

Medicaid Expansion: Texas Should Chart Its Own Course

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by Devon M. Herrick

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The 2010 Patient Protection and Affordable Care Act (ACA) required each state to expand Medicaid eligibility to individuals and families with incomes up to 138 percent of the federal poverty level or risk losing federal funding for its entire Medicaid program. However, the U.S. Supreme Court ruled that provision of Obamacare unconstitutional.

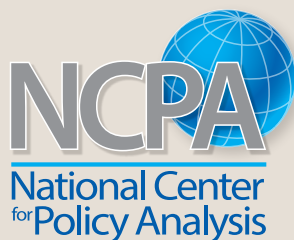


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Executive Summary

As a result, Texas and other states that have not expanded Medicaid eligibility have more options to tailor the program to better meet their unique needs.

The ACA also provides generous, sliding-scale subsidies for low- to middle-income individuals to purchase private coverage in a government-operated health insurance exchange. Exchange subsidies are more generous, and more valuable, than Medicaid:

- Exchange enrollees are getting a subsidy that, on average, is roughly 50 percent greater than the value of Medicaid coverage (\$9,000 versus \$6,000).
- In the exchange, an individual or family earning at the federal poverty level is required to pay (at most) 2 percent of their income toward a private health plan that might otherwise cost a family of four \$14,500 or more annually outside the exchange.
- However, there are no exchange subsidies for people earning below 100 percent of the poverty level — because they are expected to enroll in Medicaid — and families earning from 100 percent to 138 percent of poverty are not eligible for subsidies if they are eligible for coverage under their state Medicaid program.

On paper, Medicaid coverage appears far better than the private health coverage most Americans enjoy, with little or no cost-sharing and unlimited benefits. However, nearly one-third of Texas physicians do not accept new Medicaid patients. If more people are added to the Medicaid rolls and new patients flood doctors with requests for appointments, access to care for existing (and future) Medicaid enrollees would likely decrease even more.

Proponents of Medicaid expansion often tout the “economic benefits” that additional federal Medicaid funds might create within states. A study by economist Robert Book found that rather than stimulating the economy, Medicaid expansion is a drain on employment and slows economic growth.

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If all states expanded Medicaid, his analysis shows Texas would suffer a \$46 billion negative economic impact over 10 years. Moreover, Texas employment losses would amount to 54,445 work-years from 2014 to 2017.

In states which expand Medicaid eligibility to all legal residents earning from 100 percent to 138 percent of poverty, many of the new enrollees will be individuals who previously had private coverage. Crowd-out (or substitution) occurs when people who are already covered by employer or individual insurance drop that coverage to take advantage of the public option. An analysis of past Medicaid expansions to mothers and children in the early 1990s by recent Obama administration advisers David Cutler and Jonathan Gruber found that when Medicaid eligibility was expanded, 50 percent to 75 percent of the newly enrolled dropped private coverage. A conservative estimate is that Medicaid rolls might have to rise by 1.4 people in order to reduce the uninsured by 1 person.

Furthermore, private insurers pay much higher physician fees than state Medicaid programs. If more Texas residents were privately insured, the Texas health care economy — local doctors and hospitals — could expect far more generous reimbursements from private insurers than under Medicaid. A rule of thumb is that private insurers generally pay fees at least 50 percent higher — and often double — what Medicaid pays. Certainly, not all who qualify would enroll. But if merely 600,000 uninsured Texans with incomes above 100 percent of poverty enrolled in private coverage in the exchange rather than in an expanded Medicaid program, health care providers will receive roughly \$25 billion more over 10 years than Medicaid would have paid them.

In Texas, stakeholders composed primarily of hospitals and other providers have proposed a compromise solution they claim would cover the nearly one million individuals that fall in the coverage gap. The proposal, promoted under the banner “The Texas Way,” includes: 1) sliding-scale subsidies for low-income individuals to obtain coverage in the private market; 2) cost-sharing to encourage wellness and penalize inappropriate or unnecessary medical utilization; 3) chronic disease management; and 4) small business subsidies. Supporters claim their proposal shares ideas with the Healthy Indiana plan, often touted by conservatives as a better alternative to traditional Medicaid.

Though it depends on how the program is implemented, some of the goals of the Texas Way are consistent with those of conservative Texans who oppose Medicaid expansion. The outgoing governor’s office backed a proposal for a federal block grant that would allow Texas greater flexibility in its Medicaid program (and county indigent health care programs). A block grant might include some of the provisions in the Texas Way proposal. However, much work needs to be done to align the disparate stakeholders’ goals. Certainly, Congressional Budget Office projections following the 2012 Supreme Court decision assumed many states would negotiate with the U.S. Department of Health and Human Services to innovate state Medicaid programs.

Texas made the wise choice to forgo cookie-cutter Medicaid expansion in favor of a tailored program that would maximize the availability of private coverage for low-income residents. The states should work toward a program that meets its unique needs.

