Texas Sees Coverage Gains Under Health Care Act

By Anil Kumar

ABSTRACT: While Texas was among the states choosing not to participate in the Medicaid expansion under the Affordable Care Act, it nonetheless has seen improvement in the share of the population with health insurance coverage. Gains are notable among the non-college-educated working-age population in Texas, a state that has long ranked near the bottom in health care coverage nationally.

Texas, with one of the nation's most vibrant economies, has historically ranked among the states with the highest uninsured populations.

The gap between Texas and other states had narrowed steadily until the Affordable Care Act (ACA) took effect in 2014. After the state decided to opt out of the ACA's far-reaching Medicaid expansion, the gap again widened (*Chart 1*).

A closer look at the data before and after ACA implementation reveals that the uninsured rate declined significantly in Texas due to an increase in private health insurance coverage. Nationally, however, the rate reduction was larger.

The Texas uninsured rate remains elevated among several key demographic groups, and increases in coverage could have been larger had the state opted to expand Medicaid.

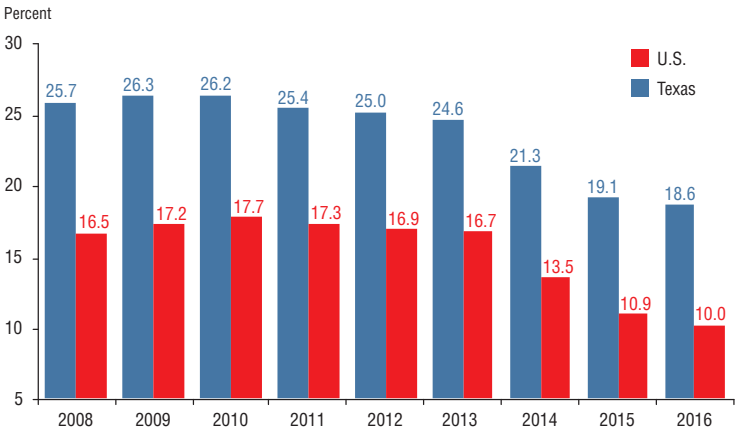
Assessing the ACA's relative impact in Texas provides useful insights into the insurance market, even amid continuing attempts in Washington to repeal the health care law and roll back the Medicaid expansion.

Qualifying for Medicaid

Medicaid is a means-tested public health insurance program for low-income individuals—mainly families with children, pregnant women, the elderly and the disabled. The program is jointly funded by federal and state governments but administered by the states under federal rules.[1] It is the largest means-tested transfer program in the U.S. and has experienced rapid long-term expenditure and enrollment growth.

Medicaid expenditures account for about 10 percent of federal spending, up from 2.4 percent in 1980.[2] Following the program's inception in 1965, eligibility was traditionally tied to receipt of welfare assistance. The program covered mainly single women with children on cash assistance, and low-income elderly people receiving Supplemental Social Security Income.

Chart 1 Uninsured Rate Declines Under ACA; U.S.–Texas Gap Widens



NOTES: Data reflect the percentage of the civilian noninstitutionalized population under 65 that is uninsured. ACA refers to the Affordable Care Act.

SOURCE: Census Bureau, American Community Survey one-year estimates.

A series of expansions in the late 1980s and the 1990s extended Medicaid to other low-income individuals who did not meet more stringent requirements for traditional cash assistance—pregnant women, and parents with children. But Medicaid eligibility remained strongly linked to family structure, with the program in most states out of reach for nondisabled, nonelderly adults without minor children, regardless of income.

Medicaid differs from Medicare—the health insurance program, financed by federal payroll taxes, for all senior (65 and older) and disabled people who are eligible for Social Security benefits. Medicare beneficiaries with low income are additionally eligible for Medicaid for some health care services not covered under Medicare—for example, long-term nursing home care beyond the 100 days covered by Medicare.[3]

Changes Under ACA

In the most sweeping Medicaid expansion since the program's inception, the ACA as signed into law in 2010 required states to extend Medicaid eligibility to all nonelderly adults—regardless of disability or family structure—whose incomes were up to 138 percent of the federal poverty line (FPL). (In 2017, the FPL for determining Medicaid eligibility was $20,420 for a family of three, increasing by about $4,200 for each additional family member.)

