



**Testimony submitted to the
Senate of Texas Committee on Health and Human Services**

Overview of Health Insurance Coverage in Texas
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Good morning, Chairwoman Kolkhorst, Vice-Chairman Perry, and senators on the committee. Thank you for inviting me to participate in this hearing. My name is Brian Blase, and I am the founder and president of Paragon Health Institute, a health policy research center dedicated to empowering patients and reforming government program. I am also a visiting fellow at the Foundation for Government Accountability (FGA). From 2017 through 2019, I served as a Special Assistant to the President for Economic Policy at the White House's National Economic Council. You have vital jobs serving the people of the great state of Texas, and it is an honor to testify before the Committee today on this important topic. My testimony today represents my views alone.

I'm here to discuss several issues concerning the Affordable Care Act's Medicaid expansion, and specifically how expansion has harmed access to care for traditional Medicaid enrollees, caused enrollment and spending to soar, put states at great financial risk, and has not improved population health outcomes. In this testimony, I will provide a brief background of the issue at hand, discuss the findings from Paragon's comprehensive case study of the effects if Florida were to expand their Medicaid program, share lessons from states that have previously adopted Medicaid expansion, highlight the implications of Medicaid expansion in Texas, and provide an overview of some reforms the state should consider to empower patients and reform government programs.

If Texas were to expand Medicaid, we estimate the state's Medicaid enrollment would increase by more than 3 million recipients with two-thirds of them replacing private coverage with Medicaid. Nearly 1.9 million exchange enrollees would replace an exchange plan, where the state bears no cost, with Medicaid, where the state would bear 10 percent of the cost. Medicaid enrollment would increase from about 13 percent of the state population to about 23 percent if the state adopts Medicaid expansion. And the ratio of workers per Medicaid recipient would decline from 3.4 workers per recipient to 2.0 workers per recipient. We estimate the fiscal cost to the states would be nearly \$2 billion a year over the next decade.

Background of Medicaid Expansion

The Affordable Care Act contained a significant Medicaid expansion to able-bodied, working-age adults in households with income below 138 percent of the federal poverty level (FPL). Thus far, 40 states, plus the District of Columbia, have adopted this expansion since it took effect in 2014. The federal government reimburses 90 percent of state expenditures on the expansion population, a much higher rate than what the federal government reimburses state expenditures of traditional enrollees such as low-income children, pregnant mothers, seniors, and individuals with disabilities. If

states adopt expansion, they accept a financing structure that discriminates against the most vulnerable people in the state and favors able-bodied, working-age adults.

In 2020, Medicaid was the largest item in state budgets and accounted for nearly 30 percent of total state expenditures.¹ Between 1988 and 2021, inflation-adjusted state expenditures increased by 175 percent, while Medicaid spending increased by nearly 600 percent. During that period, 35 percent of the growth in total state expenditures was driven by Medicaid.²

Between 1991 and 2021, inflation-adjusted Medicaid spending grew by 468 percent in Texas. During that time, 36 percent of the growth in total Texas state expenditures was driven by Medicaid.³ Medicaid growth puts pressure on states and takes away from education and infrastructure priorities.

Summary of Paragon's Research on Effects if Florida Were to Expand Medicaid

Paragon has conducted extensive research on this issue, including a research paper on the effects of Medicaid expansion for Florida that my colleague Drew Gonshorowski and I authored.⁴ Our findings for Florida provide important context for what would happen if Texas adopted Medicaid expansion.

The actuarial consulting firm Milliman provided estimates of projected enrollment and spending if Florida were to adopt Medicaid expansion. According to Milliman's estimates, enrollment in Medicaid would increase by 47 percent under mid-range estimates and 60 percent under high-end estimates by the end of this decade. This many additional Medicaid expansion enrollees would bring total Medicaid enrollment to between 28 and 30 percent of the state's population. Of those who would gain Medicaid, 65 percent of them would simply replace private coverage with welfare.^{5,6}

According to Milliman's mid-range estimates of Medicaid expansion in Florida, the 10-year total cost would be \$123 billion, with state costs of \$11.1 billion. Using the Congressional Budget Office's growth rate assumptions for per capita Medicaid costs, which is significantly higher than what Milliman assumes, the 10-year total cost would be \$176 billion, including \$17.2 billion in state costs.^{7,8}

¹ National Association of State Budget Officers, "2022 State Expenditure Report," November 18, 2022, <https://t2m.io/vrBhBJF>

² National Association of State Budget Officers, "Archive of State Expenditure Report," <https://www.nasbo.org/reports-data/stateexpenditure-report/state-expenditure-archives>

³ National Association of State Budget Officers, "1991-2023 State Expenditure Report Data," <https://community.nasbo.org/viewdocument/citation-national-association-of-s?CommunityKey=b96cf10c-e5b8-4461-a5cd-7b46c639029e&tab=librarydocuments>

⁴ Brian Blase and Drew Gonshorowski, "Resisting the Wave of Medicaid Expansion: Why Florida Is Right," Paragon Health Institute, December 2023, <https://paragoninstitute.org/wp-content/uploads/2023/12/Resisting-the-Wave-Florida-Medicaid.pdf>

⁵ Milliman, "ACA Medicaid Eligibility Expansion Fiscal Analysis SFY 24/25 through SFY 33/34," October 20, 2023, https://ahca.myflorida.com/content/download/23717/file/Medicaid_Eligibility_Expansion_Scenarios_Fiscal_Impact-SFY_2425-SFY_3334.pdf

⁶ Florida Commerce, "Employment Projections," <https://www.floridajobs.org/economic-data/employment-projections> (accessed November 6, 2023).

