



Presentation to the
Senate Health & Human Services and
Senate State Affairs Committees
on the Affordable Care Act

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Affordable Care Act

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- In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act were signed into federal law, collectively known as the Affordable Care Act (ACA).
 - Following challenges by 26 state attorneys general and the National Federation of Independent Business, the Supreme Court of the United States considered, among other questions:
 - Whether the law's individual mandate to purchase health insurance was constitutional, and
 - Whether the Medicaid expansion was unconstitutionally coercive for states
 - On June 28, 2012, the U.S. Supreme Court ruled the individual mandate constitutional, but determined that Medicaid expansion was optional for the states.

Next Steps

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- Based on the court decision, states are seeking guidance on a number of provisions related to the Medicaid expansion and eligibility changes, such as:
 - Do the ACA eligibility determination changes (Modified Adjusted Gross Income (MAGI)) apply to existing Medicaid and CHIP programs starting January 2014?
 - Do Maintenance of Effort (MOE) requirements still apply?
 - Will there be new flexibility for states choosing to implement a Medicaid expansion:
 - Later start date?
 - Lower FPL levels?
 - Phased-in implementations?
 - HHSC is currently assessing impacts and considering options related to the changes in the Medicaid provisions of the law as a result of the court decision.

Key ACA Provisions

- Some key provision of ACA include:
 - All U.S. citizens and legal residents must obtain health coverage that meets federal standards (individual mandate)
 - Eliminates lifetime and annual benefit limits/restrictions
 - Prohibits pre-existing conditions exclusions
 - Allows dependent coverage up to age 26
 - Eliminates out-of-pocket expenses for preventive services
 - Creates Health Benefit Exchanges to serve as marketplaces for individuals and small business employees to compare and purchase health coverage
- Medicaid Expansion
 - The Court upheld the Medicaid expansion up to 133 percent of the Federal Poverty Limit (FPL), with limitations, effectively making it optional for states to implement
 - If a state decides not to participate in the Medicaid expansion, the state can continue receiving funds for its existing Medicaid program

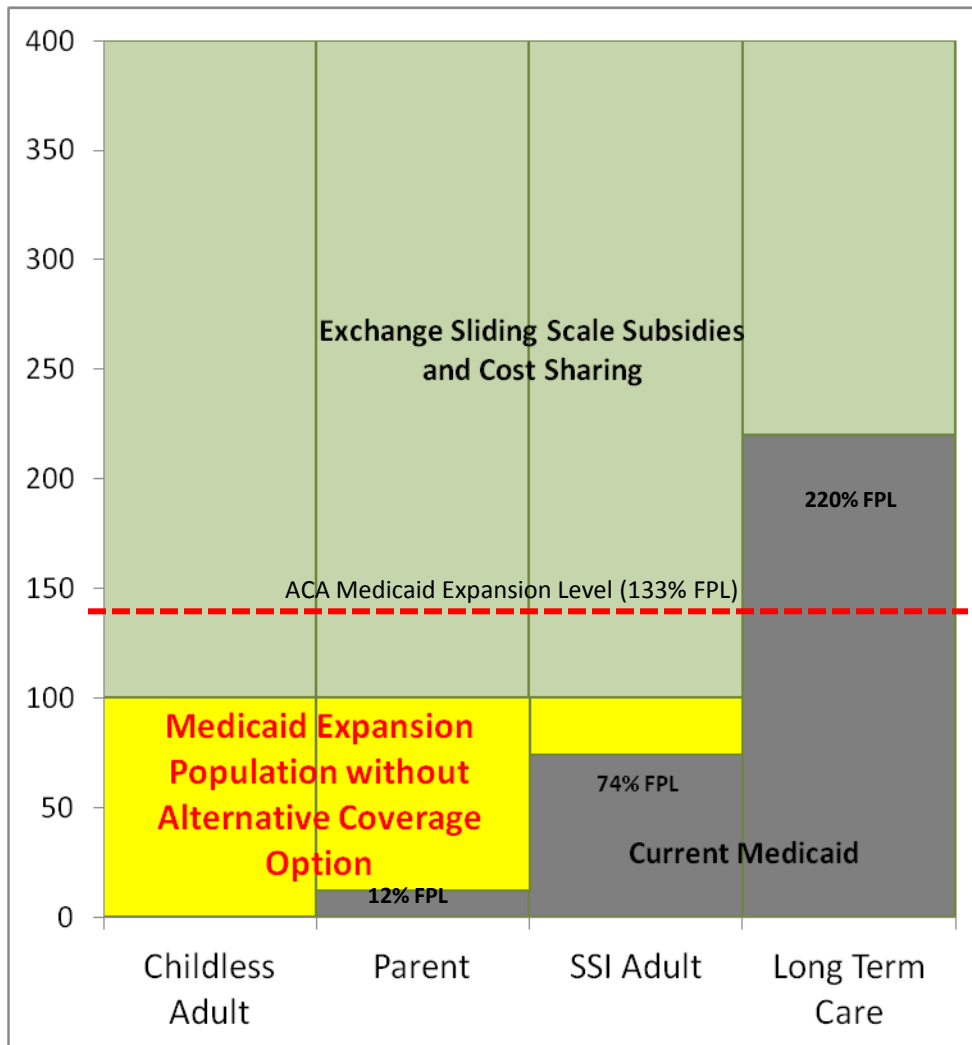
ACA Provisions Implemented to Date

- Allow children enrolled in Medicaid and CHIP to elect hospice care without waiving their rights to treatment for their terminal illness
- Made freestanding birthing centers eligible for Medicaid reimbursement
- Claim federal matching funds for school and state employees' children enrolled in CHIP
- Added tobacco cessation counseling as a Medicaid benefit for pregnant women
- Made drug rebate formulary changes
- Several program integrity provisions