About the Author

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Herrick received a Doctor of Philosophy in Political Economy degree and a Master of Public Affairs degree from the University of Texas at Dallas with a concentration in economic development. He also holds a Master of Business Administration degree with a concentration in finance from Oklahoma City University and an M.B.A. from Amber University, as well as a Bachelor of Science degree in accounting from the University of Central Oklahoma.

Introduction

A well-known provision of the 2010 Patient Protection and Affordable Care Act (ACA) required states to expand Medicaid eligibility to individuals with incomes up to 138 percent of the federal poverty level (FPL) or face the loss of matching funds for the joint federal-state health program for the poor. However, the U.S. Supreme Court ruled that provision of Obamacare unconstitutional.¹ As a result, a number of states have opted not to expand Medicaid eligibility or, as Wisconsin has done, have reduced eligibility to the federal poverty level, allowing many low-income residents earning above poverty to access private coverage rather than be forced into Medicaid.²

For states choosing to expand Medicaid eligibility to 138 percent of the FPL, the federal government will pay 100 percent of the cost of benefits for newly eligible enrollees through 2016.³ The enhanced federal match will drop to 90 percent by the end of the decade and thereafter.⁴ However, states that choose not to expand eligibility to 138 percent of poverty will receive their historic matching rate for new enrollees, rather than the enhanced rate.⁵ (The Federal Medical Assistance Percentage for states ranges from 50 percent to 73 percent.)⁶ In addition to enhanced federal matching for Medicaid expansion, other provisions of the ACA provide generous, sliding-scale subsidies for low- to middle-income individuals to purchase private health coverage in a health insurance

exchange operated by the state or federal government.

Exchange Subsidies Are More Generous than Medicaid. The ACA requires individuals with incomes below 138 percent (\$15,556) of poverty to enroll in Medicaid if it is available in their state. Individuals and families who are legal residents, who lack access to an employer-provided health plan and are ineligible for Medicaid may purchase coverage in the exchange.⁷ In the exchange, subsidies are available to individuals and families with incomes below 400 percent of the FPL — just over \$95,400 for a family of four in 2014. However, there are no exchange subsidies for people earning below 100 percent of poverty because they are expected to enroll in Medicaid.

The subsidies in the exchange are very generous. At most, a low-income individual or family earning at the federal poverty level will be required to pay 2 percent of income toward a private health plan that would otherwise cost a family of four \$14,500 or more annually. Consider what this means [see Figure I]:⁸

- Two percent of annual income is \$233 for an individual at the poverty level.
- Two percent of annual income is \$310 for someone earning 133 percent of a poverty-level income.
- For a family of four, 2 percent of a poverty-level income is \$477, while 2 percent of income for families earning 133 percent of poverty is \$634.

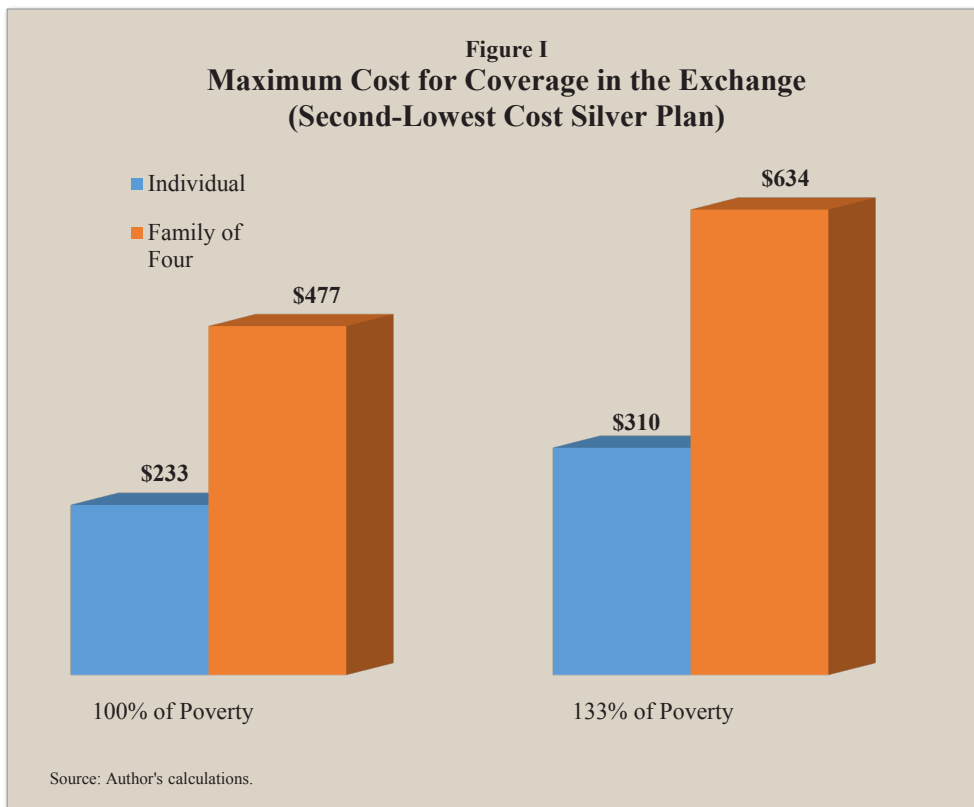
Certainly, this represents a significant amount of money for low-income families. For instance, a \$477 premium payment by a family of four at 100 percent of the federal poverty level is \$119 per year per family member, while a family of four at 133 percent of the federal poverty level would pay \$159.

