TEXAS PUBLIC POLICY FOUNDATION
PolicyPerspective

May 2020

No Expansion Necessary: How Texas Can Lead the Way on Medicaid Alternatives

by Elizabeth O'Connor
Legislative Fellow

Key Points

- There has been an increase in fraudulent enrollment in Medicaid expansion states.
- There have been no positive health outcomes that suggest that the costs associated with expansion are necessary.
- The use of alternatives to Medicaid, such as Federally Qualified Health Centers, can be a more cost-efficient way to serve at-risk and lower-income patients.

Executive Summary

On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law by President Barack Obama. In this legislation, the federal government mandated that states expand their Medicaid program to all individuals at or below 138% of the federal poverty level (Patient Protection and Affordable Care Act, 2010, p. 153-167). Challenged in the Supreme Court, this mandate was deemed unconstitutional, making Medicaid expansion voluntary. As of March 2020, 36 states and Washington, D.C., had joined the voluntary program (*National Federation of Independent Businesses [NFIB] v. Sebelius*, 2011; Kaiser Family Foundation [KFF], 2020). Texas, thus far, has chosen not to expand Medicaid. The decision is attributed to higher-than-expected costs seen in other states, and research showing that, overall, health outcomes have not been better for expansion populations compared to non-expansion populations. Rather than investing taxpayer funds into a federally regulated program, Texas policymakers can look toward state-based initiatives targeting access to health care instead of adding more individuals onto a health coverage plan that is not sustainable. Solutions such as the use of Federally Qualified Health Centers and improving telemedicine options can increase access and affordability in health care for lower-income Texans.

Introduction

With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, states were mandated to expand their Medicaid services to those who did not previously qualify under existing federal requirements. Challenged in the Supreme Court in *NFIB v. Sebelius*, Medicaid Expansion became a voluntary option states could opt in (*NFIB v Sebelius*, 2011). As of March 2020, 36 states and Washington, D.C., had chosen to expand their programs (KFF, 2020 n.d.-b).

Expanding Texas's Medicaid system is not the solution for those who are being priced out of the health insurance market in Texas. Increasing the number of people covered by insurance does not equate to more access to primary care physicians for those newly covered, nor does it improve health care outcomes. Approximately 761,000 Texans live within the coverage gap for Medicaid, which refers to uninsured adults who earn too much to qualify for Medicaid, but earn too little to qualify for subsidies to help pay for a health coverage on Texas's health insurance market exchange. Yet, there are those who qualify for Medicaid benefits that are not utilizing the services offered—approximately 582,000 people in Texas qualify and are not enrolled (KFF, 2020 n.d.-b).

Medicaid expansion aims to increase coverage to all adults living within the coverage gap. A recent study of Medicaid expansion concluded that there may have

continued

been fraudulent enrollment of households between 138% and 250% of the federal poverty level (FPL) by people misreporting their annual income (Courtemanche et al., 2019).

Expansion has not proven to lead to an increase in health outcomes for the intended population but has created an increase in federal and state spending paid for by taxpayers (Blase, 2016). There are alternatives to Medicaid expansion that states can utilize, such as Federally Qualified Health Centers (FQHC) that can actually increase access to health care (Health Resources and Services Administration [HRSA], 2018). In many parts of Texas, FQHCs currently offer access to primary care, dental care, and mental health and substance abuse services, among other services. This is an alternative to expanding Medicaid that could show positive health outcomes for the intended populations.

What is Medicaid Expansion?

The original intent of Medicaid was to assist low-income Americans and their dependents, such as children, pregnant women, the elderly, and the disabled. The Government Accountability Office has classified the Medicaid program as "high risk" since 2003. There has been measured fraud, management abuse, and waste. For fiscal year 2018, an estimated 9.8%, or $36.2 billion, of Medicaid spending was attributed to improper payments (Government Accountability Office [GAO], 2020).

Under the ACA, states were told to expand their Medicaid programs to include all adults and children with an income below 138% of the FPL. Since the Supreme Court ruled that Medicaid expansion must be optional for states, 36 states and Washington, D.C., have expanded their programs to include the new population.

Under the ACA, federal funding for the Medicaid expansion population initially equaled 100% of the program's cost for newly eligible beneficiaries in 2014 and has declined until this year, where the 2020 rates of 90% federal funding and 10% state funding will remain (Rudowitz et al., 2019). However, the cost per person in the expansion states has been 76% higher during the first three fiscal years than the Center of Medicare and Medicaid Services (CMS) projected. Ultimately, taxpayers have spent 157% more to fund the program than originally predicted (Ingram & Horton, 2018, p. 6).

