Impact of the Patient Protection and Affordable Care Act on Various Population Groups in Texas

Final Preliminary Report

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Introduction

The Patient Protection and Affordable Care Act (PPACA)[1] of 2010 will change many aspects of private and public health insurance in the United States. All of the effects on insurance coverage and affordability for various populations groups are not yet clear, especially in large and diverse states such as Texas.

This analysis is divided into five main sections: 1) key provisions of the PPACA and when they become effective, 2) statistics on the uninsured in Texas and predictions on how they will be affected by federal health care reforms, 3) details of the health insurance exchanges and how they will operate, 4) the current insurance status of different population groups in Texas and how they may react to and be affected by the health care reforms, and 5) other factors to consider such as the individual mandate, the impact of insurance reforms on Texas counties, and some conclusions. There are also four appendices at the end that are referenced in the text.

Timeline and Key Provisions of the PPACA

There are numerous provisions in the PPACA, and they take effect at different times. The more significant coverage-related highlights are mentioned here, and more details of the provisions and the implementation schedule can be found in various timelines online, including the government healthcare reform website at www.healthcare.gov.[2]

2010 Implementation

Temporary federal high-risk pool for people with pre-existing conditions (effective June 21): This risk pool will charge similar premiums to what a person would pay if they were standard risk, so they will pay much less than what current members of the Texas high-risk pool pay. To be eligible, beneficiaries must be a U.S. citizen or legal immigrant with a pre-existing condition who has been uninsured for at least six months. Current members of the Texas pool are not eligible since they are considered to be insured. The risk pool will be superseded by the health care exchange and expanded Medicaid in 2014.

Young adults aged 19-25 will be able to stay on their parents' health insurance until their 26th birthdays (effective September 23): Applies to plans beginning after the effective date. Does not apply if the young people are eligible for coverage through an employer.

Insurers cannot exclude pre-existing medical conditions for children under age 19 (effective September 23): Applies to health plan years beginning on or after the effective date for new plans and existing group plans, but does not apply to grandfathered individual plans.

Insurers must eliminate lifetime maximum benefits, must restrict annual spending caps (completely prohibited by 2014), and cannot drop policyholders who get sick (effective

September 23): These provisions apply to both individual and group plans with health plan years after the effective date.

Tax credits for small businesses and non-profits with 25 or fewer full-time employees (or equivalents) who pay for at least half of the cost of single insurance for employees and have average wages of less than $50,000 per employee: During the first phase, effective immediately, the maximum credit is 35% of premiums paid by small businesses and 25% of premiums paid by eligible tax-exempt organizations (credits vary based on size and average wages). Businesses can claim the credits starting on their 2010 tax returns. The credits will increase in 2014.

Rebates to people affected by the "doughnut hole" in prescription drug coverage in Medicare Part D: One-time rebates of $250 will be available in 2010 for people who have reached the doughnut hole in coverage. Checks will be mailed starting in June 2010 and will continue monthly through the end of the year as more Medicare beneficiaries reach the gap. Half of the doughnut hole will be eliminated in 2011 through discounts of drugs purchased out-of-pocket after reaching the coverage gap, and the gap will be fully eliminated by 2020.

Early Retiree Reinsurance Program to help employer-based plans cover early retirees aged 55-64: Businesses can start applying for assistance in June, and $5 billion will be available for this temporary program that will be superceded by the health insurance exchange in 2014 (and beneficiaries will be covered by Medicare once they reach age 65). This also applies to nonprofits and government entities that provide retiree coverage.

States can choose to cover more people under Medicaid (effective April 1): Options include covering childless adults and covering family planning services to additional women. These options would require state plan amendments, and states would receive federal matching funds. Texas is not likely to enact these options soon.

Funding for Community Health Centers: New funding ($11 billion over five years) is available for expanding services at community health centers and for construction of new centers, allowing CHCs to serve an estimated 20 million news patients nationally.

2011 Implementation

There are not many coverage changes between 2010 and 2014, but there are a variety of new benefit changes that will begin, along with some policy and financial changes.

Medicaid: Changes include allowing states the option of having Medicaid beneficiaries with serious conditions to designate a provider as a health home, providing a 90% federal match for two years for care coordination; enhanced federal matching for non-institutional long-term care services; and the Community First Choice Option to allow states to offer home and community-based services through Medicaid to certain disabled people.

Medicare: Changes include that beneficiaries will get certain preventive services for no cost, will receive a 50% discount on name-brand drugs after reaching the coverage gap, and will receive more coordinated care after hospital stays.

Long-term care: A national voluntary long-term care insurance program will be established, called the CLASS Act (Community Living Assistance Services and Support). It will be publicly sponsored but will be self-sustaining with no taxpayer money used. There will be automatic deductions from all paychecks but individuals can opt out. After five years of premium payments, individuals are potentially eligible for cash payments if they cannot perform two or more Activities of Daily Living (ADLs). Enrollment starts in 2011, a benefit plan must be designated by Health and Human Services no later than October 2012, and payout of benefits begins as soon as 2016 for eligible people who have been enrolled for five years.

Limit on insurance companies' administrative costs and profits (starting January 1): Insurers must spend at least 85% of all premiums collected for large employer plans and 80% of dollars from small group and individual plans (with some adjustments) on health care services and quality improvement. If not then the difference must be returned to customers as a rebate.

Value of Health Benefits: Employers must disclose the value of health insurance coverage on employee's annual W-2 statements.

2012 Implementation

Medicare: The Value-Based Purchasing program will offer financial incentives to hospitals to improve quality, and hospital performance measures will be required to be publicly reported.

Accountable Care Organizations: Incentives will be provided for physicians to join together to form these organizations to facilitate better care coordination, improve care quality, and increase prevention. If costs are reduced, ACOs can keep some of the money they helped to save.

Electronic Health Records: A series of changes will be implemented to standardize billing and require the secure exchange of electronic health information. This should reduce administrative burdens, save money, and reduce medical errors. The federal government is distributing a great deal of funding to promote adoption. The first regulation is effective October 1.

2013 Implementation

Insurance plans (by July 1): Consumer Operated and Oriented Plan (CO-OP) program will be established in all states to encourage the creation of nonprofit member-funded health insurance companies; $6 billion will be appropriated for loans and grants.

Medicaid (effective January 1): New funding will be available to states that choose to cover free and low-cost preventive services for Medicaid patients; increase Medicaid reimbursement rates to primary care physicians to be no less than Medicare reimbursement rates, with the difference federally funded.

State Children's Health Insurance Program (effective October 1): States will receive two more years of CHIP funding.

Medicare (effective January 1): National pilot program will be established to encourage physicians, hospitals, and other providers to work together to improve the coordination and quality of care by bundling their payments and being paid a flat rate for a procedure or episode rather than the current system of separately billing Medicare for every service and provider.

2014 Implementation

Health Insurance Exchanges (effective January 1): People without access to employer-based health insurance will be able to buy insurance directly from an exchange, a marketplace that will offer a choice of affordable plans to individuals and small businesses. Premiums will be subsidized as an advanceable refundable tax credit on a sliding scale up to 400% of the federal poverty level (FPL). Plans will be categorized into four levels (bronze, silver, gold, and platinum), plus a catastrophic-coverage-only plan that will be offered to people under the age of 30 and certain people exempt from the individual mandate.

Insurance Mandates and Penalties (effective January 1): U.S. citizens and legal residents must have qualifying health coverage or pay a phased-in tax penalty. Employers with 50 or more employees that do not offer coverage will have to pay varying fees.

Consumer Protections (effective January 1): Reforms take effect that prohibit insurance companies from refusing to renew or to sell policies due to pre-existing conditions, and prohibits charging higher rates due to gender or health status in individual and small group plans. Annual limits on coverage will also be prohibited, as well as limiting coverage due to participating in clinical trials for life-threatening conditions.

Medicaid (effective January 1): Individuals and members of families earning less than 133% of FPL will be eligible for Medicaid; states will get 100% federal funding for the first three years for the expanded coverage, then 95%, then 90% in 2020 and after; asset limits will be abolished for all enrollees except aged and disabled; youths who were in foster care will be able to received Medicaid until their 26th birthdays.

Medicaid and Medicare: Disproportionate Share Hospital (DSH) payments made to the states will be reduced. Medicare DSH payments will be initially reduced by three-fourths, then subsequently increased based on percent uninsured and the amount of uncompensated care.

2015 and After

Physician payments (January 1, 2015): Physician payments will be adjusted for quality of care.

State Waivers (by January 1, 2017): States may apply to the Secretary of Health and Human Services for a waiver of certain sections of the law provided that they develop detailed alternatives to provide affordable coverage.

Insurance Plans (by January 1, 2018): All health plans must cover approved preventive care and checkups without co-payment. Also, a new 40% excise tax will be introduced for high-cost health plans in excess of certain amounts, varying for different categories and professions, and indexed for inflation.

Medicare doughnut hole (by 2020): Gap in Medicare Part D drug coverage is eliminated.

The Uninsured in Texas: Statistics Currently and After Reforms

Uninsured by Age, Income Level, Citizenship Status, and Employment

The Center for Public Policy Priorities estimated (using Census data) that 6.1 million people in Texas were uninsured in 2008—20% of Texans ages 0-18, 32% of ages 19-64, and 3.2% of those 65 and older. The estimated income levels of the uninsured in Texas were as follows:

- 1.61 million people (26.4% of the uninsured) were making less than the federal poverty level ($22,100 for a family of four);
- 1.06 million people (17.4%) were at 100-150% FPL;
- 898,000 people (14.7%) were at 150-200% FPL;
- 751,000 people (12.3%) were at 200-250% FPL;
- 484,000 people (7.9%) were at 250-300% FPL;
- 622,000 people (10.2%) were at 300-400% FPL; and
- 682,000 people (11.2%) were above 400% FPL.[3]

When looking at types of insurance by income level, a stark contrast is seen in nonelderly adults making 133% of the FPL or less (who will mostly be eligible for Medicaid in 2014), and those making 400% FPL or more. Following is the breakdown of insurance sources for people aged 19-64 in Texas with incomes up to 133% FPL (3,533,100 people, 2007-2008 averages):

- Employer coverage: 520,000 (14.7%);
- Individual coverage: 144,400 (4.1%);
- Medicaid: 583,600 (16.35%);
- Other pubic insurance (Tricare, VA, non-elderly Medicare, etc.): 187,600 (5.3%); and
- Uninsured: 2,097,800 (59.4%).[4]

The following list shows the breakdown for people aged 19-64 in Texas with incomes 400% FPL or more (4,934,900 people, 2007-2008 averages):

- Employer coverage: 4,101,500 (83.1%);
- Individual coverage: 261,500 (5.3%);
- Medicaid: 57,100 (1.2%);
- Other pubic insurance: (insufficient data); and
- Uninsured: 405,100 (8.2%).[5]

According to 2008 U.S. Census data reported by the Center for Public Policy Priorities, approximately 4.1 million of the uninsured in Texas (68%) in 2008 were U.S.-born citizens, 352,000 (6%) were naturalized citizens, and 1.6 million (26%) were not U.S. citizens. Of those who are not citizens, it is estimated that about 40% are documented immigrants and 60% are

undocumented immigrants.[6] This makes about one million undocumented people who are not insured and still will not be insured after all the health care reforms are enacted, since they only apply to citizens and legal immigrants.