ACA Provisions in Planning Phase

- Program Integrity provisions (3/1/13)
 - Changing provider enrollment requirements in Medicare, Medicaid, and CHIP; Changing claims payment processes; Increasing audit activities; Increasing state reporting requirements; Health care acquired conditions
- Temporary Primary Care Provider Rate Increases (1/1/13 – 12/31/14)
- Dual eligibles (Medicare/Medicaid) Integrated Care Demonstration Project shared savings initiative (1/1/14)
- Medicaid and CHIP eligibility changes (1/1/14)
 - Medicaid and CHIP interface with Health Benefit Exchange
 - Other Medicaid and CHIP eligibility changes are under review based on court decision on ACA lawsuit
- LTSS Balancing Incentives Payment Program Option (10/1/12)

Medicaid Expansion Population



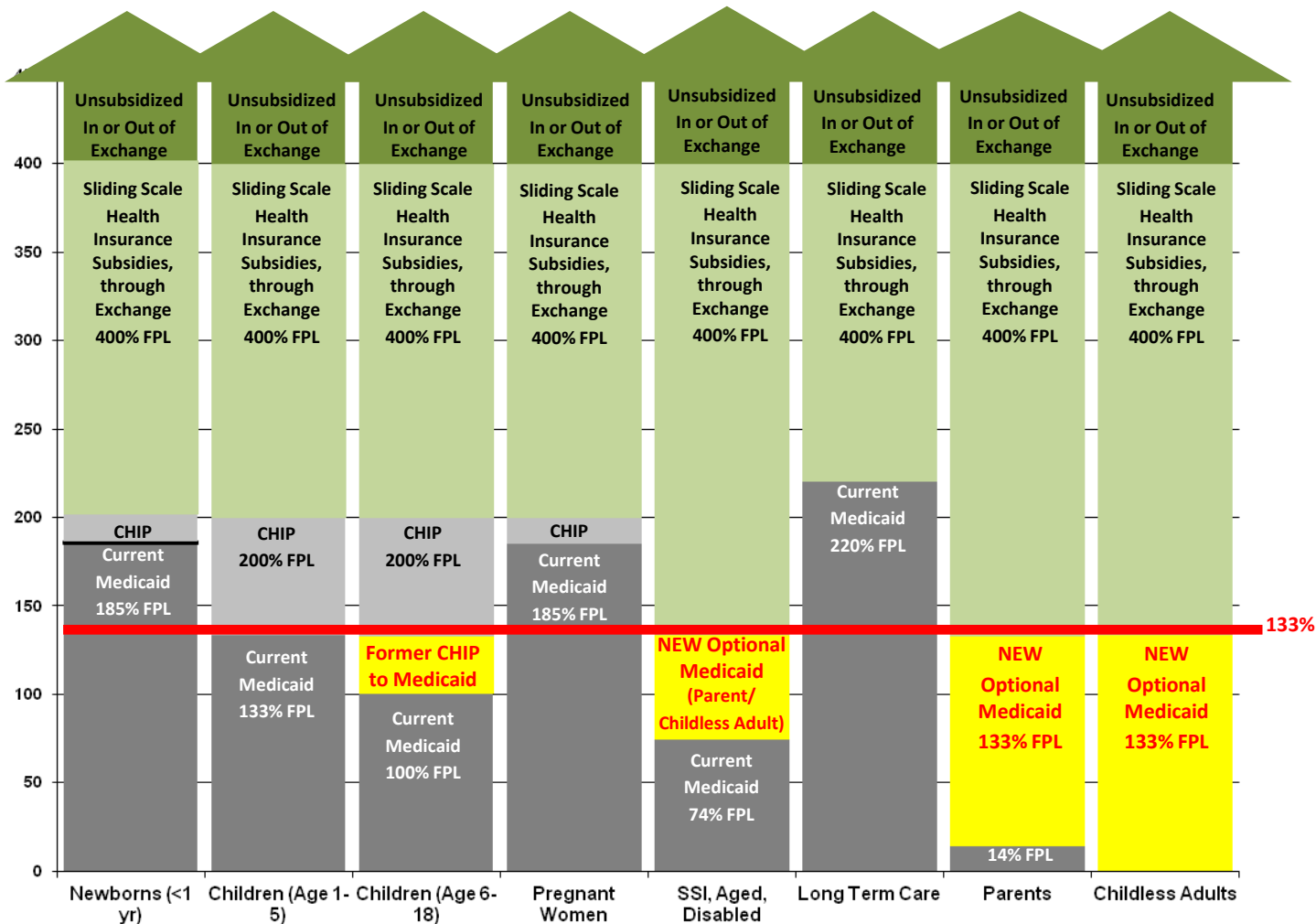
The chart to the left shows the group of uninsured low-income adults that would have no other coverage option in absence of the ACA Medicaid Expansion.

Note: The ACA expands Medicaid coverage for adults under age 65 (up to 133% FPL). However, subsidies are available to adults through the Exchange beginning at 100% FPL.

