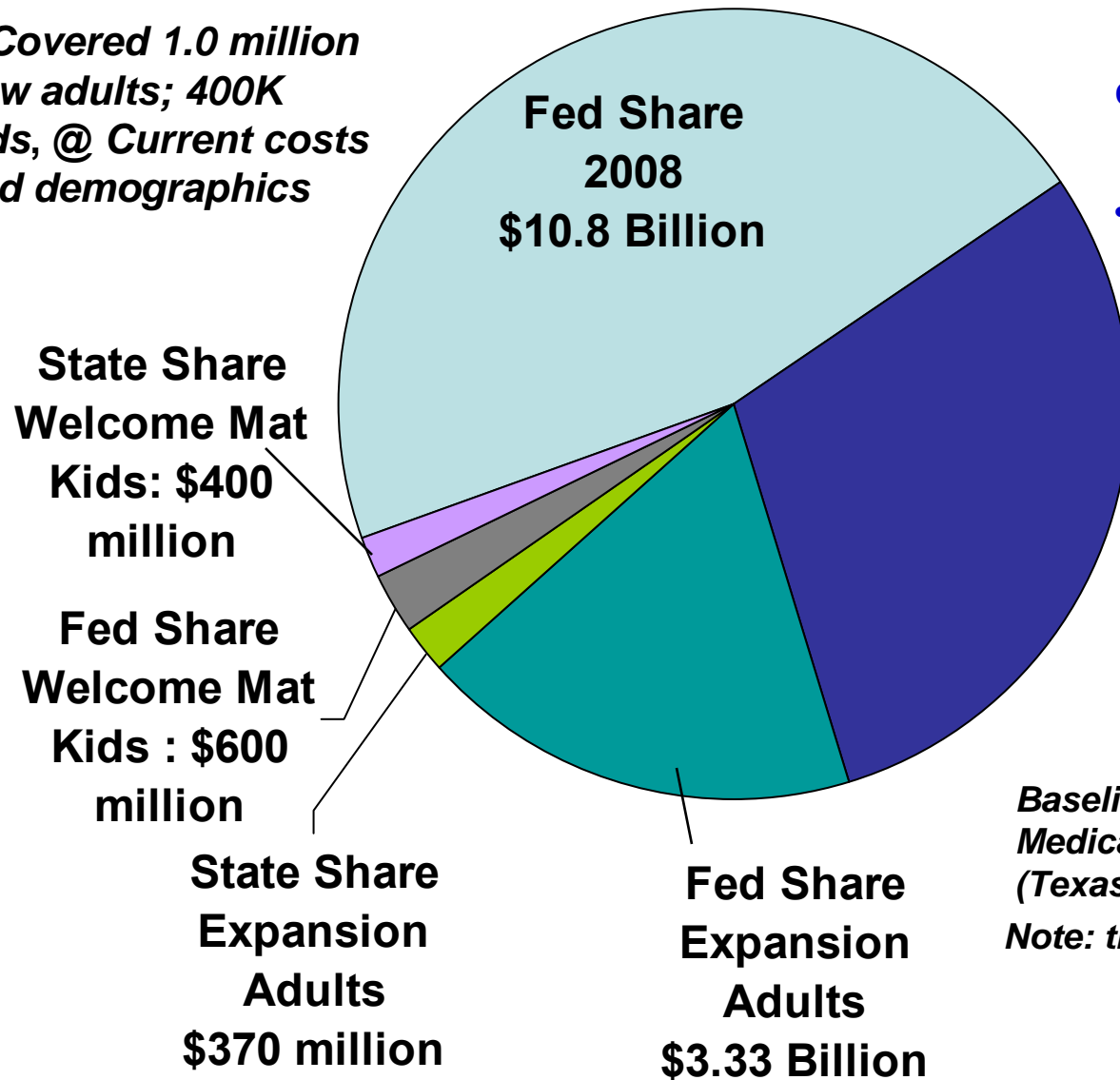
Benefits & Costs of Health Reform to State



- Medicaid expansion for adults: NO state budget costs until 2017 (federal govt. pays). In 2020, Texas gets \$9 federal for every \$1 state dollar.
- Based on other states', more currently-eligible Texas children will enroll in Medicaid; state must pay standard Medicaid share ~39% for these already-eligible uninsured Texas “welcome mat” children, **adds another significant cost to the state budget.**
- Medicaid will increase primary care fees (Medicare levels) in 2013 and 2014, Feds pay 100%. State concern: Unless Congress continues to fund, additional costs to state Medicaid budget 2015 – or rates get reduced again.
- Some providers' increased costs of covering their workers will show up passed through in Medicaid rates.
- HHSC “worst-cost” preliminary estimate thru 2023 shows 6:1 ratio of federal dollars to state costs.
- **Take-Up rates: CBO assumes ~57%; KFF/Urban Institute 75%; HHSC 91-94%!**
- **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, in context of a severe structural deficit in our state tax system and current leadership unfavorable to increasing revenue capacity, no matter how beneficial 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

