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Medicaid Expansion Resource Guide: All the Latest on the Costs and Benefits for Texas

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The US Census reports that 6.1 million Texans—nearly one in four—were uninsured in 2011. This included 1.2 million children. Texas experts predict that with moderate enrollment success, the private and public insurance coverage gains under the Affordable Care Act (ACA) would cut Texas' uninsured in half. But this level of progress depends on Texas expanding Medicaid. Without the Medicaid coverage, those experts say our uninsured rate would only improve by about one quarter. Texas' Medicaid agency, HHSC, now estimates Medicaid costs to the state budget (GR) would total **$3.1 billion GR over 4 years** from 2014-2017 ($1.3 billion for newly-eligible adults, and $1.8 billion for higher enrollment by already-eligible children), and those state funds will draw down **$27.2 billion in federal matching funds** for Texas health care providers.

This report summarizes the latest estimates from state Medicaid officials of the numbers of newly insured, the state costs, and the federal funding gains if Texas extends the new Medicaid coverage for parents and other adults. Read on to find:

- Local and state government spending that would be reduced if more uninsured Texans can enroll in Medicaid;
- The latest from reports estimating substantial net economic gains for Texas if the Medicaid expansion is implemented;
- How the official HHSC estimated costs of ACA Medicaid were calculated and what they mean for Texas counties;
- Which Texas industries and uninsured workers will benefit most from Medicaid expansion;
- The latest on flexibility available to the states that opt to allow uninsured adults to access the new Medicaid coverage.

How ACA Changes Medicaid Eligibility

- Under ACA, beginning January 2014 all U.S. citizens with near- and below-poverty incomes (up to 138% of the federal poverty income level about $31,000 a year for a family of four) could get Medicaid coverage, with minimal out-of-pocket costs. [1]
- Today, Texas Medicaid and CHIP *already cover* all lawfully-present children at these incomes, but only a very small fraction of their parents are covered today; that is, Texas Medicaid covers about 2.6 million children today, but only about 225,000 of their parents are covered. Parents must have incomes ranging from 12% to 19% of poverty to qualify for Texas Medicaid. To illustrate, a parent with two children must work fewer than 10 hours per week at minimum wage (earning less than $308 a month for family of 3). This dollar limit was set by the Texas legislature in 1985 with no inflation adjustments, and has never been updated.
- And like most states, Texas does not cover childless adults at all (unless pregnant, fully disabled, or over 65).

What does Texas pay, and what does federal government pay if we expand Medicaid to adults?

- The federal government will pick up 100 percent of the costs for the first three years of Texas' expansion to the adults, 95% in 2017, 94% in 2018, 93% in 2019, and no less than 90 percent every year after that.
- Texas will also expect to see increased enrollment—known as the "welcome mat" effect—by already-eligible but currently uninsured children, even though the ACA does not expand the income limits for children. So, Texas' children's Medicaid costs are also be expected to increase, and the state's share of that growth will be at our "regular" state Medicaid share (just under 42 cents per dollar in 2012, updated by Congress every year).

Estimated Impact: Texans Covered, State Dollars Spent, and Federal Dollar Gains

Texans Uninsured Today. Texas has the highest uninsured rate in U.S.; the latest US Census reports that 6.1 million Texans—nearly one in four—were uninsured in 2011. This included 1.2 million children (under 19).

How many would gain insurance with Medicaid expansion? National experts and Texas HHSC estimate from 1.3 to 1.8 million uninsured US citizen adults in Texas will be *eligible* for the Medicaid option in 2014, and HHSC projects just over a million of these would *actually enroll* by 2016 (note the important difference between estimates of potential eligibles versus actual participating enrollees).

Analysis of the ACA and US census data by Texas demographers Dr. Michael Cline and Dr. Steve Murdock of Rice University (research commissioned by Methodist Healthcare Ministries) projects that with only moderate enrollment, Texas uninsured will be reduced by half, with just under 50% of those gaining coverage enrolling in Medicaid or CHIP. If enrollment is robust, the researchers project a 75% drop in Texas' uninsured.[2]

"Welcome mat effect" is expected everywhere. HHSC also estimates that over 400,000 more children—already eligible today, but unenrolled and uninsured—will sign up for Medicaid by 2016 because of the "welcome mat" effect of heightened public awareness that will accompany the roll-out of private and public coverage expansions under the ACA starting January 2014. (HHSC materials refer to this group as "Increased Enrollment Due to ACA"; and HHSC has confirmed that their estimates assume 100% of this effect in Texas will occur within Medicaid categories for children and youth under the age of 19.)

Importantly, agency analysts assume that a significant share of the "welcome mat" increased enrollment of children is likely to occur in Texas *regardless of whether or not the adult expansion is underway*. This opinion is shared by national experts who project Medicaid enrollment, for a couple of reasons. First, states that have enacted major Medicaid-CHIP coverage expansions in recent years (e.g., MA, PA, IL) have observed that a surprisingly high percentage of new enrollment after and expansion—ranging from half to three-quarters—is by individuals *who were already eligible for coverage even before the eligibility extension to higher incomes*. Researchers believe that the enhanced outreach and messaging that accompanies coverage expansions raises awareness and overcomes misinformation about who is eligible. In 2014, there will be intense public awareness of the new coverage options that will be offered in health insurance Exchanges in all states, and in Medicaid in the great majority of states. Analysts thus expect that application and enrollment levels in Medicaid will increase in every state, even states that have not yet expanded adult Medicaid coverage. Additionally, despite the fact that many of the lowest-income Americans are exempt from individual mandate penalties for the uninsured,[3] public awareness of the new mandate is expected to add additional motivation for parents to try to enroll their children in Medicaid.

Table 1: HHSC-Projected Texas Medicaid Enrollment Gains under Expanded Medicaid

	Total, Additional Average Monthly Caseload	Medicaid Expansion Adults	Welcome Mat Children
2014	**472,046**	340,976	131,070
2015	**1,074,848**	776,403	298,446
2016	**1,450,329**	1,047,626	402,703
2017	**1,467,733**	1,060,198	407,535
2023	**1,576,631**	1,138,859	437,772

HHSC Assumptions: Take-up rates: 75% Adult; 50% Eligible but unenrolled children; Phase-in rates: 50% 2014; 75% 2015; 100% 2016-2023; Implementation: Jan 1 2014; 2014 has 8 months.

Source: Texas Health and Human Services Commission, *Presentation to the Senate Health & Human Services and Senate State Affairs Committees on the Affordable Care Act*, August 1, 2012; http://www.hhsc.state.tx.us/news/presentations/2012/080112-Senate-HHS-ACA-Presentation.pdf ; and *Impact to Texas Medicaid of ACA Implementation by Levels of Implementation*, HHSC Strategic Decision Support, July 31, 2012.

Official HHSC Cost Estimates. Texas' Medicaid agency, HHSC, estimates the state-budget (GR) Medicaid costs to cover both the new adults and the welcome mat children would total **$3.1 billion GR over four years** from 2014-2017, and those state funds will draw down **$27.2 billion in federal matching funds** for Texas health care providers.