Annual Income Levels

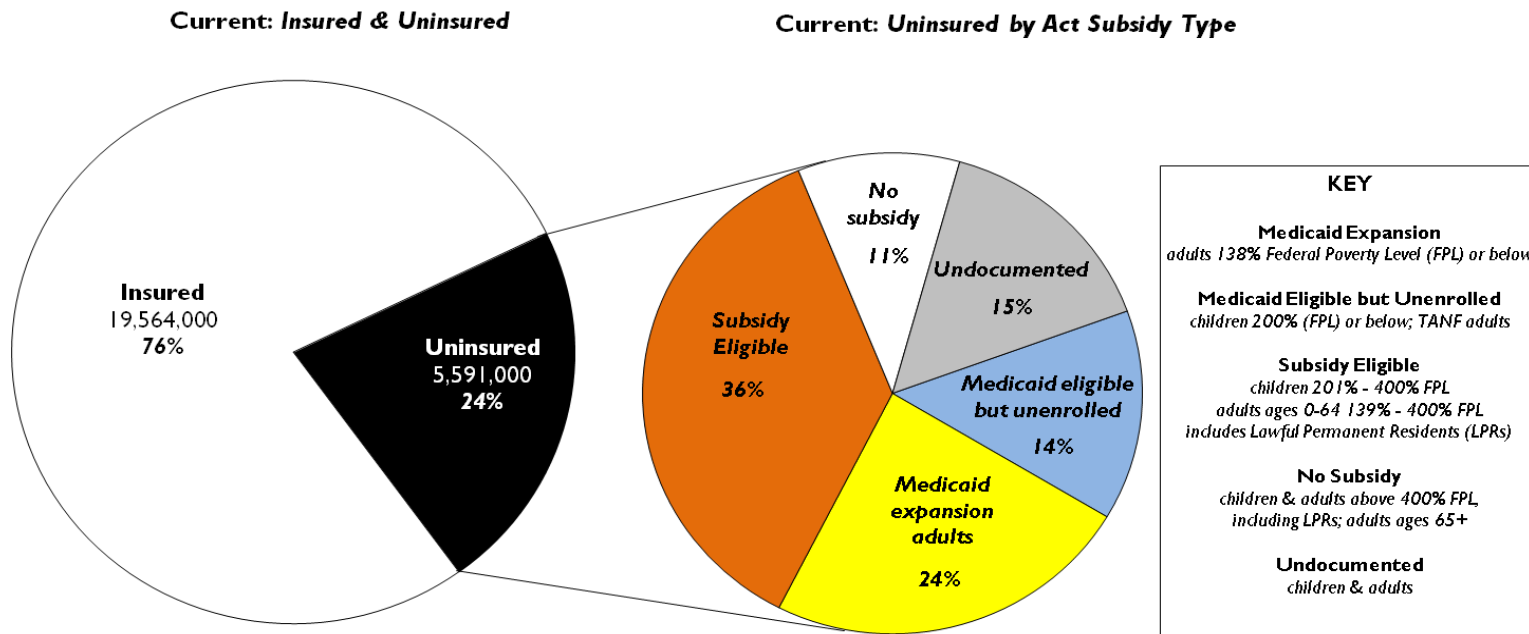
FPL Level	Individual	Family of 3
12%	\$1,340	\$2,291
74%	\$8,266	\$14,126
100%	\$11,170	\$19,090
133%	\$14,856	\$25,390
400%	\$44,680	\$76,360

Texas Health Care Coverage – Post ACA Implementation



Texas Health Insurance Estimates (2010 Population)

Texas Population — Current: Insured and Uninsured, by Affordable Care Act (ACA) Subsidy Type



Note: Due to rounding, percents may not total one hundred percent.

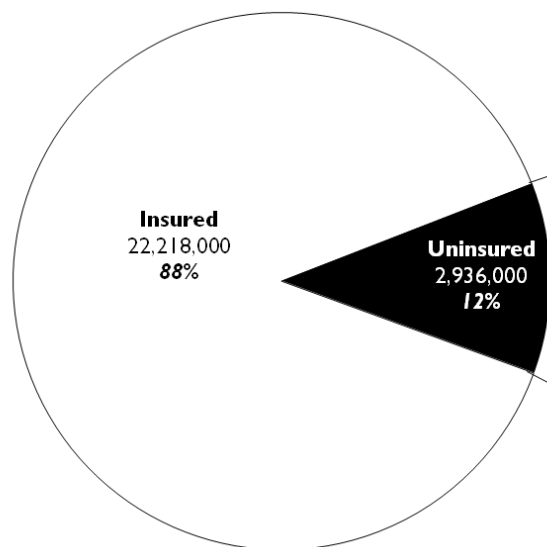
Source: U.S. Census Bureau. March 2011 Current Population Survey (CPS).

Prepared by: Texas Health and Human Services Commission, July 2012.

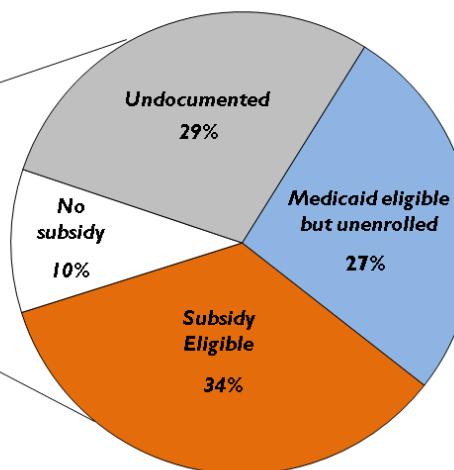
Texas Health Insurance Estimates (2010 Population)

Texas Population — Under Act WITH FULL MEDICAID EXPANSION:
Insured and Uninsured, by Affordable Care Act (ACA) Subsidy Type

