Federal Healthcare Reform

Legislative Primer

SUBMITTED TO THE 82ND TEXAS LEGISLATURE FEBRUARY 2011

LEGISLATIVE BUDGET BOARD STAFF

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FEDERAL HEALTHCARE REFORM, LEGISLATIVE PRIMER

The federal Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 are expected to make significant changes to the healthcare industry in America. These laws will affect individuals, businesses and governments in the U.S. through broad-reaching reforms in the insurance industry, expansion of health insurance coverage, and new investments in public health. This primer provides an overview of the main aspects of these laws that are expected to affect the state's budget. Taken together, the laws will be referred to as the Affordable Care Act (ACA).

According to the U.S. Census Bureau, Texas led the nation with an estimated 6.4 million uninsured individuals in 2009. This was 26 percent of the Texas population. Projections by the Congressional Research Service indicate that ACA provisions taking effect in 2014 will lead to a drop in the number of uninsured Americans from 50 million in 2013 to 31 million in 2014. In Texas, approximately 1.8 million persons will be added to the state Medicaid program and the Children's Health Insurance Program (CHIP) in fiscal year 2014. The total number of uninsured people in Texas who will receive other types of insurance is difficult to estimate since it depends on the response of individuals to the changes resulting from the ACA.

Figure 1 provides an overview of key provisions of the ACA that directly affect the state's budget. These will be discussed in more detail. Note, however, that there are many provisions that will affect Texans that do not directly affect the state's budget (e.g., tax credits for small employers that provide substantial health insurance coverage). In addition, this primer will only provide information on funding for higher education related to healthcare issues.

FIGURE 1
OVERVIEW OF THE AFFORDABLE CARE ACT, 2010

- Health insurance market reforms.
- Health insurance exchanges.
- Health insurance subsidies.
- Employer mandates.
- Medicaid expansion.
- Primary healthcare workforce expansion
- Higher education funding.

SOURCE: Legislative Budget Board.

While some of the provisions in the ACA took effect immediately upon its enactment, several provisions that will affect the state budget will not be implemented until January 1, 2014 or later. Implementation dates are included in the discussion. The appendix lists key provisions by date of implementation. Because many changes take effect at the beginning of 2014, the state will need to have processes in place to comply with the ACA requirements. For example, development of health insurance exchanges (exchanges) and changes needed to be ready for the expansion in the Medicaid population in 2014 will have to take place before the Eighty-third Texas Legislature convenes.

The ACA requires considerable changes to the health insurance market. Most plans must provide minimum essential health benefits, to be defined by the Secretary of the federal Department of Health and Human Services (DHHS), by January 1, 2014. In general, the ACA defines four levels of health insurance coverage in the individual and small group markets—bronze, silver, gold, and platinum—with the difference being the percentage of healthcare costs paid out by the plans. Grouping into four coverage levels permits easier comparison by consumers across plans. Exceptions are made for plans that provide catastrophic coverage for individuals under the age of 30, unable to afford the coverage, or under other hardships, and for coverage of certain diseases. Plans in effect on March 23, 2010, when the ACA was enacted, are exempted from many of the insurance market reforms, if they maintain their coverage levels and do not significantly increase premiums and cost sharing. These are referred to as "grandfathered" plans. Because of the rapid increase in the cost of healthcare and other reasons, state benefit systems, such as the Employees Retirement System (ERS), may be unable to retain their "grandfathered" status, as they raise premiums and cost sharing to assure sustainability.

A primary goal of the ACA is to expand health insurance coverage. To this end, the law includes a mandate requiring individuals to have health insurance starting January 1, 2014. Employers with at least 50 full-time-equivalent employees are required to provide health insurance coverage by this date or risk a penalty. It provides for the development of exchanges by January 1, 2014, with federal subsidies for

people whose family income is over 100 percent but below 400 percent of the federal poverty level (FPL). It also expands the Medicaid program on January 1, 2014 to most citizens and legal permanent resident noncitizens with income up to 133 percent of the FPL. Incarcerated individuals and undocumented residents are not eligible for coverage through the exchange or Medicaid (except for emergency services).

The ACA includes funding to increase access to primary healthcare. This includes considerable funding to expand Federally Qualified Health Centers, as well as grants and loan forgiveness for students going into primary healthcare professions. Some of this funding has already been allocated.

There are fees that are likely to affect state funding. For example, a direct fee will be imposed on the health insurance sector in fiscal year 2013. The state agencies that negotiate benefits for employees will be subject to this fee. In addition, a new annual fee on pharmaceutical manufacturers (starting in 2011) and an excise tax on the sale of taxable medical devices (starting in 2013) are likely to increase the cost of these services as manufacturers pass these costs on to insurers, including state benefit systems and the Medicaid program.

While this paper discusses many of the provisions that will directly affect state agencies and the state's budget, there are indirect effects that are not accounted for. For example, expanding Medicaid coverage is estimated to cost the state $9.2 billion from fiscal years 2014 to 2019, and bring in an estimated $83.1 billion in Federal Funds. While this increase in spending is likely to have a secondary effect, as healthcare providers and suppliers generate further economic activity, this effect is not addressed in this report.

PART I: HEALTH INSURANCE MARKET REFORMS

MARKET REFORMS

The ACA makes several changes that affect the health insurance market and carriers. **Figure 2** identifies many of the changes that will affect the health insurance market. Most of these are effective at the beginning of the plan year on or after the date listed, unless noted otherwise.

THE TEXAS DEPARTMENT OF INSURANCE

One of the Texas Department of Insurance's (TDI) primary charges is overseeing health insurance carriers. TDI will be responsible for ensuring that health insurance carriers are conforming to the new requirements listed in **Figure 2**. The agency currently reviews insurance forms and policies, and the changes must be reflected in new policies before they are issued. This review process is complicated because "grandfathered" plans are not subject to all of the changes. TDI will have to identify which plans are grandfathered and which are not, essentially having a dual set of regulations. In addition, starting in January 2014, many healthcare policies will have to comply with one of four benefit categories. **Figure 3** outlines the major functions that are likely to fall on TDI.

The ACA requires states to review premium rate increases, and provides $250 million in funding to states for federal fiscal years 2010 to 2014. The Comptroller of Public Accounts (CPA) estimates Texas' share will be $4 million per year, based on population. TDI received $1 million in the first round of grants issued in August 2010. Currently, TDI only requires justification of health insurance rate increases of 50 percent or higher, if there is a change of over 30 percent over three years, or if there are a significant number of complaints. However, TDI may decide to issue rules to use the review process to approve or deny rate increases in the future. The rate reviews will be used in the evaluation of carriers and for their being allowed into exchanges (discussed below). TDI will have to report rate increases to the federal government. TDI requested $3.3 million per year in insurance maintenance tax fees (General Revenue Funds) in an exceptional item in their Legislative Appropriations Request (LAR) to carry this out.

Starting January 1, 2011, insurance carriers will have to spend at least 80 percent (individual and small group market) or 85 percent (large group market) of premium dollars on medical care. Plans that spend less than these amounts are required to provide rebates to enrollees. TDI will be responsible for ensuring that plans adhere to these requirements.

TDI expects a significant increase in the number of consumer complaints as a result of the health insurance changes. It also anticipates the need for additional consumer education about grandfathered plans, individual mandates, employer mandates, and the changes (and timeframes) resulting from the ACA.

