

Federal Health Care Transformation: Back to the Future

**Texas Indigent Health Association
Annual Conference**
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About Texas Health Institute



OUR COMMITMENT

We are driven by a commitment to ensuring everyone has the opportunities they need, free from barriers, to pursue their best health.

It centers everything we do and how we do it.

VISION

Healthy People,
Healthy Communities

MISSION

To advance the health of all

OUR PRIORITIES



Advancing
health systems
transformation



Strengthening
public health
infrastructure



Promoting
healthy
communities



Texas Health Institute

What we Do



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Our Strategies

We are **Texas-focused** and **nationally engaged**.

We optimize our role as ***the*** independent public health institute in the state by:



Leading Through Research and Evaluation

Provide and leverage objective, participatory, and applied research.



Translating Data and Insights Into Impact

Empower communities and stakeholders with trusted and actionable information and tools.



Fostering Collaborative Action

Facilitate dialogue, partnerships and actions for shared priorities

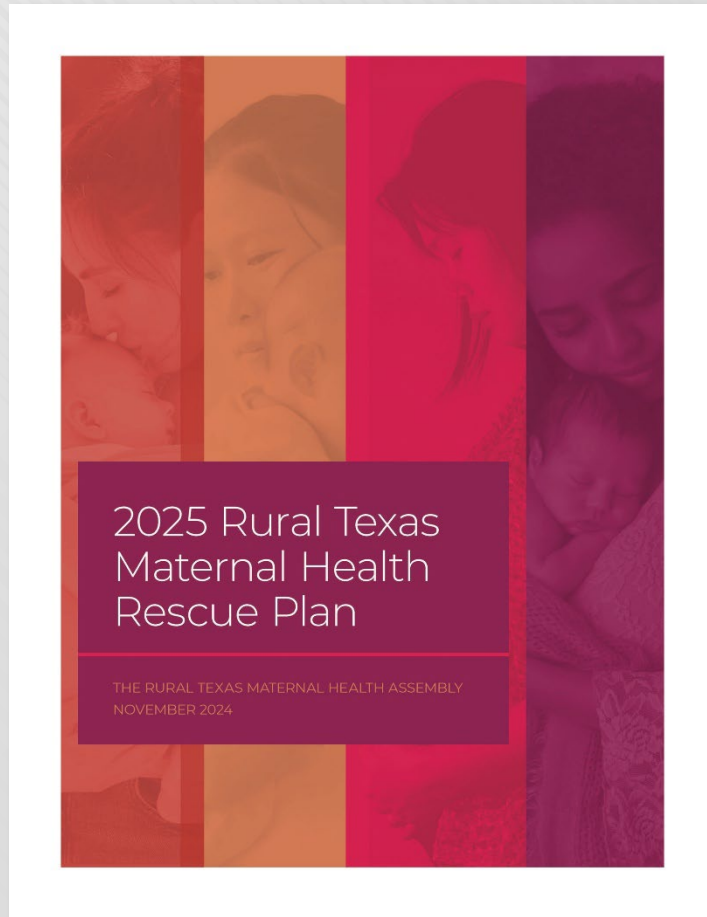


Providing Technical Assistance and Training

Ensure success and sustainability through learning and capacity building.



2025 Rural Texas Maternal Health Rescue Plan



Recommended a modern rural maternal health rescue initiative, centered on consensus-driven reforms that will promote a high-quality, enduring rural maternal health care system that fosters healthy families, sustains strong communities, and promotes economic prosperity today and for future generations.

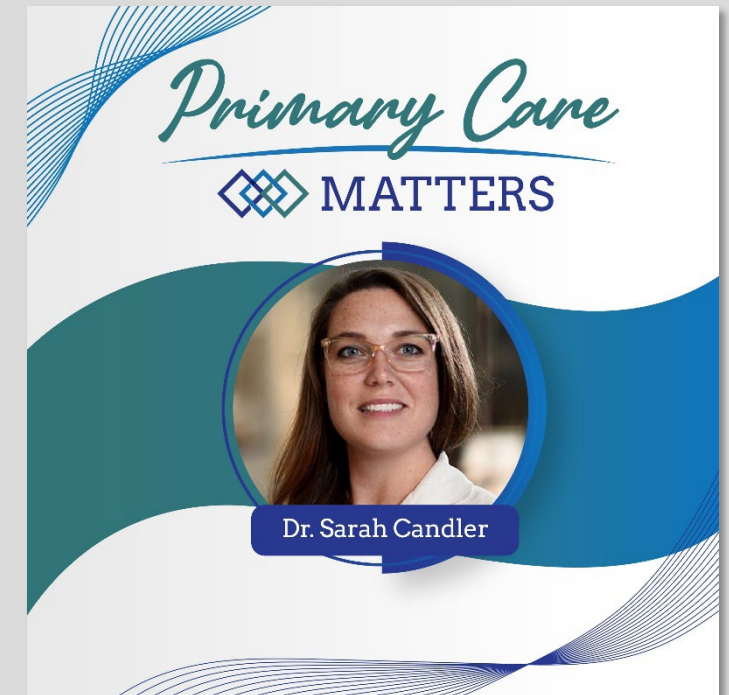




TEXAS PRIMARY CARE CONSORTIUM

The Texas Primary Care Consortium is a statewide collaborative with a mission to **advance high-quality primary care for all Texans**, co-led by the Texas Health Institute and the Texas Medical Home Initiative.

Texas Primary Care Consortium



Travis County



33.9 Years
Median Age
+34.4 yrs in Texas



13.5%
Uninsured Adults
+17.4% in Texas



8.0%
Uninsured Children
+11.1% in Texas



13.1%
Poverty Rate
+15.5% in Texas



6%
Rural Population
+15% in Texas



\$71,767
Median Household Income
+\$59,570 in Texas

Health Needs



10.20%
Preterm births
+12.2% in Texas

4
Infant mortality rate*
+6 in Texas
* per 1,000 live births

20%
Births to woman receiving late or no prenatal care
+35% in Texas



COVID-19

30,265 Cases*
+795,126
433 Deaths**
+16,558
cases from 03/04 - 10/12
deaths from 03/07 - 10/11



7.6%
Diabetes
+10.9% in Texas



469.5
HIV Prevalence
+392.7 in Texas
per 100,000 ages 13 & above



23.1%
Obesity
+33.6% in Texas

Top causes of ED utilization

1. Other chest pain
2. Acute upper respiratory infection, unspecified
3. Fever, unspecified

🇹🇽 In Texas

1. Urinary tract infection, site not specified
2. Acute upper respiratory infection, unspecified
3. Other chest pain



37.1

Heart disease
hospitalization**

🇹🇽 43 in Texas



3,582

PQI rate*

🇹🇽 4,656 in Texas



51%

Flu Vaccination

🇹🇽 46% in Texas

*per 100,000 Medicare beneficiaries

**per 1,000 Medicare beneficiaries

Mortality rate by cause

All-cause mortality rate for **Travis** county is **616.1** per 100,000 compared to 737.5 in Texas.



