



A SIDE BY SIDE ANALYSIS OF KEY DIFFERENCES FOR TEXAS IN SENATE AND HOUSE NATIONAL HEALTH CARE REFORM BILLS

Texas particularly needs national health care reform: 6.1 million Texans have no health insurance, including 1 in 3 working-age adults and 1 in 5 children. Narrowing the scope of pending legislation to address only health insurance reform won't help Texas because so many Texans cannot afford health insurance.

If Congress abandons two of the key provisions of reform—help with premiums and out-of-pocket costs for low-to-moderate income Texans and Medicaid expansion for working poor adults—Texas will see very little reduction in uninsured citizens. Over 70% of uninsured Texans have incomes below 250% of the federal poverty income level (FPL), and only slightly more than 1 in 10 uninsured Texans has income above 400% FPL, the upper limit for premium and cost-sharing assistance under the House and Senate bills.

We have prepared a side-by-side analysis from our state's perspective of the provisions of the two bills and what they would mean for Texas. We also discuss the expected new costs and responsibilities for state government, as well as the potential benefits to the state budget and to our state's overall economy. However the nation goes forward, the issues will remain the same, and this analysis will be useful in assessing the best policy choices for Texas.

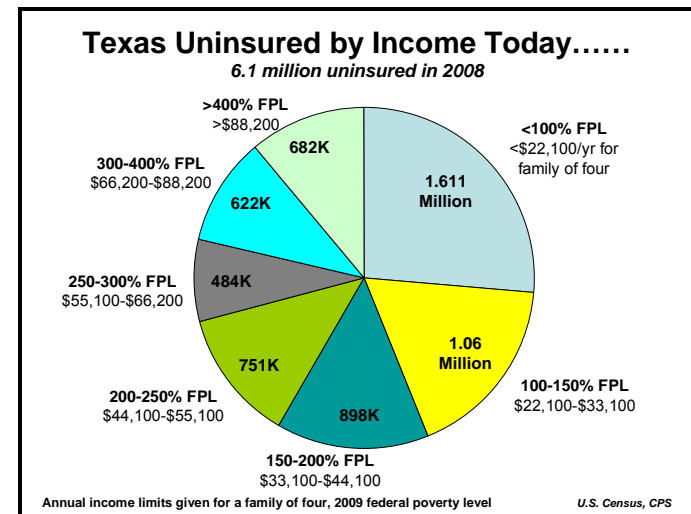
Key Reforms Common to Both Bills

Details about these provisions and special considerations for Texas are provided in the side-by-side table that follows:

- **Private health insurance reform:** no denial of coverage, no excluding pre-existing conditions, no annual or lifetime maximums, standardize benefits, no price variation for gender or occupation, limited age variation.
- **New Health Insurance Exchange(s)** where private insurers' options can be compared and purchased (like Amazon or Travelocity for insurance). Proposed to start up in 2013 House; 2014 Senate.

- **Medicaid expansion for adults:** cover all up to 133% of the federal poverty level (FPL) in 2014 (Senate), or 150% FPL in 2013 (House). (That is, \$14,404-\$16,245 for one; \$29,327-\$33,075 for a family of 4).
- **Premium assistance up to 400% of FPL** (\$88,200 for family of 4) for those who purchase insurance through the Exchange.
- **Out-of-pocket subsidies (to reduce out of pocket costs for all consumers) and out-of-pocket caps (for those with high expenses),** too, to increase affordability and reduce medical bankruptcy.
- **Individual mandate** to have coverage (with exemptions for poverty and financial hardship).
- **Some requirements for employers to contribute, with exemptions for small employers.**

Translation of Income-to-Poverty Ratios, 2009 (pre-tax incomes; 2010 values not yet released)		
Income to Poverty Ratio	Individual	Family of 4
100% FPL (poverty income)	\$10,830	\$22,050
133% FPL	\$14,404	\$29,327
150% FPL	\$16,245	\$33,075
200% FPL	\$21,660	\$44,100
250% FPL	\$27,075	\$55,125
300% FPL	\$32,490	\$66,150
350% FPL	\$37,905	\$77,175
400% FPL	\$43,320	\$88,200



Key Affordability Concerns in Merging the House and Senate Bills

Affordability remains the top focus of consumer and low-income advocates, and the House bill is substantially stronger overall in providing adequate premium and cost-sharing subsidies, as well as in creating stronger private insurance reform standards that will also make coverage more affordable for families with higher incomes who do not qualify for subsidies. The Senate unfortunately has much stronger bargaining power in this process. Still, the experts we trust the most continue to advocate for these key provisions in the compromise bill:

- (1) House bill's better premium assistance for people under 250% FPL;
- (2) Senate's better premium assistance for people between 250-400% FPL.

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- (3) House's cost-sharing subsidies (which reduce out-of-pocket costs for all who qualify, not just those with very high medical bills).
 - (4) House's broader expansion of Medicaid to 150% FPL.
 - (5) House's Medicaid primary care payment rate increases.
 - (6) House's national Health Insurance Exchange, or dramatically stronger minimum standards and federal oversight than in Senate bill at minimum.

Read more about these differences between the bills in the detailed side-by side table below.

New State Government Roles and Costs

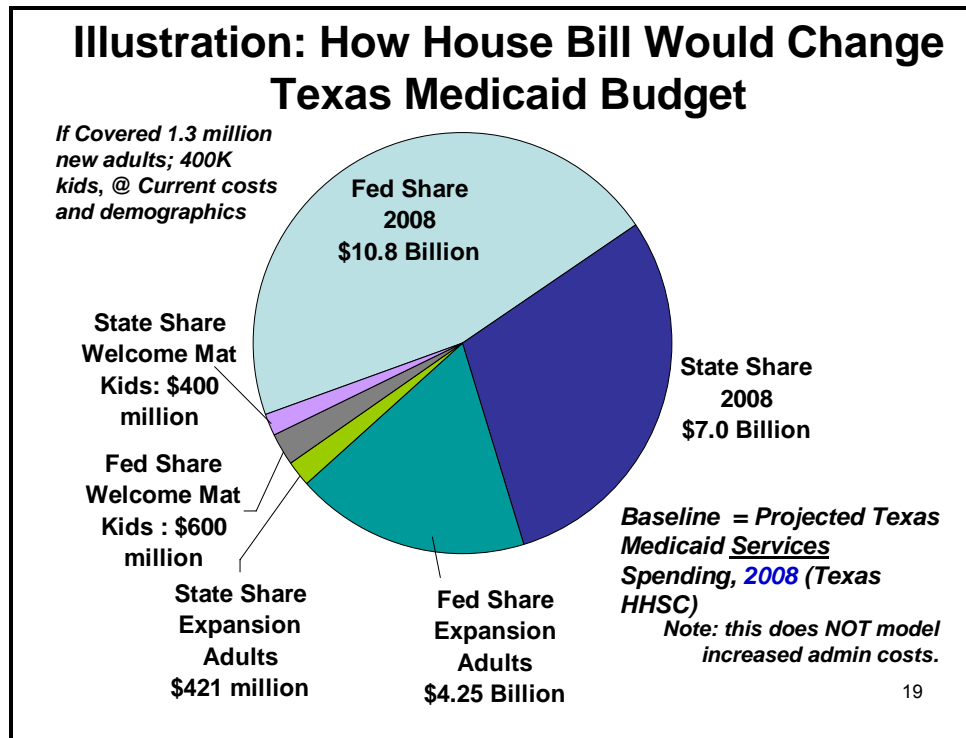
Until the final bill is adopted, the exact set of new state government responsibilities will not be known, nor can the associated potential state budget costs be estimated in a detailed way. Still, many of the major areas of future effort and expense can be identified, and Texas government agencies likely to be affected have been working internally to stay abreast of the developing bills and prepare for the work to be done on passage. Areas of expected change include:

- Possible state administration of a Health Insurance Exchange (hereafter referred to as "Exchange"), which would
 - provide a health insurance marketplace, and
 - include a major enrollment/subsidy eligibility function, including a major interface with Medicaid eligibility system.
 - If the Senate's proposed state-level Health Insurance Exchange prevails, federal start-up money will be provided, and Exchanges will be expected to become self-sustaining through assessments or user fees on participating health plans by 2015.
- Expanded role for Texas Department of Insurance in regulation (whether or not there is a state-level Exchange). TDI will retain most existing functions and in addition, help enforce new federal requirements.
- Need for Texas Health Insurance Pool ("high risk pool" for people who are uninsurable in the private market because of health conditions) will be eliminated when all reforms are in place.
- Medicaid eligibility system enhancements:
 - System must increase capacity, to accommodate both program expansion for adults and increased participation by already-eligible children.
 - Smooth interface between Medicaid enrollment and the Exchange system will be required, and
 - Bills create options for Exchange to contract with Medicaid to help determine subsidy eligibility (the state would be paid for this).

Major New State Budget Costs

- **Starting in 2015 (House) or 2017 (Senate), Texas would have to pick up a share of the costs going forward for Medicaid expansion to poor and near-poor adults, and (possible) reimbursement increases for specified Medicaid primary care services.**
 - House would cover all citizens to 150% FPL, Senate to 133% FPL. Based on today's Texas uninsured population of 6.1 million, about 1.3 million uninsured adults would qualify under the House provision, and about 1 million under the Senate's lower threshold.
 - Of course, 100% of the eligible uninsured will not enroll, and it will take several years of outreach and enrollment for coverage of the uninsured to "ramp up" to high levels.

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- Here is a rough illustration of the costs of 100% participation by eligible uninsured Texans at 2008-2009 demographics and costs:
 - Under the House bill, annual health care services for 1.3 million adults would be \$4.67 billion, and the state would start paying 9% in year three (2015), which would be about \$421 million, with the federal government paying the remaining \$4.25 billion.
 - Under the Senate bill, annual health care services for 1 million adults would cost about \$3.7 billion, and the state would start paying a share in year four (2017) when Texas would pay about 5.14% or \$188 million (federal share \$3.47 billion); in 2018, Texas would pay 6.14% or \$225 million (federal share \$3.44 billion); and in 2019 and thereafter, Texas would pay 7.14% or \$261 million (federal share \$3.4 billion).
 - It is expected that any final bill may extend 100% federal support for a greater number of years (and will eliminate the highly criticized special treatment of Nebraska in the Senate bill).
 - The costs of phasing in improved physician payment rates for primary care services (in House bill only) are not easily estimated, but the state's share is proposed to be identical (i.e., 9% from year three forward).
 - The other major Medicaid coverage costs for Texas will be due to increased enrollment (known as the “welcome mat” effect) by kids who already eligible for Medicaid under today's guidelines, but are un-enrolled and uninsured. The federal budget will only pay its “regular” (roughly 61%) share of these costs.
 - If 100% of the 440,000 currently Medicaid-eligible uninsured children were to enroll today, the current annual cost to the state budget would range from about \$350 million to \$466 million (range reflects different cost assumptions used by the Legislative Budget Board and HHSC), based on the “usual” state's share of about 39%.
 - For the illustration below, we model the cost of covering 400,000 more currently-eligible children at a total cost of \$1 billion.



- The pie chart illustration of the House bill's Medicaid coverage impact makes clear these two points:
 - The combination of mandated expansion and "welcome mat" enrollment increases, when fully phased in, is likely to increase total Texas Medicaid health care spending by nearly one third, but
 - Would increase state-dollar Medicaid costs by only about 12%, because of the very large federal contribution toward mandated expansion costs.

Administration

- The state will incur additional Medicaid administration costs related to coverage expansion, increased take-up by already-eligibles, and eligibility and enrollment functions. While these costs will not be trivial, Medicaid administrative costs are very small compared to coverage costs.
 - To illustrate, the LBB projected offsetting annual administrative savings of \$12.7 million (All Funds) from reduction of 306 eligibility workers if 12-month enrollment were adopted for children's Medicaid, yielding a total net cost of 12-month eligibility of \$519.3 million (All Funds) at full implementation (covering about 258,000 additional children).

Fiscal Benefits for Texas

- Medicaid expansion, while not “free” for Texas, will yield substantial economic benefits.
- When fully phased in, the Medicaid expansion for a million or more working-poor adults required by the reform bills—whether up to 133% FPL or 150% FPL—will require a state-budget contribution of several hundred million dollars per year.
- However, the state budget will receive from 10 to 13 federal dollars for every one state dollar that must be supplied, providing \$4.25 billion federal dollars to the state’s \$421 million under the House bill illustration, and \$3.4 billion federal dollars to the state’s \$261 million under the Senate scenario.
- Texas economist Dr. Ray Perryman has estimated (as have many other economists) that federal matching dollars from Medicaid have a short-term economic multiplier effect of 3.25, so that
 - the \$4.25 billion in annual new federal Medicaid funds under the House bill would result in over \$12 billion in near-term economic activity in Texas, and
 - the Senate’s \$3.4 billion would drive over \$10 billion in business activity.
 - Perryman also estimates that state tax revenues increase and local taxes are avoided when these federal tax dollars return to the Texas economy. In addition, insurance premiums are reduced, direct uncompensated care is reduced; individual Texans and businesses have reduced out-of-pocket costs; and cost-shifting inflation of health care prices is reduced. Overall business activity and retail sales are increased.
- Texas’ economy will also benefit from federal premium assistance and out-of-pocket cost help to families from 133% (or 150%) to 400% FPL, which will not require any state budget contribution at all. The size of this fiscal benefit will be challenging to project, but will certainly be substantial given the large number of uninsured Texans in that income range (from 2 to 2.3 million uninsured U.S. citizens) who would qualify for subsidies.

Key Implementation Concerns

- Will a Texas executive branch headed by an administration that has vocally opposed health insurance reform be provided adequate resources and support to implement reform functions competently?
- Even with \$10 to \$13 federal dollars per \$1 state share, financing the state’s new funding responsibilities in 2015 or 2017 will require responsible planning to ensure adequate revenues. While it is reasonable to assume the overall economic picture will have improved by then, unless reforms are adopted soon, Texas will still be facing a severe structural deficit in our state tax system.
- Many communities in Texas already experience physician and other provider shortages, even though one in four Texans is uninsured. While reform bills take important steps to support increased provider supply, the Texas Legislature will need to take additional actions to meet increased demand when more Texans have access to care.

Who Would Remain Uninsured Under These Bills?

- The Congressional Budget Office assumes a **small percentage of Americans will opt not to be covered**, as there is no penalty for those with the lowest incomes, and penalties for remaining uninsured are much lower than cost of coverage. If premium subsidies are inadequate—as in the Senate’s bill—a larger share of low- and moderate-income Americans may stay uninsured.

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- **Undocumented immigrants** will remain ineligible for Medicaid and CHIP, and would not qualify for premium subsidies or new high-risk pools under either chamber's bill. Under the Senate's bill, undocumented individuals would not even be allowed to buy coverage at full cost (no subsidy) from the Exchange. Best estimates are that 40% of undocumented in the U.S. today have private coverage; it is not clear how the new system would improve or worsen that statistic.
 - **Legal Permanent Residents** face continued exclusion from Texas Medicaid under our state law; in most other states they could apply after they have been in the U.S. for 5 years. They would be eligible for subsidies in Health Insurance Exchange coverage under both bills.

Health Reform and Texas: Comparing the House and Senate Bills

Focus on Insurance Coverage and State Budget Impact

This analysis focuses on changes in public and private insurance coverage, discusses the expected the new costs and responsibilities for state government, as well as the potential benefits to the state budget and overall economy.

See www.kff.org/healthreform/sidebyside.cfm for more comprehensive overview (but without Texas-specific information). In addition to Kaiser Family Foundation, this table draws on analyses from the Congressional Budget Office, Congressional Research Service, Center on Budget and Policy Priorities, Families USA, Georgetown University's Center for Children and Families, Community Catalyst, Commonwealth Fund, National Association of Insurance Commissioners, and Hewitt Associates.

Overall Coverage Impact

In Texas Today: 6.1 Million Uninsured

70% of Texas' current 6.1 million uninsured have incomes below 250% percent FPL. Among Texans of all ages, 25.1% are uninsured, and almost 28% of Texans under age 65. Nearly 75% of uninsured Texans are U.S. citizens. Just under 1.6 million are non-U.S. citizens; as many as 1 million of those may be undocumented, and the remainder are lawfully present. www.cppp.org/files/3/HIchartpack.PPT#378

House Bill: Overall Coverage Impact

Compared to 2010:

- Congressional Budget Office (CBO) estimates that under this bill's provisions, in 2019 94% of the non-elderly population will have health insurance (96% if undocumented immigrants are excluded from the calculation), **36 million will gain coverage, and 18 million will remain uninsured.**
- In 2019, 15 million more individuals (mostly childless adults and parents) would have coverage through Medicaid/CHIP and another 21 million through a new Health Insurance Exchange (House bill results in 6 million increase in employer coverage, offset by an equal decrease in the individual market).

Senate Bill: Overall Coverage Impact

Compared to 2010:

- Congressional Budget Office estimates that under this bill's provisions, in 2019 92% of the non-elderly population will have health insurance (94% if undocumented immigrants are excluded from the calculation), **31 million will gain coverage, and 23 million will remain uninsured.**
- In 2019, 15 million more individuals (mostly childless adults and parents) would have coverage through Medicaid/CHIP and another 26 million through a new Health Insurance Exchange (Senate bill results in net combined decrease of 9 million in the employer and individual markets).

