IMPLEMENTATION OF THE AFFORDABLE CARE ACT IN TEXAS

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CHAT Mission and Members

- The mission of CHAT is to support the development of an effective, comprehensive, high-quality and appropriately funded children's healthcare delivery system in Texas.
- Members:
  - Children's Medical Center (Dallas)
  - Children's Hospital of San Antonio
  - Cook Children's Health Care System
  - Covenant Children's Hospital (Lubbock)
  - Dell Children's Medical Center (Austin)
  - Driscoll Children's Hospital (Corpus Christi)
  - El Paso Children's Hospital
  - Texas Children's Hospital (Houston)

Affordable Care Act

- The Patient Protection and Affordable Care Act (ACA) passed Congress and was signed by the President in March 2010.
- The ACA encompasses:
  - a broad range of insurance reforms;
  - health coverage available through exchanges;
  - changes to Medicaid and CHIP programs;
  - adjustments to Medicare payments and benefits;
  - initiatives and demonstrations to improve the quality of health care;
  - investments in public health;
  - incentives to increase the number of health professionals;
  - offsetting tax and revenue; and
  - other miscellaneous provisions.

Impact of Initial Insurance Reforms

- Carriers that cover dependent children must extend coverage up to age 26. In Texas, 357,000 young adults maintained coverage through their parents' plans.
- The ACA established a temporary Early Retiree Reinsurance Program to reimburse employers' medical expenses for retirees 55 and older who are not eligible for Medicare.
- Texas employers received $445 million, including the state and teacher retirement systems and many local governments.
- Health plans must provide recommended preventive services without cost-sharing. Expanded preventive services were provided to an estimated 5.2 million Texans, including 1.4 million children.

Preventive Services for Babies

Well-baby exams at birth, 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months that may include immunizations and the following screenings:

- Hearing (for newborn and as the child's provider advises)
- Weight, length, and head circumference
- Hemoglobin or hematocrit (once between 9 and 12 months)
- Lead testing at ages 1 and 2, unless lead exposure can be confidently excluded
- Age-appropriate developmental/behavioral assessments

Preventive Services for Ages 3-18

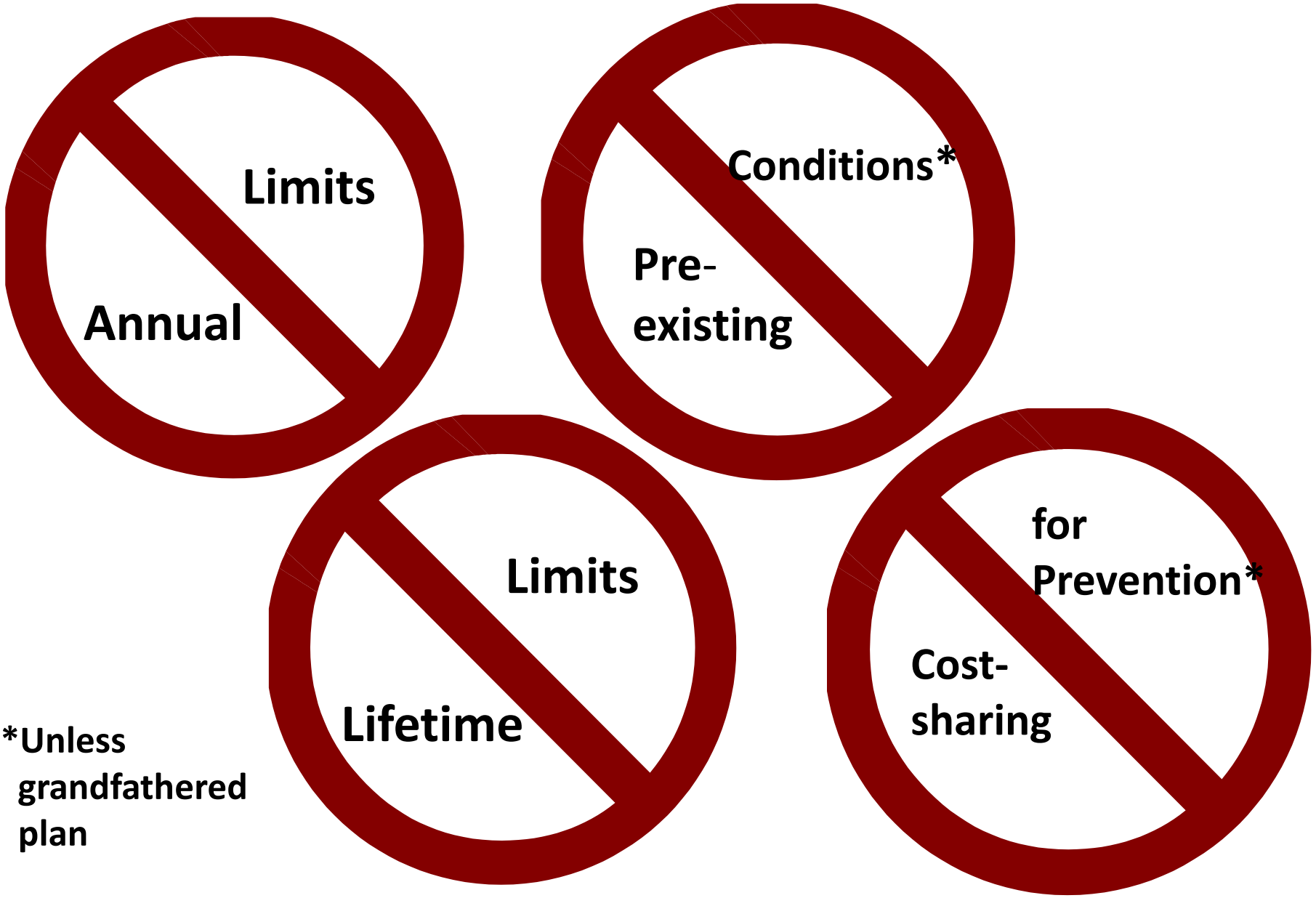
Annual well-child exams may include:

- Immunizations
- Discussions on nutrition, physical activity, healthy weight, injury prevention, avoidance of tobacco, alcohol and drugs, sexual behavior, dental health, mental health and second hand smoke)
- Screenings:
  - Blood pressure
  - Height, weight and body mass index (BMI)
  - Vision and hearing: at ages 12, 15, and 18 or as the child's provider advises
  - Chlamydia screening for sexually active
  - Age-appropriate developmental/behavioral assessments

Medical Loss Ratios

- Medical Loss Ratios set minimum amounts that health insurance issuers must spend on medical claims, starting in January 2011.
  - Large group plans: 85% on medical claims;
  - Individual or small groups: 80% on medical claims.
- Amounts exceeding those limits must be rebated to customers.
- Nationally, 14% of insurers paid more than $1 billion in rebates, based on their 2011 ratios.
- In 2012, 1.5 million Texas consumers received rebates totaling $167 million.
- Insurers have reduced administrative expenses and more insurers are now meeting the standards and spending more of their premium dollars directly on patient care and quality.
- In 2013, 726,000 Texas residents with private insurance coverage received $46 million in rebates.

Insurance Reform Prohibitions



*Unless grandfathered plan

Insurance Coverage Cancellations

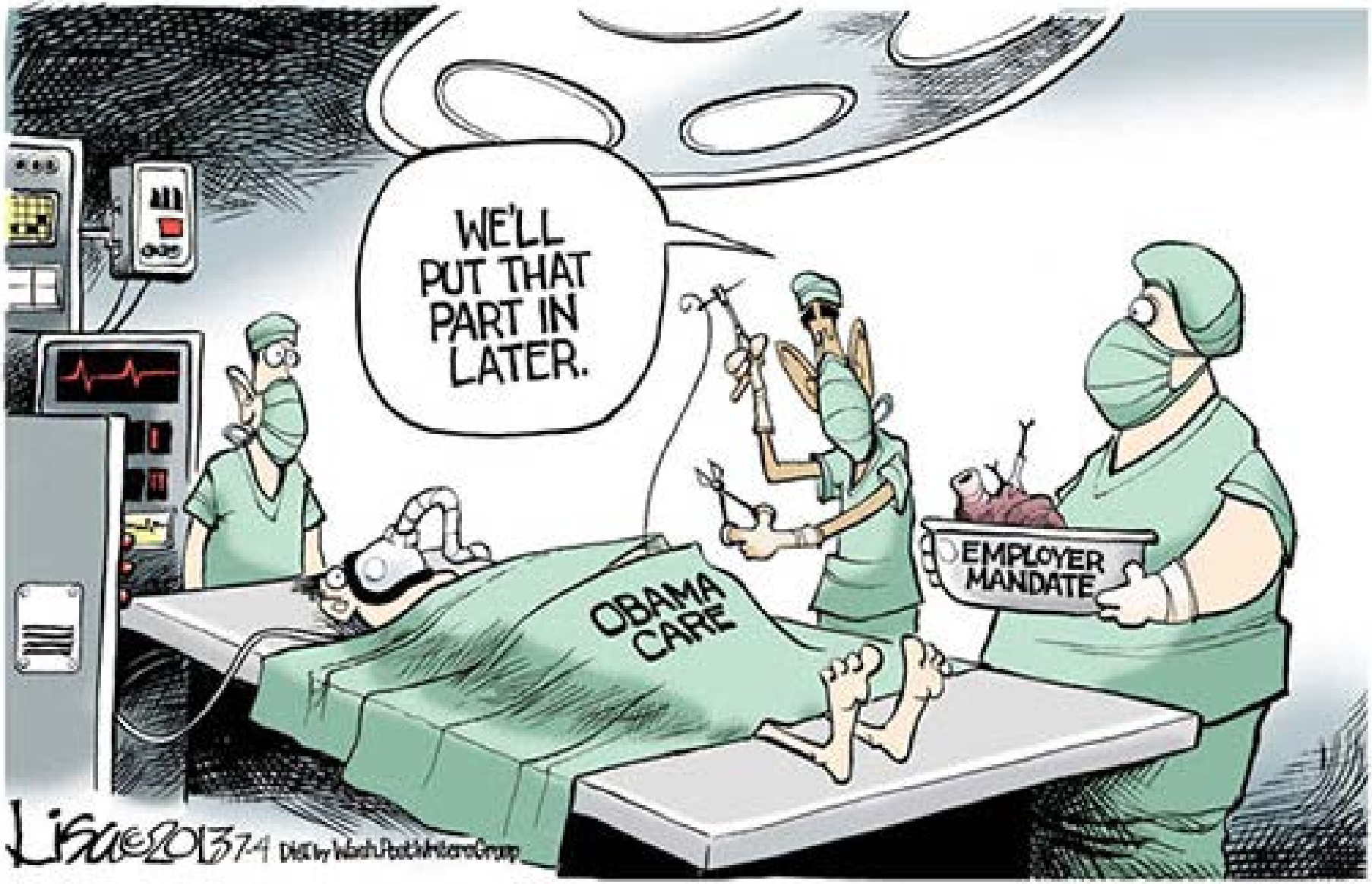
- New coverage requirements sparked cancellation of existing plans in the individual market.
- About 6% of Americans buy their own insurance on the individual market, and about half of those individuals are faced with buying a new product that is compliant with ACA requirements.
- The Administration emphasized the poor coverage typically provided in this market and the more comprehensive policies available through exchanges.
- Some people avoided cancellation by renewing policies before January 2014.
- Issuers were allowed to extend policies that did not meet ACA requirements for an additional year.