117.4

Heart Disease

🇹🇽 169.7



36.3

Stroke

🇹🇽 41.5



125.6

Cancer

🇹🇽 147.8



20.3

Drug/Alcohol

🇹🇽 18.1



12.4

Suicide

🇹🇽 12.9

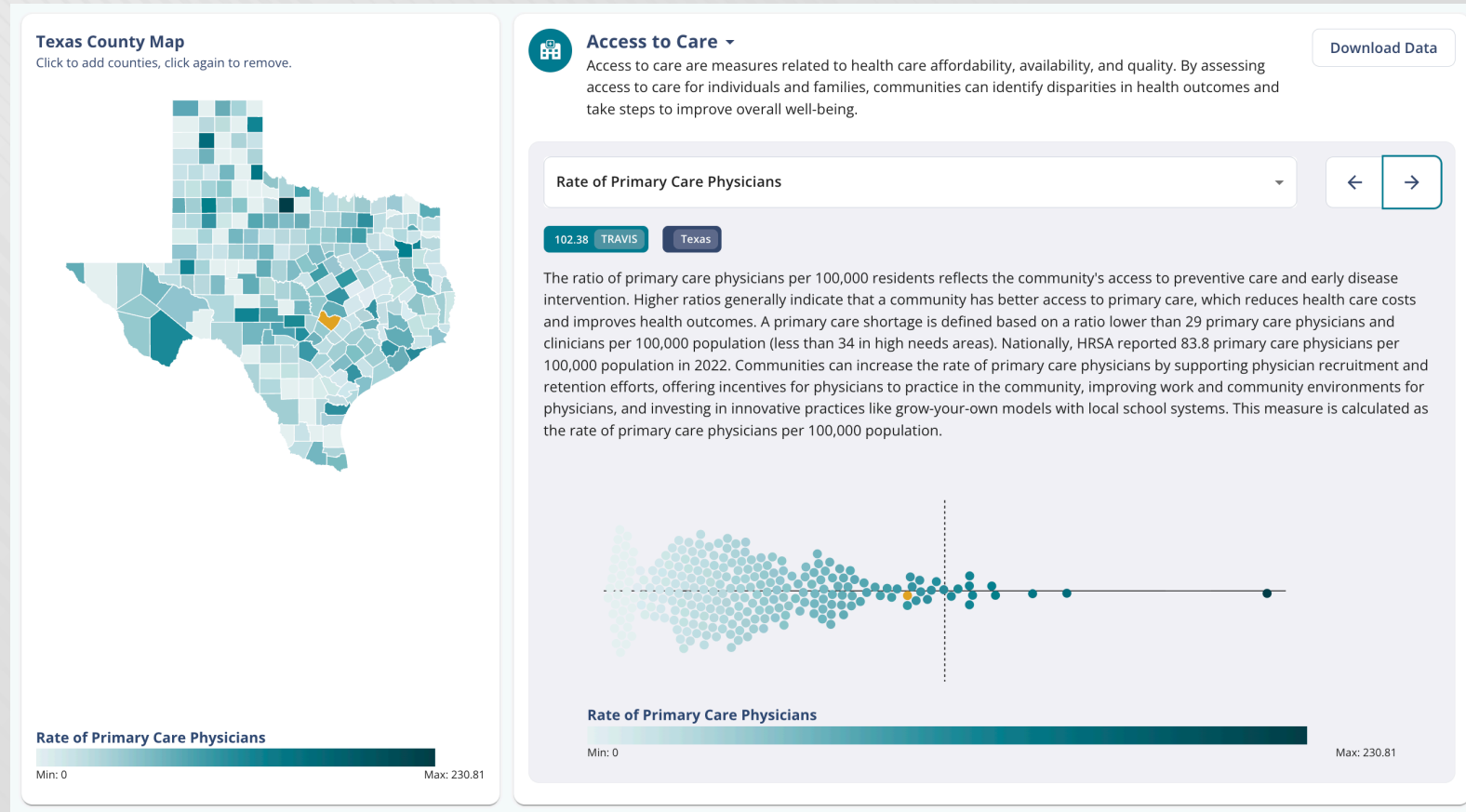


26.7

Chronic Lower
Respiratory Disease

🇹🇽 40.3

Texas Health Insights



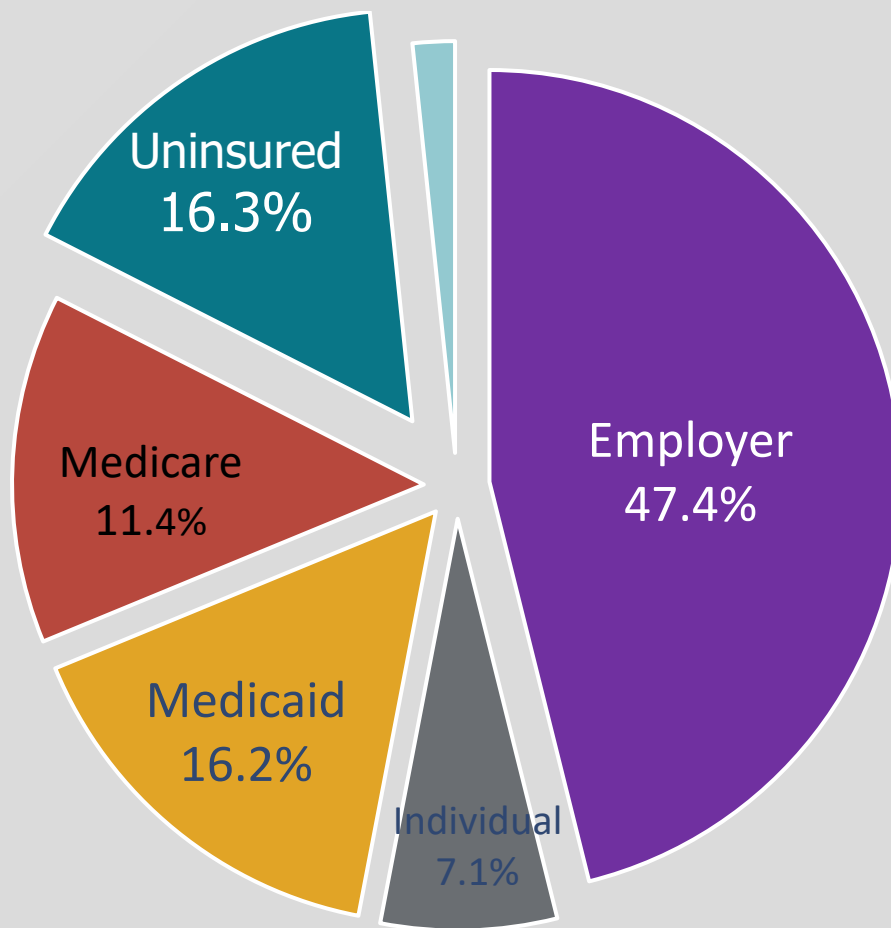
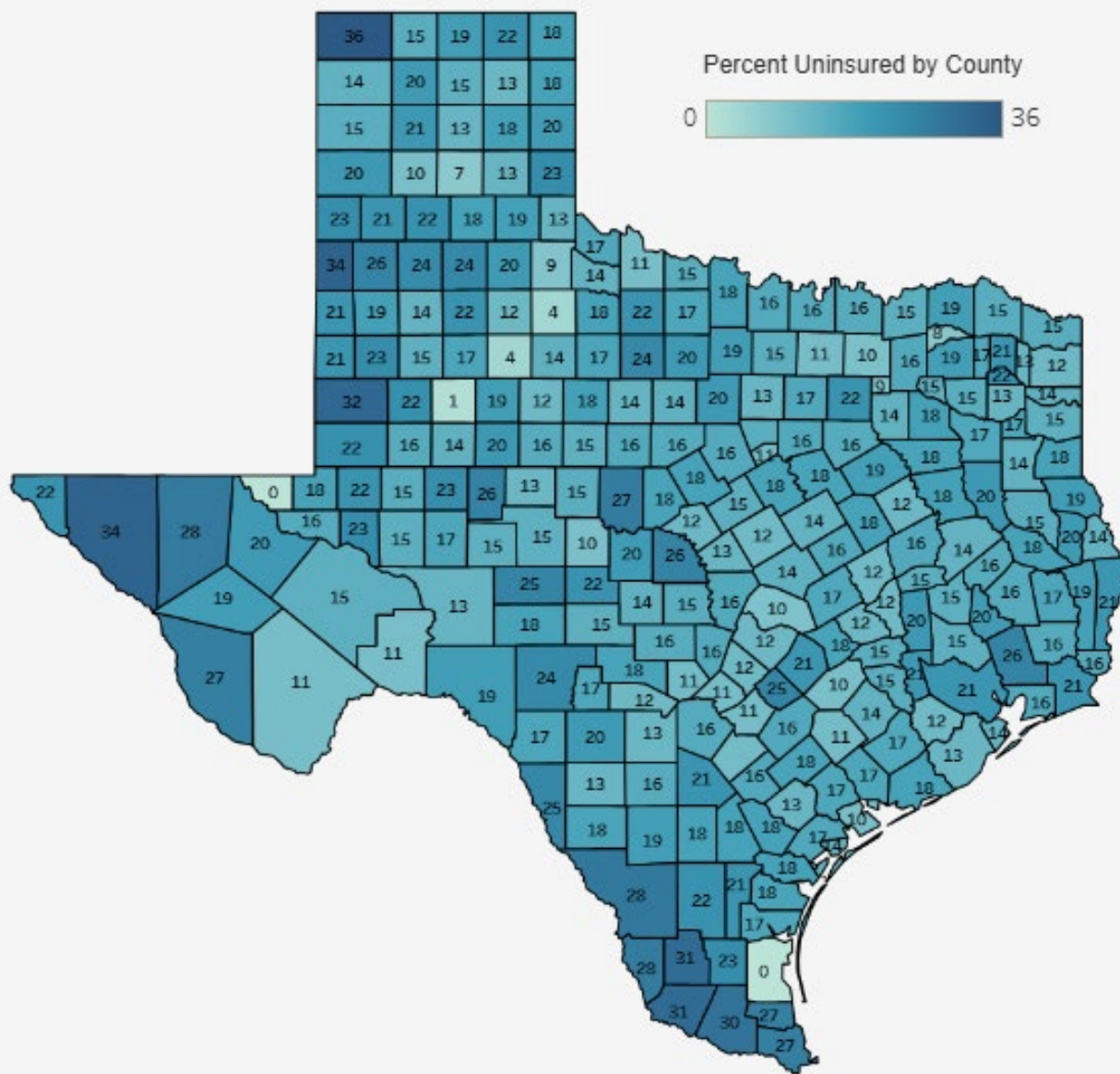
An interactive tool designed with indicators across five domains to help uncover patterns in health and highlight opportunities for improvement.