Texas has chosen not to expand Medicaid due to the issues surrounding it. Elected officials argued that this would increase health care costs in the state, even more so if the federal government's share decreased (Fernandez, 2019). Medicaid beneficiaries already face reduced access to care. A national survey conducted in 2018 found that only 70.8% of physicians were willing to accept new Medicaid patients, compared with 85.3% and 90.0% who were willing to accept new Medicare and private insurance patients, respectively. Pediatricians, general surgeons, and obstetricians/gynecologists had a higher Medicaid patient acceptance rate than physicians overall. However, only 35.7% of psychiatrists were accepting new Medicaid patients (Holgash & Heberlein, 2019).

Almost 36% of adults who live in non-expansion states but would be eligible for expansion currently have employer-sponsored health insurance, and 18% of these potentially eligible adults have purchased plans on the individual market. This means that more than half of the potentially eligible adults under Medicaid expansion are already covered by a private health plan (Horton & Ingram, 2019, p. 4). If these individuals were to join the Medicaid population, they could crowd out services from others, such as children, pregnant women, and the disabled, whom the program was originally intended to assist. They would cause the program spending to increase, causing a strain on the state budget, while only being able to use the Medicaid plans with physicians accepting new Medicaid patients. And as fewer physicians are accepting new patients compared to new patients with traditional insurance, there would be less access for all Medicaid beneficiaries.

Expansion in Other States

Looking at case studies from expansion states can allow policymakers to see the negative effects expansion has on the government system. There are systematic errors that allow for fraudulent enrollment, both in malice and by mistake.

A study published in the National Bureau of Economic Research found fraudulent enrollment in the nine states that were studied—Arkansas, Kentucky, Michigan, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, and West Virginia. Between 2012 and 2017, 1.7 million non-elderly adults gained access to Medicaid coverage in these states. This study predicted that approximately 800,000 of these new enrollees were actually income-ineligible, meaning they made more than 138 FPL. Part of this could be the result of people's tendency to minimize their income when browsing insurance plans on the individual marketplace. Marketplace searches can require an individual to include their social security number, which states use to enroll individuals (Courtemanche et al., 2019).

A state audit in Louisiana conducted between 2016 and 2018 found that 82% of Medicaid expansion enrollees were at some point ineligible during the year they were enrolled. The audit found that individuals enrolled in the expansion population were not self-reporting any changes in income, as they were required to. The Louisiana Department of

Health concluded that this might have led to an increase in per-member per-month capitation spending between $61.6 million and $85.5 million between July 1, 2016, and March 31, 2018 (Purpera et al., 2018, p.9).

A 2017 report compiled by the California Health Care Foundation found that while primary care physicians were more likely to serve individuals enrolled on the state's Medicaid program, known as Medi-Cal, versus uninsured individuals, physicians were even more likely to serve individuals with private insurance. Medi-Cal's enrollment grew due to the ACA and the state's expansion status, from 8.6 million in 2013 to 13.4 million in 2016. During this same period, the number of physicians serving those on Medi-Cal decreased from 69% to 64% (California Health Care Foundation [CHCF], 2017, p.10). In 2018, 32% of Medi-Cal eligible Californians were not enrolled despite the expansion (KFF, 2020 n.d.-b).

In January 2020, CMS announced a new block grant that could be used by state Medicaid administrators to fund Medicaid programs for previously unenrolled populations (Centers for Medicare and Medicaid Services, 2020). Known as the Healthy Adult Opportunity, this block grant cannot be used on the already served population in states like Texas, so it would not be a viable option for Texas to consider funding Medicaid services. Its purpose is to expand services to those who fit the criteria other states have used for expansion, or other populations such as those with lower income seeking mental health services. Unlike other 1115-demonstration waivers (Texas Health and Human Services [HHS], 2020) or the 1135-waiver used during COVID-19 (Office of the Texas Governor, 2020), its purpose is not to create innovation and change for those currently served but to expand the population. No states have been approved for this block grant as of April 2020. By using this block grant, more people would be enrolled in Medicaid, which can lead to crowd-out and a decrease in participating physicians, as seen in California.