Medicaid and CHIP Changes

In Texas Today: Who has Medicaid and CHIP Coverage

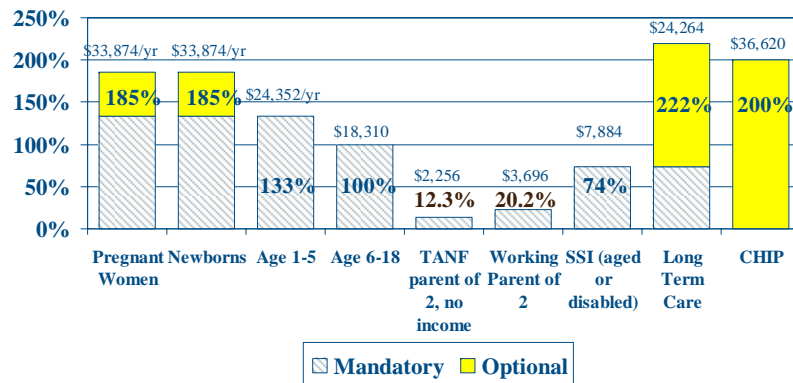
Texas currently provides Medicaid eligibility to most children (undocumented children are excluded) in or just above the federal poverty income line (FPL). CHIP picks up lawfully present uninsured children above the Medicaid limit with incomes below 200% FPL. About 2 million children received Texas Medicaid in August 2009, and another 490,000 children were covered in CHIP.

Also covered by Medicaid in August 2009 were 109,000 pregnant women (during pregnancy and for two months after delivery), 398,000 disabled adults, and 375,000 poor seniors.

In contrast to children, very few poor parents qualify for Texas Medicaid due to state policy; only about 148,000 were enrolled that month. Texas' income cap for parents was set in 1985 and has never been updated, even for inflation; as a result a working parent with 2 children cannot earn more than 20% FPL (\$308 monthly) and remain on Medicaid. In other words, most parents of children enrolled in Texas Medicaid do not get Medicaid themselves. (See charts below). In contrast, 15 states now cover parents with incomes from 100-200% FPL.

Federal Medicaid law completely excludes poor adults who are not parents (unless fully disabled, pregnant, or over 65 and below about 75% FPL).

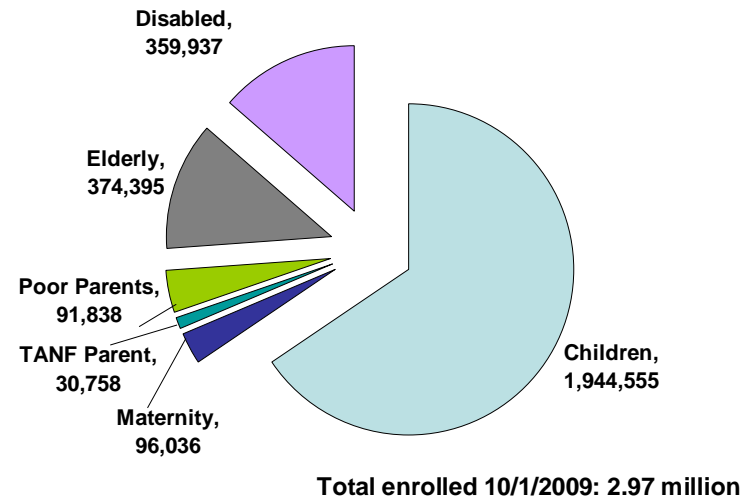
Income Caps for Texas Medicaid and CHIP, 2009



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

Texas Medicaid: Who it Helps

October 2009, HHSC data.



Coverage Mandates

House Bill: Coverage Mandates

Starting January 2013:

- All states must extend Medicaid eligibility to any U.S. citizen under age 65 and with income under 150% FPL.
 - Eliminates asset limits for most Medicaid (retained for certain age and disability-related coverage)
 - New coverage includes childless adults under age 65
- Any newborn lacking other “acceptable coverage” would be enrolled temporarily in Medicaid, and if not eligible for other coverage after 60 days, Medicaid continued.
- Transitional Medical Assistance (TMA) for persons losing Medicaid due to income or asset increases will continue until end of 2012.
- Medicare Savings Programs: Qualified Medicare Beneficiary (QMB) help with out-of-pocket Medicare costs is extended to seniors up to 150% FPL (currently at 100% FPL); state gets regular Medicaid match rate.
- Increases the asset limits for Medicare Savings Programs from current \$4,000 single/\$6,000 couple to \$17,000/\$34,000 in 2012.

Senate Bill: Coverage Mandates

Starting January 2014:

- All states must extend Medicaid eligibility to any U.S. citizen under age 65 and with income under 133% FPL.
 - Income eligibility based on Modified Adjusted Gross Income (MAGI; current thresholds must be adjusted to make sure this change does not cause any loss of eligibility)
 - No income deductions or asset limits allowed for most groups starting 2010 for most populations (does not apply to: those eligible for Medicaid because of other assistance received, the elderly, medically needy, or dual eligibles)
 - New coverage included for childless adults under age 65
- **January 2014:** Medicaid coverage (including comprehensive benefits as guaranteed under Medicaid’s Early and Periodic Screening, Diagnosis and Treatment laws for children, EPSDT) mandated through age 25 for all persons who had aged out of foster care (were in foster care when they turned 18).

Effects in Texas/Costs to State Budget: Coverage Mandates

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- **Potential New Eligible Adults:** In 2008, Texas was home to about 2 million uninsured adults (19 to 64) below 150% FPL, of whom about 1.28 million are U.S. citizens. (U.S. law excludes the undocumented immigrants from Medicaid, and Texas law excludes adult legal immigrants from Medicaid.)
 - **Take-Up Rate and Ramp-Up Speed (Unknowns):** The CBO has not estimated what share of new potential Medicaid eligibles will take up the new coverage (only gross estimates of the percentage of all Americans covered by 2019 are available), nor can we be certain how quickly newly-eligible Texans will enroll in Medicaid. Today, about 75-78% of eligible Texans are enrolled in Medicaid (based on universe of enrolled persons plus uninsured U.S. citizens). Factors that will affect the actual take-up and ramp-up rates under reform:
 1. **There will be no penalties under the Individual Mandate for persons at these low incomes who remain uninsured.** Most potential Medicaid eligibles will be exempt from Individual Mandate penalties due to income below the FPL, the federal income tax filing threshold, or meeting other financial hardship criteria. Some proportion of eligibles will always stay uninsured as long as coverage is voluntary and no penalties are imposed.
 2. **Uncertainty about the capacity of Texas' Medicaid eligibility system and new Exchange enrollment systems to process new enrollment.** If reform processes make it easier for low-income Texans to enroll and retain coverage, this proportion may increase, but it is not clear to what degree that will occur.
 3. Though relatively few currently-insured Texans below 150% FPL have private insurance today (20%), some of them would be able to shift from private coverage to Medicaid if that option became available.So, the magnitude of increased Medicaid enrollment will be affected by the unknown proportion of potential new Medicaid enrollees who will remain uninsured and the unknown number of privately insured low-income Texans who will shift to Medicaid under reform's expanded eligibility.
 - **“Welcome Mat Effect”:** Massachusetts and the several states that have made coverage available to all children have found that half or more of enrollment after their reforms actually came from residents who were already eligible before reform but had not enrolled in coverage. Once the word spreads that coverage is available for every child—the “Welcome Mat” is out—take-up rates increase significantly. Although no Individual Mandate penalties are expected to apply to most Texans below 150% FPL who remain uninsured, based on the historical increases in take-up rates in other states, Texas can expect, over time, that more of our currently-eligible children will enroll in Medicaid after reform is implemented. (Because Texas has such limited current eligibility for adults, there is relatively low risk of Medicaid Welcome Mat effect for adults.)
 - **Estimated Numbers of Welcome Mat Kids:** According to U.S. census data, about 910,000 Texas uninsured children are in families with incomes below 200% FPL. Adjusting downward by 250,000 to remove undocumented children from that number, we estimate that about 660,000 of Texas uninsured children are U.S. citizens and legal immigrant children who are eligible for, but not enrolled in Medicaid or CHIP. At least two-thirds (440,000) of these uninsured Texas children (estimates are as high as 75%) qualify for Medicaid (not CHIP) based on family income.
 - A large gap between LBB and HHSC assumptions about cost per Medicaid child and likely enrollment yield a wide range in cost estimates. In 2009, the Texas LBB projected that 12-month eligibility for children's Medicaid would bring an additional 258,000 of these already-eligible children onto the Medicaid rolls (at an annual cost of about \$206 million to the state), while the Texas HHSC

projected 376,000 children would be added at a state cost of about \$398 million. (Neither Senate nor House bill mandates 12-month enrollment for children or adult Medicaid.)

- As discussed above, there is no precise estimate of the degree by which enrollment of already-eligible kids will increase under health reform's "welcome mat" influence, but other states' experience suggests it will increase—even in a voluntary/no penalty system.
- While state costs for newly-eligible adults will largely be borne by the federal budget (see below), a robust welcome mat response by already-eligible uninsured Texas children would add another significant cost to the state budget, because the state will be responsible for our standard Medicaid state share of just under 40% for those children.
 - If the welcome mat effect were as powerful as 12-month enrollment, the state dollar annual costs (at current costs and demographics) could amount to \$200 to \$350 million (LBB vs. HHSC). If 100% of the 440,000 Medicaid currently-eligible uninsured children were to enroll today, the current annual cost to the state budget would range from about \$350 million to \$466 million (LBB vs. HHSC), based on the "usual" state's share of 39%.

House Bill A simplified illustrative static model using current uninsured numbers and Medicaid enrollment and costs (i.e., not modeling enrollment growth and inflation):

If the House Medicaid provisions to expand Medicaid to 150% FPL were fully implemented today, then:

- Roughly 1.28 million uninsured adults (U.S. citizens) would gain coverage,
- At current Texas Medicaid adult costs, one year of health care provided would cost about **\$4.67 billion**. Under the House bill, the state would pay none of this cost in 2013 or 2014;
 - From 2015 forward the state would pay 9% of the costs of new eligibles. **Under those terms,**
 - **the federal government would pay \$4.25 billion, and**
 - **Texas' state budget share would be the remaining \$421 million (of the \$4.67 billion total).**
 - **After the first 2 years of 100% federal funding, Texas would receive \$10 federal dollars for each \$1 the state spends on expanded Medicaid coverage under national health reform.**

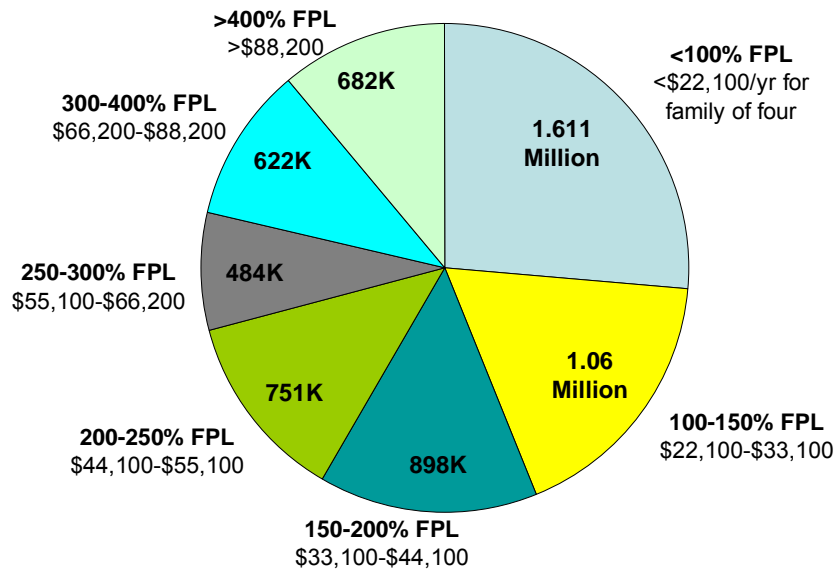
Senate Bill: Using the same simplified static model, under the Senate Bill's Medicaid expansion to 133% FPL, if fully implemented today:

- About 1 million uninsured Texas adults (U.S. citizens) would gain coverage
- At current Texas Medicaid adult costs, one year of health care for one million adults would cost about **\$3.7 billion**. Under the Senate bill, the state would pay none of this cost in 2014, 2015, or 2016;
 - In 2017 the Texas would pay about 5.14% or \$188 million, with the federal share \$3.47 billion
 - In 2018, Texas would pay 6.14% or \$225 million, with the federal share \$3.44 billion
 - In 2019 and thereafter, Texas would pay 7.14% or \$261 million, with the federal share \$3.4 billion.
 - **After the first 3 years of 100% federal funding, Texas would receive**

- \$18 federal dollars for each \$1 the state spent in 2017 on expanded Medicaid coverage;
- \$15 federal dollars for each \$1 the state spent in 2018; and
- \$13 federal dollars for each \$1 the state spent in 2019 and thereafter.

Texas Uninsured by Income Today.....

6.1 million uninsured in 2008

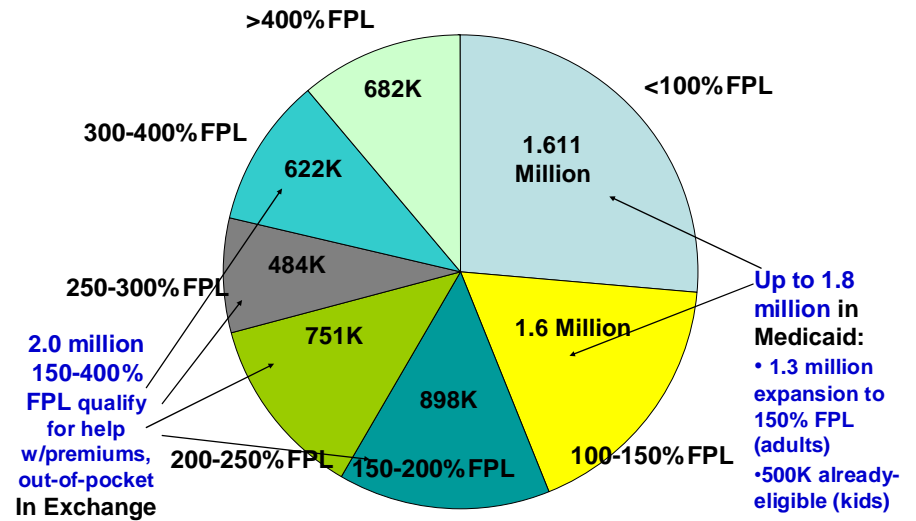


Annual income limits given for a family of four, 2009 federal poverty level

U.S. Census, CPS

.....And if House Bill Implemented Tomorrow

CBO: 3.7 to 4.7 million out of 6.1 million gain coverage



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Covering Children

House: Covering Children

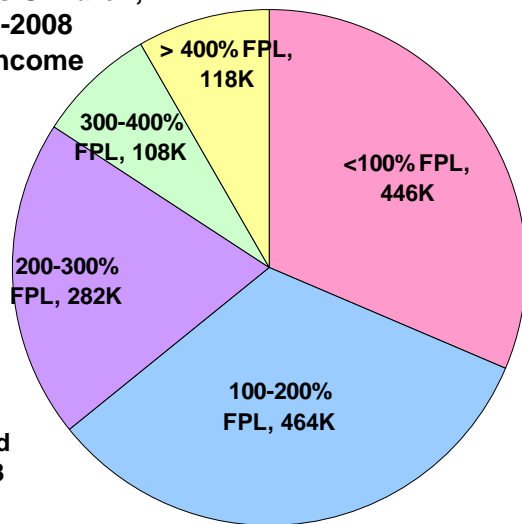
- CHIP expires at end of 2013 and children at/above 150% FPL in separate CHIP programs (like Texas') would move into Health Insurance Exchange (Exchange) subsidized coverage. Children below 150% FPL would move to Medicaid; states would still receive the higher CHIP match for these children.

Senate: Covering Children

- January 2014, states must cover all children with gross income up to 133% FPL in Medicaid (including moving into Medicaid the kids at that income who are currently covered in CHIP).
- Keeps CHIP program (with eligibility Maintenance of Effort (MOE)) through 2019, though CHIP block grant funding authorized only through September 30, 2015.

<ul style="list-style-type: none"> • Secretary of HHS reports to Congress by 12/2011 on (1) Exchange benefits compared to CHIP,(2) how to ensure comparable benefits for kids in Exchange coverage; and (3) how to transition kids for CHIP to Exchange without interruption of coverage or treatment plans. • January 2010: <ul style="list-style-type: none"> • 12 month continuous eligibility required for CHIP. • States may cover therapeutic foster care services for eligible children in out-of-home placements. • 90 days from enactment: Prohibits CHIP waiting periods for children under age 2 if (1) full cost of coverage (premiums plus out-of-pocket) exceeds 10% of family income or (2) coverage lost due to job loss. • Youths being released from incarceration must be reinstated in Medicaid; states must ensure this transition. • (Automatic enrollment of uninsured newborns in Medicaid – see previous section.) 	<ul style="list-style-type: none"> ○ If states exceed their federal CHIP block grant funding before 2015, eligible children may get subsidized coverage through the Exchange. After September 30, 2015, children could be enrolled in Exchange coverage if benefits and cost sharing are comparable to CHIP. ○ CHIP would also switch to Gross-income-based eligibility (MAGI) effective 1/1/2014. ○ States could provide CHIP coverage to children of state employees if the employee's premium and cost sharing costs exceed 5% of the family's income. To qualify, a state may not have decreased its premium contribution for family coverage below 1997 levels (adjusted for inflation). ○ The federal CHIP match rate in will be increased in 2015 by 23 percent. ○ Reauthorization of CHIP block grant would be due in 2015. ○ If children above 133% FPL transfer to or are enrolled in Exchange: <ul style="list-style-type: none"> - they must first be screened for Medicaid - Secretary of HHS must review and certify which plans in the Exchange provide CHIP-comparable benefits and cost sharing protections; - states must establish procedures to enroll the children in CHIP-equivalent coverage. • Private coverage for children: <ul style="list-style-type: none"> ○ All health plans must cover (with no cost sharing) preventive care and screenings in the American Academy of Pediatrics' "Bright Futures" standards. ○ Exchanges will offer child-only health plans. ○ Insurers would <u>immediately</u> be prohibited from excluding coverage to children for pre-existing conditions. ○ 6 months from enactment, individual and group policies must
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**Uninsured Texas Children,
(0-18) 2007-2008
By Family Income**



Total uninsured children: 1.418 million

US Census, March 2008 & 2009 CPS

provide dependent coverage for children up to age 26.