The ACA includes a process to redistribute insurance risk when exchanges are first implemented. This is to deal with the possibility of adverse selection, whereby healthier persons choose less expensive carriers and plans. Plans with lower risk profiles will be assessed a fee, to be paid to plans with higher risk profiles. Because requirements in the exchange are more

FIGURE 2
INSURANCE MARKET REFORMS

REFORM	EFFECTIVE DATE
Prohibits policy rescissions except in the case of fraud.	September 23, 2010
Prohibits imposition of lifetime limits on benefits.	September 23, 2010
Prohibits denying coverage to children based on a pre-existing condition, unless the plan is a "grandfathered" plan.	September 23, 2010
Prohibits imposition of annual limits on essential benefits for new plans.	September 23, 2010
Requires carriers that cover dependent children to cover them up to age 26.	September 23, 2010
Requires simplification of administrative and health insurance forms.	September 23, 2010
Prohibits cost-sharing for preventive health coverage, except for "grandfathered" plans.	September 23, 2010
Requires state insurance agencies to review premium rate increases, and issuers to justify unreasonable premium increases. Note: This does not mean approval.	October 1, 2010 (estimated)
Requires carriers in the individual or small group markets to spend at least 80 percent, and carriers in the large group market to spend at least 85 percent of premium dollars on medical care.	January 1, 2011 (actual date.)
Prohibits imposition of annual limits on the cost of essential benefits for all plans.	January 1, 2014
Limits the waiting period after enrolling in a plan to 90 days.	January 1, 2014
Prohibits denying coverage to adults based on a pre-existing condition, unless the plan is a "grandfathered" plan.	January 1, 2014
Limits the amount of deductibles in the small group market to $2,000 for an individual or $4,000 for a family, unless the plan is a "grandfathered" plan or is a low-cost catastrophic-only plan for adults under age 30.	January 1, 2014
Requires most plans in the individual or small group markets to include essential benefits and comply with one of the four benefit categories, unless the plan is a "grandfathered" plan or is a low-cost catastrophic-only plan for adults under age 30 or otherwise exempt.	January 1, 2014
Limits variation in setting premium rates to age, location, individual versus family, and tobacco use.	January 1, 2014
Guarantees issuance to employers and individuals.	January 1, 2014
Limits out-of-pocket spending (i.e., deductibles, co-insurance, and copayments) for families with income up to 400 percent of the FPL.	January 1, 2014 (actual date.)

NOTE: Unless noted, these changes are effective at the beginning of the plan year on or after the date listed.
SOURCE: Legislative Budget Board.

FIGURE 3
MAJOR FUNCTIONS AT THE TEXAS DEPARTMENT OF INSURANCE AS A RESULT OF THE AFFORDABLE CARE ACT

- Review forms and policies for adherence with federal requirements.
- Review premium rate increases and report to the federal government.
- Review percentage of premiums expended for healthcare, and oversee a rebate process.
- Handle consumer complaints.
- Provide consumer education about reforms.
- Operate a transitional reinsurance program to support exchanges.
- License Federal Consumer Operated and Oriented Plans.
- At state option, develop an interstate insurance program.

SOURCE: Legislative Budget Board.

stringent, the exchange is expected to be more costly and likely to benefit from the redistribution. TDI will have to carry this out, or enter into a contract with reinsurance entities to carry this out.

By July 2013, the federal government will establish Consumer Operated and Oriented Plans (CO-OPs). Each state's exchange (discussed below) will include at least two CO-OPs to increase competition. TDI will be responsible for licensing the CO-OPs in Texas. In addition, if Texas decides to allow interstate health insurance, TDI will be involved in developing such a program. This option will be allowed starting in January 2016.

HEALTH INSURANCE CONSUMER ASSISTANCE GRANTS

The ACA includes $30 million nationwide for federal fiscal year 2010 in funding for an ombudsman or independent offices of health insurance consumer assistance. It further

authorizes appropriations for subsequent years as necessary. DHHS awarded Texas $2.8 million in mid-October 2010. While TDI applied for the funding, the funding is available to be used by the Office of the Attorney General, independent state consumer assistance agencies, or other State agencies. States may also contract with non-profit organizations that serve the functions required by the grant.

HIGH RISK POOLS

One of the first programs implemented as a result of the ACA was a federal high risk pool, known as the Pre-existing Condition Insurance Plan (PCIP). This program offers health insurance options for persons with pre-existing medical conditions, if they are U.S. citizens or non-citizens lawfully present in the country, and have not had health insurance coverage within six months of applying for the new coverage. By federal law, premiums are set at the average premium charged to healthy persons in the individual market in each state. The program is to run until the exchanges are operational on January 1, 2014. Of the $5 billion appropriated in the ACA, Texas' share is $493 million over 3-1/2 years.

The ACA encouraged states to implement this program, but allowed states the option to have the federal government implement it. Citing insufficient federal funding and uncertainty regarding implementation, the Governor chose to let DHHS oversee the PCIP in Texas. The program is administered by DHHS in 23 States and the District of Columbia, with the remaining states operating their own programs. DHHS originally projected that 375,000 people nationally would be enrolled in PCIPs by the end of 2010, but as of November 1, 2010, only 8,011 people had enrolled.

The Commonwealth Fund estimates 776,160 Texans are eligible for the PCIP. Applicants in Texas could first sign up on July 1, 2010 to get insurance coverage starting August 1, 2010. As of November 1, 2010, about 400 Texans had enrolled in the federal program. Enrollment in PCIPs in other states is also very low, seldom covering even one percent of the estimated eligible population. **Figure 4** provides information for the five most populous states.

The PCIP in Texas had only one plan option in 2010, with one deductible for all medical services, including prescription drugs. However, on January 1, 2011, the PCIP in Texas began offering three plan options–Standard, Extended, and Health Savings Accounts (HSAs)–with five age groupings. These plans have different levels of premiums, annual deductibles, prescription drug deductibles and prescription drug copayments. **Figure 5** summarizes the new plans. The Standard and Extended plans vary primarily on the cost of monthly premiums, annual and prescription drug deductibles, and copayments for prescription drugs. The HSA plan provides an opportunity to open a tax-exempt account where a person can deposit funds for eligible medical expenses. It has lower premiums and higher deductibles than the other plans. However, it does not have a separate prescription drug deductible. All of the plans have an annual out-of-pocket maximum of $5,950 for in-network services and $7,000 for out-of-network services. The annual out-of-pocket maximum includes prescription drugs.

FIGURE 4
PRE-EXISTING CONDITION INSURANCE PROGRAM (PCIP) ENROLLMENT FOR THE FIVE MOST POPULOUS STATES, NOVEMBER 2010

STATE	POPULATION (IN MILLIONS)	PCIP ELIGIBLE	PCIP ENROLLMENT	PERCENT ENROLLED OF ELIGIBLE	PROGRAM START DATE	RUN BY
California	37.0	872,802	513	.06%	October 25	State
Texas	24.8	776,160	393	.05%	August 1	Federal agency
New York	19.5	339,192	201	.06%	October 1	State
Florida	18.5	478,170	293	.06%	August 1	Federal agency
Illinois	12.9	219,618	664	.30%	September 1	State

NOTE: Of these states, only New York does not operate a state-based risk pool. Population is as of July 1, 2009. PCIP enrollment is as of November 1, 2010. Program start dates are in 2010.
SOURCES: U.S. Census Bureau; U.S. Department of Health and Human Services; Commonwealth Fund.

FIGURE 5
FEDERAL PRE-EXISTING CONDITION INSURANCE PLANS AS OF JANUARY 1, 2011

PLAN OPTIONS	MONTHLY PREMIUMS	ANNUAL DEDUCTIBLES	ANNUAL PRESCRIPTION DRUG DEDUCTIBLES
Standard	$174 to $557	$2,000	$500
Extended	$234 to $749	$1,000	$250
Health Savings Accounts	$181 to $578	$2,500	$0

NOTE: The range of monthly premiums is based on age groupings, with persons under age 19 paying the lowest premiums and persons over age 54 paying the highest.
SOURCE: U.S. Department of Health and Human Services.

By offering three plans in 2011, the PCIP allows enrollees to choose a plan based on their individual needs. Persons reluctant to join the PCIP because it was so limited might be more likely to enroll in 2011. With this change, DHHS estimates that premiums in the Standard Plan in 2011 will cost enrollees about 20 percent less than in 2010. Each of the three plan options provides preventive care without cost-sharing. After meeting the deductible, participants will pay 20 percent of in-network medical costs. There is no lifetime maximum or cap on the amount the plan pays for a person's care. Furthermore, adding an annual deductible specific to prescription drugs will provide a cost-effective option to enrollees who anticipate high pharmaceutical but not high medical costs

Texas operates a state-based high risk pool, known as the Texas Health Insurance Pool (THIP). THIP began operations on February 1, 1998. It receives no appropriations in the state budget. Operating costs and claims are funded primarily by premiums. In contrast to the PCIP, THIP premiums are set at up to twice the average premium charged to healthy persons in the individual market in Texas. The state assesses automatic fees on health insurance carriers for any costs that exceed collected premiums. The assessments are based on the carriers' share in the health insurance market in Texas. In 2009, THIP collected $198.6 million in premiums and $77 million in assessments from insurance companies.

