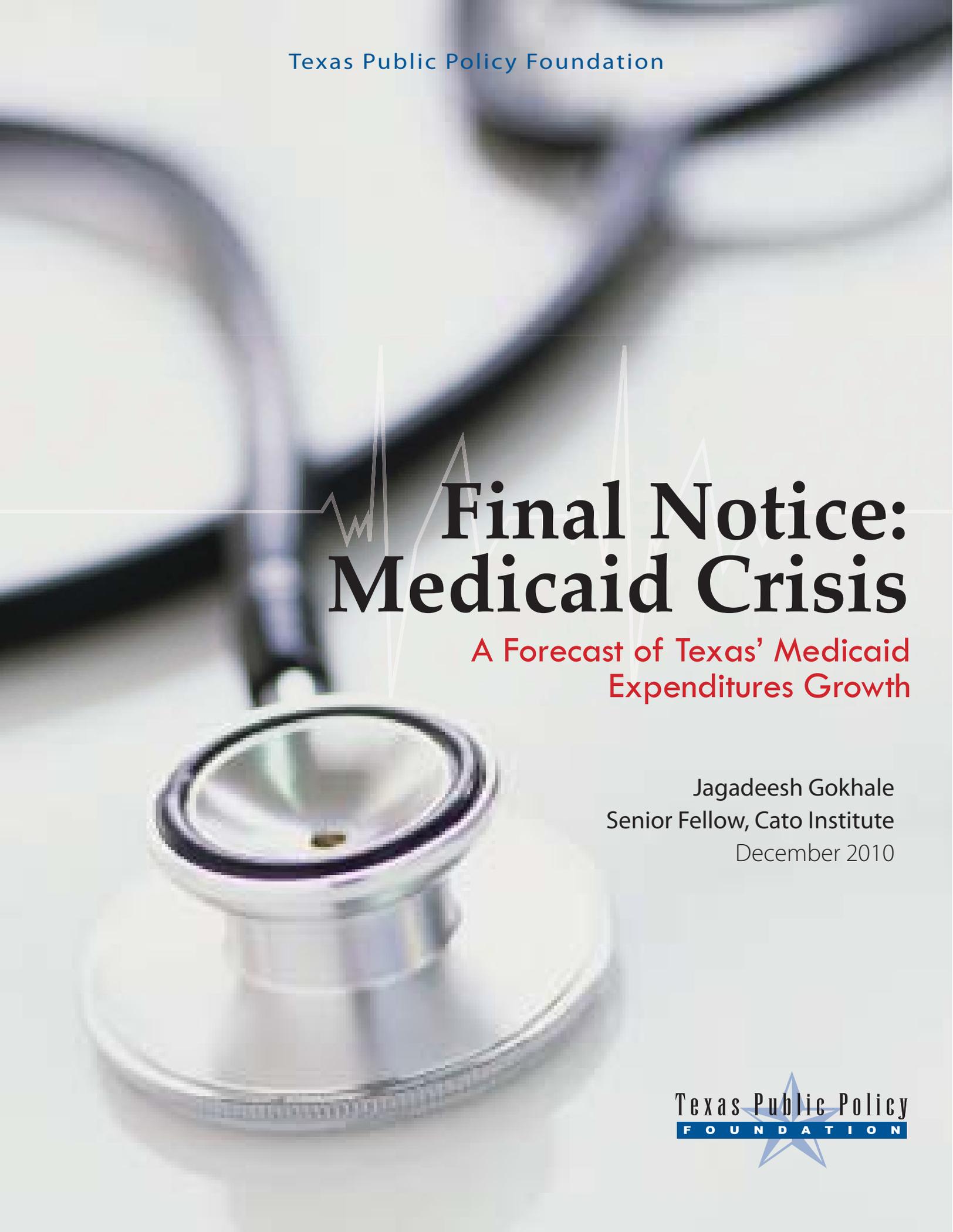


Texas Public Policy Foundation



# Final Notice: Medicaid Crisis

A Forecast of Texas' Medicaid  
Expenditures Growth

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**Table of Contents**

Executive Summary ..... 3

Introduction.....4

Medicaid: Programs, Coverage, and Financing  
in the Texas Budget .....5

Texas Medicaid: The Situation Before and After  
ObamaCare .....6

Texas Medicaid Expenditure Projections ..... 7

Conclusion.....11

Appendix: Methodology.....12

Endnotes.....22

# Final Notice: Medicaid Crisis

## A Forecast of Texas' Medicaid Expenditures Growth

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### Executive Summary

The Patient Protection and Affordable Care Act of 2010 (ObamaCare) expands Medicaid eligibility and introduces an individual mandate for all U.S. citizens and legal permanent residents to purchase health insurance. Under the new law—which will become fully effective in 2014—the federal government will almost fully cover the cost of those *newly eligible* for Medicaid through 2019, with federal financial support expected to be extended thereafter. However, additional federal financial support is not provided for *new enrollees among those eligible for Medicaid under the old laws*. The individual health insurance mandate makes it virtually certain that many more “old-eligibles” will enroll in Medicaid and increase states’ Medicaid financing burden significantly. This study examines the potential increase in Medicaid costs from ObamaCare for the State of Texas—one of several states that have challenged the validity of the individual health insurance mandate in court. This study constructs Texas’ Medicaid spending projections under ObamaCare to reveal the implied increase in that state’s Medicaid spending commitments from the new health care law. More importantly, through the spending projections *without* ObamaCare, this study shows that the Medicaid program could not be sustained for too much longer without imposing crushing new financial burdens on state residents. ObamaCare makes the situation even worse.

Under pre-ObamaCare laws, projected total Medicaid spending in Texas over the period 2014-23 would have increased by \$44 billion on the General Revenue (GR) basis and by \$112 billion on the All Funds (AF) basis (which includes federal grants) compared to keeping nominal Medicaid spending constant during that period. This projected increase—excluding the effects of ObamaCare—arises primarily because of rising health care costs; and some of it because of higher projected enrollments. The introduction of ObamaCare is estimated to increase Texas’ GR funded Medicaid costs by an additional \$31.2 billion during the first 10 years of its implementation by spurring enrollments among old-eligibles. Medicaid costs on an AF basis are projected to increase by an additional \$198 billion during the first 10 years of implementing ObamaCare. Thus, GR funds’ cumulative Medicaid spending growth is projected to be 71 percent larger; and AF Medicaid spending is projected to be a whopping 177 percent larger under ObamaCare during 2014-23. Given the strain being placed on the federal budget by deficits, debt, and the unfunded liability for Social Security and Medicare, the prospect for pushing more responsibility to the states for Medicaid seems likely. Under the assumption that the enhanced federal cost sharing rate will be reduced for newly eligible Medicaid enrollees back to the current, lower rate for old-eligibles, the 10-year Texas GR funding cost of Medicaid would increase to \$38.6 billion because of ObamaCare. The sizable prospective increase in Medicaid costs under ObamaCare may prompt Texas and other similarly affected states to consider alternatives to Medicaid in providing basic health care support to their low-income and medically needy populations.