Of that $3.1 billion total, HHSC estimates for the years from 2014-2017 (Table 2 below):

- The state's cost for the **adult Medicaid expansion totals $1.3 billion GR**, drawing another $23.9 billion in federal match.
  - For the 2014-2015 biennium, just $310 million of this GR would be needed (matched with $651 million federal funds).
  - Why does HHSC show any costs at all for the first two years, given the 100% federal funding? Because (1) the agency is assuming an 8% administrative cost increase to the program accompanying the enrollment growth, which the state shares with the federal budget, plus (2) the agency is "scoring" the new enrollees' portion of Texas' obligation to "back-fill" a 2% cut in physician fees taken by our state in 2010.
- HHSC estimates another $1.8 billion state GR and $3.3 billion federal match will result from the **"welcome mat effect" new enrollment of currently eligible children**. Both HHSC's and national expert models alike assume that new "welcome mat" enrollment in Texas Medicaid by the uninsured children who are currently eligible but not enrolled may occur to a large degree—and with about the same state-budget cost—whether or not Texas chooses to expand coverage to adults.

HHSC first presented this material in a public hearing of Texas Senate committees in August. Subsequently, CPPP and several other Texas organizations submitted a request for additional detail, and the agency provided additional detailed enrollment and cost estimate data as supplemental material. The agency presentation may be viewed at http://www.hhsc.state.tx.us/news/presentations/2012/080112-Senate-HHS-ACA-Presentation.pdf.

Table 2: ACA Medicaid: Texas Funds Needed & Federal Dollars Gained, 2014-2023

	State Dollars (Billions)	***Federal Match (Billions)***
Expansion to Adults to 138% FPL		
2014-2015 only	$0.31	$8.05
2014-2017, 4-year total	$1.34	$23.94
2014-2023, 10-year total	$8.84	$78.96
Increased Children's Medicaid Enrollment		
2014-2015 only	$650.60	$1.03
2014-2017, 4-year total	$1.80	$3.30
2014-2023, 10-year total	$6.01	$11.68
***Combined* Totals: New Adults and "Welcome Mat" Children**		
4-year total ,2014-2017	**$3.14**	**$27.24**
Average per year	***$0.78***	***$6.81***
10-year total, 2014-2023	**$14.85**	**$90.63**
Average per year	***$1.49***	***$9.06***

Source: Texas Health and Human Services Commission, *Presentation to the Senate Health & Human Services and Senate State Affairs Committees on the Affordable Care Act*, August 1, 2012; http://www.hhsc.state.tx.us/news/presentations/2012/080112-Senate-HHS-ACA-Presentation.pdf; and *Impact to Texas Medicaid of ACA Implementation by Levels of Implementation,* HHSC Strategic Decision Support, July 31, 2012.

HHSC's cost model also includes optional spending on enhanced primary care fees. The ACA will—at 100 percent federal expense—increase every state's Medicaid payment rates for a selected group of primary care services, when delivered by a federally specified list of primary care providers, up to the (higher) Medicare rates for the years 2013 and 2014. This policy applies to the entire Medicaid program, not just the ACA expansion group, so it affects state Medicaid programs whether or not they have implemented the adult expansion.

But, any state that made cuts to its Medicaid provider fees after the ACA became law must "back-fill" those rate cuts when the higher rates take effect in 2013. Because Texas cut Medicaid physician fees by 2% in 2010, Texas will have to re-fund that 2% in 2013 and 2014, and the federal government will pay for the rest of the increase to Medicare rates. Texas Medicaid primary care physician fees are on average only about 68% of what Medicare would pay for the same service, so the federal contribution will be much larger than the state's.

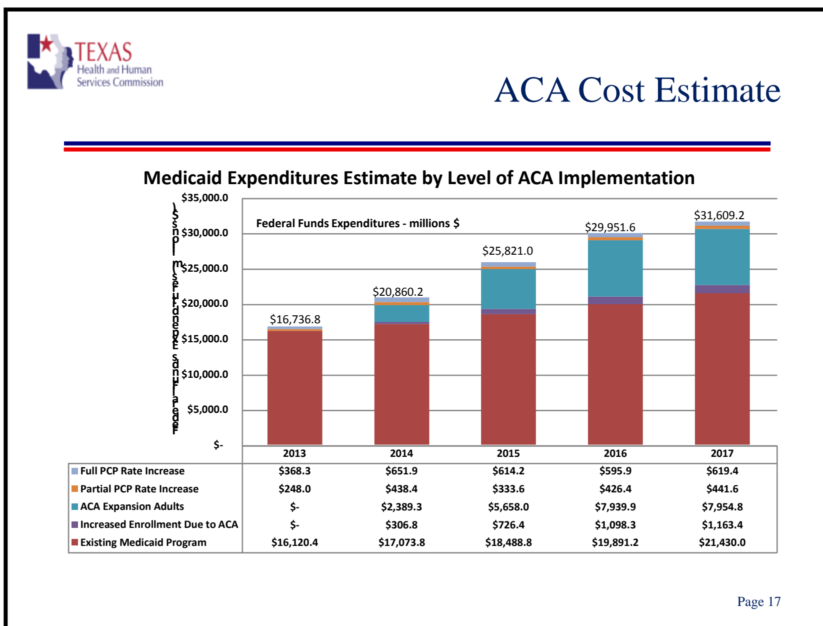
And in 2015? The ACA makes no provision for continuing the federal support for the higher fees after 2014, presumably because lawmakers were looking for ways to trim the bill's price tag. This naturally raises questions about what every state will do regarding those rates in 2015 and beyond. HHSC's August presentation to the Legislative committees included separate cost "add-on" scenarios for (1) additional costs to the state if it were to continue to pay these Medicare-level fees after 2014, and (2) the costs to extend the same increases to other kinds

of physicians. These proposals to raise fees for doctors are worthy of consideration, but it is important to note that they are not required by the ACA. Adding these optional rate increases would cost Texas an additional $915 million GR (state dollars) from 2013-2017, according to HHSC, and the agency included these proposed investments in its list of Exceptional Item funding requests for 2014-2015.

Latest HHSC cost estimates substantially reduced from earlier agency models. When the HHSC presented its updated projections in August 2012, agency officials told reporters that the new model's 10-year cost estimate is 42% lower than their earlier model. The agency pointed to a new aggregate estimate that $15.6 billion state dollars would be needed to cover Medicaid expansion from 2014 to 2023, which would draw down another $100 billion in federal matching funds (the previous HHSC model had projected increased state Medicaid costs of $27 billion by 2023).

Other important characteristics of the revised model:

- HHSC officials explained that the new, lower $15.6 billion figure still includes not only adult Medicaid expansion costs and costs of covering more "welcome mat" children in Medicaid, but also the agency's proposals for optional primary care rate increases (explained above).
- Without the inclusion of the optional rate increases, projected state coverage costs (adult expansion, welcome mat children) for the decade drop to $14.85 billion (see Table 2).
- **The state's cost of covering new adults to 138% of the federal poverty line from 2014-2023 (**excluding the costs of covering more already-eligible children and optional increases for primary care fees) **is now estimated by HHSC at $8.8 billion, drawing $79 billion in federal match for those adults' health care.**



	2013	2014	2015	2016	2017
Full PCP Rate Increase	$368.3	$651.9	$614.2	$595.9	$619.4
Partial PCP Rate Increase	$248.0	$438.4	$333.6	$426.4	$441.6
ACA Expansion Adults	$-	$2,389.3	$5,658.0	$7,939.9	$7,954.8
Increased Enrollment Due to ACA	$-	$306.8	$726.4	$1,098.3	$1,163.4
Existing Medicaid Program	$16,120.4	$17,073.8	$18,488.8	$19,891.2	$21,430.0

Caveat: Agency experts have indicated they are more confident in their near-term projections for 2014-2017 than for the 10-year period, but because HHSC had released figures previously for 2014-2023, it was appropriate to update projections for the full 10-year period.