However, after a 2012 Supreme Court ruling made additional Medicaid coverage optional for states, only 32 states (and the District of Columbia) opted in.[4] Texas was one of the 18 states to opt out and, thereby, forego more generous federal matching of state costs to cover additional beneficiaries under the ACA expansion. The expansion called for a 100 percent match from 2014 to 2016, gradually declining to 90 percent in 2020 and beyond.[5]

The ACA also dramatically overhauled the private insurance market. The law instituted an "individual mandate" requiring that most Americans have health care coverage (or face a tax penalty). It also established an "employer mandate" stipulating that employers with 50 or more full-time-equivalent workers offer affordable health insurance to employees (or pay a fee).

The "dependent-care mandate," a provision that took effect in 2010, compelled health insurance companies to allow parents to obtain coverage for dependents up to age 26. Another provision enabled workers without access to qualified employer-provided health care coverage to purchase insurance through an ACA-sponsored marketplace. Consumers with incomes of 100 percent to 400 percent of the FPL are eligible for a tax credit on health insurance plan premiums (premium subsidy), and those with incomes of 100 percent to 250 percent of the FPL are additionally eligible for assistance with out-of-pocket costs (cost-sharing subsidy).

Lesser Benefits in Texas

Even before the ACA's arrival, Texas tightly limited Medicaid eligibility for most demographic groups. While income thresholds for children and pregnant women to qualify are close to the national average, the eligibility standards for nonelderly parents have lagged significantly behind the rest of the nation.

In 2013, before the ACA took full effect, a nonelderly parent with a family of three in Texas needed a family income less than 25 percent of the FPL to qualify for Medicaid. The national average was 87 percent.[6]

With the ACA's Medicaid provisions, the eligibility cutoff rose to 138 percent of the FPL. But the cutoff fell to just 18 percent of the FPL in Texas after the state opted out of the expansion. The national average rose to almost 100 percent of the FPL.[7]

Texas' eligibility qualifications for children and pregnant women are much more generous relative to those for parents and are closer to the national average.

Like other states, Texas is required to extend Medicaid coverage to low-income elderly people who also are eligible for the Supplemental Social Security Income program, which has an income eligibility limit of 74 percent of the FPL. Unlike 33 other states, Texas does not have a medically needy program for elderly people with incomes higher than the Medicaid eligibility limit. The medically needy program allows seniors with high medical expenses, but with income above Medicaid eligibility limits, to qualify for Medicaid by spending down their household resources on medical expenses.

Medicaid Changes Under ACA

The Medicaid coverage rate for the nonelderly population in Texas was relatively high prior to the ACA—17.6 percent in Texas versus 18.6 percent for the nation.

In addition to differences in demographics and income distribution, higher Medicaid coverage among Texas' children kept the gap with the U.S. small, despite Texas' near-bottom ranking among states in Medicaid generosity for key demographic groups. The share of children on Medicaid was 39 percent in Texas versus 37 percent for the U.S.

Enrollment in Medicaid and the Children's Health Insurance Program (CHIP) rose 38 percent in Medicaid-expanding states between July–September 2013 and July 2017. Nonexpanding states also experienced a 12 percent enrollment increase, partly due to the ACA raising awareness of the program among Medicaid-eligible households that hadn't previously participated. Enrollment rose 6.9 percent in Texas, compared with 29 percent nationally.[8]

Not surprisingly, a significant U.S.–Texas gap in Medicaid coverage of the nonelderly population emerged after the ACA. While coverage remained largely flat in Texas at about 18 percent of the nonelderly population, it rose 3 percentage points nationally. Roughly 22 percent of all nonelderly Americans had received health care coverage through Medicaid as of late 2016 (*Chart 2*).

More Private Coverage in Texas

As the U.S.–Texas gap in Medicaid coverage widened, the state and national gap narrowed for those with insurance, largely due to the ACA's overhaul of the private insurance market that applied to all states (*Chart 3*).

Individuals with employer-based coverage increased 3 percentage points from 2013 to 2016 in Texas—from 51 to 54 percent. By comparison, that share nationally rose about 1 percentage point, to 59 percent.

Employer-based insurance remains the mainstay of the U.S. health insurance system because the workplace provides an efficient mechanism to pool health insurance risk. If health insurance is optional, individuals with high health risks are more likely to purchase coverage.

