Texas Health Coverage Lags as Medicaid Expands in U.S.

By Jason Saving and Sarah Greer

ABSTRACT: Texas is one of a handful of states declining to expand Medicaid coverage as part of the national health care program. The state has the largest number of uninsured residents, though more people have signed up for the low-income health plan this year.

Newspaper headlines earlier this year announced that Texas had claimed a dubious distinction: It had surpassed California as having the largest number of residents with no health insurance (5 million) despite a population two-thirds that of California.

For the past decade, Texas had led the nation in the *share* of its residents lacking health insurance—19.1 percent, according to the most recent Census Bureau calculation (*Chart 1*).

One contributor to Texas' high rate of uninsured may involve its decision to not expand eligibility for Medicaid, the federal-state insurance program for the poor. California expanded the program as envisioned by the Affordable Care Act (ACA) and will now reap the benefits from so doing. Texas, on the other hand, will likely continue to have an elevated level of uninsured individuals unless it, too, expands Medicaid.

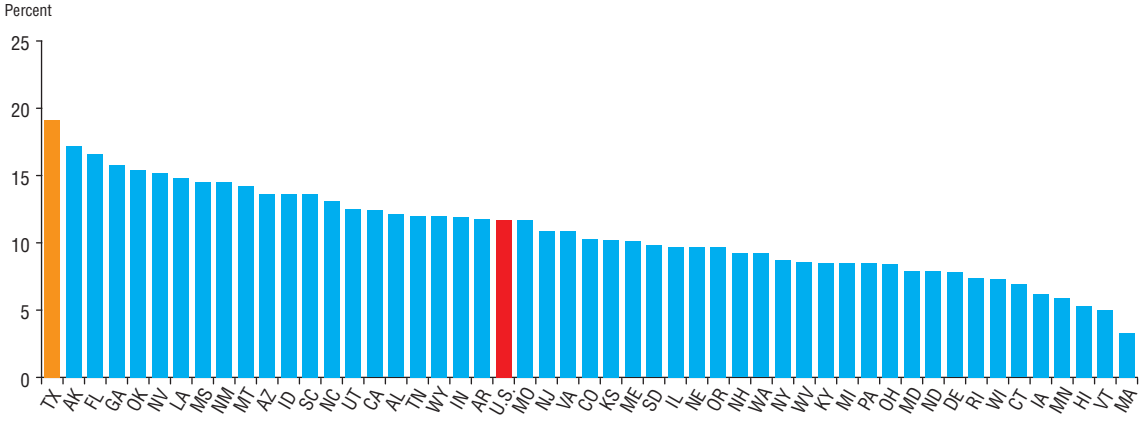
Medicaid's Unique Funding

Medicaid is the largest single funder of health services for the poor in the United States; spending exceeded $475 billion in 2014. Enacted as part of President Lyndon B. Johnson's "Great Society," the program established a comprehensive federal effort to provide low-income Americans with health coverage.

A unique aspect of Medicaid is its funding. Whereas other health assistance programs such as Medicare are purely federal responsibilities, Medicaid is a state and federal partnership funded by both. The exact matching rate for each state is determined by the state's per capita income.[1] Poorer states receive more generous matching rates, in part because poorer states would be expected to have higher caseloads while simultaneously possessing less ability to pay for them. In 2015, for example, 23 states had a matching rate between 50 and 55 percent, while in eight other states, it was 70 percent or higher (*Chart 2*).