However, exchange enrollees are getting a subsidy that, on average, is roughly 50 percent greater (\$9,000 versus \$6,000) than the value of Medicaid.⁹ Indeed, the Congressional Budget Office initially projected that about half of the potential newly eligible Medicaid population would reside in states that would only partially expand Medicaid, choosing not to expand eligibility above 100 percent of poverty.¹⁰

Benefits to Health Care Providers. If Texas residents were privately insured, they would have easier access to doctors willing to treat them. That is because the Texas health care economy — local doctors and hospitals — could expect far more generous reimbursements from private insurers than Medicaid. How much more? Although it varies by state (and insurer), a rule of thumb is that private insurers generally pay fees at least 50 percent higher — and often double — what Medicaid pays.¹¹ Texas Medicaid physician fees are about 53 percent of what a private insurer would pay for the same service.¹²

Because of the greater subsidy in the exchange and the contributions toward their premiums by the individuals covered, there will

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be more funds available for the health care of individuals in the exchange than if they were covered by Medicaid. Certainly, not all who would be eligible would enroll—take-up of public programs varies from one state to another. But, if 600,000 uninsured Texans with incomes above 100 percent of poverty enroll in private coverage in the exchange rather than in an expanded Medicaid program, health care providers will receive roughly \$25 billion more over 10 years than Medicaid would have paid them.¹³

Why Not Expand Medicaid? On paper, Medicaid coverage appears far better than the private health coverage most Americans enjoy, with lower cost-sharing and unlimited benefits.¹⁴ However, Medicaid enrollees fare worse than similar patients with private insurance.¹⁵ They tend to be

in poorer health and face barriers to care.

Poor Access to Care. Studies across the United States show it is easier for the uninsured to make doctors' appointments than it is for Medicaid enrollees.¹⁶ [See Figure II.]

- Nearly one-third of physicians do not accept new Medicaid patients.¹⁷
- This is nearly double the portion of doctors who have closed their practices to new Medicare patients (17 percent) and to new privately insured patients (18 percent).¹⁸
- Physicians are four times more likely to turn away new Medicaid patients as they are to refuse the uninsured who pay out-of-pocket (31 percent versus 8 percent).¹⁹

According to a 2011 survey, nearly one-third of Texas physicians are not accepting new Medicaid patients — similar to the national average. However, according to a more recent survey, the proportion of specialty physicians who accept Medicaid in large urban areas is much lower. Texas-based physician recruiter Merritt Hawkins surveyed specialty physicians in 15 major American cities, including Dallas and Houston. Across the specialties surveyed, Merritt Hawkins found the average Medicaid acceptance rate was only 23 percent in Dallas and 56 percent in Houston. This means that just over three-quarters of Dallas specialty physicians and 44 percent of Houston specialists surveyed do not accept Medicaid patients.²⁰

In addition, the Health and Human Services Office of Inspector General recently found that half the doctors listed as affiliated providers for Medicaid managed care plans were not in a position to provide care to enrollees who called seeking an appointment. More than one-third of listed physicians were no longer at the listed location, while 8 percent did not participate in the plan. An additional 8 percent were participating in the plan but were not accepting new Medicaid enrollees.²¹ If more people are added to the Medicaid rolls and new patients flood doctors with requests for appointments, access to care for Medicaid enrollees would likely decrease even more.

Low Medicaid Provider Fees. Low reimbursement rates are one of several factors contributing to the shortage of physicians willing

to treat Medicaid enrollees.²² On average, Medicare pays 81 percent — and Medicaid 53 percent — of what private insurers pay physicians. [See Figure III.] For primary care, Texas Medicaid only pays just under half (49 percent) as much as private insurers for the same service.²³

As with low Medicare reimbursements, Medicaid fees often do not cover the cost to physicians of treating enrollees. Physicians must have more highly reimbursed, privately-insured patients to offset the lower fees paid by Medicaid. Low provider reimbursement rates make it more difficult for Medicaid enrollees to find physicians willing to treat them, limiting their access to care. If more people are placed in Medicaid, many more physicians will balk at accepting them.