Regarding employment, 55% of unemployed working-age Texans lacked health insurance in 2008, compared to 29% of employed Texans. Employees of small companies with less than 25 people were most likely to be uninsured (lacking private coverage), at an estimated 52%. At companies with 25-99 employees, 38% were uninsured, and 29% at companies with 100-499 employees.[7] The low rate of employer-based coverage cannot be attributed only to the state's percentage of small businesses, as this is similar to national averages; larger contributors are smaller percentages of manufacturing jobs, larger percentages of construction and farming jobs, lower rates of unionization, and higher rates of people in low-wage and part-time jobs.

Estimates of the Newly Insured and Uninsured after Health Care Reforms

If federal healthcare reform were fully implemented today, the Center for Public Policy Priorities estimates that of the 6.1 million uninsured Texans, about 2.5 million children and adults would qualify for subsidized health coverage in the health care exchanges, about half a million would qualify for insurance through the exchange at full cost, 1 million adult citizens would newly qualify for Medicaid, and about 500,000-700,000 children qualify for Medicaid and the Children's Health Insurance Program (CHIP) now who are not on it so they could enroll. CPPP reports that the Congressional Budget Office (CBO) predicts that 1.5 to 1.8 million people in Texas would still be uninsured.[8] This would include those undocumented people who do not have access to insurance (they are not eligible for public programs but may have private insurance), plus others that qualify for exemptions to the mandate to have health insurance or who choose to pay the penalty instead of buying coverage. (See Appendix A for a collection of coverage estimates from this report.)

The CBO estimated that 81% of people in the U.S. under age 65 were covered by health insurance in 2010 (83% excluding the undocumented), and that by 2019, 92% of people under age 65 (94% excluding the undocumented) will be covered; so by these estimates there will still be some uninsured people, though at much smaller percentages than before (see Appendix B for table).[9] The Rural Policy Research Institute estimated that 75% of all Texas residents were insured before health care reform and that 90% will be insured after (their national estimates are 83% before and 93% after, using their own simulation model). For those newly insured in Texas, the Institute estimated that the breakdown of people newly covered will be 33% adults getting on Medicaid, 28% adults receiving subsidized coverage on the health insurance exchange, 8% adults receiving other mandated coverage, and 32% children receiving new coverage from any source (they also calculated estimates for rural and urban Texans, which vary by a few percentage points).[10]

U.S. citizens with very low incomes and who would pay more than 8% of their incomes for the cheapest exchange policy will have no penalty for not having insurance, so may stay uninsured. Other citizens with more income may remain uninsured because the penalty will be about one-sixth the cost of family coverage on average, so they may choose to pay the penalty instead. For those who are legal permanent residents and not citizens, adults who came to the U.S. after 1996

cannot enroll for Medicaid under Texas law, but they can purchase insurance from the exchange and get subsidies if needed. For those who are undocumented, they will not qualify for Medicaid or CHIP before or after the reforms are enacted, and will not be able to purchase insurance from the exchange, even at full cost, so they are likely to remain uninsured.[11]

Health Insurance Exchanges

Description

One of the biggest changes called for in the federal health care reforms is the health insurance exchanges to be implemented in 2014, so an understanding of their design and function is helpful. People without access to employer-based health insurance will be able to buy insurance directly from an exchange, a marketplace that will offer a choice of affordable plans to individuals and small businesses. Premiums will be subsidized as an advanceable refundable tax credit on a sliding scale for those up to 400% FPL. Plans will be categorized into four levels: bronze, silver, gold, and platinum, which represent benefits that are actuarially equivalent to 60, 70, 80, and 90 percent, respectively, of the full actuarial value of the benefits (based on defined essential health benefits provided to a standard population, not necessarily the actual population of the plan). Actuarial value is the percent of health care charges paid by a plan, not including premiums.[12] Different combinations of covered benefits and cost sharing can yield the same actuarial value, which is a single number that indicates the general level of comprehensiveness.[13]

Qualified health plans are required to offer a uniform benefits package as defined in the PPACA, which includes these services at a minimum (called the essential health benefits package):

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.[14]

A catastrophic-coverage-only plan will also be offered to people under the age of 30 and people exempt from the individual mandate due to hardship or no access to affordable coverage. These plans will be restricted to the individual market and must offer all the defined essential benefits plus at least three primary care visits annually once the deductible is reached.[15] Preventive services would be covered with no cost-sharing as they must be under all plans.

The exchanges are intended to simplify the purchase of health insurance for citizens and legal immigrants who do not have access to affordable employment-based coverage. Small businesses with fewer than 100 employees can also use the exchange for coverage (from 2014-2016 states can limit this to businesses with up to 50 employees), and starting in 2017 states can allow any business to get insurance through the exchange. States can establish a Health Benefits Exchange for individuals and a separate exchange for businesses called the Small Business Health Options

Program (SHOP), or can combine both types into one exchange. States also have flexibility in choosing who operates the exchange—a state entity, a nonprofit, or the federal government. States can opt to have regional exchanges, or a multi-state exchange shared with other states.[16,17]

States can apply for planning grants to design and implement their exchanges, with funding available from 2011 through January 2015, and after that the exchange must be self-supporting through administrative fees charged to participating insurers or other means. Exchanges will maintain a website allowing people to compare coverage and will have toll-free telephone numbers to answer questions. They will review the premiums being charged by health plans and determine which ones should be offered through the exchange, will screen for and provide information on public programs like Medicaid and CHIP as well as plans in the exchange, and will certify whether certain people qualify for an exemption to the individual mandate.[18]

The exchange websites will link to the state's Medicaid and CHIP programs and will allow consumers to compare subsidies, apply, and renew coverage online. The federal government will develop a single streamlined form for those applying on the basis of income to subsidy programs (including Medicaid, CHIP, and the exchange) to reduce the administrative burden on applicants, and states can develop their own single form if it meets the same standards. Exchanges will offer navigator programs to provide impartial and culturally appropriate information on various coverage options and exchange subsidies, and to facilitate enrollment. The "no wrong door" approach requires that Medicaid, CHIP, and the exchanges coordinate with each other so that states enroll people in Medicaid or CHIP who are determined to be eligible by an exchange without requiring any additional paperwork (unless there are inconsistencies or insufficient information to determine eligibility), and that people found ineligible for Medicaid or CHIP are screened for the exchange and enrolled and given information on applicable premiums assistance without having to submit more paperwork.[19]

The Congressional Budget Office predicted that 8 million people nationally will be enrolled in the exchange in 2014, increasing to 24 million in 2019. They estimated that the number of subsidized enrollees will be 7 million in 2014 up to 19 million in 2019. The average subsidy per subsidized enrollee will be $5,200 in 2015 and $6,000 in 2019 (see Appendix B). The Democratic Policy Committee of the U.S. Senate estimated that 3.3 million people in Texas from 2014-2019 who purchase health insurance through the exchange will receive tax credits to help make the premiums more affordable.[20]

State Role and Options

As mentioned above, states have some options in how to design their health insurance exchanges. They can decide who will operate it, if they will offer more than one exchange in the state, and if they will join with other states to create an exchange. Allowing the federal government to run the exchange would relieve the state of a large administrative undertaking, but would not allow the state to have flexibility to address the state's unique features and to modify the exchange as needed for market conditions, and would make it harder to coordinate with the state's existing programs. A large state such as Texas probably would not want to combine their exchange with other states for those same reasons, and creating regional exchanges within the state may add to administrative costs and complexity.[21]

States can decide if the exchange will be a connector only, providing standardized information on qualified plans and costs and referring people to plans, or if they will act as a purchasing alliance, negotiating the best rates and collecting and paying premiums. A more expansive role could result in insurers discounting their rates more, and could lower administrative costs per enrollee since costs would be shared over all enrollees, but there is no guarantee that it would achieve desired results over the long term. A more limited role that makes the market more transparent by allowing consumers to more easily compare policies may be sufficient for the goal of creating more competition and lowering prices.[22] The State Coverage Initiatives program of the Robert Woods Johnson Foundation has published a timeline for state policymakers to use to help identify major decisions in planning the implementation of the exchanges.[23]

States also have the option of implementing the Basic Health Program (BHP) for citizens and legal residents with incomes at or below 200% FPL who are not eligible for Medicaid or CHIP due to income (over 138%) or citizenship status. States choosing this option will contract with health plans to provide coverage at least as affordable and comprehensive as subsidized coverage in the exchange, and will receive 95% of what the federal government would have spent in tax credits and subsidies for BHP enrollees. States can also choose to supplement federal subsidies in the exchange for this population, which would offer access to larger provider networks in the exchange but would use state dollars instead of federal dollars.[24]

Costs, Subsidies, and Examples

People have the option of purchasing insurance through the exchanges if it is not offered from their employers or if their employer's insurance has an actuarial value (AV) of less than 60% or premiums are more than 9.5% of income (percent to be adjusted starting in 2015), and if they are not eligible for other essential coverage programs such as Medicare, Medicaid, and CHIP.[25]

Premium subsidies will be offered to eligible individuals and families with incomes up to 400% FPL based on modified adjusted gross income (MAGI, which is the adjusted gross income from a tax return with certain deductions added back in). Premiums will be capped on a sliding scale at the following percentages, which will be adjusted over time:

- 2% of income up to 133% FPL (applicable for legal residents not Medicaid-eligible);
- 3-4% for 133-150% FPL;
- 4-6.3% for 150-200% FPL;
- 6.3-8.05% for 200-250% FPL;
- 8.05-9.5% for 250-300% FPL; and
- 9.5% for 300-400% FPL.[26]

The premium credit amount will be tied to the lesser of the actual premium paid or the second lowest-cost silver plan in the area adjusted only for the enrollee's age (married couples must file joint returns to be eligible for subsidies). Premium subsidies can be applied to any plan in the exchange, but only people enrolled in the silver plan are eligible for cost-sharing subsidies. Undocumented immigrants are not included in family size for purposes of calculating FPL, but their incomes are taken into account. Plans must reduce cost-sharing for eligible people so that the minimum AV of the plans for subsidized individuals and families are the following:

- 94% for 133-150% FPL;
- 87% for 150-200% FPL;
- 73% for 200-250% FPL; and
- 70% for 250-400% FPL.[27]

The federal government will make payments to health plans equal to the value of the reductions. Out-of-pocket maximums (annual cap) for enrollees are based on a percentage of the health savings accounts limits in individual high-deductible plans in 2014 and will be indexed to the average rate of premium growth.[28] The maximums in 2010 dollars for various levels of income are as follows for individuals/families (small group market deductibles are different):