This HHSC graphic presented to members of the Texas legislature illustrates the large increase in federal funds expected for Texas.

How Texas' Share of ACA Medicaid Compares to other Medicaid and Health Spending

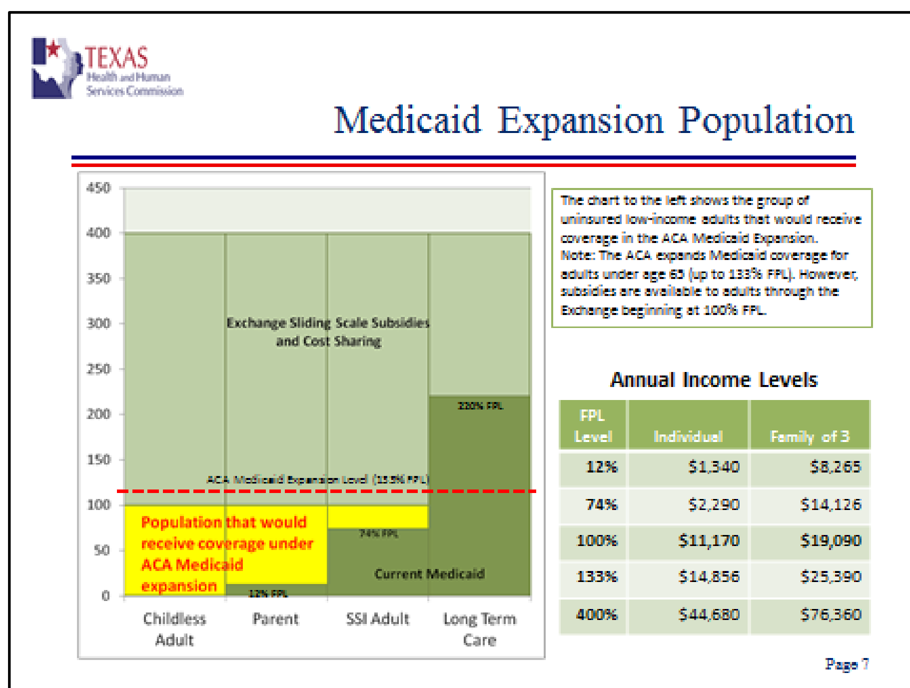
Texas' required costs to accept the ACA's adult Medicaid coverage are small relative to the large federal match they would bring. The size of the additional state investment should be considered in proportion to other current state health care spending.

- The Texas Medicaid program paid health care bills totaling $23.6 billion in 2012, with the state shouldering $9.8 billion and the remainder paid by the federal government. Another $3.9 billion went to special hospital payments and Medicare costs of poor and very low-income seniors.
- Texas hospitals currently spend about $5 billion in a single year for uncompensated care, about half of which is supported by public hospitals with local property tax dollars,[4] but without the benefit of the nine-to-one match those local tax dollars would receive under the ACA's Medicaid expansion opportunity.

- The Texas 1115 Medicaid "Transformation" waiver allows local governments statewide to raise about $12 billion in state match, in order to attract a maximum of $17 billion in federal match over 5 years from 2012 to 2016, all at the state's traditional Medicaid match rate of about 41 state cents per dollar spent. This works out to $1.45 federal match for each $1 Texas dollar spent.
- In contrast, the ACA Medicaid option would leverage $9 federal for every $1 Texas dollar spent, plus give health coverage to over 1.5 million uninsured Texans. And for $1.3 billion in state match, it would draw $24 billion from 2014-2017, all based on Texas HHSC estimates.
- In 2017, when the state would first pay a share of the costs of the newly-covered adults, HHSC estimates ACA adults would add 5% to the state GR costs for the existing Medicaid program—and federal funds for Texas Medicaid that year would jump by 37%.
- For that 5% increase in costs, over 1.1 million uninsured adults would gain Medicaid coverage.

If Texas does <u>not</u> expand Medicaid in 2014:
No Coverage Options for Texas' Uninsured Adults Below the Poverty Line

- The ACA makes sliding-scale premium assistance for private coverage in the exchange available <u>only</u> to persons <u>above</u> 100 percent FPL (with an exception for legal immigrants excluded from Medicaid). **This means without the adult Medicaid expansion, uninsured Texas adults below 100 percent FPL will have no assistance with coverage available in 2014.** The Texas Health and Human Services Commission provided this graphic to Legislators to illustrate the gap in coverage options for Texans that would result without accepting the Medicaid option.
- Under ACA, those from 100-138 percent FPL would be eligible for premium assistance, but because the statute and the system were designed with assumption that this group would have Medicaid, some of these near-poor will have difficulty affording the coverage, even with a cap on premiums of 2% of family income.
- Without the Medicaid coverage for adults, costs of care for uninsured poor Texas adults will continue to be carried primarily by local property taxpayers supporting our urban hospital and health districts, secondarily by other charity care providers, and without benefit of the 90 percent-plus federal matching dollars available.



FPL Level	Individual	Family of 3
12%	$1,340	$8,265
74%	$2,290	$14,126
100%	$11,170	$19,090
133%	$14,856	$25,390
400%	$44,680	$76,360

Helpful Tools: Texas and the ACA Medicaid Expansion

Recent tools help illustrate the value of the new Medicaid option for our state, using data from the state Medicaid agency, U.S. Census, and Texas demographers and economists.

Choices and Challenges: How Texas County Uninsured Rates Will Drop Under Health Care Reform (09/19/2012). A recent model from Michael E. Cline, Ph.D., and Steve H. Murdock, Ph.D. of Rice University provides county-level projections to help local officials and residents plan for how increased coverage under the Affordable Care Act could affect their communities.

Your County and the ACA (09/27/2012). CPPP has compiled data for all 254 Texas counties to illustrate the expected impact of Affordable Care Act (ACA). The sheets compare what uninsured rates would look like with and without the ACA's Medicaid expansion. Also, the sheets include an estimate of how much additional net federal health care revenue would come to your county every year on average from 2014 to 2017. The sources are drawn from respected and reliable experts including the US Bureau of the Census, Texas demographers Michael Cline, Ph.D. and Steve Murdock, Ph.D., and the Texas Health and Human Services Commission.

Texas Has Only One Rational Choice: Expanding Medicaid Under the Affordable Care Act (October 2012). This recent analysis by The Perryman Group finds that every $1 spent by the State of Texas to expand Medicaid coverage under the Affordable Care Act (ACA) returns $1.29 in dynamic State government revenue over the first 10 years of the expansion. http://www.perrymangroup.com/

Government Effectiveness and Efficiency Report 2013 (January 2013). This biennial report to the Legislature by Legislative Budget Board staff includes a chapter analyzing the costs and benefits of the ACA Medicaid expansion and recommending that counties be enabled to finance and implement the expansion.