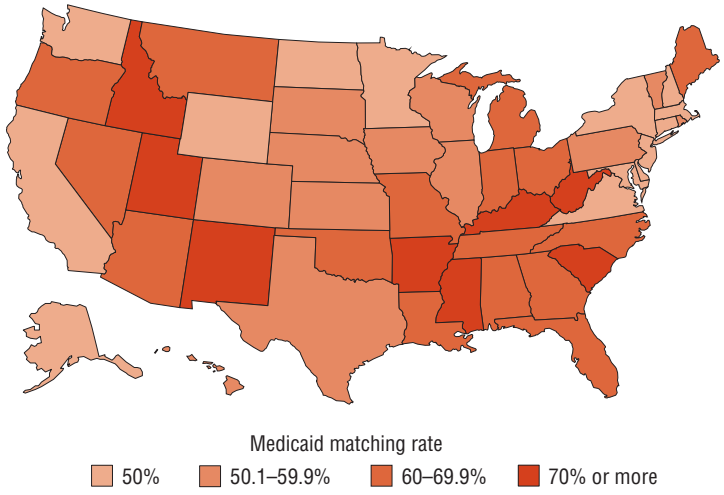
Another unique aspect of the program is that the federal government does not set Medicaid eligibility standards. Rather, each state is empowered to set its own eligibility cutoff as a percentage

Chart 1 Texas Led Nation in Share of Residents with No Health Insurance in 2014



SOURCE: Census Bureau.

Chart 2 Poorer States Receive Higher Federal Matching Rates



SOURCE: Kaiser Family Foundation.

of the federal poverty level.[2] Historically, some states have set their cutoffs at more than 100 percent of the poverty level, which guarantees access to more low-income residents but requires additional state resources. On the other hand, some states have set their rates at less than 20 percent of the poverty level, which reduces costs but raises the rate of uninsured in those states. Texas and Alabama tie for the lowest coverage threshold, 18 percent of the poverty level, while Connecticut's 201 percent is the highest (*Chart 3*).

Cost-sharing, coupled with substantial state discretion, was initially viewed as a way to encourage state participation in the program, because state participation was not—and is not—mandatory. Indeed, only 26 states opted into Medicaid when it was implemented in 1966.

Some of the remaining states strenuously objected to the Medicaid program or to their state's proposed share of Medicaid funding, but most joined the program within a few years as they saw federal tax dollars flowing to their neighbors: 15 states alone from 1967–69. The last two holdouts, Alaska and Arizona, joined in 1972 and 1982, respectively.

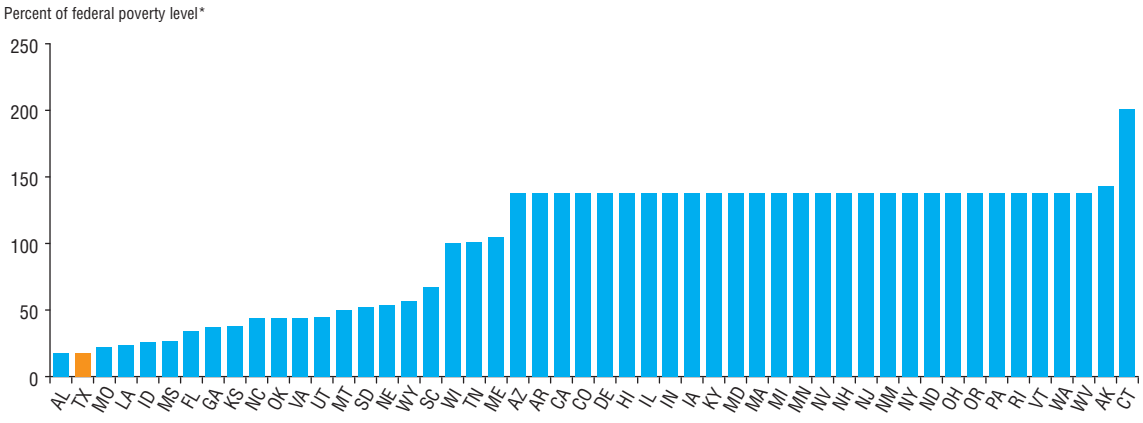
Today, Medicaid and the Children's Health Insurance Program serve 61.7 million people, about 19 percent of the nation's population. Since its inception, about 57 percent of total program funding has come from federal government general revenue (such as the income tax) and the remaining 43 percent from state general revenue (including sales taxes and state income taxes).