- $1,983/$3,967 for 100-200% FPL;
- $2,975/$5,950 for 200-300% FPL;
- $3,967/$7,933 for 300-400% FPL; and
- $5,950/$11,900 for incomes of 400% FPL or more.[29]

The following example shows White House and Congressional Budget Office estimates of the income-based premium caps and average premiums for a silver plan for a family of four in 2016 (the FPL is projected to be about $24,000 for a family of four in 2016).[30]

Examples of Family Insurance Costs at Various Income Ranges, 2016

Annual Income	Premium Cap as a Share of Income	Middle of Income Range (family of 4)	Avg Annual Premium (family)	Premium Subsidy (share of premium)	Avg Cost-Sharing Subsidy
100-150% FPL	2.1–4.7%	$30,000	$600	96%	$3,300
150-200% FPL	4.7–6.5%	$42,000	$2,400	83%	$1,800
200-250% FPL	6.5–8.4%	$54,000	$4,000	72%	0
250-300% FPL	8.4–10.2%	$66,000	$6,100	57%	0
300-350% FPL	10.2%	$78,000	$9,200	44%	0
350-400% FPL	10.2%	$90,100	$14,100	35%	0

The following table shows examples of costs through the health insurance exchange starting in 2014 for families at various income levels. Annual premium costs, actuarial value, caps on out-of-pocket spending (not including premiums), and caps on total spending are shown.[31]

Examples of Family Insurance Costs at Various Incomes, 2014

Income for Family of Four	Maximum Annual Premiums	Average Percent of Health Costs Covered by Plan ("actuarial value")	Cap on Uncovered Spending (excluding premiums)	Cap on Total Family Spending
150% FPL ($33,075)	$880	94%	$3,967	$4,847 (15% income)
250% FPL ($55,125)	$4,465	73%	$5,950	$10,415 (19% income)
350% FPL (77,175)	$7,332	70%	$7,9763	$15,305 (20% income)
450% FPL ($99,225)	no max	buyer's choice: 60-90%	$11,900	none

The Kaiser Family Foundation has a webpage called the Health Reform Subsidy Calculator where people can enter income, age, and other variables and see if they might be eligible for subsidies and what their estimated premiums would be in 2014. It can be found at http://healthreform.kff.org/SubsidyCalculator.aspx.

The lower the actuarial value of a plan, the few health care costs it covers, so deductibles and cost-sharing will be much higher in a bronze plan than a platinum plan, even though all will offer the same essential services (and accordingly, premiums will be lowest for a bronze plan). For example, the Urban Institute shows that a typical employer-sponsored HMO with an AV of 93% (qualifying as a platinum plan since the AV is over 90%) might offer coverage with no deductible, $20 office visit co-payments, $250 hospitalization co-payment, and prescription drug co-payments of $10, $25, and $45 for generics and preferred/non-preferred name-brand pharmaceuticals. A gold plan at 80% AV or more could be a PPO with 20% co-payments for in-network office visits and hospitalizations, annual deductibles of $400 per individual or $700 per family, out-of-pocket maximums of $2,000 per individual and $3,500 per family, and the same pharmaceutical benefit as above (or various cost-sharing levels could be adjusted up or down, as long as it still added up to 80% AV or more). A silver plan would have higher deductibles and out-of-pocket costs that would make its AV at least 70% but less than 80%, and a bronze plan at 60% AV would have higher cost-sharing still, such as 20% co-insurance, an individual deductible of $3,000, and an out-of-pocket maximum of $5,950.[32]

There have been questions on whether current high-deductible plans that qualify for accompanying health savings accounts would be allowed in the exchanges. Some policymakers favor these plans since they give consumers more control and incentivize people to avoid unnecessary health care costs. It appears that most current HSA-qualified high-deductible plans have sufficient actuarial value to be offered in an exchange, but not all will. The typical employer-sponsored HSA-qualified high-deductible plan has an AV of 76%, with a $1,500 annual deductible, 20% co-insurance, and a $3,000 out-of-pocket max. If the federal government decides that HSA contributions count in determining the actuarial value, then the AV for this plan could be as high as 93% (platinum instead of silver). In the individual market, which is much less generous, the average high-deductible plan that is HSA-qualified would have an AV of 61% (without counting HSA contributions), so it would qualify as a bronze plan.[33]

Impact of PPACA on Specific Demographic Groups in Texas

Children

Of the 6.4 million children under age 18 in Texas in 2008, about 1.4 million (20%, the highest rate in the nation) were uninsured. More than 2.5 million children (about 39.4%) received insurance through Medicaid and CHIP, leaving about 2.5 million who had insurance through their parents' employers or other group or individual policies. More than 500,000 children without insurance (more than a third) lived in families making more than twice the FPL, an increase of 95,000 in the past five years.[34] Since 200% of poverty is usually the cut-off for public assistance such as CHIP and insurance premiums continue to rise, an increasing number of people considered moderate or high-income cannot afford insurance for their children. That leaves about 900,000 children who were uninsured and had family incomes under 200% FPL.

The Center for Public Policy Priorities calculated from Census data that more than half of the uninsured children in Texas are eligible by income for Medicaid or CHIP,[35] so that would be more than 700,000 eligible, assuming they met other criteria such as the CHIP asset test for children 150-200% FPL. (The remaining children, less than 200,000, would not to be eligible due to citizenship status or other factors.) There are several reasons that eligible children might not be enrolled, including their families being unaware of the programs or being intimidated by enrollment procedures, undocumented parents of documented children being fearful to apply for government aid, or families trying to enroll and being thwarted by recent problems in the state enrollment systems.

Currently in Texas, the main eligibility categories for Medicaid are newborns and pregnant women, who can have incomes up to 185% of the federal poverty level, children 1-5 who qualify at up to 133% FPL, and children 6-18 who qualify at up to 100% FPL (there are other ways to qualify for other groups such as the disabled, aged, and those on cash assistance).[36] To qualify for CHIP, children up to age 18 must have family incomes at or below 200% FPL, and must pass an asset test if their incomes are 150%-200% FPL.[37]

After the health care reforms take effect, for children under age 6 there will be no increase in Medicaid availability except for those who are currently excluded because of the asset test. For children ages 6-18, instead of being eligible for Medicaid up to 100% FPL, starting in 2014 they will be eligible up to 138% FPL, so the group of children with family incomes of 100%-138% FPL who now qualify for CHIP will be moved to Medicaid. (The provisions of the act and many other sources often refer to 133% FPL, but the effective standard is actually 138%, as eligibility is based on a modified adjusted gross income of 133% FPL with no asset or resource test plus a special adjustment of 5%.)[38] Kaiser Family Foundation estimates that 24% of children currently in separate CHIP programs nationally could be moved to Medicaid.[39] See Appendix C for a chart showing the main insurance options for children in Texas after the reforms are enacted.

Getting rid of copays for CHIP will probably increase the number who enroll in CHIP. The "no wrong door" approach should also increase enrollment and continuity. Another impact should be that although the state's match for those who were and are on Medicaid remains the same, the average cost of a Medicaid enrollee should decrease since high-cost enrollees tend to have been enrolled by providers, and it is mostly the well who will be added after the reforms. CHIP enrollees who move over to Medicaid because of the dropping of the Medicaid asset test (in 2014) will keep the CHIP federal match, which is higher than the normal Medicaid match. To reiterate, the state will still be responsible for current enrollees and those who are currently eligible, but since the newly eligible 6- to18-year-olds should be less costly than the average 6- to 18-year-old and also because continuous eligibility should reduce average costs, the overall addition to cost of children is complex and difficult to estimate, though it will certainly increase. Because the state is responsible for a larger portion of the matching funds for children already eligible than those newly eligible, there will be a risk that the state will not prioritize enrollment of those children before or after 2014.

Another group that will be affected by the reforms are children of low-income State of Texas employees who now are covered by a state-funded equivalent of CHIP called SKIP, but now will be eligible for CHIP starting in 2010 due to the federal law against CHIP funding for children of

state employees being changed. This should save the state money since the federal government will now pick up a large portion of their costs.

One recent study estimated that "for every 1,000 jobs lost, 311 privately insured children lose coverage and more than 45% of the poorest and most vulnerable of privately insured children become uninsured."[40] If employment remains tenuous for many this is a problem that may increase. More fundamentally, a recent article using 2006 data estimated that "33% of all uninsured children had been enrolled in Medicaid or CHIP during the previous year, and 42% of all children who were uninsured but eligible for one of the programs had been enrolled the year before."[41] Sommers goes further in his 2010 article where he looks at trends between 2006 and 2008 in both dropping out of CHIP and Medicaid as well as failure to take up the programs when eligible. He attributes the somewhat improved retention rate to the extension from 6 months to 12 months for eligibility in some states for CHIP or Medicaid. At the same time the lower take-up rate is attributed possibly to the requirements in the Deficit Reduction Act of 2005 which required by July 2006 that all new applicants to these programs have proof of citizenship. The number of uninsured children stayed at between 10.5% and 11.7%. And although the retention rate improved, there were still 2 million children who dropped out of the program even though they remained eligible for one of the programs. He speculates that there may be some improvement as the CHIP Reauthorization Act (CHIPRA) is implemented since it contains a number of incentives for states to be more proactive in enrolling children and allows a less stringent proof of citizenship or more than five years legal residence.[42]

It is important to note that although there will be some changes regarding asset tests and movement between CHIP and Medicaid, that other than some children of very low-income state employees, the PPACA does not provide additional coverage to anyone 18 or below. There is an enhanced CHIP match of 95% in October 2015 (and CHIP will have to be reauthorized by September 2015). States may be able to put CHIP enrollees in the exchange if the plan is comparable to the existing and approved CHIP plan. According to CPPP there are between 500,000-700,000 uninsured children in Texas below 200% of poverty. There is no doubt that there will be a push to increase enrollment of this population, and moving to annual enrollment, fewer barriers, "no wrong door" to enrollment should definitely lead to an increase from the status quo. At the same time virtually by definition the parents of these children will face no or minimal fines for not obtaining coverage, and these children are currently eligible for the most part and are not enrolled. This expansion will cost substantial additional general revenue since for Medicaid the roughly 60/40 match will hold. Those who move to Medicaid from CHIP because of the removal of the asset test will still have a current CHIP match rate.

HHSC Commissioner Tom Suehs, in his April testimony to the Texas House Select Committee on Federal Legislation, estimated that the take-up rate for existing eligible but currently not enrolled children and newly eligible adults would be 91% in 2014, increasing to 93% in 2015 and 94% ongoing for Medicaid and CHIP due to awareness of the individual insurance mandate. (Though the mandate will in reality probably not apply to many of these individuals and families due to low income.) Based on these assumptions he estimated that the numbers in the following table would represent the additional CHIP/Medicaid enrollees aged 18 and under and the additional adult Medicaid enrollees.[43]

These would represent extremely high adoption rates and an achievement far beyond levels that have been achieved before in Texas. Since Texas does not intend to begin any of this enrollment early it is highly unlikely this level of enrollment will be seen. For children in particular, since nearly all of them are currently eligible, it will be necessary for the state to significantly ramp up outreach and enrollment in the years prior to 2014 if they wish to come anywhere near this projection.

