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Health and Human
Services Commission

Presentation to Joint Committee for Senate State Affairs and Health and Human Services

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November 23, 2010

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Update Since Last Hearing

- Guidance from the federal government:
  - CMS and the Office of Consumer Information and Insurance Oversight (OCIIO) have indicated they intend to cover the costs associated with development of the Exchange through federal grants through 2014.
  - New proposed federal regulations will allow states to receive 90% federal match for changes to Medicaid eligibility systems and 75% federal match for operations and maintenance. Current federal match is 50%.
    - Although it appears the federal government will pick up the cost of the Exchange, we do not know the extent to which system changes to Medicaid for development of required simplified eligibility processes can be considered as Exchange costs.
- Affordable Care Act (ACA) includes numerous grant opportunities and demonstrations for which states can apply. HHSC has set up a process with the other HHS agencies to provide analysis on grant opportunities as they are released:
  - To ensure grants do not require a financial maintenance of effort in order to apply
  - To ensure programs could be sustained after grant funds expire
  - To ensure grants would support state health priorities

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Federal Health Care Reform
Health Insurance Exchange Update

- Health Insurance Exchange
  - Overview
  - Costs in FY 2012 – 13 related to the ACA
  - Key Decision Points
  - Comparison of Utah and Massachusetts Models
- Legislative Direction Needed Related to ACA

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Health Insurance Exchange

- Each state to establish a Health Insurance Exchange (Exchange) by January 2014
  - To assist individuals and small employers access affordable health insurance
  - Administered by a governmental agency or non-profit
  - Federal readiness review by January 2013
  - Must be self-sustaining beginning January 1, 2015
  - If Texas opts not to establish an Exchange, the federal government will designate an entity to do so

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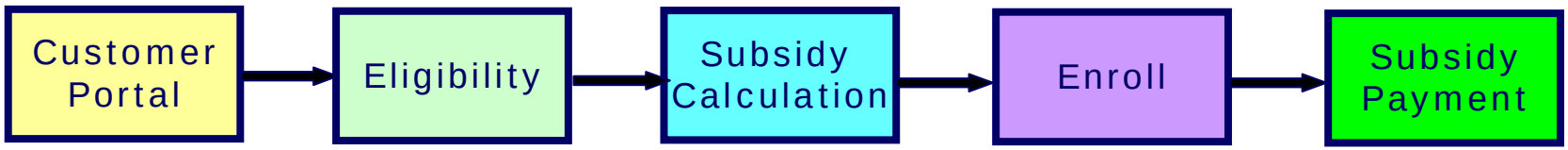
Health Insurance Exchange



2010/2011
Funding for Exchange Planning

2013
Readiness Review

2014
Exchanges Operational

Plan & Engage

- State vs. Federal
- Governance
- Enabling Legislation
- Market Assessment
- Plan for 2014

Design & Build

- Design
- Vendor Selection
- Systems Architecture
- Stakeholder Input
- Product/Plan Standards

Test, Certify, Launch

- QHP Certification
- Receive Plan Data
- Outreach and Education

Operate & Sustain 2014 & Beyond

- Market Exchange
- Enroll Members
- Member Service
- Monitor/Regulate Performance

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Health Insurance Exchange Participants

- Based on national estimates, 5 million Texans may participate in the Exchange by 2018
  - 1.65 million Texans in 2014
  - 2.5 million Texans in 2015

- Participation levels will be determined by outreach efforts to individuals and small businesses

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Major Exchange Functions

- Qualified health plan (QHP) management
  - Certify qualified health plans for the Exchange
  - Rate each qualified health plan in each benefit level on the basis of relative quality and price
  - Utilize a standardized format for presenting health benefits plan options in the Exchange
- Eligibility/subsidy determination and enrollment
  - Streamlined eligibility for the Exchange, Medicaid, and CHIP
  - Enable single application for all programs (via online, in person, by mail, or by telephone)
  - Certifications of exemption from the individual mandate

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Major Exchange Functions Continued

- Operate a consumer call center
- Maintain a web portal for application and comparative information on qualified health plans
- Establish a Navigator program to conduct public education and facilitate enrollment
- Premium collection, payment and reconciliation (functions not explicitly listed in ACA)