In November 2010, THIP enrollment was 26,478 persons. Between November 2009 and October 2010, the number of new policies issued each month ranged from 491 in November 2009 to 682 in March 2010. THIP has five plans that vary by cost of premiums, deductibles, and out-of-pocket maximums. Premiums differ based on age, gender, tobacco use, and geographic location. Having a variety of plans has provided options for consumers. However, in general, a person's pre-existing condition is not covered until a year after they enroll, in spite of having no waiting period before other medical care is covered. **Figure 6** compares THIP with the 2010 PCIP in Texas.

FIGURE 6
COMPARISON OF TEXAS HEALTH INSURANCE POOL (THIP) AND THE FEDERAL PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) IN TEXAS, 2010

	TEXAS HEALTH INSURANCE POOL	PRE-EXISTING CONDITION INSURANCE PLAN
Monthly premiums	$160 to $2,207	$323 to $688
Annual Deductible	$1,000 to $7,500	$2,500
Annual Out-of-Pocket Spending Maximum	$3,000 to $12,500	$5,950
Waiting period for pre-existing conditions	12 months	No waiting period
Preventive care	No cost	No cost

NOTES: Monthly premiums in THIP vary based on age, gender, tobacco use, and geographic location; premium differences in PCIP are based only on age. The THIP out-of-pocket spending maximums pertain only to services provided by Preferred Provider Organizations.
SOURCES: U.S. Department of Health and Human Services; Texas Health Insurance Pool.

Certain plans in THIP may be better for individuals in certain situations, but the PCIP generally has lower out-of-pocket costs for lower premiums. The low enrollment in the PCIP has several possible explanations. First, the PCIP is restricted to people who have not had insurance within the last six months. Texans in the state-run high risk pool will not be allowed in the PCIP unless they drop their current insurance for six months. In general, this is an unlikely choice for those dependent on coverage due to a serious medical condition. Likewise, people with serious pre-existing medical conditions who lose private insurance coverage are not likely to want to wait if they can afford THIP coverage.

Second, even though the PCIP premiums and deductibles are generally lower than those offered through THIP, specific plans in THIP may better suit individuals. The lack of choice of premiums and coverage offered by the PCIP in 2010 may have led Texans to enroll in a THIP plan rather than the PCIP.

Third, THIP offered better coverage for high-range prescription drugs in 2010. The highest cost plan included a $1,250 prescription drug deductible and a $1,500 pharmacy copayment maximum. The maximum annual out-of-pocket prescription drug cost was thus $2,750. In comparison, the PCIP in 2010 had no cost-sharing maximum specific to pharmacy costs. Enrollees could reach the out-of-pocket annual limit of $5,950 with just prescription drug expenses. An individual with high pharmacy costs but low non-pharmacy medical expenses would probably benefit more from the Texas Health Insurance Pool.

While there could be some decrease in the number of applicants for the state's high risk pool from persons who do not already have health insurance, TDI does not expect this to be significant.

EXCHANGES

About 6.4 million Texans or about 26 percent of the state's population lack health insurance coverage. The ACA requires the development of state health insurance exchanges to provide convenient access to health insurance and to help individuals and small businesses purchase it. While many of the uninsured Texans would qualify for an expanded Medicaid program (discussed below), a significant number of them would meet the criteria for purchasing insurance through an exchange. **Figure 7** lists the main functions exchanges are required to serve.

The ACA requires plans inside the exchange to offer at least one plan at the silver level and one at the gold level of coverage. However, low-cost catastrophic-only plans are available for adults under age 30 and individuals exempt from the individual mandate due to cost or other hardship. In addition, the ACA directs the federal Office of Personnel Management to enter into contracts with health insurance carriers to offer at least two multi-state qualified health plans through each exchange in each state. Participants in exchanges and in the "outside" market are considered to be in the same risk pool for a given carrier, and carriers must agree to charge the same premium rate for each of its health plans whether the plan is offered through an exchange or outside the exchange.

An exchange has considerable latitude in determining which health plans it will allow. For example, exchanges can decide whether to be open to any plan that meets specific requirements, or to limit the number of participating plans through a negotiation or bidding process. This decision will not only determine how costly the exchange will be to run, but also could affect the cost of plans within the exchange. Limiting the number of plans would probably make decision-making easier for consumers, but would also limit their choices. Conversely, the bidding process might result in more competition and hence lower the cost of plans in the exchange. Analyses to inform this decision are not currently available, but TDI has indicated that it will be hiring a consultant to work through the issue for Texas. The agency hopes to have information for the upcoming legislative session.

States may develop and operate one or more exchanges themselves or contract with non-profit entities; however, the federal government will develop exchanges if states refuse to or do not meet federal standards. If the legislature decides to have the state develop and operate the exchange, it must decide who will do so. While the ACA allows for separate exchanges for the individual and the small group markets, states are allowed to combine these into a single exchange. In addition, states can decide to have a statewide exchange or several regional exchanges. Exchanges must be operational by January 2014, and federal funding is available for planning and early implementation. However, exchanges must be self-sustaining by January 1, 2015, and states have to decide how ongoing operations will be funded. Texas was awarded an initial $1 million planning grant on September 30, 2010.

FIGURE 7
HEALTH INSURANCE EXCHANGE FUNCTIONS

- Certify health plans to be in the exchange and rate them.
- Collect information to determine federal premium tax credits and cost-sharing subsidies; certify that an individual is exempt from the requirement to get health insurance coverage based on income; coordinate information and funding between the U.S. Department of the Treasury, DHHS, and health plan issuers regarding subsidies.
- Screen and refer to, or determine eligibility for Medicaid and Children's Health Insurance Program (CHIP), in coordination with the Texas Health and Human Services Commission (HHSC).
- Coordinate with employers, including payment of "Free Choice" vouchers from employers to health plan issuers.
- Establish a "Navigator" program to carry out certain outreach and education duties.
- Maintain a website and toll-free hotline.
- Gather data and report to the federal government.
- Implement quality activities.
- Develop effective appeals processes.

SOURCE: Legislative Budget Board.

DHHS is expected to provide more funding for planning activities at a later date.

The ACA limits out-of-pocket expenses for families up to 400 percent of the FPL. Exchanges are responsible for providing information to DHHS to determine eligibility for federal premium tax credits or cost-sharing subsidies for people who get insurance coverage through the exchange, and whose family income is between 100 percent and 400 percent of the FPL. In performing this function, exchanges may need to collect information regarding the health insurance offered by the person's employer, who could be assessed a penalty under certain circumstances. The exchange and insurance providers will be notified when the individual qualifies for subsidies.

States also have the option to create a Basic Health program for uninsured individuals with incomes from over 133 percent to 200 percent of the FPL, who would otherwise be eligible to receive premium subsidies in the exchange. Federal funding for these individuals is 95 percent of the amount the federal government would have paid through federal premium and cost-sharing subsidies.

Most Texans whose incomes are 133 percent of the FPL or lower will be eligible for Medicaid. The ACA indicates that exchanges must enroll persons in Medicaid or CHIP if the exchange determines they are eligible for these programs. The exchange has to coordinate closely with the state Medicaid and CHIP office at HHSC. Conversely, the state Medicaid office has to refer a qualified individual that is not eligible for Medicaid or CHIP to the exchange. DHHS has not yet issued guidance on whether persons eligible for Medicaid or CHIP can receive subsidies in the exchange, or what would happen if a state decides not to participate in the Medicaid and CHIP programs.

Decisions regarding whether requirements of plans inside the exchange will be applied to plans outside of the exchange need to be made to avoid adverse selection. Having the same requirements in both markets would result in a more even playing field, increasing the likelihood that the exchange will remain solvent and successful.

The ACA includes mandated benefits, federal guidance about which will be developed by DHHS. State mandates that go beyond these are allowed, but the state is liable for the cost for these benefits to plans within the exchange. In order to limit the liability to the state when the exchange is operational, the Legislature may want to consider modifying the list of benefits that insurance carriers must offer in the state.

For more in-depth analysis of exchanges in Texas, see Develop and Operate a State Health Insurance Exchange to Comply with Federal Standards in the *2010 Government Effectiveness and Efficiency* report by the Legislative Budget Board.

MULTI-STATE COMPACTS

The ACA includes a provision to allow two or more states to enter into an agreement to allow one or more qualified health plans to be offered in the individual market in each state. The issuer would only be subject to most of the laws and regulations of the state in which the plan was written or issued. The issuer, however, would still be subject to certain practices and consumer protections of the state in which the purchaser resides, and would be required to be licensed in all the states in which it operates. This provision is not effective before January 1, 2016.