Texas Health Care Coverage Landscape



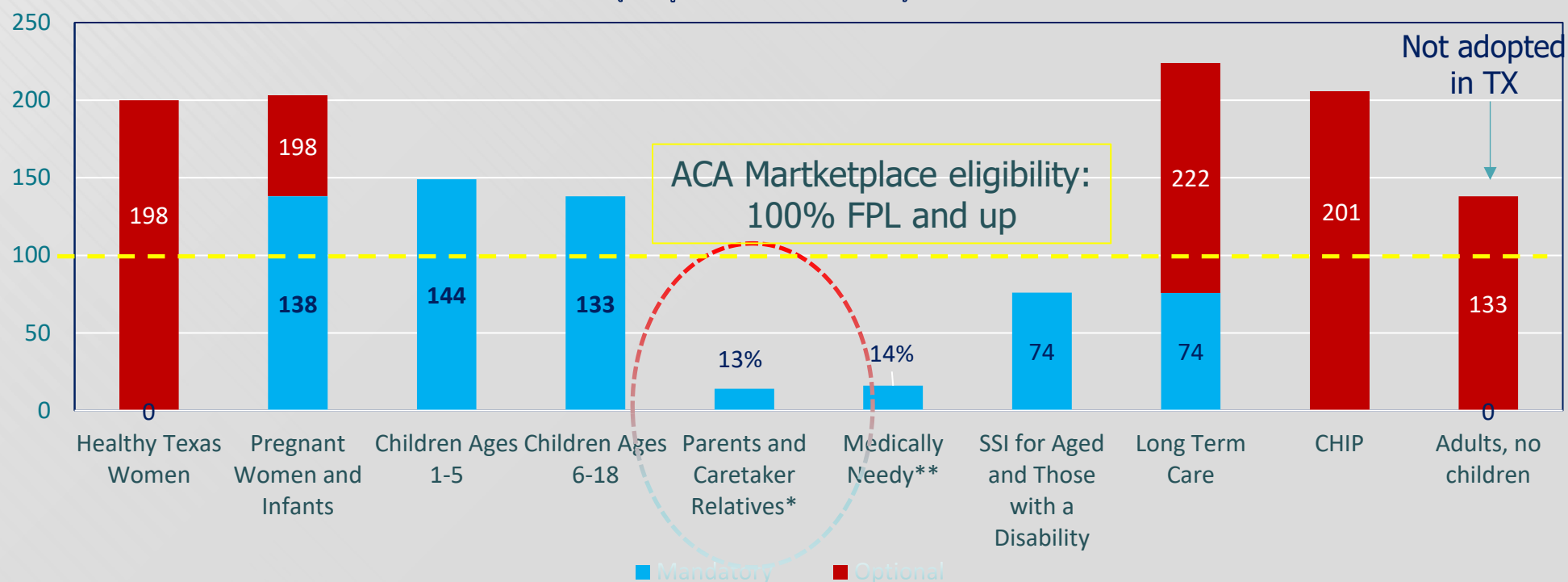
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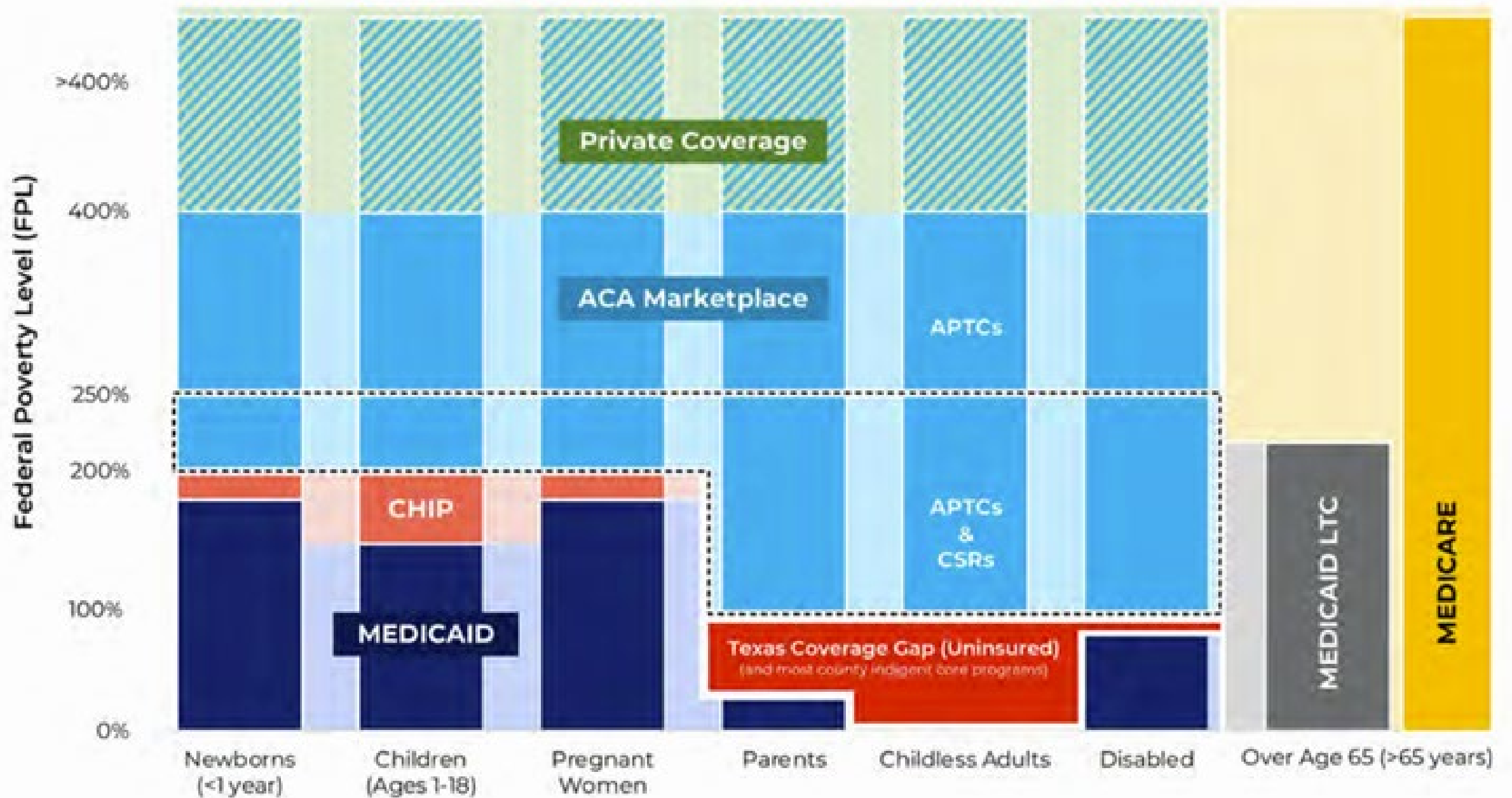


Texas Medicaid and CHIP: Who They Help

Texas Medicaid & CHIP Income Levels
Selected Programs
(as percent of FPL)



Applicants eligible for additional 5% income disregard as specified in federal law.
In 2025, the federal poverty level is \$15,660 for an individual and \$26,652 for a family of 3.



Federal Health Care Policy Terrain

What it Means for You



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HR 1, AKA One Big Beautiful Bill (OB3)

- Reduces federal health care spending by \$1.1 trillion over ten years and initiates significant new health policy direction across all federally funded health care programs
- Uses an array of administrative, eligibility, and programmatic financing restrictions to curtail health coverage and costs
- The bulk of OB3 reductions will be achieved by requiring Medicaid expansion states to enact stricter Medicaid eligibility and enrollment policies in addition to tighter financing limits
 - Mandatory work requirements, among other restrictions, will not apply here
- Texas will be most impacted by changes to ACA Marketplace eligibility, enrollment and costs as well as anticipated Medicare cuts prompted by mandatory sequestration
- OB3 staggers implementation over multiple years



OB3 Major Provisions

Health Care Transformation

ACA

Medicaid & CHIP

Medicare

- Invests \$50 B toward rural health transformation
- Redefines certain Direct Primary Care (DPC) arrangements as not health insurance & makes compatible with Health Savings Accounts (HSAs)
- Permits HSA pairings with ACA Bronze & catastrophic plans
- Caps federal student loans for professional degrees at \$200k; total borrowing at \$257k

- Omits extension of enhanced premium tax credits*
- Discontinues eligibility for APTCs for certain lawfully present immigrants and DACA recipients
- Eliminates special enrollment periods
- Eliminates auto enrollment for enrollees receiving tax credits
- Expands HSA options for select ACA plans
- *Parallel ACA regulations increase out-of-pocket costs and further tighten eligibility & enrollment*

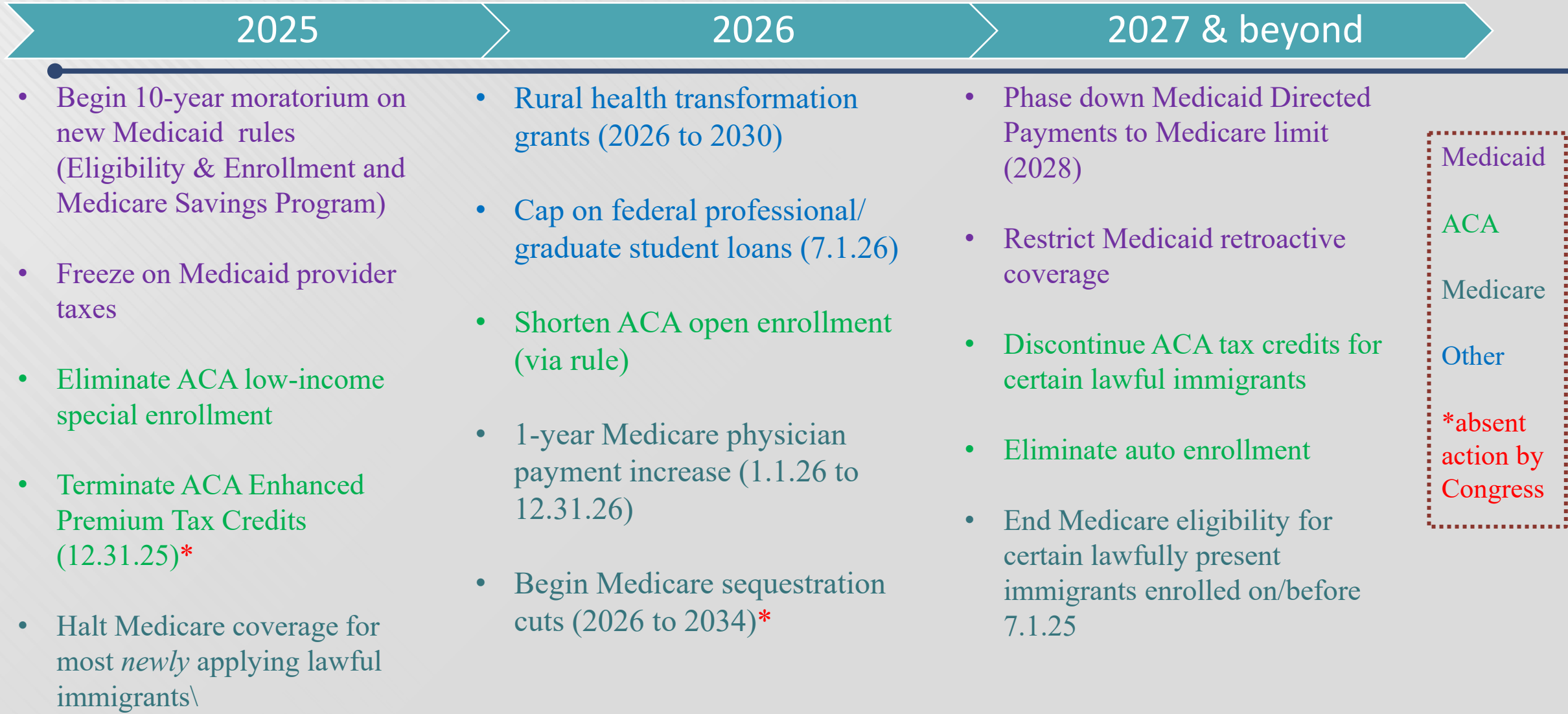
- Halts rules regarding eligibility & enrollment simplification (Texas must implement provisions pertaining to CHIP patient protections, including eliminating 90-day waiting period)
- Reduces Medicaid retroactive coverage period to 2 months
- Freezes Medicaid provider taxes at 2025 rates
- Limits supplemental directed payment programs for hospital, rural health clinics, and other entities

