Expanding Medicaid in Texas: Smart, Affordable and Fair!

Extending Medicaid to Low-Income Adults Will Grow the Economy and Save Local Tax Dollars

Myths, Mistakes and Misinformation: Why the Arguments Against Medicaid Expansion Are Wrong

1. ***Texas cannot afford to expand Medicaid. It is too expensive.***

    a. Texas already spends enough in 29 piecemeal state health programs on the expansion-eligible population to pay for the expansion over the next ten years. There will be no net new cost to the state for the adult expansion over the next ten years.

    b. Preliminary estimates indicate that Texas will spend at least $1.2 billion in these programs in the 2014-2015 biennium and more in future years as adults transfer over to a Medicaid expansion that is fully funded at 100 percent from 2014 through 2016, declining gradually to no less than 90 percent starting in 2020. The state expense for these programs over the next ten years is estimated at about $8.9 billion—$1 billion more than the state match required for the Medicaid expansion to adults.

    c. Of the estimated $100 billion in federal funds that Texas would receive over the ten years, about $79 billion applies directly to the adult portion of the expansion. That amount of new federal funds would significantly stimulate the state's economy, generating an estimated $1.5 billion in dynamic new state tax revenue and $2.1 billion in new local revenue, as well as $272 million in new premium tax revenue, from 2014-2017. It would also add an estimated 200,000 new jobs by 2016 and reduce $4.4 billion in annual uncompensated care costs at the local level. The expansion would benefit all parts of the state economically.

2. ***Expanding Medicaid to adults would crowd out other needs in the state's budget. Medicaid is already 25 percent of our state general revenue expenditures and by some estimates would increase to nearly 33 percent if the state opted in to the expansion.***

    a. Since the net new cost to the state is $0, the expansion will not crowd out other needs. In fact, expanding Medicaid to adults would make $1.2 billion in unrestricted General revenue (a net of $900 million after meeting expansion administrative costs) available for the next biennium under the current spending limit to meet other pressing needs.

    b. Instead of increasing from 25 percent to 33 percent due to the expansion, the Medicaid portion of the general revenue budget would increase by a little more than 1 percentage point—from 22.8 percent to 24.1 percent, and reductions in non-Medicaid health care programs due to adults moving to Medicaid would offset this amount further.

    c. Currently, according to the Legislative Budget Board, the Medicaid portion of the general revenue budget is $22.8 billion for the 2014-2015 biennium in the most recent appropriation bill, about 22.8 percent of the total $100 billion up for appropriation. The Health and Human Services Commission estimates that in 2022-2023, given projected caseload increases and health care cost increases, that the cost for the adult expansion would be almost $3.0 billion, which would increase the Medicaid share of the total to 25.1 percent—an increase of 2.2 percentage points, not 8 percentage points.

    d. However, even this small increase is offset to a degree since most adults currently served in the Medicaid program at about a 40 percent state match rate would shift to a maximum state match rate of 10 percent. That offset, amounting to preliminary estimates of more than

$1.3 billion of the $3 billion state match requirement in 2022-23, means that the actual percentage increase would be only about 1.3 percentage points, an increase from 22.8 percent to 24.1 percent.

3. ***Texas should not rush into an expansion and should take the time to design something new. Texas delayed implementing the Children's Health Insurance Program (CHIP), and it didn't cost the state anything.***

   a. Texas will permanently lose the opportunity to gain nearly $300 million per month in federal funds starting in January 2014 and $7.7 billion for the 2014-2015 biennium if Texas delays expanding Medicaid.

   b. Unlike the CHIP program delay, Texas will not be able to recoup these funds.

   c. The only cost to gaining these funds for the next biennium is administrative costs of up to $300 million, which the $1.2 billion in state General revenue that the state already spends in costly state health programs that serve these adults would more than cover—and with $900 million left over.

   d. The "new" things under discussion are policies that would reduce participation, which of course, would reduce federal funds and the associated economic benefits. Any reduction in participation would also create local costs as ineligible adults would continue to use local emergency rooms.

   e. There is no reason why the state cannot expand Medicaid to adults beginning in January 2014 and pursue waivers for anything truly innovative at the same time. The state has been implementing innovations while continuing to serve Medicaid beneficiaries throughout the decades.