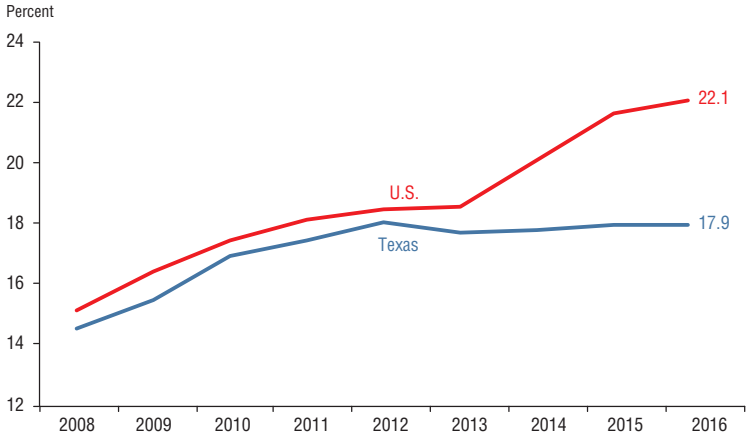
When insurers are unable to determine the exact health status of individual prospective policyholders, they tend to charge high premiums for directly purchased insurance or may not cover preexisting conditions—an attempt to minimize potential losses. Thus, the cost of private, nongroup insurance is substantially higher than for employer-based group plans. Through the individual mandate and the health insurance marketplace, the ACA attempted to create a diversified risk pool for nongroup private insurance.

About 1.2 million Texans were enrolled in an ACA marketplace health insurance plan during 2017, with 83 percent eligible for premium tax credits and 61 percent qualifying for cost-sharing subsidies.[9] Insurance from all private sources (including employers) increased 7 percentage points in Texas—compared with a 4-percentage-point gain nationally.

Increases in both Medicaid and private insurance coverage at the national level suggest that the Medicaid expansion didn't simply crowd out private insurance. A substantial crowd-out can neutralize much of the gain from increased Medicaid coverage if beneficiaries drop private coverage in favor of Medicaid.

Significant declines in the uninsured rate among the nonelderly suggest that the crowd-out was small. The uninsured rate fell 7 percentage points to 10 percent nationally and 6 percentage points to 19 percent in Texas. The nonelderly population includes children and people below age 26 who benefited from the dependent care mandate of the ACA.

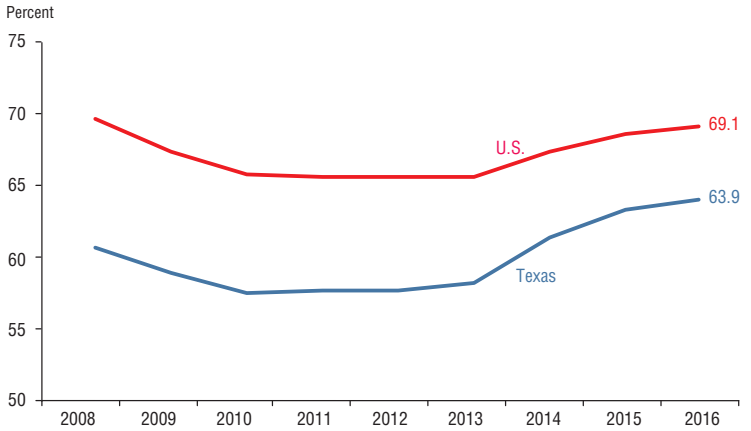
Chart 2 Medicaid Coverage Jumps in U.S. as ACA Takes Effect



NOTES: Data reflect the percentage of the civilian noninstitutionalized population under 65 with Medicaid. ACA refers to the Affordable Care Act.

SOURCE: Census Bureau, American Community Survey one-year estimates.

Chart 3 Private Health Insurance Coverage Climbs Under ACA



NOTES: Data reflect the percentage of the civilian noninstitutionalized population under 65 with private health insurance. ACA refers to the Affordable Care Act.

SOURCE: Census Bureau, American Community Survey one-year estimates.