- Provides temporary, 1-year physician payment increase
- Permits additional Medicare sequestration cuts due to deficit spending*
- Sets new eligibility restrictions for lawfully present refugees and asylum seekers
- Freezes rules streamlining Medicare Savings Program enrollment processes

**absent Congressional action*

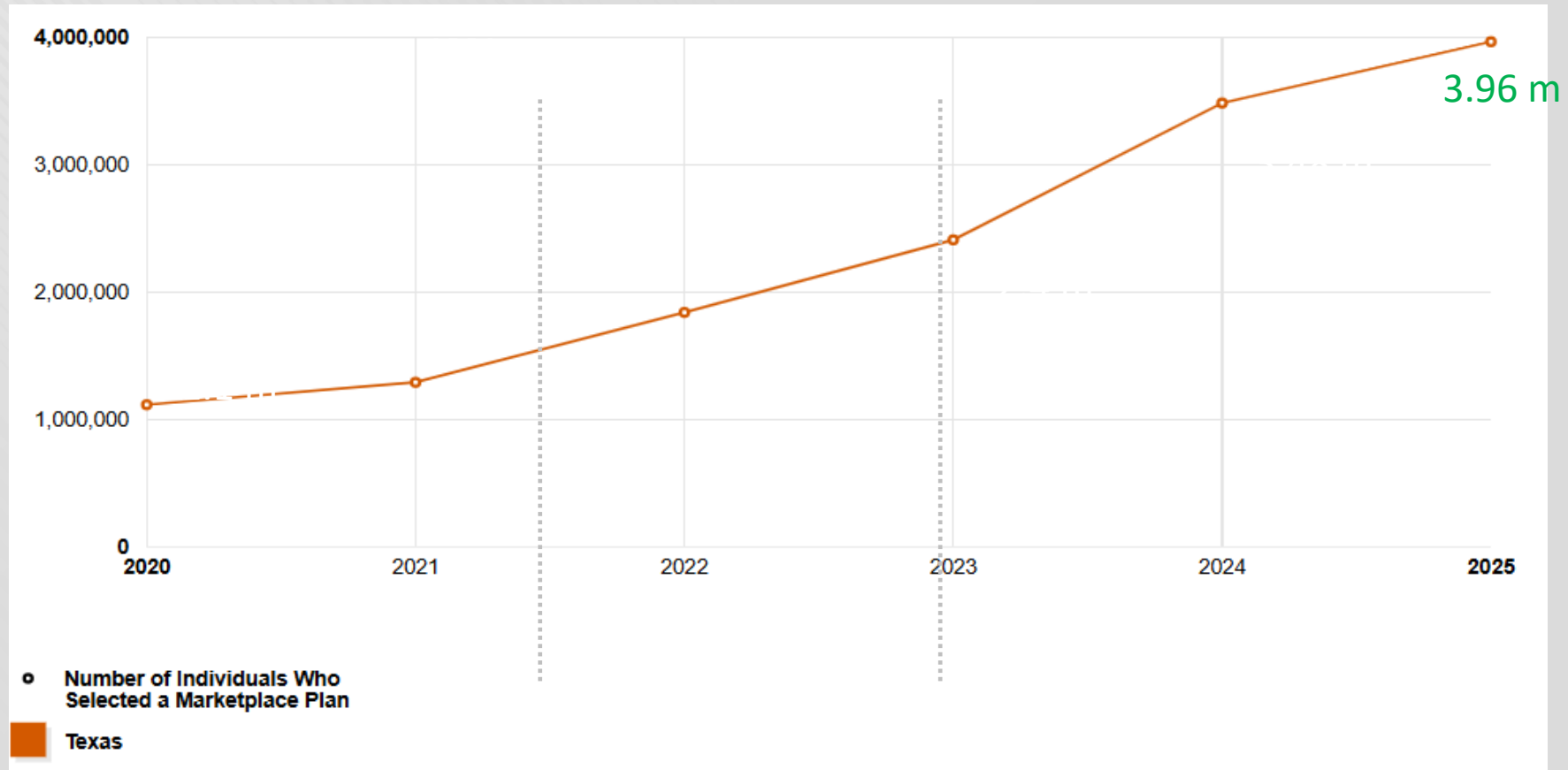


OB3: Timeline of Major Provisions



Texas ACA Enrollment Growth 2020-25

255% increase (2.85 million)

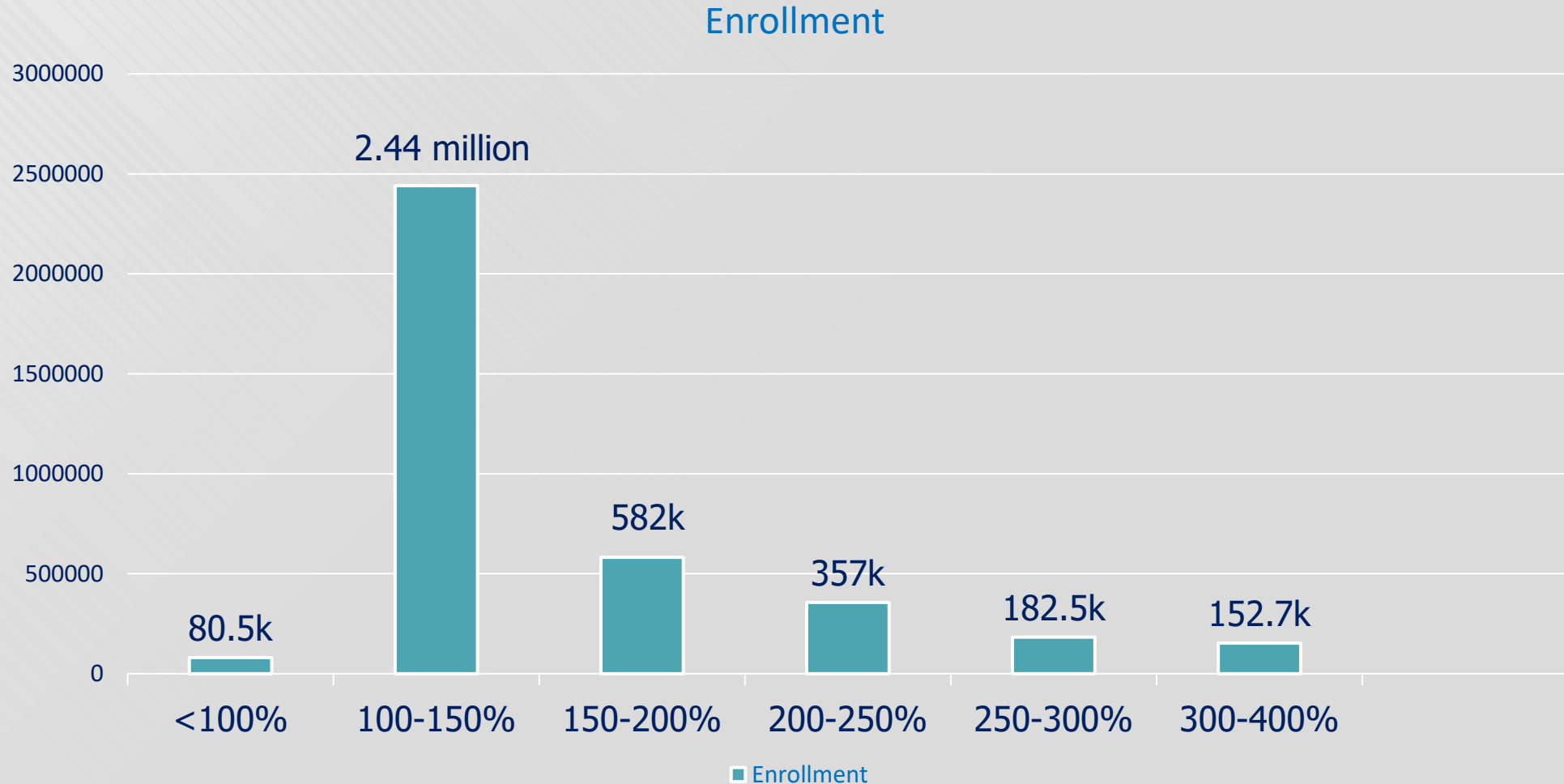


Source: [Marketplace Enrollment, 2014-2025 | KFF State Health Facts](#)