Effects in Texas: Covering Children

House Bill

- If the House provision to end CHIP program in 2013 were enacted—with children below 150% FPL going to Medicaid and those above 150% to Exchange coverage or their parents' employer plans:
 - Over one-third of Texas current CHIP children would be shifted to exchange coverage or a parent's job-based coverage: 181,110 or 36.7% of December 2009 child enrollees were in families above 150% FPL.
 - The remaining two-thirds below 150% FPL would transfer to Medicaid (312,470).
- Children moving to Exchange and other private coverage would not be guaranteed as comprehensive benefits as CHIP; and would be subject to somewhat less rigorous out-of-pocket protections. However, the entire family would have out-of-pocket protections under reform, while CHIP's protections apply only to the child.

Senate Bill

- If Senate provisions are enacted, Texas CHIP coverage though at least 200% FPL would remain in place at least through 2015 (CHIP is federally funded through 2015), and possibly through 2019 (eligibility MOE required through 2019).

- Children in CHIP below 133% FPL would transition to Medicaid in 2014. HHSC does not routinely report on enrollment at 133% FPL, but in December 2009 63% of Texas CHIP children (312,470) were in families below 150% FPL. Given the concentration of CHIP enrollment at the lower incomes, at least half of current Texas CHIP children would transition to Medicaid under the Senate provisions.

House: Maintenance of Effort (MOE) Requirements

- State Medicaid eligibility standards, methodologies, procedures and waivers may not be any more restrictive than those in effect on June 16, 2009.
- States would also be required to maintain their current (6/16/09) CHIP eligibility rules, methodologies, and procedures (though state could establish a waiting list if its federal funding runs out) until December 31, 2013.
- Some MOE exceptions allowed in 2013 to allow eligible persons to access subsidized coverage through the Exchange.

Senate: Maintenance of Effort (MOE) Requirements

- States must maintain (i.e., may be no more restrictive than) current child Medicaid and CHIP income standards and enrollment procedures through **9/30/2019**.
- States must maintain current Medicaid adult eligibility levels until Secretary of HHS declares Exchanges fully operational (target date January 2014).
- Above two bullets are a condition of receiving federal Medicaid matching funds.
- States would be required to maintain any existing adult Medicaid eligibility levels above 133% of the FPL until 2014.
 - Beginning in 2011, states could be exempted from maintaining eligibility levels for non-disabled adults above 133% of the FPL if state “certifies” current or next-year budget deficit.
- States must implement MOE in a way that ensures that no eligible persons lose coverage in the transition to using MAGI.

Federal Matching Funds

In Texas Today

States submit their actual expenditures for Medicaid and CHIP health care services to federal authorities regularly and are reimbursed for the federal government’s share (FMAP). Each state’s match rate is adjusted annually by Congress. Right now, Medicaid matching rates are more complex than ever because they are temporarily increased under the federal ARRA (stimulus) bill. If ARRA FMAP increases are NOT extended in 2010, Texas’ federal share will drop back to around 60.56%, compared to 71% in the current quarter. CHIP match rates were not increased by ARRA, and Texas’ current rate is 71% federal.

House: Federal Matching Funds

- **Immediate effect:** Extension of ARRA matching increases for 2 additional quarters (through 6/30/2011)
- **2013-2014:** 100% federal funding of mandated eligibility expansions for children, adults, and newborns; from **2015 on** federal share is 91%.

Senate: Federal Matching Funds

- **Jan. 2011:** New increase to FMAP for states recovering from a major disaster, most notably Louisiana.
- **October 2015:** Federal share of CHIP increased by 23 percentage points in each state, up to 100% maximum. (To illustrate only, if applied today this

<ul style="list-style-type: none"> • 2010-2014: 100% federal match applies to the INCREASE in Medicaid primary care fees (above 6/16/09) through 2014; 2015 and thereafter federal share is 91%. • State retains CHIP match rate for kids under 150% FPL who transition from CHIP to Medicaid. • Expansion of QMB coverage from 100-150% FPL (Medicaid pays Medicare Part B premiums and out-of-pocket costs) would be shared at “regular” Medicaid match rate. • States that opt for new HIV coverage (see next section) would receive higher CHIP match rate (from enactment until Exchange start-up). • GAO report on FMAP formula and possible revisions due to Congress 2/15/2011. 	<p>would increase Texas 2009 CHIP match rate from 71% to 94%.)</p> <ul style="list-style-type: none"> • 2014-2016: 100% federal funding of mandated eligibility expansions for children and adults. • 2017: federal share for Texas is (regular match + 34.3 percentage points) and in 2018 (regular match + 33.3 percentage points); 2019 and thereafter EVERY state will get (regular match + 32.3 percentage points). No state can get more than 95%. • “Early Implementer” states that already cover childless adults and parents above 133% FPL have no newly-eligible adults. These states would receive a temporary (2014 through September 20, 2019) 2.2 percentage point increase in their FMAP for adults under 134% of the FPL. Massachusetts will receive an additional 0.5 percentage point FMAP increase to cover currently eligible adults through 2016. • Nebraska would receive full federal funding for newly-eligible adults for all fiscal years. • Preventive services with U.S. Preventive Service Task Force grade A or B draw 1 percentage point higher federal match if no cost sharing required.
<p>House: <u>New Coverage Options</u></p> <p>Immediately on Enactment:</p> <ul style="list-style-type: none"> • State option to cover low-income persons with HIV infection; state gets higher CHIP match rate; coverage option <u>ends</u> when Exchange coverage begins (1/2013). • State option to provide family planning coverage up to same income as Medicaid/CHIP maternity coverage limit without requiring a “waiver.” • State option to use income disregards to allow individuals with very high medication costs to retain Medicaid coverage. 	<p>Senate: <u>New Coverage Options</u></p> <ul style="list-style-type: none"> • April 1, 2010: State option for early implementation of new coverage category for childless adults under age 65. Regular match rate would apply until 2014, after which the higher expansion match rate provisions described above would be applied to any early-option populations. • On Enactment: State option to provide family planning coverage up to same income as Medicaid/CHIP maternity coverage limit without requiring a “waiver.”

Medicaid Benefits and Delivery

House: Medicaid Benefits and Delivery

- **Jan. 2013:** New childless adult population may not be enrolled in managed care unless state demonstrates plan has capacity to meet physical, mental, and substance abuse needs of population.
- **Jan. 2013:** Medicaid “benchmark” benefit packages must meet national Exchange benefit and cost-sharing standards for “basic” plan.
- **July 2010:** Preventive care and vaccines recommended by Task Force for Clinical Preventive Services must be covered without cost sharing.
- **Jan. 2010:** State Medicaid programs may cover:
 - smoking cessation products;
 - nurse home visit programs (1st-time mothers and children < age 2);
 - free-standing birth centers (on enactment).
- **Jan. 2010:**
 - Translation services provided to adults will be at enhanced match rate (75% or higher);
 - Podiatry added as mandatory service; optometry added 90 days from enactment;
 - Non-emergency Medical Transportation required in law (previously under regulation);
 - School-based clinics funded with grants from this act must be paid using Federally Qualified Health Center (FQHC) methodology.
 - States may cover therapeutic foster care services for eligible children in out-of-home placements.

Senate: Medicaid Benefits and Delivery

January 2011: States may begin reimbursing for care coordination for “health home” for persons with chronic illness; these services matched at 90% federal for 2 years; allocates \$25 million in planning grants from Secretary of HHS.

- **Jan. 2014:** Newly-mandated adult population would receive “benchmark” coverage that is more limited than usually provided under Medicaid. (States currently only have the option to offer this coverage to higher-income Medicaid beneficiaries under provisions of the Deficit Reduction Act of 2005.)
 - However, benchmark coverage must meet the same “minimum essential health benefits” requirements as Exchange plans, including Rx coverage and mental health parity.
- **January 2014:** States must offer premium assistance option—if cost effective—to adults qualified for Medicaid who have access to employer-sponsored insurance.
- **January 2013:** Preventive services with U.S. Preventive Service Task Force grade A or B draw 1 percentage point higher federal match if no cost sharing required.
- **On enactment:** Requires state Medicaid programs to cover deliveries in free-standing birth centers (on enactment unless state law must be changed).
- **January 2014:** Allows for first time Medicaid coverage for smoking cessation drugs, barbiturates, and benzodiazepines.
- **Children in Medicaid** could receive hospice services concurrently with other treatments.

Community and Long-Term Services and Supports

House: Community and Long-Term

Senate: Community and Long-Term

<ul style="list-style-type: none"> • January 2011: “CLASS Act” creates new voluntary payroll-deduction-based insurance program to provide cash to buy community services and supports. All adult workers enrolled unless they opt out. <ul style="list-style-type: none"> ○ Assessment of sufficient capacity to serve CLASS beneficiaries, including state-conducted assessment of capacity for both Medicaid and CLASS. • Funds National Clearinghouse for long-term care information. • Allocates \$6 billion from 2010-2013 for enhanced payments to nursing facilities providing higher-quality care. • 3-year demonstration program in 4 states to develop core competencies, training curricula, and best practices for long term services and supports. • Nursing facility transparency reporting regulations within 2 years of enactment; reporting 90 days from issuance of regulations. 	<ul style="list-style-type: none"> • January 2011: “CLASS Act” creates new voluntary payroll-deduction-based insurance program to provide cash to buy community services and supports. All adult workers enrolled unless they opt out. <ul style="list-style-type: none"> ○ 5-year vesting period to get benefits; specifies not less than \$50/day benefit. • October 2010: Community First Choice Option allows all states to provide community-based attendant care services (not full Medicaid coverage) to all persons up to 150% FPL who have a disability that would qualify them for institutional care, as a state plan option (no waiver required). States opting in would get additional 6 percentage points in federal match for these services; option sunsets after 5 years. <ul style="list-style-type: none"> ○ This new option resembles Texas’ current Community Attendant Program (formerly called “frail elderly”), created under §1929(b) of the Social Security Act; Texas CAP program includes clients up to 3 times the SSI income, about 222% FPL. Texas will likely draw the additional federal match for at least a portion of our existing CAP program if this provision is enacted. • October 2010: New state option to provide home and community-based services as a state plan option (no waiver required) for persons with a greater level of need and up to 3 times the maximum SSI income limit, along with full Medicaid benefits. • Money Follows Person Demonstration program extended to 2016; clients must reside in nursing home at least 90 days. • Ageing and Disability Resource Center continued funding 2010-2014 at \$10 million per year. • Adds spousal impoverishment protections to 1915(c) Home and Community-Based Services waivers for 2014-2018. • October 2011-September 2015: creates temporary State Balancing Initiative Program giving enhanced match to states that expand the share of non-institutional long term services and supports in their Medicaid programs. • Nursing facility transparency reporting regarding ownership, spending, and accountability measures, posted on Medicare website.
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Special Provisions for “Dual Eligibles”

This term refers to seniors and adults with disabilities who qualify for both SSI-linked Medicaid and Medicare. For these folks, Medicaid picks up all Medicare out-of-pocket costs and provides important benefits not included in Medicare, such as eyeglasses and hearing aids (and in some states, dental care).

In addition, persons just above the SSI income cap (around 75% of the FPL) but still below or just above the poverty line get help paying their Medicare out-of-pocket costs through “Medicare Savings Programs” administered by state Medicaid programs, and are sometimes referred to as “partial duals.”

House: Dual Eligibles

Senate: Dual Eligibles

<ul style="list-style-type: none"> Secretary of HHS must establish new office or program at the federal Centers for Medicare and Medicaid Services (CMS) to improve care coordination for duals. Increases the asset limits for Medicare Savings Programs from current \$4,000 single/\$6,000 couple to \$17,000/\$34,000 in 2012. 	<ul style="list-style-type: none"> New Federal Coordinated Health Care Office established at CMS March 2010, must align policies across programs.
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Medicaid Coordination with Health Insurance Exchange(s)

In Texas Today – Infrastructure for Coordinated Enrollment

- Texas’ eligibility determination and enrollment systems for Medicaid and CHIP (and Food Stamps and TANF) have been in a state of crisis since 2006, causing delays, gaps in coverage, and erroneous denials and ultimately lawsuits and heightened federal oversight. In Fall 2009 HHSC launched a major campaign to increase staff numbers and improve performance, customer service, and working conditions for staff. Success of this improvement process will be critical to competent implementation of expanded coverage under reform legislation.
- Texas lacks online application and renewal functionality in Medicaid. A new CHIP online function has proven popular, but major technical hurdles must be resolved before HHSC can provide that option for the much larger Medicaid program and the new Exchanges.
- Texas provides legal immigrant children below 200% FPL with CHIP coverage, including during their first 5 years in the U.S., and beginning May 2009 will “sort” those children between Medicaid and CHIP according to income, exercising the new CHIPRA option and drawing federal match for those children.
- Texas is one of only 7 states that does not provide Medicaid to legal immigrant adults even after the federal 5-year bar (AL, MS, ND, OH, VA, WY).

House: Coordination with Exchange

Note: House bill provides for one strong National Health Insurance Exchange, with a state option to establish a state exchange that must meet the same rigorous standards.

- State MOU with Exchange required; state must assure enrollment into coverage of Medicaid-eligible persons referred from Exchange.
- State must automatically enroll childless adults found Medicaid-eligible by the Exchange into Medicaid; state option to use identical procedures for parents and children found eligible by Exchange.
- Allows national Exchange to contract with state Medicaid program to determine eligibility for subsidies under Exchange;
 - States doing this would be reimbursed;
 - Applicants must agree request/consent to having Medicaid agency determine their eligibility.

Senate: Coordination with Exchange

Note: Senate bill provides for state-level Exchanges with weaker price negotiation powers and insurance reform standards.

- January 2014:** States must establish and run a website to allow single, streamlined online application for Exchange, Medicaid or CHIP. In-person, mail; and telephone options also required.
- State Exchange and Medicaid must assure that persons applying for coverage through either “door” are directly enrolled in the appropriate program without additional paperwork or determinations (i.e., each must be capable of making full determination).
- State Medicaid program may contract with Exchange to perform income eligibility determination for subsidies.
- 5-year waiting period for lawfully residing immigrants remains in effect.**

- **5-year waiting period for lawfully residing immigrants remains in effect.** Bill would not change current federal Medicaid (and CHIP) rules that prohibit any federal matching funds during the five-year period after lawfully residing adults enter the U.S. (the state option—created by CHIPRA—to waive this waiting period for children and pregnant women would remain).

- **Legal immigrants** barred from Medicaid during their first 5 years in the U.S. will still be subject to individual mandate to obtain coverage under the bill, and will be eligible for premium and out-of-pocket subsidies in the Exchange.
- **Undocumented immigrants** would remain ineligible for Medicaid and CHIP, and would be ineligible for subsidies through the Exchanges. They would be allowed to buy Exchange coverage at full cost.

Bill would not change current federal Medicaid (and CHIP) rules that prohibit any federal matching funds during the five-year period after lawfully residing adults enter the U.S. (the state option—created by CHIPRA—to waive this waiting period for children and pregnant women would remain).

- **Legal immigrants**, though barred from Medicaid during their first 5 years in the U.S., will still be subject to individual mandate to obtain coverage under the bill, and will be eligible for premium and out-of-pocket subsidies in the Exchange.
- **Undocumented immigrants** would remain ineligible for Medicaid and CHIP, and could not obtain coverage through the Exchanges, even at full cost.

Medicaid/CHIP Enrollment, Retention, and Outreach

In Texas Today

Texas CHIP provides 12 month continuous coverage, but Texas law limits children in Medicaid to 6 months of coverage. Texas requires written signatures on applications and renewals, and currently lacks full online application and renewal capacity for Medicaid.

House: Enrollment, Retention, and Outreach

- **On Enactment:** separate state CHIP programs must provide 12-month continuous enrollment for kids <200% FPL.
- **On Enactment:** Removes the asset tests for most populations, except for those receiving long-term care services.
- **90 days from enactment:** Prohibits CHIP waiting periods for children under age 2 if (1) full cost of coverage (premiums plus out-of-pocket) exceeds 10% of family income or (2) coverage lost due to job loss.
- Secretary of HHS must create guidance, standards for outreach & enrollment in Medicaid and CHIP, including presumptive eligibility.
- Medicaid out-stationed enrollment expanded to all participating hospitals.