⁷ Milliman, "ACA Medicaid Eligibility Expansion Fiscal Analysis SFY 24/25 through SFY 33/34," October 20, 2023,

https://ahca.myflorida.com/content/download/23717/file/Medicaid_Eligibility_Expansion_Scenarios_Fiscal_Impact-SFY_2425-SFY_3334.pdf. Milliman's mid-range estimates assume that the morbidity of Florida's expansion population would be similar to the experience observed in other expansion states and a per capita expenditure growth rate of 4.45 percent. For take-up of the expansion, of those made eligible for Medicaid due to the expansion, Milliman assumes 95 percent of exchange enrollees and the uninsured below 138 percent of the FPL would gain Medicaid, while 25 percent of those with government coverage (active-duty military and veteran coverage) and 50 percent of those with employer coverage in this income range would shift to Medicaid. In the high scenario, Milliman assumes 100 percent of exchange enrollees and the uninsured below 138 percent of the FPL would gain Medicaid, while 30 percent of those with government coverage and 60 percent of those with employer coverage in this income range would shift to Medicaid. Milliman assumes the same enrollment ramp up rate (over a period of 24 months) for all scenarios.

⁸ CBO, "Baseline Projections: Medicaid," May 2023, <https://www.cbo.gov/system/files/2023-05/51301-2023-05-medicaid.pdf>. CBO projects a 6.3 percent growth rate for ACA Medicaid expansion enrollees from 2025 to 2033.

Under the mid-range and high estimates, total Medicaid spending would increase by 30 percent and 43 percent, respectively, in Florida by the end of the decade.⁹ The mid-range estimate of the state share of expansion costs would be around \$1.5 billion, equivalent to about 2.6 percent of the Florida budget, and the high estimate of the state share would be \$2.0 billion, or about 3.5 percent of the budget.¹⁰ In Florida, Medicaid spending would increase from 31 percent to 40 percent of the state's budget — a dramatic rise from the 9 percent of state spending that went to Medicaid in 1988.^{11,12}

Funding the expansion would be a challenge, requiring either an increase in state sales tax or cuts from other crucial state programs such as education, infrastructure, or transportation. If funded by an increase in Florida's sales tax, it would need to rise from 6.0 percent to about 6.4 percent.¹³ If Florida adopted Medicaid expansion, the ratio of Florida workers to Medicaid recipient ratio would fall from 2.5 workers per recipient to 1.6 workers per recipient with the mid-range assumptions and 1.5 workers per recipient with the high range assumptions — an indication of the magnitude of the growth in the welfare state that occurs when states adopt expansion.¹⁴

Medicaid expansion states are particularly vulnerable to any change in federal fiscal policy that would reduce the amount of money that states receive from Washington. When Congress pursues measures of long-term deficit reduction to address the rising debt and federal interest payments, lowering the federal medical assistance percentage (FMAP) for the Medicaid expansion population — as previously proposed by President Obama's 2012 budget and included in legislation passed by the House of Representatives in 2017 — will likely be considered.¹⁵ For Florida, if the current expansion FMAP of 90 percent is lowered to Florida's standard FMAP of around 60 percent, Florida's projected Medicaid expansion would create a fiscal risk of \$40.5 billion over 10 years.¹⁶

Lessons from States that Adopted Medicaid Expansion

Here are twelve key lessons from states that have adopted the ACA's Medicaid expansion:

⁹ Milliman, "ACA Medicaid Eligibility Expansion Fiscal Analysis SFY 24/25 through SFY 33/34," October 20, 2023, https://ahca.myflorida.com/content/download/23717/file/Medicaid_Eligibility_Expansion_Scenarios_Fiscal_Impact-SFY_2425-SFY_3334.pdf.

¹⁰ This estimate is derived from State of Florida, Long-Range Financial Outlook: Fiscal Years 2024-25 Through 2026-27, September 8, 2023, http://edr.state.fl.us/Content/long-range-financial-outlook/3-Year-Plan_Fall-2023_2025-2027.pdf; and Milliman 2023. It takes Milliman's estimates for increased spending and divides by Florida's projected budget amounts in the last projected year, FY2027. These estimates are inflated by roughly 4.4 percent per year (the percentage growth from FY 2026 to FY 2027) to estimate FY2029 spending.

¹¹ National Association of State Budget Officers, "Archive of State Expenditure Report," <https://www.nasbo.org/reports-data/stateexpenditure-report/state-expenditure-archives>

¹² From 1990 to 2019, Florida's budget excluding Medicaid grew by 3.9 percent. Assuming this rate of growth, Florida's budget excluding Medicaid would be \$84 billion in 2028. Milliman estimates in the middle scenario that total Medicaid spending would be \$54.1 billion in 2028, or 39 percent of the state's budget. Under the high scenario, Milliman estimates that total Medicaid spending would be \$57.2 billion in 2028, or 41 percent of the state's budget. These figures include the federal and state share of Medicaid spending. If enrollment and spending exceed Milliman's projections, then Medicaid's share of the state budget would increase even further.

¹³ This estimate is derived from taking Florida's tax revenue for FY2027 of \$49 billion, of which 60.6 percent was funded by a general sales tax according to the most recent year of data, meaning \$29.7 billion was sales tax revenue. A \$2 billion increase due to Medicaid expansion means the sales tax would be raised 6.7 percent assuming no behavioral effects from the higher sales tax.