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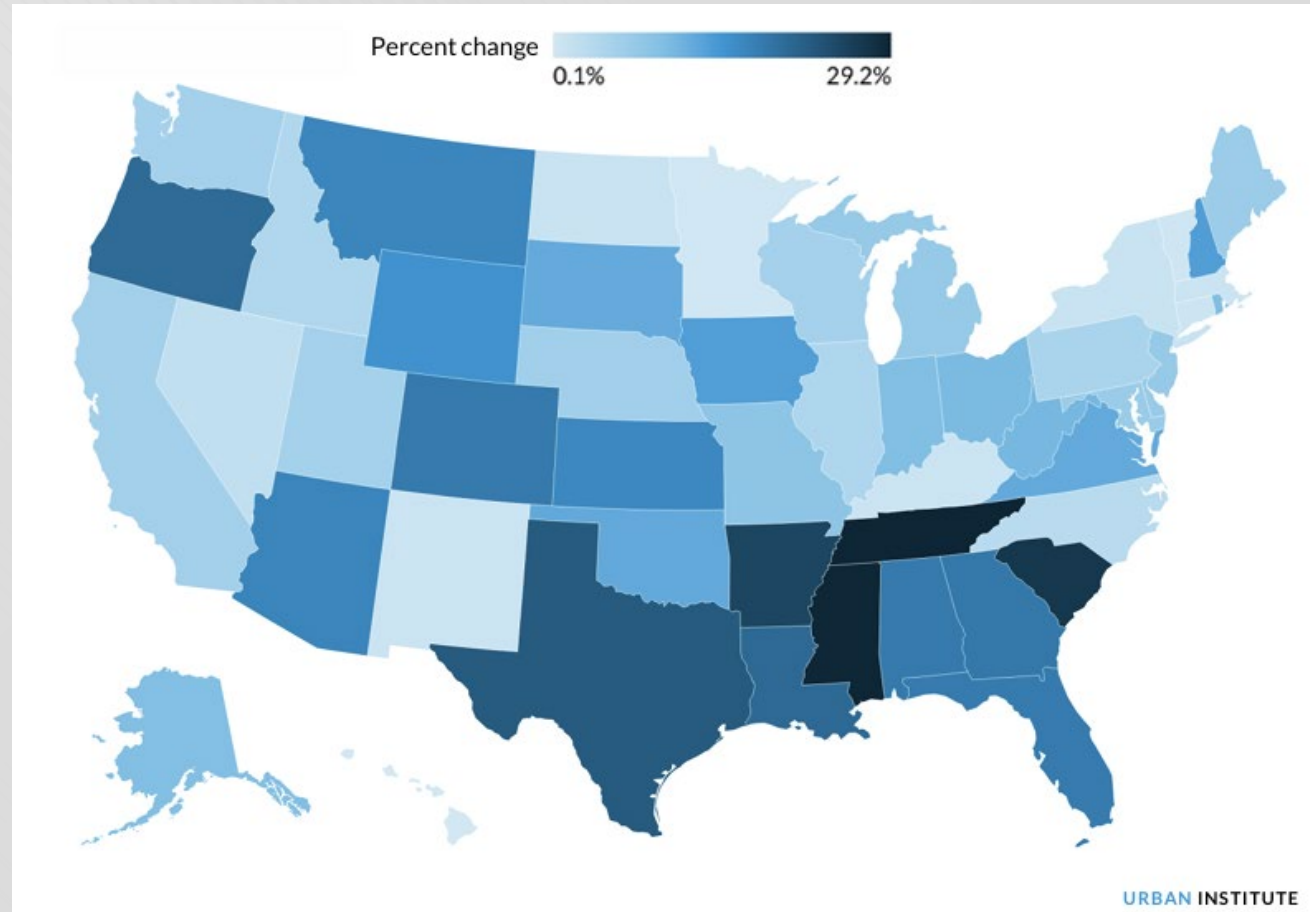
ACA Marketplace by Household Income (2025)



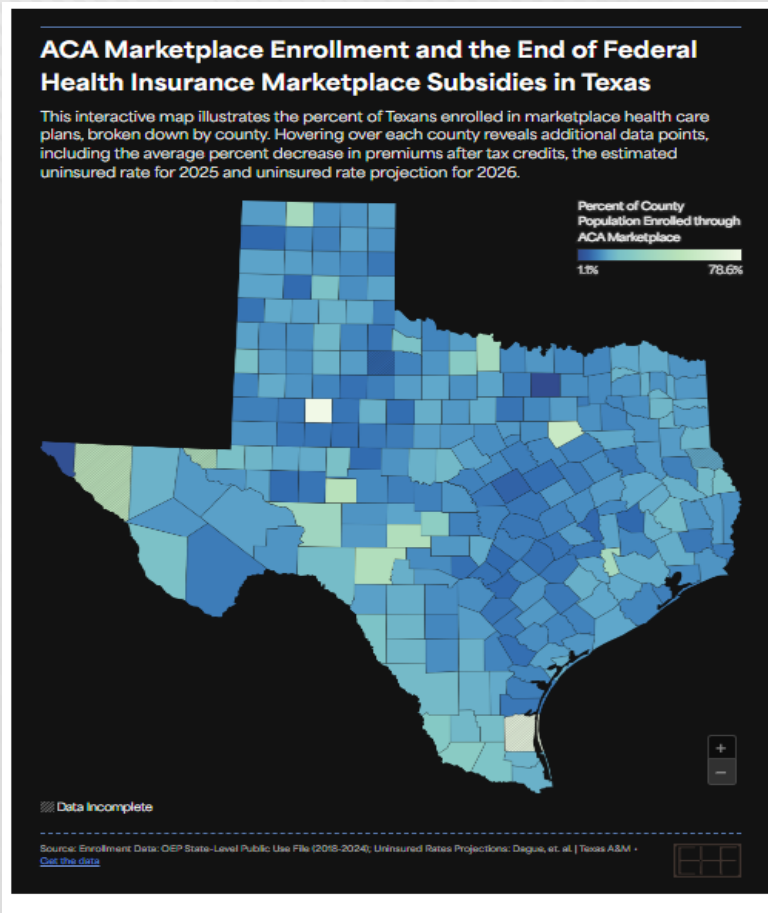
[Marketplace Plan Selections by Household Income | KFF State Health Facts](#)



Percent Increase in Uncompensated Care if EPTCs Expire



Expiration of ACA Enhanced Premium Tax Credits (EPTCs)



Between 665,000 and 1.45 million Marketplace enrollees will not continue individual Marketplace coverage in Texas in 2026, representing declines of 17- 37% from 2025, or 797,747 newly uninsured people

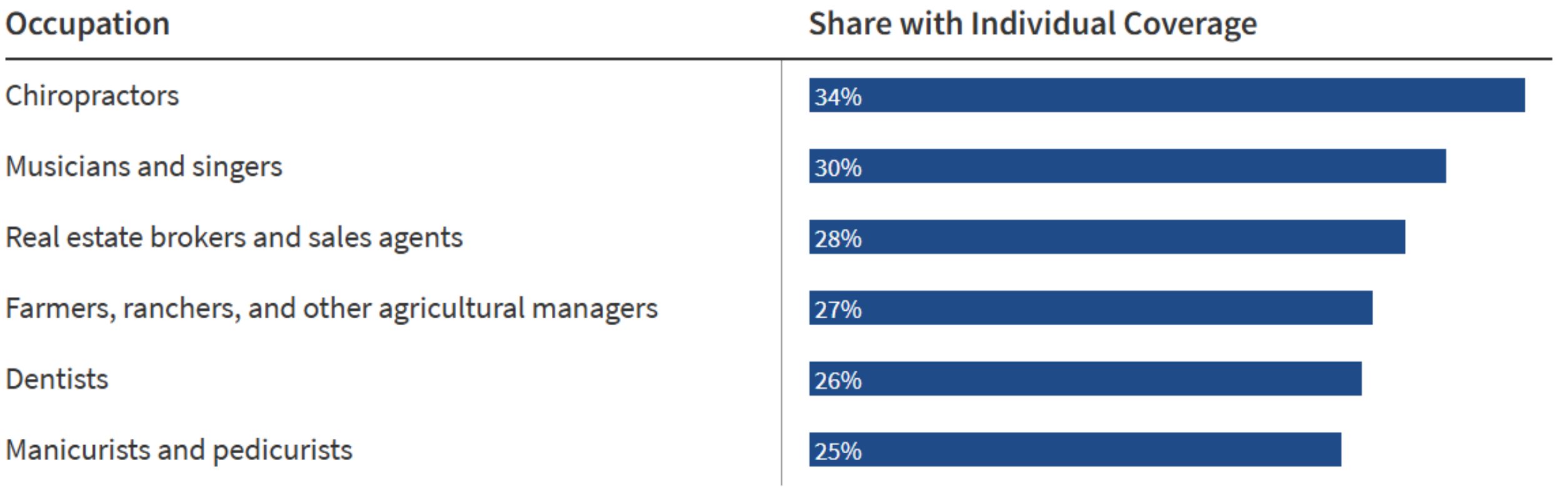
Source: Projected Uninsurance Increases from the End of Federal Health Insurance Marketplace Subsidies in Texas



Episcopal Health Foundation, Sept. 18, 2025
texashealthinstitute.org



Occupations Where at least 25% of Adult Workers Rely on Individual Market Coverage, 2023



Rural Health Transformation Grants

Coming to Texas Soon



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Rural Health Transformation Grants

- \$50 billion allocated over five years (2026 to 2030)
 - \$25 B = split evenly among all states with approved application
 - \$25 B = distributed by CMS based on specific factors, including state's rurality, state adoption of or commitment to CMS's priority policy actions; and other CMS priorities
 - CMS Strategic Goals for RHTG:
 - Make rural America healthy again
 - Support sustainable access
 - Promote workforce development
 - Enhance Innovative care
 - Support tech innovation
- Funds cannot be used to supplant existing state or federal funding, offset Medicaid cuts, or specifically to keep rural hospitals open.