Nonexistent Stimulus. Proponents of Medicaid expansion often tout the “economic benefits” that additional federal Medicaid funds might create within states.²⁴ A common argument stakeholders use to encourage state policymakers to expand Medicaid is that an influx of federal money is a stimulus that creates jobs. For instance, one Texas economist estimates that Medicaid expansion could create 300,000 jobs in Texas. Another consultant claims it would generate nearly \$68 billion in “economic output.”²⁵ Implausibly, one group even argued Medicaid expansion would prevent the untimely death of nearly 6,000 Texans in 2014.²⁶ And one advocacy group contended Medicaid expansion would generate productivity gains from workers taking “fewer sick days.”²⁷

There is little evidence to support predictions that Medicaid dollars boost job growth beyond the industry that experiences the influx. Indeed, analysis by Altarum, a health consultancy, found that health care employment growth was actually greater in states that did not expand Medicaid.²⁸ A study by economist Robert Book found that rather than stimulating the economy, Medicaid expansion is a drain on employment and slows economic growth.²⁹ If all states expanded Medicaid, his analysis shows Texas would suffer a \$46 billion negative impact on economic activity from 2014 to 2023. Moreover, employment losses would number 54,445 work-years from 2014 to 2017.³⁰

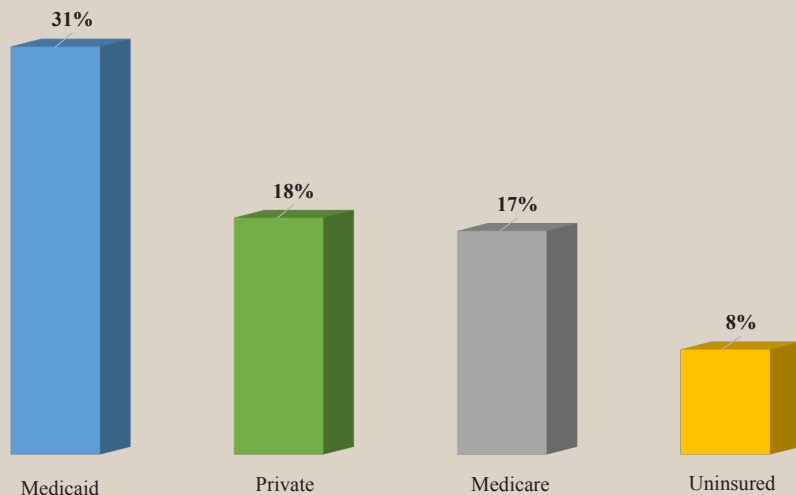
In reality, economists have always found it difficult to identify the economic value of activities that are generally assumed to have beneficial spillover effects in industries far

removed from the initial spending. For instance, a macroeconomic study published by the National Bureau of Economic Research indicates that, since 1950, government defense spending has actually reduced national economic output below what it would have been otherwise.³¹

Economist Lauren Cohen and her colleagues also found that the multiplier from additional federal spending might be negative. Increased government spending also crowds out the private sector by competing with it for labor and reducing private investment in research and development.³²

The ACA includes substantial tax increases that potentially reduce federal and state revenues needed to finance both existing Medicaid and any Medicaid expansion. State officials should keep in mind that models predicting large economic

Figure II
Physicians Not Accepting New Patients
(by Type of Insurance)



Source: Sandra L. Decker, “In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help,” *Health Affairs*, Vol. 31, No. 8, August 2012, pages 1,673-1,679.

Healthy Indiana

Healthy Indiana is a Medicaid pilot project that has been in limited use since 2008. An updated version, Healthy Indiana 2.0, is currently awaiting approval from the U.S Department of Health and Human Services. The original version coupled high-deductible plans with a type of personal health account called a Power Account. Indiana deposits \$1,100 into the account for enrollees to use toward their deductibles. Enrollees are also required to make monthly contributions into their Power Accounts. Contributions range from \$3 to \$25, to use toward cost-sharing under the deductible. Thus, enrollees have an incentive to use medical services carefully, because unnecessary care would deplete their Power Accounts and require additional out-of-pocket costs. The insurer that administers the Medicaid plan reports reduced Emergency Room utilization — a persistent problem in traditional Medicaid programs. The insurer also pays higher reimbursements, which improves enrollees' access to care.⁴¹ HHS has extended the original Healthy Indiana program until December 31, 2015.⁴²

increases from reallocated federal spending generally ignore the fact that the money must come from somewhere. Economic impact studies tend to overlook the fact that additional federal spending crowds out private activity and depends on additional government revenues extracted from the private sector. For instance, an additional \$1.00 of federal spending to Texas is financed by equal tax liabilities on all states. Such results suggest the net effect of the new health law will be a decline in national gross domestic product as the federal government consumes a larger share of national income to fund its programs. Basically, people will cut their other consumption to pay the increased tax burden.