4. ***Medicaid expansion will cost taxpayers money.***

   a. In fact, opting out will cost taxpayers money. Texans will be paying in to the Federal Treasury for the expansion whether the state opts in or opts out. Opting out will not enable Texans to keep their money. They will be leaving their billions with the federal government. Opting in will allow Texans to get their money back.

   b. At the same time that Texans are out dollars that should be paying for insuring low-income adults through the expansion, Texans will continue to fund health care for adults in the costly "Unmatched Locally Funded Emergency-Room Treatment" program and at least 29 other piecemeal state funded programs. Opting in, on the other hand, would provide relief, and the freed revenue at the state level alone would be enough to provide the expansion's state match for the next ten years.

   c. In addition, employers face a potential liability of up to $299-$448 million in federal tax penalties automatically triggered by uninsured employees between 100-138 percent of poverty that can claim premium tax credits if the state opts out of Medicaid, according to a Jackson Hewitt Tax Service study released in March. These employers also face a potential liability of another $255-$384 million or more for currently insured employees who could also take that option, using the same methodology. Opting in to Medicaid would protect these employers against the penalties because it would make individuals below 138 percent of poverty ineligible for the premium tax credits.

   d. Any delay in expanding Medicaid will expose these employers to penalties starting in January 2014. Changes to Medicaid eligibility that limit participation by making adults ineligible, such as the Governor's proposed assets test, would also expose these employers to penalties under the Affordable Care Act.

   e. Opting out of the expansion will hurt Texas' economic development. Businesses with employees who have incomes less than 138 percent of poverty will not want to locate in states that have opted out because they will not want exposure to tax penalty liabilities for employees who may claim premium tax credits that trigger employer penalties. Fewer businesses locating in Texas would mean less tax relief and greater tax burdens for all Texans.

   f. Children who are currently eligible and not enrolled in Medicaid or the Children's Health Insurance Program (CHIP) will begin enrolling in 2014 whether the state expands Medicaid or not, due to the ACA exchanges. The state will have to find new revenue to meet the state match—up to $889

million for the next biennium, with moderate enrollment levels—but without the new tax revenues that an expansion would generate unless the state opts in.

5. Medicaid is "broken."

a. The real broken system is the "Unmatched Locally Funded Emergency-Room Treatment" program that people are using now. Shifting low-income adults to Medicaid managed care would provide them with preventive care and would reduce local taxpayer and hospital burdens as well.

b. Expansion-eligible adults below 100 percent of poverty will have no choice but to use this broken program if Texas does not expand Medicaid to adults since the Affordable Care Act (ACA) does not allow them to access subsidies under the exchange as it originally assumed all states would expand Medicaid.

c. The increase in provider rates to the Medicare rate nationwide under the ACA for 2013 and 2014, and paid for with federal funds, will increase access to physicians and providers. Dynamic new tax revenues would enable the state to continue the rate beyond 2014, but these funds will only materialize if Texas opts in to the expansion.

d. The streamlining in eligibility and other systems that the ACA is already requiring states to initiate, regardless of whether or not they expand Medicaid, will allow states to handle the influx of new enrollees.

e. Texas has already substantially reformed Medicaid by moving services to managed care. The statewide rollout of Medicaid managed care is the direct result of its success in delivering cost savings.

f. When President Obama said that "Medicaid is broken" in 2009, it was an appeal to pass the Affordable Care Act, which would "fix" Medicaid that had a history of low physician participation due to poor state reimbursement rates and which also has had cumbersome eligibility processes. The ACA increased provider rates to the Medicare rate for 2013 and 2014 and fully funded it, giving states time to begin receiving the benefits of the Medicaid expansion and thus, to afford to continue paying physicians at the Medicare rate. It also simplified and streamlined the eligibility process.