Smart, Affordable and Fair: Why Texas Should Extend Medicaid Coverage to Low-Income Adults (January 2013). This new report from Billy Hamilton Consulting provides a comprehensive model estimating the costs and benefits to local taxing authorities (including cities, counties and hospital districts) and state government. Using the Cline-Murdock model data, the authors conclude that state match needed for the Medicaid expansion are far less than current state, local, and hospitals spending on health care for low-income adults, and project $1.8 billion in new state revenue will be generated by the expansion from 2014 through 2017, offsetting about half of the required state match.

Medicaid Expansion Will Increase Federal Spending Dramatically at County Level

Using the Texas HHSC projections of new federal Medicaid spending from 2014-2017, and the agency's records of how Medicaid payments were distributed across the counties in 2010, we can model the average expected county gain is federal funds **each year** from 2014-2017. As Table 3 below shows, in major population centers the potential economic gains are quite large. But even in least populated counties, the increased health care spending will provide a significant economic infusion. For example, Anderson County would expect to average an additional $13 million every year from 2014-2017 in new federal health care spending (see all 254 counties here).

Table 3: Large Urban Counties & Medicaid Expansion: 2014-2017

	Bexar	El Paso	Dallas	Harris	Hidalgo	Lubbock	Nueces	Tarrant	Travis
Yearly Avg. NEW Fed Medicaid Funds	$503.5 million	$222 million	$580.1 million	$935.3 million	$404.7 million	$77.7 million	$127.1 million	$324.2 million	$224.1 million
Uninsured 2010	396,475	208,379	601,492	1,025,922	219,213	66,405	78,275	415,186	233,067
Estimated # Gaining Medicaid	179,654	51,462	131,042	223,165	50,509	19,693	22,403	97,157	55,676

Sources: Texas HHSC projections of ACA Medicaid expansion costs; THHSC historical Medicaid spending by county, 2010; Cline & Murdock estimates of ACA insurance gains by county, commissioned by Methodist Healthcare Ministries.

How ACA Medicaid Would Offset Local and State Budget Spending

As noted above, local governments will see large amounts of new federal health care funding flowing through their economies with ACA Medicaid expansion, but that is not the only potential benefit for local taxpayers. Other benefits and offsets that counties will also experience are described below.

Medicaid expansion is needed to maximize ACA fiscal benefits for local and State government. As uninsured Americans gain coverage under the ACA's public and private coverage reforms in 2014, both local and state governments will experience important reductions in the need and demand for health care programs they currently provide to uninsured and underinsured citizens. Many services that are funded today with 100% local taxes or state GR dollars can be provided to newly-insured persons in 2014 instead with substantial federal funding.

But Texas' ability to shift from reliance on unmatched local and state tax support to recouping a large share of these costs through federal matching will be dramatically diminished in Texas unless our state accepts the Medicaid coverage opportunity for adults. Without the Medicaid coverage option, most uninsured Texas adults below the poverty line will have no new coverage help from the ACA (more details below). And, as described above, Texas demographers Cline and Murdock predict that nearly half of the potential gains in insured Texans under ACA in Texas will only come about if we implement the Medicaid expansion.

Categories of Expected Offsets to State and Local Spending

Though Texas is known for relatively low investment of state dollars per state resident (43rd among the states in 2009), the state budget still includes significant areas where sums of unmatched state dollars today are being applied to health-related costs that will be reduced from 2014 forward as Texans gain health coverage under the ACA. But, since roughly half the Texans *potentially* gaining coverage will only do so if they are allowed to enroll in Medicaid, and since the Medicaid coverage would target the poorest and often most costly of the uninsured, the lion's share of state-budget cost offsets from ACA depends squarely on Texas pursuing this option. And because Texas cities and counties are the "payers of last resort" for a range of health care services provided to the uninsured, city and county governments and local taxpayers would experience some of the largest reductions in current costs.

Every county is different, but two of Texas' largest counties have calculated the potential impact on their current caseloads. **Bexar County** officials report that analysis of their University Health System's CareLink population

indicates that 26,000 out of 55,000 would be covered by Medicaid under the expansion, offsetting over $60 million in annual spending. The **Harris Health System's** (Harris County's hospital district) board of managers adopted a legislative agenda supporting the expansion and noting that Harris Health System at end of fiscal year 2012 had spent $167 million on inpatient and outpatient care for uninsured US citizen adults who would qualify for Medicaid under the optional Medicaid Expansion.

Here are key examples of state, county, and city-funded programs that would experience reduced demand and costs if US citizen adults below 138% FPL gain Medicaid coverage:

Savings within Texas Medicaid. Texas HHSC has acknowledged that the Medicaid program itself will generate certain cost offsets if the ACA adult coverage is implemented. **Drug Rebates** (required from drug manufacturers for their Medicaid earnings) will grow along with the increased enrollment, and Medicaid managed care health plans will pay additional premium taxes on the newly insured. Enrollment in the new Medicaid coverage and in the private exchange options will reduce today's **Medicaid maternity costs** in two ways. First, women who enroll in comprehensive coverage in Medicaid and become pregnant will be covered at the ACA enhanced match rate (i.e., 100% 2014-2017, phasing down to 90% in 2020), dramatically reducing Texas' costs for Medicaid births. And, women above the 138% FPL income who gain new private coverage through the exchange and other market reforms will even further reduce the demand for Medicaid maternity coverage. At this time, state officials have not provide official estimates of the cost offsets from either drug rebate increases or maternity care cost reductions. However, with current all-funds (federal and state combined) Medicaid maternity spending exceeding $1 billion annually, costs savings of about $300 million annually are likely if enrollment rates in the new adult Medicaid coverage are robust.

State Health Insurance Premium Tax Revenues. Texas can expect to gain significant new tax revenues from health insurers, both from private market coverage increases and from Medicaid expansion, because virtually all Medicaid recipients in the state today are enrolled in managed care health plans. The state has not yet released official projections of the anticipated premium tax gains connected to Medicaid expansion, but 2010 comptroller estimates and preliminary estimates from Texas Medicaid managed care experts and health care providers all point to revenue gains in excess of $100 million per year if enrollment matches HHSC projections.

State and Locally Funded Coverage Programs. Increased Medicaid coverage of the poorest uninsured adults will reduce the total demand for unmatched state and local tax revenues now supporting health care, including from County Indigent Health Care, public hospitals, and health and hospital financing districts. All of these entities today spend substantial amounts on low-income uninsured adults, but without benefit of the 90% and higher federal match offered by the ACA Medicaid option.

State Mental Health and Substance Abuse Spending. Medicaid coverage in 2014 would include strong behavioral health benefits (required to be offered in parity with physical health coverage), reducing the demand for federal block grant, GR, and locally funded mental health services. Medicaid coverage will make possible ongoing care and treatment of many now-uninsured adults who have chronic mental health issues, which can help reduce jail and ER costs for "frequent fliers."