Displaces Private Insurance.

In states which expand Medicaid eligibility to all legal residents earning from 100 percent to 138 percent of poverty, many of the new enrollees

will be individuals who previously had private coverage. Crowd-out (or substitution) occurs when people who are already covered by employer or individual insurance drop that coverage to take advantage of the public option. Crowd-out is likely to be a significant problem for states that expand Medicaid eligibility to adults who are not disabled. Estimates of crowd-out are controversial among analysts. Some researchers predict a high rate of Medicaid substitution for private coverage, while others believe the effect will be negligible. Estimates of crowd-out for diverse populations vary:

- An analysis of past Medicaid expansions to mothers and children in the early 1990s by economists and Obama administration advisers David Cutler and Jonathan Gruber found that when Medicaid eligibility was expanded, 50

percent to 75 percent of the newly enrolled dropped private coverage.³³

- A recent analysis by Gruber and Kosali Simon estimated crowd-out for the Children's Health Insurance Program averages about 60 percent.³⁴
- Academic researchers Steven Pizer, Austin Frakt and Lisa Iezzoni estimated the crowd-out of working adults (the target of Medicaid expansion under the ACA) could reach 82 percent.³⁵
- Thus, a conservative estimate is that Medicaid rolls might have to rise by 1.4 people in order to reduce the uninsured by one person.³⁶

Who Is Left Out? Estimates vary, but maybe 5.3 million adults and children lack health coverage in Texas. More than 1 million of those are thought to be undocumented immigrants who are ineligible for either exchange subsidies or Medicaid. Approximately 3.8 million have incomes above 100 percent of the poverty level.³⁷ Many of these likely qualify for exchange subsidies. The so-called coverage gap applies to those with incomes above the state Medicaid eligibility level but below the poverty level (where eligibility for exchange subsidies begins). According to the Kaiser Family Foundation, 948,000 Texas adults fall into the coverage gap.³⁸

Stakeholders' Proposals.

Stakeholders composed primarily of hospitals and other providers have proposed a compromise solution they claim would cover the nearly one

million individuals who fall in the coverage gap.³⁹ Those who fall into the coverage gap are mostly low-income adults — about two-thirds of whom don't have dependent children. The compromise proposal, promoted under the banner “The Texas Way,” includes: 1) sliding-scale subsidies that allow low-income individuals to obtain coverage in the private market; 2) use of cost-sharing to encourage wellness and penalize inappropriate or unnecessary medical utilization; 3) chronic disease management; and 4) small business subsidies. Supporters claim their proposal shares ideas with the Healthy Indiana plan often touted by conservatives as a better alternative to traditional Medicaid.⁴⁰ [See the sidebar, “Healthy Indiana.”]

The Texas Way also bears some resemblance to a two-year pilot project in Tennessee. Tennessee has received approval for a waiver that would allow it to use federal funds to subsidize low-income individuals' contributions to employer-sponsored health insurance. Some other individuals would have access to a special program called TennCare, which features cost-sharing and incentives for individuals to take preventive measures. Income eligibility for the Tennessee program would be capped at about the same level as under the ACA.⁴³

Depending on how the Texas Way program were implemented, some of its goals could be consistent with the aims of conservative Texans who oppose expanding Medicaid under the ACA provisions. Outgoing Governor Rick Perry backed a proposal for a federal block grant that would allow

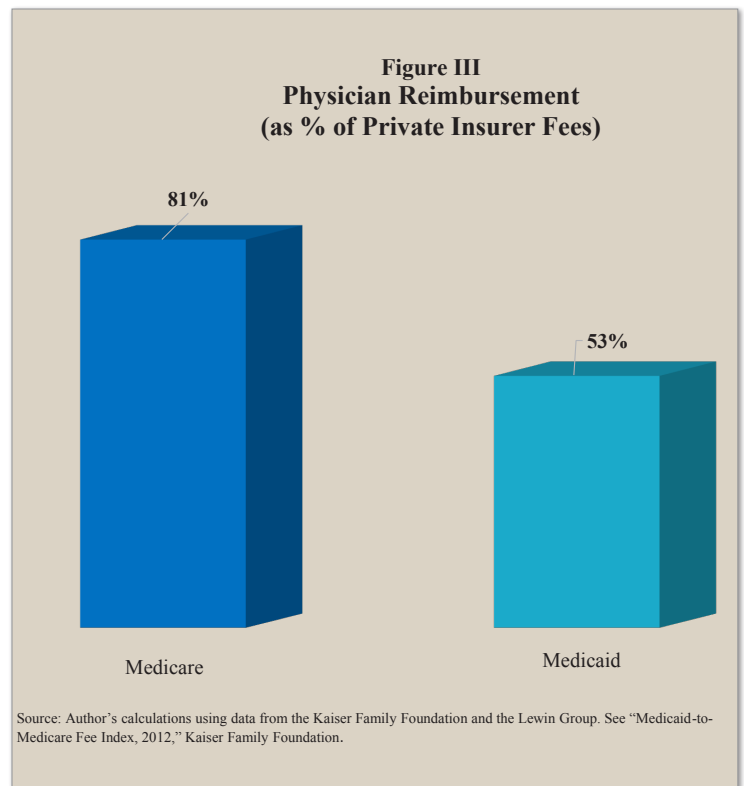
Texas greater flexibility to tailor its Medicaid (and county indigent health care) programs.⁴⁴ The block grant request could include some of the provisions in the Texas Way proposal.⁴⁵ However, much work needs to be done to align the disparate stakeholders' goals.