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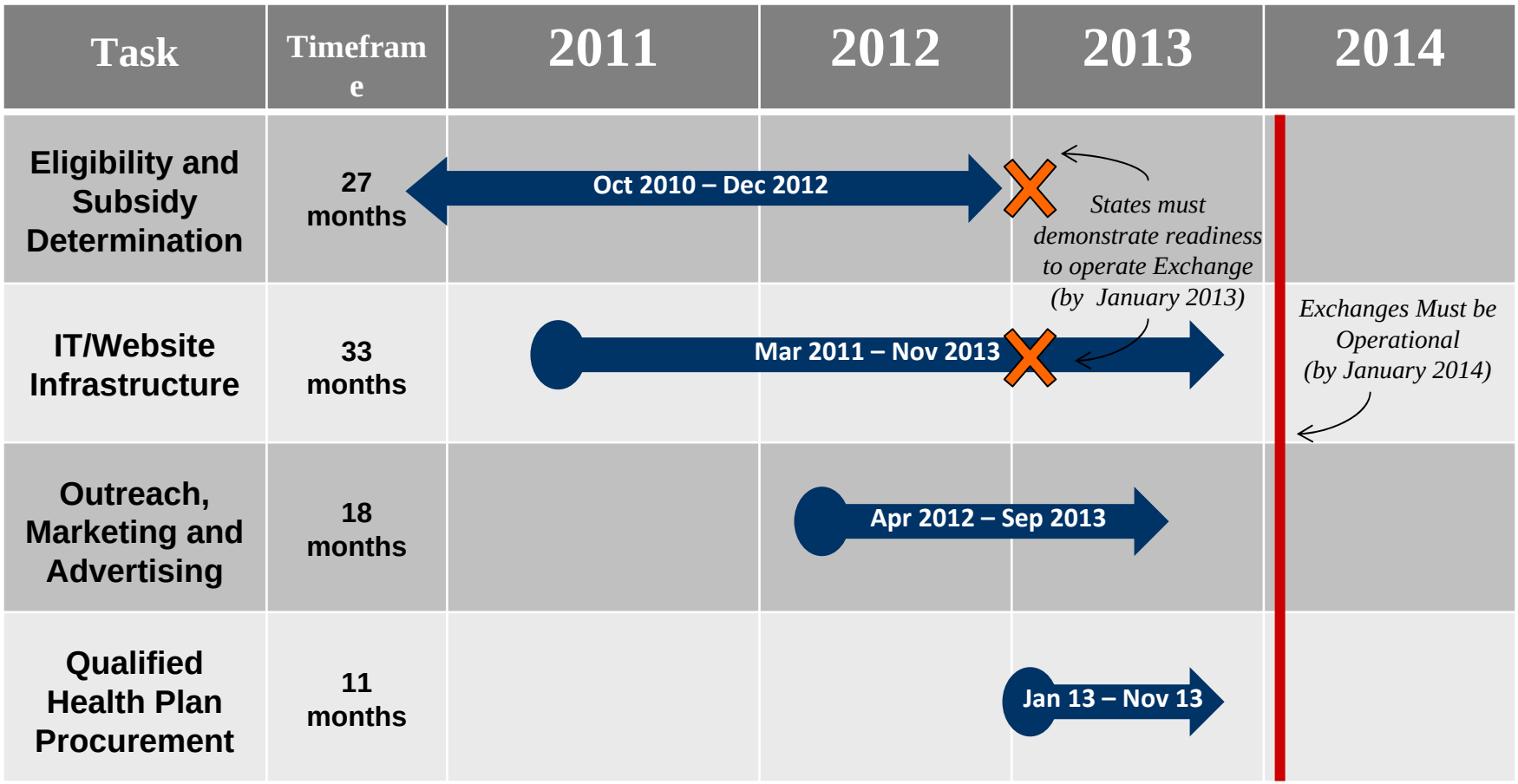
Timeline to Develop and Implement an Exchange

- Texas Exchange requirements are not yet established, pending anticipated federal and state guidance in 2011.
- Based on known requirements, if Texas elects to operate the exchange, implementation activities should begin immediately to meet the federal requirements for readiness and implementation, particularly for:
  - Eligibility/subsidy determination
  - IT/Web infrastructure