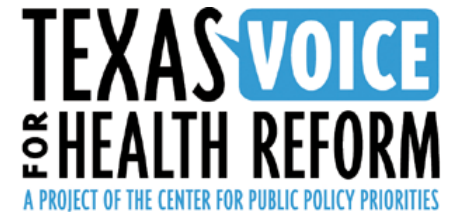
Baseline "Now" = Projected Texas Medicaid Services Spending, 2008 (Texas HHSC)
Note: this does NOT model increased admin costs.

Medicaid in 2012-2013 Texas 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)

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 options for community care services in 2014

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 who “age out” of foster care** (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)

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? (CBO:
- 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.

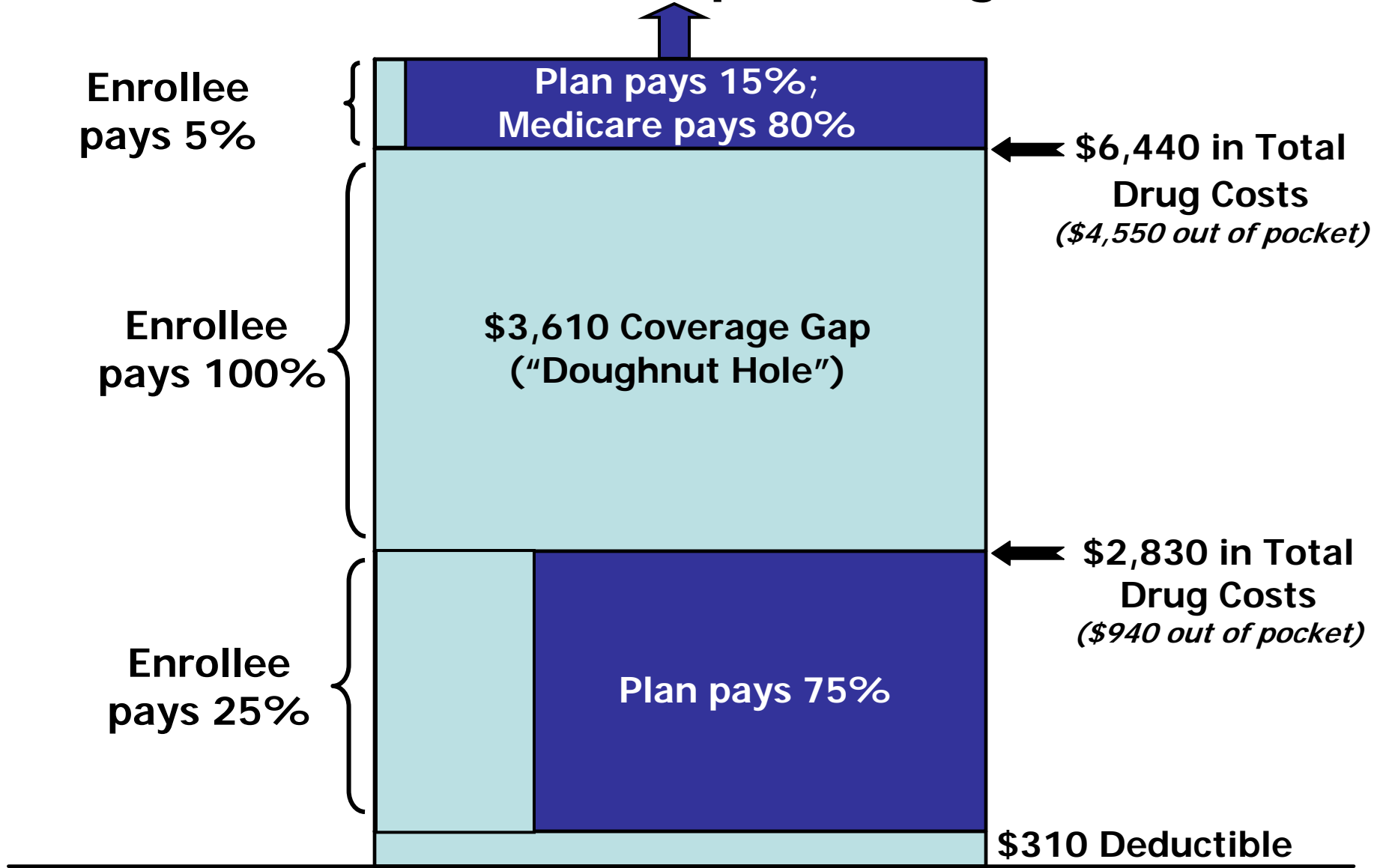
Medicaid DSH



- 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 \$0.5 billion in 2014; \$0.6 billion in 2015 and 2016; 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 and 2016, \$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.