OTHER FUNDING

As a result of the mandate for individuals to have health insurance coverage by 2014, more insurance policies will be sold. Texas has a fee on each policy sold, so the increase in the number of policies will result in an increase in the fees paid to the state treasury. The Comptroller of Public Accounts estimates that state insurance premium taxes for those enrolling in private insurance plans will increase by $1.3 billion from 2010 to 2019 due to the ACA.

PART II: IMPACTS ON THE STATE AS AN EMPLOYER

STATE EMPLOYEE BENEFIT SYSTEMS

The ACA imposes several requirements on employers. Four systems in Texas government provide employee and retiree health benefits: the Employees Retirement System (ERS), the Teacher Retirement System (TRS), The University of Texas System,(UT-System) and the Texas A&M University System (TAMU). Federal guidelines indicate that retiree-only health plans, such as TRS-Care, are not subject to most of these requirements. In contrast, the health benefits provided through the other systems are subject to most of the ACA provisions identified in **Figure 2.** Because these agencies already meet most of these standards, these changes will have little effect on them. However, some of the requirements, such as elimination of cost sharing for preventive services, could result in the need for higher premiums from plan participants or more funds from other funding sources. As mentioned earlier, while the health plans in these agencies could be "grandfathered," modifications required to assure plan soundness means they probably will not. ERS covered

489,075 employees, retirees and dependents under their healthcare plan in 2010. TRS estimates it had 202,778 retirees and dependents under their healthcare plan in 2010. This does not include active teachers, who are covered through local school districts. UT-System and TAMU covered 34,700 and 16,833 individuals, respectively, in 2010 using state funding. Another 64,024 people were covered under the Higher Education Government Insurance program through ERS in 2010.

EARLY RETIREE REINSURANCE PROGRAM

The Early Retiree Reinsurance Program is a temporary program that reimburses employment-based health insurance plans for high medical expenses of their retirees ages 55 and older who are not eligible for Medicare. The reinsurance covers annual health expenses falling between $15,000 and $90,000 for each person during the plan year. For the first year, only plan year expenses exceeding $15,000 on or after June 1, 2010 are considered. Insurance plans must have programs in place that generate cost savings for high-cost or chronic conditions to be eligible for the reinsurance. Reimbursements cannot go into the General Revenue fund, but must be used in the health insurance programs. For example, the TRS reimbursement will go into their healthcare trust fund.

The program provides $5 billion in funding nationwide, and the amounts that will be provided to any given plan will depend on the total amount requested by all plans. In Texas, ERS, TRS, UT-System, and TAMU have been approved to receive this funding. **Figure 8** shows the amounts granted to or requested by these systems. Note that these systems are not guaranteed the amounts they have requested. On the other hand, any reimbursement received can be used to support the health insurance offered by these plans. While the program is established through December 31, 2013, funding is not expected to be available for that long, and some anticipate it ending as early as 2012.

FIGURE 8
EARLY RETIREE REINSURANCE PROGRAM REIMBURSEMENTS GRANTED TO OR REQUESTED BY STATE BENEFIT SYSTEMS FISCAL YEARS 2010 AND 2011 (IN MILLIONS)

	FISCAL YEAR 2010 (JUNE – AUGUST) GRANTED	FISCAL YEAR 2011 REQUESTED
Employees Retirement System	$21	$48
Teacher Retirement System	47	120
The University of Texas System	0	10
Texas A&M System	1	4
Total requested	**$69**	**$182**

SOURCES: Employees Retirement System; Teacher Retirement System; The University of Texas System; Texas A&M System.

FREE CHOICE VOUCHERS

Employees with income under 400 percent of the FPL, who cannot afford health insurance offered by their employers, can receive federal subsidies through an exchange, as mentioned earlier. However, if their employer has 50 or more full-time equivalent employees, the employer will be assessed a fine unless the employer provides to the exchange an amount equal to what the employer would have paid for that employee's premium. This is called a Free Choice Voucher. State benefit systems anticipate providing Free Choice Vouchers for the relevant employees in order to avoid the fines. In general, the fine is equal to $250 per month per full time employee receiving a federal subsidy. At this time, state benefit systems are unable to estimate their costs, since the number of full time employees that will request and receive a subsidy is unknown. Since federal regulations have not been issued, how the Free Choice Voucher amount will be determined is also unknown.

PATIENT-CENTERED OUTCOMES RESEARCH

Another cost to state benefit systems is a fee for patient-centered outcomes research. The fee is paid by health insurance plans to the federal government, which will provide funding for research in the provision of healthcare to improve outcomes for patients. According to DHHS, Patient-Centered Outcomes Research "compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations. The goal is to empower you and your doctor with additional information to make sound healthcare decisions." The savings from these improvements, if realized, cannot be estimated at this time. The fee will be assessed beginning with the plan year that ends in August 2013. The fee per covered life is $1 in 2013; $2 in 2014; and adjusted thereafter for inflation through 2019.

Figure 9 shows the additional funding ERS, UT-System, and TAMU have estimated they will need in appropriations in fiscal years 2012–13. TRS indicates that this provision will have minimal effect on it. More federal guidance is expected in 2011. **Figure 9** does not include funding from non-appropriated funding sources such as beneficiary

FIGURE 9
SELECTED ANTICIPATED COSTS FOR TEXAS STATE BENEFIT SYSTEMS
2012–13 BIENNIUM

PROVISION		EMPLOYEES RETIREMENT SYSTEM	THE UNIVERSITY OF TEXAS SYSTEM	TEXAS A&M SYSTEM	TOTAL COST
Patient-Centered Outcomes Research Fee	General Revenue Funds and General Revenue–Dedicated Funds	$190,838	$43,000	$18,750	$252,588
	All Funds	$309,000	$43,000	$18,750	$370,750
Expanding Coverage to Dependents Up to Age 26	General Revenue Funds and General Revenue–Dedicated Funds	$9,932,244	$1,554,531	$1,227,916	$12,714,691
	All Funds	$16,082,000	$1,554,531	$1,227,916	$18,864,447
Eliminating Cost-Sharing for Certain Preventive Care	General Revenue Funds and General Revenue–Dedicated Funds	$18,390,275	$2,738,936	$1,339,200	$22,468,411
	All Funds	$29,777,000	$2,738,936	$1,339,200	$33,855,136

NOTE: Includes only the share of costs requiring an appropriation; does not include beneficiary contributions or other non-appropriated funding.
SOURCES: Employees Retirement System; The University of Texas System; Texas A&M University System.

contributions or payments out of agency or institution trust funds. The cost in 2014 will be about twice the amount in 2013.

EXPANDING COVERAGE TO DEPENDENT CHILDREN UP TO AGE 26

Starting in fiscal year 2012, state benefit systems are required to cover dependent children up to age 26, if they cover dependent children. Coverage is required even if the child is married, but will not cover any grandchildren. Currently, children are covered up to age 25, and lose coverage if they marry. **Figure 9** shows the additional funding ERS, UT-System, and TAMU have estimated they will need in appropriations to expand coverage to dependent children up to age 26. This is not the total cost. For example, based on information from ERS' Legislative Appropriation Request, this provision will cost their plan $32.2 million over the biennium, but only $16.1 million is from appropriated funds.

ELIMINATING COST-SHARING FOR CERTAIN PREVENTIVE CARE

As indicated in **Figure 2**, certain preventive services will have to be covered by health insurance with no co-payments or other cost-sharing. The cost of this provision for ERS, UT-System, and TAMU are identified in **Figure 9**.

STATE KIDS INSURANCE PROGRAM

The State Kids Insurance Program (SKIP) is a state-funded program that subsidizes the health insurance premiums for children of state employees whose income is under 200 percent of the FPL. The FPL was $22,050 per year for a family of four in 2010. The SKIP program was developed because the federal CHIP law did not allow these children onto CHIP. ERS estimates an average monthly enrollment of approximately 13,000 children on SKIP in fiscal year 2010.

The ACA changed the CHIP prohibition, allowing children of state employees to enroll in CHIP if:

1. the agency spent more per employee on insurance coverage in the preceding federal fiscal year than they did in federal fiscal year 1997, adjusted by the Consumer Price Index, or
2. the state determines, on a case-by-case basis, that the employee's family spent more than 5 percent of their annual income on insurance premiums and cost-sharing.

This provision was effective upon enactment of the ACA in March 2010.