Program Expansion?

The ACA became law in 2009 and was designed in large measure to raise the percentage of Americans with health insurance. To understand how and why expanding Medicaid entered that equation, it's important to know how Americans received health insurance in the pre-ACA world.

In the early 20th century, retailer Montgomery Ward pioneered employee health coverage as a way to encourage workforce efficiency. Employer-provided coverage grew slowly until World War II. Amid labor shortages, businesses expanded alternative compensation programs, such as health benefits, in response to government-imposed wage controls. Since then, employer-provided coverage has remained the dominant form of health insurance, with 49 percent of Americans receiving health benefits from this source.

Chart 3 Texas Ties with Alabama for Most Stringent Medicaid Income Threshold



SOURCE: Kaiser Family Foundation.

The remaining 51 percent of Americans fall into four broad categories: those who are old enough to receive Medicare (13 percent), those who are poor enough to receive Medicaid or the Children's Health Insurance Program (19 percent), those who purchase their own individual policies (often at relatively high cost) from the marketplace (6 percent) and those without health insurance (10 percent).[3]

One portion of the ACA created state health insurance exchanges at which individuals who earn more than 100 percent of the federal poverty line could purchase subsidized coverage if their employer didn't offer a plan (or offered a plan that was too expensive to fit their budgets). The second part expanded Medicaid eligibility to 138 percent of the federal poverty line. These twin provisions would result in almost everybody either receiving coverage outright (Medicaid) or having the opportunity to purchase insurance at a discount (the exchanges).

However, questions immediately arose about expanding Medicaid. Under the ACA, any state that refused to expand Medicaid would also lose access to federal funding for its *existing* Medicaid program. Yet, past court decisions have found that the federal government cannot force states to "enact or administer" federal regulatory programs.

Was the ACA's sanction against nonparticipating states so severe it would constitute an unconstitutional compulsion? In a 7–2 decision in 2012, the Supreme Court ruled that it was and said that each state could make its choice on Medicaid expansion without threat of financial sanctions.[4]

State-by-State Decisions

Though Medicaid state reimbursement rates range between 40 percent and 60 percent depending on the state's per capita income, the ACA offered a much more generous rate for any new Medicaid spending that resulted from the expansion: 100 percent funding for the first three years and 90 percent funding for the following seven.

Twenty-four states, along with the District of Columbia, expressed their immediate intention to sign on to the expansion and began participating on the first day full federal funding was available, Jan. 1, 2014. An additional four states agreed to participate over the next year and a half, with three other states—Alaska, Montana and Utah—taking steps to join in the second half of 2015.

Provided these decisions come to fruition, 31 of the nation's 50 states will be participating by the end of this year (*Chart 4*).

Evidence to date suggests participation in Medicaid expansion has enabled these states to dramatically decrease the rate of the uninsured. While almost all states have experienced declining rates from 2013–14 as the economic recovery took firmer hold and the exchanges offered discounted insurance plans, nine of the 10 states whose rates of the uninsured fell fastest had implemented the expansion.[5]

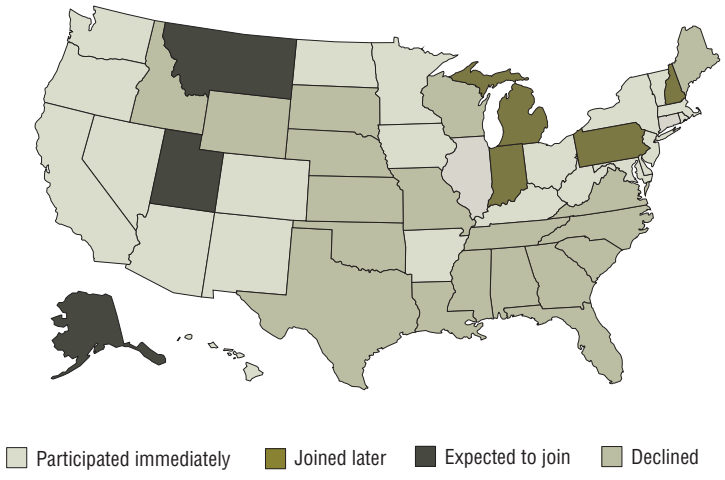
Given that the dramatic decline in the ranks of the uninsured has been driven at least in part by Medicaid expansion and the federal government's generous matching rate, it begs the question: Who opted out and why?