Non-College-Educated Groups

Focusing on the nonelderly population over age 26 with no college education can provide more precise estimates of the effects of broadening Medicaid eligibility. The non-college-educated population would have been more intensely affected by the Medicaid expansions. Previously, the uninsured rate among this group was 43 percent in Texas and 29 percent elsewhere in the U.S.[10]

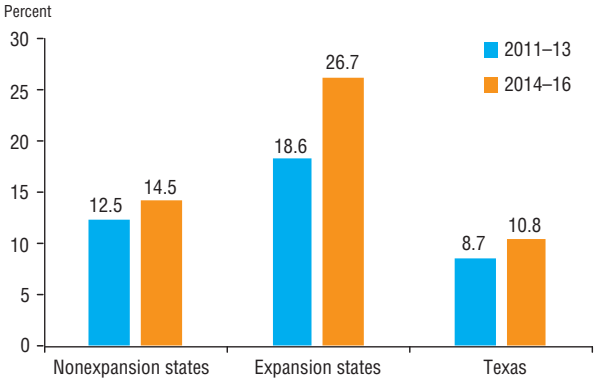
Comparing the states that expanded Medicaid and those that did not also helps in the analysis. Medicaid coverage among those without college increased 8 percentage points in states that expanded Medicaid but just 2 percentage points in states that did not expand (*Chart 4A*). Assuming other factors followed similar trends, the difference of 6 percentage points can be largely attributed to the expansion.

While employer-provided coverage remained virtually unchanged in both groups of states, private coverage increased almost 5 percentage points in expanding states and 6 percentage points in nonexpanding states.

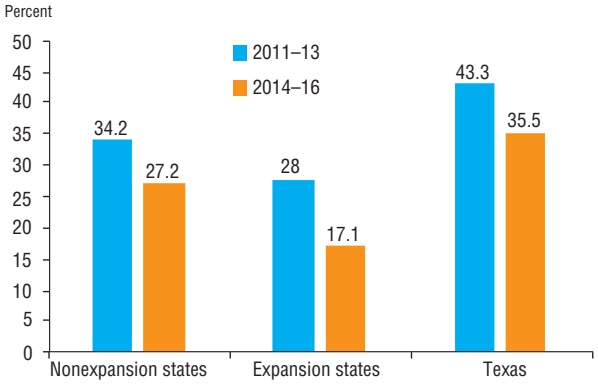
Thanks to negligible crowd-out from Medicaid expansion, the uninsured rate for the non-college group

Chart 4 Affordable Care Act's Expansion Boosts Coverage for Non-College-Educated Individuals

A. Medicaid Coverage Among Non-College Educated Increases More in Medicaid-Expanding States



B. Uninsured Rate Among Non-College Educated Drops More in Medicaid-Expanding States



NOTES: The sample was restricted to 27–64-year-olds with no college education. Expansion states include those that expanded Medicaid coverage effective Jan. 1, 2014.

SOURCES: Census Bureau, CPS-IPUMS, March supplement; author's calculations.

dropped 11 percentage points in expanding states, compared with 7 percentage points in nonexpanding states (*Chart 4B*). Thus, the additional decline of 4 percentage points in the uninsured rate in the expanding states could potentially be tied to the expansion.

Texas, without broader Medicaid coverage, benefited from changes in the private insurance markets through the ACA. While Medicaid among non-college-educated adults increased about 2 percentage points, private insurance coverage jumped 7 percentage points. The uninsured rate for this group fell 7 percentage points to 36 percent.

Despite improvements, the uninsured rate remains elevated across key demographic groups in Texas and elsewhere in the nation (*Table 1*). The gap is particularly wide among the non-college educated. Lower Medicaid coverage across the board in Texas is a primary reason.

Law's Economic Impact

Medicaid expansions and the ACA's subsidies, which led to increased health care coverage, came at a cost to taxpayers. The Congressional Budget Office (CBO) projected a net price tag of $1.4 trillion between 2017 and 2026.[11] An important component of that is the negative impact on work effort, namely employment and hours.

Researchers have understood that expanding entitlement programs such as Medicaid can have important implications for the labor market. The most basic effect on such outcomes—employment, work hours and earnings—is similar to increasing wealth or income. If eligible low-income individuals value Medicaid and think of it as more income, they tend to work less, just like anyone else who feels wealthier.

Besides income effects, the income eligibility cutoffs create other incentives for changing the employment and work hours of those who are close to benefit thresholds. Those just above the limit might reduce earnings to qualify for Medicaid; those below the new limit would be open to work more and increase earnings because they can still qualify for Medicaid.

