



## COST-BENEFIT ANALYSIS OF MEDICAID CHANGES IN NATIONAL HEALTH CARE REFORM: HUGE POSITIVE GAINS FOR TEXAS

In explaining why they oppose national health care reform, specifically the Senate Finance Committee's version, Governor Rick Perry<sup>1</sup> and Senator John Cornyn<sup>2</sup> both point to the increase in the cost of Medicaid for the state budget based on a preliminary estimate by the Texas Health and Human Services Commission (HHSC). HHSC says<sup>3</sup> costs would increase by "\$20.4 billion over 10 years." In this paper, we analyze HHSC's cost estimate and compare it to the benefit to Texas' economy from Medicaid expansion. We explain that HHSC's estimate includes paying for already eligible but unenrolled children and a shift of certain costs from local to state. We also explain that the estimate cannot be compared to other national estimates because it covers a longer time. We conclude that the agency estimate is unrealistically high, but that by any measure, including the estimate itself, the economic benefit to Texas dramatically outweighs the cost to the state budget.

- **As the state with the highest percentage of uninsured, Texas has the most to gain from health reform.**
- **Almost a third of HHSC's recently publicized health reform cost estimate is for covering already eligible but unenrolled children and about a third is merely shifting local costs to the state.**
- **The economic benefit to Texas from Medicaid expansion could generate as much as \$402.8 billion in near-term economic activity, far outweighing the cost to the state budget.**
- **Low- and moderate-income Texans would get a tremendous economic boost with protection from unlimited out-of-pocket health care costs.**

### National Health Reform Brings Dramatic Economic Benefits to Texas

Because Texas ranks first in the percentage of uninsured, Texas stands to gain the most from national health care reform. Thus, while HHSC projects an increase of \$20.4 billion over 10 years from 2014-2023 in Medicaid costs, the very same HHSC analysis also shows Texas benefiting from a net gain of \$124 billion in increased federal funds over the same 10 year period.<sup>4</sup> In other words, spending one state dollar would bring Texas six federal dollars. According to Texas economist Ray Perryman, federal Medicaid and CHIP dollars spent on health services have a short-term economic multiplier of 3.25, meaning that the new \$124 billion in federal health care spending would generate a total of \$402.8 billion in economic activity in the near term, as those health care dollars are spent in local Texas economies.

But that is not all Texans would get for their money. Expanded Medicaid would cover millions of Texans living in or near poverty. Even more funding—with no state matching dollars required—will flow to Texas from premium assistance to low-to-moderate income families who buy insurance through the new health insurance exchange. All those Texans would get better health outcomes, allowing them to be more productive economically. Protection from unlimited out-of-pocket health care costs would provide these families a tremendous economic boost, a point almost totally overlooked in the ongoing debate. Local uncompensated care bills for taxpayers would drop dramatically, and local health care providers would have to provide far less uncompensated care. And since costs of care for the newly insured would no longer be shifted to those who can pay, those who have insurance now would see lower premiums.

## Health Reform Coverage Costs Are Only 5 Percent over Current Program Costs

Texas Medicaid paid out \$17.8 billion for medical bills for poor children, seniors, disabled, and pregnant women in 2008. HHSC projects spending \$19 billion in 2009 and \$21.4 billion in 2010. According to HHSC figures reported to federal Medicaid authorities, the average annual increase in Texas Medicaid health care payments from 1999-2009 has been about 8.1 percent. Based on this historical trend data, without any changes in law, Texas Medicaid over the 2014-2023 period of the HHSC analysis would be expected to pay for about \$425 billion in health care bills, of which Texas would pay about \$177 billion. As explained in more detail below, HHSC's \$20.4 billion cost projection has three components:

- about 40 percent is from expanding Medicaid;
- another 30 percent is from insuring Texans eligible today under current law but unenrolled; and
- the remaining 30 percent is from the state replacing local tax dollars now used to pay hospitals.

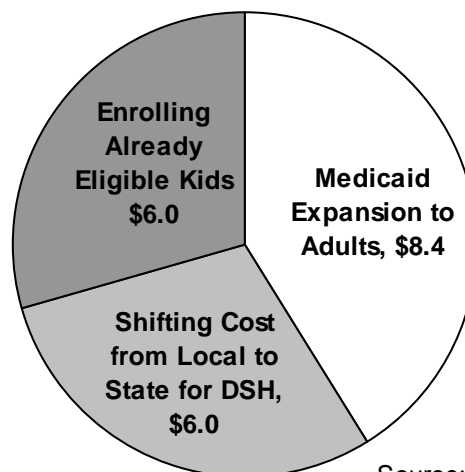
This economic benefit to Texas (plus the benefit of covering 2.5 million more uninsured Texans) vastly outweighs the increase of \$8.4 billion, or 5 percent above the baseline, to cover working poor adults, and an additional 3 percent to cover our already-eligible unenrolled children.