Under CHIP in Texas, there is an enrollment fee of up to $50 per year, but no monthly premiums. Copayments range from $0 to $10 for office visits and $0 to $20 for prescription drugs. Copayments are capped at 1.25 percent to 2.5 percent of family income, based on a sliding scale.

Under state employment, the state pays the entire premium for the state employee, and half of the premiums for their dependent/family coverage; the other half is the responsibility of the state employee. With SKIP, the state pays for both the state's half of the cost of the premiums for dependent children and most of the employee's half of the premium through the

SKIP subsidy. In fiscal year 2011, state employees' share of premiums to cover their children at ERS range from $137 to $168 per month without the SKIP subsidy. With the SKIP subsidy, employee premiums are $15 or $25 per month. Premiums are the same for all families in a given plan, irrespective of the number of children covered. All of the employees' unmarried children under age 25 can be covered. SKIP, however, only covers children up to age 19. In addition, families have to pay deductibles and copayments for healthcare services they receive. Under ERS' HealthSelect program, for example, the copayment to see a primary care physician is $25; specialists cost $40 per visit. Furthermore, employees could pay up to $2,000 in coinsurance per person per year for in-network services; out-of-network coinsurance maximums are considerably higher.

Hence, the cost to families that enroll their children in CHIP is considerably lower than having coverage under plans available through ERS. If SKIP funding to subsidize the cost of insurance premiums for the children is eliminated, many of these low-income families would be unable to pay the employee portion of the health insurance premium to cover their families at ERS, but could seek healthcare coverage under CHIP. Note that without SKIP, families that have children ages 19 to 25 would be responsible for the cost of premiums at ERS for the older children since they are ineligible for CHIP. The state would still pay its share of the premiums for these children. If the state employee did not choose to enroll them, the 19 to 25 year old children could also become uninsured.

If the state were to eliminate SKIP, the state could expect to have reductions in the cost to General Revenue Funds for several reasons. First, there will be savings of the actual SKIP subsidy payments. General Revenue Funds for the subsidies in SKIP would be about $12.8 million in 2012–13. Second, the premium cost per child to the state for CHIP is lower than its cost under SKIP. CHIP funding is about 30 percent General Revenue Funds and 70 percent Federal Funds, while SKIP funding is about 58 percent General Revenue Funds and 42 percent other funds available to ERS. General Revenue Funds directed towards premiums for children of families in SKIP is estimated at $14.1 million in 2012–13, compared with a cost of $10.7 million in General Revenue Funds for the same number of children in CHIP. Third, if employees cannot afford the ERS premiums for the children and do not enroll them in CHIP, the state will not be subsidizing the healthcare for the employee's children in either system, and will not incur the cost of the healthcare. These savings are not estimated. Net savings in General Revenue Funds if SKIP is eliminated is estimated to be $16.2 million over 2012–13. Without a SKIP program, these funds could be used by the state for other purposes.

OTHER PROVISIONS IMPACTING STATE EMPLOYEE BENEFIT SYSTEMS

Figure 10 lists other provisions that could affect health plans operated by state benefit systems. The effect of most of these provisions cannot be determined at this time. Some require federal guidance and others are based on unpredictable behavior of individuals or businesses.

PART III: MEDICAID, CHIP, AND OTHER PUBLIC HEALTH PROGRAMS

MEDICAID

In addition to requirements around the development of exchanges, the ACA expands health insurance coverage through the Medicaid program. The Medicaid program provides financial assistance to states for payments of medical assistance on behalf of cash assistance recipients; children, pregnant women, and the elderly who meet income and resource requirements; and other categorically eligible groups. Starting in January 2014, Medicaid will be available to most citizens and legal permanent resident noncitizens with income up to 133 percent of the FPL, who are not eligible for Medicare. The ACA allows for a five percentage point exclusion of income, making the effective income limit 138 percent of the FPL. Except for emergency services, undocumented residents are ineligible for Medicaid. Incarcerated individuals also are not eligible. Determination of income will be simplified and will be based on a modified version of the Internal Revenue Service's adjusted gross income, except for aged and disabled populations.

Figure 11 shows the estimated number of people, averaged from fiscal years 2014 to 2023, that will be added to Medicaid and CHIP because of the ACA, according to HHSC. Currently, few non-disabled adults qualify for Medicaid coverage, so this group comprises most of the newly eligible. In addition, HHSC anticipates a significant number of people who qualify for Medicaid, but are not enrolled, will decide to enroll because of the individual mandate in the ACA. HHSC estimates that Medicaid and CHIP will increase by 739,284 people, on average over fiscal years 2014 to 2023, as a result of this "woodwork" effect. Further, the expansion increases the income limit for children ages 6 to 18 from 100 percent to 133 percent of the FPL These

FIGURE 10
OTHER PROVISIONS LIKELY TO IMPACT STATE EMPLOYEES BENEFIT SYSTEMS

PROVISION	DESCRIPTION	EFFECTIVE DATE
New fees on pharmaceutical manufacturing sector	Adds new fees to the pharmaceutical manufacturing sector. While not directly costing the state's employee benefit systems, the new fees are likely to be passed on to health insurance plans, resulting in pressure to raise premiums, copayments, or state funding.	January 1, 2011
Changes to the Medicare prescription drug program	Reduces the coverage gap known as the "donut hole" in the Medicare prescription drug program over several years. In doing so, it may result in state employee benefit systems losing their "actuarial equivalency" rating that allows them to receive a federal subsidy for the prescription drugs they cover for Medicare participants. At this time, the effect is unknown.	January 1, 2011
Reduced contribution limits to flexible spending accounts	Lowers the limit on contributions to flexible spending accounts from $5,000 to $2,500 per family per year. Lowering the contribution limit results in higher taxable income, which will increase the amount of employer taxes having to be paid by the benefit systems. ERS indicates that about 15 percent of persons using flexible spending accounts are contributing more than $2,500 per year.	January 1, 2013
90-day waiting period	Prohibits a waiting period of more than 90 days to be covered by employer-sponsored health insurance after enrollment. Current state employee benefit systems start health insurance coverage on the first day of the calendar month after 90 days have passed. ERS estimates this will cost $118.9 million from fiscal years 2014 to 2019.	September 1, 2014
Excise tax on insurers	Adds a 40 percent excise tax on insurers on the aggregate value of health plans exceeding $10,200 per individual or $27,500 per family. ERS and TRS have indicated that their plans could be subject to this tax in the future.	January 1, 2018

SOURCES: Legislative Budget Board; Comptroller of Public Accounts.

FIGURE 11
AVERAGE NET CHANGE IN THE NUMBER OF PEOPLE ON MEDICAID AND CHIP, BY CATEGORY
FISCAL YEARS 2014 TO 2023

CATEGORY	NUMBER
Medicaid currently eligible, not enrolled	567,074
Medicaid Expansion, adults	1,388,194
CHIP currently eligible, not enrolled	172,210
TOTAL	**2,127,478**

NOTE: About half of those identified as "CHIP currently eligible, not enrolled" will be enrolled under Medicaid due to the higher income limits in 2014.
SOURCE: Health and Human Services Commission.

children are currently in the CHIP program, so will move over to Medicaid, with no net change anticipated.

The newly eligible populations will be 100 percent federally funded from 2014 to 2016. It then declines to 90 percent by 2020. At the same time, the federal share of funding for CHIP increases by 23 percentage points from October 2015 through September 2019. **Figure 12** shows the federal medical assistance percentages (FMAPs) from 2014 to 2020 for newly eligible populations in Medicaid and for CHIP.

Figure 13 provides an estimate of the additional state funding required to cover the healthcare costs of the new people on Medicaid and CHIP, as well as the additional federal funding that would come to the state. The ACA requires states to increase Medicaid rates for primary care services provided by primary care physicians to the Medicare rate in calendar years 2013 and 2014. **Figure 13** assumes the rates for CHIP will be the same as the rates for Medicaid. Federal financial participation for the increase in the Medicaid rates will be 100 percent for these two years. After 2014, it is up to states to maintain the higher rates or to lower them. The fiscal estimates in **Figure 13** assume the rates will not return to the lower level (i.e., that they will continue at the Medicare level). This amount includes $300 million to $500 million in General Revenue Funds per year after 2014 to maintain payments at the Medicare level. It includes another $500 million to $1 billion in General Revenue Funds per year in fiscal years 2016 to 2023 to extend the rate increase to all primary care services and doctors, which HHSC says will be necessary to keep primary care providers in the Medicaid and CHIP programs. Note that the relatively small increase in the cost to the state in fiscal year 2016 in **Figure 13** reflects the increase in the federal share of CHIP. The cost to the state increases appreciably in fiscal year 2017 because the federal share of Medicaid for new populations begins to decline.