Under Act: Insured & Uninsured



Under Act: Uninsured by Act Subsidy Type



KEY

Medicaid Eligible but Unenrolled
children 200% FPL and below;
adults 138% FPL and below

Subsidy Eligible
children 201% - 400% FPL
adults ages 0-64 139% - 400% FPL
includes Lawful Permanent Residents (LPRs)

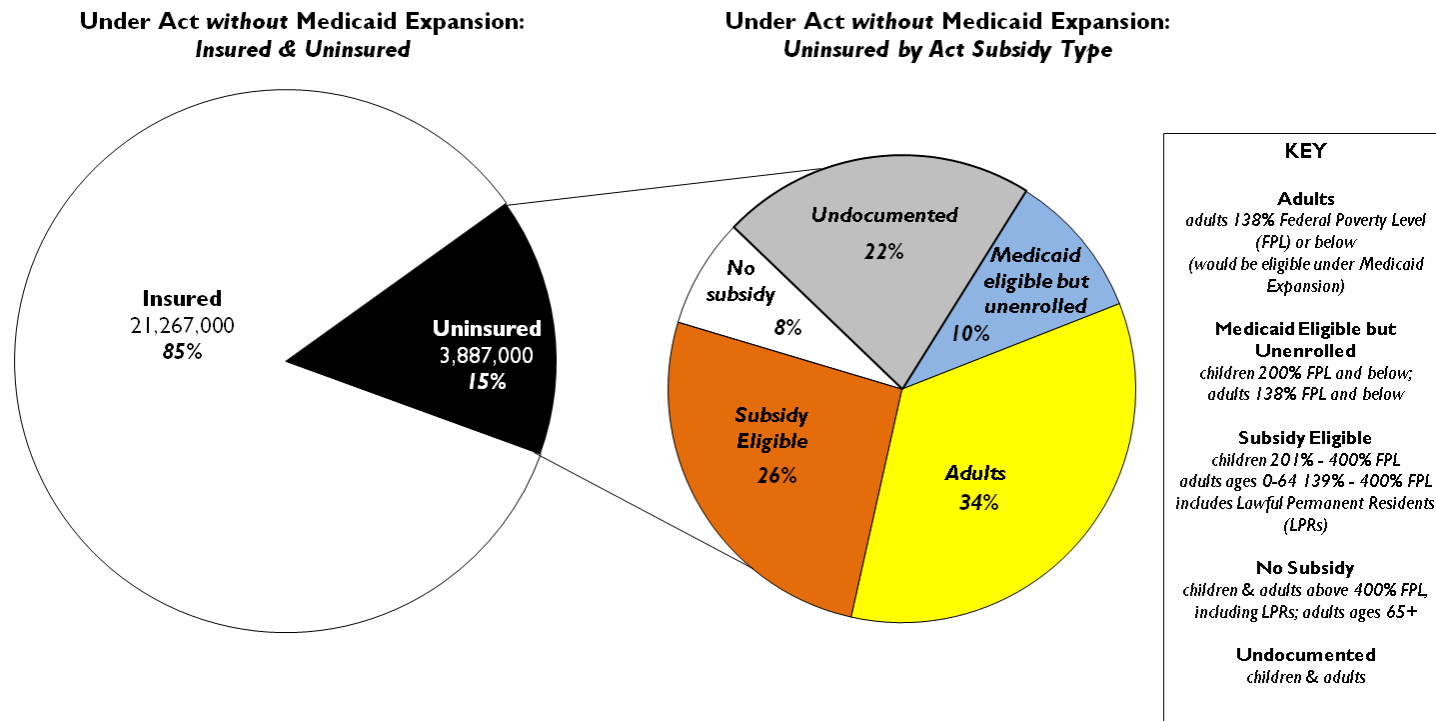
No Subsidy
children & adults above 400% FPL,
including LPRs; adults ages 65+

Undocumented
children & adults

Texas Health Insurance Estimates (2010 Population)