Senate: Enrollment, Retention, and Outreach

- **On Enactment:** Removes the asset tests for most populations (does not apply to: those eligible for Medicaid because of other assistance received, the elderly, medically needy, or dual eligibles).
- States must enable Medicaid application and renewal entirely online (including accepting electronic signature).
- No changes to current law that Medicaid eligibility must be determined by public agencies.
- States can get federal support for “navigators” who help with education and enrollment.
- Annual report from states required starting Jan. 2014 on Medicaid caseloads, population changes, outreach and enrollment processes,

	<p>monitoring both enrollment and retention.</p> <ul style="list-style-type: none"> • Hospitals allowed to make Medicaid presumptive eligibility decisions. • Requires states to conduct Medicaid and CHIP outreach to vulnerable populations including children, homeless youth, Children with Special Health Care Needs, pregnant women, racial and ethnic minorities, rural populations, victims of trauma, individuals with mental health/substance abuse related disorders, and individuals with HIV/AIDS. • Includes an additional \$40 million for CHIPRA outreach and enrollment grants for the period FY 2009- FY 2015.
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Provider Payment Rates, Reforms, and Delivery/Payment Pilots

<p>House: Rates & Delivery</p> <ul style="list-style-type: none"> • Phase-in increasing <u>Medicaid</u> fees for selected primary care services to parity with <u>Medicare</u> (80% 2010 , 90% 2011, 100% 2012 forward). Applies to both fee-for-service and Medicaid managed care. <ul style="list-style-type: none"> ○ Federal financing for related increased state costs same as for mandated coverage expansion (100% for 2 years; 91% thereafter). ○ States must submit state plan amendment for CMS approval specifying rates within 90 days of implementation. • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective January 1, 2010) Requires annual state reporting on Medicaid rates and processes for public input into rates. • New requirements for hospital reporting and state posting of charges for most common inpatient and outpatient services; compliance required within 2 years of implementation. • Adds Graduate Medical Education (GME) to the statutory definition of the scope of Medicaid and requires states to report on GME payments, goals and uses. 	<p>Senate: Rates & Delivery</p> <ul style="list-style-type: none"> • (No direct provision for rate increases.) • Medicaid and CHIP Payment and Access Commission (MACPAC) scope expands to entire Medicaid population. <ul style="list-style-type: none"> ○ MACPAC directed to review eligibility, enrollment, and retention policy and process; care quality, and Medicaid-Medicare interactions. • Establishes CMS Innovation Center in 1/2010 to test, evaluate, and replicate payment structures that foster patient-centered care, improve quality, and reduce rates of cost growth. • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July, 2011) • <u>Pilot</u>: Medicaid and CHIP Accountable Care projects which could share cost savings with providers. • <u>Pilot</u>: Medicaid payment for stabilizing adults in freestanding psychiatric facilities when required by EMTALA. • <u>Pilot</u>: global payment system projects in large safety net hospital systems in up to 5 states (starting 2010). • <u>Pilot</u>: bundled payment projects for acute & post-acute care in up to 8 states (starting 2012). • <u>Pilot</u>: \$100 million for grants for Medicaid “healthy lifestyles” projects (starting 2011).
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- Medicaid and CHIP Payment and Access Commission (MACPAC, established under CHIPRA in 2009) scope expands to entire Medicaid population.
 - Must report on pediatric sub-specialty rates by 1/2011; nursing facility rates by 1/2012.
 - Requires reporting on health reform implementation and Medicaid and CHIP, including access issues.
- Establishes CMS Innovation Center in 1/2011 to test payment & delivery models that improve quality and efficiency.
 - Replicate those that improve quality and are cost-neutral or provide savings; OR produce savings without diminishing quality.
- **Pilot:** Accountable Care Organization project to test payment incentives and qualifications for patient-centered Medicaid medical homes.
 - Matching funds rate for administering project 90% in first 2 years; 75% in years 3-5.
- **Pilot:** Medicaid medical home 5-year project, same enhanced administrative match.
- **Pilot:** Medicaid payment for stabilizing adults in freestanding psychiatric facilities when required by EMTALA.

Any incentives provided under such projects may not affect their “eligibility for, or amount of, benefits under the Medicaid program.”

Disproportionate Share Hospital Payments

In Texas Today: DSH

Federal Medicaid laws require that state Medicaid programs make special payments to hospitals that serve a disproportionately large share of Medicaid, low-income, and indigent patients. The federal DSH allotment share for Texas in 2009 was capped at \$936.7 million, with a temporary \$23.4 million increase under ARRA increasing that amount to \$960 million. When combined with the state’s matching share, Texas pays out about \$1.5 to \$1.7 billion per year in DSH. In FY 2007, DSH payments were received by 3 state-owned teaching hospitals, one state chest hospital (primarily for tuberculosis treatment), ten state psychiatric hospitals and approximately 165 non-state hospitals. The state’s share of these payments is drawn from state general revenue for the state-owned facilities, and match for the 165 non-state facilities’ payments from local tax dollars transferred from Bexar County, Dallas County, Ector County, El Paso, Harris County, Lubbock County, Tarrant County, and Travis County.

DSH payments made up about 21% of Texas Medicaid payments to hospitals in 2007, and 6.7% of total program spending in that year.

House: DSH

- Report to Congress on continued role of DSH in January 2016, including recommendations on allocation across states and targeting within states.
- Reduce national Medicaid DSH allotments by \$1.5 billion in 2017; \$2.5 billion in 2018; and \$6 billion in 2019), imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments per the recommendations in the 2016 report.

Senate: DSH

- **When a state's uninsured rate decreases by 45% or more**, reduces state's DSH allotment by 50% (25% for "low-DSH" states). DSH allotments will not fall below 50% of their 2012 allotment if states' uninsured rates continue to decrease. (Effective October 1, 2011).

Effects in Texas: DSH

The House formula does not support a precise state-level estimate, since the size of reduction would depend on state's position relative to other states. In 2008, Texas' federal DSH allocation of \$900 million was 8.7% of the national total \$10.4 billion. If cuts were allocated in proportion to state's share of the total federal DSH "pot", then Texas' share would be reduced by \$130 million in 2017, \$217 million in 2018, and \$521 million in 2019. But since cuts are to be reduced for states with the highest uninsured rates, Texas would expect smaller cuts than these amounts, though it is not possible to estimate how much smaller.

The Senate formula would trigger a 50% cut in Texas' federal allocation (i.e., at least a \$450 million cut, or a bit more depending on the exact amount of the state allocation for the year imposed), only when the state's uninsured rate for persons under age 65 drops by 45% or more. **By this measure, Texas' non-elderly uninsured rate will have to drop from the current 27.7% to 15.2% before any DSH reductions are taken.** Given Texas' relatively large share of both uninsured U.S. citizens and undocumented residents (the latter ineligible for Medicaid, CHIP, or premium subsidies), Texas will likely lag well behind other states in reaching a 45% reduction in the uninsured rate. Under the Senate's implementation schedule launching Exchanges and Medicaid expansions in 2014, it is unlikely that Texas could achieve a reduction of that magnitude before 2017 at the earliest, and perhaps even later.

Affordability Under Reform: Individual Mandate, Premium Subsidies, Out-of-Pocket Caps

Affordability of health care for families under reform depends on the interaction of provisions regarding individual mandates, premium subsidies, out-of-pocket caps, and actuarial values (measures of the average percentage of health care costs a particular plan would cover, with the remaining share paid out-of-pocket by the enrollee).

Health care debt is the number one cause of bankruptcy in the United States, accounting for 62% of U.S. bankruptcies in 2007, compared with just 8% in 1981. Most medical debtors were well educated, owned homes, and had middle-class occupations—and three quarters had health insurance. Because out-of-pocket costs for the insured are driving most U.S. bankruptcies, true affordability standards must be closely linked to caps on out-of-pocket spending, and minimum actuarial value standards for health plans.

Individual Mandate

House: Individual Mandate

- **January 2013:** Individual requirement to have “acceptable health coverage.”
- **Exemptions:**
 - Persons in households with incomes below the federal income tax filing threshold (in 2009 the threshold for taxpayers under age 65 is \$9,350 for singles and \$18,700 for couples);
 - Religious objections;
 - Financial hardship (to be defined).
- **Penalty for failing to get coverage:** the LESSER of
 - 2.5% of adjusted household income above the filing threshold (prorated for months without coverage);
 - Maximum is average national premium for coverage under “basic” plan sold in Exchange.

*** Red Flag Comment:** *Unlike Senate (which exempts families who must pay for than 8% of income for qualifying coverage), House individual mandate lacks affordability penalty exemption for those who earn too much to qualify for subsidies, but cannot find affordable coverage.*

Senate: Individual Mandate

- **January 2014,** all U.S. citizens and legal residents will be required to obtain coverage for themselves and for their dependents.
- Coverage must meet minimum “qualifying coverage” requirements.
- **Exemptions:**
 - Lowest-price available qualifying plan costs more than 8% of family income;
 - Income below 100% FPL;
 - Financial hardship (to be defined);
 - Religious objections;
 - Native Americans;
 - Undocumented immigrants;
 - Incarcerated persons;
 - Gaps in coverage less than 3 months.
- **Penalty for failing to get coverage:**
 - Assessed as a federal income tax penalty;
 - Penalty is per uninsured person;
 - Maximum a family (IRS household) penalized is greater of 3 times the individual penalty, or 2% of family income;
 - Penalties phase in from 2014 to 2016, with penalty the greater of:
 - \$95 per year or 0.5% of income in 2014,
 - \$495 per year or 1% of income in 2015,

	<ul style="list-style-type: none"> ▪ \$750 (half that amount for children under age 18) or 2 % of income in 2016 and beyond. ▪ Annual inflation updates after 2016.
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Who Qualifies for Premium and Cost-Share Subsidies?

<p>House: Who Qualifies?</p> <ul style="list-style-type: none"> • To qualify for premium and cost-sharing subsidies, individuals must: <ul style="list-style-type: none"> ○ Be citizens or certain other lawfully present individuals, ○ Be enrolled in an exchange <u>basic</u> plan (actuarial value of 70%) not through an employer, and ○ Have income below 400% FPL. • To qualify, individuals must <u>not</u> be <u>enrolled</u> in Medicare, Medicaid, military service related coverage, employer-sponsored insurance, a grandfathered plan, or “other coverage recognized by the Secretary.” • To qualify, individuals must <u>not</u> be eligible for employer-sponsored insurance for which an adequate employer contribution is available, or Medicaid. <ul style="list-style-type: none"> ○ Beginning in 2014, exception for full-time employees eligible for employer-sponsored insurance if premiums would exceed 12% of income. • Beginning in 2015, individuals could receive premium subsidies for plans in tiers besides basic, but would have to pay additional premiums and would also be <u>ineligible</u> for cost-sharing subsidies. 	<p>Senate: Who Qualifies?</p> <ul style="list-style-type: none"> • To qualify for premium and cost-sharing subsidies, individuals must: <ul style="list-style-type: none"> ○ Be citizens or certain other lawfully present individuals who file tax returns, ○ Be enrolled in an exchange silver plan (actuarial value of 70%) not through an employer, and ○ Have income below 400% FPL. • To qualify, individuals must not be <u>eligible</u> for Medicare, Medicaid, CHIP, military or Peace Corps service coverage, employer-sponsored insurance, a grandfathered plan, or “other coverage recognized by the Secretary.” <ul style="list-style-type: none"> ○ Exception for employees if their payment for employer-sponsored insurance premiums would exceed 9.8% of their income, or if the plan pays for less than 60% of covered expenses.
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Interactions of Premium Subsidies, Out-of-Pocket Caps, and Cost-Sharing Subsidies

Both chambers’ bills provide premium and cost-sharing subsidies, and cap out-of-pocket costs on a sliding scale, but the cost exposure for families varies considerably between the bills and across income groups. The tables below illustrate the interaction of the three provisions by family income as a percentage of the FPL.

Table 1: Comparison of Premiums and Out-of-Pocket Caps for Subsidized Families, by income
(Source: **Community Catalyst**, www.communitycatalyst.org/doc_store/publications/affordability_priorities_for_merger.pdf)

Income		House Bill			Senate Bill		
Income Ratio to Federal Poverty Level	Income (for a family of FOUR)	Premiums (as percent of income)	Annual Out of Pocket Cap (as percent of income)	Total potential health care costs*	Premiums (as percent of income)	Annual Out of Pocket Cap (as percent of income)	Total potential health care costs*
100%	\$22,050	1.5%	5%	7%	2.0%	21%	23%
133%	\$29,547	1.5%	4%	6%	2.0%	16%	18%
150%	\$33,075	3.0%	4%	7%	4.6%	14%	19%
200%	\$44,100	5.5%	5%	11%	6.3%	11%	17%
250%	\$55,125	8.0%	9%	17%	8.1%	13%	21%
300%	\$66,150	10.0%	15%	25%	9.8%	11%	21%
350%	\$77,175	11.0%	14%	25%	9.8%	12%	22%
400%	\$88,200	12.0%	14%	26%	9.8%	11%	21%

*as percent of income

Two Very Different Tools: Cost-Sharing SUBSIDIES versus Cost-Sharing CAPS

One of the factors behind out-of-pocket cost exposure is of course the extent to which the insurance plan covers the costs of care for the enrollee. A measure of the average percentage of health care costs a particular plan would cover is called the “actuarial value” (detailed explanation at www.cbpp.org/cms/index.cfm?fa=view&id=2949). Both the Senate and House tie premium subsidies (a.k.a. “credits”) to the Exchange plans that provide an average actuarial value of 70%; that is, would pay 70% of the costs of medical expenses for a typical population.

The House and Senate bills then add to the mix cost-sharing subsidies, which are applied to the 70% actuarial value plans to **increase the actuarial value of the plan**. As Table 2 below illustrates, the House bill offers these subsidies up to 400% FPL, but the Senate ends its cost-sharing subsidies at 200% FPL. This is where comparing the two bills on affordability gets confusing, because the Senate appears to offer a lower out-of-pocket cap above 250% FPL (Table 1), but at the same time offers a lower actuarial value plan at that income level and therefore exposes all enrollees to greater out-of-pocket spending on deductibles and other upfront costs. A few points that may help clarify:

- A higher actuarial value means all enrollees, in good and poor health, will experience lower out-of-pocket costs.
- The out-of-pocket cap reduces costs strictly for families with high medical bills (i.e., those who hit that cap).
- A study by Georgetown University based on actuarial analysis indicates that under the Senate bill, people with incomes just over 200% FPL—e.g., an individual making \$22,000 a year or a family of four making \$50,000—**would face deductibles five or six times higher than under the House bill**.
 - As a result, under the Senate bill people just above 200% FPL buying subsidized coverage through the Exchange to comply with the individual

mandate would pay substantial premiums for coverage that would likely not pay for routine care (other than for preventive services, provided without any cost-sharing) because their health expenses would be less than their annual deductibles.

- In short, while out-of-pocket caps provide critical stop-loss protections against devastating medical expenses, cost-sharing subsidies that reduce the actuarial value of the plan will provide more valuable affordability protections to more people. Table 2 below lays out the effective actuarial values that flow from the cost-sharing subsidies in the House and Senate bills, illustrating the stronger protections offered by the House bill, particularly between 200-300% FPL.

Table 2: How Cost-Sharing Subsidies Effect Actuarial Value of Coverage

Income for a family of four		Actuarial value of coverage	
Percent of poverty line	Annual dollar amount	House bill	Senate bill
133% – 150%	\$29,327 – \$33,075	97%	90%
150% – 200%	\$33,075 – \$44,100	97%	90%
200% – 250%	\$44,100 – \$55,125	93%	80%
250% – 300%	\$55,125 – \$66,150	85%	70%
300% – 350%	\$66,150 – \$77,175	78%	70%
350% – 400%	\$77,175 – \$88,200	72%	70%
400%	\$88,200	70%	70%

Source: Center on Budget and Policy Priorities www.cbpp.org/cms/index.cfm?fa=view&id=3045

Out-of Pocket Caps

The bills include provisions that set upper limits on deductibles, co-payments and coinsurance for persons receiving subsidized coverage, purchasing coverage through the Exchange, and also apply some caps in the marketplace outside the Exchange(s) as well. These caps provide “stop-loss” protection against catastrophic medical costs.