FIGURE 12
FEDERAL SHARES FOR NEWLY ELIGIBLE PERSONS IN MEDICAID AND FOR CHIP
2014 TO 2020

CALENDAR YEAR	FEDERAL MEDICAID PERCENTAGE	FEDERAL FISCAL YEAR	FEDERAL CHIP PERCENTAGE (ESTIMATED)
2014	100%	2014	70%
2015	100%	2015	70%
2016	100%	2016	93%
2017	95%	2017	93%
2018	94%	2018	93%
2019	93%	2019	93%
2020	90%	2020	70%

SOURCE: Legislative Budget Board.

FIGURE 13
ESTIMATED NET FISCAL IMPACT OF HEALTHCARE REFORM ON MEDICAID AND CHIP
FISCAL YEARS 2014 TO 2019 (IN MILLIONS)

FISCAL YEAR	ADDITIONAL FEDERAL FUNDING	NET COST TO THE STATE
2014	$10,051	($840)
2015	$11,252	($1,022)
2016	$14,159	($1,174)
2017	$14,781	($1,797)
2018	$15,867	($2,057)
2019	$17,032	($2,347)

NOTE: Only includes the effect on client services.
SOURCE: Health and Human Services Commission.

To qualify for federal Medicaid funding, states are prohibited from making "eligibility standards, methodologies, and procedures" more restrictive for adults until state exchanges are operational (in January 2014), and for children through September 2019. DHHS will need to fully define these terms, but similar terms were used in the American Recovery and Reinvestment Act of 2009 (ARRA). Under ARRA, states could not reduce maximum income levels or lower the number of waiver slots available. States were only allowed to lower rates paid to providers and eliminate or reduce optional services.

In the Texas Health and Human Services System Consolidated Budget, HHSC identifies funding it will need in 2012–13 in response to the ACA. The main impacts result from the interaction of the Medicaid and CHIP programs with the exchange and from the expansion of Medicaid. The funding is primarily to ensure that the technological infrastructure to handle the interactions with the exchange and the increased workload associated with the Medicaid expansion is in place by January 2014.

After HHSC published the Consolidated Budget, DHHS released a proposed rule to provide enhanced federal funding for changes to Medicaid automated systems related to exchanges and eligibility determination. Once finalized, states that meet the requirements in the rule would receive 90 percent or 75 percent federal funding for the design, development, installation, or enhancement of their Medicaid automated systems. The 90 percent federal funding is available through calendar year 2015. The 75 percent federal funding would be available after 2015 if the systems continue to meet the federal requirements.

Assuming the higher match rates where appropriate, HHSC estimates a cost of $7.6 million in General Revenue Funds ($24 million in All Funds) to connect with the exchange. It estimates a cost of $16.6 million in General Revenue Funds ($61.0 million in All Funds) to build system capacity for the Medicaid expansion.

Changes in the ACA related to prescription drug funding will also affect Texas. Starting retroactively in January, 2010, the federal share of the rebate of prescription drugs under the Medicaid program increased. Prior to the ACA, manufacturers were required to rebate 15.1 percent of the cost of brand-name prescription drugs, and a lower percentage for other prescription drugs. The federal share of the manufacturer rebates was the FMAP rate. In cases where states negotiated a higher rebate percentage, the federal share was also the FMAP. The ACA changed the required rebate to 23.1 percent for brand-name prescription drugs, and increased the rebate for other prescription drugs by two percentage points. Under ACA, all of the rebates between the old minimum rate (e.g., 15.1 percent) and the new minimum rate (e.g., 23.1 percent) are to go to DHHS. ACA also expanded manufacturer rebates to Medicaid managed care organizations. Along with the increase in the Medicaid population starting in 2014, this will increase the amount of rebates to the state.

Figure 14 shows the estimated net effect of these changes from fiscal year 2010 to 2019. Note that federal guidance has changed since these estimates were developed, and HHSC is in the process of developing new estimates. The shift from cost to savings occurs in 2014 because of the expansion of Medicaid in 2014. Before this, the state only has the changes to rebates described above. The expanded population will significantly increase the amount of rebates that will come to

FIGURE 14
ESTIMATED NET EFFECT OF CHANGES TO DRUG REBATE PROGRAM
FISCAL YEARS 2010 TO 2019 (IN MILLIONS)

FISCAL YEAR	NET EFFECT
2010	($2.1)
2011	($16.9)
2012	($19.8)
2013	($21.4)
2014	$272.9
2015	$310.7
2016	$344.3
2017	$372.2
2018	$402.5
2019	$435.2

SOURCE: Comptroller of Public Accounts.

the state. However, **Figure 14** does not include the cost of medications, which will also rise significantly.

The ACA includes other provisions that affect the Texas Medicaid program. For example, the federal match for preventive services and vaccines increases by one percentage point for states that eliminate cost-sharing for these services, starting January 1, 2013. Beginning January 1, 2011, $25 million in grants will be available to states to develop a health home program under a Medicaid State Plan Amendment. While the planning grants will require a state match, client services will be funded at a 90 percent federal, 10 percent state rate for two years. The health home program is to develop care options for people with multiple chronic conditions. Further, the enhanced federal match for the "Money Follows the Person Rebalancing Demonstration" (MFP), to increase non-institutionally based long term care services, is extended from 2011 to 2016. The ACA also reduces the minimum amount of time a person must have been in the institutional setting to qualify for MFP funding from six months to 90 days. It also requires states to provide Medicaid for individuals up to age 26 who aged out of the Foster Care system.

CHIP

CHIP provides health insurance coverage for children from low-income families who are not eligible for Medicaid and do not have access to affordable health insurance. As with Medicaid, states are required to maintain or relax eligibility requirements in CHIP. Enacting changes which result in more restrictive eligibility for CHIP will result in forfeiting matching federal funds. This provision was made active upon enactment of the ACA and continues through September 30, 2019.

In addition, CHIP was reauthorized to October 2015. If CHIP is reauthorized beyond this date, states that continue to have a CHIP program will receive a 23 percentage point increase in the federal share of CHIP from October 1, 2015 through September 30, 2019.

As discussed earlier, children who are currently enrolled in the State Kids Insurance Program (SKIP) may qualify for CHIP. In addition, children of public school teachers had been ineligible for federal support under CHIP, but received full state funding for CHIP services through HHSC. These children might now qualify for CHIP federal funding, depending on DHHS guidance. The state cost for children of public school teachers in 2010–11 was $47.3 million, which does not include the cost of vendor drugs. The net savings in state funding by moving them to CHIP is estimated to be $41.6 million in 2012–13.

MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

The Medicaid Disproportionate Share Hospital (DSH) program provides supplemental federal funding to hospitals who serve disproportionately high numbers of Medicaid and uninsured patients. The funding is intended to reimburse hospitals for the uncompensated care and additional costs of treating Medicaid patients. Due to the expectation of significant reductions in the number of uninsured individuals resulting from the expansion of overall health insurance coverage, the ACA includes a provision to scale back DSH funding for uninsured patients. DHHS is charged with developing a methodology that imposes the largest percentage of reductions on states that have fewer uninsured people, and hospitals with low levels of uncompensated care and low volumes of Medicaid patients. Nationwide, DSH allotments will be reduced by $0.5 billion in 2014, rising to $4 billion by 2020. HHSC reported Texas' federal DSH allotment in fiscal year 2010 to be $1 billion for state and non-state hospitals. The reduction in Texas is unknown at this time.

OTHER PROVISIONS RELATED TO MEDICAID AND CHIP

Figure 15 lists other provisions in the ACA that relate to the Medicaid or CHIP programs.

Figure 16 lists some of the grants and demonstration projects in the ACA that relate to the Medicaid or CHIP programs.