HHSC Estimated Additions to CHIP and Medicaid Caseload in Texas (Thousands)

	2014	2015	2016	2017	2018	2019
Additional Children	574	664	717	731	746	761
Additional Adults	1,232	1,284	1,324	1,351	1,378	1,405
Total	1,807	1,948	2,041	2,082	2,124	2,166

There are several reasons to think that these and other estimates of coverage for children in Texas due to the health care reforms are high. These include the fact that many eligible children are in families with one or more parent who does not have documented status in the U.S., that there are many in families where one or more parents have lost their jobs and access to health insurance (in principle they could get Medicaid but they often do not), and there is the history of low take-up rates of both Medicaid and CHIP in Texas and elsewhere. Except for children previously excluded for asset reasons and children moving from CHIP to Medicaid, there are virtually no new eligibility groups in this population

Regarding private insurance, the health insurance exchanges must offer child-only policies (up to age 21), so that will be a potential source of insurance for children starting in 2014 who are not on family policies and who do not qualify for CHIP or Medicaid, and whose parents either have insurance somewhere else or are not insured but choose to cover their children separately.

Low-Income Adults

For people in Texas ages 19-64, the main source of health insurance is employment-based, covering 54% (employees and family members) in 2008. Medicaid and Medicare coverage for this age group was low (6% and 3% respectively), and 32% of this age group was uninsured, so that leaves 5% of working-age adults who had other insurance sources such as individual plans or military coverage.[44] These estimates (originally from the Census Bureau's 2009 Current Population Survey) are for people without insurance for the entire year. If people uninsured for only part of a year are taken into account, other studies show numbers much higher than the estimated 6.1 million uninsured. Families USA estimated that about 9.3 million nonelderly people in Texas (44% of all residents under age 65) were uninsured for part or all of the two-year period from 2007-2008, 81% of them for six months or more.[45]

Except for undocumented residents and many documented adults who came to the U.S. after 1996, low-income adults below 138% of the poverty line will become eligible for Medicaid in 2014, and it is estimated by the state that many will choose to obtain it, especially if they are under the impression that they will be fined if they don't obtain it, whether that is true or not. This will be where the main increase in insurance coverage will come from. Now very few low-income adults are covered by employment-based or government insurance, and of the rest those

who do get health care receive it from county indigent programs, hospital districts, or charity. See Appendix D for a chart showing the main insurance options for nonelderly adults in Texas after the reforms are enacted.

For the population below poverty there are several current sub-breaks that may be important. The break points are $188 a month for TANF eligibility (income cap of mother with two children and asset limit of $1,000), which means automatic eligibility for Medicaid; 21% of poverty for mandatory county indigency; 100% of poverty for families with children over 5; and 138% of poverty to pick up the additional adults who will be covered by Medicaid starting in 2014.

Currently, the federal government covers 50% to 76% of states' Medicaid costs, depending on the state per capita income (the matching rate is higher for CHIP, at 65%-83%). The matching rate, called the Federal Medicaid Assistance Percentage (FMAP), varies annually and was 60.56% for Medicaid and 72.39% for CHIP in Texas in FFY 2008.[46] The American Recovery and Investment Act of 2009 provided a temporary increase in the FMAP to states to help during the recession (an additional 6.2% from October 2008 to December 2010), and the increase was extended in August 2010 to be 3.2% in the first quarter of 2011 and 1.2% in the second quarter.[47] The PPACA requires states to cover all people up to age 65 with incomes up to 138% FPL who are not otherwise already eligible for Medicaid starting in 2014, including in some states such as Texas moving children already on CHIP to Medicaid so families can be covered together. The cost of all of these newly eligible Medicaid beneficiaries will be covered 100% from the federal government from 2014-2016, then will get a federal matching rate of 95% in 2017, 94% in 2018, 93% in 2019, and 90% after that (except for children already on CHIP, who will continue to receive the CHIP federal match, which is higher than the standard Medicaid match but lower than the new Medicaid match, and will be increased by 23 percentage points in 2015).[48] Almost no children will be eligible for the 100% and subsequent high Medicaid matching rates, since most are not newly eligible.

States are required to maintain their current eligibility standards and enrollment procedures until the exchanges are operational in 2014, and until September 30, 2019, for children, so they cannot take current eligible people off of Medicaid (except maybe for adults over 138% FPL) but they could theoretically cut reimbursement rates and optional benefits. States have the option starting in 2010 to move early to provide Medicaid to people up to 138% FPL through a state plan amendment and still qualify for enhanced federal matching starting in 2014, but Texas is not likely to pursue this option.[49]

How Medicaid expansion under the act is implemented will have a big impact on how many people enroll and gain coverage. The Kaiser Commission on Medicaid and the Uninsured points out several factors such as that Medicaid will need to be introduced to the public in an appealing new way as affordable health care for working families (a new name is even suggested) and that Medicaid enrollment and renewal needs to be made easy. Also, funding for state capacity-building is important as states will need federal help in streamlining state enrollment systems, and Medicaid coverage must translate into access to care so there must be enough providers to see enrollees and reimbursements must be adequate.[50]

Holahan and Headen estimated that after eligibility for Medicaid is expanded in 2014, 15.9 million additional adults nationally would enroll resulting in a 45% reduction in uninsured adults under a standard scenario, which predicts that 57% of people newly eligible would participate (and lower percentages among those already eligible but not enrolled). Under an enhanced outreach scenario, which assumes more aggressive outreach and enrollment campaigns and a new "culture of coverage" due to the individual mandates, they estimated that 75% of the adults newly eligible would participate (and less of those already eligible but not enrolled, but more than in the standard scenario). In this scenario, an estimated 22.8 million more adults would be in Medicaid by 2019, resulting in a 70% reduction in uninsured adults.[51] CBO estimated that 16 million more people will be on Medicaid and CHIP by 2019 (see Appendix B for table with breakdown of changes due to reforms).

Holahan and Headen point out that low-eligibility states such as Texas and Alabama with higher uninsured rates will see larger reductions in the uninsured. They estimated that under their standard participation scenario, Texas would gain 1,798,314 new Medicaid enrollees by 2019, with 1,379,713 of them being uninsured previously, for a reduction of 49.4% in the adult uninsured rate. This would result in 45.5% more Medicaid enrollees at an additional state cost of 3% from 2014-2019 and additional federal cost of 38.9%, due to the favorable federal matching rate. Under the enhanced scenario, Texas could gain 2,513,355 Medicaid participants, of whom 2,055,888 would be newly eligible, resulting in a 73.6% reduction in the uninsured. In this scenario, the state would have 5.1% additional costs over baseline and the federal government would have 45.9% additional costs from 2014-2019.[52]

As mentioned in the previous section on children, HHSC predicted a 91% take-up rate for existing eligible children and newly eligible adults for Medicaid and CHIP starting in 2014, increasing to 94% after 2015 (with numbers of people shown in the table in the previous section), but this is much higher than even the enhanced outreach scenario in the Holahan and Headen paper. It is unlikely that this will be achieved in Texas for adults or children, even with the individual mandate and attention newly focused on health insurance, due to needing much more outreach and enrollment and the experience of low take-up rates in the past.

Many adults will qualify for the new health insurance exchanges in 2014, whether individually or as part of a small business, as explained in the previous section on the exchanges. If their family incomes are four times the poverty level or less, they will also qualify for reduced prices on their insurance coverage. Adults up to age 30 and certain people excluded from the individual mandate to have insurance are also eligible to buy inexpensive catastrophic-only insurance policies through the exchanges. Access to plans in the exchange should also help self-employed individuals locate affordable coverage.

Young adults ages 19-25 have another option for health insurance if they qualify, which is to remain on their parents' private insurance plans and continue to receive dependent coverage until their 26th birthdays (previously this coverage often ended at age 18 or when they were no longer students). Beneficiaries do not have to be living with a parent, do not have to be students, and do not have to be classified as a dependent on a parent's tax return. They can be married, but their spouse and children do not qualify for coverage. They cannot have access to employer-sponsored coverage, and must have dependent coverage through a group plan that was in place

prior to March 23, 2010.[53] The coverage extension is effective to new plan years on or after September 23, 2010, so young adults may have to wait for a new plan year in order to enroll, though some insurers are extending coverage earlier to those who would temporarily lose it.[54] The White House estimates that this new benefit could help approximately 161,000 young adults in Texas have access to affordable health insurance through their parents.[55]

Employees at Small and Large Firms

As stated in the statistics section, 29% of employed Texans lacked health insurance in 2008, and people at smaller companies were much more likely to be uninsured than people at larger companies (52% at small companies, 38% at medium companies, and 29% at larger companies with over 100 employees).[56] For 2009 it was estimated that 94% of firms in Texas with 50 or more employees offered health insurance, while only 34.2% of firms with fewer than 50 employees did so (the same statistics are 96.2% and 41% for the U.S. as a whole).[57] Small businesses pay an average of 18% more for health insurance with the same coverage as large businesses, and insurance premiums have gone up three times faster than wages in the past 10 years.[58]

Under the PPACA, employers are not directly required to offer health insurance to their employees, but there are incentives for many of them to do so. Starting in 2014, large employers (with at least 50 full-time equivalent employees the previous year) will face penalties if one or more of their employees (working 30 or more hours a week, not counting seasonal employees) obtains subsidized coverage through an exchange, due to the employer not offering coverage or it being inadequate or unaffordable (more than 9.5% of the employee's income). Employers that do offer insurance will be required to provide a "free choice" voucher (in the amount that they would have contributed to the worker's plan) to certain low-income employees that allows them to enroll in a plan offered by an exchange instead of by the employer (though they cannot received subsidies), with no penalty to the employer. Employers that have more than 200 employees and offer health insurance will be required to automatically enroll them in the company's health plan, but employees can choose to opt out.[59]

Starting in 2010, small businesses can receive tax credits to help them afford to offer health insurance. Firms are eligible if they have 25 or fewer full-time equivalent employees, average annual wages under $50,000, and the employer covering at least half of the premium costs. From 2010-2013, the maximum credit is 35% of the employers' costs for businesses, and 25% for nonprofits. From 2014 on, the maximum credit is 50% of employers' costs for businesses, and 35% for nonprofits, available for two years. The maximum credit is for small employers with 10 or fewer employees and average wages under $25,000, and the credit decreases as size and wages increase.[60]