House: Out-of Pocket Caps

- House established an “essential benefits package” that is the standard required

Senate: Out-of Pocket Caps

- Senate established an “essential benefits package” that is the standard

<p>for meeting “qualified plan” status and thus complying with individual and employer mandates.</p> <ul style="list-style-type: none"> • Out-of-pocket spending limits for <u>unsubsidized</u> coverage with the essential benefits package limited to \$5,000/individual and \$10,000/family for coverage in or out of the Exchange (some exceptions for “grandfathered” coverage). • For subsidy-eligible individuals and families up to 400% FPL, the limits are: <ul style="list-style-type: none"> ○ 133-150% FPL: \$500/individual; \$1,000/family ○ 150-200% FPL: \$1,000/individual; \$2,000/family ○ 200-250% FPL: \$2,000/individual; \$4,000/family ○ 250-300% FPL: \$4,000/individual; \$8,000/family ○ 300-350% FPL: \$4,500/individual; \$9,000/family ○ 350-400% FPL: \$5,000/individual; \$10,000/family <p>(Effective January 1, 2013)</p>	<p>required for meeting “qualified plan” status and thus complying with individual and employer mandates.</p> <ul style="list-style-type: none"> • Out-of-pocket spending limits for <u>unsubsidized</u> coverage with the essential benefits package are limited to current 2010 health savings account limits (\$5,950/individual and \$11,900/family) for coverage in the Exchange and for individual and small group coverage outside of the Exchange (some exceptions for “grandfathered” coverage). • Reduces these out-of-pocket limits for incomes up to 400% FPL: <ul style="list-style-type: none"> ○ 100-200% FPL: one-third of HSA cap (\$1,983/individual and \$3,967/family); ○ 200-300% FPL: one-half of HSA cap (\$2,975/individual and \$5,950/family); ○ 300-400% FPL: two-thirds of HSA cap (\$3,987/individual and \$7,973/family). ○ These reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.
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Implications for Low- and Moderate-Income Texans

As the tables above illustrate, the House bill generally provides much stronger affordability protections for low-income families than the Senate’s, with one key exception. **The best provisions for uninsured Texans in the merger of the bills would be:**

- **Premium subsidy structure:**
 - House bill for people earning less than 250% FPL; and
 - Senate bill for people earning more than 250%.
- **Cost-Sharing Subsidies:**
 - House bill provides much stronger protection, as indicated by the higher actuarial values in Table 2.

***Red Flag Comment:** Because over 70% of uninsured Texans have incomes below 250% FPL, it is critical for our state that the final bill adopt affordability provisions closer to the House version.

More on Premium and Cost Share Subsidies

House: More on Subsidies

- Premium and cost-sharing subsidies are paid by the Exchange Commissioner directly to insurers on behalf of qualified individuals.
- Individuals and families pay their premium share to the plan, not the Exchange.
- Annual open enrollment period, with exceptions for qualifying events.
- Exchange-eligible people apply for subsidies to the Exchange, or to another entity if a formal arrangement made by the Exchange Commissioner.

- Individuals will report their income from most recent tax year return to apply for subsidies.
 - Exchange will work with Treasury to verify income information.
 - Alternative procedures for verifying income if no tax return is available for most recent tax year.
 - Individual/family may apply for a change in subsidy when there's a significant change to income from previous year.
 - Exchange Commissioner establishes rules for these processes.
- Subsidized persons and families will be auto-enrolled in a plan, taking into account their provider preferences and "other factors."
- Subsidized persons and families must report "significant changes in income."
 - Subsidies will be adjusted accordingly, up or down.
 - If fail to report change or deliberately misrepresent income, can be required to repay excess in full and other penalty may be added.

🚩***Red Flag Comment:** House's lack of a "safe harbor" cap on repayment liability could deter low-income enrollment.

Senate: More on Subsidies

- Premium subsidies are paid directly to individuals through advanceable, refundable tax credits.
- Cost-sharing subsidies are paid directly to insurer by Secretary of HHS.
- Annual open enrollment period, with exceptions for qualifying events.
- Individuals will report their income ("MGI") from the prior year tax return to their state Exchange to apply for premium and cost-sharing subsidies.
 - Procedures would be developed for people who do not file returns or who experience a "significant" change in circumstances.

- The Medicaid and CHIP agency may enter into an agreement with state Exchanges, in which the Medicaid or CHIP agency will determine if individuals are eligible for subsidies.
- Under penalty of perjury, applicants would declare their citizenship and lawful residency status, which would be verified through the Social Security Administration and the Department of Homeland Security.
- Special rules would also be put in place for counting income of families with mixed immigration status.
- No provision for reporting mid-year changes in circumstance or for getting increased or reduced subsidies.
- Maximum annual repayment for over-subsidy limited to \$250 per individual, \$400 per family.

🚩***Red Flag Comment:** Senate's protections against excessive repayment obligations are welcomed, but a provision to adjust subsidies up or down mid-year when there are major income or family circumstance changes is needed.

Essential Benefits Package

In Texas Today: Benefit Standards

Texas, like all other states and the federal government, sets minimum standards, called mandated benefits, for which benefits must be included in a health insurance policy. Examples of mandated benefits in Texas include mammography and emergency care. In Texas, benefit mandates vary by the market the policy is sold in: individual, small employer, or large group market.¹ In addition to traditional health insurance policies, to which all mandated benefits apply, Texas law also allows the sale of “consumer choice” plans with fewer mandated benefits.

Texas does not have any standardized, state-regulated health insurance policies available for individuals or small employers. The infinite variability of plans available on the market makes it challenging for consumers and employers to make effective comparisons among plans.

House Bill: Benefit Standards

- Creates an essential benefits package with comprehensive services. The essential benefits package will have a 70% *actuarial value*
 - Actuarial value represents the percentage of expected health claims costs for the average person that would be covered by the plan. For example, with a 70% actuarial value, the plan would cover 70% of the costs of benefits for the average person, with the enrollee paying the other 30% out-of-pocket through deductibles, copayments, and coinsurance. Higher actuarial value means a greater share of benefits are covered by the plan and lower actuarial value means enrollees pay a greater share through out-of-pocket cost sharing.
- Package would be equivalent in scope to the average employer-sponsored health plan.
- Annual cost sharing will be limited to \$5,000 for an individual and \$10,000 for a family. This limit is adjusted annually for inflation.
- No cost sharing will apply to preventive services and annual and lifetime benefit limits are prohibited.
- The Health Benefits Advisory Committee will make

Senate Bill: Benefit Standards

- Creates an essential benefits package with comprehensive services. The essential benefits package will have at least a 60% actuarial value.
- Annual out-of-pocket cost sharing is capped at the maximum amount allowed in High Deductible Health Plans that qualify for Health Savings Accounts (currently \$5,950 for an individual and \$11,900 for a family a year). In addition, in small group plans, deductibles are capped at \$2,000 a year for individuals and \$4,000 for family coverage (amounts adjusted annually).
- No deductibles will apply to preventive services, and annual and lifetime benefit limits are prohibited.
- The HHS Secretary would define and periodically update essential benefits coverage and ensure it is equivalent in scope to typical employer-sponsored health plans.
- Beginning in January 2014, all individual and small group plans in and outside of the Exchange must cover at least the essential benefits, except grandfathered individual and small group plans.

recommendations on benefit standards to the Secretary, who must adopt essential benefits by rule within 18 months after enactment.

- All qualified health benefit plans (in and outside of the Exchange) must offer at least the essential benefits. Essential benefits take effect on January 2013 for new coverage group coverage and Exchange coverage, but existing group coverage is “grandfathered” until 2018, when it must come into compliance. Existing individual plans are grandfathered (and not subject to essential benefits) as long as there are no changes to the terms or conditions of the coverage.

Effects in Texas: Benefit Standards

- **Comprehensive Benefits:** Both bills will define a standard set of comprehensive health insurance benefits, which will improve Texans’ access to comprehensive health insurance coverage.
- **House Bill Applies to More Coverage:** The House bill does a much better job, however, of ensuring that most people will eventually have comprehensive coverage by exempting only grandfathered individual plans from benefit standards.
*** Red Flag Comment:** The Senate bill, on the other hand, indefinitely exempts existing small group and individual plans, and essential benefits coverage is not required in the large group market (51+ employees) or in self-insured (ERISA) plans, leaving a significant proportion of Texans lacking coverage subject to minimum benefit standards.
- **Out-of-pocket Costs:** The essential benefits package in the House bill has a higher actuarial value, which means that enrollees will shoulder less of the cost of care through cost sharing such as deductibles and co-payments. The lower cost sharing requirements and out-of-pocket maximums in the House bill provide better financial security and protection from medical bankruptcy, especially for moderate-income families.
- **State Employee Coverage:**
 - **House Bill:** It seems likely that Texas’ state employee health benefits, which are fairly comprehensive, will be able to meet the standards of the House bill’s essential benefits package when defined by the HHS Secretary, with few changes. Changes may be required with respect to first-dollar coverage for preventive services and the prohibition on lifetime limits on benefits. HealthSelect, the self-funded plan offered statewide to state employees applies \$20-\$30 co-pays to services like physicals, annual well-woman exams, and immunizations, which may be considered preventive services not subject to co-pays after health reform. Also, HealthSelect has no lifetime maximum for in-network care, but has a \$1 million lifetime maximum out-of-network. HealthSelect has higher cost-sharing for out-of-network care to steer enrollees to in-network options, which will help mitigate any

added cost of removing the lifetime limit on out-of-network coverage. The full extent of changes required to coverage for state employees and the amount of any added cost to the state is unknown.

- **Senate Bill:** The Senate bill does not subject grandfathered plans or self-insured plans (like the Texas' state employee benefits), to essential benefit provisions, thus no change should be required.

Health Insurance Exchange

In Texas Today: Exchange

In general, a health insurance exchange is an organized market that facilitates the purchase of health insurance. The Massachusetts Connector and the Utah Health Exchange are examples of existing state-wide exchanges. Texas does not have a similar statewide exchange. The Federal Employees Health Insurance Plan functions as an exchange for federal employees' health coverage, much as the Employees Retirement System does for Texas state employees.

Exchange Functions

Exchanges can serve a variety of functions depending on the authority they are given and the markets they play a role in. At a basic level, exchanges can present clear, comparable information to consumers on health insurance choices and allow them to purchase coverage, bringing what Travelocity or Expedia do for air travel to health insurance. On the other end of the spectrum, exchanges can be a proactive market force to improve the value of coverage offered to consumers by competitively selecting health plans (as in Massachusetts), negotiating with insurers, and regulating premiums and/or coverage.² Health reform bills envision the exchange(s) also administering the premium and cost-sharing credits for low- and moderate-income individuals.

If an exchange presents clear and comparable information to consumers, and insurers are not allowed to turn applicants down or charge them more based on health status or pre-existing conditions, it is hoped that insurers in the exchange will have to compete on price and value instead of competing by avoiding risks. This could help lower premiums. If an exchange has a large share of the consumer market buying through it, it could have more clout in the market and encourage better pricing for its customers. This effect would be enhanced if the exchange was empowered to negotiate with insurers and limit participation to select insurers that provide the best value. Per-enrollee administrative costs of marketing and enrollment functions could also be reduced.

To be effective, an exchange must avoid adverse selection—attracting a less healthy, more costly population in the exchange than that outside of it. Adverse selection can be prevented if individuals and groups who are exchange-eligible are prohibited from buying coverage outside of the exchange. Short of that, it can be mitigated by enrolling a large and diverse risk pool through the exchange, applying the same rules (plan design, rating, guaranteed issue, etc.) to health plans in and outside of the exchange, charging the same premium inside and outside of the exchange, and using risk adjustment mechanisms to spread risk more evenly among health plans.³

House Bill: Exchange

Exchange Administration

The House bill creates a **national** Health Insurance Exchange that facilitates the selection and purchase of health insurance by eligible individuals and small businesses. The Exchange will be administered the Health Choices Administration, a new independent federal agency headed by a Commissioner appointed by the president.

Instead of participating in the national exchange, states would be allowed to operate their own state-based exchange (or a group of states could create one Exchange) if the Commissioner certifies the state can adequately negotiate and contract with health plans, enroll eligible individuals and employers, maintain sufficient local offices to meet users needs, administer affordability credits using the same income verification methods as the national Exchange, and conduct enforcement activities. In addition, the state must ensure that a state-based Exchange will not result in any increased costs to the federal government. No more than one Health Insurance Exchange may operate in any one state

Role of the Exchange

- Solicit bids from health plans that include information on premiums and affordability, negotiate terms, and contract with health plans to offer coverage in the Exchange;
- Enforce standards for health plan participation in the Exchange, including requirements that health plans be licensed in states where they offer coverage, report data to the Commissioner, implement affordability credits, participate in risk pooling mechanisms established by the Commissioner, contract with essential community providers, and provide culturally and

Senate Bill: Exchange

Exchange Administration

The Senate bill creates **state-based** American Health Benefit Exchanges (for individuals) and Small Business Health Option Programs (SHOP) Exchanges (for small businesses) to facilitate the purchase of qualified health insurance. States may elect to offer one Exchange for both individuals and employers if the Exchange has adequate resources to assist both populations. Federal grants to establish exchanges will be available to states through 2014. State-based exchanges will be administered by a governmental agency or a nonprofit organization established by the state. If a state does not have exchanges that meet certain standards operational by January 1, 2014, the federal government will establish and operate an exchange in the state. State Exchanges must be self-sustaining by January 1, 2015. Exchanges may assess participating health plans to cover operations costs. Exchanges must consult with stakeholders including consumers, entities with experience facilitating health plan enrollment, small businesses, self-employed individuals, state Medicaid offices, and advocates for enrolling hard-to-reach populations.

Role of the Exchange

- Certify plans as “qualified” or Exchange-eligible if they:
 - Meet requirements created by the HHS Secretary related to marketing, benefit design, provider network, essential community providers, accreditation, quality improvement strategies and enrollment periods; and
 - Are determined by the Exchange to be in the interest of Exchange-eligible individuals and employers. Exchanges cannot exclude plans simply because they are fee-for-service, or impose explicit premium price controls;

linguistically appropriate communications and health services;

- Make timely determinations of whether individuals and small employers are Exchange eligible. Eligibility determinations for “affordability credits” (subsidies) may be made through the Health Insurance Exchange or another entity as determined by the Commissioner;
- Provide clear, comparable information to consumers on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction of Exchange plans;
- Maintain a toll-free hotline and website to give consumers plan information, assistance with choice, and information on how to enroll;
- Enroll eligible individuals and employers by mail, phone, website, and in person;
- Distribute affordability (premium and cost-sharing) credits to health plans in the Exchange (premiums owed by individuals and employers will be paid directly to the health plan); and
- Establish and coordinate a risk pooling mechanism for Exchange health plans to minimize adverse selection for any plan.

Who is Eligible?

- **Individuals** can only buy health insurance through the Exchange if they are not enrolled in other acceptable health coverage (such as employer-sponsored health insurance,

- However, health plans must submit justification for premium increases to the Exchange before the increase takes effect, and the Exchange may take premiums into account when determining whether to include a plan in the Exchange;
- Make only qualified health plans available for purchase.
- May also offer stand-alone dental benefits;
- Certify, recertify, and decertify health plans as qualified health plans;
- Operate a toll-free hotline for consumer assistance and maintain a website with comparative information on plans presented in a standardized format;
- Assign each plan a rating indicating the relative quality and price of the plan within its benefit level (bronze, silver, or gold). The rating system would be developed by the HHS Secretary and implemented by Exchanges;
- Inform individuals about Medicaid, CHIP, and relevant state or local coverage programs; and directly enroll individuals in these programs if they are determined eligible by screening their Exchange application;
- Create and post an online calculator that determines a person’s actual cost for coverage after premium and cost-sharing subsidies are applied; and
- Establish a navigator program that awards grants to trade associations, community groups, chambers of commerce, and insurance agents to educate small employers, the self-employed, and the uninsured about the Exchange and facilitate their enrollment.

Who is Eligible?

- **Individuals** can buy coverage in the Exchange if they are U.S. citizens or legal immigrants and are not incarcerated.
- The Senate bill allows **small employers with 100 or fewer**

Medicaid, or Medicare), or if their share of the premium for employer-sponsored health insurance exceeds 12% of their income. Once an individual is deemed Exchange-eligible, they remain so until they become eligible for Medicare or Medicaid or until they disenroll from Exchange coverage.

- **Small employer eligibility** will be phased in based on the size of the business. Exchange eligibility would extend to business with 25 or fewer employees in 2013, 50 or fewer employees in 2014, and 100 or fewer employees in 2015.
- Beginning in 2015, the Commissioner may let larger employer access the Exchange.
- Once an employer enrolls in Exchange coverage, the business remains Exchange-eligible regardless of the number of employees.
- Employers enrolled in exchange coverage must make the minimum contribution required of employers (72.5% of employee-only premiums for the lowest cost coverage and 65% of premiums for family coverage).
- Employees of businesses with Exchange coverage may select coverage from any plan in the Exchange.

Market Outside of the Exchange

- Existing individual market plans would be grandfathered as long as there are no changes to the terms or conditions of coverage.
- Starting in 2013, all new individual plans must be sold through the Exchange and the public option and premium & cost-sharing credits will only be available in the Exchange.
- The small group market would exist outside of the Exchange, but all existing plans would have 5 years to come into compliance with all the regulations and benefit standards that apply to Exchange plans.

employees to purchase coverage through the Exchange;

- however, in 2014 and 2015, states may elect to count only businesses with 50 or fewer employees as small employers for the purpose of determining Exchange eligibility.
- Beginning in 2017, state Exchanges may elect to allow employers with more than 100 employees into the Exchange.
- Employers that purchase Exchange coverage may contribute toward a chosen level of coverage (e.g. silver or gold) and employees may choose any plan at that coverage level.
- Members of Congress and their staff will be able to choose coverage only through an Exchange.

Market Outside of the Exchange

- The Senate bill allows for individual and small group markets outside of the Exchange.
- Insurers are required to pool the risk of all people in all plans by market, both inside and outside of the Exchange (i.e. each insurer will have a single rating pool for the individual market inside and outside the Exchange, another for the small group market inside and outside the Exchange, and another for the large group market inside and outside the Exchange).
- The national plans administered by the Office of Personnel Management and premium & cost-sharing credits will only be available in the Exchange.

What Coverage is Offered?