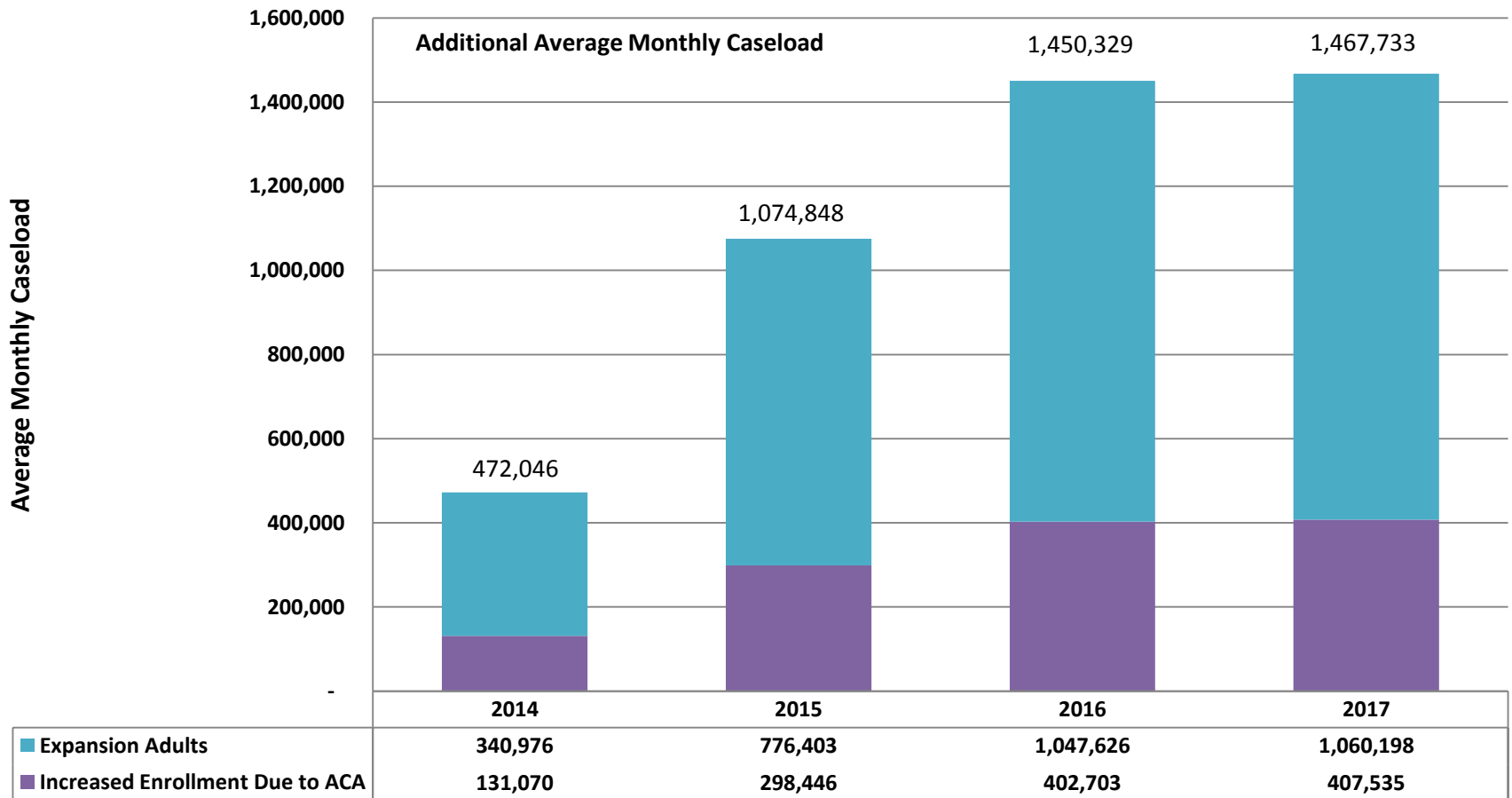
Texas Population — Under Act WITHOUT IMPLEMENTING MEDICAID EXPANSION:

Insured and Uninsured, by Affordable Care Act (ACA) Subsidy Type



Note: Due to rounding, percents may not total one hundred percent.
Source: U.S. Census Bureau, March 2011 Current Population Survey (CPS).
Prepared by: Texas Health and Human Services Commission, July 2012.

Medicaid ACA Caseload Estimates 2014 - 2017



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- Increased Enrollment Due to ACA
 - Includes costs for individuals currently eligible for Medicaid, but not enrolled. Medicaid enrollment is expected to increase due to the individual mandate and interactions with the exchange.
 - Regular state/federal match applies (no enhanced federal funding).
 - GR cost is \$193 million in FY 2014 and \$1.8 billion through FY 2017.
 - ACA Expansion Adults
 - Includes costs for expanding the Medicaid income limit to 133 percent of the FPL.
 - 100 percent federal match for 3 years (2014 – 2016).
 - GR cost is \$92 million in FY 2014 and \$1.3 billion through FY 2017.
 - Federal funding amount is \$2.4 billion in FY 2014 and \$24 billion through FY 2017.