¹⁴ For February 2020, this ratio is calculated by taking total employment in Florida, 9,043,330 divided by Medicaid enrollment from Kaiser Family Foundation, 3,600,457. For SFY 2029, we estimated the employment based on projections from Florida Commerce for 2025 and 2030 and used a linear adjustment to get an estimate for SFY 2029 of 10,596,074 people. Florida specific employment data can be found at <https://www.floridajobs.org/economic-data/employment-projections> and annual2020stwssector(f).xlsx (live.com) respectively.

¹⁵ Office of Management and Budget, "Living Within Our Means and Investing in the Future," September 2011, <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf>

¹⁶ This is calculated by assuming that the expansion population receives Florida's standard FMAP. For 2024 this was 57.96 percent, and that percentage was used for this estimate over the entire period. If the state also did not receive the 5 percent additional match for expansion, the state would lose another \$3.5 billion in the first two years of expansion. Under Milliman's high scenario, state costs would increase by \$56.9 billion over 10 years.

1. Expansion enrollment was much higher than expected.

States that adopted Medicaid expansion experienced much greater enrollment in the program than expected. CBO reported in March 2016 that “the number of people estimated to have been enrolled in Medicaid in 2015 who were made eligible for the program by the ACA was significantly higher than ... previously projected.”¹⁷ In fact, I found in 2016 that enrollment was over 50 percent higher than what CBO expected when the ACA was enacted.¹⁸ A 2018 FGA report found that states enrolled more than twice as many expansion enrollees than they expected.¹⁹ Finally, when comparing Medicaid expansion enrollment projected in 2012 by the Urban Institute for 2022 with actual enrollment from February 2020, enrollment across expansion states exceeded projections by 52 percent.²⁰

2. Expansion spending was much higher than expected.

The high number of expansion enrollees led to higher spending. Expenditure data from April 2019 to March 2020 shows that spending on Medicaid expansion exceeded the Urban Institute’s 2012 projections for 2022 by 32 percent, and they likely would have been between 40 to 50 percent higher if comparable years were used. Several states experienced spending much greater than anticipated: Alaska (96 percent), California (66 percent), District of Columbia (218 percent), Connecticut (110 percent), Iowa (104 percent), Illinois (81 percent), Maryland (66 percent), Minnesota (114 percent), Montana (67 percent), New Mexico (99 percent), and Washington (333 percent).²¹ Additionally, CMS reported in 2018 that Medicaid expansion spending per enrollee was 56 percent higher than what CMS predicted for the same year before the expansion took effect.²² In its 2018 report, FGA found that the overall cost of the expansion was more than twice what states expected.²³

3. Expansion led to a surge of Medicaid waste, fraud, abuse, and low-value spending.

Medicaid’s improper payment rate soared with expansion as millions of people were enrolled without proper eligibility reviews. CMS reported that the national Medicaid improper payment rate rose to 21.7 percent in 2020, which was nearly quadruple the pre-ACA rate.^{24,25} Annual federal improper payments in Medicaid increased from an estimated \$14.4 billion in 2013 to \$98.7 billion in 2021.²⁶

Large Medicaid improper payments are particularly concerning given overwhelming evidence of the low benefit that able-bodied, working-age enrollees receive from the program. According to a 2015

¹⁷ CBO, “Updated Budget Projections: 2016 to 2026,” March 24, 2016, <https://www.cbo.gov/publication/51384>

¹⁸ Brian Blase, “Evidence Is Mounting: The Affordable Care Act Has Worsened Medicaid’s Structural Problems,” Mercatus Center, September 14, 2016, <https://www.mercatus.org/research/research-papers/evidence-mounting-affordable-care-act-has-worsened-medicare-structural>

¹⁹ Jonathan Ingram and Nic Horton, “A Budget Crisis in Three Parts: How ObamaCare is Bankrupting Taxpayers,” The Foundation for Government Accountability, February 1, 2018, <https://thefga.org/wp-content/uploads/2018/02/A-Budget-Crisis-In-Three-Parts-2-6-18.pdf>

²⁰ John Holahan et al., “The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis,” Urban Institute, November 28, 2012, <https://www.urban.org/research/publication/cost-and-coverage-implications-aca-medicare-expansion-national-and-state-state-analysis>; and CMS, “Medicaid Enrollment – New Adult Group,” updated August 21, 2023, <https://data.medicare.gov/dataset/6c114b2ccb83-559b-832f-4d8b06d6c1b9>

²¹ John Holahan et al., “The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis”