Individual Mandate

- Citizens and legal permanent residents are required to have health coverage or pay tax penalties (effective January 2014).
- Penalties begin at $95 in 2014 and increase to $695 by 2016 (or up to 2.5% of income).
- Penalties for children are half of the adult amounts.
- Exemptions include individuals who:
  - Have income below the tax filing threshold;
  - Cannot afford coverage (costs exceed 8% of income);
  - Are ineligible for Medicaid based on a state's decision not to expand the program; and
  - Have a gap in coverage lasting less than 3 consecutive months.
- The Congressional Budget Office projects that less than 2% of Americans will have to pay a penalty.

Employer Requirements

- Employers with over 50 workers must offer health coverage to employees or pay a penalty.
- Penalties equal $2,000 per full-time worker, with the first 30 employees exempted.
- There are no penalties or obligations for employers with 50 or fewer employees.
- Tax credits are available to certain small business owners for assisting in the purchase of employees' health insurance.
- Assistance with plan selection will be available through the health insurance exchange.

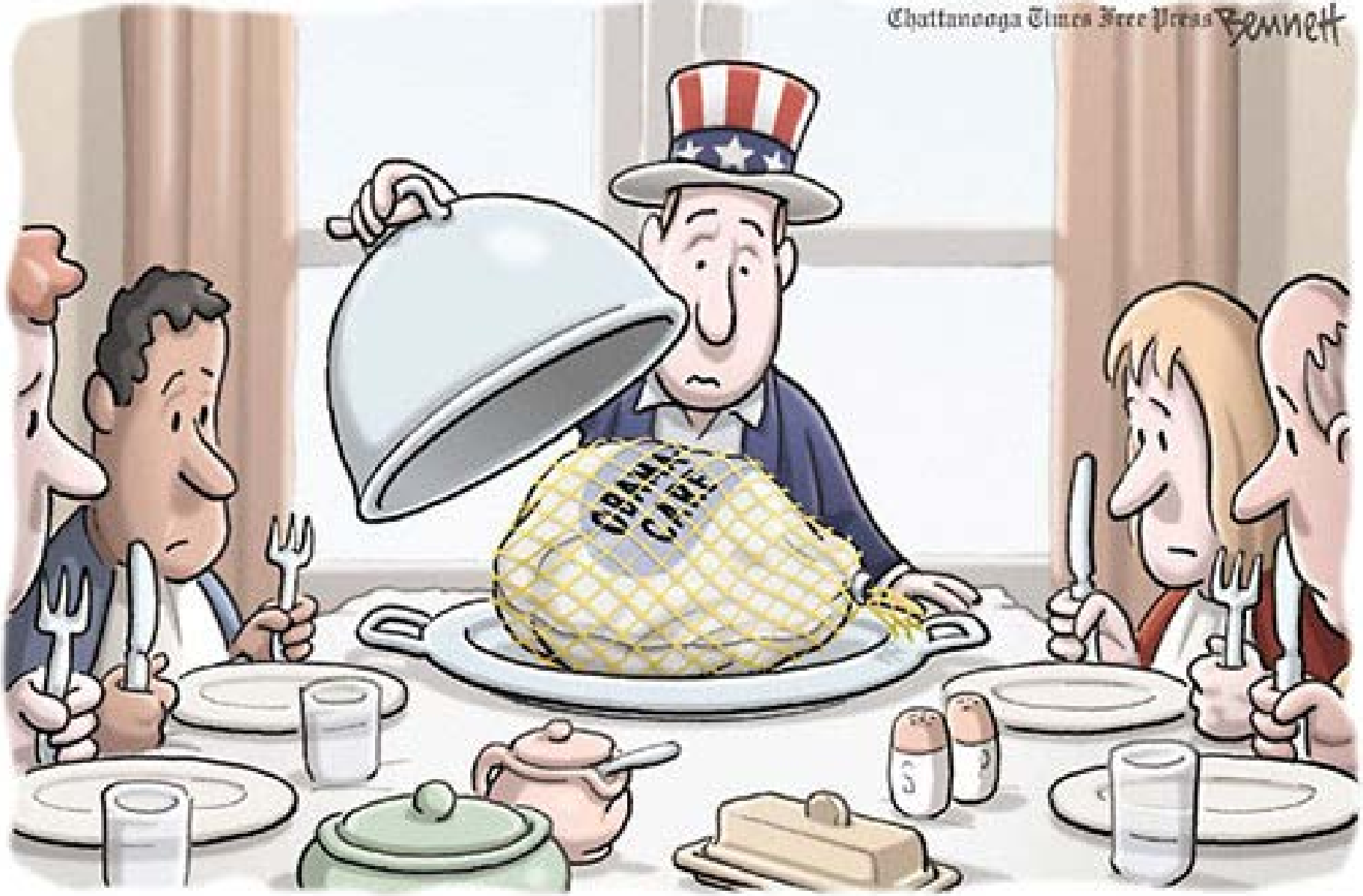

WE'LL PUT THAT PART IN LATER.
OBAMA CARE
EMPLOYER MANDATE

Employer Mandate Delay

- In July 2013 the Administration postponed implementation until 2015.
- February 10, 2014 the Administration announced further delays:
  - Employers with 50-99 workers will be given until 2016 to comply;
  - Employers with 100 workers or more must offer insurance to 70% of full-time workers in 2015 (rather than 95%).
  - The requirement that employers offer coverage to full-time employees' dependents will not apply in 2015 to employers taking steps to arrange such coverage to begin in 2016.