Timeline to Develop and Implement an Exchange



ACA-Related Administrative Costs

Costs Related to Administering the Exchange :

- Direct costs for the Health Insurance Exchange
  - To establish and administer the Exchange
- Indirect costs related to Medicaid Eligibility
  - State Medicaid programs will be required to simplify eligibility determination processes, increase capacity, and work with the Exchange to provide seamless eligibility determination processes between the two programs
- May also impact Dept. of State Health Services
  - Licensing and regulatory compliance for growing health care facilities and workforce
  - Implementing billing and eligibility systems to support health care reform
  - Measuring and reporting on health care quality improvements included in ACA

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ACA-Related Administrative Costs Federal Funding for the Exchange

- CMS and the Office of Consumer Information and Insurance Oversight (OCIIO) have indicated they intend to cover the costs associated with development of the Exchange through federal grants through 2014:
  - The Exchange must be self-sustaining beginning January 1, 2015
  - HHSC and TDI are working together on Exchange planning
  - Texas received an initial one-year, $1 million Exchange planning grant
  - Additional grants will be awarded in early 2011
  - HHSC RFP for health care reform consulting services to assist in planning and implementation (award expected January 2011)

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ACA-Related Administrative Costs Federal Match for Medicaid

- CMS is proposing to pay states a higher federal match for Medicaid eligibility changes:
  - State Medicaid programs will be required to simplify Medicaid eligibility determination, implement use of Modified Adjusted Gross Income (MAGI) for income verification, increase capacity for Medicaid expansion, and work with the Exchange to provide seamless eligibility determination processes between the two programs
  - Historically, states have only gotten a 50% federal match on changes to Medicaid eligibility systems
  - New proposed federal regulations will allow states to receive 90% federal match for changes to Medicaid eligibility systems and 75% federal match for operations and maintenance. (Comments on the proposed rules are due to CMS on January 7, 2011. Enhanced match will become available on the effective date of the final rule.)

Updates to HHS Consolidated Budget

- New information regarding the higher match rates for Medicaid Exchange related expenditures will change the estimates for state costs reported in the HHS Consolidated Budget for eligibility related IT changes and claims processing.
- Updated costs are as follows:

	From Consolidated Budget: FY 2012-2013 Biennial Total		Updated Estimates FY 2012-2013 Biennial Total	
	GR	All Funds	GR	All Funds
Build System Capacity – includes claims processing changes (Table v.1)	**$24,242,475**	**$71,643,840**	**$16,600,785**	**$61,041,427**
Establish Connection between Medicaid Eligibility System and the Exchange (Table v.3)	**$11,476,800**	**$24,000,000**	**$7,594,560**	**$24,000,000**

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ACA-Related Administrative Costs Outstanding Issues

- It is difficult to fully estimate HHSC Medicaid eligibility costs for FY 2012-13 until the state defines the extent of integration of the Medicaid and Exchange eligibility processes.

- It is unknown at this time the extent to which the demand for eligibility workers will increase in FY 2014.
  - Eligibility determination processes will be simplified for most people receiving Texas Medicaid; however, an estimated 1.2 million additional Texans will receive Medicaid services.

    Individuals applying for SNAP (Food Stamps) will also likely increase.

- After federal funding for the Exchange expires on December 31, 2014, ongoing operations of the Exchange will likely require a surcharge or other financing mechanism to Texas health plans.

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Other ACA Fiscal Impacts

- ACA increased required rebates from drug manufacturers, with the entire increase going to the federal government. This change means Texas loses some of its share of the state's Medicaid supplemental rebates:
  - $45.2 million loss in FY 2012-2013
  - $25.5 million loss in FY 2010-2011

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Texas Vision and Goals

- The Texas vision for the role of the Exchange and its relationship with the existing insurance market will drive the state's decisions regarding the Exchange.
  - State or federally-based Exchange
  - Governance and organizational structure
  - Market organizer or active purchaser
  - Mechanisms to guard against adverse selection

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State or Federal Exchange?