## Introduction

This paper focuses on Medicaid expenditures in the state of Texas. Ever since the introduction of Medicaid during the mid-1960s surge in Great Society programs, state policymakers have had to constrain spending on infrastructure, education, and other vital public services because of the growing burden of funding Medicaid expenditures. The Patient Protection and Affordable Care Act (ObamaCare) enacted in March 2010 promises to expand, yet again, states' Medicaid funding burdens by increasing enrollments among those already eligible for Medicaid and expanding eligibility to Medicaid benefits for additional categories of people and for income groups both above and below the federal poverty level (FPL).

Medicaid enrollments and health care costs per capita have been growing rapidly during recent years, causing Texas state Medicaid expenditures to increase more rapidly than the Texas economy and state government revenues. This study projects Medicaid cost growth into the future on a pre- and post-ObamaCare basis to explore by how much the burden of financing Medicaid will accelerate in the state of Texas because of the new health care law. The results suggest that even without ObamaCare, Texas would have experienced rapid growth in future Medicaid spending; and ObamaCare is projected to hasten Medicaid enrollments, thereby reinforcing upward pressure on health care costs and transmitting downward pressure through the state budget on other vital public services.

As described in the Appendix, Texas' historical Medicaid eligibility, enrollment, reciprocity, and per-recipient benefit rates are extended into the future—separately for detailed demographic and special-eligibility population groups. The projections are first implemented by excluding the effects of ObamaCare: They suggest that total Texas All Funds (AF, which includes state funds and federal grants) Medicaid expenditures would more than double, increasing from \$46.2 billion in the 2008-09 biennium (28.2 percent of AF expenditures) to \$97.2 billion by the 2020-21 biennium (32.0 percent of projected AF expenditures), and to \$366.4 billion by the 2040-41 biennium (39.3 percent of projected AF expenditures).

Taking just GR funded Medicaid expenditures, Texas' Medicaid expenditures would increase from \$16.6 billion in the 2008-09 biennium (20.1 percent of GR expenditures) to

\$38.3 billion by the 2020-21 biennium (24.2 percent of GR expenditures), and to \$144.5 billion by the 2040-41 biennium (29.7 percent of GR expenditures).

Thus, even if ObamaCare had not been enacted, projected growth in Texas' Medicaid spending beyond 2014 would have been on a trajectory that appears to be unsustainable. Adding ObamaCare's expansion of eligibility for Medicaid coverage in Texas would increase Texas' AF Medicaid expenditures to \$139.5 billion by the 2020-21 biennium (45.9 percent of AF expenditures), and to 460.5 billion by the 2040-41 biennium (49.4 percent of AF expenditures). On a GR funding basis (excluding federal grants), ObamaCare increases Medicaid expenditures to \$45.6 billion in the 2020-21 biennium (28.7 percent of GR expenditures), and to \$160.4 billion by the 2040-41 biennium (33.0 percent of GR expenditures).

Assuming that all enrollment increases take effect fully during the 2014-15 biennium—when ObamaCare laws become fully effective—the increase in Texas' Medicaid budget costs would take up an additional 3.8 percentage points (increasing from 23.3 percent to 27.1 percent) of the Texas GR funds. The corresponding cost increase would be by 4.6 percentage points by the 2020-12 biennium, and by 3.3 percentage points by the 2040-41 biennium. The reason for the decline in the percentage point difference in later biennia is the exhaustion of the potential for additional enrollments in later years relative to enrollments projected by excluding ObamaCare. The cumulative additional Medicaid cost for the first 10 years of ObamaCare (2014-23) is estimated to be \$31.2 billion on a GR budget basis and \$198 billion on an AF basis.

Under ObamaCare, the Federal government is to pay the full cost for those newly made eligible for Medicaid during the first three years (2014-16). Under the new law, the *marginal federal cost sharing rate* (for newly eligible Medicaid enrollees) would be gradually reduced from 100 percent to 92.8 percent by 2019. The standard expectation (or assumption) among budget experts is that the marginal cost sharing rate will remain at 92.8 percent after 2019. However, the federal budget is already under considerable strain with unprecedented budget deficits projected through 2019 and beyond. That puts all programs funded out of federal general revenues, including Medicaid support for states, at risk. To account for a possible further reduction in federal

marginal cost sharing for newly eligible Medicaid beneficiaries, Medicaid's cost profile for Texas is calculated under alternative assumptions regarding federal financial participation beyond 2019. For instance, assuming that federal financial support for newly eligible Medicaid beneficiaries is gradually reduced after 2019 at a rate consistent with making it equal to the standard Federal Medical Assistance Percentage (FMAP) rate after 10 years (after 2028), Texas' Medicaid cost on a GR basis will increase by even more—reaching \$181.6 billion by the 2040-41 biennium (37.4 percent of GR expenditures).

With the enactment of ObamaCare, concern about runaway Medicaid costs is motivating Texas policymakers to find ways to restrain Medicaid expenditures. One way would be to reduce costs and eliminate waste, fraud, and abuse while attempting to maintain benefits for the most vulnerable groups. Another method receiving serious consideration are alternatives to Medicaid in providing basic health coverage to low-income and medically needy groups financed exclusively out of GR funds.

## Medicaid: Programs, Coverage, and Financing in the Texas Budget

Medicaid refers to the collection of state-operated welfare programs providing subsidized health care to low-income and medically needy individuals. Federal guidelines specify individuals who must be covered based on income and asset thresholds, medical conditions, and special groups such as children, the disabled, the aged, and pregnant women. However, states exercise discretion in covering additional groups—by expanding income and asset eligibility thresholds beyond federally mandated levels and by including special categories of medically needy individuals. For example, Texas covers children and pregnant women whose family incomes are insufficient to cover medical costs even though they exceed the state's eligibility levels. Those eligible for Medicaid coverage under various optional programs in Texas include non-disabled children and their related caretakers, pregnant women, the aged, blind, disabled, and others with necessary medical costs in excess of their incomes.<sup>2</sup>