6. Only 31 percent of physicians accept Medicaid in Texas, according to a survey by the Texas Medical Association. Texas cannot add a million more people to the system.

a. The Austin American-Statesman's "PolitifactTexas" column found the statement that "only three in ten Texas doctors accept new Medicaid patients" is "Mostly False."

b. The TMA survey showed that about 58 percent of physicians accept Medicaid in Texas (32 percent accept **all** new Medicaid patients and another 26 percent accept a **limited** number of **new** Medicaid patients.

c. Texas does have a shortage of doctors accepting Medicaid, however, because Texas has historically underpaid physicians. The Medicaid rate in 2012 was 61 percent of the Medicare rate. Other states with higher rates do not have shortages. Increasing the rate to the Medicare rate would increase the percentage of physicians accepting Medicaid to 78.6 percent nationally, according to a detailed study published in Health Affairs. This would increase the number of physicians accepting Medicaid in Texas by 35 percent.

d. The ACA increases rates provided to primary care physicians, including many sub-specialties, for 2013 and 2014 to the Medicare rate and pays for it with 100 percent federal funding. Expanding Medicaid will create the economic stimulus and additional premium insurance tax revenues necessary to generate the funding required to continue this rate increase after 2014.

7. ***Expanding Medicaid will increase the federal deficit. The government will have to print money or borrow it from China to pay for the expansion. New estimates by the Congressional Budget Office (CBO) show that the ACA will no longer cover its own costs.***

    a. According to a CBO release on March 20, 2013, the CBO has not revised its estimate that the ACA would reduce the federal deficit by $210 billion over 10 years. However, the report directs readers to a CBO fiscal note in July 2012 on an attempt to repeal the ACA that estimated repealing the ACA would increase projected federal deficits by $109 billion over ten years. Specifically, the CBO report said that repealing the ACA would "reduce direct spending by $890 billion and reduce revenues by $1 trillion between 2013 and 2022, thus adding $109 billion to federal budget deficits over that period." So, it is logical to infer that keeping it would reduce the federal deficit by $109 billion. (The original 2010 estimate was a reduction in the deficits over ten years of $210 billion.

    The CBO is the nonpartisan arm of Congress that estimates the costs of bills. The confusion may be coming from the report the CBO released in February that only revised part of their estimates on the ACA. That release showed the effects of the insurance coverage provisions that may be misinterpreted to reach a false conclusion that the ACA overall increases costs to the government. Here is what the CBO said in its March 20, 2013, release to clarify that issue: "Those amounts do not reflect the total budgetary impact of the ACA. That legislation included many other provisions that, on net, will reduce budget deficits. On balance, CBO and JCT have estimated that the legislation as a whole will reduce deficits over a 10-year period. We have not updated our estimates of the total budgetary impact of the ACA; for our most recent estimate of the budgetary impact of repealing the law, see the *Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act*." This letter includes the $109 billion fiscal note cost for repealing the ACA referred to earlier.

    b. The ACA includes a number of new revenue streams that will pay for the expansion. These include: an increase in the Medicare tax on high income earners; a net investment income tax on unearned income for wealthy individuals; an insurance premium tax and an additional tax on high-end insurance policies; changes to health flexible spending arrangements, an annual fee on health insurance providers, a 10-percent excise tax on indoor tanning services; a 2.3-percent medical device excise tax on manufacturers and importers; tax penalties for individuals above 138 percent of poverty who do not maintain insurance; tax penalties for certain employers that do not maintain certain coverage levels; and offset savings in Medicare, among others.