ACA Cost Estimate

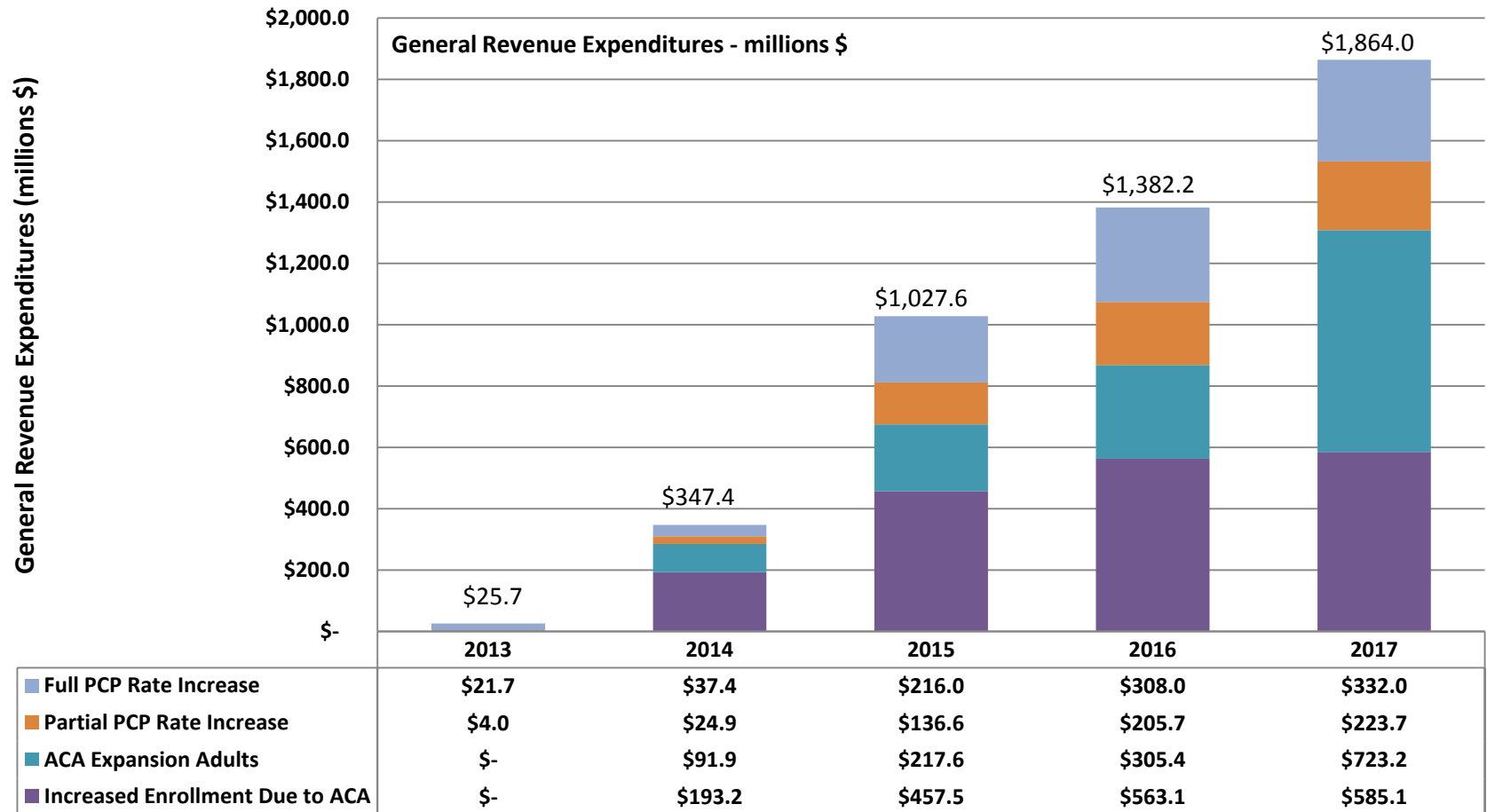
- Primary Care Provider (PCP) Rate Increase – Minimum provider types and medical services required by ACA
 - ACA requires certain primary care services and providers to be paid at least the Medicare rate.
 - Regular state/federal match rate for 2 percent of the increase up to the Medicare rate for services provided to individuals who are currently enrolled or currently eligible but not enrolled.
 - 100 percent federal match for balance of Medicaid PCP rate increase for calendar years 2013-2014.
 - GR cost is \$4 million in FY 2013 and \$595 million through FY 2017.
 - GR cost includes cost for the initial mandatory increase to be extended beyond 2014.

ACA Cost Estimate

- PCP Rate Increase – Including additional providers
 - Includes costs for an increase equal to the Medicare rate for primary care services delivered by any Medicaid provider.
 - Regular state/federal match rate for individuals eligible under current eligibility criteria (e.g., income limits and family composition).
 - 100 percent federal match for Medicaid PCP rate increase for 3 years (2014-2017) for optional expansion population.
 - GR cost is \$22 million in FY 2013 and \$915 million GR through FY 2017.