Other noteworthy potential benefits for Texans with MH/SU conditions, state and local government, and communities include:

- **Foster Care:** The ACA requires states to extend Medicaid coverage (with full EPSDT benefits) for children up to age 26 who were in foster care when they turned 18 (starting January 2014). This will provide a stronger continuum of care for these youth and young adults, who have much higher than average behavioral health needs. It provides a parallel safety net for young adults who often lack parental ties to that offered other youth since 2010 through the extension of family coverage to older children up to age 26.

With Medicaid expansion and private coverage through the exchange Marketplace in place, these young adults will retain access to affordable care even after they age out of extended foster care Medicaid at 26.

- **Family Therapy:** In addition, a large share of parents of children in families where CPS interventions have occurred would gain Medicaid coverage and be able to access the ongoing therapies to help break family cycles of abuse and neglect. Today, local governments are limited to small and inadequate "pots" of funding to provide parents with services; but if Texas allows Medicaid expansion, many more families will be served effectively and counties will see savings on both the direct services and from reduced recidivism.

Prison and Jail cost offsets: If Texas extends Medicaid coverage, the program could pick up inpatient hospital costs for a large share of prison and jail inmates: any 24-hour stay in free-world hospital by US citizen inmates below 138% FPL could be covered. This would reduce both state prison and local jail costs.

State Spending on Public Health Services. State and local costs for direct care to the uninsured will be reduced (not eliminated) with increased Medicaid coverage of the poorest adults. Programs affected include immunizations, primary and preventive care, infectious disease prevention and control, STD detection and treatment, HIV services, and others.

Caveat: Even robust Texas coverage gains will not fully eliminate need for Safety Net

Of course, if Texas fails to expand Medicaid, many of these potential savings cannot materialize. But the need for state and local safety net programs will not be eliminated, even with Medicaid expansion and robust enrollment by uninsured Texans in coverage in 2014 and beyond. The Congressional Budget Office's scoring of the ACA assumes that 9% of Americans will remain uninsured in 2019 (and estimates that without ACA the share would have been 20%). Several factors contribute to this reality:

- **Many US citizens will remain uninsured.** Under the ACA, the poorest citizens do not face an "individual responsibility requirement" tax penalty for being uninsured. Also, any citizen may choose to pay the tax penalty rather than enroll in health coverage. Some may simply choose this because the tax penalty is about 20% of the cost of insurance, while others may find the costs of coverage more than they can afford, even with sliding-scale premium assistance available for many low- and moderate-income Americans.

- **Some types of safety net services will still not be provided through private insurance or Medicaid.** Both state and local safety net programs often include services that are not typically covered by private insurance, such as care coordination for persons with chronic or serious illness, and non-medical services and supports to keep individuals living as independently as possible.

- **Undocumented immigrants and some legal immigrants will remain uninsured.** Undocumented residents are excluded from all of the ACA's coverage offerings, whether from Medicaid-CHIP or from private coverage. An estimated 1.1 million of Texas' 6.1 million uninsured in 2011 were thought to be undocumented, with another 600,000 lawfully present non-citizens. Lawful immigrants with long-term residence status in the US are, despite their legal status, more likely to be uninsured than US citizens. This is due in part to the federal-law exclusion of adult legal immigrants from Medicaid for their first five years in the U.S., and also to the Texas-law exclusion from Medicaid after that 5 year federal exclusion ends. Low-income legal permanent resident adults in 2014 Texas will have to have adequate cash resources to afford sliding-scale insurance through the exchange Marketplace, unless Texas reverses its decision to exclude adult lawful immigrants from Medicaid.

In summary, experts agree that a number of factors will result in significant numbers of uninsured Texans remaining, even if the great majority of the uninsured take up new ACA coverage options. As health coverage expands, Texas state and local officials must take care to avoid premature reductions in critical safety net programs, including ongoing care for the remaining uninsured.

For More on Potential State and Local Budget offsets: The Perryman Associates and Hamilton Consulting reports cited above provide detailed Texas models estimating state and local offsets and gains. A national guide to analysis of state and local cost offsets can be found here: http://www.statenetwork.org/wp-content/uploads/2012/09/State-Network-Medicaid-Expansion-Framing-and-Planning-a-Financial-Impact-Analysis.pdf

Spotlight on Potential Prison and Jail Cost Offsets

Federal law denies Medicaid to incarcerated persons, but federal policy for over a decade has allowed inpatient hospital care provided for stays of 24 hours or more in a free-world hospital to be billed to Medicaid. The share of inmate stays for which Texas jails (and state prisons) can claim today is limited by the fact that very few adults qualify under state and federal limits for Medicaid. Most incarcerated individuals by definition cannot be considered caretakers of dependent children, which today is the only basis for Medicaid eligibility for Texas adults who are not either fully disabled, pregnant, or elderly and poor. As a result, states including Texas are currently only able to charge Medicaid for births to female inmates, whose pregnancies qualify them for coverage of delivery costs when there is a 24-hour or longer admission in a non-prison, free-world hospital.

Because the ACA Medicaid option would cover all US citizen adults under age 65 up to 138% of the FPL, regardless of whether they are caring for children, the ability to bill Medicaid for inpatient stays in free-world hospitals will extend to a much larger percentage of inmates if Texas accepts the Medicaid expansion. Not every inmate will qualify, because some will have ongoing income streams that disqualify them, and because both undocumented and many legal immigrants will still be excluded from Medicaid.

Jails should also be aware that incarcerated persons at higher incomes with private insurance through the new Health Insurance Exchanges in 2014 will be able keep their coverage while they are held *pending disposition of charges*. For these persons awaiting disposition, their private coverage should remain fully in force for all services, not just inpatient costs. This should make it possible to better access and maintain care for acute and chronic needs, including medications and mental health treatment.

While jails and prisons will clearly still have significant health care budgets, jails and communities that maximize coverage under Medicaid and private Exchange insurance will not only reap significant direct savings, but also indirect savings from reduced demand—the result of improved continuity of care for community members. It will be very important for county jails to coordinate with their local health and human services agencies to ensure that strong application and enrollment systems are in place for all residents including the jail population, both to save on jail costs and to promote the care that can actually reduce jail and E.R. traffic.

Read a report by the National Association of Counties on ACA coverage implications for county jails here: http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf

Benefits to the Texas Economy and Tax Revenue Gains

The Perryman Associates and Hamilton Consulting reports both also predict other very substantial economic benefits for Texas at the state and local levels, including increased revenue collection.

Perryman projects for each $1 in state funds that is invested in the Medicaid expansion:

- a net gain of $1.29 in state revenues, "in other words, the State actually makes money by participating in the Medicaid expansion;"
- a reduction of $1.21 in local taxes to support uncompensated health care;
- a local government revenue gain of $0.51;
- over $6 in increased retail sales;
- increased income for the uninsured Texans who gain coverage; and
- a reduction in uncompensated care costs that are shifted to health insurance premiums.

The **Hamilton Consulting** report concludes that:

- state funds needed for the Medicaid expansion "could be met many times over" with the state, local, and hospital current expenditures on health care for low-income adults;
- every Texas county and region will benefit;
- $1.8 billion in new state revenue will be generated by the expansion from 2014 through 2017, which would offset about half of the state match required; and
- economic activity from the infusion of federal funds would boost statewide Texas economic output by $67.9 billion, and add $2.5 billion to local revenues during fiscal 2014-17.