Considerations

- Regulatory authority over large share of Texas health insurance market
- Consistent rating/underwriting rules inside and outside the Exchange will guard against adverse selection
- State is better positioned to coordinate benefits and eligibility across programs and control costs
- Challenge and cost of creating new institutions
- Must be self-sustaining by 2015
  - Must keep fees low while providing high-quality customer service and meeting all federal requirements

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Public Agency or Not-for-Profit Organization?

- **If Texas chooses to establish a state-based Exchange, where to house it?**
  - Existing or new state agency
  - Quasi-governmental entity
  - Not-for-profit organization
- **Considerations**
  - Success depends on the ability to sell health insurance and provide high quality customer service
  - Fundamental role of Exchange is to market insurance products — very different than TDI's and HHSC's current roles
  - Must react quickly to changes in insurance markets - public agency less agile than a not-for-profit entity due to state agency requirements (e.g. length of public notice, open meetings, procurement timelines)
  - If the Exchange is through a public agency, may be beneficial to exempt it from certain state government administrative requirements

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Public Agency or Not-for-Profit Corporation?

- **Considerations (continued)**
  - Public agency may allow increased public oversight and accountability
  - Need to determine whether premium payments would be “on budget” for the state if the Exchange is a public agency
  - If placed in an existing state agency, will leverage agency administrative support functions and facilitate coordination between the Exchange and the agency where it is housed
  - Must determine the roles of TDI and the Exchange in regulating the insurance market within the Exchange
  - Branding - non-state entity may have a better public reception

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Comparison with Utah and Massachusetts Exchanges

- Massachusetts (MA) and Utah each developed state Exchanges prior to the passages of ACA based on their states' health insurance coverage goals
  - "**Market organizer**" – Utah's Health Exchange organizes the market, allowing consumers to compare a wide variety of health plans sold by any insurers that wants to participate.
  - "**Selective contractor/active purchaser**" - The MA Connector has a subsidized program and an unsubsidized program. Both programs limit health plan participation, either through procurement or a screening process.

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Comparison with Utah and Massachusetts Exchanges

- ACA Exchange requirements are most closely aligned with the Massachusetts model
- However, ACA contains Exchange requirements that go beyond both the MA and Utah models
- Potential size of the Texas Exchange (5 million) greatly exceeds 2010 participation for MA and Utah
  - < 200,000 people in MA
  - < 500 people in Utah