8. ***Texas needs a block grant system instead of extending Medicaid.***

    a. Delaying a Medicaid expansion on the tiny and unrealistic hope of a block grant will cost Texas nearly $300 million per month in 2014 and $7.7 billion for the 2014-15 biennium.

    b. Extending Medicaid would not jeopardize Texas' ability to negotiate a block grant or a waiver in the future. Instead, it would ensure a larger block grant because our funding would be larger--a factor that would give us more flexibility should we ever get a block grant. Not extending Medicaid will not force the federal government's hand to give us one. It will only leave Texas out in the cold.

9. ***Texas is unique, and we do not need a "one-size-fits-all" Medicaid program.***

    a. Texas is not unique other than that we have the highest rate of uninsured in the nation. Otherwise, we are just like other states. We have many uninsured adults below 138 percent of poverty just like other states. They need medical care for the same reasons that other people in other states need medical care. The diseases are the same. All states have physicians and providers, hospitals and clinics. Texas is no different.

    b. Medicaid is only a payment system in which the state buys premiums on a per member per month basis, just like an employer does, from private, for-profit and nonprofit managed care organizations on a competitive basis. These organizations, in turn, contract with physicians, hospitals, and other

providers to provide health care to the insured through a system of managed care. Because the state can leverage its buying power for 3.5 million people, mostly children and the elderly, the state can purchase coverage at less cost than comparable plans that individuals or employers negotiate. The Congressional Budget Office, the non-partisan arm of Congress, has estimated that private policies cost $3,000 more on average than comparable Medicaid benefit plans.

10. Any program extending insurance to low-income adults needs to have an assets test.

a. An assets test would expose employers with more than 50 employees to potential tax penalty liabilities for employees who would be ineligible for Medicaid (due to the assets test) since they could claim premium tax credits, which would trigger the employer penalties.

b. Nearly all states had eliminated the assets test before the Affordable Care Act did due to administrative costs and difficulties. The removal of the assets test will significantly reduce states' administrative costs, increase access, and create a more transparent eligibility framework. When Oklahoma eliminated its own Medicaid asset test in 1997, the state saved approximately one million dollars. Delaware's asset test removal resulted in "administrative simplicity," and Rhode Island stated that, "[the asset test] would cost more in administrative costs than the savings in denying care to low-income people."

c. Adding an assets test would bog down the process resulting in administrative delays as well as reduced federal funds to the state because fewer people would enroll.

11. Any program extending insurance to low-income adults needs to require co-pays, premiums and deductibles.

a. Any such requirements reduce the return of federal funds to the state while taking money out of Texans' pockets. They also reduce federal funds because fewer people cannot afford to access services.

b. Any such requirements increase administrative costs. Texas already requires some co-pays, which likely cost more to administer than they are worth.

c. Any such requirements shift costs to physicians who usually waive them; while waiving small co-pays may not be a problem for many physicians, asking too much in out-of-pocket costs would reduce the number of physicians willing to take on Medicaid patients.

12. Forcing people into Medicaid when they could do so much better with private insurance is not the answer.

a. Expanding Medicaid to adults would not force anyone to enroll in the program. People always have the option of buying insurance in the private market. People below 100 percent of the poverty level will not be eligible for a government subsidy under the ACA, but they are welcome to buy private insurance anytime they want. Or, they can pay their health care bill themselves.

b. If, however, they want the government to pay their bill, then they will need to enroll in Medicaid if the state expands it to cover them. If the state does not expand Medicaid, then local governments and hospitals will continue to pick up their tab—costs that could be paid with 100 percent federal funds, and local employers will be subject to potential tax penalties for employees between 100-138 percent of poverty who claim premium tax credits.

13. The high costs of uncompensated care are actually due to people on Medicaid using hospital emergency rooms for routine treatment.

a. The $4.4 billion in annual local costs ($2.5 billion for local governments and a conservatively estimated $1.8 billion for hospitals) do not include any costs of people insured by Medicaid. They also do not include bad debt caused when insured people do not pay their copayments. The costs include only those of uninsured individuals who seek treatment. These estimates exclude costs of all government programs.