FIGURE 15
OTHER MEDICAID- AND CHIP-RELATED PROVISIONS

PROVISION	DESCRIPTION	EFFECTIVE DATE
Community First Choice Option	Allows states to offer community-based long-term care services through a state plan amendment, rather than through a waiver. The federal match increases by six percentage points, but states must maintain current spending levels for these services. As an entitlement, demand for the program could not be limited by the state.	October 1, 2011
Family Planning Option	Allows states to offer family planning services through a state plan amendment, rather than through a waiver.	March 23, 2010
Healthcare acquired conditions	Prohibits Medicaid reimbursement for healthcare acquired conditions.	July 1, 2011
Medicare Prescription Drug Cost-sharing	For people dually eligible for Medicare and Medicaid, changes cost-sharing for prescription drugs to be the same for people that receive home and community based services as it is for people in institutions .	January 1, 2012 or later
Coverage of childless adults in Medicaid	Allows states to provide Medicaid coverage of childless adults under 133 percent of the FPL before January 2014. Federal funding is the FMAP rate.	April 1, 2010 through December 31, 2013

SOURCE: Legislative Budget Board.

FIGURE 16
DEMONSTRATION PROJECTS AND GRANTS THAT RELATE TO MEDICAID OR CHIP

PROJECT	DESCRIPTION	TOTAL FUNDING AND AVAILABLE DATES
Emergency psychiatric funding	Provides funding for three year demonstration projects to provide Medicaid payments to institutions of mental disease to provide medical assistance to stabilize an emergency psychiatric condition of adult Medicaid enrollees (ages 21–65).	• $75 million • October 1, 2010 to December 31, 2015
School-Based Health Clinic/ Center (SBHC) Grants	Provides grants to establish and operate SBHCs that serve a large population of children eligible for Medicaid or CHIP.	• $50 million per year for construction and equipment; no matching requirements. • Authorization for funding (but no appropriation) to operate SBHCs; 20 percent non-federal matching requirement. • Maintenance of effort required. • October 1,2009 to September 30, 2013
Healthy Lifestyles Grants	Provides grants to states to provide incentives for Medicaid beneficiaries to develop a healthy lifestyle. Programs must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities.	• $100 million • No matching requirements. • January 1, 2011 or earlier • Lasts 5 years
Integrated care payments for hospitalizations	This demonstration project will evaluate the use of bundled payments for care of Medicaid recipients involving a hospitalization. It will be conducted in up to eight states.	• Funding level not specified. • January 1, 2012 to December 31, 2016
Global capitated bundled payments	This demonstration project will test the cost-effectiveness of global capitated bundled payments for care of Medicaid recipients at large safety net hospital systems. It will be conducted in up to five states.	• Authorizes funding as necessary. • Federal fiscal years 2010 to 2012
Pediatric Accountable Care Organizations	This demonstration project shares the cost savings of qualified pediatric providers that are accountable care organizations by providing them with incentive payments.	• Authorizes funding as necessary. • January 1, 2012 to December 31, 2016

SOURCES: Legislative Budget Board; National Conference of State Legislatures.

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

The ACA provides $1.5 billion nationwide from federal fiscal years 2010 to 2014 for grants to states to develop and enhance their home visitation program for new mothers and young children. According to federal guidelines, the program is designed: (1) to strengthen and improve the programs and activities carried out under the Maternal and Child Health Care Block Grant (under Title V of the federal Social Security Act); (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The goals include improving maternal and young child health and development, improving parenting, and increasing school readiness, especially for families at risk. States have to conduct a statewide needs assessment to identify high-risk communities and the capacity for providing services to meet the needs in these communities. Risk factors include concentrations of premature and low weight births, high infant mortality, poverty, crime, high school drop-outs, substance abuse, unemployment, and child maltreatment. The needs assessment is also a condition for states to receive their Maternal and Child Health Care Block Grant allocation for federal fiscal year 2011. Families that reside in communities identified in the state-conducted needs assessment and that meet certain criteria are eligible to participate in the program.

The Texas Department of State Health Services (DSHS) was awarded $7.4 million as of September 2010. States must use the funds to supplement, not supplant funds from other sources for early childhood home visitation programs. There is no state matching or maintenance of effort requirement associated with the grant award.

PREGNANCY ASSISTANCE

The ACA includes $25 million per year in funding for pregnancy assistance programs from federal fiscal years 2010 to 2019. States are to make grants to universities and high schools to assist pregnant or parenting teens and women. Funding may also be used by the state's Office of the Attorney General to help address domestic violence toward pregnant women. The funding must supplement, not supplant other funding for these purposes. Public institutions of higher education must contribute 25 percent of funding for their programs, which can be cash or in-kind.

HEALTH INFORMATION TECHNOLOGY

Several sections of the ACA promote the development and use of health information technology. It requires DHHS to develop "interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs" within 180 days of the law's enactment. These standards and protocols are to cover information matching, submission of documents, reuse of stored eligibility information, and communication with people seeking or receiving services through electronic means. In addition, they must allow individuals to apply, recertify, and manage their eligibility information online.

The law allows DHHS to require states to incorporate these standards and protocols as a condition of receiving federal funds for investment in health information technology. This could affect the state's health and human services agencies if they are required to modify existing automated systems to be in compliance with the new federal standards and protocols.

DHHS is authorized to award grants to states, political subdivisions of states, and local governmental entities to develop new and adapt existing technology systems to meet these standards and protocols. However, the law does not indicate the amount of funding available. For more in-depth analysis of health information technology in Texas, see Health Information Technology Initiatives in Texas in the *2010 Government Effectiveness and Efficiency* report by the Legislative Budget Board.

PART IV: HEALTH WORKFORCE AND FACILITY CAPACITY

The ACA addresses the affordability of healthcare. As a result, the demand for primary care is expected to increase sharply. Even before passage of the ACA, Texas had a shortage of primary care professionals. In 2010, 169 of Texas' 254 counties were designated as a whole county primary medical care Health Professional Shortage Area (HPSA)—defined as an area with a primary care doctor-to-population ratio of 1:3,500 or less. Another 20 counties were designated as a partial county HPSA. According to DSHS, about 14 percent of Texans live in a shortage area and are unable to find a primary care physician. Shortages of some other healthcare professionals and facilities are even greater.

The ACA contains many provisions to increase funding for education and retention of primary care physicians to deal with the increased demand for primary care services. It also provides funding for other health professionals and facilities.

The three general goals for this funding are: to provide incentives for people to pursue careers in healthcare by providing scholarships, fellowships, and loan repayment for healthcare education; to provide funding to educational and training institutions to enhance their healthcare programs; and to increase healthcare access for patients—especially those in HPSAs—by funding community health centers and other healthcare institutions. These provisions are summarized in **Figure 17**; only a few select programs are listed. While many of these provisions do not directly affect funding in the state budget, they do assist the state in improving employment and retention of healthcare workers. Note that funding is allocated nationally; it is unclear at this time what portion of this funding will be received in Texas. In addition, much of the funding indicated in **Figure 17** is authorized by the ACA, but will require separate federal appropriations before the funding is available. Further, many of these are competitive grants which have to be applied for and awarded to Texas.

In addition to these general categories, the ACA provides $4.5 million per year in federal fiscal years 2010 to 2014 for State and Regional Centers for Health Workforce Analysis. These centers establish grants to collect and analyze data on workforce issues, provide program evaluation, and submit workforce data to the National Center for Health Workforce Analysis to evaluate the health workforce and establish a national database. In Texas, this function is primarily served by the Texas Statewide Health Coordinating Council, which researches and develops a plan to address health care needs of the state.

Another provision in the ACA that was included to encourage citizens to pursue careers in healthcare is the expansion of the National Health Service Corps (NHSC). The NHSC provides scholarships and student loan repayment for medical students and practitioners who commit to serve patients in HPSAs. The ACA authorizes the appropriation of $4 billion of federal funding, starting with $0.3 billion in federal fiscal year 2010 and increasing incrementally each year to $1.2 billion in federal fiscal year 2015 to account for projected increases in the cost of health profession education. Unlike most other provisions, the NHSC appropriations are set to continue indefinitely.