Hospital groups arguably want to boost federal reimbursements to hospitals — not more efficiently manage the funds already spent on poor Texans.

As more states hold out, the U.S. Department of Health and Human Services may entertain novel programs that afford states more control — and responsibility for cost overruns. Certainly, the Congressional Budget Office assumed the 2012 Supreme Court decision allowing states to opt out of Medicaid expansion would result in more negotiated experiments between HHS and state Medicaid programs.⁴⁶

Conclusion

On paper, Medicaid coverage appears far better than what most Americans enjoy — with lower cost-sharing and unlimited benefits. But by almost all measures, Medicaid enrollees fare worse than similar



patients with private insurance and often experience worse health issues than patients with no insurance. Texas made a wise choice when it decided to forgo a cookie-cutter Medicaid expansion in favor of a tailored program that would maximize the availability of private coverage for Texas' low-income residents. Individuals earning above the federal poverty level are better off having access to subsidized private coverage in the federal exchange.

For uninsured individuals living below the poverty level, Texas needs a unique solution. Much remains to be done. However, Texans should not be tempted to go after the cash grab of Medicaid expansion. Rather, the state should work toward a program that meets its unique needs.

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Notes

1. MaryBeth Musumeci, “A Guide to the Supreme Court’s Affordable Care Act Decision,” Kaiser Family Foundation, July 2012. Available at <http://www.kff.org/healthreform/upload/8332.pdf>. Also see I. Glenn Cohen and James F. Blumstein, “The Constitutionality of the ACA’s Medicaid-Expansion Mandate,” *New England Journal of Medicine*, Vol. 366, No. 2, January 12, 2012, pages 103-104.
2. Devon M. Herrick, “Medicaid Expansion: Wisconsin Got It Right,” National Center for Policy Analysis, Issue Brief No. 151, October 7, 2014. Available at <http://www.ncpa.org/pub/ib151>.
3. Eligibility is technically cut off at 133 percent of the FPL, but individuals with incomes up to 138 percent of poverty may be eligible, due to a 5 percent income disregard.
4. Future Congresses have the right to renew, alter or cancel the federal match.
5. Robin Rudowitz, Samantha Artiga and MaryBeth Musumeci, “The ACA and Recent Section 1115 Medicaid Demonstration Waivers,” Kaiser Family Foundation, February 5, 2014. Available at <http://kff.org/report-section/the-aca-and-recent-section-1115-medicaid-demonstration-waivers-issue-brief/>.
6. “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier,” Kaiser Family Foundation, FY 2015. Available at <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.
7. MaryBeth Musumeci, “A Guide to the Supreme Court’s Affordable Care Act Decision.”
8. “Annual Update of the HHS Poverty Guidelines,” *Federal Register*, January 22, 2014. Available at <https://www.federalregister.gov/articles/2014/01/22/2014-01303/annual-update-of-the-hhs-poverty-guidelines>.
9. Charles Blahous, “Medicaid Under the Affordable Care Act,” in Jason J. Fichtner, ed., *The Economics of Medicaid: Assessing the Cost and Consequences* (Arlington, Va.: Mercatus Center at George Mason University, 2014), pages 83-97. Also see “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” Congressional Budget Office, July 2012, page 4. Available at <http://www.cbo.gov/sites/default/files/43472-07-24-2012-CoverageEstimates.pdf>.
10. “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision.”
11. The two exceptions are Alaska and Wyoming. Texas Medicaid fee-for-service physician fees are only about 65 cents on the dollar of what Medicare reimburses a physician for the same service. Medicare reimburses physicians about 81 percent of what a private insurer reimburses physicians for the same service. See “Medicaid-to-Medicare Fee Index, 2012,” StateHealthFacts.org, Kaiser Family Foundation. Available at <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>.
12. Ibid. For all services, Texas physician fees are about 65 percent of what Medicare pays for the same service. Medicare pays about 81 percent of what private insurers pay [$0.65 \times 0.81 = 0.53$].
13. Author’s calculations based on 600,000 new exchange enrollees earning above 100 percent of poverty. Medicaid take-up varies from state-to-state. Estimated take up ranges from 55 percent to 75 percent. Private insurers tend to pay fees that are often double the physician fees paid by fee-for-service Medicaid. Thus, the amount of funds spent on care should be higher under private coverage than if that individual was on Medicaid.
14. Evelyne P. Baumrucker and Bernadette Fernandez, “Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families,” Congressional Research Service, February 28, 2013. Available at <http://www.fas.org/sgp/crs/misc/R42978.pdf>.
15. Kevin Dayaratna, “Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured,” Heritage Foundation, November 7, 2012. Available at <http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured>.
16. Brent R. Asplin et al., “Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments,” *Journal of the American Medical Association*, Vol. 294, No. 10, September 14, 2005. Available at <http://jama.ama-assn.org/cgi/content/abstract/294/10/1248>.
17. Sandra L. Decker, “In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May