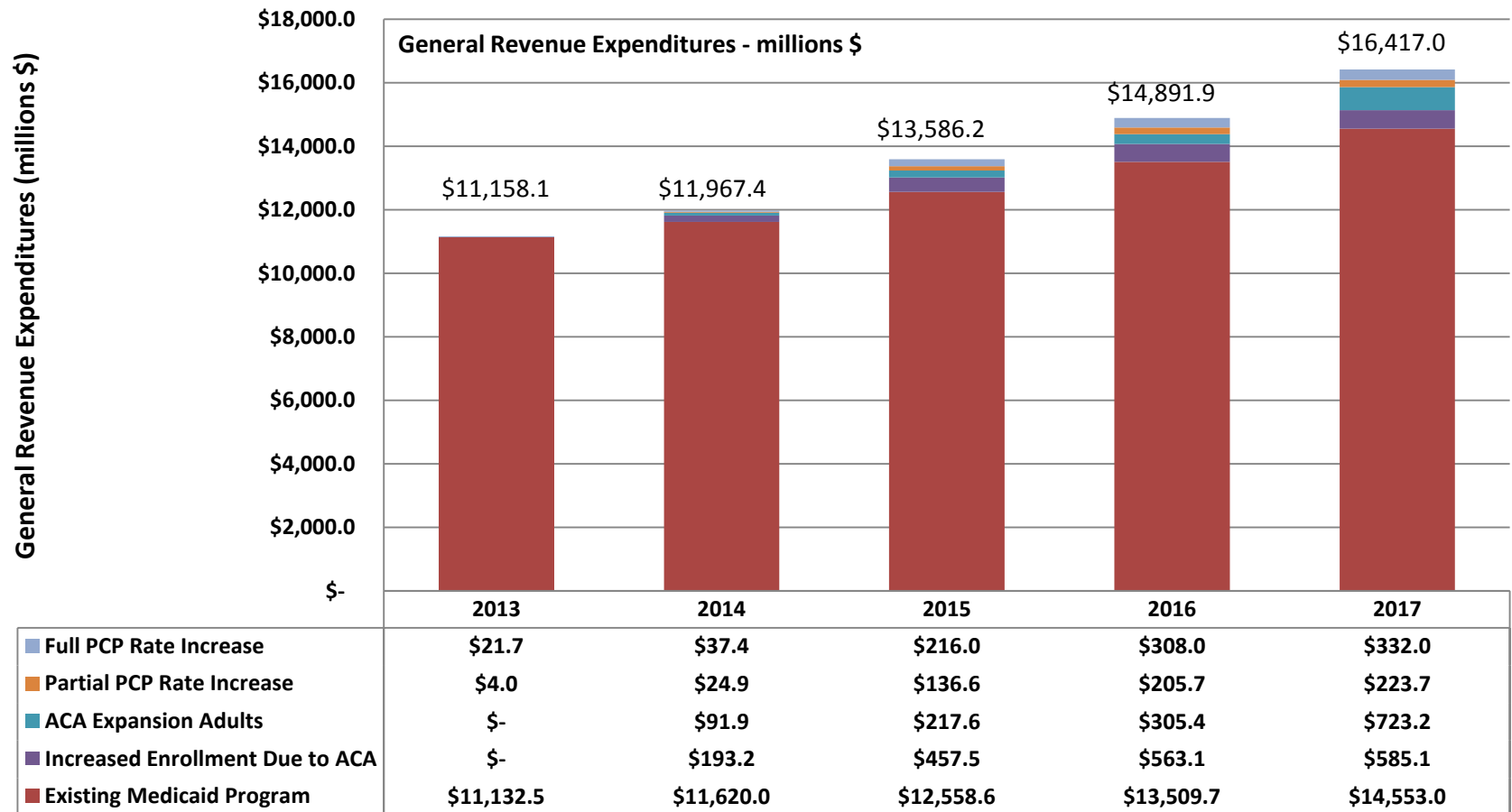
ACA Cost Estimate – GR

Medicaid Expenditures Estimate by Level of ACA Implementation



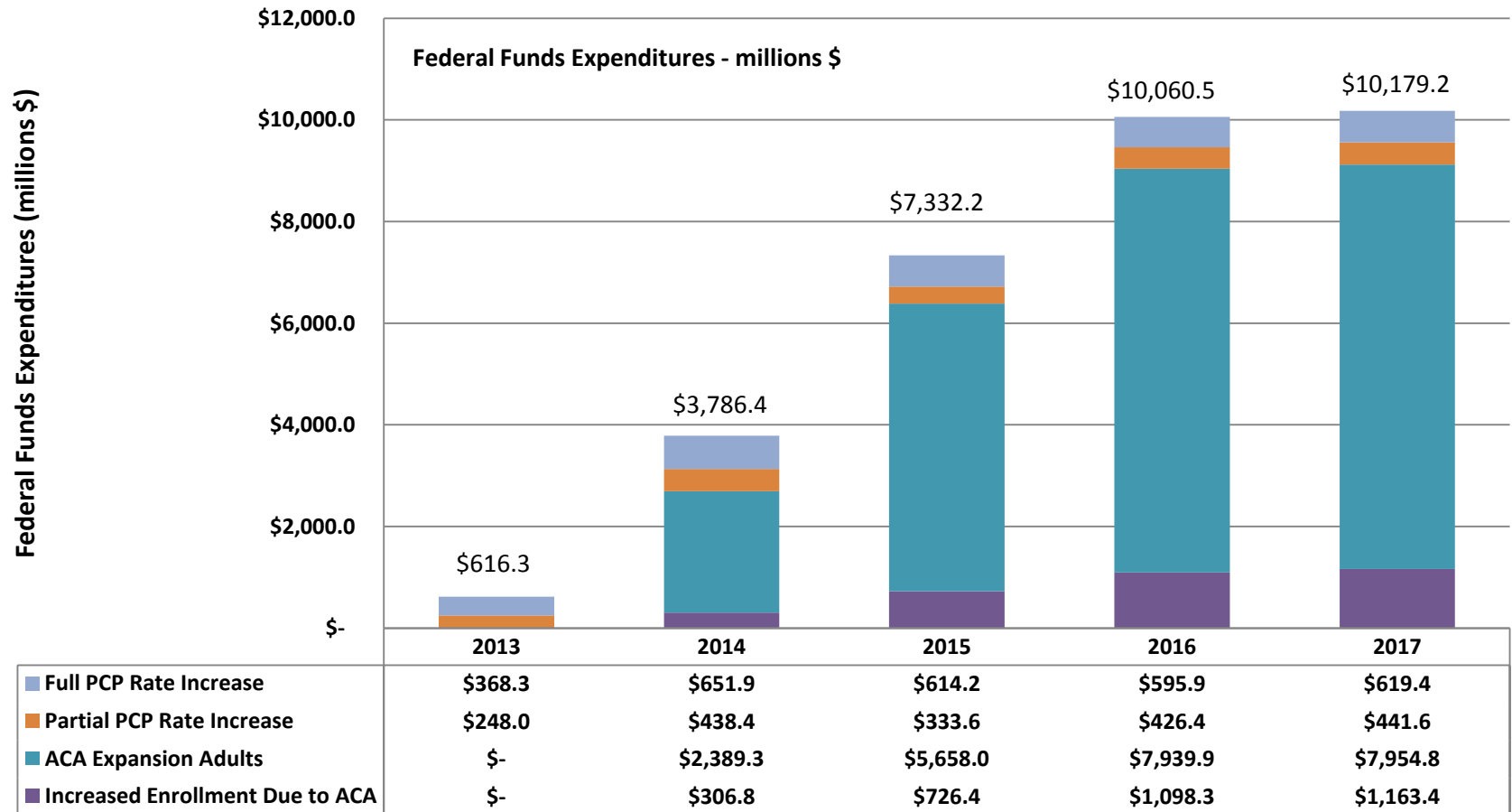
ACA Cost Estimate – GR

Medicaid Expenditures Estimate by Level of ACA Implementation



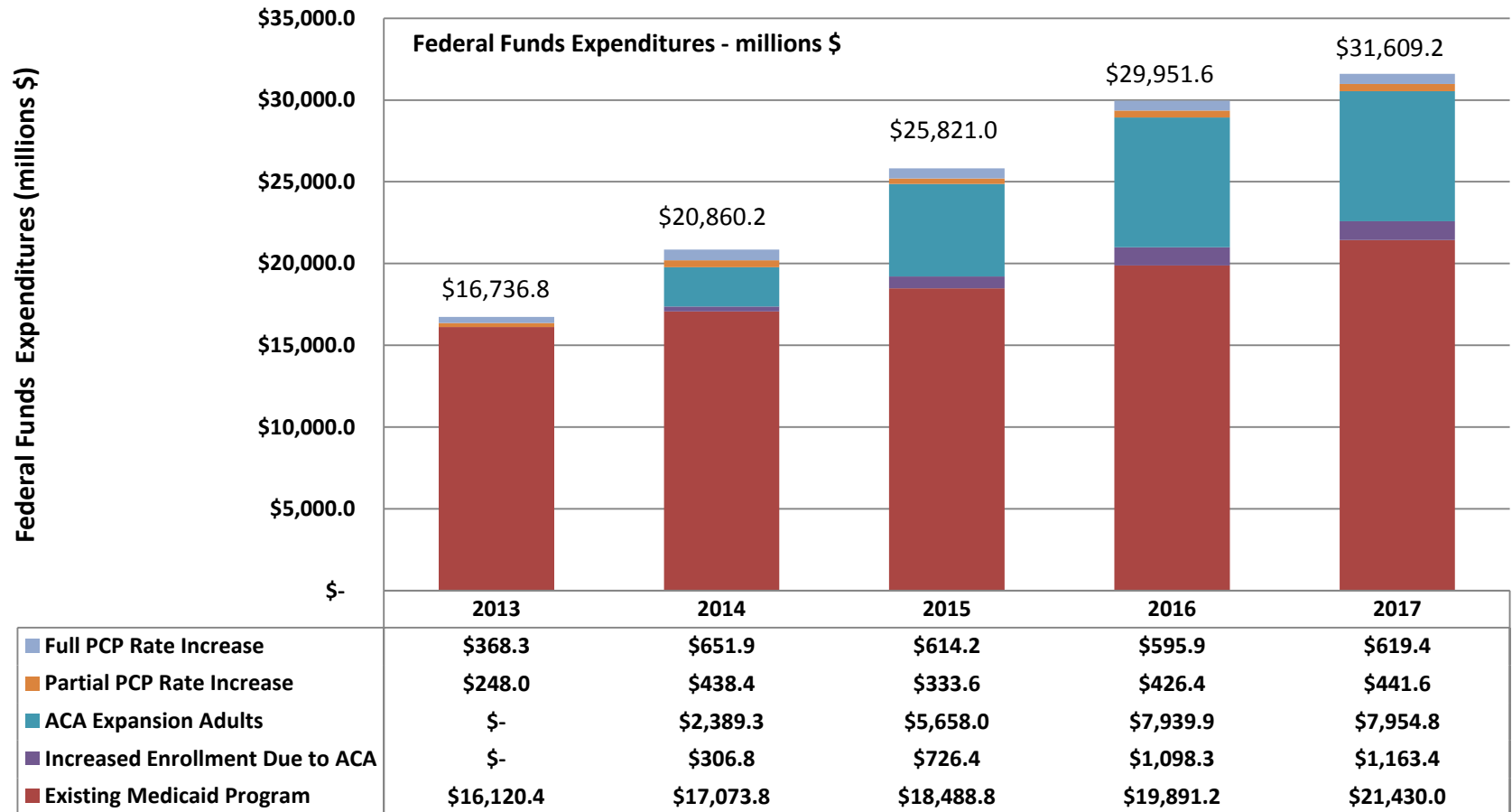
ACA Cost Estimate – FF

Medicaid Expenditures Estimate by Level of ACA Implementation



ACA Cost Estimate – FF

Medicaid Expenditures Estimate by Level of ACA Implementation



Changes Since First ACA Cost Estimate

New and updated information resulted in several changes to the cost estimate:

- **Reduced uptake rates from 91-94 percent to 85 percent:**
 - Individual Mandate is not enforceable for the Medicaid population.
 - Caseload growth in Children's Medicaid has reduced the percentage of eligible but not enrolled children in Texas over the past two years.
- **Reduced caseload growth trend:**
 - The original model assumed caseload growth at 2 percent annually; updated model uses 1.2 percent to reflect recent stabilization of Medicaid caseload growth.
- **Caseload phase-in:**
 - The original model included no phase-in; the updated model assumes 50 percent and 75 percent for the first two years to reflect lack of enforceable Individual Mandate for the Medicaid population.
- **Implementation date:**
 - The new model uses an implementation date of January 2014 rather than the start of FY 2014, subtracting four months of costs.
- **Provider rate increases:**
 - The reductions in caseload described above result in a lower cost of the primary care provider rate increases.
- **Medical costs:**
 - Original model assumed medical cost growth at 6 percent annually. Updated model uses 4 percent, reflecting recent national declines in medical cost growth and the impact of Cost Containment steps taken in the last two years in Texas.