Availability of ACA marketplace subsidies for nonelderly adults starting at 100 percent of the FPL and gradually phasing out at 400 percent of the FPL widens the scope of workers that might adjust their incomes to maintain eligibility for those subsidies. The reduction in subsidies with higher earnings acts as an effective tax on additional work. Also, the ACA's employer mandate may induce some employers to rely more on part-time workers.

Moreover, many low-income individuals may hold regular full-time jobs simply to maintain employer-based health insurance. Medicaid eligibility may prompt these people to give up full-time jobs and opt for lighter and more flexible schedules with fewer hours. Some could retire early if Medicaid were available before age 65.

Such behavioral effects suggest that Medicaid expansion should lower labor force participation, employment and hours worked. The CBO estimates that various provisions of the ACA would lower total hours worked 1.7 percent and total earnings about 1 percent by 2025; there would be 2 million fewer full-time-equivalent workers in 2025 than would be the case without the ACA.[12]

At a time when labor force growth is already projected to slow due to an aging population and retiring baby boomers, ACA-related employment declines could be a further drag on growth. Nevertheless, some positive spillovers from increased health care coverage helped limit the CBO's estimate of reduced employment.

First, some individuals stay with their employers simply to maintain insurance even though they could be more productive elsewhere, and quitting could render them uninsured until they find another job. Availability of public insurance coverage through Medicaid should reduce such an

Table 1 Health Insurance Coverage Lags in Texas, Especially Among the Non-College Educated

A. Percent with Medicaid Coverage Before and After the ACA, by Race and College

	White		Black		Hispanic		All	
	Pre-ACA	Post-ACA	Pre-ACA	Post-ACA	Pre-ACA	Post-ACA	Pre-ACA	Post-ACA
College								
U.S. (ex. Texas)	4.9	7.8	11.2	14.2	10.3	15.4	6.2	9.4
Texas	2.5	3.8	5.3	7.9	3.7	4.6	3.1	4.4
Non-college								
U.S. (ex. Texas)	13.2	17.8	24.6	29.1	18.8	26.6	16.5	22.1
Texas	7.0	8.9	17.4	21.0	8.3	9.9	8.7	10.8

B. Percent Uninsured Before and After the ACA, by Race and College

	White		Black		Hispanic		All	
	Pre-ACA	Post-ACA	Pre-ACA	Post-ACA	Pre-ACA	Post-ACA	Pre-ACA	Post-ACA
College								
U.S. (ex. Texas)	12.8	9.5	20.5	15.1	24.5	14.9	14.8	10.7
Texas	16.2	12.3	23.4	17.6	28.6	21.9	20.4	15.1
Non-college								
U.S. (ex. Texas)	22.1	15.6	30.2	19.6	44.3	29.2	28.7	19.6
Texas	28.2	24.2	34.3	27.2	53.7	44.2	43.3	35.5

NOTES: Sample restricted to those 27–64 years old. ACA refers to the Affordable Care Act.

SOURCES: Census Bureau, CPS-IPUMS, March Supplement; author's calculations.

"employment lock" and make the labor market more efficient.

Second, Medicaid expansion through increased income eligibility limits could lead to reduced welfare caseloads among individuals who maintained welfare eligibility simply to qualify for Medicaid. With enhanced limits, they may be drawn into the labor market because they could still qualify for Medicaid. Previous research has found compelling evidence of the positive effects of Medicaid expansions on the "welfare lock."

Employment, Consumer Spending

Employment data before and during the ACA that compares Medicaid-expanding and nonexpanding states suggests the employment rate was little changed even for the most-affected individuals—non-college-educated adults—in the two groups of states. Other detailed research has reached similar conclusions.[13] Except for select groups, such as childless adults and dependents who benefited from the dependent care mandate, the Medicaid expansions have largely been neutral with respect to key labor market outcomes.

Other ripple effects of more widely held insurance also help offset the cost to taxpayers. Lack of health insurance is a key driver of financial distress for those without coverage. Not surprisingly, increases in Medicaid coverage are strongly associated with lower personal bankruptcy rates.[14] The Medicaid expansions and ACA's marketplace subsidies should ease financial stress among low-income people who obtain health care coverage.