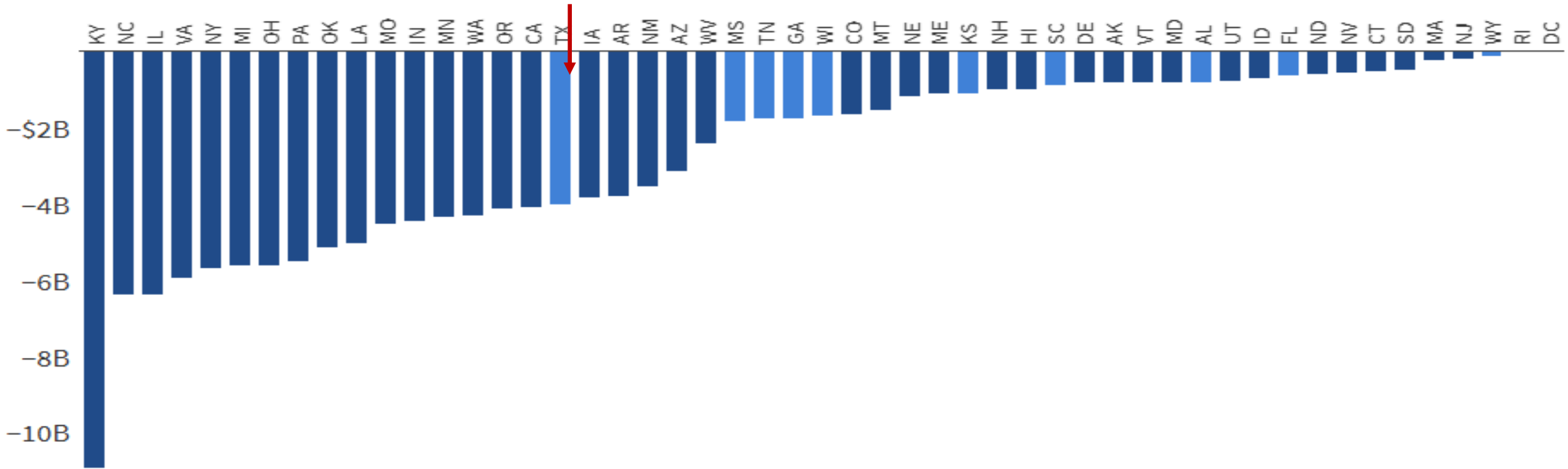
Rural Health Transformation Grants

- States must use funds for at least 3 of the following:
 - Prevention and chronic disease management
 - Health care provider payments for specified services
 - Consumer-facing, technology-driven solutions for chronic disease prevention and management
 - Technology-enabled solutions that improve care delivery in rural hospitals
 - Recruiting and retaining clinical workforce talent to rural areas
 - Technology solutions designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
 - Initiatives to help rural communities right size their health care delivery systems
 - Supporting access to opioid and substance use disorder treatment and mental health services
 - Value-based care arrangements and alternative payment models
 - Secretary approved initiatives to promote sustainable access to high quality rural health care
- Texas priority populations include pregnant women, elders, uninsured individuals, children/adolescents
- One-time state application due Nov. 5, 2025 with CMS approval granted by Dec. 31, 2025



Federal Medicaid spending in rural areas is estimated to decrease by \$137 billion over a 10-year period under the enacted reconciliation package

■ Non-expansion ■ Expansion



Texas' share RHTG

\$100 million over 5 years

(tranche 1)

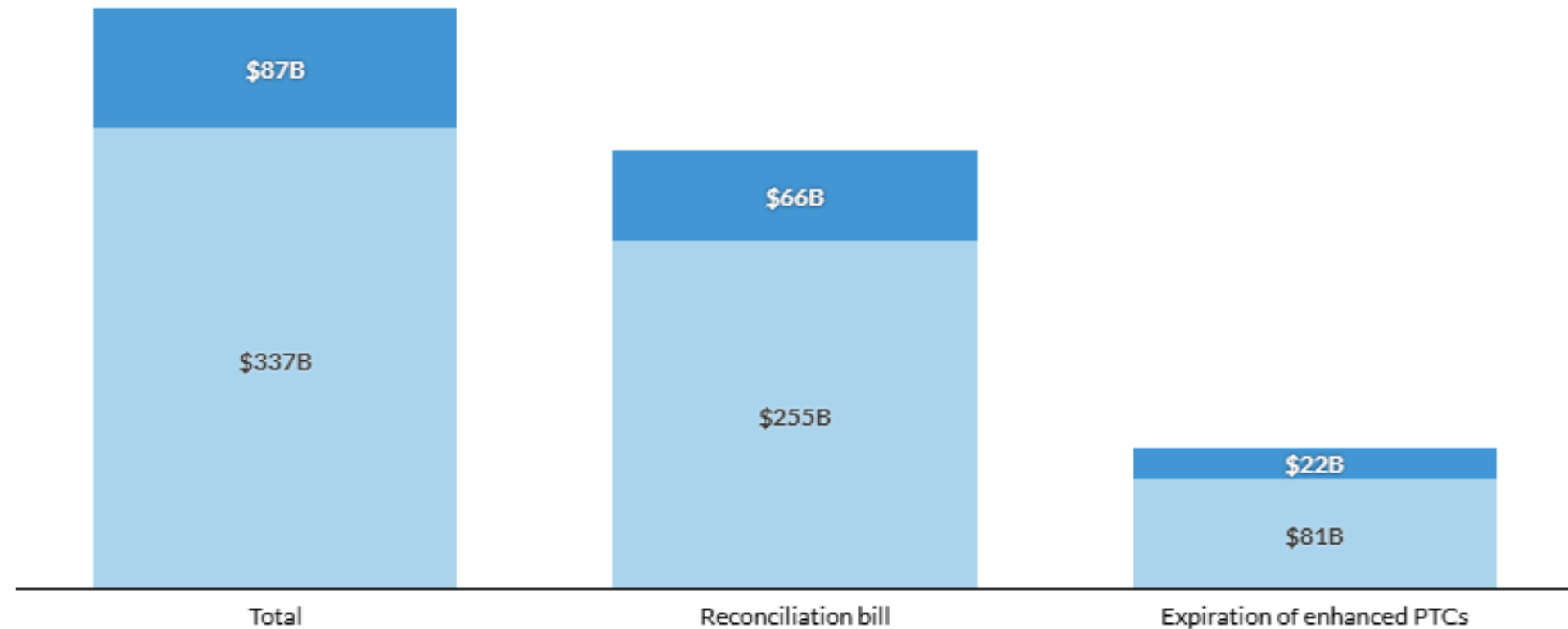
+ \$\$\$ tranche 2 (tranche 2)

Source: KFF

Rural Hospitals Would See Hospital Spending Decline by \$87 Billion over the Next Decade Because of Proposed Medicaid and Marketplace Actions

Billions (\$)