The state has a new program passed by the legislature in 2009 called Healthy Texas that could help more small businesses offer health insurance, especially in conjunction with the new federal tax credits. This program creates a public/private health insurance initiative to offer lower-cost insurance to employees of small businesses that do not currently offer insurance. It creates a state-funded reinsurance pool to pay for a portion of high enrollee costs, and the Texas

Department of Insurance states that it "has the potential to provide insurance to a significant portion of the 5.9 million Texans currently without health insurance."[61]

Enrollees in the Healthy Texas program will select from a variety of state-approved private health plans, which will be able to offer premiums that are an estimated one-third less than would be normally offered due to the state reducing the insurers' exposure to high-cost claims. For an enrollee's claims that fall between $5,000 and $75,000 in a calendar year, the reinsurance program will pay 80% of the cost (the plan will cover costs below and above those thresholds as usual, plus the remaining 20% between them). The program will also make insurance more available because it will require only 60% of an employer's eligible employees to participate, compared to the current standard of 75% participation. Other eligibility criteria include having 2-50 employees, no group insurance offered within the past 12 months, at least 30% of employees earning 300% of the poverty level or less, and the employer must pay at least 50% of the premium costs for employees. The legislature allocated $17.4 million in annual reinsurance funding and $171,000 for limited administrative, development, and outreach for the 2009-2011 biennium.[62]

A Kaiser Daily News item cited several state-level news organizations that claim that eligibility for the new tax credit for small businesses ranges from 86% of all small businesses in Colorado to 85% in Utah and 82% in Arizona.[63] For Texas, Families USA estimated that there are 307,800 small businesses (fewer than 25 employees) in the state, and that 248,700, or 80.8%, are eligible for the small business tax credit. Of these, 79,100 business are eligible for the maximum credit.[64] The Democratic Policy Committee reports that up to 292,593 small businesses in Texas will be eligible for tax credits.[65]

Firms that have more than 50 full-time employees (or equivalents) and don't offer health insurance may have to pay penalties under the reforms, as well as some of those who do offer coverage. If no coverage is offered and at least one full-time employee gets subsidized coverage in the health insurance exchange, the company will have an annual assessment of $2,000 per full-time worker (excluding the first 30 employees). This penalty is about 23% of the employer's cost for family coverage. If coverage is offered but at least one full-time employee gets subsidized coverage in the exchange (allowed if employees' premium share is over 9.5% of their family income), then the employer's annual penalty will be the lesser of $3,000 per subsidized employee or $2,000 for each full-time employee.[66,67]

The Office of House Speaker Nancy Pelosi reports that 94.2% of firms in Texas are completely exempt from any responsibility requirement due to having fewer than 50 employees, and that 91.6% that would be eligible to pay assessments already offer health insurance to employees.[68] One impact of the penalties is that larger firms may be more incentivized to contract much low-wage work out to firms of less than 50 employees so as to move their health insurance costs for those who do not get a significant tax break for it off the company's books.

The Census Bureau's Statistics for U.S. Businesses program reports on the business size and enterprise size (each physical location of a business) on the national, state, and county level. This data does not include nonemployer businesses (self-employed with no paid employees), private households, railroads, agricultural production, or most government entities. The

following table shows the breakdown of firm size and establishment size for Texas, as well as the number of employees as of March 2007.[69]

Number of Firms, Establishments, and Employees, Texas, 2007

Enterprise Employment Size	Number of Firms	Number of Establishments	Employment
0-4	229,814	230,224	391,980
5-9	70,929	71,871	465,043
10-19	43,941	46,472	587,326
20-99	38,792	51,039	1,474,118
100-499	8,869	25,036	1,230,452
500 and over	5,339	96,766	4,892,111
Totals	***397,684***	***521,408***	***9,041,030***

The business employees shown in the table are estimated to be about three-fourths of the workers in the state, since the 2000 Census identifies the classes of workers in Texas as follows: 78% private wage and salary workers, 14.6% government workers, 7.1% self-employed, and 0.3% unpaid family workers.[70] In addition, the Census Nonemployer Statistics for 2008 show 1,835,870 businesses in Texas with no paid employees. Nonemployers are counted by tax returns, not physical locations, and are mostly self-employed individuals with very small unincorporated businesses that may or may not be the owner's main source of income. Nonemployers account for a majority of all business establishments, but average less than 4% of all sales or receipts.[71]

A minority of small businesses currently offer health insurance, but if they buy it through the exchange starting in 2014, it should be easier to get and less expensive than what they currently pay. Also businesses smaller than 25 employees are even less likely to buy insurance and those are the ones that get the larger tax credits to buy. Similarly those with lower-income employees tend to be much less likely to offer health insurance, and there may not be much of an incentive to offer it even with the tax credits. A positive factor for small businesses is that the exchanges should make the process of obtaining coverage more transparent and in many cases less expensive. And the Healthy Texas program, if it persists, along with tax credits should make insurance more accessible.

Joseph Newhouse argues in a recent *Health Affairs* commentary that it is unlikely that many employers with more than 50 employees will drop insurance because of the mix of incentives to retain it. He gives the example of a single person making $40,000 a year who has a $5,000 premium policy, all of which cost is deductible. This would amount to a $1,250 subsidy in reduced federal income taxes in addition to an unknown subsidy due to reduced state and local taxes. If the employee goes to the exchange for insurance he would receive a subsidy of a little less than $1,200, but the employer must pay a penalty of $2,000 for all those who receive a subsidy and in addition all employees above 400% FPL receive no subsidies, and their marginal tax rates are likely to be higher.[72]

It is difficult to estimate how many small businesses that do not offer insurance will start offering it due to favorable reforms such as the tax credits starting in 2010 and the exchanges starting in 2014, since just as it does now, it will depend on the cost of the insurance and what they and

their employees can afford. This in turn depends on many variables such as the type of business, geographic location, types of workers, and their ages and income levels. It is also hard to estimate how many more people this would add to the insurance rolls, since some employees of small businesses may already have coverage from other sources such as a spouse's employer-sponsored insurance.

People with Pre-Existing Conditions: State and Federal High Risk Pools

To be eligible for the Texas high risk pool (called the Texas Health Insurance Pool), one must be a legal Texas resident under age 65 and be able to meet at least one of the eligibility criteria that include rejection by an insurer for health reasons, offer of insurance that would exclude pre-existing conditions, or diagnosis of one of the medical conditions giving automatic eligibility such as cancer, AIDS, or organ transplant.[73] Premiums for the Texas high risk pool depend on which of the five health plans is chosen (each one has a different deductible,) and also on age, gender, zip code, and tobacco use. State statute requires that premiums be set at twice the average rates charged in the commercial market.[74]

Enrollment in the Texas high risk pool was 26,556 at the end of 2009, with a total of 33,621 people served during that year. Members enrolled at the end of the year had been covered for an average of 40 months, and total departures from the pool in 2009 were 7,065. According to the report to the governor, 33% left the pool because of inability to pay premiums or a rate increase, 24% obtained other insurance, 22% reached age 65, 14% did not give a reason, 4% did not respond, and 3% died. Members live in every metro area in the state and in all but four counties in Texas; the counties with the highest enrollments were Dallas at 2,748 people and Harris at 3,323. The insurance industry came up with about $89 million in charges to make up the deficit between costs and the premiums received in 2009.[75]

To be eligible for the new federal high risk pool that took effect in 2010 (and will likely be phased out when the health insurance exchanges come online in 2014), one must be a citizen or legal resident of the U.S., have been uninsured for the last six months, and have been denied insurance due to a pre-existing condition. Premiums for the federal pool (called The Pre-Existing Condition Insurance Plan) will be based on standard rates so will be about half of those charged in the Texas high risk pool. The program website says that in Texas, monthly premiums are $323 for ages 0-34, $387 for ages 35-44, $495 for ages 45-54, and $688 for 55 and over. Covered in-network services have a $2,500 annual deductible and have co-payments for doctor's visits and medications.[76]

If states choose the option in the PPACA to contract with the federal government to operate their own new state high risk pools to offer subsidized coverage to people with pre-existing conditions, they have to show maintenance of effort and agree to continue to spend the same amount in their existing state pools as in the previous year; however, if states choose to use the new federal program as Texas (and 21 other states) did, then they do not have to show maintenance of effort.[77] In fact, the Texas risk pool issued a letter to new applicants in May 2010 telling them that the federal risk pool would soon be available to those who qualify (including by being uninsured for six months), and that rates will be half those of the state risk pool, so applicants should determine which risk pool program best fits their needs.[78]

The Texas Legislature passed a bill in 2009 that provides sliding-scale premium discounts for lower-income members of the Texas high risk pool beginning January 1, 2011. Enrollees with incomes below 200% of poverty will receive a 50% discount and those between 200-300% FPL will receive a 30% discount. This will be funded by the fines health insurance companies and HMOs pay. Applications were mailed to current members in July 2010, and are not available for those not currently enrolled due to insufficient funding, so this will not expand access to this program.[79] The new federal high risk pool will not provide subsidies for low-income people, so in effect low-income people would pay roughly the same for coverage in both programs.

Not only does it take significant resources to stay enrolled in the Texas high risk pool, but the net cost to the insurance industry will not be high when this population migrates to the health insurance exchanges since they already bear much of the cost of the high risk pool through assessments on health insurers. In fact to the extent that some of these people are those who have spent beyond their policy limits in the next few years this category will not increase. For the people who leave the Texas risk pool due to running out of money, there may be a limited and short-term role for providers or charities in helping them (and others in similar situations) obtain needed health services so they can wait six months without insurance and then apply for the new federal high risk pool. Another option would be to help pay the premiums in the federal risk pool for uninsured people with costly medical conditions who can't afford it even though the premiums are at standard rates, so they can join and become insured, thus reducing uncompensated care. This would also be temporary and assumes that they can obtain subsidized insurance from an exchange in 2014.

A potential problem with these strategies of helping people enroll in the federal high risk pool is that only $5 billion is appropriated for the new high risk pool and many analysts believe it will run out of funds before 2014. The allocation to Texas for the 3.5 years of the program is $493 million.[80] The Congressional Budget Office estimates that to fully fund the pool to last through the end of 2013 without capping enrollment would take $10-$15 billion.[81]

The National Institute for Health Care Reform used data from the 2007 Medical Expenditure Panel Survey (MEPS) to estimate how many people nationally were without health insurance for at least six months and had a high-cost chronic condition. The number of people meeting these criteria that are ages 19-64 is estimated to be 6.24 million nationally.[82] Assuming they are spread proportionally throughout the states (even though Texas has a higher uninsured rate so this estimate might be low), Texas had 8.1% of the national population in 2009,[83] so that percentage of the estimate gives 505,440 potentially eligible nonelderly adults in Texas, though not all would be expected to be interested or to try to enroll. The Democratic Policy Committee of the U.S. Senate estimated that there are as many as 715,954 people in Texas who are uninsured and have pre-existing conditions.[84]

The CBO expects enrollment in the federal risk pool will be capped by the federal government using its authority under the act so that the program can stay within budget, therefore they estimate an average of 200,000 enrollees per year nationally. They estimate that if the program was not capped and that additional funding was provided, national enrollment could be 400,000 in 2011 and increase to 600,000-700,000 in 2013.[85]

As of mid-August 2010 (about six weeks after the new federal risk pools began operating in some states), only 3,600 have applied (and 1,200 approved so far) in the states operating their own risk pools, and only 2,400 have applied in the states that are using the federal risk pool program.[86] So at only 6,000 applicants so far, even though all states are not operational yet there is a long way to go to reach the CBO's estimate of 200,000 people per year in the plans. The plans need more publicity, which is going to start in some areas as the company that has contracted with the federal government to run the plans in the 22 states starts its marketing campaign. The low enrollment also speaks to the need to help subsidize these plans for lower-income individuals and families who are uninsured and have no other choices until Medicaid expansion and the exchanges start in 2014.