Exchanges/Marketplace

- The ACA creates health insurance exchanges for one-stop insurance shopping, with a goal of increased competition and greater transparency.
- Duties include:
  - Certifying insurance plans as meeting minimum benefit standards;
  - Providing information to consumers (organized and standardized to facilitate comparisons);
  - Reviewing and approving requests for rate increases;
  - Providing a seamless enrollment process for subsidies, Medicaid and CHIP; and
  - Assisting small businesses in qualifying for tax credits.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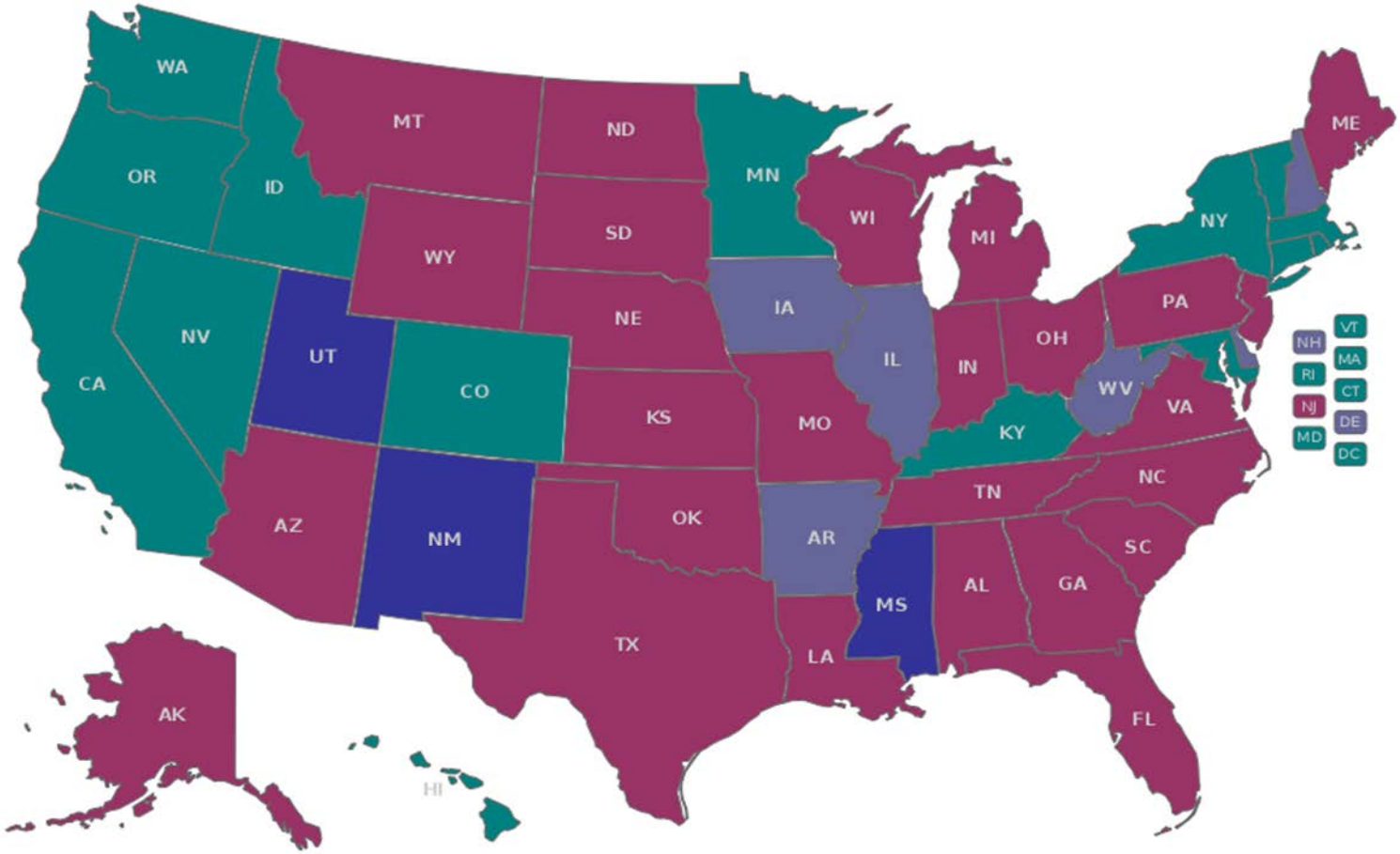
Where States Stand on Exchanges

*Map updated December 9, 2013



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Key:

- 16 State-based exchanges
- 6 Partnership exchanges
- 26 Federally facilitated marketplaces
- 3 State-based SHOPs with federally facilitated individual marketplaces

Topics:

Exchange Federal-State Partnership Exchange Governance Federal Exchange

Essential Health Benefits (EHBs)

- Health coverage offered through the exchanges or through small group and individual plans sold outside the exchanges must include 10 service categories:
  - ambulatory patient services
  - emergency services
  - hospitalization
  - maternity and newborn care
  - laboratory services
  - mental health and substance use disorder services
  - rehabilitative and habilitative and services and devices
  - pediatric services (including oral and vision care)
  - prevention/wellness services
  - chronic disease management
  - prescription drugs

- Insurers can offer a comprehensive plan that includes dental benefits or a stand-alone dental plan.
- Families are not required to purchase stand-alone dental plans and affordability issues are a concern.