Texas' Medicaid programs cover the full range of health care service costs including physician, hospital (in-and out-patient), lab, nursing, home health care, and pharmacy

costs. These costs are shared by Texas' treasury and the federal government. Federal shares of states' Medicaid costs are determined by the FMAP formula based on per-capita income in each state relative to the national per-capita income.<sup>3</sup> The statutory minimum FMAP percentage for all states is 50 percent, the maximum being 83 percent. The average FMAP value across all states is about 59 percent. During 2009-10, FMAP rates were higher than normal because of the temporary FMAP enhancement enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009. Texas' FMAP pre-ARRA values for fiscal years 2009 and 2010 are set by the department of health and human services at 59.44 and 58.73, respectively. The ARRA-inclusive (year-end) values are 69.85 and 70.94, respectively. During those two years, therefore, Texas must pay about 30 cents out of each dollar of enrollees' Medicaid costs. Thus, for example, of Texas' total estimated Medicaid spending in 2009 of \$22.9 billion, the state's share would be \$6.9 billion (given its FMAP percentage for that year of 69.85). When making projections of future Texas Medicaid costs, we assume that the 2011 state share of 39.44 percent (one hundred minus the Texas 2011 FMAP percentage of 60.56) will continue to apply to those who are Medicaid eligible on a pre-ObamaCare basis and, unless covered by non-Medicaid insurance, would enroll into Medicaid to satisfy the individual health insurance mandate.<sup>4</sup>

ObamaCare mandates new spending commitments for state governments under Medicaid. Because Texas lawmakers, like those of most other state governments, are constrained by their state's constitutional balanced budget requirement, increased spending commitments from entitlements such as Medicaid—which, once introduced, are difficult to reduce—and plunging revenues from high unemployment are on a collision course. The Texas state budget for the 2010-11 biennium is already facing a revenue shortfall estimated at about \$13 billion with tax collections not expected to rebound for many months. Census Bureau reports show that Texas state revenues from sales, licensing, and other taxes declined by 9 percent between 2008 and 2009.<sup>5</sup>

The budget situation in Texas is complicated by the fact that its constitutional balanced budget requirement is augmented by limits on welfare spending, on the rate of growth of appropriations from certain state taxes, and on debt service.<sup>6</sup> Thus, unless the increased Medicaid spending com-

mitment is consistently matched by federal financial support, it could force steep cuts in other state programs such as education and related human development services, judicial and law-enforcement services, natural resource development, and business and economic support services—or require Texans to pay more taxes. Texas' tax revenues are declining from the recession and the revenue increasing potential of higher taxes remains very low if not nonexistent. That makes the alternative of increasing tax rates to fund additional federally mandated Medicaid coverage economically undesirable: Higher taxes could reduce the state's attractiveness to individuals and businesses and could further jeopardize long-term economic growth.<sup>7</sup> As a consequence, a shift in funding from other budget functions and toward health care appears to be underway already: The 2010-11 Texas budget envisions a 4.4 percent increase in funding for Medicaid but a 3.7 percent reduction in that for business and economic development.<sup>8</sup>

## Texas Medicaid: The Situation Before and After ObamaCare

Texas' Medicaid financing occurs through the state's GR fund plus matching federal funds. Expenditures during the 2008–09 biennium amounted to \$46.2 billion. Appropriations for the 2010-11 biennium are based on temporarily increased FMAP allocation for 2010 from ARRA enacted in 2009.<sup>9</sup> Once ARRA allocations expire, an additional \$6.0 billion in Medicaid funding cost will have to be covered by the Texas budget during the 2012-13 biennium.

ObamaCare expands those eligible for Medicaid by increasing income eligibility thresholds for children and adults. Children living in families with incomes less than 138 percent of the Federal Poverty Level (FPL) (gross with the new 5 percent income disregard added) will now qualify for Medicaid. In addition, adults with or without qualifying children are also made eligible under the new FPL threshold. Expanded eligibility levels under ObamaCare will increase Texas AF Medicaid expenditures. But it will not significantly increase Texas GR Medicaid costs, at least in the short-term, because of the high marginal cost sharing provided by the federal government for newly eligible individuals. Texas GR funded Medicaid costs would increase by little if enrollment rates among those eligible on a pre-ObamaCare basis remains low. That's unlikely, however, because of ObamaCare's individual health mandate that

forces purchase of health insurance or payment of a fine. The mandate will force an increase in enrollment by those who were eligible under the old laws but were not enrolled in Medicaid or any other health insurance plan. Although ObamaCare provides full federal support for newly eligible Medicaid enrollees (through 2019), it provides zero additional support for new enrollees among "old eligibles."

ObamaCare also envisions special efforts to advertise the availability of health care coverage to newly eligible populations—to increase enrollment rates among old and newly eligible children and adults. Texas GR Medicaid costs may also increase if the enrollment facilitation drives envisioned under ObamaCare induces some "old eligibles" to switch from non-Medicaid to Medicaid coverage because the latter is subsidized and imposes zero or minimum cost on beneficiaries. The increase in Texas' future AF and GR Medicaid expenditures will depend substantially on how successful those efforts turn out to be.<sup>10</sup>

In calculating enrollments on a post-ObamaCare basis, it is assumed that enrollments by those newly eligible will either follow the same enrollment rates as those presently eligible or they will enroll at the rate of those with no other health insurance depending on which rate is larger. A similar method is followed for those who are eligible for Medicaid under the old laws but are not enrolled in Medicaid. Applying these rules yields a sizable increase in enrollments in 2014.

Even before the enactment of ObamaCare in March 2010, Texas' Medicaid enrollments were projected to increase substantially. The Medicaid program accounts for more than 80 percent of spending growth in the Texas budget because of projected increases in clients entitled to services under federal law. Table 1 shows Medicaid enrollment projections with and without ObamaCare. It shows that even on a pre-ObamaCare basis, the number of Texans enrolled in Medicaid would have increased rapidly—from about 4.4 million people in 2009 to 5.2 million by 2014 (an increase of about 18 percent). Continuing enrollment trends forward would generate enrollments of 6.3 million by 2020, 8.2 million by 2030, and 10.7 million by 2040. For some demographic and eligibility groups, rates of additional Medicaid enrollments are smaller during the 2040s because enrollments are projected to reach 100 percent by 2030.