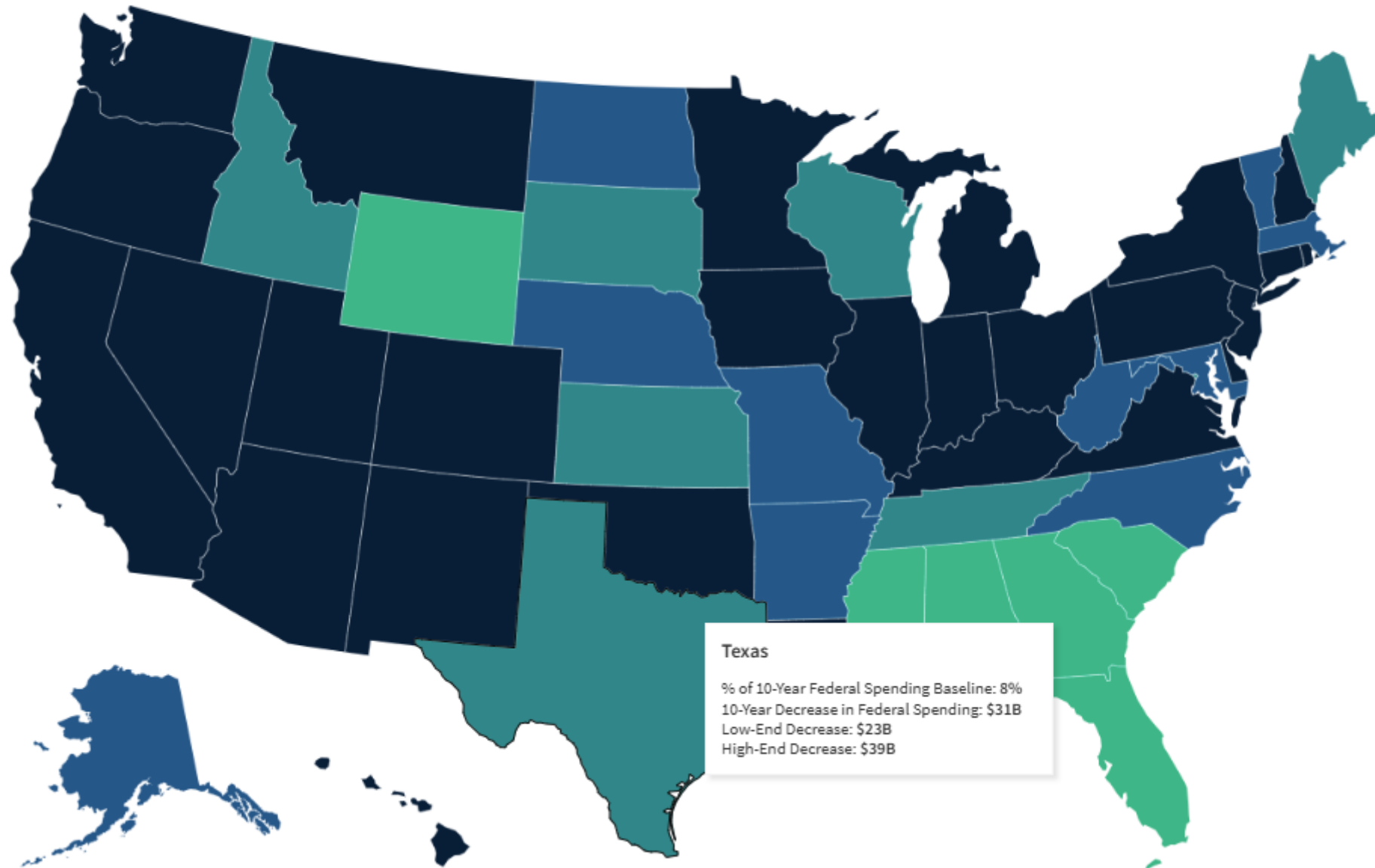
Urban Rural



Federal Medicaid Cuts in the Enacted Reconciliation Package, By State

As a % of 10-year baseline federal spending (2025-2034)

< 7% 7%–10% 10%–13% $\geq 13\%$

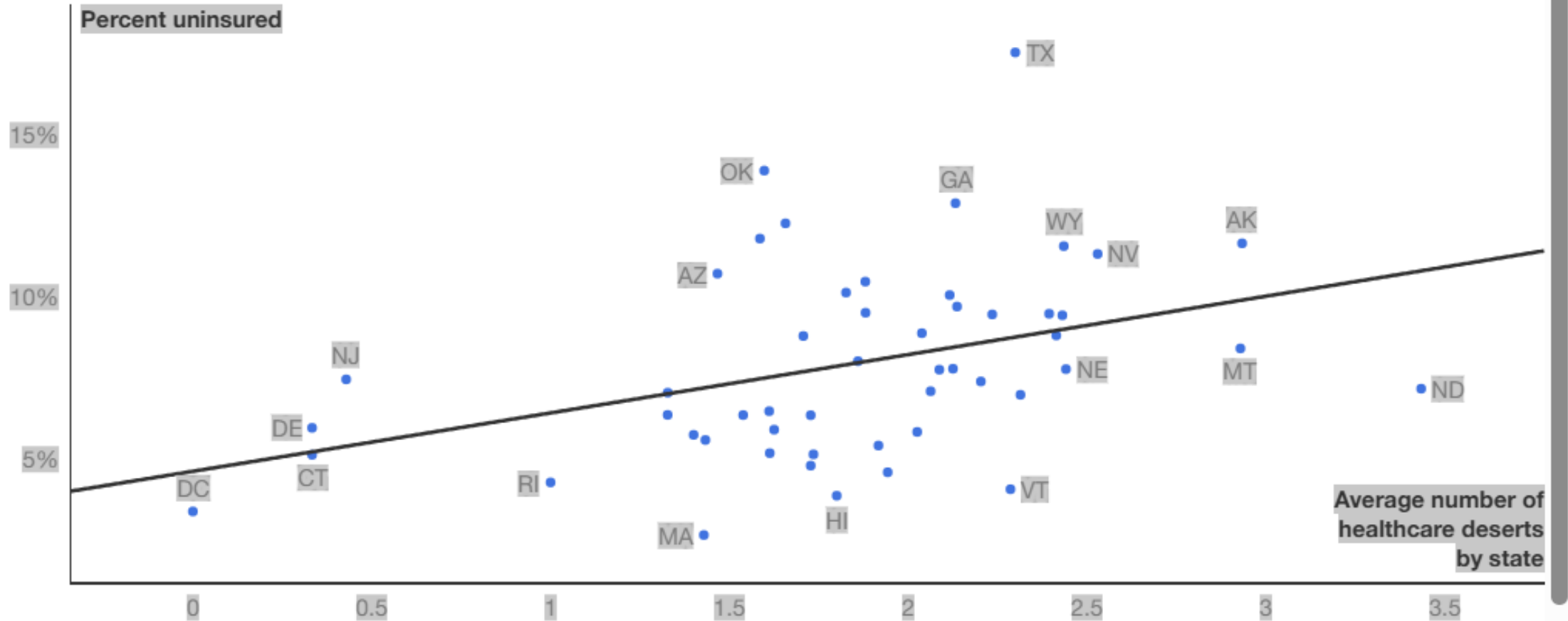


Healthcare Deserts and Percent Uninsured

Insurance

Income

Internet Access

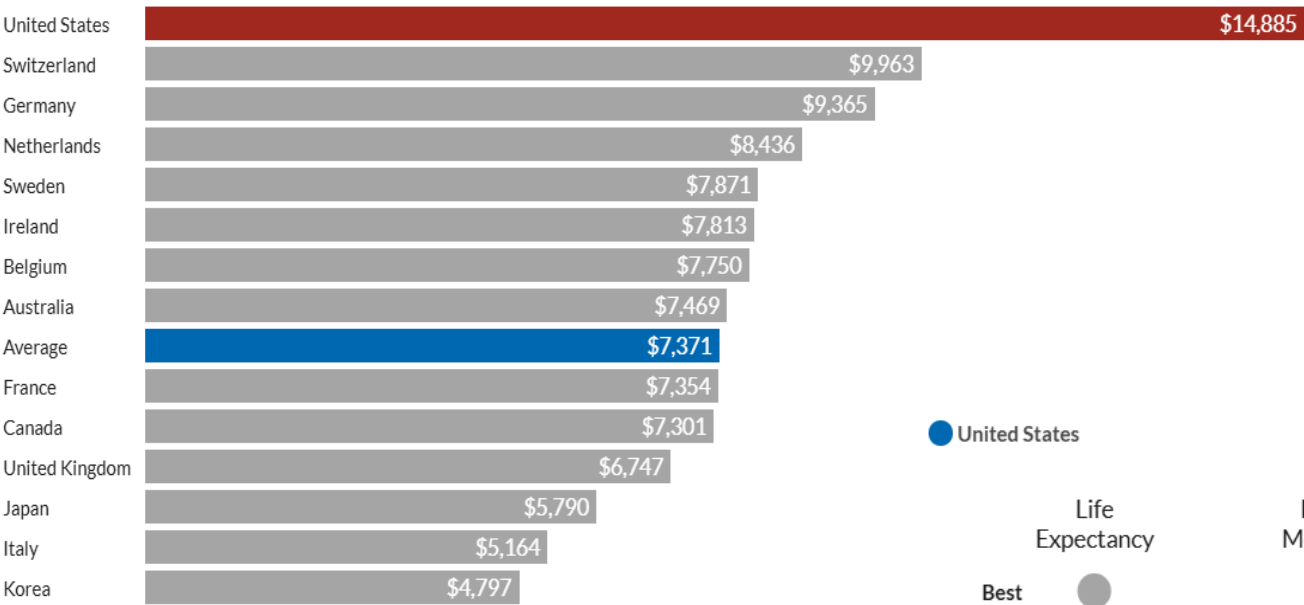


Appendix A: Health Reform Considerations for Charity Care Programs

I. Delivery System		
	2010 – 2013	2014 and Beyond
Benefit design	<ul style="list-style-type: none"> Anticipated higher proportion of undocumented members. Interface with temporary high-risk pools. 	<ul style="list-style-type: none"> Supply of providers willing to participate given a larger insured population. Unknown adaptability of programs to the new charity care population. Unclear health status of the new charity care population, resulting in unknown optimal benefit package and delivery system requirements. Likelihood that charity care programs (except those affiliated with insurance carriers) will not satisfy the individual coverage mandate.
Eligibility and outreach	<ul style="list-style-type: none"> Importance of maintaining current programming to address the growing uninsured population. Role in educating uninsured individuals about possible new coverage options and obligations, and how to transition to these programs in 2014. Role in expanded Medicaid eligibility screening and enrollment. 	<ul style="list-style-type: none"> Need to determine charity care eligibility of those who claim they cannot afford to participate in the exchanges, and mandate “scofflaws.” Challenges of reaching undocumented residents. Role and availability of community partners to enroll members.
Care coordination and patient navigation	<ul style="list-style-type: none"> Help in transitioning the care coordination of members as they move to other coverage. 	<ul style="list-style-type: none"> Cultural competency of providers relative to the new charity care population. System navigation needs of the new charity care population.
II. Business Model		
	2010 – 2013	2014 and Beyond
Financing	<ul style="list-style-type: none"> Anticipated reduction in DSH resources. 	<ul style="list-style-type: none"> Availability of public (e.g., DSH) and private donor funding. Continued support from nonprofit hospitals to meet their community benefit requirements.
Member cost-sharing		<ul style="list-style-type: none"> Potentially different member incentives needed, and willingness to participate in cost-sharing among the new charity care population.
Provider payments and incentives	<ul style="list-style-type: none"> Need to accommodate payment expectations of Medicaid providers now receiving Medicare rates. 	<ul style="list-style-type: none"> Competition from commercial/Medicaid plans offering higher reimbursement rates.