Qualified Health Plans (QHPs)

- The Marketplace splits Texas into 26 geographic rating areas (25 Metropolitan Statistical Areas (MSAs), plus one for the remainder of the state.
- The number of QHPs available in each MSA ranges from 25 to 80.
- All health plans are assigned a “metal tier” based on the percent of costs covered:

Platinum:	90%	Silver: 70%
Gold:	80%	Bronze: 60%

- Subsidies are tied to the cost of the second-lowest silver plan.
- Monthly premium costs for child coverage in silver plans range from $102 to $214.

Essential Community Providers (ECPs)

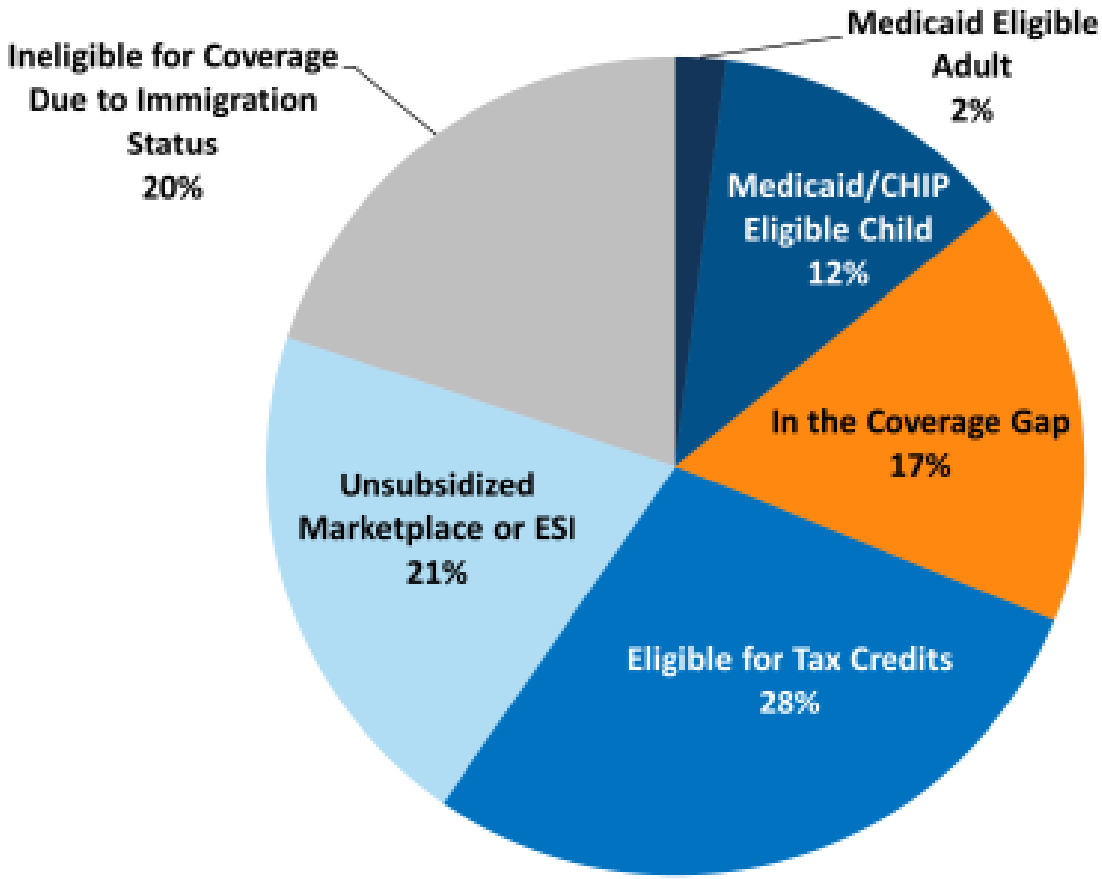
- QHPs must meet network standards for inclusion of ECPs.
- Children's hospitals are considered ECPs, but network standards do not guarantee their inclusion in QHPs.
- QHPs must meet 1 of 3 standards:
  - Contract with 20% of ECPs in the service area (including at least 1 ECP in each county in each of 6 provider categories);
  - Contract with 10% of ECPs in the service area and provide a narrative justification of adequacy; or
  - Provide a detailed narrative justification of how the network will provide access for low-income and medically underserved enrollees and how the issuer plans to increase future ECP participation.

Participation by Children's Hospitals

- Concerns have been raised about the narrow networks in QHPs.
- The ACA required QHPs to have sufficient numbers and types of providers to insure all services will be accessible without unreasonable delay.
- Texas statutes specify additional requirements for access to primary care, specialists and hospital care (e.g., distance, appointment, etc.).
- In-network participation varies among CHAT member hospitals, ranging from contracts with 1 out of 4 issuers in a hospital's home county to 6 out of 7 issuers.

Figure 2

Eligibility for Coverage as of 2014 Among Currently Uninsured Texans



Total = 6.2 Million Uninsured Nonelderly Texans

Notes: People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.
SOURCE: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey.

Low-income Subsidies

- Criteria to receive advanced premium tax credits to purchase coverage through the exchange:
  - Income between 100 and 400% of the Federal Poverty Level (FPL);
  - No access to affordable employer-sponsored insurance;
  - Ineligible for Medicaid, CHIP, Medicare or military-based coverage;
  - Legal immigration status.
- Individuals with income up to 250% FPL are also eligible for reductions in cost-sharing (e.g., deductibles and co-pays).