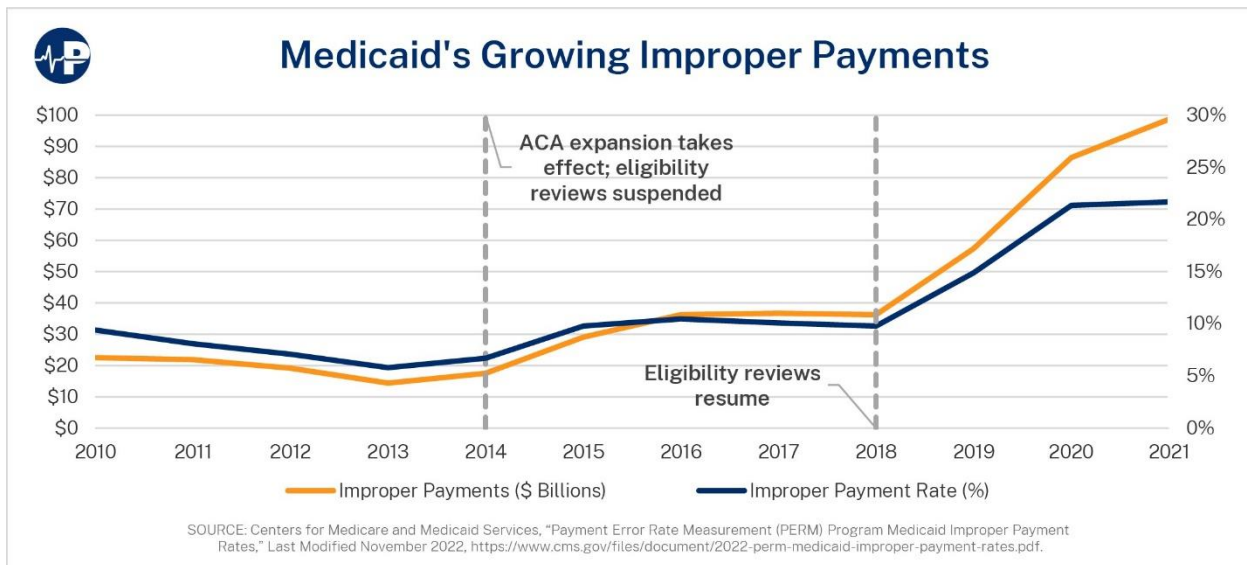
²² CMS, Office of the Actuary, “2018 Actuarial Report of the Financial Outlook for Medicare,” Table 22, <https://www.cms.gov/files/document/2018-report.pdf>

²³ Jonathan Ingram and Nic Horton, “A Budget Crisis in Three Parts”

²⁴ CMS, “Medicaid and CHIP 2013 Improper Payments Report,” <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2013MedicaidandCHIPImproperPaymentsReport.pdf>

²⁵ CMS, “PERM Error Rate Findings and Reports,” <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicaid-and-chip-compliance/perm/permerrorratefindingsandreport>

²⁶ CMS, “PERM Program Medicaid Improper Payment Rates,” last modified November 2022, <https://www.cms.gov/files/document/2022-perm-medicare-improper-payment-rates.pdf>



study from economists at MIT, Harvard, and Dartmouth that looked at Oregon's pre-ACA expansion of Medicaid, "welfare benefit to recipients from Medicaid per dollar of government spending range[s] from about \$0.2 to \$0.4."²⁷

4. Expansion led to a reallocation of services away from existing Medicaid enrollees.

With Medicaid expansion comes a surge in demand for health care services, and a resulting reallocation of services. The people who suffered the most are existing Medicaid enrollees. Former public trustee for the Medicare and Social Security program Charles Blahous co-authored research in 2022 which found "strong evidence of a shift of financial resources away from certain vulnerable enrollee populations, the most notable being from low-income children" and instead toward non-disabled, working age adults. According to Blahous and Sigaud, "[p]er capita Medicaid spending growth on children in expansion states was less than one-third what it was in nonexpansion states and less than one-quarter of national average per-capita healthcare spending growth." Medicaid enrollment of the disabled and spending growth rates on the aged also declined in expansion states.²⁸

5. Expansion led to a significant crowd-out of private health coverage.

The expansion of Medicaid leads to a decline in private health coverage, which typically has superior access to care. Two main sources of crowd-out result from Medicaid expansion. First, people in households with income between 100-138 percent of the FPL enrolled in an exchange plan would lose eligibility for a premium tax credit and replace the exchange plan with Medicaid. Second, many individuals insured through employer plans would lose that plan and move to Medicaid.

²⁷ Amy Finkelstein, Nathaniel Hendren, and Erzo F. P. Luttmer, abstract of "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," Massachusetts Institute of Technology, working paper, June 2015.

²⁸ Charles Blahous and Liam Sigaud, "The Affordable Care Act's Medicaid Expansion Is Shifting Resources Away from Low-Income Children," Mercatus Center, December 13, 2022, <https://www.mercatus.org/research/research-papers/affordable-care-acts-medicare-expansion-shifting-resources-away-low-income>

Several studies show that the crowd-out from previous Medicaid expansions was significant. Economists David Cutler and Jonathan Gruber estimated that Medicaid expansion in the late 1980s and early 1990s led to a 50 percent crowd-out, meaning one out of every two people newly enrolled in Medicaid replaced private coverage with Medicaid.²⁹ Gruber and Kosali Simon estimated a crowd-out rate of 60 percent for expansions for children from 1996 through 2002, while more recent studies find crowd-out ranges from 35 to 43 percent.^{30,31} As mentioned above, Milliman estimated a crowd-out rate of 65 percent if Florida were to expand Medicaid.