Without such coverage, the uninsured can't pay for their hospital stays and emergency room visits, shifting the cost to the insured through higher insurance premiums and to taxpayers through higher levies. Such uncompensated care costs have declined following ACA implementation.[15]

Expanded health care coverage also boosts consumer spending by limiting the need for precautionary saving to meet the out-of-pocket costs of unforeseen medical expenses among potentially eligible households.[16] Increased spending among those with health coverage could be partly offset by reduced consumption among those facing higher taxes to fund the expanded coverage. Because low-income individuals spend a relatively larger share of additional income than higher-income households do, the net effect of the redistribution on consumer spending could be modestly positive.[17]

Remaining Challenges

Although Texas opted out of the Medicaid expansion, the uninsured rate in the state fell among major demographic groups because of sharply higher private insurance coverage. Challenges remain, however, as the uninsured rate for some groups remains elevated and the gap between Texas and the nation has increased.

Thus far, there appears little evidence of negative effects on the labor market in states that participated in Medicaid expansion. Whether the large gains in health coverage are worth the budgetary cost remains an open question.

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Notes

[1] The federal share of state Medicaid costs is governed by the federal matching assistance percentage—a formula based on a state's per-capita personal income relative to the nation—and ranges from 50 percent to 74 percent, with lower per-capita income states receiving a higher share.

[2] See "Trends in Medicaid Spending," Medicaid and CHIP Payment and Access Commission, June 2016, www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf.

[3] See Centers for Medicare and Medicaid Services for more details on the Medicare-Medicaid relationship, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/index.html.

[4] See "Status of State Action on the Medicaid Expansion Decision," Kaiser Family Foundation, Nov. 8, 2017, www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

[5] For further details on the fiscal impact of the decision on Texas, see "Texas Health Coverage Lags as Medicaid Expands in U.S.," by Jason Saving and Sarah Greer, Federal Reserve Bank of Dallas *Southwest Economy,* Fourth Quarter, 2015.

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[6] See "Medicare Income Eligibility Limits for Parents, 2002–2017," Kaiser Family Foundation, www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents.

[7] Part of this decline could be due to changes in how the eligibility limit is calculated post-ACA. The cutoff published by the Texas Health and Human Services Commission differs slightly—$230 in monthly income or 16 percent of the FPL.

[8] Enrollment numbers are based on Medicaid data for July 2017. See www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Medicaid caseload data from the Texas Health and Human Services Commission indicate that Texas' Medicaid enrollment rose 13.4 percent in 2014.

[9] See "2017 Marketplace Plan Selections with Finance Assistance," Henry J. Kaiser Family Foundation, 2017.

[10] The analysis of 27–64-year-olds with no college education is based on CPS-IPUMS data. See Integrated Public Use Microdata Series, Current Population Survey: Version 4.0 [dataset], by Sarah Flood, Miriam King, Steven Ruggles and J. Robert Warren, University of Minnesota, 2015, http://doi.org/10.18128/D030.V4.0.

[11] See Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline, Congressional Budget Office, www.cbo.gov/sites/default/files/recurringdata/51298-2016-03-healthinsurance.pdf.

[12] See "How CBO Estimates the Effects of the Affordable Care Act on the Labor Market," by Edward Harris and Shannon Mok, Congressional Budget Office, Working Paper no. 2015-09, December 2015.

[13] See "The Effects of the Affordable Care Act on Health Insurance Coverage and Labor Market Outcomes," by Mark Duggan, Gopi Shah Goda and Emilie Jackson, National Bureau of Economic Research, NBER Working Paper no. 23607, July 2017.

[14] See "Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid," by Tal Gross and Matthew J. Notowidigdo, *Journal of Public Economics*, vol. 95, no. 7, 2011, pp. 767–78.

[15] See "The Impact of Medicaid Expansion on Uncompensated Care Costs," by Deborah Bachrach, Patricia Boozang and Mindy Lipson, Robert Wood Johnson Foundation, June 2015, www.rwjf.org/en/library/research/2015/06/the-impact-of-medicaid-expansion-on-uncompensated-care-costs.html.

[16] See, for example "Public Health Insurance and Private Savings," by Jonathan Gruber and Aaron Yelowitz, *Journal of Political Economy*, vol. 107, no. 6, 1999, pp. 1,249–74.

[17] See "The Stimulative Effect of Redistribution," by Bart Hobijn and Alexander Nussbacher, *FRBSF Economic Letter*, Federal Reserve Bank of San Francisco, no. 2015–21, June 2015.

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