The essential health benefits package will be available with four cost-sharing tiers:

- Basic: 70% actuarial value (plan would cover 70% of the costs of benefits for the average person, with the enrollee paying the other 30% out-of-pocket through deductibles, copayments, and coinsurance).
- Enhanced: 85% actuarial value
- Premium: 95% actuarial value
- Premium-Plus: 95% actuarial value, plus oral health and vision care

Annual out-of-pocket maximum capped at \$5,000 for individuals, \$10,000 for families and are reduced on a sliding scale for individuals and families that qualify for cost-sharing credits.

What Coverage is Offered?

The essential health benefits package will be available with four cost-sharing tiers:

- Bronze: 60% actuarial value
- Silver: 70% actuarial value
- Gold: 80% actuarial value
- Platinum: 90% actuarial value

A young adult catastrophic policy that covers preventive services would also be available to people age 30 and under.

Annual out-of-pocket maximum capped of \$5,950 for individuals and \$11,200 for families and are reduced on a sliding scale for individuals and families that qualify for cost-sharing credits.

Comparing Exchange Provisions in the Bills

The national Exchange as established in the House bill, in most respects, is more likely to result in improved value for Exchange consumers than the state-level Exchanges created in the Senate bill, because the House's Exchange moves more of the market into the Exchange and empowers the Exchange with better regulatory oversight tools as well as the ability to negotiate and competitively select participating insurers.

House Bill Gives Exchange Greater Market Share and More Leverage

To help mitigate adverse selection and attract competitive insurers to the Exchange, the Exchange must have a large segment of the market buying through it. A recent analysis by the Committee for Economic Development asserts that to be stable and effective, each Exchange will need at least 100,000 people in it (preferably more), and should include at least 20-25% of the population that is not enrolled in Medicare or Medicaid.⁴ To achieve this size, the authors believe that the individual and small group markets should be in one combined Exchange, and all uninsured individuals and employers with fewer than 100 employees should be required to use the Exchange. But even with these requirements, some state-based Exchanges in smaller states may not have enough people to create a stable risk pool.⁵ The Exchange as envisioned in the House bill will move more of the market into the Exchange to create a much larger risk pool giving the

Exchange greater leverage to enhance value, lower administrative costs, and foster competition.

- The House bill creates one national Exchange for individuals and small businesses, assembling a much larger risk pool than the state-based Exchanges in the Senate bill. 🚩* **Red Flag Comment:** The Senate bill further divides the risk pool among Exchanges by creating separate state Exchanges for the individual and small group markets (unless a state chooses to merge them) and allowing states to create more than one Exchange to serve distinct geographic areas. This will further segment the risk pool, reduce market leverage, and increase complexity.
- Other than grandfathered plans, the House moves the entire individual market into the Exchange, but the Senate bill maintains the individual market outside of the Exchange. Both bills maintain the small group market outside of the Exchange.
- The House requires extension of Exchange coverage to larger firms sooner, expanding to businesses with up to 100 employees in 2015 (not required under the Senate bill until 2016); it also allows Exchanges to open up to larger businesses (100+ employees) sooner (allowed in the House bill in 2015, not allowed in the Senate bill until 2017). The House bill opens the Exchange up to larger businesses sooner in part because the House bill timeline has the Exchange up and running a full year sooner than in the Senate bill (2013 in the House; 2014 in the Senate). The House bill provides for a three-year ramp-up in eligible business size from 25 employees in year 1, 50 employees in year 2, and 100 employees in year 3, with an option to expand to firms with more than 100 employees also in year 3. The Senate bill does better here, at least in the first year, requiring businesses with up to 50 employees in years 1 and 2 (the bill sets the limit at firms with up to 100 employees in the first two years, but allows states to adjust that down to 50) and like the House bill, requiring access for businesses with 100 employees in year 3.

House Bill Empowers the Exchange to Improve Value

If designed well, the Exchange can be a proactive force in the market, aggressively negotiating to get better deals for consumers. The House bill empowers the Exchange to add more value for consumers, while the Senate bill allows the creation of much more passive Exchanges.

- The House bill explicitly requires the Commissioner to use a competitive bidding process to select Exchange plans, negotiate contracts to increase value for consumers, and reject plans that are a poor value. If the Exchange has a large risk pool, it may be able to negotiate significant discounts. This authority is especially important since health reform will not include a strong public plan designed to control costs.⁶
- The Senate bill, on the other hand, does not establish a process of competitive selection and negotiation. State Exchanges will have to verify plans that are qualified to participate in the Exchange by making sure they meet standards. State Exchanges can only offer plans if the Exchange determines that making the plan available is in the interest of consumers, taking into account excessive premium increases. This provision allows states that are so inclined to reject low-value plans; however, it appears if states could accept all minimally qualified plans regardless of value if they “determine it is in the interest of consumers.” State Exchanges must also rate plans based on quality and price and post ratings along with justification for premium increases. While posting plan ratings and premium

information can help consumers make more informed choices, these tools do not provide health plans with as powerful an incentive to offer high-value plans as the House bill's ability to reject insurers from participating.

🚩* **Red Flag Comment:** In states like Texas that have chosen to engage in no oversight of health insurance premiums, it is possible that under the Senate provision, the state-operated Exchange will merely accept all qualified plans and fail to use the Exchange as a tool to increase value.

- Under the House bill, the Commissioner has the authority to deny excessive premium increases in the Exchange. The Senate bill allows Exchanges to take excessive premiums into account when certifying plans, but does not grant the Exchange authority to reject rate increases.


Effects in Texas: Exchange

Increasing transparency and access: Both bills will set up Exchanges that will increase transparency of and access to comprehensive health insurance coverage for uninsured individuals and small businesses in Texas. **For the reasons listed above, we believe that the House bill will generally do a better job of creating an effective Exchange that will create more value for Texans purchasing health insurance.**

Federalism: Today, health coverage is regulated by both the federal and state governments under a variety of complex schemes depending on the type of coverage (e.g. the federal government administers Medicare and regulates self-insured health plans; states regulate fully insured health plans; and states administer federal law in Medicaid and HIPAA as it relates to insured plans). Both bills create new federal and state roles in regulation, modifying the already complex system of federalism in health insurance oversight. The Exchanges in the Senate bill will add additional complexity by making states responsible for implementing federal law. The House bill avoids this particular complexity by implementing the federal health reform law through one federal Exchange. The Commonwealth Fund observes that historically such state implementation of federal health programs has been “at best awkward, and at worst ineffectual.”⁷ This approach will lead to uneven implementation, with strong Exchanges in some states and weak ones in others. **Given that Texas has historically been reluctant to aggressively regulate insurance companies, especially in the areas of access and affordability, we believe that Texans would have access to a more consumer-friendly Exchange if it were administered at the federal level, as in the House bill.**

On the other hand, the House bill adds complexity to state/federal roles by establishing a federal Health Choices Administration that oversees the national Exchanges. This structure will require TDI to collaborate with the federal agency on responsibilities like rate review, and react to decisions made by the federal Commissioner that effect state regulation (for example, benefits required in the Exchange by the federal Commissioner could affect solvency requirements overseen by state regulators).

Undocumented immigrants: Both bills prevent undocumented immigrants from receiving subsidies for coverage in the Exchange.

 **Red Flag Comment:** Unfortunately, the Senate bill takes an unnecessary and punitive extra step by specifically barring undocumented immigrants from buying coverage in the Exchange at full cost with their own money. This provision conflicts with the coverage goals of health reform and will unnecessarily restrict access to full-cost, private coverage for uninsured, undocumented immigrants in Texas.

State action required:

- **Senate Bill:** Under the Senate bill, Texas would have to create and administer all aspects of an Exchange for individuals and small businesses (or create a nonprofit organization to do so), including determining eligibility for subsidies, enrolling people in coverage, maintaining customer service call centers, determining whether health plans are qualified, conducting risk adjustment in and outside of the Exchange, and reporting to the federal government.
 - Texas could act to limit employer participation for the first two years to those with fewer than 50 employees (but should not), and could allow businesses with over 100 employees to participate in 2017.
 - The state could choose to operate one Exchange for both individuals and small businesses.
 - Texas could also opt to set up multiple Exchanges in the states, as long as each serves a distinct geographic area.
 - The Senate bill provides funds to help states establish Exchanges through 2014. By 2015, they must be self-sustaining, which could be achieved through surcharges on participating health plans or enrollees.
 - The state may also request that the federal government operate an Exchange in the state for a period of years. Should Texas fail to implement an Exchange under the Senate bill, the “federal fallback” would allow the federal government will create an Exchange in the state.
- **House Bill:**
 - Under the House bill, Texas could elect to establish and operate its own state Exchange if it can demonstrate to the federal government that it can meet all requirements of the Exchange.
 - If state law mandates benefits in excess of the essential benefits package, the state will have to reimburse the federal government for the amount that the additional benefits increase spending on federal premium credits.

Health Insurance Regulation

In Texas Today: Regulation

Compared to other states, Texas engages in very limited regulation of health insurance pricing and affordability. For example, 40 states actively review rates to determine whether they are appropriate in the small employer or individual markets, and 32 states set guidelines for medical loss ratios. Texas does neither.

Texas' record in regulations that govern access (guaranteed issue, pre-existing conditions, ages of dependents, etc.) is mixed. Texas has failed to take steps to increase access to coverage for individuals and sole proprietors, but Texas was a leader in extending the age to which children can stay on parent's insurance policies. **Texas insurance current law and regulations include the following.**

- **Denial of Coverage:** Small employers (those with 2 to 50 employees) are the only group that cannot be turned down for coverage (small employers have "guaranteed issue" under both federal and state law). In the Texas individual market, insurance companies turn down applicants or offer them less coverage based on their medical history, body mass index, credit history, past criminal convictions, hobbies, type of job, and other factors.
- **Pre-existing Condition Exclusion Periods:** In the individual market, insurers can exclude coverage for pre-existing conditions for up to two years, and can "look back," or consider your health history for the previous five years when looking for pre-existing conditions. In the group market, coverage for pre-existing conditions can be excluded for up to a year, with a 6-month look-back period.
- **Lifetime or Annual Limits:** No specific prohibitions on lifetime or annual limits to coverage.
- **Rate Review:** Texas does not require group insurers to submit rates or justifications for rate increases to the Texas Department of Insurance (TDI) and, unlike many states, TDI lacks the authority to review rates charged by carriers to ensure that they are adequate and not excessive.⁸ Texas is one of just ten states that fail to actively review health insurance rates to determine whether they are appropriate in the group or individual health insurance markets.⁹
- **Rating Rules in the Small Group Market:** In the Texas small employer market today, insurance companies cannot deny coverage to small businesses, but they can legally set premiums so high that they price many people out of the market. Insurance companies in Texas today base small employer premiums on six factors: the health status, gender, and age of employees as well as type of work done, location of business, and number of employees. Within these rating factors, premium variation is very loosely limited in law by using "rate bands" (limits on maximum variation allowed) for group size, industry classification, and health status. However, Texas sets no limits with regard to premium variation based on age, gender, and geography. As a result, Texas Department of Insurance (TDI) data show that insurers may legally charge premiums as high as \$62,000 per person per year to a small employer group.¹⁰ **In practice, the TDI data show real-world maximum annual per-person premiums as high as \$29,000 for Texas small employers.**¹¹ **Rate bands established by the Legislature in Texas are looser than in most states and allow premiums to vary by a factor of 25:1 or greater.**¹² In other words, a "high-risk" small business may pay \$25,000 or more a year for the same policy a "low-risk" small businesses buys for \$1,000 a year.
- **Rating Rules in the Individual Market:** Consumer protections are even worse in the Texas individual market, where insurance companies base premiums on factors like gender, health status, medical history, credit history, past criminal convictions, and hobbies. Texas has no laws that limit the amount premiums can vary from one person to the next for the same policy in the individual market.
- **Medical Loss Ratios:** A medical loss ratio is the percentage of health insurance premium dollars that are spent on medical care as opposed to administrative costs and profits. Setting minimum medical loss ratios prevents insurance companies from charging excessive rates and retaining large margins for profit and other non-medical expenses. Thirty-two states set guidelines for medical loss ratios for

group and/or individual health insurance.¹³ Texas sets no standards for medical loss ratios and fails to make comparable medical loss ratio data available to consumers. For health insurance policies sold in Texas from 2003 through 2006, the overall market medical loss ratio averaged 72% for the small employer market and 84% for the large employer market.¹⁴ In some years, some health plans reported surprisingly low medical loss ratios for Texas-based business as low as 22%.

- **Rescission of Coverage:** Rescission is the retroactive cancellation by a health insurance company of a policy in force. Texas has the 6th highest rate of rescission in the nation.¹⁵ A study by the Robert Wood Johnson Foundation found that Texas law does not effectively limit insurers' ability to rescind policies only in cases of fraud, leaving Texas consumers vulnerable to terminations of coverage for inappropriate reasons.¹⁶
- **Dependent Coverage:** State law allows dependents to remain on their parent's health insurance until they turn 25, regardless of whether they are a student.
- **High Risk Pool:** The Texas Health Insurance Pool sells coverage to eligible Texas residents who due to medical conditions are unable to obtain coverage from commercial insurers. Premiums are set at 200% of the prevailing individual market rate for comparable coverage. The average premium is over \$600 a month, annual deductibles range from \$1,000-\$7,500, and annual out-of-pocket caps range from \$3,000 to \$12,500 per year. Coverage has up to a 12-month pre-existing condition exclusion period. Risk pool coverage is paid for by enrollee premiums and an assessment on health plans. No state budget funding is used to support the pool.

House Bill: Regulation

- **Denial of Coverage:** Coverage must be offered on a guaranteed issue and guaranteed renewal basis in the group and individual markets. Effective January 2013.
- **Pre-existing Condition Exclusion Periods:** Reduces allowed pre-existing condition exclusions from 12 to 3 months for group coverage, with a 30-day look-back period (HIPAA protections stay in place); effective upon enactment. Pre-existing condition exclusions are prohibited entirely in qualified plans; effective January 2013.
- **Lifetime or Annual Limits:** Lifetime and annual limits prohibited in qualified plans as of January 2010.
- **Rate Review:** Health plans must submit justification for premium increases to the HHS Secretary and state insurance regulators ("states") before they are implemented, effective upon enactment. States must report on premium increase

Senate Bill: Regulation

- **Denial of Coverage:** Coverage must be offered on a guaranteed issue and guaranteed renewal basis in the group and individual markets. Effective January 2014.
- **Pre-existing Condition Exclusion Periods:** Bans pre-existing condition exclusions in coverage for children through age 18; effective six months after enactment (HIPAA protections stay in place). Pre-existing condition exclusions are prohibited entirely; effective January 2014.
- **Lifetime or Annual Limits:** Lifetime limits prohibited and annual limits restricted six months after enactment. Annual limits prohibited in qualified plans in 2014.
- **Rate Review:** The HHS Secretary and state insurance regulators ("states") will establish a process for annual review of increases in premiums (premiums will be subject to approval only if required by state law). Health plans must submit

trends and recommend whether health plans should be excluded from the Exchange based on unjustified premium increases.

- **Rating Rules:** Premiums cannot be based on health status. Premiums can only vary based on age (limited to a 2:1 ratio between the highest and lowest cost premium), geography, and family enrollment (individual, individual and spouse, family, etc.). Rating rules apply to all plans in the Exchange and to the group market outside of the Exchange (individual coverage would be sold only inside the Exchange).
- **Medical Loss Ratios:** Effective January 2010, sets a minimum medical loss ratio no less than 85% in the group market and requires health plans to issue rebates to policyholders if they do not meet the standard. This standard also applied to the individual market unless the HHS Secretary finds that the provision would destabilize the market.
- **Rescission of Coverage:** Prohibits policy rescissions except in cases of fraud and requires independent review of rescissions, effective July 2010.
- **Dependent Coverage:** Children may remain on their parent's health insurance until they turn 27. Effective January 2010.
- **Temporary High Risk Pool:** Establishes a temporary high risk pool for individuals with pre-existing conditions effective immediately and until the Exchange is up in 2013. Program administered by HHS Secretary, with option to build on current state pools.

justification for increases reviews indicate are unreasonable. States must review premium trends and recommend to the Exchanges whether plans should be excluded based on unjustified premium increases. Effective six months after enactment.

- **Rating Rules:** Premiums cannot be based on health status. Premiums can only vary based on age (limited to a 3:1 ratio between the highest and lowest cost premium), geography, family enrollment, and tobacco use (limited to a 1.5:1 ratio). Rating rules apply to all plans in the Exchange and to the individual and small group markets outside of the Exchange.
- **Medical Loss Ratios:** Effective January 2011, sets a minimum medical loss ratio no less than 85% in the large group market and 80% in the small group and individual markets. Requires health plans to issue rebates to policyholders if they do not meet the standards. The HHS Secretary may adjust the minimum medical loss ratio in the individual market if the Secretary finds that the provision would destabilize the market. All health plans must annually report medical loss ratios to be posted online by the HHS Secretary.
- **Rescission of Coverage:** Prohibits policy rescissions except in cases of fraud, effective six months after enactment.
- **Dependent Coverage:** Unmarried children may remain on their parent's health insurance until they turn 26. Effective six months after enactment.
- **Temporary High Risk Pool:** Requires states to establish a temporary high risk pool for individuals with pre-existing conditions effective 90 days after enactment and until the Exchanges are up in 2014. Program administered by HHS Secretary, who may contract with states or nonprofits to administer.