6. Expansion reduced access to care.

While supporters of Medicaid expansion expect that expansion will help people obtain health care, evidence shows that Medicaid enrollees have significantly less access to timely and proper health care services. Medicaid's historically low physician payment rates have led to many providers refusing to treat Medicaid enrollees, forcing Medicaid enrollees to receive a disproportionate amount of non-emergent care in emergency rooms. Fewer than one-third of Texas doctors accepted Medicaid patients in 2010.³²

In expansion states, Medicaid recipients have had even greater challenges finding providers to treat them. One post-expansion study found that one-third of primary care physicians do not accept Medicaid patients.³³ A 2015 survey of primary care providers showed that 45 percent of providers were willing to accept new Medicaid patients, compared to 94 percent willing to accept privately insured patients. Medicaid recipients in expansion states experience long wait times, reduced appointment availability, and increased wait times for ambulances, all of which lead to delayed medical care.^{34,35} According to a 2019 meta-analysis, Medicaid patients were 1.6 times less likely to obtain a primary care appointment and 3.3 times less likely to obtain a specialty appointment than people with private insurance. The study also found that, prior to expansion, Medicaid patients were half as likely as someone with private insurance to get an appointment, while patients were only one-third as likely as someone with private insurance to get an appointment after states expanded.³⁶

7. Expansion did not help hospitals.

Hospitals can lose money through expansion, since expansion leads to crowd-out of private

²⁹ David M. Cutler and Jonathan Gruber, "The Effect of Medicaid Expansions on Public Insurance, Private Insurance and Redistribution," *American Economic Review* 86, no. 2 (May 1996): 378-383, <https://www.jstor.org/stable/2118156>

³⁰ Jonathan Gruber and Kosali Simon, "Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?," *Journal of Health Economics* 27 (2008): 201-17.

³¹ Robert Kaestner et al., "Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply," *Journal of Policy Analysis and Management* 36, no. 3 (Summer 2017): 608-642, <https://doi.org/10.1002/pam.21993>. This study assessed the effect of Medicaid expansion on non-high-school graduates and low-income adults and found modest private crowd-out. Conor Lennon finds a 43 percent crowd-out rate consisting of a 10.7 percentage point relative increase in Medicaid coverage among low-income adults and a 4.6 percentage point relative decline in private health insurance among respondents in states that expanded Medicaid eligibility. Conor Lennon, "Did the Affordable Care Act's Medicaid Eligibility Expansions Crowd Out Private Health Insurance Coverage?," University of Louisville, November 12, 2021, http://www.conorjennon.com/uploads/3/9/6/0/39604893/mcicaid_crowd_out_-_august_2021.pdf.

³² Associated Press, "Doctors Threaten to Pull Out of Texas Medicaid," July 11, 2010, <https://www.cbsnews.com/news/doctors-threaten-to-pull-out-of-texas-medicaid/>

³³ Kayla Holgash and Martha Heberlein, "Physician Acceptance of New Medicaid Patients," Medicaid and CHIP Payment and Access Commission, January 24, 2019, <https://www.macpac.gov/publication/physician-acceptance-of-new-medicaid-patients-new-findings/>

³⁴ Sarah Miller and Laura Wherry, "Health and Access to Care during the First 2 Years of the ACA Medicaid Expansions," *New England Journal of Medicine* 376 (2017): 947-956, <https://www.nejm.org/doi/full/10.1056/NEJMsa1612890>

³⁵ Charles Courtemanche et al., "The Affordable Care Act and Ambulance Response Times," *Journal of Health Economics* 67 (2019), <https://www.sciencedirect.com/science/article/abs/pii/S0167629618300523>

³⁶ Walter Hsiang et al., "Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis," *Inquiry* 56 (January-December 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6452575/>

insurance that pays 40 percent more on average than Medicaid for services.³⁷ In a 2023 report, FGA found that Medicaid shortfalls (the difference between the costs of providing the service and the Medicaid payment received) between 2013 and 2016 at hospitals in expansion states grew by roughly 50 percent. Hospital profit margins increased in non-expansion states and declined by 10 percent in expansion states. Nearly 50 hospitals in Medicaid expansion states closed after those states adopted expansion.³⁸ A 2024 FGA report found that hospital profits increased in non-expansion states and decreased in expansion states between 2013 and 2021, in part because hospital shortfalls grew in expansion states.³⁹ According to FGA's estimates, the current Texas Medicaid shortfall would grow from \$410 million to \$864 million if the state adopts expansion.⁴⁰

8. Expansion caused emergency room use to surge.

Medicaid expansion results in a surge of emergency room utilization for non-emergent care. According to Oregon's 2008 Medicaid expansion experiment, Medicaid coverage significantly increased emergency room use for non-emergent care.⁴¹ Brookings Institution also found a 20 percent increase in hospital use for newly enrolled individuals after the ACA's Medicaid expansion, with the increase primarily occurring through emergency room visits for conditions "treatable outside of the emergency department."⁴² A 2018 academic paper assessed Medicaid expansion in California and found a significant increase in emergency department use and spending with the increased utilization being driven entirely by those who replaced private insurance with Medicaid.⁴³

9. Medicaid enrollment does not produce clear health benefits to those gaining Medicaid.

According to a study assessing outcomes from 900,000 major operations in the United States, Medicaid patients were twice as likely to die in the hospital as were people with private insurance and 13 percent more likely to die in the hospital than the uninsured.⁴⁴ Separately, the 2008 Oregon Medicaid expansion experiment showed that while Medicaid enrollment increased health care utilization, there was no significant improvement in basic measures of physical health such as blood pressure, cholesterol, and blood sugar.⁴⁵ The results of the Oregon experiment mirror results from a RAND health insurance experiment in the 1970s and 80s, showing that more generous health insurance leads to more health care utilization but not improved health outcomes.⁴⁶

³⁷ John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," CMS, Office of the Actuary, June 5, 2018, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf>

³⁸ Hayden Dublois, "Medicaid Expansion Is Closing Hospitals," FGA, February 10, 2023, <https://thefga.org/research/medicaid-expansion-is-closing-hospitals/>

³⁹ Hayden Dublois and Michael Greibok, "Medicaid Expansion Dramatically Increases Hospital Shortfalls...and Puts Their Futures at Risk," The Foundation for Government Accountability, March 8, 2024, <https://thefga.org/research/medicaid-expansion-dramatically-increases-hospital-shortfalls/>

⁴⁰ Id.