Affordability Leads to Access

There has been an increase in individual health care costs that has made health care access unaffordable for some. Between 2008 and 2018, families covered by large employers saw their premiums and out-of-pocket spending combined increase on average by 67% (Rae et al., 2019). Over this same period, employer contribution to health care costs on average increased as well. Out-of-pocket spending and health care spending have also increased more than workers' wages have (Rae et al., 2019). A study conducted by the Heritage Foundation attributed the rising costs in premiums and deductibles to the ACA. The study noted that the requirements imposed on essential health benefits and cost adjustments based on age, among other requirements, led to these rising costs (Haislmaier & Badger, 2018).

Patients can also utilize FQHCs if they are not insured. They then pay a rate based on a sliding income scale (HRSA, 2018). FQHCs are community-based health care centers and providers that assist in underserved areas. They can provide primary and preventative care, oral care, mental health, and substance abuse services. They are approved through the federal Health Resources and Services Administration and receive partial funding from grants. In Texas, less than half of the collective FQHC funding came from government grants (KFF, 2020 n.d.-a). These centers can offer health care to vulnerable populations in both rural and urban communities.

Texas currently has 73 FQHCs operating 300 sites across the state (Texas Department of State Health Services [DSHS], 2019). In Texas, they range in size of annual budget from $2 million and $159 million (Texas Association of Community Health Centers [TACHC], 2020). A study conducted in 2016 reviewed national FQHC data and determined that approximately 19.3% of all low-income, nonelderly adults received care at an FQHC, 16.3% of whom used an FQHC as their usual source of care. For all nonelderly adults, regardless of income bracket, 9.2% in 2014 used an FQHC, with approximately 8% using one as their usual source of care (Weiss et al., 2016). The study also found that individuals would use an FQHC regardless of their income bracket, age, gender, race, or other identifying characteristics, making them a hub of health care services for all members of a community.

The implementation of telemedicine in Texas can also increase access for lower-income individuals, particularly those who are unable to leave home or work for regular appointments and those who live in rural communities and may need constant care. Health care providers are increasingly using telephones, audiovisual platforms, smartphone applications, and other technologies to assess, monitor, diagnose, and even treat their patients remotely (HealthIT, 2017). One of the major benefits of telemedicine is cost-effectiveness, for both providers and patients. Providers do not have the same overhead when conducting a telemedicine appointment, and patients do not have to plan a form of transportation to attend an appointment. Advocates of FQHCs in Texas see telemedicine as a beneficial service for lower-income Texans in both urban and rural areas (Camacho, 2018).

Recommendations

As policymakers in the Texas Legislature begin to consider new and innovative ways to solve the affordability problem in Texas's health care market, they should look past

expansion in order to create new avenues for access and affordability in health care, by

- Looking at ways to encourage the usage of FQHCs as a health care business model in lower-income communities, which can bring essential primary care services, among other necessary health services, to communities across the state.
- Making permanent the liberalization of telemedicine in order to increase access for lower-income individuals who have difficulty attending appointments.
- Not applying for a Healthy Adult Opportunity block grant, which would limit patients' access to providers enrolled in Texas's Medicaid program. This has the potential to divert physicians from enrolling to be providers and can overrun the health care system in Texas with those who are not considered to be the most vulnerable populations.

Conclusion

Coverage is not care, and expanding Medicaid enrollment does not automatically, or even over time, make a state healthier. Increased coverage via Medicaid has not resulted in an improvement in health outcomes for individuals in expansion states, nor has it increased physician enrollment in these states in order to have an adequate number of providers for new enrollees. The idea that the only way for a person to be healthy is to enroll in fee-for-service insurance is antiquated and inaccurate. Knowledge of other services available in the market can show people how to reduce their personal costs and maintain a healthier lifestyle. ☆

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ABOUT THE AUTHOR

Elizabeth O'Connor is a legislative fellow at the Texas Public Policy Foundation. Her research has covered the history of government intervention in the U.S. healthcare system, and she has written for *The Hill* and the *Washington Examiner*.

Prior to joining the Foundation, O'Connor was a policy intern during the 86th Legislative Session in the senate, where she researched topics such as agriculture, water, and rural policy. She was also a visiting fellow at the Wales Centre for Public Policy, studying youth homelessness in Cardiff, Wales.

O'Connor has a master of public service and administration from the Bush School of Government and Public Service at Texas A&M University. There, she focused her studies on public policy analysis and public management in a state government context. As an undergraduate, she attended Manhattan College, where she received a B.A. in government, international studies, and economics.

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