U.S. healthcare spending per capita is twice the average of other wealthy countries

Healthcare Costs per Capita (\$)

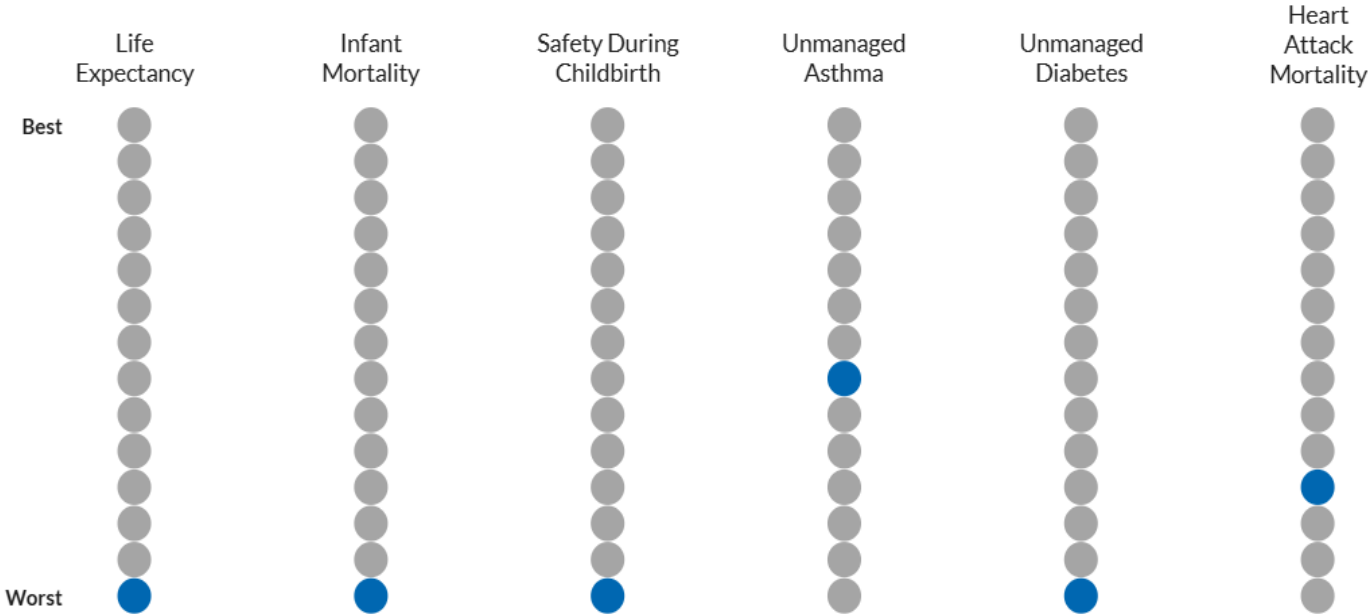


Source: [Organisation for Economic Co-operation and Development](#) • [Embed](#) • [Download image](#)

Notes: Data are for 2024. Average does not include the United States. The five countries with the largest economies and those with both an GDP per capita, relative to all OECD countries, were included. Chart uses purchasing power parities to convert data into U.S. dollars.

US Health Care Spending versus Health Outcomes

● United States

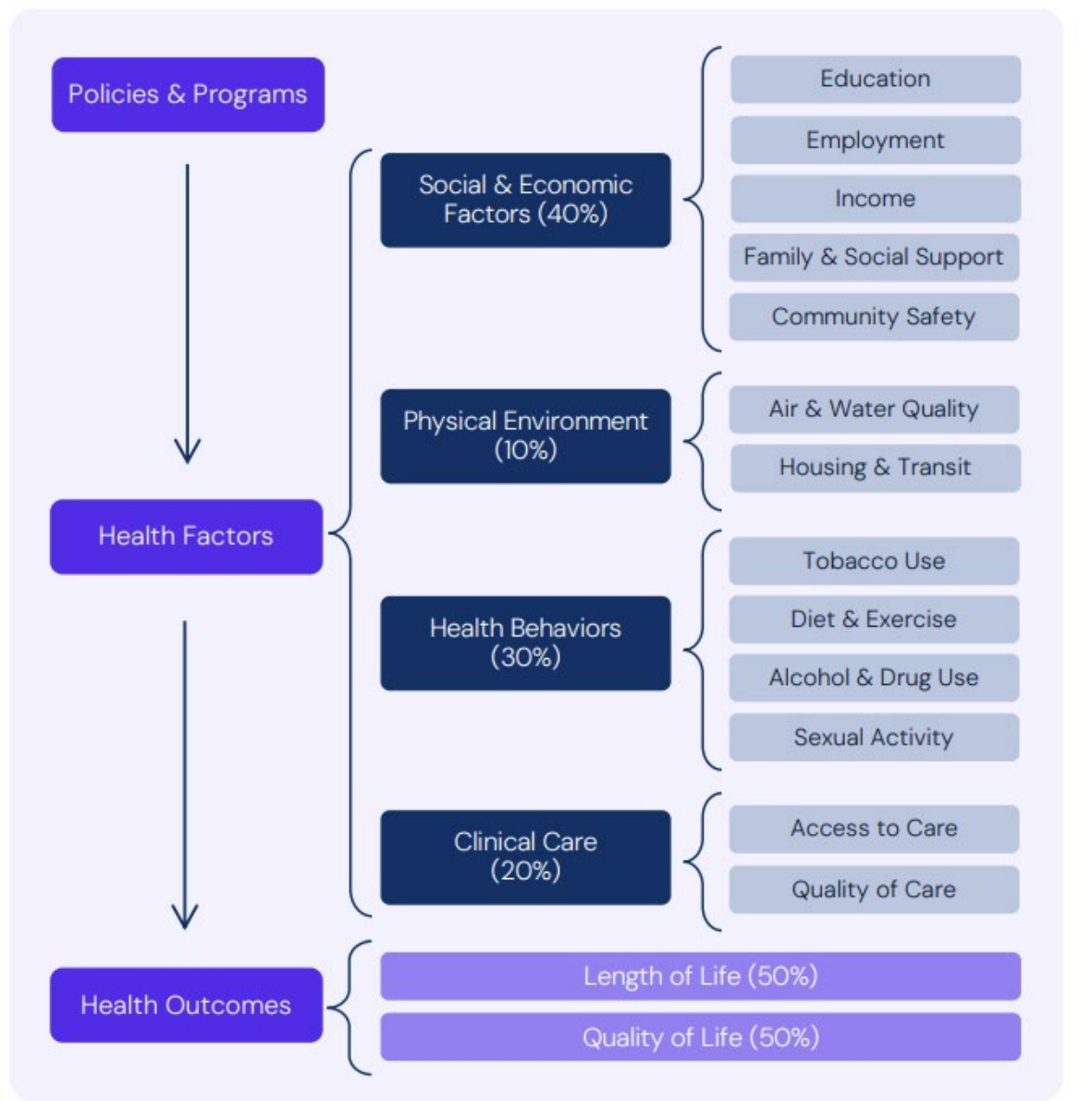


Source: [Organisation for Economic Co-operation and Development](#) • [Embed](#) • [Download image](#)

Notes: Data are for 2023 or latest available.



Framework of Determinant Health Factors



80% of health outcomes driven by non-clinical factors

OB3: Evaluating Impact, Preparing Mitigation Tactics, Challenging Status Quo

Impact

- Higher rates of uninsured
- Increased use of emergency departments
- Higher uncompensated care costs
- Escalate health insurance premiums
- Decrease revenue for mission-driven initiatives
- Flatten or reduce health care workforce
- Diminish health care capacity

Mitigation

- Increase cross sector collaboration and community engagement
- Spark care coordination reforms
- Boost payment reform
- Quell consolidation
- Fuel formation of new provider types and insurance models (mobile medicine, pop up clinics, etc)
- Promote efficiency and paperwork reduction
- Prompt public discussion about tackling health care access, quality and affordability



Strengthening Primary Care Capacity and Support Services to Boost Access, Improve Outcomes & Constrain Costs

- Access to effective primary care contributes to “fewer emergency department visits, preventable hospitalizations, mortality, healthcare expenditures.”
- On average, each additional in-person primary care visit was associated with a total cost reduction of \$721 (per patient per year).
 - first visit achieved largest savings: \$3,976 (average), with savings greater among high-risk patients
 - Among the top 10% of high-risk patients, the first in-person primary care visit reduced costs by 19% (\$16,406).

[The Effect of Primary Care Visits on Total Patient Care Cost: Evidence From the Veterans Health Administration - PMC](#)



Strengthening Primary Care Capacity - Key to Increasing Access and Outcomes, While Reducing Health Care Costs

Improving access to high quality primary care teams requires multiple strategies:

- Payment. Adopt alternative payment models to reward better outcomes
- Capacity: Pay for primary care teams to deliver care, not just doctors, including community health workers, social workers, care coordinators
- Access. Ensure that high-quality primary care is available to individuals and families in every community.
- Workforce. Train primary care teams where people live and work
- Digital Health. Design health information technology that serves the patients, family, and interprofessional care team.

Health Science and Vaccine

Threading a Needle

Stay in touch with us

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**We believe everyone
should have the
opportunity to achieve
optimal health.**