⁴¹ Sarah L. Taubman et al., "Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment," Science, January 2, 2014, <https://www.science.org/doi/10.1126/science.1246183>

⁴² Craig Garthwaite et al., "All Medicaid Expansions Are Not Created Equal: The Geography and Targeting of the Affordable Care Act," Brookings Institution, September 5, 2019, <https://www.brookings.edu/wp-content/uploads/2020/10/Garthwaite-et-al-final-draft.pdf>

⁴³ Cameron Ellis and Meghan Esson, "Crowd-Out and Emergency Department Utilization," Fox School of Business Research Paper No. 18-038, July 16, 2018, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3214825

⁴⁴ Damien J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," Annals of Surgery 252, no. 3 (September 2010): 544-551, https://journals.lww.com/annalsofsurgery/Abstract/2010/09000/Primary_Payer_Status_Affects_Mortality_for_Major.16.aspx

⁴⁵ Katherine Baicker et al., "The Oregon Health Insurance Experiment," <http://www.nber.org/oregon>. The Oregon Medicaid expansion experiment did find improved self-reported health and a reduction in the prevalence of depression.

⁴⁶ Robert H. Brook et al., "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," RAND Corporation, 2006, https://www.rand.org/pubs/research_briefs/RB9174.html

10. Expansion possibly resulted in negative overall population health outcomes.

Since the public health insurance expansion leads to a surge in demand for care with a relatively fixed supply of care, the resulting reallocation of resources reduces access to care for many other people in the state, particularly existing Medicaid recipients. In Tennessee's expansion of Medicaid through TennCare in the late 1990s, the expanded program was not associated with much of a change in overall utilization, which shows evidence of a relatively fixed supply of care. After TennCare, individuals reported worse health in Tennessee than in neighboring states, fewer people — women in particular — received regular check-ups, and, despite similar mortality trends among Tennessee and its neighboring states in the pre-expansion period, post-TennCare mortality trends in Tennessee were worse than all eight of the neighboring states.⁴⁷

In a paper I coauthored for the Texas Public Policy Foundation (TPPF) in 2020, I found that mortality for non-elderly adults worsened in expansion states relative to non-expansion states after the ACA's key provisions took effect.⁴⁸ From 2014 to 2017, the first three years of the ACA's coverage expansion, life expectancy declined across the United States. A contributing factor to these trends could be that Medicaid expansion states experienced a greater increase in opioid related deaths than non-expansion states after 2013.

In the TPPF paper, I did a thorough review of academic papers on the health effects of Medicaid and Medicaid expansion. My conclusion was that large public coverage expansions disappoint for several reasons: uninsured people receive nearly 80 percent as much care as similar insured people, the large crowd-out of superior private coverage, and indirect effects on others such as longer wait times for care.

11. Expansion produced negative incentives for work.

In 2015, the Congressional Budget Office estimated that Medicaid expansion would reduce newly eligible individuals' participation in the labor force by almost four percent. CBO also projected that the ACA would decrease the labor supply by 0.86 percent, or about two million full-time equivalent workers, in 2025.⁴⁹ A study from 2014 to 2016 found that employment was reduced by 1.6 percent in states that expanded Medicaid and a second study found that public insurance reduced employment by 5 percentage points in Wisconsin.^{50,51} Yet another study found that, in states with expanded Medicaid, older workers were more likely to retire in states that adopted expansion.⁵²

⁴⁷ Brian C. Blase, "Statewide Health Impact of Tennessee's Medicaid Expansion" (PhD diss., George Mason University, 2013).

⁴⁸ Brian Blase and David Balat, "Is Medicaid Expansion Worth It? A Review of the Evidence Suggests Targeted Programs Represent Better Policy," Texas Public Policy Foundation, April 2020, <https://www.texaspolicy.com/wp-content/uploads/2020/04/Blase-Balat-Medicaid-Expansion.pdf>

⁴⁹ Edward Harris and Shannon Mok, How CBO Estimates the Effects of the Affordable Care Act on the Labor Market, Congressional Budget Office, December 2015, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/workingpaper/51065-acalabormarketeffectswp.pdf>

⁵⁰ Audrey Guo and Jonathan Zhang, "Labor Market Effects of Medicaid Expansion and Premium Subsidies: New Evidence from Panel Data," Santa Clara University, Leavey School of Business, July 19, 2021, <https://www.scu.edu/business/economics/research/papers/labor-market-effects-of-medicaid-expansion-and-premium-subsidies-new-evidence-from-panel-data.html>

⁵¹ Lizhong Peng, Xiaohui Guo, and Chad Meyerhoefer, "The Effects of Medicaid Expansion on Labor Market Outcomes: Evidence from Border Counties," *Health Economics* 29, no. 3 (March 2020): 245-260, <https://onlinelibrary.wiley.com/doi/10.1002/hec.3976>

⁵² Sezen O. Onal, "Does the ACA Medicaid Expansion Encourage Labor Market Exits of Older Workers?," *Journal of Labor Research* 44 (June 2023): 56-93, <https://link.springer.com/article/10.1007/s12122-023-09342-9>