Help,” *Health Affairs*, Vol. 31, No. 8, August 2012, pages 1,673-1,679.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ “Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates,” 2014 Survey, Merritt Hawkins, 2014. Available at <http://www.merrithawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf>.

²¹ Vincent Greiber et al., “Access to Care: Provider Availability in Medicaid Managed Care,” Office of Inspector General, Department of Health and Human Services, Publication OEI-02-13-00670, December 2014. Available at <http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

²² Peter J. Cunningham and Len M. Nichols, “The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective,” *Medical Care Research and Review*, Vol. 62, No. 6, December 2005.

²³ Author’s calculations using data from the Kaiser Family Foundation and the Lewin Group. See “Medicaid-to-Medicare Fee Index, 2012,” Kaiser Family Foundation. Available at <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>.

²⁴ For instance, the argument follows that federal money is a multiplier of state spending. The effect ripples throughout the economy from health care providers to their vendors and employees. See “The Role of Medicaid in State Economies: A Look at the Research,” Kaiser Family Foundation, January 2009.

²⁵ Anne Dunkelberg, “Medicaid Expansion Resource Guide: All the Latest on the Costs and Benefits for Texas,” Center for Public Policy Priorities, February 2013. Available at http://forabettertexas.org/images/HC_2013_02_PP_MedicaidExpansion.pdf.

²⁶ “Lives and Livelihoods Lost: The High Cost of Rejecting Medicaid Expansion,” Health Care for America Now, December 2013. Available at <http://usaction.org/wp-content/blogs.dir/4/wp-content/uploads/2013/12/Medicaid10.pdf>.

²⁷ Families USA, February 2013.

²⁸ Melanie Evans, “Economists Find No Evidence that Medicaid Expansion Adds Healthcare Jobs,” *Modern Healthcare*, November 26, 2014.

²⁹ Robert Book, “Expanding Medicaid Will Not Stimulate the Economy or Create Jobs,” American Action Forum, December 11, 2014. Available at <http://americanactionforum.org/research/expanding-medicaid-will-not-stimulate-the-economy-or-create-jobs>.

³⁰ Ibid. Table 1 and Table 2. In an email, Dr. Book explained that using methodology similar to the President’s Council of Economic Advisor’s economic model implies that this negative economic impact would amount to 54,445 work-years from 2014 to 2017.

³¹ Robert J. Barro and Charles J. Redlick, “Macroeconomic Effects from Government Purchases and Taxes,” National Bureau of Economic Research, Working Paper No. 15369, September 2009. Available at <http://www.nber.org/papers/w15369>.

³² Lauren Cohen, Joshua Coval and Christopher Malloy, “Do Powerful Politicians Cause Corporate Downsizing?” National Bureau of Economic Research, Working Paper No. 15839, March 2010. Available at <http://www.nber.org/papers/w15839>.

³³ David Cutler and Jonathan Gruber, “Does Public Insurance Crowd Out Private Insurance?” *Quarterly Journal of Economics*, Vol. 111, No. 2, May 1996, pages 391-430.

³⁴ The actual rate varied depending on the conditions governing expansion and the populations covered. Jonathan Gruber and Kosali Simon, “Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” *Journal of Health Economics*, Vol. 27, 2008, pages 201-217.

³⁵ Steven D. Pizer, Austin B. Frakt and Lisa I. Iezzoni, “The Effect of Health Reform on Public and Private Insurance in the Long Run,” *Health Care Financing & Economics*, Working Paper No. 2011-03, February 17, 2011. Available at http://www.hcfe.research.va.gov/docs/wp_2011_03.pdf.

³⁶ A ratio of 1.4 new Medicaid enrollees to reduce the uninsured by 1 assumes a crowd-out rate of 29 percent [$1 - (1/1.4)$]. One analysis found about one-quarter of the newly insured children in families earning less than 200 percent of poverty had substituted public coverage for private

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coverage. See Peter J. Cunningham, James D. Reschovsky and Jack Hadley, “SCHIP, Medicaid Expansions Lead to Shifts in Children’s Coverage,” Center for Studying Health System Change, Issue Brief 59, December 2002, page 4. Available at <http://www.hschange.com/CONTENT/508/508.pdf>.