**Table 1: Texas Medicaid Enrollments  
Pre- and Post-ObamaCare Basis (in thousands)**

	2009		2014		2020		2030		2040	
	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males
<b>Pre-ObamaCare Basis</b>										
Children	1,380	1,472	1,643	1,751	1,952	2,093	2,448	2,735	3,126	3,582
Non-disabled Adults 19-64	382	31	452	24	567	29	746	39	933	50
Aged	290	139	329	170	394	221	556	352	718	472
Disabled/Blind	237	202	290	248	346	307	452	416	609	552
Other Special Eligibility Categories	246	48	266	59	296	78	378	127	501	197
Total by Gender	2,536	1,892	2,980	2,252	3,555	2,727	4,580	3,669	5,887	4,853
Total (% change from earlier period's value)	4,428		5,232 (18.2)		6,283 (20.1)		8,249 (31.3)		10,740 (30.2)	
<b>Post-ObamaCare Basis</b>										
Children	"	"	1,976	2,046	2,276	2,391	2,810	3,027	3,538	3,869
Non-disabled Adults 19-64	"	"	1,651	1,116	1,923	1,217	2,309	1,419	2,723	1,641
Aged	"	"	527	269	622	337	838	513	1,012	637
Disabled/Blind	"	"	345	369	411	471	538	674	712	947
Other Special Eligibility Categories	"	"	266	59	296	78	378	127	501	197
Total by Gender	"	"	4,764	3,859	5,528	4,494	6,872	5,760	8,485	7,373
Total (% change from earlier period's value)	4,428		8,623 (94.7)		10,023 (16.2)		12,632 (26.0)		15,859 (25.5)	
New Enrollees: Difference Post-minus Pre-ObamaCare (% Increase Post- Over Pre-)			3,391 (64.8)		3,740 (59.5)		4,383 (53.1)		4,985 (47.7)	
New Enrollees (newly eligible)			2,753		3,066		3,562		4,120	
New Enrollees (old eligibles)			638		674		821		999	

Source: Author's calculations based on the Current Population Survey and the Medicaid Statistical Information System.

With ObamaCare, however, Medicaid enrollment increases are projected to accelerate. **Table 1** shows that enrollments would be about 65 percent larger with ObamaCare than without in 2014. By 2040, about 15.9 million Texans would be covered under Medicaid—an increase of 47.7 percent over the pre-ObamaCare projections. The next two sections describe the key results obtained in this paper on the projections of Texas' Medicaid expenditures on a pre- and post-ObamaCare basis. A detailed description of the methods used to obtain the results is provided in the Appendix.

## Texas Medicaid Expenditure Projections

The estimates of the effects of ObamaCare on the Texas budget reported here are based on standard methodology. They assume that those newly eligible for Medicaid under

ObamaCare will either follow the same enrollment rates as those presently eligible or will enroll at the rate of those who do not have non-Medicaid health insurance depending on which rate is larger.<sup>11</sup> A similar method is applied to those previously eligible for Medicaid but not yet enrolled into the program: States must pick up only a small portion of the cost beyond 2016 for those newly eligible for Medicaid under ObamaCare and *all* of the cost for those welfare and low-income individuals who were Medicaid-eligible under the old eligibility rules but were not enrolled in Medicaid. Most of the latter group of individuals would be induced to enroll into Medicaid by the new law's health insurance mandate. Under that mandate such individuals would enroll through health Exchanges and would enroll into Medicaid as a matter of course—unless they prefer coverage through other non-Medicaid sources. These groups' enroll-

ment rates are set to the larger of 1) the pre-ObamaCare enrollment rate among the entire “old-eligible” population and 2) the rate of those uninsured among pre-law eligible-but-not-enrolled individuals estimated from the Current Population Surveys 2000-08.

### Texas Medicaid Expenditure Projections on a Pre-ObamaCare Basis

Table 2 shows Texas Medicaid spending projections beginning with the 2008-09 biennium. The projections are shown in two ways: General-Revenue funds basis and All-Funds basis. The first set of columns show Medicaid expenditures projected on a pre-ObamaCare basis using detailed information on Texas’ Medicaid eligibility rules, enrollment trends, benefit reciprocity among enrollees, and average benefits per enrollee. A detailed description of the methodology used is provided in the Appendix to this paper. **Table 2** (next page) also shows projected shares of Texas Medicaid expenditures in total Texas budget expenditures—again on a GR and AF basis. Texas budget expenditure projections are determined by growing historical expenditures according to projected growth of the Texas economy. That growth rate is projected by assuming that 1) the future growth rate of Texas’ gross state product (GSP) will change in the same direction, and in the same proportion, as the change assumed by the Congressional Budget Office for projected growth in the nation’s gross domestic product (GDP) and 2) Texas state budget expenditures will grow at the same rate as the overall Texas economy.<sup>12</sup>

Table 2 shows the result of extending Texas’ historical trends in Medicaid eligibility, enrollment, reciprocity, and benefits per recipient into the future on a pre- and post-ObamaCare basis. It shows that pre-ObamaCare, AF Medicaid expenditures would more than double, increasing from \$46.2 billion in 2008-09 biennium (28.2 percent of AF expenditures) to \$97.2 billion by the 2020-21 biennium (32.0 percent of projected AF expenditures), and to \$366.4 billion by the 2040-41 biennium (39.3 percent of projected AF expenditures).

Applying the Federal Medical Assistance Percentage (FMAP) rates projected for Texas and taking the ratio of state Medicaid expenditures to total state budget expenditures (the GR fund’s Medicaid share) the Texas Medicaid expenditures would increase from \$16.6 billion in the 2008-09 biennium (20.1 percent of GR expenditures) to \$38.3 billion by the 2020-21 biennium (24.2 percent of GR expenditures), and to \$144.5 billion by the 2040-41 biennium (29.7 percent of GR Funds expenditures). Thus, even if ObamaCare had not been enacted, projected growth in Texas’ Medicaid spending would capture about 10 additional percentage points of Texas budget expenditures on a General Funds basis by 2040-41—which appears to be unsustainable.

One qualification that should be mentioned about long-term Medicaid expenditure shares (as reported in Table 2) is that they are based on relatively crude assumptions about future Texas GDP growth and state expenditure growth. Independent calculations of U.S. demographic and economic trends by the author suggest that future economic growth is

Table 2: Projected Texas Medicaid Spending Pre- and Post-ObamaCare

Biennium	Billions of Dollars						Percent of Projected Texas State Budget Expenditures					
	Pre-ObamaCare		Post-ObamaCare		Difference (Post-Pre)		Pre-ObamaCare		Post-ObamaCare		Difference (Post-Pre)	
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF
2008-09	16.6	46.2	:	:	:	:	20.1	28.2	:	:	:	:
2014-15	26.4	67.0	30.7	101.3	4.3	34.4	23.3	30.8	27.1	46.6	3.8	15.8
2020-21	38.3	97.2	45.6	139.5	7.2	42.2	24.2	32.0	28.7	45.9	4.6	13.9
2030-31	72.5	183.8	82.9	244.7	10.4	60.9	26.1	34.5	29.9	46.0	3.7	11.5
2040-41	144.5	366.4	160.4	460.5	15.9	94.1	29.7	39.3	33.0	49.4	3.3	10.1

Texas Budget Terms: GR=General Revenue funds; AF=All Funds.