The ACA also increases authorization for appropriating funding for federally qualified health centers (FQHCs). FQHCs serve medically underserved populations or are located in medically underserved areas. FQHCs include community health centers, migrant health centers, healthcare for the homeless, and public housing primary care. As

FIGURE 17
FUNDING FOR HEALTH WORKFORCE DEVELOPMENT

TYPE	SELECT PROGRAMS	NATIONWIDE FUNDING
Funding to individuals—scholarships, fellowships, and loan repayment	• National Health Service Corps	$0.7 billion designated for federal fiscal year 2010, with two programs authorized to receive funding as necessary for 2010.
	• Pediatric Specialty Loan Repayment	
	• Allied Health Workforce Recruitment and Retention Program	$3.9 billion more designated to be disbursed from 2011 to 2015, with six additional programs authorized to receive funding as necessary.
Funding to educational and training institutions for workforce expansion	• State Healthcare Workforce Development Grants	$1 billion designated for federal fiscal year 2010, with two programs authorized to receive funding as necessary for 2010.
	• Mental and Behavioral Health Education and Training Grants	$1.8 billion more designated to be disbursed from 2010 to 2016, with six additional programs authorized to receive funding as necessary.
	• Graduate Nurse Education Demonstration	
Funding to healthcare institutions to increase access to care	• Federally Qualified Health Centers	$3.3 billion designated for federal fiscal year 2010, with one program authorized to receive funding as necessary for 2010.
	• Nurse Managed Health Centers	
	• Primary Care Extension Program	$31.9 billion more designated to be disbursed from 2010 to 2015, with three additional programs authorized to receive funding as necessary.

SOURCES: Legislative Budget Board; National Conference of State Legislatures; Congressional Research Service.

certified Medicaid providers, FQHCs are eligible for Medicaid reimbursement. Authorization for federal fiscal year 2010 increased to about $3.0 billion, a $0.4 billion increase over the prior authorization. The authorization increases annually to $8.3 billion in federal fiscal year 2015. The additional funding is expected to increase the ability of these centers to provide comprehensive primary and preventive healthcare services to Medicaid and other low-income populations.

CONCLUSION

The ACA provides challenges and opportunities for the state. These include provisions that change both the private and public health insurance markets. While many changes take effect at the beginning of calendar year 2014, the state will need to have processes in place to comply with the ACA requirements. Development of exchanges must occur before the Eighty-third Texas Legislature convenes. Similarly, changes required for the expansion in the Medicaid population must be identified and planned before 2014. The Eighty-second Texas Legislature will have the opportunity to fully consider and address these issues so implementation in 2014 is smooth, with minimal disruption of insurance markets.

APPENDIX

KEY PROVISIONS IN THE AFFORDABLE CARE ACT, BY CALENDAR YEAR OF IMPLEMENTATION

2010

Insurance Reforms

- Covers dependent children up to age 26 on their parent's policy.
- Insurance reforms:
  - Prohibits rescinding coverage, except in cases of fraud.
  - Prohibits denying coverage to children based on pre-existing conditions.
  - Prohibits limiting the lifetime dollar value of coverage.
  - Prohibits limiting annual dollar value of new coverage.
  - Requires health plans to provide preventive services without cost-sharing.
- Establishes a temporary high-risk pool for people with pre-existing conditions.
- Provide tax credits to small employers that purchase health insurance for employees.
- Creates a temporary reinsurance program for employers providing health insurance coverage to retirees age 55 or older who are not eligible for Medicare.
- Provides grants to states for reviewing premium increases.
- Provides grants to states to develop health insurance exchanges.

Medicaid and CHIP

- Creates a state option to cover childless adults and family planning services though a Medicaid state plan amendment.
- Increases the Medicaid drug rebate percentages and extends the drug rebates to Medicaid managed care plans.
- Opens CHIP to children of state employees and teachers.
- Requires states to maintain or ease eligibility standards for Medicaid and CHIP.
- Establishes the Federal Coordinated Health Care Office to improve care coordination for dually eligible persons(i.e., eligible for both Medicare and Medicaid).
- Creates a state option to offer home- and community-based services through a Medicaid state plan amendment and permits states to extend full Medicaid benefits to them.

Public Health, Prevention and Wellness

- Establishes a non-profit Patient-Centered Outcomes Research Institute to conduct research that compares the clinical effectiveness of medical treatments.
- Appropriates funding to support prevention and public health programs.
- Expands eligibility for the 340(B) drug discount program to more hospitals and other entities.
- Permanently authorizes and increases funding for the federally qualified health centers and National Health Service Corps programs.

Healthcare Workforce

- Increases workforce supply and supports training of health professionals through scholarships and loans.
- Expands workforce support through scholarships and loans.
- Establish Teaching Health Centers to provide payments for primary care residency programs in community-based ambulatory patient care centers

2011

Insurance Reforms

- Requires health plans to provide rebates if they spend too little of premium dollars on healthcare.

Medicaid and CHIP

- Prohibits federal payments to states for healthcare acquired conditions in Medicaid.
- Provides incentives to Medicare and Medicaid beneficiaries to complete programs to prevent chronic disease.
- Provides funding for health home programs, with a 90 percent FMAP for two years.
- Provides enhanced federal match to increase non-institutional long-term care.
- Provides funding for community-based attendant support services for people with disabilities.

APPENDIX (CONTINUED)

KEY PROVISIONS IN THE AFFORDABLE CARE ACT, BY CALENDAR YEAR OF IMPLEMENTATION

Other

- Establishes a national, voluntary insurance program for purchasing community living assistance services and supports.
- Creates demonstration projects on tort reform.
- Establishes the community-based Collaborative Care Network Program to coordinate and integrate healthcare services.
- Imposes new annual fees on pharmaceutical manufacturers.
- Restricts the liability of health reimbursement accounts, health savings accounts (HSAs) and Archer medical savings accounts (MSAs) for over-the-counter drugs.
- Increases the tax on distributions from HSAs and Archer MSAs that are not used for qualified medical expenses to 20 percent of the disbursed amount.

2012

Medicaid and CHIP

- Creates new demonstration projects for Medicaid for bundled payments.

2013

Insurance Reforms

- Creates a Consumer Operated and Oriented Plan (CO-OP) program.

Medicaid and CHIP

- Increases Medicaid payments for primary care to the Medicare level for 2013–14, with 100 percent federal funding.
- Extends CHIP to 2015.
- Provides 1 percent increase in FMAP in Medicaid for preventive services and recommended immunization.

Other

- Limits the amount of contributions to a flexible spending account for medical expenses to $2,500 per year (adjusted annually for cost of living).
- Increases the threshold for deductions for unreimbursed medical expenses on those younger than 65 from 7.5 percent to 10 percent of adjusted gross income.
- Increases Medicare taxes for higher-income taxpayers.
- Creates a federal excise tax of 2.3 percent on certain medical devices.

2014

Insurance Reforms

- Requires U.S. citizens to have qualifying health coverage.
- Requires employers with over 50 workers to offer coverage or pay penalties.
- Creates insurance exchanges.
- Allows employers to offer cost coverage rewards for participating in wellness programs.
- Prohibits annual limits on the dollar value of coverage for everyone.
- Limits deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families.
- Limits any waiting periods for coverage to 90 days.
- Requires guaranteed issuance and renewability of health insurance.
- Limits rating variation in the individual and small group market and the exchange based on:
  - Age (limited to 3 to 1 ratio).
  - Tobacco use (1.5 to 1 ratio).
  - Premium rating area.
  - Family composition.
- Requires the Federal Office of Personnel Management to contract with insurers to offer:
  - At least two multi-state plans in each states exchange.
  - At least one plan from a non-profit entity.
  - At least one plan that does not provide coverage for abortions beyond those permitted by federal law.
- Provides subsidies to families with income up to 400 percent of FPL.
- Allows states to create a Basic Health Plan for uninsured individuals with incomes between 133 percent and 200 percent of FPL, who would otherwise be eligible to receive premium subsidies in the exchange.

APPENDIX (CONTINUED)

KEY PROVISIONS IN THE AFFORDABLE CARE ACT, BY CALENDAR YEAR OF IMPLEMENTATION

Medicaid and CHIP

- Expands Medicaid coverage to 133 percent of FPL for most people under age 65.
- Reduces states' Medicaid Disproportionate Share Hospital (DSH) funding.
- Ensures Medicaid coverage to individuals through age 26 who aged out of foster care.

Other

- Imposes new fees on the health insurance sector.

2015 AND LATER

- Allows states to form interstate healthcare choice compacts.
- Increases CHIP federal match rate by 23 percentage points through federal fiscal year 2019.
- Reduces federal matching funds for the expansion population in Medicaid.
- Imposes an excise tax on employer-sponsored health plans over $10,200 for individuals and $27,500 for families.

NOTE: Most of the provisions extend beyond the initial year of implementation.
SOURCES: Legislative Budget Board; Kaiser Family Foundation.