14. Studies have shown that people are better off being uninsured than on Medicaid.

a. The Tampa Bay Times Pulitzer-Prize winning column "Politifact.com" has found the statement that expanding Medicaid "will worsen health care options for the most vulnerable" as "False."

b. Physicians and scientists have completely debunked the interpretation of the studies as proving that people are better off uninsured than on Medicaid in an article published in The New England Journal of Medicine.

c. Criticisms of these studies show that they do not take into account how long a person was on Medicaid or uninsured before arriving at the hospital for surgery. (Many uninsured people enroll in Medicaid when they present to a hospital due to being medically needy. Likewise, many uninsured people may present to an emergency room having been recently employed with private insurance but then lost their jobs and insurance because of illness.)

d. Surgical patients are often dual enrollees in Medicaid and Medicare, indicating the presence of significant disabilities and serious long-term illnesses, and so are often more ill even than the uninsured and have longer hospital stays. But, to interpret this as Medicaid somehow being the cause, is absurd.

e. It makes no sense to suggest that not having a doctor at all is better than having to wait to see a doctor. Studies have shown that having insurance saves lives, not the other way around. Most recently, a Harvard University study found that recent Medicaid expansions in several states reduced one death for every 176 additional adults enrolled in Medicaid compared with neighboring states that did not extend Medicaid. In Texas, assuming enrollment of about 1 million, that equates to about 5,700 adults each year saved from a premature death if Texas expands Medicaid.

15. Medicaid is "socialized medicine."

a. Medicaid is not socialized medicine. Socialized medicine as practiced in Western Europe, and specifically Great Britain, is a system under which the government not only funds but also operates hospitals, hires health care providers and controls every aspect of health care. Medicaid does not do these things; patients and their health care providers make health care decisions. Medicaid in no way meets the definition of "socialized medicine."

b. Medicaid is a federal health insurance program that matches state funding to provide health care to eligible, low-income citizens who cannot afford private health insurance. States receive federal matching funds and administer the program under federal rules that limit eligibility to certain groups and services and that provide states with flexibility within certain eligibility and service requirements. Texas participates in many similar federal programs that require state matching funds, including transportation, historic preservation and homeland security programs, among others.

c. Medicaid is only a payment system in which the state buys premiums on a per member per month basis from private, for-profit and nonprofit managed care organizations on a competitive basis. These organizations, in turn, contract with physicians, hospitals and other providers to provide health care to the insured through a system of managed care. Because the state can leverage its buying power for 3.5 million people, mostly children and the elderly, the state can purchase coverage at less cost than comparable plans that individuals or employers negotiate. The Congressional Budget Office, the non-partisan arm of Congress, has estimated that private policies cost $3,000 more on average than comparable Medicaid benefit plans.

16. Employer-insured adults that shift to Medicaid will hurt insurance companies, causing some of them to go under and creating a new class of uninsured.

a. Although some employer-insured adults may shift to Medicaid, even if all of them shifted, the 1.5 million projected to enroll in insurance through the Affordable Insurance Exchange would

overwhelm this amount. The additional enrollment in insurance due to the Affordable Care Act will provide a huge boost to the insurance industry in Texas.

b. Opting in to Medicaid will protect Texas employers from hundreds of millions of dollars in potential tax penalty liability from employees between 100-138 percent of poverty who can claim premium tax credits (that trigger the penalties) unless Medicaid is otherwise available.

17. Arizona and Maine expanded Medicaid in the last decade but found that it overwhelmed their budgets, increased uncompensated care costs and failed to reduce the percentage of uninsured, experiences that will also happen here.

a. There will be no net new cost to the state over the next 10 years (since we already spend the state share of the expansion on this population in 29 state health programs) and there will be a positive impact on the state's budget due to the dynamic new tax revenues and insurance premium revenues that it will generate.

b. Arizona and Maine have high state match rates like our current one of 40 percent, but unlike the expansion in the last decade, the present adult expansion under the ACA provides for the federal government to fund 100 percent for the next three years and no less than 90 percent by 2020.