Source: Author’s calculations based on the Current Population Survey, the Medicaid Statistical Information System, and CMS-64 Reports.

likely to be even slower than CBO projections. The reason for this includes slower projected population growth and the transition of the baby-boomers from working into retirement. The latter implies a net reduction of experienced workers from the labor force—a factor that the CBO ignores in its calculations. In addition, a changing composition of the population, more intense foreign competition, slower rates of education and skill acquisition, and lower labor-force participation rates (more part- and less full-time work) are projected to partially offset the growth enhancing forces of more capital per worker and better technology.<sup>13</sup> These factors are not considered by the CBO in making future economic growth projections, implying that CBO's 10-year GDP economic growth projections for the nation may be optimistic. It implies, by extension to Texas, that long-term (through 2040-41) estimates of the share of Medicaid spending in total budget expenditures that are reported above may also be optimistic.

### *Texas Medicaid Expenditure Projections on a Post-ObamaCare Basis*

ObamaCare extends medical insurance to the uninsured population by expanding eligibility to Medicaid beginning in 2014. The primary means by which this is accomplished is by increasing the FPL thresholds for determining eligibility. For children, eligibility will now be based on family income less than 133 percent of FPL, with a new 5 percent income disregard for all. The increase means children in families with incomes between 100 and 138 percent of FPL would now become newly eligible for coverage under Medicaid. Adults were earlier eligible based on their children's eligibility. Conditional on incomes being less than 138 percent of FPL, all adults will now become newly eligible for Medicaid—with eligibility no longer linked to their children's coverage status. Pre-ObamaCare, children in foster care who age out of federal conservatorship at age 18 qualify for Medicaid through their 21st birthday in Texas. Post ObamaCare, they would have continued eligibility through age 25. Children who are adopted or who moved out of foster care before 18 could remain eligible only on the basis of pre-ObamaCare child-eligibility rules or the new ObamaCare eligibility rules applicable to adults.

These rule changes significantly expand the number of Medicaid enrollees among those already eligible on a pre-law basis. And ObamaCare will increase the total number of new Medicaid eligibles in the population. The introduc-

tion of ObamaCare increases eligibility among children only slightly—mainly because of the new 5 percent income disregard—because most children in that income category are already covered under Medicaid. However, among those not in special eligibility categories, very few adults were covered on a pre-law basis—by satisfying the Aid to Families with Dependent Children (AFDC), Temporary Assistance for Needy Families (TANF), or Supplemental Security Income (SSI) programs' income eligibility criteria. In many cases, ObamaCare's income based eligibility rule (income less than 138 percent of FPL) would dominate pre-ObamaCare conditional coverage rules based on child-eligibility, disability, pregnancy, qualification for AFDC, TANF, SSI, etc. And the new income based eligibility rule brings in others who are not eligible under the old rules onto Medicaid's rolls. The result is a significant projected increase in new Medicaid-eligibles in 2014 (and beyond) among working aged adults.

One issue in estimating additional Medicaid costs concerns the enrollment rate to apply to those eligible under the old law but not previously enrolled in Medicaid—who must now obtain health insurance because of the individual mandate included in ObamaCare. Some of these individuals have other insurance coverage (private, employer, etc.) or they could be uninsured. Evidence from the Current Population Surveys (2000-08) suggests that those who receive no Medicaid benefits are covered under alternative health insurance programs (private, employer, etc.) at higher rates: between 1 and 1.5 times larger than the alternative coverage rate in the population of Medicaid eligibles. Thus, for calculating the number of pre-law eligible non-enrollees who would enroll into Medicaid because of ObamaCare's individual health insurance mandate, the rate applied to such non-enrollees equals the larger of 1) the original (overall) enrollment rate observed on a pre-ObamaCare basis, and 2) the rate of non-insurance among all eligibles.<sup>14</sup> This procedure is likely to yield conservative estimates of the increased enrollment rate among old-eligibles from ObamaCare's individual health insurance mandate. The reason is that past episodes of Medicaid expansion have induced many people with private insurance coverage to switch to Medicaid—an effect that, in general, is difficult to calibrate and project for future years. We note that past experience in this regard is quite likely to be repeated under ObamaCare because a call to the Exchange for private insurance would be routed to Medicaid if the caller is found to be Medicaid eligible.

Table 1 shows that on a pre-ObamaCare basis, the total number of enrollees into Medicaid is projected to increase from 4.4 million people in 2009 to 6.3 million by 2020, and to 10.7 million by 2040. With ObamaCare, however, the growth in Medicaid caseloads is projected to be even more rapid: enrollments—estimated at 8.6 million in 2014—would be 65 percent larger than the pre-ObamaCare projection. By 2040, caseloads would approach 16 million. Under ObamaCare, most of the enrollment increases are projected to occur among non-disabled adults—those who would qualify on the basis of new eligibility rules and old-eligibles who would be induced to enroll because of the individual mandate. Enrollment facilitation drives proposed under ObamaCare will result in a significant increase in enrollments by old-law eligibles, the cost of whose care will fall on the Texas budget. Not included in these estimates is the effect—among both categories of new enrollees—of switching coverage from private insurance to Medicaid. Note that in Table 1, the pre- and post-ObamaCare counts of special eligibility enrollees are identical—ObamaCare, by itself, is not projected to increase the incidence of health episodes that lead to Medicaid eligibility under these categories.

The last two rows of Table 1 also show that in 2014, about one in five new enrollees are projected to be among old Medicaid eligibles—those who qualify under pre-ObamaCare laws but would now enroll because of the individual health care mandate and cause state GR funded Medicaid expenditures to increase. The calculations assume that en-

rollments among newly eligible and old-eligibles will occur immediately. Under most circumstances, one can expect there to be a lag between when a new health-care law becomes effective and when those made newly eligible enroll into the program. In this case, however, the individual mandate’s fines may induce people to make enrollment decisions very quickly after the law becomes effective.

Medicaid cost projections for Texas resulting from the procedures described earlier are shown in Table 2. Adding ObamaCare’s expansion of eligibility for Medicaid coverage and the individual mandate’s effect on old-eligibles would increase Texas’ AF Medicaid expenditures to \$139.5 billion by the 2020-21 biennium (45.9 percent of AF expenditures), and to 460.5 billion by the 2040-41 biennium (49.4 percent of AF expenditures). On a GR funding basis (excluding federal grants), ObamaCare increases Medicaid expenditures to \$45.6 billion in the 2020-21 biennium (28.7 percent of GR funded expenditures), and to \$160.4 billion by the 2040-41 biennium (33.0 percent of GR expenditures).

Assuming that all enrollment increases take effect during 2014-15 biennium—when ObamaCare laws become fully effective—the increase in Texas’s budget costs would take up an additional \$4.3 billion or 3.8 percentage points (increasing from 23.3 percent to 27.1 percent) of the Texas GR funded budget. The cumulative additional cost for the first 10 years of ObamaCare (2014-23) is estimated to be \$31.2 billion on a GR budget basis and \$198.3 billion on an AF basis.