FPL Level	Individual	Family of 3
100%	$11,170	$19,090
133%	$14,856	$25,390
250%	$27,925	$47,725
400%	$44,680	$76,360

Reconciliation of Subsidies

- Although people can choose to receive credits when they file their tax returns, most people will claim advance credits (paid to insurers) based on projected income.
- During the year, people are expected to report to the Marketplace:
  - Changes in income
  - Changes in household (e.g., birth or child leaving home)
  - Offers of employer-sponsored insurance.
- People receiving advance credits will have to reconcile amounts received based on their estimated income with actual income as reported on their tax return.
- Repayment amounts are capped according to FPL, but if income exceeds 400% FPL, individuals will have to repay the entire amount of advance credits.

Payment of Premiums

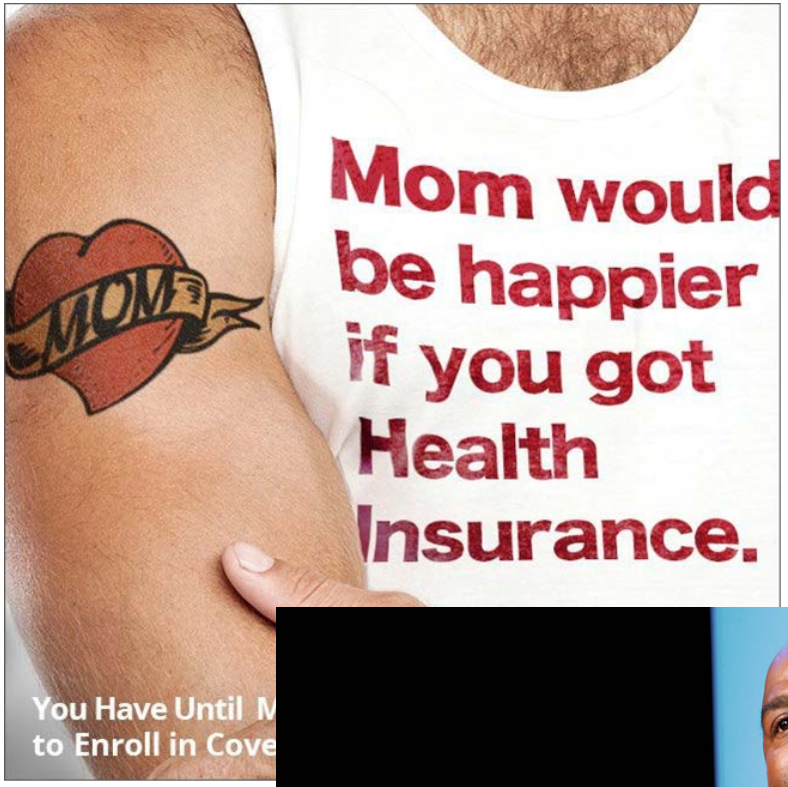
- The ACA provides a 90-day grace period to consumers who obtain subsidized coverage through an exchange but fail to pay their share of the premium.
- In the first 30 days, insurers must continue to pay incurred claims, but they are not required to pay claims for the following 60 days.
- Providers could be faced with collecting payment from low-income patients who fail to make their premium payments.
- Recommendations have been made to require issuers to notify providers within the first 15 days of the grace period or be held financially responsible for services incurred in the last 60 days.

Navigators

- The ACA establishes “Navigators” in each state for in-person assistance to consumers and small businesses.
- 8 Texas organizations were awarded $10.9 million.
- More than half of Texas’ allocation went to United Way of Tarrant County for Consumer Health Insurance Marketplace Enrollment Services (CHIMES), a collaboration with 17 organizations to provide assistance across the state.
- The Texas Department of Insurance recently adopted rules for individuals performing Navigator activities, with additional training, background checks and other requirements.

Other Outreach and Education

- Certified Application Counselors (CACs) may perform many of the same functions as Navigators.
- Hospital staff may be CACs, but must complete about 5 hours of training.
- A search function on the federal website identifies CACs by zip code (www.healthcare.gov).
- Online applications for CACs are available at: http://marketplace.cms.gov/help-us/cac.html
- Community health centers in Texas have been awarded $9.9 million to make people aware of their options.
- Many other groups are doing outreach and education (e.g., Texas Organizing Project, Catholic Health Association, etc.).


MOM
Mom would be happier if you got Health Insurance.
You Have Until M
to Enroll in Cove


#Getcovered


TAKE CARE
PEOPLE!
YOU CAN DO IT!

Who is signing up?

- Between October 1, 2013 and February 1, 2014, 3.3 million people had enrolled and selected a QHP (nationally).
- Texans accounted for 6% of these individuals (207,546).
- Females in Texas accounted for 56% of enrollees.
- 7% of enrollees from Texas are children (about 14,500).
- 62% of Texas enrollees have selected a silver plan.
- Almost 4 out of 5 Texas enrollees (79%) are eligible for subsidies.