c. Arizona experienced higher than anticipated caseload growth because their equivalent to our Legislative Budget Board used extremely poor forecasting techniques, including five-year old base data that underestimated the number of people who could enroll. They also used totally inappropriate and incorrect cost data to estimate the costs, relying solely on costs for parents, which are much lower than for childless adults, who are older, even though that information was readily available. If calculated correctly using accurate data available to them at the time, they would have been on target.

d. Uncompensated care costs and the number of uninsured climbed in these states over the decade because of high population growth rates and the economic crash that threw more people into poverty, out of work and out of insurance, along with higher health care costs in that decade, as confirmed by Census data. If they had not expanded Medicaid, the uncompensated care costs would be much higher.

e. The number of uninsured would also be higher. In Arizona, an additional 376,600 would be uninsured, increasing Arizona's uninsured rate by about 6 percentage points, from 17.2 percent to 23.1 percent. The issue is the same with Maine, who had about 146,600 adults in their Medicaid program in 2010-11. If the adults on Medicaid were to lose benefits, the uninsured rate in Maine would increase from about 10.8 percent to 24.8 percent.

f. Arizona governor, Jan Brewer (R), has touted their Medicaid program as "the nationally-recognized gold standard for cost-effective, managed care in this country," and recently made the decision to expand Medicaid despite initial reservations. Apparently, she does not believe that the state will have the same problems it experienced before, nor does she seem to think that Medicaid is "broken" in her state.

g. Massachusetts currently has 98.1 percent of its population insured, largely due to a major expansion of Medicaid to adults under Governor Mitt Romney in 2006 that relied heavily on expanding Medicaid. Currently, Medicaid insures 25 percent of Massachusetts residents and extends eligibility to 300 percent of poverty. In contrast, Texas only insures about half that—13.3 percent—through Medicaid.

h. A progress report issued in 2011 found that "although the number of enrollees in employer-based coverage has fallen since the start of the economic recession, employer participation in offering health insurance has risen under health reform." About 73 percent of Massachusetts employers with three or more employees offered health insurance coverage to their employees in 2010, up seven percentage points since 2005. This compares favorably to 69 percent of employers with health coverage nationwide.

i. Massachusetts does not view its Medicaid program as "broken": two-thirds of the state's residents support the program. More than four out of five beneficiaries report high levels of satisfaction, including "satisfaction with their choice of doctors and other health care providers, the range of services covered, the quality of care available, the application process, and the ease of enrolling in a health plan," according to the report. Massachusetts pays its providers at a considerably higher rate than Texas: 68 percent of the Medicare rate for primary care compared to Texas' 61 percent and 77 percent overall compared to Texas' 65 percent, according to the Kaiser Family Foundation.

Note: Funding estimates for the expansion vary. The estimates in this document are similar to those developed by the state's Health and Human Services Commission. The Legislative Budget Board has recently issued lower estimates, based on lower caseloads and cost per member, and lower administrative costs. Their estimate for the next biennium is $4 billion in federal funds for a state administrative cost of $50 million. For ten years, it is $45 billion for a state match of $4 billion.

Commissioned by Texas Impact and Methodist Healthcare Ministries of South Texas, Inc., Billy Hamilton Consulting, a widely respected consulting firm headed by Texas' former Chief Deputy Comptroller, developed these data for the recently published reports, Smart, Affordable and Fair: Why Texas Should Extend Medicaid to Low-Income Adults and Preliminary Estimates of GR Availability in State Health Programs if Texas Expanded Medicaid to Low-Income Adults.

Download county and legislative district impact data at http://www.texasimpact.org/content/2013-medicaid-extension-county-postcards and www.texasimpact.org/Local-Taxpayers-Win-With-Medicaid. Download the full report at www.mhm.org, and the executive summary and the state general revenue estimates report at www.texasimpact.org.

For more information about the report, "Smart, Affordable and Fair," contact Texas Impact at (512) 472-3903 or medicaidreport@texasimpact.org.