**In-depth Look:
Closing the Medicare Prescription
Drug Doughnut Hole**

Standard Medicare Prescription Drug Benefit, 2010



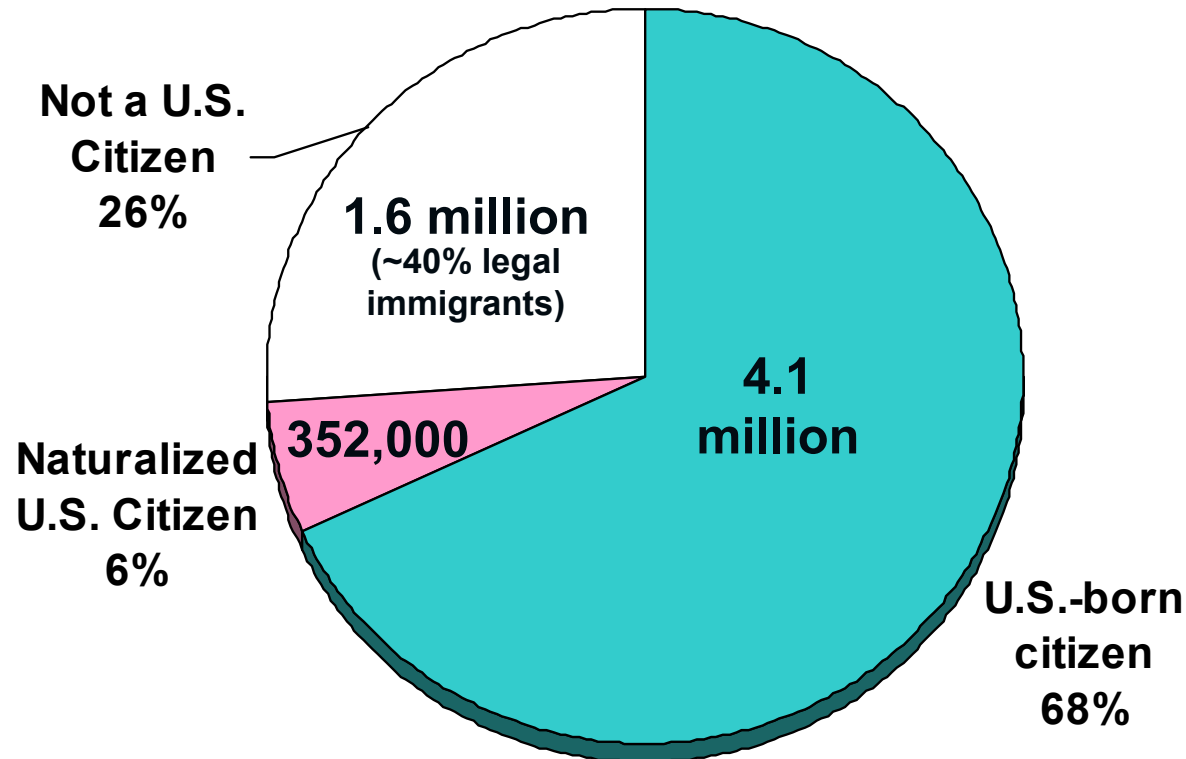
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2010 (standard benefit parameter update from Centers for Medicare & Medicaid Services April 2009).

In-depth Look: Coverage and Citizenship Status

Most Uninsured Texans are U.S. Citizens

(6.1 million Uninsured in 2008)

Uninsured by Citizenship Status, 2007-08 Average

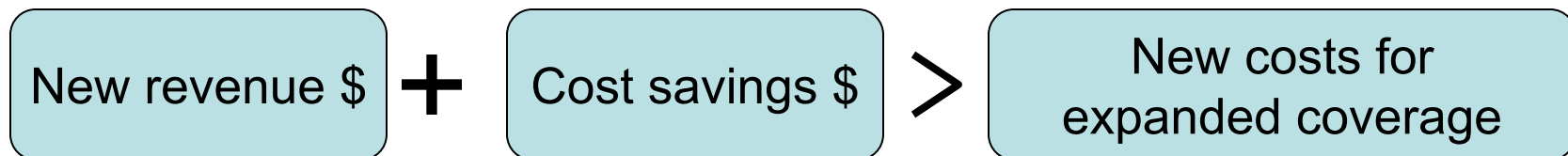


Source: CPS Annual Social & Econ. Supplement
www.census.gov/hhes/www/hlthins/hlthins.html

Paying for Health Reform

How is Health Reform Paid For?