12. Expansion led to a windfall for health insurers, the main beneficiaries of expansion.

The surge in Medicaid enrollment and spending drastically increased revenue for insurers participating in Medicaid, as over 70 percent of Medicaid recipients are enrolled in managed care.⁵³ In inflation-adjusted dollars, Medicaid spending through managed care organizations has quadrupled from around \$100 billion in 2010 to \$420 billion in 2021.⁵⁴ Insurers have fared very well from the ACA's large subsidies, including Medicaid expansion, with insurer stock prices outpacing the S&P 500 by three times over the past decade.⁵⁵

Enrollment and Cost Implications of Medicaid Expansion in Texas

Paragon's back-of-envelope estimates suggest that 3.1 million people would be added to Medicaid if Texas were to adopt expansion. This includes 1.9 million low-income people in households with income between 100-138 percent of the FPL who selected an exchange plan during the 2024 open enrollment period.⁵⁶ If Texas expands Medicaid, these individuals will replace their exchange plan with Medicaid, as would many people who have income below 100 percent of the FPL.⁵⁷ Based on Milliman's projections for Florida, we estimate that about 0.2 million Texans would replace an employer plan with Medicaid if the state expands. Thus, consistent with the Florida projections, only about one-in-three new Medicaid enrollees would otherwise be uninsured.⁵⁸ If Texas were to adopt expansion, two-thirds of new Medicaid enrollees would be people who replaced private coverage, principally an exchange plan, with welfare.

Medicaid enrollment would increase from about 13.2 percent of the state population to 23.2 percent if Texas adopts expansion. And the ratio of workers per Medicaid recipient would decline from 3.4 workers per recipient to 2.0 workers per recipient.

For the 1.9 million low-income Texans on the exchange, the federal government is bearing the entire cost of subsidizing their health insurance with no state contribution. If the state were to adopt expansion, the state would bear 10 percent of the cost. The Texans under 138 percent of the FPL will receive roughly \$13 billion in federal subsidies this year.⁵⁹ Assuming this entire population is converted to Medicaid coverage with a similar overall cost of Medicaid and an exchange plan, the state's cost of covering these people would be about \$1.3 billion under a 90 percent match.⁶⁰ Over

⁵³ Elizabeth Hinton and Jada Raphael, "10 Things to Know About Medicaid Managed Care," KFF, March 1, 2023, <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

⁵⁴ Health Management Associates, "Medicaid Managed Care Spending Tops \$420 Billion in 2021," September 1, 2022, <https://www.healthmanagement.com/blog/medicaid-managed-care-spending-tops-420-billion-in-2021/>

⁵⁵ Paragon Health Institute, "Insurer Stock Prices Soaring After Giant ACA Subsidies," <https://paragoninstitute.org/paragon-pic/insurer-stock-prices-soaring-after-giant-aca-subsidies/>

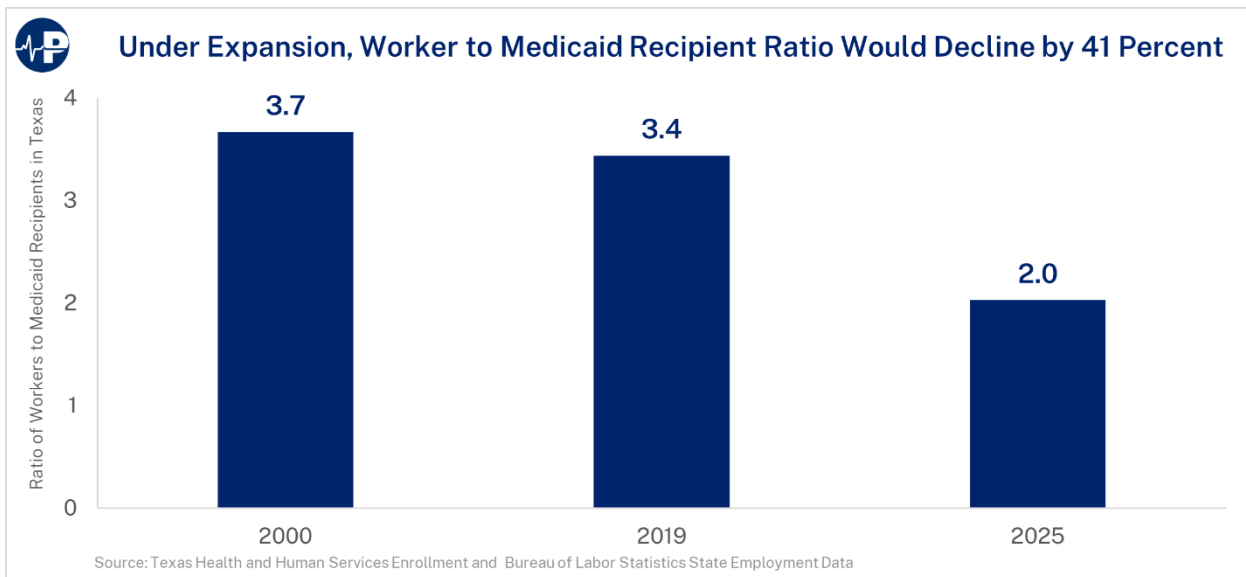
⁵⁶ This combines data from the open enrollment file and Drake, Tolbert, Rudowitz and Damico, "How Many Uninsured Are in the Coverage gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?," <https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/>

⁵⁷ CMS "2024 Marketplace Open Enrollment Period Public Use Files," <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files>

⁵⁸ To estimate the number of Texans replacing an employer plan, we assumed this proportion to be consistent with the proportion estimated for Florida by Milliman in its 2023 analysis.