States opting out are predominantly—though not exclusively—located in the South and have generally offered sparser Medicaid coverage than their peers who are participating in the expansion. Some of the reasons given for nonparticipation stem from opposition to the program itself, either because it potentially discourages work or because it may crowd out private insurance (*see Box*). But questions have also been raised about the specific nature of this expansion, such as future costs.

One argument made in Texas and elsewhere is financial: that even a 10 percent share of the cost is too much. The Congressional Budget Office estimated last year that 50-state Medicaid outlays will rise by an additional $46 billion between 2015 and 2024 because of the ACA's Medicaid expansion. This would represent an increase of about half a percentage point in overall state spending over that period of time—a burden that would have to be carefully weighed against the benefit of a lower uninsured rate.

A related argument revolves around the staying power of the 90 percent matching rate. Some state officials have expressed skepticism that the rate will be maintained over the long run and fear being caught in a situation where they would be induced to accept Medicaid expansion only to see the favorable rate end after 10 years (or be rescinded earlier by Congress).

Chart 4 Thirty-one States Expected to Participate in Medicaid Expansion by Year-end 2015



SOURCE: Kaiser Family Foundation.

Does Medicaid 'Crowd Out' Private Insurance?

The question of Medicaid crowd-out is not new, but it has been reignited with the recent Affordable Care Act (ACA)-related expansion. The term "crowd out," coined by health economists in 1996, is the notion that public health care expansion does little to grow coverage rates because many recipients would have purchased private insurance if no public option were available.[1]

Past studies of crowding out focused on earlier expansions that affected children and pregnant women, while the ACA would target both parents and childless adults above the poverty line.

While Medicaid coverage varies from state to state, it provides health care at little to no cost, which is better than any private plan could offer—hence, the concern that newly eligible people will substitute public for private insurance. On the other hand, Medicaid has notoriously low reimbursement rates to physicians, causing many providers to opt out of serving those patients. This restricts where patients can receive care and may act as a deterrent to switching to Medicaid.

Access to employer-sponsored insurance (ESI) is an important factor. Those enrolled in ESI may be less likely to substitute Medicaid because they will only receive a portion of the savings. That said, access to affordable ESI isn't prevalent among the low-income workers who would qualify for Medicaid.

Most estimates of crowd-out range from very minimal—around 3 percent—to quite large—about 50 percent. A study that focused on effects of adult enrollees in Ohio found that while 19 percent of eligible adults substituted public for private insurance, only 2.9 percent made the switch.[2] This is in stark contrast to an earlier analysis that suggested a crowd-out rate of 49 percent.

There are some important differences in these studies, however. The Ohio study focused on adults rather than children and used a narrower definition of crowd-out. The second, earlier calculation is the reduction of private insurance relative to the increase in Medicaid coverage, rather than intentional substitution.

Since the expansion due to ACA will mostly affect adults, the experience in Ohio seems more relevant to the recent discussion, suggesting that the crowd-out effect of Medicaid expansion will likely be relatively low.[3]

One final point concerns the ACA's mandate of minimum coverage requirements for health insurance plans. Even without Medicaid expansion, higher minimum standards might themselves crowd out low-cost private plans that could otherwise have served as an alternative to Medicaid.

Notes

[1] See "Does Public Insurance Crowd Out Private Insurance?," by David M. Cutler and Jonathan Gruber, The *Quarterly Journal of Economics*, vol. 111, no. 2, 1996, pp. 391–430.