Without arguing the relative merits of the two models or their findings, the fact that both groups of Texas experts predict significant revenue gains, cost offsets, and job creation (below) underscores the need for Texas decision-makers to give serious consideration to the potential gains to our state economy that would accompany the Medicaid expansion.

ACA Medicaid, Texas Jobs and Employers

Job Creation. Clearly, the addition of over $6 billion per year (see HHSC estimates, Table 2) to Texas' economy will not only pay many health care bills, but also create additional jobs. As CPPP's analysis of the Texas HHSC Medicaid expansion estimates by county impact noted, $6 billion per year is enough to pay the salaries of 89,000 more Registered Nurses or 33,000 more Family Practice doctors for a year—even without assuming any multiplier effects. Texas analysts Perryman Associates and Hamilton Consulting use different models and assumptions to arrive at their estimates of job creation associated with Medicaid expansion. Texas Economist Dr. Ray Perryman estimates the Medicaid expansion would generate over 300,000 Texas jobs per year on average ("3.03 million person-years" of employment) over 10 years, even after netting out the impact of diverting the state's required matching contribution. Billy Hamilton Consulting projects economic activity from the ACA Medicaid expansion would generate an estimated 231,000 jobs by 2016, and several times that number in later years.

Which Texas Workers will be Covered under ACA Medicaid Expansion?

Texas employers in certain industries will see large shares of their workers qualify for coverage if ACA Medicaid expansion is implemented. And, workers in certain occupations will see high rates of eligibility. Texas-specific data from the US Bureau of Labor Statistics and the US Census illustrate the high uninsured rates among low-income Texas workers in a wide range of the most common jobs, as well as the large share of Texas jobs paying average annual wages that would qualify a worker for the new Medicaid coverage.

As Table 4 below illustrates, average Texas wages of most front-line entry-level workers in health care; food service, fast food, and restaurants; hotels and motels; construction trades; meat packing and processing; and retail sales would qualify the worker for ACA Medicaid if:

- the worker is employed for 30 hours or less, and is childless, or
- the worker is working full time and supporting 1 or more children.

Notable in the list of occupations are the personal care and home health aides, who are the workforce that serve nearly 200,000 seniors and Texans with disabilities with attendant services that allow those Medicaid beneficiaries to live in the most integrated possible community settings, and to avoid more costly institutional care. Many of these workers are today uninsured. If these workers can access Medicaid coverage or affordable private coverage in the health insurance exchange Marketplace in 2014, it could make finding and retaining good reliable personal attendant care much easier than it is today.

Table 4: Workers Likely to Qualify for Coverage under ACA Expansion: Texas Occupations with Average Annual Wages Below 138% FPL, by Family Size

Maximum Income to Qualify for ACA Medicaid	Texas Occupations with Average Wage *Below* ACA Medicaid Limit for Given Family Size
Single worker: $15,856; Maximum for worker with one dependent: $21,404	***Eligible if single worker working 30 hours or less, or full-time with one or more dependents***: Home Health Aides, Personal Care Aides; Psychiatric Aides; Fast Food, Short-order, Cafeteria, Institutional, and Restaurant Cooks; Restaurant Prep Cook; Bartenders; Waiters/Waitresses; Dishwashers; Host/Hostesses; Hotel/Motel Maids and Housekeeping staff; Bellhops and Porters; Hotel Desk Clerks; Salon Helpers; Tour Guides; Child Care Workers, Agricultural Graders/Sorters; Laundry Workers; Pressers, Lifeguards
Worker with two dependents: $26,951	***Eligible if Full-Time, supporting two or more dependents:*** Nurse Aides; PT/OT Aides; Veterinary Aides; Pharmacy Aides; Parking Enforcement; Security Guards; Crossing Guards; Landscaping; Hairdressers; Manicurists; Concierges; Residential Advisors; Recreation Workers; Counter Clerks; Retail Salespersons; File Clerks; Receptionists; Library Clerks; Agricultural Equipment Operators; Farmworkers; Floor Sanders; Construction Laborers; Helpers –Carpenters', Brick, Stone, Carpet, Flooring; Bakers; Butchers; Meat Packers; Factory Food Workers; Sewers/Tailors; Shoe Repairs; Textile Workers; Extruding Machine Operators; Cabinet makers; Furniture Finishers; Taxi Drivers/Chauffeurs; Ambulance Drivers; School Bus Drivers;

US Bureau of Labor Statistics, May 2011 State Occupational Employment and Wage Estimates, Texas, http://www.bls.gov/oes/current/oes_tx.htm

Table 5: Texas Businesses with the Most Uninsured Workers Qualified for ACA Medicaid

	All Eligible Workers, ACA Medicaid Expansion [A]	Sector's share of all Texas ACA Medicaid-eligible workers	Medicaid-Eligible Workers with Health Insurance in 2011	Medicaid-Eligible Workers Without Health Insurance in 2011	% of Medicaid-Eligible Workers who are Uninsured
TOTAL, ALL SECTORS	**1,522,732**	**100%**	**716,351**	**806,381**	**53%**
RETAIL TRADE	249,530	16.4%	116,585	**132,945**	53%
ACCOMMODATION AND FOOD SERVICES	211,605	13.9%	82,207	**129,398**	61%
HEALTH CARE AND SOCIAL ASSISTANCE	224,252	14.7%	117,292	**106,960**	48%
CONSTRUCTION	114,214	7.5%	33,591	**80,623**	71%
OTHER SERVICES	111,086	7.3%	43,638	**67,448**	61%
BUSINESS SUPPORT SERVICES	101,063	6.6%	40,268	**60,795**	60%
MANUFACTURING	84,641	5.6%	43,054	**41,587**	49%
EDUCATIONAL SERVICES	114,091	7.5%	73,750	**40,341**	35%
TRANSPORTATION AND WAREHOUSING	53,422	3.5%	23,273	**30,149**	56%
PROFESSIONAL, SCIENTIFIC, AND TECHNICAL SERVICES	50,084	3.3%	24,545	**25,539**	51%
WHOLESALE TRADE	25,817	1.7%	11,675	**14,142**	55%
ARTS, ENTERTAINMENT, AND RECREATION	33,344	2.2%	19,227	**14,117**	42%
FINANCE AND INSURANCE	31,086	2.0%	17,252	**13,834**	45%
AGRICULTURE, FORESTRY, FISHING, AND HUNTING	17,382	1.1%	5,642	**11,740**	68%
REAL ESTATE AND RENTAL AND LEASING	24,447	1.6%	13,137	**11,310**	46%
All other sectors, with fewer than 2% share of Medicaid-eligible workers [b]	76,668	5.0%	51,215	**25,453**	33%
TOTAL, ALL SECTORS	**1,522,732**		**716,351**	**806,381**	**53%**

Source: U.S. Census, American Community Survey, Public Use Microdata Sample, 2011.

a. US citizens, in Texas, between 18-64, 0-138% FPL, who worked in the previous year.

b. Other sectors: Public Administration; Information; Mining, Quarrying, And Oil And Gas Extraction; Utilities; Military.