Health reform reduces the federal deficit:



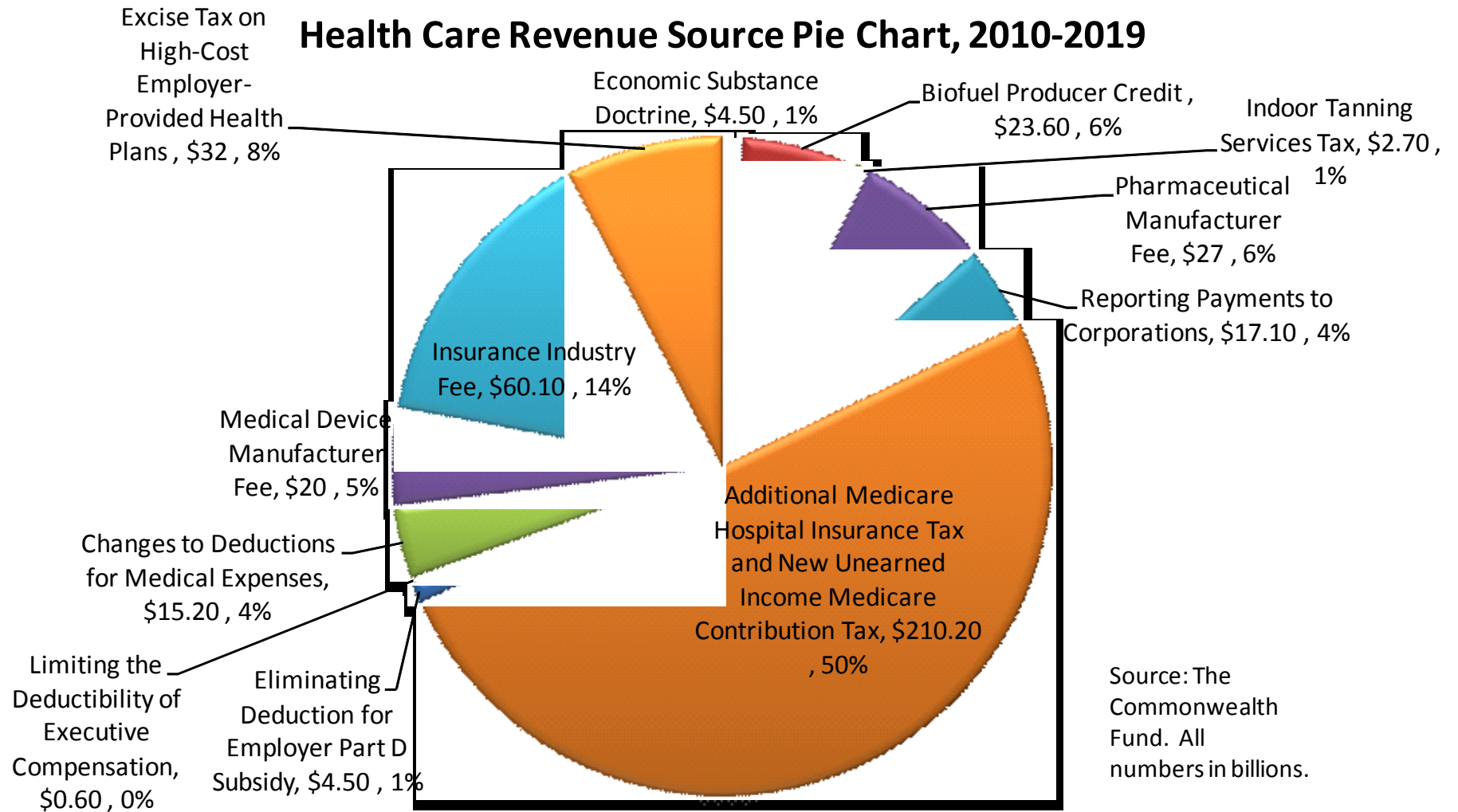
New Revenue

- Higher Medicare tax on individuals/couples earning more than \$200K/\$250K per year (2013)
- Fees on health care industries gaining millions of new customers
- Large employer and individual responsibility requirements

Cost Savings

- Reduces overpayments to Medicare Advantage plans (currently cost 13% more than regular Medicare)
- Reduces the rate of growth in Medicare's costs

Health Care Revenue Source Pie Chart, 2010-2019



Source: The Commonwealth Fund. All numbers in billions.