[2] See "Public-Private Substitution Among Medicaid Adults: Evidence From Ohio," by Eric E. Seiber and Timothy R. Sahr, *Medicare & Medicaid Research Review*, vol. 1, no. 1, 2011.

[3] Effects of crowd-out in Texas are likely very low, since Medicaid eligibility is currently so limited.

Depending on how Medicaid costs evolve, this could result in a larger-than-expected state Medicaid expenditure over the long run.

What About Texas?

Texas is one of the 20 states that has neither embraced Medicaid expansion nor signaled it will likely do so by the end of 2015. The best available estimates suggest that Texas, by not signing on, will save about $5.7 billion in state funds over the 2014–22 period, providing somewhat greater room to spend on other priorities such as education and infrastructure. On the other hand, those $5.7 billion in state funds would have been accompanied by an estimated $65.6 billion in federal funds that would have flowed to Texas if it were participating in Medicaid expansion (*Chart 5*).[6,7]

Remarkably, the $65.6 billion Texas would receive from the federal government nearly matches California's $68.8 billion despite California being far more populous. This difference primarily stems from the fact that ACA's favorable matching rate for Medicaid expansion applies to everyone who is newly eligible for Medicaid, no matter how low a state's pre-ACA threshold might have been.

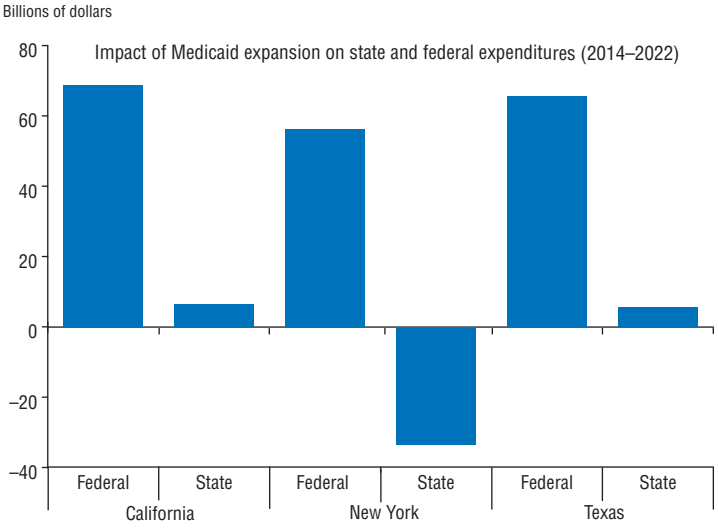
That means states such as Texas, whose pre-ACA thresholds are low, would receive disproportionately large federal support for expanding Medicaid. Meanwhile, states such as California, whose pre-ACA thresholds were high and who have expanded Medicaid, are receiving disproportionately low payments.

A look at how the rate of the uninsured fell nationwide in 2013–14 illustrates something interesting about Texas. While Texas did not expand Medicaid, its share of the uninsured fell by a full 3 percentage points—the 13th largest drop nationally (*Chart 6*). Why did Texas' rate fall so much when the state didn't expand Medicaid?

The primary reason: the ACA's health insurance exchanges, which were primarily designed to capture people whose employers didn't offer the benefits (or workers who found the plans too costly). In part because Texas has a disproportionate number of low-wage workers, Texans are about 5 percentage points less likely to be covered through their employers.[8] For this reason, it would be expected that the exchanges would have a disproportionate impact on the uninsured in Texas.

Still, Texas Medicaid enrollment rose 11.8 percent in the 18 months following the nationwide Medicaid expansion rollout. While this was surely due in large part to a deterioration of state economic conditions following the Great Recession, it is also true that Texas has not historically been a state that broadly advertised its Medicaid program and indeed recently experienced substantial turbulence in its program administration.