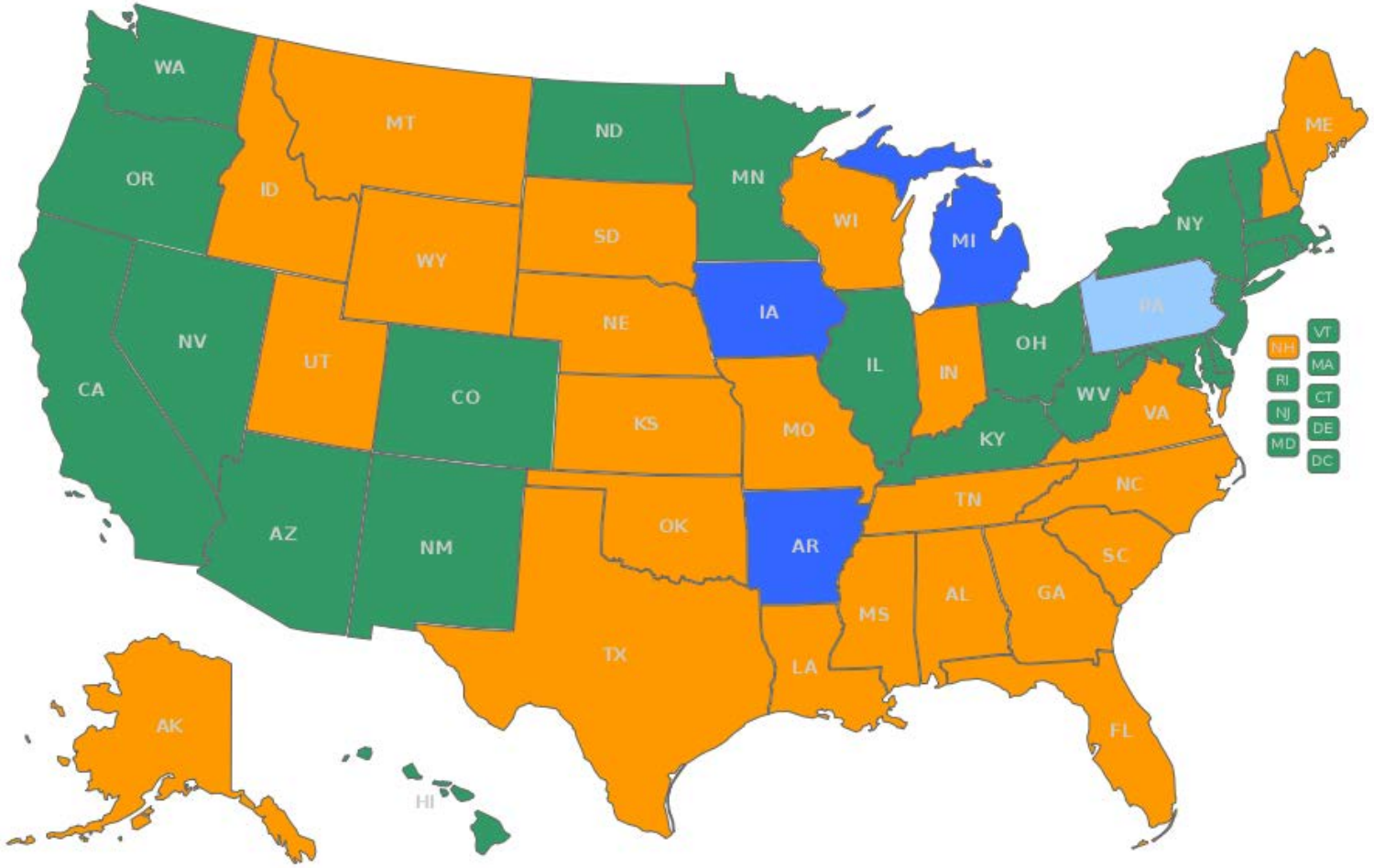
34% of enrolled Texans are less than 34 years old.

Medicaid Expansion

- The ACA expanded Medicaid coverage to nonelderly individuals up to 133% of the FPL ($11,170 annually for an individual).
- Although the Supreme Court upheld the individual mandate in June 2012, the Court determined that requiring states to expand Medicaid was overly coercive. The expansion is now optional.
- The federal government covers 100% of the costs for the Medicaid expansion population the first 3 years, phasing down to 90% by 2020.
- If a state chooses not to expand Medicaid, these individuals fall into a coverage gap, since they are not eligible for subsidized coverage through the Marketplace.

Map: Where States Stand on Medicaid Expansion Decisions

*Map updated February 7, 2014



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Key:

- 24 states are not expanding Medicaid in 2014
- 23 states are expanding Medicaid in 2014
- 3 states are expanding Medicaid in 2014, but using an alternative to traditional expansion
- 1 state with Medicaid expansion waivers pending approval from CMS

Arguments Made for Medicaid Expansion

- Medicaid expansion could provide benefits to more than a million Texans, reducing the uninsured population by almost a quarter.
- Over 10 years Texas would forego up to $100 billion in Federal Funds.
- State costs would be offset by savings in other state programs (e.g., mental health services, HIV medications, etc.).
- Federal Funds could replace county taxes for indigent care and hospital costs for uncompensated care.
- Expanded health care would generate additional tax revenue and create an estimated 230,000 new Texas jobs.

Arguments Made against Medicaid Expansion

- Medicaid “is broken” (e.g., runaway costs, fraudulent activity, complex administration, etc.).
- Medicaid provides poor care to people.
- There are not enough providers participating in Medicaid to serve an expanded population.
- A growing portion of the state budget must be devoted to Medicaid expenses.
- Distrust that the federal government will continue its share of funding, eventually shifting additional costs to the state.
- Senate Bill 7, 83rd Legislature, prohibits HHSC from expanding Medicaid eligibility.

Currently Eligible/Not Enrolled in Medicaid

- In March 2013 Texas' Health and Human Services Commission (HHSC) estimated that 790,000 Texas children were eligible for Texas Medicaid benefits, but not enrolled.
- Offering coverage through the Marketplace creates a "welcome mat" effect for children who are eligible, but not enrolled.
- HHSC expected about 384,000 of these children would sign up for Medicaid due to implementation of the ACA.
- If the state expanded Medicaid to adults within 133% FPL, HHSC projected roughly 337,000 additional children would sign up.
- The 100% federal match rate (declining to 90%) for Medicaid expansion is not available for this population.