Census data from 2011 allow us to identify US citizen adult workers 18-64 with incomes below 138% FPL—the workers who would qualify for ACA Medicaid coverage if Texas allows the new coverage. Key findings from Table 5 above include:

- Texas had **over 1.5 million adult US citizen workers below 138% FPL in 2011**, and more than half of those workers (over 800,000) were uninsured,
    - Some trades have even higher uninsured rates among their low-income workers: in construction over 70%, and in hotel/motel and food industries over 60% are uninsured.
- In the three sectors **Retail Trade; Accommodation and Food Services; and Health Care and Social Assistance:**
    - Each employs over 200,000 Texas workers with earnings below 138% FPL;
    - Each has over 100,000 of these same low-income workers who are uninsured;
    - Together, these 3 sectors account for 45% of Texas workers eligible for the ACA Medicaid expansion.
- **Construction** is a close fourth place, with over 110,000 US citizen workers below 138% FPL, and over 80,000 of those without health care. If Construction business is added in, the 4 top sectors account for 53% of the Texas workers who would qualify for ACA Medicaid.
- A large number of working adult Texans have incomes at or below the federal poverty line. Any adult who is working near the minimum wage and supporting one or more children is indeed likely to fall into the new Medicaid coverage income group.

Other Benefits for Texas Employers from Medicaid Expansion

As described above, Texas businesses are expected to benefit indirectly from the job creation and economic activity that will result from the injection of tens of billions of dollars into our health care systems. Some other, more direct, potential benefits for employers are worth noting. Clearly, Texas employers with large numbers or percentages of employees working at low wages (and/or part-time) would see the most direct gains.

As Table 5 illustrates, more than half of Texas workers with incomes in the Medicaid expansion eligibility range (<138% FPL) are uninsured, and in some industries over 60% and 70% are without coverage. Some of the potential benefits of ACA Medicaid coverage for these employers:

- Workers with health coverage will, on average, have lower absenteeism and greater productivity.
- Many direct health care workers in Texas—those who assist seniors, Texans with disabilities, and medically frail persons—are not offered insurance through their work. Ensuring that there is not a gap in coverage for workers below 100% FPL will enable these Texas agencies to provide better care for consumers.
- Workers who enroll in Medicaid will do so at no cost to the employer.
- Workers who enroll in Medicaid do not trigger a penalty for the employer.
    - (Employers with fewer than 50 full-time equivalent employees have no penalties at all under ACA, but those with 50 or more can be penalized if (1) they do not provide coverage, and (2) if their full-time workers then enroll in taxpayer-subsidized health plans in the exchange Marketplace.)
- Employers will know that their low-wage US citizen workers can get access to decent, affordable health care regardless of their exact income level or the number of hours they work.

Research: Medicaid Coverage Improves Health and Well-Being

Children Do Better when their Parents are Insured

U.S. studies have found these important benefits for children when their low-income parents also get coverage:[5]

- **When parents are covered, more eligible children enroll.** Low-income families with uninsured parents are three times as likely to have eligible but uninsured children as families with parents covered by private insurance or Medicaid.
- **Children whose parents are enrolled are more likely to stay enrolled.** Studies have found that children are less likely to experience breaks in their own Medicaid and CHIP coverage and remain insured when their parents are also enrolled.
- **Children whose parents are covered get more preventive care and other health care services.** Studies have found that insured children whose parents are also insured are more likely to receive check-ups and other care, compared to insured children whose parents are uninsured.
- **Parents' health can affect children's health and well-being.** The Institute of Medicine reports that a parent's untreated poor physical or mental health can contribute to a stressful family environment that may impair the health or well-being of a child. Beyond that, uninsured parents who can't get routine and ongoing care may be unable to work, or may end up with big medical bills even when they do get care. In either case, the financial consequences have a big impact on children—even when the children themselves have coverage.

Medicaid Boosts Health Status and Access, Financial Stability, and Reduces Premature Deaths

- Adults on Medicaid report fewer unmet health needs and received more care than the uninsured, according to a national study comparing low-income uninsured adults with adults on Medicaid.6
- States that expand Medicaid for adults have had improved access to care and reduced death rates, from a study of three states (Arizona, Maine and New York).[7]
- In an Oregon controlled study, Medicaid clients had substantively and statistically significantly higher health care utilization (including primary and preventive care as well as hospitalizations), lower out-of-pocket medical expenditures and medical debt (including fewer bills sent to collection), and better self-reported physical and mental health than the control group.[8]

Federal Medicaid Policy and State Flexibility

As this report is released, a number of conservative Republican Governors have announced their intention to pursue the Medicaid expansion in their states. Arizona Governor Jan Brewer made this statement about her decision in her state of the state address:

> *"By agreeing to expand our Medicaid program, we will:*
>
> - *Protect rural and safety-net hospitals from being pushed to the brink by their growing costs in caring for the uninsured;*
> - *Take advantage of the enormous economic benefits – inject 2 Billion dollars into our economy – save and create thousands of jobs; and,*
> - *Provide health care to hundreds of thousands of low-income Arizonans.*
>
> *With this move, we will secure a federal revenue stream to cover the costs of the uninsured who already show up in our doctor's offices and emergency rooms. Under the current system, these costs are passed along to Arizona families. Health care premiums are raised year after year to account for expenses incurred by our hospitals as they provide care to the uninsured.*

Saying 'no' to this plan would not save these federal dollars from being spent or direct them to deficit reduction. No, Arizona's tax dollars would simply be passed to another state – generating jobs and providing health care for citizens in California, Colorado, Nevada, New Mexico or any other expansion state."

The Arizona Governor also recommends health delivery and provider payment reforms, as well as a new broad-based provider fee. Other Governors are also proposing and discussing with federal Medicaid officials different ways in which states can put their stamp on ACA Medicaid expansion. Federal Medicaid law (in the Social Security Act, as amended by the ACA) does provide for some major areas of flexibility that are clear, and also defines some areas that are off-limits. Between the two extremes there are likely some policy changes where negotiations are possible.

Two big picture areas of Medicaid law where states have significant flexibility include:

Benefits: Texas has flexibility to offer a lesser Medicaid benefit package for the new ACA expansion adults, than the traditional adult benefits. Benefit packages for the new adults can be based on private market benchmarks, subject to the same minimum standards as private coverage. Another flexibility option would allow Texas Medicaid to offer special targeted benefits packages based on need for individuals with special needs such as mental health conditions, and chronic illnesses like HIV or diabetes.

Cost Sharing: Texas can initiate co-payments broadly for the new adult group, and also some (more limited) co-pays for the historical population (aged, disabled, children, and maternity coverage). New federal rules proposed in January 2013 would extend and simplify some of the standards for Medicaid cost sharing. Still, certain fundamental protections in law and regulation for the lowest income Medicaid enrollees, children, and pregnant women are expected to be enforced. Premiums or enrollment fees are allowed only for Medicaid enrollees with incomes above 150% FPL.

Off the Table: Expanding to an Income limit below 138% FPL. Recent federal guidance clarified that US HHS is not going to consider expansions that are phased in or stop coverage at an income limit below 138% FPL, saying "The law does not provide for a phased-in or partial expansion." The same guidance indicated that 1115 waivers related to the ACA expansion will only be approved at the traditional (i.e., in Texas 61:39) federal match rate. The scope of this directive also makes it clear that more sweeping restructuring such as block grants or per capita caps are not up for approval at the state level.