³⁷ “Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL),” Kaiser Family Foundation, 2013. Available at <http://kff.org/uninsured/state-indicator/distribution-by-fpl-2/>.

³⁸ Rachel Garfield and Anthony Damico and Jessica Stephens and Saman Rouhani, “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update,” Kaiser Family Foundation, November 12, 2014. Available at <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

³⁹ See “The Texas Way.” Available at <http://texasway.org/>.

⁴⁰ Jim Landers, “Hospitals seek a Texas Way to expand Medicaid,” *Dallas Morning News*, November 17, 2014. Available at <http://www.dallasnews.com/business/columnists/jim-landers/20141117-hospitals-seek-a-texas-way-to-expand-medicaid.ece>.

⁴¹ Maureen Groppe, “From support to outrage, Hoosiers speak out on Healthy Indiana Plan,” *Indianapolis Star*, September 28, 2014. Available at <http://www.indystar.com/story/news/politics/2014/09/26/support-outrage-hoosiers-speak-healthy-indiana-plan/16262971/>.

⁴² “Feds OK extension of original Healthy Indiana Plan,” Associated Press, November 17, 2014. Available at <http://wishtv.com/2014/11/17/feds-ok-extension-of-original-healthy-indiana-plan/>.

⁴³ Loise Radnofsky, “Tennessee Moves to Expand Medicaid,” *Wall Street Journal*, December 15, 2014. Available at <http://www.wsj.com/articles/tennessee-moves-to-expand-medicaid-1418666256>

⁴⁴ Becca Aaronson, “Perry Directs HHSC to Pursue Medicaid Block Grant,” *Texas Tribune*, September 16, 2013. Available at <http://www.texastribune.org/2013/09/16/perry-directs-hhsc-pursue-medicaid-block-grant/>.

⁴⁵ For example, see James Capretta, Arlene Wohlgenuth and John Davidson, “Save Texas Medicaid: A Proposal for Fundamental Reform,” Texas Public Policy Foundation, March 2013. Available at <http://www.texaspolicy.com/sites/default/files/documents/2013-03-RR05-MedicaidBlockGrants-Final.pdf>.

⁴⁶ “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” Congressional Budget Office, July 2012. Available at <http://www.cbo.gov/sites/default/files/43472-07-24-2012-CoverageEstimates.pdf>.

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

The NCPA developed the concepts of Health Savings Accounts and Roth IRAs.

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA’s proposal for an across-the-board tax cut became the centerpiece of President Bush’s tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax.

A major NCPA study, “Wealth, Inheritance and the Estate Tax,”

completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Senate Majority Leader Bill Frist (R-Tenn.) and Senator Jon Kyl (R-Ariz.) distributed a letter to their colleagues about the study. The NCPA recently won the Templeton Freedom Award for its study and project on free market solutions to the problems of the poor. The report outlines an approach called Enterprise Programs that creates job opportunities for those who face the greatest challenges to employment.

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, “Ten Steps to Baby Boomer Retirement,” shows that as 77 million baby boomers begin to retire, the nation’s institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are inadequately funded. State and local institutions are not doing better — millions of government workers are discovering that their pensions are under-funded and local governments are retrenching on post-retirement health care promises.

Pension Reform.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of

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employees into companies' 401(k) plans, automatic contribution rate increases so that workers' contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

Environment & Energy.

The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

Educating the Next Generation.

The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

Promoting Ideas.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the Wall Street Journal, the Washington Times, USA Today and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from BurrellesLuce, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

What Others Say About the NCPA



"The NCPA generates more analysis per dollar than any think tank in the country. It does an amazingly good job of going out and finding the right things and talking about them in intelligent ways."

Newt Gingrich, former Speaker of the U.S. House of Representatives



"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like Health Savings Accounts. These things work, allowing people choices. We've seen how this created America."

John Stossel, host of "Stossel," Fox Business Network



"I don't know of any organization in America that produces better ideas with less money than the NCPA."

Phil Gramm, former U.S. Senator



"Thank you . . . for advocating such radical causes as balanced budgets, limited government and tax reform, and to be able to try and bring power back to the people."

Tommy Thompson, former Secretary of Health and Human Services

The NCPA is a 501(c)(3) nonprofit public policy organization. We depend entirely on the financial support of individuals, corporations and foundations that believe in private sector solutions to public policy problems. You can contribute to our effort by mailing your donation to our Dallas headquarters at 12770 Coit Road, Suite 800, Dallas, TX 75251, or visiting our Web site at www.ncpa.org and clicking "Support Us."