- Eligible individuals (or dependents) have been denied coverage, offered coverage at higher rates than the risk pool, have an eligible medical condition, or have been uninsured for at least 6 months. Individuals are not eligible if they are eligible for Medicaid, CHIP, Medicare, or employer-sponsored coverage.
- Premiums are capped at 125% of the prevailing rate in the market for comparable coverage. Premiums can vary by a ratio of 2:1 based on age. Annual deductibles are capped at \$1,500 for an individual, with out-of-pocket maximum capped at \$5,000 for an individual.
- Coverage cannot have a pre-existing condition waiting period.
- Maintenance of effort required by states for existing high risk pools.

Other items:

Market that reforms apply to and grandfathered plans: Insurance market reforms listed above are imposed in the Exchange and in the insured group market outside of the Exchange, except for grandfathered plans.

Once the Exchange is operating, the individual market will move exclusively into the Exchange, except for “grandfathered” individual plans (which can remain grandfathered indefinitely only if there are no changes to the terms of coverage).

Existing employer-sponsored plans will be grandfathered for up to 5 years (until 2018) as long as no changes are made to the plan, including benefit and cost-sharing changes. By 2018, all group plans must meet all of the requirements of qualified health plans.

- Eligible individuals are U.S. citizens and legal immigrants with pre-existing conditions who have been uninsured for at least 6 months.
- Premiums will be set based on a standard population.
- Premiums can vary by a ratio of 4:1 based on age with out-of-pocket maximums capped at Health Savings Account amounts (currently about \$6,000 for an individual and \$12,000 for a family each year).
- Coverage cannot have a pre-existing condition waiting period.
- Maintenance of effort required by states for existing high risk pools.
- Higher than average expected claims costs paid by \$5 billion allocated by the bill, effectively subsidizing premiums for the pool.

Other items:

Market that reforms apply to and grandfathered plans: The application of regulations in the Senate bill is complex. Individual and small group policies sold through the Exchange must meet all of the standards laid out in the bill, but not all regulations apply to all other types of insurance. 🚩* **Red Flag Comment:** In fact, large segments of the market are exempted from many health reforms, for example, self-insured (ERISA) do not have to provide coverage with essential benefits. All health plans in place upon enactment are grandfathered and unlike in the House bill, changes to coverage are not prohibited to maintain grandfathered status indefinitely. This creates a loophole that prevents new consumer protections from applying to people enrolled in existing coverage, including prohibitions on pre-existing condition exclusions, lifetime limits and annual limits, and the extension of coverage to adult children up to age 26.

Grants to states: The HHS Secretary can provide State Health Access Program Grants (SHAP grants) to help states undertake reform initiatives and coverage programs before 2013. *(Texas received a 5-year SHAP grant in 2009 to support state coverage expansions. More information in Public Option, CO-OPs, and Choices in Coverage section.)*

Purchase across state lines: As of January 2015, states could form interstate compacts to allow the sale of health insurance across state lines. Coverage would be primarily subject to laws in one participating state, but other compact states could enforce their consumer protection laws.

Insurance market reforms (guaranteed issue, rating, pre-existing condition exclusions) are imposed on the individual and small group markets, both in and outside of the Exchanges. As of 2014, all new health plans in these markets, both inside and outside of the Exchange, must offer essential benefits in the four defined tiers.

Grants to states: Effective upon enactment, the HHS Secretary may award grants to states to **establish or expand an Office of Health Insurance Consumer Assistance** or Health Insurance Ombudsman to assist policyholders with filing complaints and appeals; track problems; help consumers enroll in coverage; and help small employer obtain premium tax credits.

Purchase across state lines: As of 2016, states could form interstate compacts to allow the sale of health insurance across state lines. Coverage would be subject to consumer protection laws in the purchaser's state, but may not be subject to every law in the state. States must pass laws to enter into such compacts, and get approval from the Secretary.

State option for basic health program: States may create a "basic health program" for uninsured people between 133-200% of the FPL who are under 65 and not Medicaid-eligible. If a state creates a basic health program, individuals between 133-200% of the FPL would not qualify for subsidies in the Exchange; however, states must ensure that eligible individuals would pay no more in premiums and cost sharing than they would in the Exchange.

The program would provide at least the essential benefits package and maintain a medical loss ratio of at least 85%. States creating programs will receive 95% of the amount that would have been paid out for this population in premium and cost sharing subsidies. States could use this option to provide coverage to lawfully residing immigrants not eligible for Medicaid with income below 200% of

	<p>FPL</p> <p>State option for health reform waiver: Beginning in 2017, states may apply for a waiver for up to five years for reform requirements related to qualified health plans, Exchanges, cost-sharing caps, tax credits, and individual and employer mandates, provided that they demonstrate they can provide coverage to all residents that is at least as comprehensive and affordable as Exchange plans with no increase to the cost to the federal government. States must pass authorizing laws to apply for a waiver.</p> <p>Wellness Penalties. Allows premium surcharges or increases in cost-sharing of 30-50% based on whether or not an enrollee reaches a wellness goal, such as lowering cholesterol or decreasing body mass. HIPAA rules currently allow employer-sponsored health insurance plans to increase premiums by 20% based on wellness goals. The Senate bill increases the surcharges linked to wellness goals and extends them into the individual market. 🚩* Red Flag Comment: Neither current law nor the bill establishes any standards for such programs or requires them to be based on medical or scientific evidence. Penalizing workers and individuals who do not meet certain goals could make health coverage unaffordable for those who need it most, undermining the bill's affordability provisions aimed at low- and moderate-income families. It also creates a serious potential loophole in the bill's prohibition against setting premiums based on health status and pre-existing conditions.¹⁷</p>
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Effect of Bills in Texas: Regulation

Improved Access: Both bills will expand access to health insurance in Texas by requiring guaranteed issue of policies and prohibiting pre-existing condition exclusions; however, the House bill puts stronger standards in place that will increase access to coverage for more Texans. First, the standards in the House bill apply to more of the market than the Senate bill. The Senate bill contains numerous large loopholes

that indefinitely exempt existing plans and ERISA plans from many reforms. Second, the standards in the House bill are better for consumers. For example, the House bill will only allow a 2:1 variation in premiums based on age, which provides better affordability protection for middle-aged workers than the Senate bill's 3:1 ratio.

Immediate High Risk Pools: Both bills will establish an immediate but temporary high risk pool to offer coverage to people with pre-existing conditions. This immediate point of access is important because more meaningful coverage expansions are put off until 2013 (House bill) or 2014 (Senate bill). **It appears that both bills create more affordable risk pool premiums than in the Texas Health Insurance Pool today, and both bills prevent a pre-existing condition exclusion that exists in Texas' risk pool today.** Eligibility in the Senate bill requires that a person be uninsured (or “go bare”) for six months. This will unnecessarily restrict access to health care for six months for people who have lost coverage due to job loss, expiration of COBRA coverage, etc. The House bill does not require a person to go bare and has eligibility similar to current requirements in Texas' pool.

Both bills appropriate \$5 billion to support the risk pools until 2013 or 2014. 🚩* **Red Flag Comment:** This level of funding is not sufficient to support a significant expansion of enrollment in high risk pools.¹⁸

Both bills will eliminate the need for the Texas high risk pool once all reforms are in place and people cannot be denied coverage or charged more due to health conditions.

Adverse Selection: The current regulation of the individual and small group markets in Texas makes coverage much cheaper and easier to access for the young and healthy. Especially in the small group market, most other state have done a better job of reducing the amount of premium variation for things like health status, age, group size, etc., and spreading risk better between the more and less costly groups (the essential function of health insurance is to do just this). Health reform will increase access and affordability for older and less healthy enrollees and require insurance companies to spread risk more broadly.

Because the Senate bill allows indefinite grandfathering of existing plans, however; it invites adverse selection. As small groups with older or less healthy workers migrate to new plans in the Exchange that are more comprehensive, younger, healthier groups will tend to hang onto their existing coverage, causing premiums in the Exchange to rise. States that have already passed significant reforms in their individual and small group markets will face less risk of significant adverse selection under the Senate bill than Texas.

On top of that, the Senate bill allows certain employees with job-based coverage to use their employer's contributions for group insurance to instead buy individual insurance in the Exchange (see information on free choice vouchers in the Shared Responsibility for Employers section below). An employer with a grandfathered or self-insured plan could take advantage of this feature to “dump” bad risks on the Exchange.¹⁹ Employers in self-insured plans could cut benefits or possibly increase age rating, which would steer less healthy and older employees to the Exchange. Texas will need to be especially vigilant and proactive about avoiding adverse selection under the Senate bill.

To mitigate adverse selection in the Exchange, Texas may have to update our state regulations—that would govern coverage outside of the Exchange—so that the same rules apply to both markets.

Changes to State Laws: Both bills continue to rely on existing state laws for licensing health plans and regulation of solvency, but set new federal standards related to the access, premium rating, benefits, etc., which will require states to adopt conforming laws and modify existing laws.²⁰ For example, Texas law includes guaranteed issue in the small employer market, but not in the individual market, and permits pre-existing condition exclusions of one to two years. These state laws, and several others, must be changed, or will be pre-empted by federal law. To allow time for implementation in 2013, state laws must be passed in the 2011 regular session or a subsequent special session. If implementation is put off until 2014 (as in the Senate bill), Texas will have another regular session in 2013 prior to full implementation. Bills passed in 2013, however, may not leave enough time for regulations to be written, health insurance companies to adjust and re-file policy forms, rates, etc., with TDI, and TDI to review and approve changes before they must take effect.

The health reform bills set floors for state regulations, but do not prevent states from adopting stronger regulations. For example, states could choose to prohibit age rating by state law, in which case plans operating in the Exchange—including the multi-state plans administered by the OPM and other markets as directed by the state law—would have to meet the more stringent state requirements.

Agency Implementation: Existing regulations will need to be updated and several new regulations will need to be established. Some provisions that take place immediately will require state regulatory action. For example, any immediate changes related to pre-existing condition exclusion periods, lifetime limits, and rescission, will likely require that insurers modify their policies on file with TDI.

The temporary high risk pool is another early reform found in each bill. The Senate bill requires to the state to establish a high risk pool. Because Texas already has one, it is possible that its coverage could be modified to meet reform standards. Texas' high risk pool is a quasi-public entity, established in state law, administered by a board of directors appointed by the Commissioner of Insurance, but not supported with state funds. Under the House bill, the temporary high risk pool will be established at the federal level, but the federal government may contract with states to administer the program.

Compacts With Other States: Texas would have to pass a state law and get federal approval to enter into multi-state compacts that allow the sale of health insurance across state lines.

State Options: The Senate bill creates a couple of state options that Texas could choose. It provides funding to establish or expand an Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman to assist policyholders with filing complaints and appeals; track problems; help consumers enroll in coverage; and help small employer obtain premium tax credits. Texas could establish this office at TDI or the Office of Public Insurance Counsel, or could establish a nonprofit organization to administer these important consumer assistance functions.

The Senate bill also gives Texas and other states two waiver-like options to implement health reform within the state differently. The first would allow Texas to implement a basic health plans for people between 133-200% of FPL, instead of giving them access to federal subsidies in the Exchange. The other option is a state waiver that allows states tremendous flexibility in restructuring most coverage provisions in health reform. Both waivers require the state to demonstrate to the federal government that it can cover at least as many people with at least as good quality of coverage, but for less money. Waivers could allow innovative states to test new models that did not pass as part of federal reform, like a public option or single-payer state system. On the other hand, depending on the quality of federal oversight, such waivers could create a race to the bottom in states like Texas that have been reluctant regulate the health insurance industry in ways that improve access and affordability.

Public Option, CO-OPs, and Choices of Coverage

In Texas Today: Choices of Coverage

Texas has 75 health insurance companies (that make up 37 health insurance groups) licensed to sell in its \$18 billion per year health insurance market. Health Care Service Corp. Group (Blue Cross and Blue Shield of Texas) has the largest market share with about a third of the health insurance market.²¹ Forty-six insurers are licensed to sell in the small employer market, the top five of which account for 68% of the market.²²

Healthy Texas

Texas has invested in a couple of public/private partnerships to help make private health insurance more affordable and accessible for small businesses. Healthy Texas, passed as part of SB 78 in 2009 and under development by TDI, will be a new, statewide plan that offers basic, lower-cost coverage to eligible small employers that have low-income employees. A state-funded “reinsurance” pool will be used to help pay for some high cost medical claims, lowering risk for insurers and lowering premiums for employer and employees. Healthy Texas is expected to start offering coverage in summer 2010, with average monthly premiums around \$200 per person. Healthy Texas was appropriated \$35 million in GR for 2010-11, which should allow enrollment to reach around 25,000 individuals.

Three-Share Programs

In 2007, the legislature authorized and provided seed grants to start “three-share programs,” which help make coverage more affordable for low-wage employees of small businesses by splitting the premium for basic coverage among employers, employees, and public funds. Regional three-shares are operating in Galveston, Austin, and Houston; with others under development in El Paso, Dallas, and the Bryan/College Station area. In 2009, about \$4 million was allocated in the state budget to help support three-shares. In September 2009, Texas received a federal State Health Access Program (SHAP) grant of up to \$10 million a year for five years for Healthy Texas start-up costs and to provide enhanced premium or cost-sharing assistance to low-income enrollees in Healthy Texas and three-shares.

House Bill: Choices of Coverage

Creates a **public option** that will be offered through the Exchange that must meet the same standards applied to other Exchange coverage. The HHS Secretary will negotiate public option rates with providers. Rates will be no lower than Medicare and no higher than average rates paid by other health insurers. The public option will be offered in all four benefit tiers for plans in the Exchange. It will be financed exclusively through premiums by enrollees. Providers participating in Medicare would participate in the public option, unless they opt out, and all providers may elect to participate.

Creates a **Consumer Operated and Oriented Plan (CO-OP)** program of loans and grants (\$5 billion) used to foster creation of nonprofit, member-run health insurance companies in all states. Profits earned by CO-OPs must be used to lower premiums, or improve benefits or quality of care. Awards to establish CO-OPs must be made by July 2013.

Senate Bill: Choices of Coverage

Requires the **Federal Office of Personnel Management (OPM)**, which currently manages federal employee health benefits, to negotiate contracts with insurers to make at least two multi-state qualified plans (one of which must be nonprofit) available in each state's Exchange. Multi-state plans must meet all standards for qualified plans in Exchanges. The OPM could prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums.

Creates a Consumer Operated and Oriented Plan (CO-OP) program of loans and grants (\$6 billion) used to foster creation of a nonprofit, member-run health insurance company in each state. Profits earned by CO-OPs must be used to lower premiums, or improve benefits or quality of care. Awards to establish CO-OPs must be made within three years after enactment.

Effects in Texas: Choices of Coverage

The introduction of any of the options above will give Texas consumers more choice in general, and choice of a nonprofit health plan specifically. CO-OPs are unlikely to have enough enrollment to be a strong market competitor or negotiate lower rates with providers. National plans overseen by the OPM may be able to provide a bit more accountability and competition in the market, depending on the ability of the OPM to elicit competitive bids and negotiate the best value for policyholders. The public option in the House bill remains the best of the available alternatives for increasing choice, accountability, and competition.

The new coverage portions of the bill may not require significant state action. CO-OP plans can not be sponsored by state or local governments and the public option or OPM plans would be federally administered. Texas would have to license and regulate CO-OPs, and if plans selected by the OPM are not already licensed in Texas, they would have to be.

Shared Responsibility for Employers

In Texas Today: Employer Responsibility

Texas does not have a “play or pay” law—there is no requirement that any employers offer health insurance or contribute a minimum amount toward premiums or face a financial penalty.

In 2008, 49% of private businesses in Texas provided health insurance, but large firms were much more likely to provide health benefits than small firms. Only 30% of firms with fewer than 25 employees offer health insurance compared to 88% of firms with 25 or more employees. Private businesses (all sizes) in Texas on average contributed 80% of employee-only premiums and 68% of family premium in 2008.²³

House Bill: Employer Responsibility

Employers must provide coverage to employees and contribute at least 72.5% of the premium for employee-only coverage and 65% of the premium for family coverage for the lowest cost plan that meets the essential benefits package standards for full-time employees. Employer contribution amounts are prorated for part-time employees. Effective January 1, 2013.

Employers with an aggregate payroll of over \$500,000 in the preceding calendar year who do not offer insurance will be subject to an excise tax based on the employer’s payroll according to the schedule below:

- Payroll less than \$500,000 a year: exempt from penalty;
- Payroll between \$500,000 and \$585,000 a year: penalty equal to 2% of payroll;
- Payroll between \$585,000 and \$670,000 a year: penalty equal to 4% of payroll;
- Payroll between \$670,000 and \$750,000 a year: penalty equal to 6% of payroll;

Senate Bill: Employer Responsibility

The Senate bill does not require that employers of any size provide health benefits. Employers with more than 50 employees, however, will face penalties if they do not provide coverage that meets minimum standards and at least one full-time (30 or more hours per week in the Senate bill) employee receives a premium subsidy for coverage in the Exchange. Coverage provided must meet standards including at least a 60% actuarial value, out-of-pocket caps at HSA limits, and employees’ premiums cannot exceed 9.8% of their income. Effective January 1, 2014.