Undocumented Immigrants

It is unclear how the undocumented population and their incomes can be measured, but it is important because of their systematic exclusion from not only Medicaid, tax credits, subsidies, and the high risk pool, but also because they are also excluded from the obligation to have health insurance, or at least from having to pay the fine for not having it. Undocumented people as well as legal permanent residents can receive coverage from Medicaid only in emergency situations (including childbirth). In state fiscal year 2007, 5% of non-full Medicaid beneficiaries were legal and illegal residents, which amounts to 9,655 people who received emergency-only care.[87] In another report, the Texas Health and Human Services Commission estimates that 63% of the non-citizens served in 2006 were undocumented, so that would make about 6,083 undocumented immigrants served in this program.[88]

The enumeration of undocumented immigrants is complicated by the fact that they often are married to a legal resident or citizen and may have citizen children who are eligible for CHIP or Medicaid. There are some estimates that 40% of the undocumented have private health insurance, but this seems like an overestimate. More accurate measurement of this population is vital not only to identify the size of the population not likely to be covered but also the eligible children whose parents often are not likely to enroll them in CHIP or Medicaid for fear of the authorities becoming aware of their immigration status.

It is important to note that very few undocumented immigrants are over the age of 55 since most who are that old were in the U.S. in 1986 or soon after when IRCA granted wide legalization. Also many may be in the 18-35 age range. When counting those who won't have to pay if they don't have insurance it is important to take this group and also the low-income group but not double count. According to statistics reported by the Center for Public Policy Priorities, there are about one million undocumented people in Texas who are not insured and still will not be insured after all the health care reforms are enacted.[89]

Sources of care for this population include Community Health Centers (318 CHCs in Texas), which are being substantially upgraded in terms of funding, but it is likely that the availability of indigent care in public and other hospitals and the availability of specialty care will be reduced since the federal subsidies will have been reduced and charity only for the undocumented is less politically palatable. It is hard to see how the reform legislation will improve access to care for

this population, especially since some of the employers through whom they or their spouses receive coverage are likely to depend on the new exchanges.

Legal Permanent Residents

After five years adult legal permanent residents are eligible for Medicaid in many states, but not in Texas. Although after five years legal permanent residents are eligible to become citizens, many are not prepared to take the naturalization test in English. As mentioned above, legal permanent residents as well as undocumented residents can receive emergency services from Medicaid, and in state fiscal year 2007, 9,655 non-citizens received emergency-only care.[90] The proportion estimated to be legal permanent residents was 37%,[91] for a total estimate of 3,572 served.

Children who legally entered the U.S. on or after August 22, 1996, are not eligible for Medicaid or CHIP for five years after entering (with some exceptions), according to federal law, so Texas covers these children under CHIP with 100% state funds if they are otherwise eligible for CHIP or Medicaid. After five years, children eligible for CHIP are covered under that program with both state and federal funds, but Texas does not provide Medicaid to legal permanent resident children (with some exceptions), so those who are eligible for Medicaid continue to receive CHIP with state funds.[92] The only time CHIP covers legal and illegal immigrant children with no questions asked and with both state and federal funds is in the CHIP Perinatal program, which covers children pre-birth (prenatal care for mothers) and post-birth for 12 months total—63,001 children were served in SFY 2009,[93] and nearly all of the mothers were non-citizens.[94] It is estimated that 95% of children in Texas are U.S. citizens and 5% are not citizens.[95]

The lowest-income adult legal residents are not eligible for full Medicaid and also wouldn't have to pay if they don't play, but they are eligible for insurance through the exchange, so that is another potential source of insurance for this population.

A study in *Health Affairs* found that 1,140,000 U.S. citizen children in Texas (2004-2006 average) were in mixed families, defined as one or both parents being non-citizen immigrants (legal status could not be discerned from the CPS data); 4,586,000 Texas children were in all-citizen families. They calculated that 70.6% of children in mixed families in Texas had health insurance, compared to 85.2% in all-citizen families. For low-income children in Texas (less than 150% FPL), they estimated that 70.8% in mixed families had health insurance compared to 79.7% in low-income all-citizen families.[96]

Regarding Medicaid coverage, the authors estimated that 44.3% of children in mixed families in Texas were on Medicaid, vs. 24.8% in all-citizen families. Regarding employer-sponsored insurance, they estimated that 27.5% of children in mixed families were on their parents' employer's insurance, compared to 56.2% of children in all-citizen families. When children with low family incomes (less than 150% FPL) were looked at in conjunction with employer-sponsored coverage, the percentages drop dramatically—only 11.2% in mixed families and 19.8% in all-citizen families were covered by this type of insurance. Due to the decline in employer-sponsored insurance and the low rate of this coverage in mixed families, more incentives for small low-wage businesses to offer insurance and expanding public insurance

programs are better policy options for covering more of this population than subsidizing private employer-based insurance premiums.[97]

Early Retirees: Reinsurance Program

The new reinsurance program for health insurance for early retirees (ages 55-64) will reimburse plan sponsors 80% of the cost of claims that are more than $15,000 and less than $90,000 per retiree, adjusted annually for inflation. It is estimated that one-third of the 4,500 organizations who participate in the program will be state and local governments. The $5 billion allocated for the program is projected to run out in one to three years, and applications and claims will be processed on a first-come, first-served basis.[98]

In Texas the program will apply to the Teachers Retirement System and the Employees Retirement System of Texas (state government), and some retirees from local governments, unionized firms, and large corporations. Note that this is primarily to incentivize employers to keep retiree insurance in place at least until 2014, it does not help early retirees who do not have an employer-based plan and it does not apply to those over 65 who are presumably eligible for Medicare. It is estimated that only 31% of large firms provided retiree health insurance in 2008, down from 66% in 1988.[99]

Someone who is an early retiree who has conditions that do not permit him to buy standard coverage may be able to buy a policy through the new federal high risk pool. In this case it is unlikely that this subsidy will motivate firms to develop this benefit—for one reason it would be unusual to add a benefit after an employee has retired. It is there to incentivize firms to maintain the coverage until the exchanges are rolled out in 2014. In this case and maybe a few other situations the point is not that people will gain from PPACA relative to what they had in 2009, but rather if this subsidy did not exist some employers would have reduced benefits.

A recent national survey by Hewitt found that 76% of large employers that offer retiree health insurance plan to participate in the reinsurance program. Hewitt estimates that the average federal reimbursement for each early retiree will represent approximately 25%-35% of total health care costs, and for a company that covers 1,000 retirees under age 65 that participation in the program could result in $2-$3 million in reinsurance proceeds each year.

The White House estimates that 207,000 people in Texas retired before they were eligible for Medicare and have health coverage through their former employers.[100] It is unclear how many of these would have lost coverage over the next few years without the new reinsurance program and how many organizations will be incentivized to continue to offer these benefits.[101]

Retirees: Medicare

Most people aged 65 and over qualify for health coverage under Medicare. In Texas, 92.2% of people aged 65 or over had Medicare in 2008, and only 3.2% lacked insurance of any kind.[102] Medicare has recently increased coverage for preventive care, but many of these services come with large deductibles and copayments that can discourage people from taking advantage of the benefits. Under the new reforms, deductibles and copayments will be eliminated for all

preventive services covered under Medicare, and a free annual physical exam will also be covered. These changes will make health care more affordable to retirees, and prevention could improve their health status.[103]

One major thing that health reform will change in Medicare is to eliminate the so-called "doughnut hole," the gap in prescription drug coverage in Medicare Part D. In 2010, the doughnut hole begins after people have $2,830 in total prescription costs, and coverage ends until they have spent an additional $3,610 in out-of-pocket costs on pharmaceuticals, at which point catastrophic coverage kicks in. The PPACA gradually reduces the gap by offering one-time $250 rebates in 2010 to those in the doughnut hole, and offering increasing discounts on pharmaceuticals from 2011-2020 until the gap is eliminated in 2020.[104] It is estimated that 4 million seniors nationally will be eligible for the rebates in 2010.[105]

The White House states that approximately 237,000 Medicare beneficiaries in Texas reached the doughnut hole and received no assistance in defraying the cost of their prescription drugs in 2009. As of early August 2010, 42,247 people on Medicare in Texas have already received their $250 rebate checks, and more will continue to be mailed through the end of the year.[106]

Discussion and Other Impacts

Individual Mandate

Keeping health insurance affordable requires spreading the risk over a large pool that includes healthy people, so an individual mandate will take effect in 2014. At that time, most U.S. citizens and legal residents will be required to have coverage for themselves and their dependents that meets minimum standards, or they will have to pay a penalty (undocumented residents are not included). The penalty is designed to create an incentive for personal responsibility, and also to help support the safety net for the uninsured. People are exempt from the penalty if the lowest-priced exchange plan costs more than 8% of family income, they are below the income level that has to file taxes, they have financial hardship (to be defined), they are religious objectors or are incarcerated, they are Native Americans, they are undocumented, or they have a gap in coverage of less than three months.[107]

The penalty is an income tax penalty based on the number of uninsured in a family, and the family maximum when fully phased starting in 2016 will be the greater of three times the individual adult penalty or 2.5% of family income.[108] There will be annual updates for inflation. The average cost of family coverage under a group insurance policy in Texas is about $13,000 per year, so with the maximum family penalty of $2,085 being only 16% of the typical cost of insuring a family, some might choose the penalty instead.[109,110]

Annual Penalties for People without Health Insurance (Unless Exempt)

	In 2014	In 2015	In 2016 and after
Adults (18+)	Higher of $95 or 1%	Higher of $325 or 2%	Higher of $695 or 2.5%
Children	Half of adult rate	Half of adult rate	Half of adult rate
Max per family	$285 or 1%	$ 975 or 2%	$2,085 or 2.5%

The Congressional Budget Office and the staff of the Joint Committee on Taxation estimated that about 21 million people under the age of 65 will be uninsured in the U.S. in 2016, and that a majority of them will not be subject to the penalty (such as undocumented immigrants), while others will be exempt due to low income or other factors. Some of those who are subject to the penalty will voluntarily report it on their tax returns and pay it, while others will try to avoid the penalty, so their estimates take into account likely compliance rates. They estimate that about 4 million people nationally will pay a penalty for being uninsured in 2016 (including children), and that the IRS will collect about $4 billion per year from 2017-2019.[111]

The CBO states that, "In general, households with lower income will pay the flat dollar penalty, and households with higher income will pay a percentage of their income. In 2016, households with income that exceeds 400 percent of the FPL are estimated to constitute about one-third of people paying penalties and to account for about two-thirds of the receipts from those penalties." These numbers are based on the following calculations for people paying a penalty for calendar year 2016, including children with payments made on their behalf. The FPL for 2016 is estimated to be $11,800 for a single person and about $24,000 for a family of four.[112]

- 9% of people paying a penalty will have incomes less than 100% FPL (4% of payments)
- 16% of people paying will have incomes 100-200% FPL (7% of payments)
- 21% of people paying will have incomes 200-300% FPL (11% of payments)
- 18% of people paying will have incomes 300-400% FPL (13% of payments)
- 12% of people paying will have incomes 400-500% FPL (11% of payments)
- 24% of people paying will have incomes over 500% FPL (55% of payments).