## Nearly a Third of HHSC's Estimate Is the Cost of Complying with Current Law to Cover Eligible but Unenrolled Children

As the chart below shows, about \$6 billion of the HHSC cost estimate includes the costs to our state budget of providing Medicaid to hundreds of thousands of Texans—mostly children—who qualify today but are not enrolled because of our inadequate public benefits enrollment system.<sup>5</sup> The cost of expanding Medicaid to include poor parents and childless adults (the latter is a new population, not covered by Medicaid today) would be paid for roughly 90 percent by the federal budget, and 10 percent by states.<sup>6</sup>

In contrast, any new costs to the state for covering eligible children—who Texas should have enrolled in Medicaid all along but did not—are shared with the federal government

**Components of HHSC Preliminary Estimate, Senate Finance 9/16 filed version, Medicaid/CHIP Provisions  
(Billions of General Revenue Dollars, 2014-2023)**



Source: Texas HHSC

at the usual matching funds rate of about 58 percent federal and 42 percent state. HHSC models roughly \$14.4 billion in net Medicaid and CHIP expansion-related state-dollar spending increases from 2014-2023, and about \$8.4 billion of this total would be related to the expansion to adults, with the remainder (\$6 billion) attributed to HHSC's assumptions about increased enrollment by Texans who were already Medicaid-eligible, but unenrolled.

### **Nearly a Third of HHSC's Estimate is Merely Shifting Cost from Local to State Taxpayers**

The remainder (another \$6 billion) of HHSC's \$20.4 billion figure is related to providing state-dollar funding for adequate Medicaid hospital fees. For many years, Texas has paid below-cost fees to hospitals. As noted in the HHSC analysis, in part to mitigate the inadequate payments to hospitals, Texas provides special "disproportionate share hospital" (DSH) payments.<sup>7</sup> Current federal law allows Texas local public hospitals to put up local tax dollars for the matching federal funds for the DSH program. HHSC posits that national health care reform may eliminate the DSH program. In other words, in its analysis, **HHSC assumes that the ability to use local funds (as opposed to state dollars) to draw that federal match might be lost, requiring that local dollars be replaced with state dollars.**

The HHSC analysis identifies the state's potential additional expenditures to replace the local matching dollars at \$6 billion from 2014-2023. These costs should be considered separately from direct costs of Medicaid expansion since it is not clear whether Texas would ultimately have to replace these local funds at all, and because replacing the local dollars is merely shifting the cost from local to state taxpayers. This is not a new cost to Texas.

### **HHSC Estimate for the Medicaid "Take-Up" Rate Is High**

HHSC cost estimates for both the mandated Medicaid expansion and the increase in enrollment by Texans already eligible for Medicaid but currently unenrolled

assume very high Medicaid take-up rates. HHSC's analysis assumes that 94 percent of eligible Texans would be enrolled in Medicaid, up from the current take-up estimate of 78 percent. This is based on the Congressional Budget Office projection (the CBO, which determines the official costs of federal legislation) that, under the Senate Finance bill, 94 percent of Americans under age 65 (excluding the undocumented) will be insured.<sup>8</sup>

However, this overall coverage assumption is not intended by CBO to function as an actual participation rate, and in fact, CBO does not specify any participation or take-up rate for Medicaid. The Senate Finance bill does not impose any penalty on uninsured Americans with incomes below 100 percent of the federal poverty income level. As such, the Medicaid take-up rate under reform would be expected to be lower than for Texans at higher incomes who do face penalties.

CBO projects a total net increase in Medicaid and CHIP enrollment from 2010 to 2019 of 11 million nationwide, and specifically indicates that this number includes both Medicaid and CHIP enrollment net increases. HHSC projects a net increase of 1.7 million in Medicaid plus 768,000 in CHIP, for a combined total of 2.479 million (*for a different and longer time period, see below*). This number would mean Texans would make up an unlikely 23 percent of CBO's assumed total national enrollment growth in Medicaid and CHIP, so it seems clear that CBO is assuming a lower take-up rate for Medicaid and CHIP than HHSC is using.