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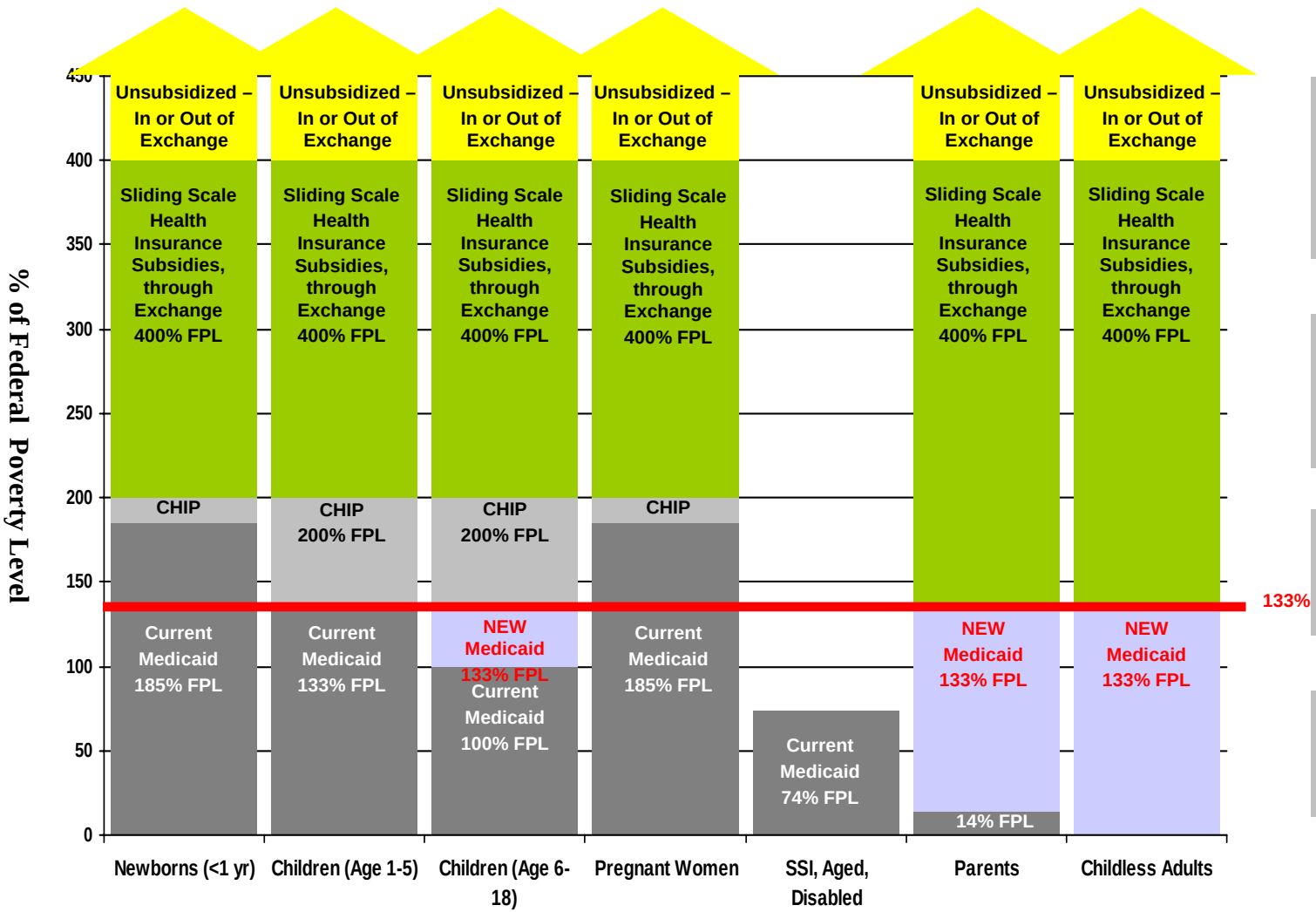
Comparison with Utah and Massachusetts Exchanges

- Advantages of the Utah Exchange model
  - Maximizing health plan participation may increase competition and innovation
  - Consumers have access to a broad range of carriers and benefit plans
  - Small business friendly - defined contributions
  - Minimal state administrative structure
- Advantages of the MA Exchange model
  - A bid/negotiation process may increase consumer protection and plan value (re. rates and quality improvements)
  - Limiting plan design may aid consumer choice and discourage risk selection due to benefit/cost sharing design

Texas Health Care Coverage – Post Implementation



Estimated Insured but not Subsidized (In or Out of Exchange)
15.5 million

Estimated Insured & Subsidized in Exchange
1.9 million

Estimated Medicaid/CHIP
5.6 million

Estimate of Ongoing Uninsured
2.3 million

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82nd Legislative Session
Requested Legislative Direction

- If the Legislature wants Texas to establish the Exchange, guidance is needed on the following:
  - Which entity will administer the Exchange – existing or new state agency, or quasi-governmental/non-profit?
  - If non-profit, what governance structure should be established?
  - Should eligibility and subsidy determination for the Exchange be integrated with the Medicaid infrastructure?
  - Should other functions of the Exchange, such as the call center, development of the web portal and outreach, be procured through new contracts or integrated with existing state agency contracts?
  - What should be the interplay between the Exchange and TDI to ensure that both the market inside and outside the Exchange remain viable?
  - Should health plans in the Exchange be competitively procured, or should any willing health plan meeting requirements be allowed to participate?

82nd Legislative Session
Requested Legislative Direction

- New Medicaid and CHIP Provider Screening Requirements

  The ACA allows states to impose a $500 fee (in 2011, adjusted annually thereafter) on non-physician providers, such as hospitals, skilled nursing facilities, community mental health centers, and durable medical equipment providers, who are applying to become Medicaid and CHIP providers, if they have not previously paid an enrollment fee for Medicare. Hardship exemptions and waivers for certain medical providers are allowed. If the Legislature intends for the State to collect this fee:

  - HHSC will need statutory authority to impose a fee on providers
  - HHSC will need the fee collection to be a dedicated revenue source