Chart 5 Texas Saves State Funds by Not Expanding Medicaid, Loses Federal Funds



SOURCE: "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," by John Holahan, Matthew Buettgens,Caitlin Carroll and Stan Dorn, Nov. 28, 2012, Urban Institute.

When visitors to healthcare.gov—the ACA internet homepage—enter their personal information to see if they qualify for subsidized coverage, rejected candidates who are sufficiently poor are advised to look into Medicaid as an alternative. This may have played a secondary role in driving up Medicaid enrollments among Texans who were previously eligible for Medicaid but either weren't aware of the program or might have had qualms about signing up.

Growth Trade Off

Texas now leads the nation in the number of individuals who lack health insurance coverage, in part because the state has declined to participate in the ACA's expansion of Medicaid.

Historically, Texas has been relatively accepting of inequality as the cost of faster-than-average growth, and it can be argued that health insurance inequality is a consequence of this trade off.

But, the high rate of those lacking insurance imposes very real costs, from less access to health care for the poor to higher county hospital tax payments. It remains to be seen whether a way can be found to reduce the ranks of the uninsured in Texas while preserving the state's low-tax governance.

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Notes

[1] More precisely, the matching rate is a function of a rolling three-year average of per capita income provided by the Bureau of Economic Analysis.

[2] States can also decide whether to include childless adults in their Medicaid program and, if so, set a separate coverage threshold for them.

[3] Data are from the Kaiser Family Foundation and are available at http://kff.org/other/state-indicator/total-population/. Medicaid estimate includes the Children's Health Insurance Program (CHIP).

[4] See the Supreme Court case *National Federation of Independent Business v. Sebelius.*

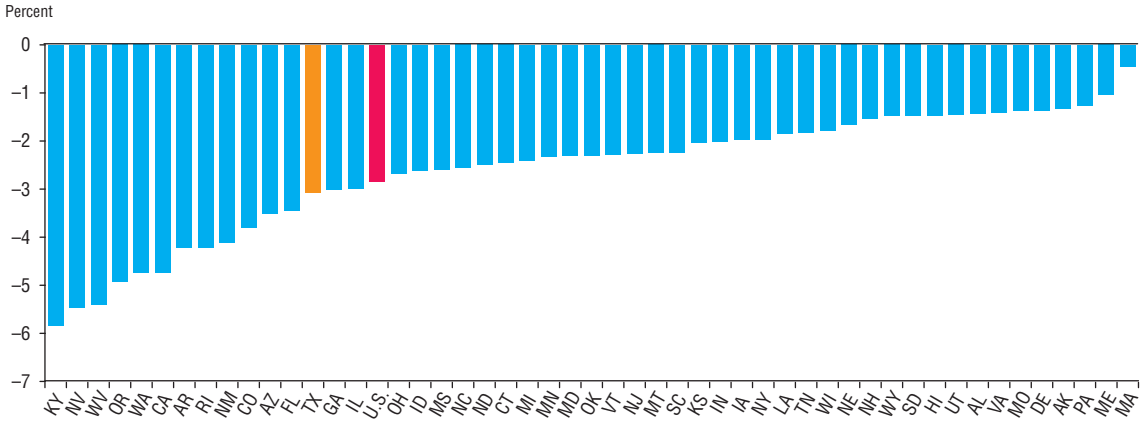
[5] Because most children receive health coverage under CHIP, the gains would come predominantly from adults.

[6] See https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384_es.pdf.

[7] Opting out of Medicaid expansion may also impact states' ability to partially offset the cost of uncompensated care with Medicaid funding. The five-year waiver under which Texas receives federal funds for this purpose expires in September 2016, and its prospects for renewal are unclear at this time.

[8] See www.texmed.org/uninsured_in_texas/.

Chart 6 Texas Records 13th-Largest Drop in Rate of Residents Lacking Health Insurance



NOTE: Drop is from 2013 to 2014.
SOURCE: Census Bureau.