**Table 3: Projected Texas General Revenue Funded Medicaid Expenditures Under Alternative Marginal FMAP Support Assumptions**

Biennium	Pre-Obamacare	Post-Obamacare Baseline	Post Obamacare FMAP Reduced Gradually	Post Obamacare Marginal FMAP Eliminated After 2028	Pre-Obamacare	Post-Obamacare Baseline	Post Obamacare FMAP Reduced Gradually	Post Obamacare Marginal FMAP Eliminated After 2028
	1	2	3	4	1	2	3	4
	Billions of Dollars				Percent of General-Revenue-Funded Expenditures			
2008-09	16.6	N/A	N/A	N/A	19.2	N/A	N/A	n.a.
2014-15	26.7	32.2	32.2	32.2	23.6	28.4	28.4	28.4
2020-21	39.1	46.9	47.2	48.7	24.6	29.6	29.8	30.7
2030-31	74.7	85.6	89.2	95.7	26.9	30.8	32.1	34.5
2040-41	149.6	165.9	175.6	180.5	30.8	34.1	36.1	37.1

Source: Author’s calculations based on Current Population Surveys, Medicaid Statistical Information System, and CMS-64 Reports.

Given the precarious condition of the federal budget—with unprecedented deficits projected by the Congressional Budget Office through the next 10 years—two alternative projections are constructed for Texas' Medicaid expenditures and expenditure shares. The first incorporates a gradual reduction in marginal federal FMAP support after 2019 and the second a more rapid reduction of the same. The results are shown in **Table 3**.

The first two columns of Table 3 repeat the results of Table 2 on pre- and post-ObamaCare basis. The columns labeled “3” shows that if the marginal FMAP cost sharing rate under ObamaCare is gradually reduced by 1 percentage point per year until it reaches the standard FMAP rate of 60.56 percent, state Medicaid costs on a GR basis would increase to \$174.5 (instead of 160.9 billion) or 35.9 percent of GR funded expenditures instead of 33.0 percent by the 2040-41 biennium.

If after 2019, the marginal FMAP cost sharing rate is reduced in equal step-wise decrements so that federal financial support for newly eligible Medicaid enrollees reverts to the standard FMAP value of 60.56 percent after 2028, Texas' GR funded Medicaid expenditures would increase by even more—to \$181.6 billion, or to 37.4 percent of GR expenditures by the 2040-41 biennium. If marginal FMAP support is targeted for elimination in this manner, the 10-year Texas GR funding cost of Medicaid would increase to \$38.6 billion (up from 31.2 billion under the standard assumptions) because of ObamaCare. Given the fragile status of federal finances—with looming shortfalls on account of Social Security and Medicare—the likelihood that marginal FMAP support would be gradually reduced rather than maintained at its 2019 value of 92.8 percent appears more likely than not.

## Conclusion

A detailed estimate of the effect of ObamaCare on the Texas state budget reveals an unfunded mandate to pay \$31 billion in Medicaid costs over 10 years (2014-23) for a larger group of enrollees from among those eligible for Medicaid under pre-ObamaCare eligibility rules. ObamaCare promises to pay fully for the additional cost of newly eligible enrollees for only 3 years, with the marginal federal cost sharing rate set to decline to 93 percent by 2019. However, given the insecure state of federal finances, the decline in marginal cost sharing for newly eligible Medicaid enrollees may

be steeper, leaving states to fund the additional entitlement from their own resources. If marginal federal cost sharing for this group of enrollees is targeted for elimination by 2028—that is, the applicable FMAP reverts to its standard value of 60.56 percent—Texas' GR funded Medicaid costs would escalate to \$38 billion during the first 10 years of implementing ObamaCare. In addition, state lawmakers are concerned and aware of the need to conserve budgetary resources to meet emergent challenges in the health care sector itself, such as the growing incidence of diabetes projected over coming decades.<sup>15</sup>

It should be noted that the estimates reported here of projected Medicaid costs in Texas, both pre- and post-ObamaCare, are based on standard assumptions and methods for extending eligibility, enrollment, benefit reciprocity, and benefit award rates into the future. The estimates are likely to be conservative for the reasons discussed in this study—mainly because potential future shifts from private coverage to Medicaid post ObamaCare are not fully incorporated. The results are also uncertain because future trajectories of all of these rates will be affected by many factors not considered here—the general economic environment in Texas, the specifics of how ObamaCare laws are implemented, the availability and quality of alternative health insurance coverage for those eligible for Medicaid, and so on.

Concern about runaway Medicaid costs is motivating Texas policymakers to find ways to restrain Medicaid expenditures. One way would be to reduce costs and eliminate waste, fraud, and abuse while attempting to maintain benefits for the most vulnerable groups. These initiatives could include allowing the quality of Medicaid-covered health care services to deteriorate in order to prevent the crowd-out of private health coverage that has historically occurred after every expansion of the Medicaid program. Another possibility is to restructure Medicaid altogether, and still provide basic health coverage to low-income and medically needy groups. Alternatively, supporting such high Medicaid cost increases will require considerably higher taxes or steep reductions in other public services, both of which are economically undesirable. This explains the growing support among citizens and policymakers in Texas—and, presumably, in many other similarly affected states—to alter ObamaCare laws, if not to repeal them. If efforts to repeal ObamaCare are successful or if several of the most populous states opt out of Medicaid, ObamaCare would ultimately produce results that are directly opposed to its proponents' intentions. ☆

## Appendix: Methodology for Projecting Texas Medicaid Expenditures Under ObamaCare

Section A1 explains the general methodology; Section A2 describes how the Texas population is projected; Section A3 describes historical trends of Medicaid eligibility, enrollment, reciprocity, and average benefits per enrollee separately for various demographic groups and eligibility categories—children, adults, the elderly, blind/disabled, and others qualifying for Medicaid under special rules.

### A1. Methodology for Projecting Medicaid Expenditures in Texas

The Medicaid Statistical Information System (MSIS)—State Data Mart website provides administrative information on the number of Medicaid beneficiaries by gender (*g*), age-category (*a*), and eligibility group (*e*) for years 1999-2008. It also provides information on total Medicaid benefits awarded to Texas residents (*B\_Texas*) in those years.

Texans qualify for Medicaid benefits based on a range of income and asset related criteria. In addition, special categories of individuals such as children, pregnant women, aged, blind, disabled, and medically needy individuals qualify for “categorical coverage” even though their incomes and resources exceed federally mandated income and asset qualification thresholds.