"Statewideness." Federal Medicaid law requires that coverage be available statewide, a requirement that generally can only be altered under an 1115 waiver. Given the guidance that no 1115 waivers will be granted on the ACA coverage expansion unless a state gives up its 100% federal funding, experts believe that Texas cannot limit expanded adult coverage to selected counties. However, this does not rule out an approach to financing Texas' costs (presumably net of the cost offsets and new revenues described earlier) that uses local contributions in some way—as long as a statewide expansion is achieved.

What Else? Across the country, states are proposing creative ways to integrate above-poverty enrollees into the health insurance Marketplace, and discussing specific kinds of benefit package adjustments. Texas should aggressively look for ways to tailor the Medicaid expansion to the needs of our state, while still meeting minimum standards for quality and fundamental protections for the lowest-income Medicaid recipients.

How Texas Estimates of Medicaid Expansion Enrollment, Federal Funds Gains and State-Dollar Costs Compare to National Sources:

The most detailed 5-state projections of the impact of Medicaid Expansion have been produced by the Urban Institute based on modeling of US Census data, and commissioned and published by the Kaiser Family Foundation (Urban-KFF). In their most recent report, their model produces numbers that are not identical to, but are quite consistent in scale to the Texas HHSC projections.

Costs and Gains: The Urban-KFF model projects costs and enrollment for 2022 with and without Medicaid expansion, and assumes a big increase in overall Medicaid take-up rates among eligible persons of all ages, from a current 64.0% without the ACA to 72.4% under the ACA with all states implementing the Medicaid expansion. Because the Urban model is complex, and builds in assumptions about persons gaining and losing private insurance, the researchers look at the change in state and federal Medicaid costs in two ways:

1. Medicaid spending under the ACA with All States Expanding Medicaid, as Compared to a No ACA Baseline; and

2. Medicaid spending under the ACA with All States Expanding Medicaid, as Compared to No States Expanding Medicaid.

Under #1 In Texas, Urban-KFF projects an additional $77 billion in federal Medicaid funds requiring $9.6 billion state match from 2013-2022. The HHSC projects $79 billion federal match for and $8.8 billion state share for the adult expansion from 2013-2023. Though the two time frames are different, the two estimates are comparable in magnitude.

Under the #2 scenario, Urban-KFF estimates an additional $65.6 billion in federal Medicaid funds, calling for $5.7 billion in state match. The researchers also project Texas would see an offset of $1.7 billion reduction in uncompensated care costs.

Enrollment: Urban-KFF projects about 1.8 million in Medicaid enrollment (both expansion population and increased take-up by currently-eligible children) in 2022, compared to the HHSC estimate of 1.6 million for 2023. Consistent with the Cline-Murdock/MHM estimates, they project Texas uninsured rate will be reduced by just over half (51.6%) if Texas includes Medicaid expansion in our ACA implementation. They estimate Texas will have only a 35% reduction in uninsured if Medicaid not expanded. In comparison, the Cline-Murdock/MHM model projects that uninsured gains in Texas depend even more on Medicaid expansion, whereas Texas HHSC officials have made recent statements (but not published estimates) indicating they attribute a lower share of Texas potential coverage gains to the Medicaid expansion.

Characteristics of the Newly Covered Texas Medicaid Adults: Urban-KFF analysis/modeling of Texas adults (19-64) under 138% of FPL, potentially eligible if Texas allows this coverage. Of these:

- More than three-quarters have incomes below 100 percent FPL;
- 48% are Hispanic (the largest share of any state), 33% White, and 14% Black *(compare to 19% Hispanic, 55% White, and 19% Black nationwide)*;
- 52% are women, with about 37% of the total in the age 19-44 prime child-bearing years *(compared to US average of 48% women, with 30% 19-44);*
- One-third are parents with dependent children (e.g., parents whose kids are on Medicaid today), and two-thirds adults without dependent children *(compared to 18% parents and 82% childless adults nationally);*
- 88% are US citizens and 12% legal immigrants (the latter are about 214,000 of the 1.75 million; and *not eligible for Medicaid under current Texas law*).

Texas looks different from national averages largely because our current Medicaid coverage of parents is so extremely limited. As a result, Texas "newly-eligible" population will include many adults who would have already qualified in other states, resulting in larger percentages of women and parents. Texas' much larger than average Hispanic population also results in a larger share of new coverage to Hispanics than the national average.

Conclusion: Medicaid expansion for adults makes good sense for Texas. We have an opportunity to provide a regular source of health care for more than 1 million of our poorest adults—many of them raising children—while reducing local uncompensated health care that today forces providers to charge more to patients with insurance, increasing premiums for everyone, and increasing local property taxes to pay for indigent care. Expanding Medicaid will also make our mental health, criminal justice and child protection systems more effective as the adults they serve gain access to mental health care and substance abuse treatment. Criminal justice systems would also be relieved of significant medical costs. Expansion would be affordable, with the federal government covering 100 percent of the costs for the first three years, phasing down to 90 percent after that. Over the first four years, for $1.3 billion in state dollars, Texas would get $24 billion in federal dollars infused into our health care system, creating hundreds of thousands of new jobs. As other states have proposed, if the federal government reduced its financial commitment, Texas could reverse the expansion. In the meantime, the massive increase in federal money would build our health care workforce and strengthen our system.

Health Policy intern Marcus Denton provided important research support for this report.

For More Information

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ENDNOTES

[1] In 2014, the ACA also eliminates for all Medicaid categories except SSI-related coverage of seniors and persons with disabilities, the hundreds of current varying state-level income disregard policies. Those varying policies will be replaced with a single, standard disregard of 5% of income, which effectively increases the ACA Medicaid threshold of 133% FPL to 138% FPL. For this reason, readers will encounter both numbers in the literature.

[2] Choices and Challenges: How Texas County Uninsured Rates Will Drop Under Health Care Reform; http://library.cppp.org/research.php?aid=1231; September 19, 2012.

[3] Americans in households with incomes below the filing threshold for federal income taxes are not subject to tax penalties for being uninsured under the ACA.

[4] For a recent analysis, see Texas Government Effectiveness and Efficiency Report, Legislative Budget Board, January 2013, pp. 158-166; http://www.lbb.state.tx.us/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf#AuthorizeCountiesToFund

[5] Georgetown University Health Policy Institute Center for Children and Families, *Expanding Coverage for Parents Helps Children: Children's Groups Have a Key Role in Urging States to Move Forward and Expand Medicaid*; July 2012, http://ccf.georgetown.edu/wp-content/uploads/2012/07/Expanding-Coverage-for-Parents.pdf

[6] Long S, Stockley K, Grimm E, et al. "National Findings on Access to Health Care and Service Use for Non-elderly Adults Enrolled in Medicaid." The Medicaid and CHIP Payment and Access Commission, 2012.

[7] Sommers BD, Baicker K, Epstein AM. "Mortality and Access to Care among Adults after State Medicaid Expansions." July 2012. New England Journal of Medicine 10.1056/NEJMsa1202099, http://www.nejm.org/doi/full/10.1056/NEJMsa1202099#t=article.

[8] Finkelstein A, Taubman S, Wright B, et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." NBER Working Paper Series, Working Paper 17190. Cambridge, MA: National Bureau of Economic Research, 2011. http://www.nber.org/papers/w17190.