⁵⁹ This calculation is derived by multiplying the average premium of Texas enrollees on the exchange (\$6,792) by the number of plan selections from the 2024 open enrollment file, 1.9 million.

⁶⁰ This calculation assumes that the state's cost of covering each enrollee remains the same as the average premium on the exchanges, \$6,792. This, however, is likely not to be the case. The per-person cost of covering a traditional adult Medicaid enrollee in Texas in 2021 was \$8,381. In most states, states are spending more on expansion adults than existing non-disabled, working-age adults on a per-person basis. However, assuming Texas can cover these enrollees at the cost of a traditional adult, costs to the state rise to \$1.6 billion a year at a 90 percent FMAP. Each



the first decade of expansion, we estimate that total taxpayer costs of the Medicaid expansion would be \$189 billion and state costs would exceed \$18.4 billion.⁶¹

As highlighted above, when Congress is forced by the deteriorating U.S. fiscal position, including higher interest rates and inflation, to pursue long-term deficit reduction, Congress will likely consider proposals that reduce the FMAP for the expansion population. Reducing the expansion FMAP has attracted bipartisan support in the past. As discussed earlier, President Obama included a proposal to reduce the expansion FMAP in his 2012 budget. Many other congressional proposals have gone further. The American Health Care Act, which passed the House of Representatives in May 2017, phased out the expansion FMAP.

If Congress were to adopt a policy phasing out the expansion FMAP, the cost to Texas for expanding Medicaid would be substantial. Using Texas' standard FMAP, the state share of the expansion population would be roughly \$72 billion over the decade. For only the population that lost exchange coverage and gained expansion coverage, a population that currently has coverage at zero additional cost to the state, the state share would be about \$47 billion over a decade.

Alternatives to Medicaid Expansion

In the 2020 TPPF paper, I noted that "Recent research from economists Nathaniel Hendren and Ben Sprung-Keyser showed that health programs geared toward lower-income children had a substantially positive rate of return but that the return was negative for health programs broadly targeted at lower-income adults (Hendren and Sprung-Keyser). Additionally, programs that focus aid on providers that care for lower-income populations are almost certainly a better public investment than programs aimed at boosting coverage. For example, federally qualified community health centers have been shown to have a much higher cost-effectiveness with respect to reducing

additional 1 million enrollees on Medicaid results in \$840 million in additional state costs. The American Rescue Plan Act signed in March 2021 offers non-expansion states a five-percentage point increase in their expansion FMAP for two years after expansion.

⁶¹ The federal taxpayer costs would be significantly less than this amount since enrollees with income between 100-138 percent of the federal poverty level would replace a subsidized exchange plan with Medicaid.

mortality than Medicare (Bailey and Goodman-Bacon). Ultimately, the enormous outlays of economic resources plowed into Medicaid expansion likely could have been used in a variety of ways to better improve the economic well-being and health of Americans.”⁶²

For a set of positive health reforms Texas can consider that would expand consumer choice, increase beneficial competition to the state’s health care market, and reform government programs, I would direct you to Paragon’s state health reform book, *Don’t Wait for Washington: What States Can Do To Reform Health Care Today*. This book contains chapters on how states can reform the state employee health plan to obtain broader reforms in the state health care market, conduct vigorous oversight of Medicaid, expand coverage options like Farm Bureau plans (which Texas did in 2021) and short-term limited-duration health insurance, repeal certificate of need laws, permit health care providers to practice to the top of their training, and expand telehealth coverage. In addition to this list, states should consider requiring site-neutral payments in their Medicaid and state employee health programs to avoid unnecessary overpayments to hospitals and reduce incentives for consolidation in the state health sector.

Texas expanded Farm Bureau plans for health coverage in 2021. Farm Bureau plans are extremely attractive coverage for many individuals and households. The state has determined that this coverage is not considered health insurance for state regulatory purposes, which exempts this coverage from federal insurance regulation, including the ACA. As such, people have access to high-quality coverage that is more affordable and, unlike ACA plans, they can enroll anytime during the year. There is initial underwriting to get an offer of coverage, but the coverage is renewed at standard price increases regardless of the change in an individual’s health status.

Finally, Texas can consider Indiana’s approach to help small employers offer coverage to their workers by making individual coverage health reimbursement arrangements (ICHRA) more attractive. With an ICHRA, employers can use pre-tax dollars to reimburse the premiums for individual market coverage selected by their employees. In 2023, Indiana enacted a temporary (two-year) tax credit for employers with less than 50 full-time employees that offer ICHRA.⁶³ The ICHRA tax credit helps small employers offer coverage, would improve Texas’s individual market, and would reduce Medicaid enrollment.

⁶² Brian Blase and David Balat, “Is Medicaid Expansion Worth It? A Review of the Evidence Suggests Targeted Programs Represent Better Policy,” Texas Public Policy Foundation, April 2020, <https://www.texaspolicy.com/wp-content/uploads/2020/04/Blase-Balat-Medicaid-Expansion.pdf>

⁶³ Brian Blase and Al Hubbard, “To Improve Health Care, Let Consumers Choose,” Newsweek, May 15, 2023, <https://www.newsweek.com/improve-health-care-let-consumers-choose-opinion-1799776>