First, the total Texas population is calculated by gender, age-category, income range (*f*) relative to the federal poverty level (FPL), and year (*t*), based on data from the Current Population Survey, *CPS\_TXPOP<sub>g,a,f,t</sub>*.<sup>16</sup> Because the CPS undercounts the Texas population relative to Census Bureau counts, the Census population *CEN\_TXPOP<sub>g,a,t</sub>* is also categorized according to gender, age-category, and year cells. The latter population is used to rescale the CPS population counts: For each demographic cell, the ratio of the two populations

$$U_{g,a,t} = \frac{CEN\_TXPOP_{g,a,t}}{\sum_f CPS\_TXPOP_{g,a,f,t}}$$

provides a measure of the cell specific population over- or under-counts in the CPS relative to the Census population. Finally, annual total population counts provided by the

Texas Health and Human Services Commission (HHSC) are used to again rescale each age-gender-year cell to deliver a historical population series applicable to Texas (and the ratio *U<sub>g,a,t</sub>* is also re-adjusted as appropriate).

Next, populations of Texas Medicaid benefit-eligible individuals by demographic cells are calculated from the CPS: *CPS\_E\_TX<sub>g,a,f,t</sub>*. These cells are calculated separately for specific income ranges (*f*) relative to FPL values.<sup>17</sup> Prior to the new health care law, Medicaid’s federal income eligibility threshold was 100 percent of the FPL for children aged 1 through 19. For newborns and pregnant women, the income limit was at 133 percent of FPL, with options for states to increase it up to 185 percent of FPL. The new law increases income eligibility thresholds but also introduces an income disregard at 5 percent of family income. Other special deductions were applied before the new health care laws were enacted. These included items such as work-related and dependent care expenses, child support payments, earnings of children under age 19 and in school, all income from SSI, other public assistance, and educational assistance. Those who have not received Temporary Assistance for Needy Families (TANF) benefits during the last four months must have net income less than the “budgetary needs” levels established by each state after subtracting one-third of the applicants’ earned income. TANF recipients must satisfy the “recognizable needs test”—state determined income thresholds that must exceed the applicants’ income net of deductions (described above) including an additional 90 percent earned income deduction.

The older Aid to Families with Dependent Children (AFDC) program no longer exists, but rules using AFDC qualifying thresholds and conditions still apply to determine Medicaid eligibility. Citizens with dependent children with incomes less than the AFDC qualifying thresholds are Medicaid eligible. In addition, for two parent households, the primary earner must either be unemployed (or disabled), or be earning less than the AFDC income threshold, or be under-employed (working less than 100 hours per month).

SSI recipients are also eligible for Medicaid benefits. SSI qualifying rules consider unearned income (net of a monthly \$20 exclusion) and earned income (net of a monthly \$65 exclusion and an annually determined student earned income exclusion), the sum of which must be below a specific annually indexed dollar threshold (\$11,472 for a couple in 2009). Additionally, retirees and disabled individuals qualify for subsidies to pay for Medicare costs (premiums, copays, etc.) funded out of Medicaid. These rules require individuals to be receiving Social Security or Railroad Retirement benefits and have family income less than 200 percent of FPL. Further, disabled workers with earned income less than 250 percent of FPL qualify for the Medicaid buy-in program.

Finally, women aged 18-44 with incomes below 185 percent of FPL qualify for Medicaid family-planning services (of which pregnant women receive full Medicaid benefits). All of the rules described here are coded to determine eligibility to Medicaid among the CPS sample populations by age, gender, FPL-relative income category, and those eligible under special rules for the years spanning 2000 and 2008—the latest year for which CPS data are available.

Take male Texans aged  $a$  in 2008. Adults qualify for Medicaid coverage if they have a covered child. In turn, the child is Medicaid eligible if the income of the child's family falls within the income threshold or the child qualifies based on non-income related criteria such as disability and foster care (for which the income limits are different). Thus, the eligibility rate,  $e$ , for adults aged  $a$  of gender  $g$  with FPL-relative income  $f$  and in year  $t$  can be calculated conditional on their children's eligibility as

$$e_{g,a,f,t} = \frac{U_{g,a,t} \times E\_CPS_{g,a,f,t}}{U_{g,a,t} \times CPS\_TXPOP_{g,a,f,t}}$$

Here, the numerator refers to the total number of Texans found to be Medicaid eligible in the CPS after applying the eligibility rules and the population adjustment ratio,  $U_{g,a,t}$  (described above).

Next, the *enrollment rate*,  $n$ , is calculated as the number of Medicaid enrollees divided by the number of Medicaid eligibles:

$$n_{g,a,t} = \frac{N\_MSIS_{g,a,t}}{U_{g,a,t} \times \sum_f E\_CPS_{g,a,f,t}}$$

Here, the numerator is the total number of male Texans aged  $a$  of gender  $g$  in year  $t$  that are enrolled in Medicaid based on data obtained from MSIS. One limitation of the data from MSIS is that they are not decomposed by FPL-relative income categories. Therefore, the average age-gender enrollment rate is applied to all three FPL categories. Next, the *recipiency rate*,  $r$ , is calculated as the number of Medicaid recipients (or beneficiaries) among Medicaid enrollees.

$$r_{g,a,t} = \frac{R\_MSIS_{g,a,t}}{N\_MSIS_{g,a,t}}$$

Again, data for the number of Texans who received Medicaid benefits are obtained from MSIS. Finally, *average Medicaid benefits per recipient*,  $b$ , in Texas are calculated from the MSIS as

$$b_{g,a,t} = \frac{B\_MSIS_{g,a,t}}{R\_MSIS_{g,a,t}}$$

where the numerator refers to total Medicaid benefits for this group. The average age-gender ratios  $rg_{a,t}$  and  $bg_{a,t}$  are applied to those who are Medicaid eligible in each FPL-relative income categories. Thus, total Texas Medicaid expenditures in 2008 on males aged  $a$ , gender  $g$ , FPL category  $f$ , and year  $t$ , can be represented as:

$$M_{g,a,f,t} = U_{g,a,t} \times CPS\_TXPOP_{g,a,f,t} \times e_{g,a,f,t} \times n_{g,a,t} \times r_{g,a,t} \times b_{g,a,t}$$

This method of calculating the four rates can be applied to all age groups and both genders and aggregated to yield total (MSIS based) Medicaid expenditures for the year in question.

Total Medicaid expenditures derived in this manner for the base year (2008) are benchmarked to total (expended) Medicaid expenditures in 2008 as reported in the Texas budget. This step takes account of Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), and Medicaid administrative expenditures that are not included in MSIS data. Thus, these additional expenditures are implicitly distributed across age, gender, and eligibility categories in the same proportion as Texas Medicaid expenditures included in MSIS data.

The simplest way to project Texas' Medicaid expenditures for future years is to represent total expenditures in earlier years by age and gender,  $Mg,a,f,t$ ,  $t=2001-2008$ , as above, and extrapolate each of the component elements over future years. The product of those terms in future years provides estimates of future Medicaid expenditures in Texas for each particular gender, age, and FPL category. Summing over all categories provides the future year's total Medicaid expenditures.