- If an employer with more than 50 employees does not offer insurance and a full-time employee gets a premium subsidy in the Exchange, the employer is assessed \$750 a year for each full-time employee. The penalty will increase each year starting in 2015 by the annual average percent increase in health insurance premiums.
- If an employer with more than 50 employees does offer insurance and a full-time employee gets a premium credit in the Exchange (employees with access to job-based coverage can only seek Exchange coverage if the job-based coverage does not

- Payroll over \$750,000 a year: penalty equal to 8% of payroll;

meet benefit standards or the employee's share of the premium exceeds 9.8% of income), the employer is assessed the lesser of \$3,000 for each employee receiving a credit or \$750 for each full-time employee.

- Employers are prohibited from imposing health coverage waiting periods on new employees of more than 90 days. Employers with more than 50 employees who impose waiting periods over 60 days on coverage for new hires are assessed \$600 for each full-time employee in a 60-90 day waiting period.

Employers who offer coverage must also offer a "free choice voucher" to employees under 400% of FPL whose share of premiums is between 8% and 9.8% of their income. The amount of the voucher is equal to what the employer would have contributed toward group coverage and can be used by the employee to buy subsidized coverage in the Exchange. Employers will not pay penalties for employees who buy subsidized Exchange coverage using vouchers.

Effects in Texas: Employer Responsibility

House Bill

The vast majority of employers in Texas (82%) have annual payrolls under \$500,000 and will not be subject to penalties if they do not provide health insurance. The following break-down shows the number of employers reporting to the Texas Workforce Commission by payroll size as of August 2009.

Number of Texas Employers by Annual Payroll, August 2009			House health reform bill: penalty if health insurance not offered (as % of payroll)
total annual payroll	number of employers	percent of total employers	
≤ \$500,000	349,464	82.47%	exempt
500,001-585,000	8,534	2.01%	2%
585,001-670,000	6,619	1.56%	4%
670,001-750,000	5,120	1.21%	6%
> 750,000	54,010	12.75%	8%
TOTAL	423,747	100.00%	

Employer payroll data from the Texas Workforce Commission. Data current through close of business August 11, 2009. Employers include all types of TWC contributing employers.

Only 18% of Texas employers have payrolls over \$500,000 a year, which could make them subject to a penalty, and only 13% have payrolls over \$750,000, which would make them subject to the maximum penalty of 8% of payroll if they do not provide health insurance.²⁴

Penalties Cost Less Than Coverage: As illustrated in the table below, penalties assessed to larger businesses for not providing health insurance are generally less than the cost of providing coverage (but more than the penalties under the Senate bill). Even penalties assessed at the highest rate—8% of payroll—are less than the average national employer cost of coverage as a share of payroll at 12%.²⁵

No Change for “Average” Employer: For most employers in Texas, the House health reform bill does not require them to do anything other than what they are doing today. Not only are most businesses small businesses, and thus, exempt from penalties, most of the larger businesses that could face penalties already provide health insurance.²⁶ And on average, Texas employers already contribute more toward premiums than is required by the House bill—80% of employee-only premiums and 68% of family premium in 2008.²⁷

Larger Businesses Must Provide Coverage: Just because the House bill will not require changes for the “average” Texas employer doesn’t mean it won’t require changes of many Texas employers; it will. Mid-sized businesses, especially with payrolls just over \$500,000 are probably the most likely to face new costs through health reform because many do not provide coverage today. In Texas, 29% of businesses with 25-99 employees do not provide coverage. Most of these employers likely have payrolls over \$500,000, so would have to pay a penalty of 2% to 8% of payroll if they do not start providing coverage.

Some Larger Business Must Contribute More Toward Existing Coverage: Another group of businesses that will have to make changes in response to the House health reform bill is those that provide health coverage today, but do not contribute at least 72.5% of the premium

for employee-only coverage and 65% for family coverage. As noted above, on *average*, Texas businesses already meet the standards in the House bill, but the average blends together employers that make little to no contribution with those who pay 100% of the premium. Undoubtedly, many businesses with annual payrolls over \$500,000 will have to increase the share they contribute for employee and/or dependent coverage to avoid the penalty.

State Employee Coverage: If governmental employers must meet the same standards as private employers, the state will have to ensure its health benefits and contributions toward coverage are sufficient or possibly incur penalties. The House bill requires employers to offer at least the essential benefits package and make minimum contributions toward coverage. As noted above, the health plan offered to Texas state employees will likely meet the essential benefits package, when defined, with just a little tweaking. The state already makes sufficient contributions toward coverage—state contributions range from 67% for family coverage to 100% for employee-only coverage.

Senate Bill

In general, the Senate bill requires less from employers than the House bill, and as illustrated in the table below, penalties in under the Senate bill are generally lower than those imposed under the House bill. Business with fewer than 50 employees (72% of all private firms in Texas)²⁸, are exempt from penalties. Today, 92% of businesses with 50 or more employees in Texas already provide health insurance.²⁹ Coverage at most of these firms will meet the minimum standards in the bill.³⁰

Many Large Businesses Will Face Penalties:

- Even though most large employers in Texas provide coverage, many of these businesses with low-wage employees will face penalties as lower wage employees get subsidized coverage in the exchange because their job-based coverage exceeds 9.8 % of their income. Low-wage workers are more likely to face premiums in excess of 9.8% of their income if they are the only wage-earner in the family (as with single mothers).³¹
- In 2008, for Texas employers with 50 or more employees, the average total employee-plus-one premium (for an employee and their spouse or child) was \$8,277 per year, of which employees contributed \$2,540 on average.³² Using this average amount, the employee's share of premiums would exceed 9.8% of income for employees who earn less than about \$25,900/year (or about \$13 per hour) and buy employee-plus-one coverage.
- Most of the 8% of Texas businesses that have 50 or more employees but do not offer health benefits will almost certainly face penalties because one or more of their full-time workers receives subsidized coverage in the Exchange. Premium subsidies in the exchange extend to families up to 400% of FPL, or about \$88,000 a year for a family of four.
- **🚩* Red Flag Comment:** The structure of the Senate's play-or-pay penalty is troubling because employers are fined based on other coverage obtained only by their full-time low- and moderate-income employees (under 400% of FPL) who receive premium subsidies in the Exchange. This creates clear disincentives for employers to hire and retain low- and moderate-income workers and incentives for employers to convert full-time positions held by lower-income employees to part-time, or to "contract out" their work.³³

State Employee Coverage:

Under the Senate bill the state’s plan will not be subject to essential benefit standards. The state could face penalties of \$3,000 for each full-time state employee that gets subsidized coverage in the Exchange because their share of premiums exceeds 9.8% of their income. This would occur for state workers at the lowest salaries, particularly those with larger families. To illustrate, a state employee who is a single mother and buys state coverage for herself and her children could opt into Exchange coverage if her income is under about \$18,000 a year (when her premium contribution, \$148/month, would exceed 9.8% of her income).

Examples of Employer Coverage and Penalty Costs

	House Bill			Senate Bill		
	Penalty	Cost of Coverage*	Eligible for Tax Credit?	Penalty	Cost of Coverage*	Eligible for Tax Credit?
Employer A: small retail business 15 full-time employees; \$360,000 payroll; \$24,000 average wage	None	\$80,908	Yes	None	\$80,908	Yes
Employer B: small professional firm 15 full-time employees; \$720,000 payroll; \$48,000 average wage	\$43,200 (6% of payroll)	\$80,908	No	None	\$80,908	Yes
Employer C: mid-size retail business 70 full-time employees; \$1.68 million payroll; \$24,000 average wage	\$134,400 (8% of payroll)	\$377,570	No	\$52,500 if no coverage is offered and an employee gets subsidized exchange coverage; or \$3,000-\$52,500 if coverage is offered, but because it is unaffordable, one or more employees receive subsidized exchange coverage.	\$377,570	No
Employer D: mid-size professional firm 70 full-time employees; \$3.36 million payroll; \$48,000 average wage	\$268,800 (8% of payroll)	\$377,570	No	\$3,000-\$52,500 if coverage is offered, but because it is unaffordable, one or more employees receive subsidized exchange coverage.	\$377,570	No

*Cost of coverage estimated using 2008 Texas averages for job-based premiums, employer share of coverage, and share of employees enrolled by type of coverage for employee-only, employee plus one dependent, and family coverage shown below.

Health Coverage at Texas Businesses, 2008			
Type of coverage	employee only	employee plus one dependent	family coverage

Average total cost of coverage	\$4,205	\$8,278	\$11,967
Average employer contribution toward premium (percent)	\$3,661 (80%)	\$5,712 (69%)	\$8,095 (68%)
Average share of employees enrolled in this type of coverage	50.6%	19.2%	30.2%

MEPS-IC 2008, Reflects averages across all Texas firms that offer health insurance.

Small Business Incentives

In Texas Today: Small Business Incentives

Texas provides a meager tax incentive for small employers to begin offering health insurance. Employers with 2 to 50 employees who did not provide health insurance in the previous year can deduct half their share of premiums when computing their margins tax in the first year and 25% in the second year. Because the incentive is a *deduction* (as opposed to the tax *credits* in health reform) from a tax with a low tax rate (just 1%), the added benefit to employers is quite small relative to the cost of coverage, and not likely to persuade many employers to start offering coverage. Texas employers who qualify will get an extra tax savings of just 0.5% of the cost of coverage in the first year and half of that in the second year.

House Bill: Small Business Incentives

Small businesses with fewer than 25 employees (counts employees earning at least \$5,000 a year) and average annual wages less than \$40,000 could get a tax credit of up to 50% of the employer's premium cost for up to two years. The full 50% credit is available for businesses with 10 or fewer employees and average annual wages under \$20,000. The credit phases down as the number of employees and average wage increases and will not apply toward coverage for employees earning over \$80,000 a year.

The tax credit is non-refundable (available only to a business with a tax liability). Non-profit organizations would not be eligible for the tax credits. Effective January 1, 2013.

Senate Bill: Small Business Incentives

Small businesses with 25 or fewer full-time equivalent employees and average annual wages less than \$50,000 could get a tax credit for up to two years if they provide coverage and pay half of the premium cost. The full credit is available for businesses with 10 or fewer employees and average annual wages under \$25,000. The credit phases down as the number of employees and average wage increases.

- 2010-2013: The maximum credit is 35% of a small business' contributions toward coverage. A 25% credit available to eligible non-profit organizations that meet the requirements above (this credit is taken against payroll taxes due as opposed to income tax).
- 2014 and after: The maximum credit is 50% of the employer's contributions (35% for non-profit organizations) for coverage

purchased in the Health Insurance Exchange for up to two years.

Effects in Texas: Small Business Incentives

Both bills provide a much stronger financial incentive to offer coverage than the modest incentive in Texas' margins tax today, and both bills target help to the smallest businesses with low- and moderate-wage employees. The Senate bill makes tax credits available more quickly and for more years, and makes more small businesses eligible.

The big differences in the two bills are:

- The Senate bill makes a reduced tax credit (35%) available right away, for four years until Exchange is operating. Then the credit is increased to 50% of two years. The House bill has the same 50% credit for two-years after the Exchange starts (2013 in the House bill), but does not have the reduced credits available in the interim.
- The Senate bill extends tax credits to small employers with average annual wages up to \$50,000, while the House bill limits eligibility to those with average wages up to \$40,000.
- Whether nonprofit organizations can also receive tax credits (no in the House bill and yes in the Senate bill).

Nationally, nearly one out of ten jobs is with a nonprofit organization.³⁴ Some nonprofit organizations have no employees and some are larger employers like hospitals. But many nonprofits are churches, charitable organizations, community groups, and professional associations with small staffs that struggle to afford health insurance, just as for-profit small businesses do. The Senate bill provides tax credits to eligible nonprofit organizations, but the House bill does not.

¹ The Texas Department of Insurance lists mandated benefits by market for traditional and consumer choice plans in its consumer publication *Your Health Care Coverage*, available at www.tdi.state.tx.us/pubs/consumer/cb005.html.

² Timothy Stoltzfus Jost, *Health Insurance Exchanges in Health Care Reform: Legal and Policy Issues*, The Commonwealth Fund, December 2009, www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Dec/Health-Insurance-Exchanges-in-Health-Care-Reform-Legal-and-Policy-Issues.aspx.

³ Ibid.

⁴ Alain Enthoven, William E. Kramer, David R. Riemer, and Joseph J. Minarik, *Making Exchanges Work in Health-Care Reform*, Committee for Economic Development, December 2009, www.ced.org/images/library/reports/health_care/exchangememohc09.pdf.

⁵ To remedy this, the authors recommend giving the HHS Secretary authority to combine Exchanges in small states with those in other states to achieve a large enough risk pool.

⁶ Ibid.

⁷ Ibid, page 25. See footnote 82 on page 42 for a history of issues with HIPAA implementation, which like the Exchanges in the Senate bill, asked states to implement federal law and provided a federal fallback for states that did not. As noted, this led to slow and uneven implementation of HIPAA.

⁸ State-by-state listing of health insurance rate filing and review authority in the National Association of Insurance Commissioners, *Compendium of State Laws on Insurance Topics*,

Filing Requirements for Health Insurance Forms and Rates, updated as of November 2007.

⁹ Adele M. Kirk and Deborah Chollet, “State Review of Major Medical Health Insurance Rates,” *Journal of Insurance Regulation*, Summer 2002, pp. 3-18.

¹⁰ Data as reported by Aetna Life Insurance Company to TDI in the 2006 TDI Annual Group Accident and Health Survey. Aetna subsequently confirmed to TDI that this could be a potential maximum rate quote to a Texas small business (i.e. if a small group had very high risks associated with all six allowable rating factors, the per-person premium in Texas could actually come out to \$62,000 a year).

¹¹ Texas Department of Insurance, Annual Group Accident and Health Survey, 2006

¹² National Association of Insurance Commissioners, *State Innovations in Modernizing Health Insurance and Extending Coverage to the Uninsured*, Preliminary Draft Report, June 2008.

¹³ America’s Health Insurance Plans, *State Mandatory Medical Loss Ratio Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations*, September 2009.

¹⁴ Medical loss ratios calculated from premiums and claims data collected by TDI in the 2003-2006 Annual Group Accident and Health Surveys.

¹⁵ National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee, Regulatory Framework Task Force, *Rescission Data Call*, Draft Report, December 2, 2009, www.naic.org/documents/committees_b_regulatory_framework_0912_rescission_report.pdf.

¹⁶ Harbage P, Haycock H and Ledford MK, Robert Wood Johnson Foundation, *Post Claims Underwriting and Rescission Practices: Findings from Texas in the Individual Health Insurance Market*, August 24, 2009, www.rwjf.org/files/research/texasestudyaug2009.pdf

¹⁷ For more information see resources from Families USA at www.familiesusa.org/assets/pdfs/wellness-amendment-in-senate-bill.pdf, and the American Heart Association and others at [http://americanheart.org/downloadable/heart/1263933283725HIPAA%20Sign-On%2012-18-09%20\(FINAL\).pdf](http://americanheart.org/downloadable/heart/1263933283725HIPAA%20Sign-On%2012-18-09%20(FINAL).pdf).

¹⁸ Kaiser Family Foundation, Issues for Structuring Interim High-Risk Pools, January 2010, www.kff.org/healthreform/upload/8040.pdf.

¹⁹ See National Association of Insurance Commissioners, Letter to Speaker Pelosi and Majority Leader Reid, January 6, 2009, www.naic.org/documents/testimony_100106_health_reform_letter_officers.pdf, for more information on the downsides to indefinitely grandfathered plans and free choice vouchers.

²⁰ William G. Schiffbauer, Schiffbauer Law Office, Implementing Federal Health Insurance Reform, testimony to the National Association of Insurance Commissioners, December 4, 2009, www.naic.org/documents/committees_b_0912_hearing_testimony_schiffbauer.pdf, accessed on December 30, 2009.

²¹ Texas Department of Insurance, 2009 Annual Report, Part I, page 4, www.tdi.state.tx.us/reports/commish/documents/2009part1.pdf.

²² GAO, *Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market*, February 2009.

²³ Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey – Insurance Component, 2008.

²⁴ Employer payroll data from the Texas Workforce Commission. Data current through close of business August 11, 2009. Employers include all types of TWC contributing employers: regular, governmental, and political subdivision.

²⁵ The Commonwealth Fund, *Health Insurance Provisions of the 2009 Congressional Health Reform Bills: Implications for Coverage, Affordability, and Costs*, January 2009, www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2010/Jan/Coverage%20Report/1343_Collins_cong_bills_coverage_report_172010.pdf.

²⁶ Unfortunately, the breakdown of Texas businesses that offer health insurance isn’t available by annual payroll, but it is available by business size. Many businesses will hit \$500,000 in payroll with 10-25 employees. In 2008, 77% of businesses with 10 or more employee and 87% of businesses with 25 or more employees provided health insurance.

²⁷ MEPS-IC, 2008

²⁸ MEPS-IC, 2008

²⁹ MEPS-IC, 2008

³⁰ Center for Budget and Policy Priorities, “Senate Health Bill Improves Employer Responsibility Provision,” www.cbpp.org/cms/index.cfm?fa=view&id=3003.

³¹ Center for Budget and Policy Priorities, “Senate Health Bill Improves Employer Responsibility Provision.”

³² MEPS-IC, 2008.

³³ See Center for Budget and Policy Priorities, “Senate Health Bill Improves Employer Responsibility Provision,” www.cbpp.org/cms/index.cfm?fa=view&id=3003 for a full discussion of the Senate bill’s play or pay provisions.

³⁴ Independent Sector, “Facts and Figures about Charitable Organizations,” www.independentsector.org/programs/research/Charitable_Fact_Sheet.pdf.