Impacts on Texas Counties

The net impact on a county will vary depending on where they currently set the bar on medical indigency—the minimum is 21% of poverty and some counties with hospital districts like Harris and Dallas Counties set it at 100% of poverty. Although Medicaid will cover all U.S. citizens now being covered by county indigent care, immigrants who are not citizens will remain the responsibility of the counties, and covering undocumented people will be at the discretion of the county or hospital district. It will also be useful to look at the county reports to see how much care they covered and what categories of residents were covered. In the big city hospital districts it will be difficult to estimate this impact. It is important to understand that the mandated county obligations are only for the poor who are not on Medicaid.

For the measurement of current impact on a county and projected impact it is possible to get the annual reports to the Department of State Health Services from counties that have chosen the County Indigent Care option. For counties that have chosen the hospital district or public hospital option there are the reports of the hospitals on charity care and community impact along with their overall financials reported to the Texas Hospital Association and DSHS,[113] and possibly also reports to the Comptroller's Office. One problem in measuring county impact is that these hospitals care for patients from outside their home county. A further difficulty will be that disproportionate share allocations to hospitals will be reduced in both Medicare and Medicaid starting in 2014, but this reduction in DSH funding will only occur when the uninsured rate in the state is reduced by 45%, an event that is probably very much in the future. With current state budget constraints, it is unclear if the state will slow-walk the implementation of the

act where possible, especially with those who are currently eligible but not enrolled in Medicaid and CHIP, since they will require some state funding and not be covered by 100% federal funding at first like the newly eligible.

The Center for Public Policy Priorities states that after the expansions are fully implemented in 2014 it will take several years to ramp up, and that there is uncertainty about the adequacy of premium assistance and how many people will remain uninsured. They also point out that there is an inadequate number of providers in Texas for everyone, not just Medicaid patients, so expanded capacity in the health care system is critical. There may be misconceptions that safety-net programs will no longer be needed or will only be needed for the undocumented, and there may be a temptation to start dismantling the safety net before reforms have lessened the need.[114]

Conclusions

This report provides an overview of the provisions of the PPACA and an account of some of the early attempts to estimate its impact on health insurance coverage in the U.S. and in Texas. For the purposes of further analysis on population groups in the state as a whole as well as smaller geographic areas such as counties, we believe some of the distinct issues that should be raised and demographic groupings that are especially important are as follows. It should be noted that the choices the state government makes over the next three years will be of particular importance in determining the impact of these initiatives.

1. *Children below 138% of poverty.* These children who are documented are currently all eligible for Medicaid or CHIP. Almost all below 185% FPL are eligible at birth and are enrolled. An analysis of state and county data that tracks Medicaid enrollees, beneficiaries, and eligibles would be a good place to start and to identify variations in take-up and unenrolled eligibles. To do a county level analysis it would also be useful to see what kind of fall-off there is through age 5 where all below 133% of poverty are eligible for Medicaid. It would be interesting to see if current variations in take-up by those who are eligible are related to the proportion of the county that is Hispanic or the proportion of the county that is low-income. Children who did not meet the Medicaid asset requirements or who are 6-18 who are 100-133% of poverty will be shifted from CHIP to Medicaid in 2014.

   Our gut feeling is a 91-94% enrollment rate projection for this population in 2014 is very aggressive and improbable. Unless there is a significant effort before then the rates will be unlikely to be much higher than they are today since there will be few if any incentives to enroll and there will be a significant increase in cost to the state in expanding enrollment, even though the new enrollees will probably be less expensive than the average current enrollee. Between 2014 and 2019 it is likely that implementation of a number of the reforms will lead to higher enrollment. One key here is that this is not an expansion category and the state has not achieved anything near 90% coverage for this population to date.

2. *Children 138-200% of poverty.* This population group will continue to be difficult to track since they go in and out of income eligibility just as families on Medicaid do. It

will also be more complex since there are likely to be a number who will be covered through exchanges as well as CHIP. And here, unlike the under 133% FPL population, there will be a population above 150% who were unlikely to be eligible because of assets or who were deterred from participating because of significant cost-sharing. Those disincentives will be substantially reduced. It would be instructive to identify numbers of uninsured in this population by county and to identify initiatives that might be effective. As with the under 138% FPL population, the immigration status of parents might be an important determinant of the likelihood of enrollment. Rural vs. urban influences on enrollment percentages currently might be useful to track down.

3. *Adults below 138% of poverty.* This will be quantitatively the largest group that will be added to Medicaid. Holahan and Headen try to replicate what they infer to be the CBO's assumption that 57% of the newly eligible will be enrolled by 2019. They do not provide estimates for 2014, 2015, or other years. Since this is a group that will have essentially a 100% match there should be substantial interest in states in drawing down the additional funding that is provided—especially since it is care for this population that much of the disproportionate share funding is dedicated to serving. At the same time there is no clear cost to this population in not enrolling since if they then have an emergent or serious problem they can sign up or be signed up by the health care facility from which they seek care. And there is still a welfare stigma in some people's minds related to Medicaid and others don't want the potential hassle of going through eligibility both because of potential immigration issues as well as not being eager to deal with government. Language and immigration status of family members would clearly be factors. A little clearer picture of just who this population is in Texas probably needs to be done before going after county level data.

4. *Adults from 138-200% of poverty.* This population has a low cost of obtaining coverage through the exchanges, but also has quite low penalties to pay for not participating in them. The size of this population needs to be studied as well as their family structures, current employment, and insured status.

5. *Adults and families between 200% and 400% of poverty (possibly in 50% tranches).* This group needs to be examined as to current coverage, family composition, and size. A further factor might be cost of living in different parts of the state when determining whether the coverage would be affordable at these income levels and what the uptake would likely to be for the exchanges.

6. *Adults and families above 400% of poverty.* At these levels the maximum penalties begin to make coverage likely, especially if the premiums through the exchange are not too expensive.

7. *People employed by large and small businesses/organizations with and without health coverage.* These numbers and also numbers of people who have coverage through a spouse will need to be determined. This will all be important at both a county and a state level.

Other factors for the exchanges and for coverage in general depend on how consumer-friendly the exchanges are likely to be, what the true level of medical and health plan inflation will be from 2014 onward, and of course what the level of employment and wages are in the years ahead.

Endnotes

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[2] For detailed timelines see the federal website for understanding the act at http://www.healthcare.gov/law/about/order/byyear.html; the Kaiser Family Foundation timeline at http://www.kff.org/healthreform/8060.cfm; and Wikipedia at http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act#Provisions. Also see state of Texas as well as national provisions and implications analyzed by the Center for Public Policy Priorities in their presentations given around the state at http://www.cppp.org/events/index.php (see Powerpoint files).

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[13] Stan Dorn, Urban Institute, "State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals" (State Coverage Initiatives, Updated 8/5/10, p. 8), available at http://www.statecoverage.org/files/SCI_Dorn_Report_2010_Final_updated_8.5.10.pdf, accessed 8/24/10.

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[15] Ibid., paragraph (e) – Catastrophic Plan.

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Appendix A. Estimates of Additional Coverage in Texas Under Health Care Reforms

This appendix pulls together various predictions of future Medicaid and Children's Health Insurance Program (CHIP) coverage in Texas as mentioned in several sections in the body of the report, plus the exchanges from one source. Not all estimates are directly comparable due to what insurance they include and what years they are for (current population or future population as the base), but can be used to show general ranges.

Children

Note that not many children (ages 0-18) are newly eligible for Medicaid and CHIP, so much of predicted gains in coverage result from more children who are now eligible signing up due to more outreach, referrals from the exchange, and the individual mandate.

1. The Center for Public Policy Priorities estimated that about *500,000-700,000 uninsured children in Texas now qualify for Medicaid and CHIP* but are not enrolled, so that many more could be added to the programs if everyone was incentivized to enroll after reforms are implemented.[1]

2. The Rural Policy Research Institute estimated that the insured rate in Texas will go from 75% to 90% after reforms are fully implemented, with 32% of the newly covered people being children receiving new coverage from any source, so this includes the health insurance exchange in addition to Medicaid and CHIP. Using an estimated current Texas population of 24.8 million gives 3,720,000 newly insured, and taking 32% gives *1.19 million children with new insurance from any source*.[2]

3. The Health and Human Services Commission estimated that with take-up rates of 91% the first year of full reforms, 93% the second year, and 94% after, that the following *additional numbers of children could be enrolled in Medicaid and CHIP* by each of the following years:
   - 2014: 574,000
   - 2015: 664,000
   - 2016: 717,000
   - 2017: 731,000
   - 2018: 746,000
   - 2019: 761,000.[3]

Adults

1. The Center for Public Policy Priorities estimated that about that about *1 million uninsured adults* in Texas would newly qualify for Medicaid if reforms were implemented today.[1]

2. The Rural Policy Research Institute estimated that the insured rate in Texas will go from 75% to 90% after reforms are fully implemented, with 33% of the newly covered people being adults enrolling in Medicaid. Using an estimated current Texas population of 24.8 million gives 3,720,000 newly insured, and taking 33% gives *1.23 million adults with Medicaid*. They also estimate that 36% of the newly insured people would be adults getting on insurance from the exchange or other sources, making *1.34 million adults with other types of new insurance*.[2]

3. Holahan and Headen estimate that under their standard participation scenario (57% take-up rate), Texas would gain *1,798,314 new adult Medicaid enrollees by 2019* (with 1,379,713 of them being uninsured previously). Under their enhanced scenario, (75% take-up rate), Texas could gain *2,513,355 new adult Medicaid participants by 2019*, of whom 2,055,888 would be newly eligible.[4]

4. The Health and Human Services Commission estimated that with take-up rates of 91% the first year of full reforms, 93% the second year, and 94% after, that the following *additional numbers of adults could be enrolled in Medicaid* by each of the following years:
   - 2014: 1,232,000
   - 2015: 1,284,000
   - 2016: 1,324,000
   - 2017: 1,351,000
   - 2018: 1,378,000
   - 2019: 1,405,000.[3]

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Appendix B. Effects of Health Care Reform Bills on Insurance Coverage, U.S.