### **Why CBO and HHSC Projections Differ**

CBO "scores" (cost projections) for the national reform bills cover the ten years from 2010-2019. The Medicaid expansion in the Senate Finance bill would begin in the fifth year, thus the official CBO score for the bill covers just six years of Medicaid expansion costs beginning in 2014. HHSC's \$20.4 billion estimate uses a ten-year period from 2014-2023. As discussed above, HHSC's analysis adds to Medicaid expansion costs the cost of complying with current law (and assumes very high take-up rates); in addition it includes four more years of

Medicaid costs than CBO. Thus, a good part of the higher HHSC cost projection is due to inflation and population growth over four extra years.

### **U.S. Senate Finance Committee Estimates Only a 2.8 Percent Cost Increase for Texas**

The U.S. Senate Finance Committee released estimates (produced by the Urban Institute) of baseline Medicaid costs state-by-state, compared to increased costs expected under the committee's bill. The committee predicts state savings from 2010 to 2013 (due to employer coverage increasing and coverage through the health insurance exchange), with increased state Medicaid costs beginning in 2014. Netting out savings from reduced optional Medicaid coverage, reduced CHIP spending, and Medicaid drug savings (all of which are also netted out in HHSC's estimates), the committee predicts an increase in state-dollar layout from 2010 to 2019 (again, a different period from HHSC's model) of \$2.9 billion, or a 2.8 percent increase above the baseline without reform. This increase would be above the national average—to be expected because Texas Medicaid adult coverage today is far below the national average—but lower than that predicted for Arkansas, Colorado, Maryland, New Jersey, and Virginia.

### **Conclusion**

HHSC made a good faith effort on a short deadline to model Medicaid impacts for this preliminary estimate of the now-much-revised Senate Finance bill, and the agency is working to make its future modeling more detailed and

accurate for analysis of final House and Senate bills. Texas officials certainly should analyze and project all the costs associated with health reform including both direct costs and those that may result from state policy and budget choices—e.g., our high numbers of uninsured who already qualify for public insurance but are not enrolled due to red tape, staff shortages, system failures, and lack of outreach. In communicating models to the public, the fact that new federal funding dramatically outweighs new costs—in this estimate, by a 6 to 1 margin—should be clearly explained, in addition to distinguishing the costs of required Medicaid expansion from those resulting from removing barriers for those already eligible for the program or from cost shifts.

Texas can expect significant increases in state-dollar Medicaid spending from 2010-2019 if a health reform bill expands Medicaid through a combination of newly eligible Texans and greater enrollment by Texans who are already qualified. Even under the HHSC's "high-end" estimate 2.5 million more uninsured Texans would gain coverage in Medicaid and CHIP—compared to current Medicaid-CHIP combined enrollment of 3.4 million—an enormous human benefit for the investment. And, the 90 percent federal matching contribution for costs for expansion will result in a very large net influx in federal tax dollars returned to our state as well. Whatever the exact cost of national health care reform, Texas stands to be the biggest winner—with a tremendous positive impact to our economy.

<sup>1</sup> See Governor's Official Website: <http://governor.state.tx.us/files/press-office/O-BaucusMax20090923.pdf>. Governor Perry's letter was based on an earlier, now superseded, analysis different from the one used by Senator Cornyn.

<sup>2</sup> See Senator's Official Website: [http://cornyn.senate.gov/public/index.cfm?FuseAction=ForPress.NewsReleases&ContentRecord\\_id=e2d73004-802a-23ad-4283-9badc66523c8&Region\\_id=&Issue\\_id=](http://cornyn.senate.gov/public/index.cfm?FuseAction=ForPress.NewsReleases&ContentRecord_id=e2d73004-802a-23ad-4283-9badc66523c8&Region_id=&Issue_id=)

<sup>3</sup> The HHSC analysis is based on the U.S. Senate Finance chairman's mark filed on September 16, 2006.

<sup>4</sup> "New" spending figures include spending above levels currently projected by HHSC for program growth under current law.

<sup>5</sup> See CPPP, "Texas' Eligibility System Continues to Fail Needy Texans," October 1, 2009, [www.cppp.org/research.php?aid=918](http://www.cppp.org/research.php?aid=918).

<sup>6</sup> See CBO, page 4, [www.cbo.gov/ftpdocs/105xx/doc10572/09-16-Proposal\\_SFC\\_Chairman.pdf](http://www.cbo.gov/ftpdocs/105xx/doc10572/09-16-Proposal_SFC_Chairman.pdf).

<sup>7</sup> Disproportionate Share Hospital (DSH) payments are also intended to make up for significant free care provided to the uninsured.

<sup>8</sup> CBO projects 91 percent of non-elderly Americans overall (i.e., without attempting to exclude undocumented) will be insured.