Medicaid Eligibility Determinations

- ACA requires states to base eligibility on Modified Adjusted Gross Income, without asset tests or income disregards.
- This required a significant re-tooling of automation and extensive training.
- Changes present huge challenges in client communication.
- The Marketplace is supposed to provide a seamless application process for families who appear eligible for Medicaid or CHIP.
- To date, the transfer of these applications to HHSC has been problematic.
- The impact on Medicaid and CHIP rolls is uncertain.

Presumptive Eligibility

- Presumptive eligibility allows providers to begin the enrollment process based on key pieces of information at the point of service.
- Medicaid claims for a person are allowable while HHSC's full determination process takes place.
- The ACA allows hospitals the option to make eligibility decisions.
- States may
  - require an attestation of citizenship or satisfactory immigration status and/or residency;
  - require hospitals to assist individuals in submitting full applications;
  - establish standards for hospitals related to success in assisting individuals;
  - develop other proficiency standards, training requirements and audits for hospitals authorized to make determinations.
- System changes in Texas are scheduled for December 2014.

Medicaid DSH Reductions

- Disproportionate Share Hospital payments supplement hospitals for uncompensated care and the shortfall in Medicaid rates.
- Cook Children's Medical Center will receive an estimated $11 million in DSH funds for 2013.
- The ACA reduced national DSH funding starting at $500 million in 2014, growing to $5.6 billion by 2019.
- Texas' estimated DSH reduction in 2014 was 5.5% ($56 million).
- However, the Bipartisan Budget Act passed by Congress in December eliminates the reduction scheduled for 2014 and delays the cut in 2015.

Medicaid Payment at Medicare Rate

- The ACA provides a 2-year rate increase for certain primary care providers and services, beginning January 2013.
- Payment for Evaluation and Management (E&M) services, as well as administration of vaccines, must be at least Medicare rates, using 100% federal funds.
- Providers must be board-certified in family medicine, general internal medicine, pediatric medicine or a subspecialty within those designations; OR
- 60% of Medicaid billings for the prior year must be for E&M codes specified in federal regulation.

Medicaid Payment Rates (continued)

- Providers must complete an attestation form:
  - http://www.hhsc.state.tx.us/medicaid/medicaid-attestation-ACA.pdf
- If completed by April 1, rates are retroactive to January 2013.
- Payments through Managed Care Organizations should begin in February (although amounts related to administration of vaccine will not be included then).
- In April the Texas Medicaid Healthcare Partnership (TMHP), Texas' claims administrator, begins quarterly payments for fee-for-service reimbursement.
- At the national level medical associations and child advocacy groups are pushing for extension of the minimum payment requirements.

Other Medicaid Program Changes

- Children may receive hospice services without waiving rights for treatment of terminal illness (effective in 2010).
- States must cover tobacco cessation services for pregnant women (effective in 2010).
- More stringent screening processes for provider enrollment are implemented (based on the level of risk).

Children's Health Insurance Program (CHIP)

- Beginning March 2010 eligible children of state employees and school employees could enroll in CHIP, with the state drawing federal funds for the cost of their health coverage.
- Starting January 2014, care for children with family income between 100 to 133% FPL shifts from CHIP to Medicaid.
- HHSC is transferring currently enrolled children when coverage is renewed.
- However, a child does not have to wait until the scheduled renewal date (which could be almost a year later).
- Children's hospitals might want to proactively advise families that need more comprehensive Medicaid benefits to request Medicaid sooner.
- CHIP caseloads are expected to decline by 9% in 2014 and 35% in 2015, from 630,430 in 2013 to 373,594 by 2015.

Summary of Impact on the Uninsured

- This month the Congressional Budget Office projected the impact of the ACA on the uninsured.
- By 2024, the number of nonelderly people who have health insurance will increase by 25 million.
- 31 million nonelderly are likely to remain uninsured:
  - 30% unauthorized immigrants
  - 20% eligible for Medicaid, but not enrolled
  - 5% live in a state that chose not to expand Medicaid
  - 45% will not purchase insurance even though they have access through an employer, an exchange, or an insurer.

Prevention and Public Health Fund

- The ACA established a $15 billion fund to support additional public health programs.
- First year funding (2010) was spent mainly on infrastructure and workforce.
- In 2011 and 2012, more assistance was dedicated to prevention (e.g., tobacco).
- Beginning in 2013, the Fund was reduced by $6.25 billion from the original amount authorized over 9 years, to fund an extension of Medicare physician payments, to address sequestration and to support insurance enrollment activities for the Marketplaces.
- Instead of investments in new public health initiatives it is being used to sustain existing workforce and public health programs.

Grants for Home Visiting Programs and Childhood Obesity Demonstrations

- The ACA appropriated funds to strengthen maternal, infant and early childhood home visiting programs.
- Grants targeting high-risk populations totaled $100 million in 2010, increasing to $400 million by 2013.
- The ACA provided $25 million for the period 2010 to 2014 for childhood obesity demonstrations.
- The University of Texas Health Science Center at Houston is 1 of the 3 projects receiving an award.

Caloric Content

- Regulations are expected early this year to implement ACA requirements for restaurant chains with more than 20 locations to post caloric information.
- Companies that operate 20 or more vending machines will also be required to post caloric information.
- A grace period of at least a year for compliance is anticipated.

SUMMARY: BIG UNKNOWNS

- How many people will enroll through the Marketplace?
- Will the mix of enrollees include enough healthy individuals to adequately spread risk?
- What will Marketplace plans cost in subsequent years?
- Will other policies to control health care costs work (e.g., coordinated care, bundling, wellness, etc.)?
- How will employers react to the mandates?
- What impact will policies have on labor force participation?
- Will additional states decide to expand Medicaid?
- Will there be enough providers to provide care to the newly insured?
- Will CHIP be reauthorized beyond 2015?
- Will Congress make changes to the ACA?