In Millions of Nonelderly People, by Calendar Year

Includes the 50 States and the District of Columbia

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage										
Medicaid and CHIP	40	39	39	38	35	34	35	35	35	35
Employer	150	153	156	158	161	162	162	162	162	162
Nongroup, Medicare, and Others	27	26	25	26	28	29	29	29	30	30
Uninsured	50	51	51	51	51	51	52	53	53	54
Total	*267*	*269*	*271*	*273*	*274*	*276*	*277*	*279*	*281*	*282*
Change (+/-)										
Medicaid and CHIP	*	-1	-2	-3	10	15	17	16	16	16
Employer	*	3	3	3	4	1	-3	-3	-3	-3
Nongroup, Medicare, and Others	*	*	*	*	-2	-3	-5	-5	-5	-5
Exchanges	0	0	0	0	8	13	21	23	24	24
Uninsured	*	*	-1	-1	-19	-25	-30	-31	-31	-32
Post-Policy Uninsured Population										
Number of Nonelderly People	50	50	50	50	31	26	21	21	22	23
Insured Share of Nonelderly Pop.										
All Residents	81%	82%	82%	82%	89%	91%	92%	92%	92%	92%
Excluding Undocumented	83%	83%	83%	83%	91%	93%	95%	95%	95%	94%

* = between 0.5 million and -0.5 million people.

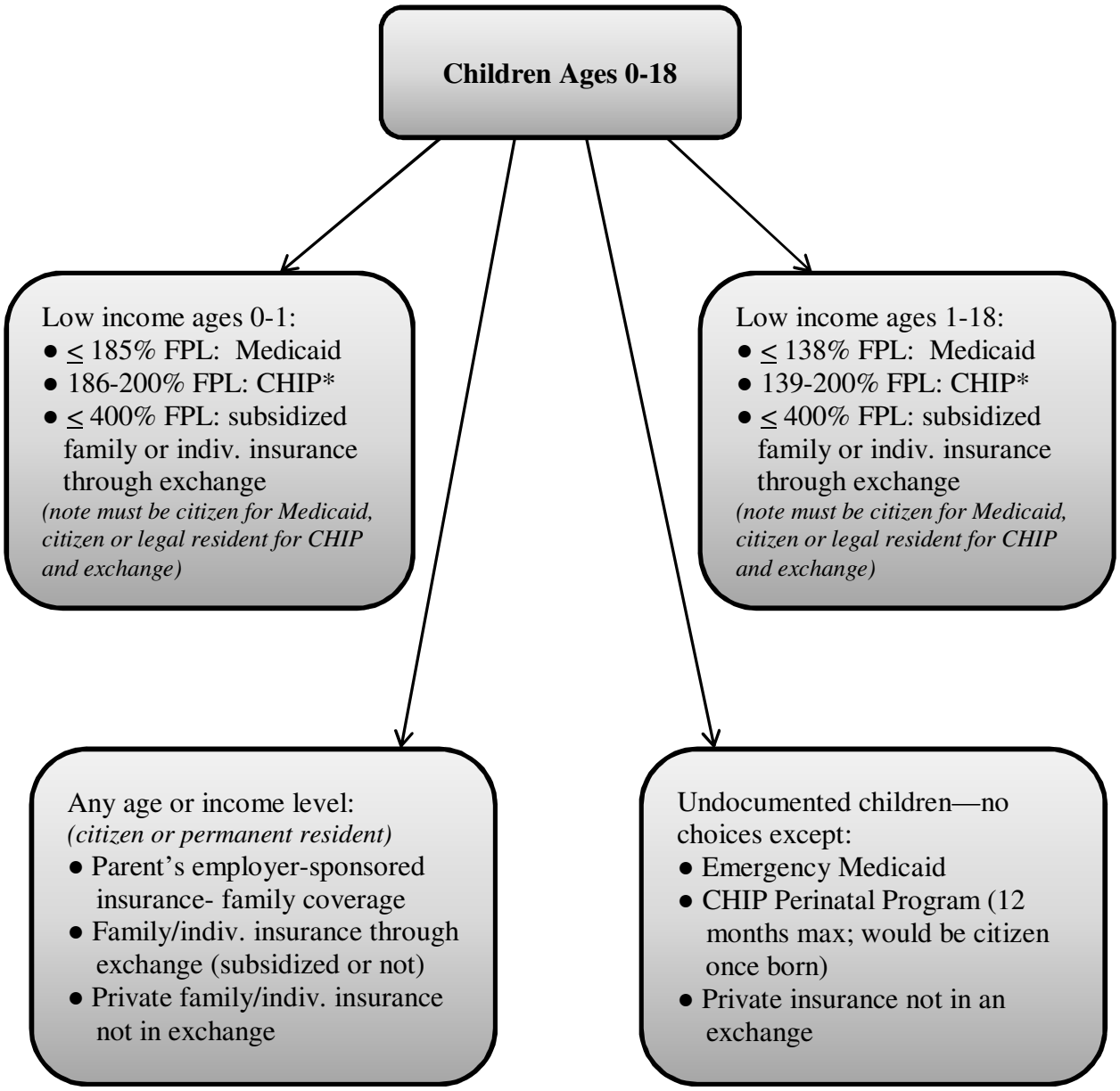
Exchange Enrollees and Subsidies, in Millions of Nonelderly People, by Calendar Year

	2014	2015	2016	2017	2018	2019
Number with Unaffordable Offer from Employer (could receive subsidies)	*	1	1	1	1	1
Number of Unsubsidized Enrollees	1	2	4	5	5	5
Average Exchange Subsidy per Subsidized Enrollee		$5,200	$5,300	$5,500	$5,700	$6,000

* = between 0.5 million and -0.5 million people.

Source: Congressional Budget Office, Letter to Nancy Pelosi, "Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate," (3/20/10, p. 21), available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf, accessed 8/23/10.

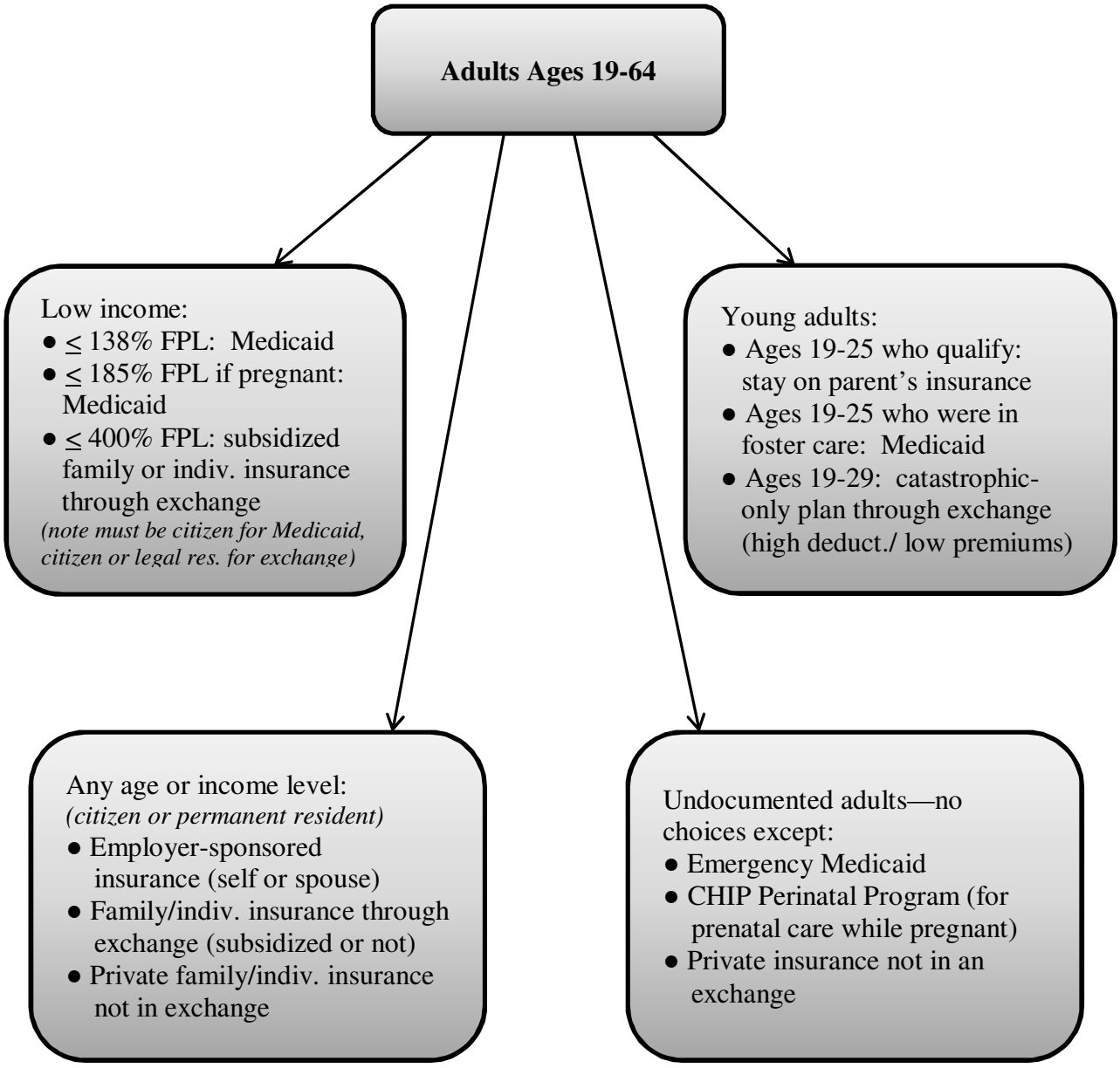
Appendix C.
Chart: Main Health Insurance Options for Texas Children after Reforms



* Children with incomes 150-200% FPL must also pass an asset test to qualify for CHIP.

Notes: Shows common choices only, does not include military-related insurance, different public coverage options for the disabled and others, and other relatively uncommon insurance. Some people may not have any insurance even after reforms due to very low incomes or choosing to be uninsured (and pay a penalty). People without insurance can pay out-of-pocket or accept charity care if they need health services.

Appendix D.
Chart: Main Health Insurance Options for Nonelderly Texas Adults after Reforms



Notes: Shows common choices only, does not include military-related insurance, different public coverage options for the disabled and others, and other relatively uncommon insurance. Some people may not have any insurance even after reforms due to very low incomes or choosing to be uninsured (and pay a penalty). People without insurance can pay out-of-pocket or accept charity care if they need health services.