The reason for calculating and independently projecting each of these component rates when constructing Medicaid's expenditure projections is that those rates capture different policy or environmental factors, each with the potential to exhibit its own future trend. For example, while the Medicaid eligibility rate for a particular population sub-group is determined by federal and state policies about which types of individuals should qualify for Medicaid benefits, enrollment rates for different population sub-groups may be determined by the availability and cost of alternative health insurance coverage, individual perceptions about their health care needs, the quality and out-of-pocket costs of Medicaid's health care provision, and public awareness about the availability of Medicaid coverage for people with similar demographic, economic, and health characteristics.

Furthermore, Medicaid reciprocity rates could be different among different population sub-groups by age, gender, and other characteristics, depending on their frequencies of adverse health episodes and health service needs. Finally, average benefit rates would differ depending on the incidence of chronic conditions, whether recipients are elderly or disabled, the type, quality, and cost of health care treatments that are locally available, and so on. Basing projections on detailed historical information on the group-specific trends of all four components separately—by age, gender, whether disabled, income level (relative to the federal poverty level), whether medically needy, unemployed, single-or-dual headed family, child status, etc., provides greater confidence that the rich variety of independent influences of policies, environmental conditions, and behavioral propensities on Medicaid expenditures have been adequately accounted for.

ObamaCare changes eligibility rules for low-income individuals, and mandates health insurance coverage for all. In addition it envisions a vigorous public-awareness

and enrollment facilitation drives that would increase enrollment rates among both, those eligible under the old laws and those newly eligible for Medicaid. So Texas Medicaid costs under ObamaCare are likely to be quite different (and considerably larger) compared to under the old health-care laws.

## A2. Texas population projections

Texas' projected total Medicaid expenditures are anchored by projections of Texas' total population by age and gender. The population projections are obtained by applying appropriately calibrated mortality, fertility, and immigration assumptions to the 2008 Census population for Texas. Mortality assumptions by future year, age, and gender are taken from the Social Security Administration's "intermediate" assumptions—independently available to the author from the Social Security Administration.

For fertility rates, the Social Security administration's year specific fertility rates are used after making a parametric adjustment for Texas. The adjustment for 2010 ensures that growth in the newborn population between 2009 and 2010 equals the average growth rate between the years 2002 and 2009. The same parametric adjustment is retained for years after 2010. Nevertheless, Texas' projected crude fertility rate—which also depends on the number of women in the child-bearing age-range of 14 through 49—changes as expected. The population of Texas newborns continues to grow under these assumptions at a rate of just above 1 percent per year—only slightly lower than in past decades.

Finally, immigration levels are calculated by pro-rating the Social Security Administration's total (legal plus illegal) immigration counts according to the ratio of Texas' total population to the national population, both taken from Census counts. **Figure A1** shows Texas population distributions by age and gender for selected years between 2005 and 2030.

Under the methods and assumptions described earlier, projected population distributions suggest continued growth in Medicaid eligible populations—children, women of child-bearing age, and the elderly, especially older women who enjoy lower mortality rates compared to men. These results suggest that future Medicaid spending in Texas may increase significantly even under pre-ObamaCare policies.

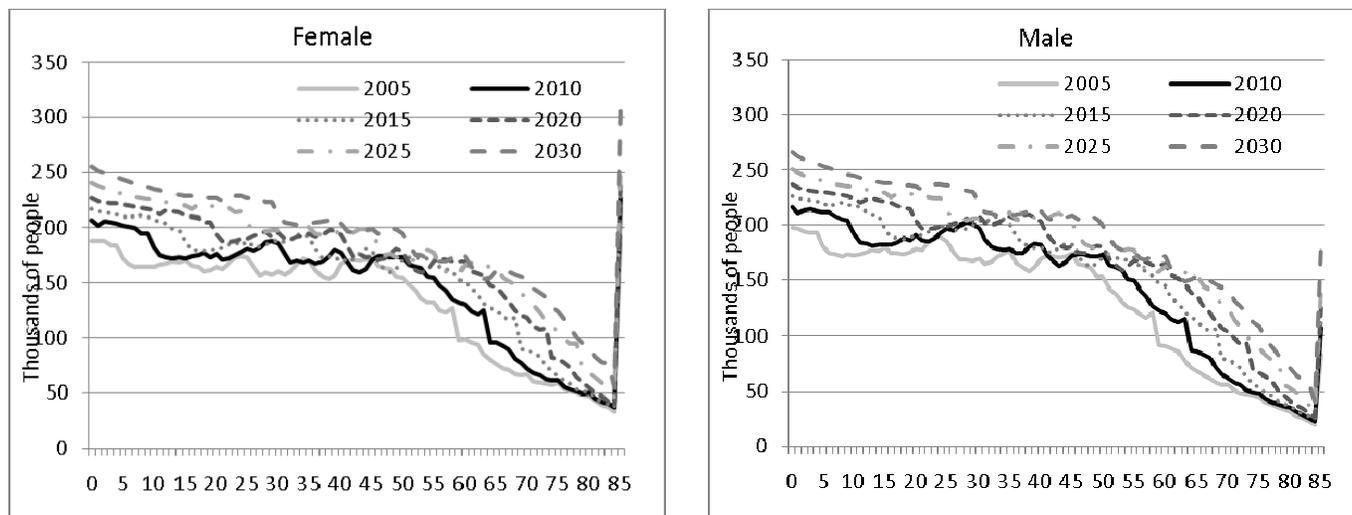


Figure A1: Texas' past and projected age-gender population distributions (2005-2030). *Source: Census Bureau and author's calculations.*

### A3. Medicaid Eligibility, Enrollment, Reciprocity, and Average Benefits Per Enrollee

This section describes information obtained from calculating each of the four components noted in Section 4 above—namely, eligibility rates, enrollment rates, reciprocity rates, and average benefits per recipient. Because eligibility conditions and health needs differ substantially by age and gender, the four items are calculated separately for various age groups (see note 14), gender, and FPL-relative income levels. In addition, special eligibility groups such as medically needy, foster-care children, family planning, and others are treated separately. The calculations span the years 2000-08 corresponding to the latest available data from the CPS (on eligibility rates) and MSIS (enrollment and reciprocity rates; average benefits per recipient).

#### a) Children

The four charts in **Figure A2** show information on the four rates, respectively, for female children by age groups—newborns, 1-5, 6-12, 13-14, and 15-18. **Figure A3's** charts shows analogous information for male children. Children are split between those who are in foster care and those who are not. **Figures A2.1** and **A3.1** show shares of female and male non-foster-care children, respectively, who are Medicaid eligible in the 0-100 percent FPL category—as calculated from the CPS. All newborns are eligible, but eligibility rates for older children are less than 100 percent. Children are eligible only if they reside in families with

income less than 133 percent of FPL. Income is calculated net of allowable deductions, exemptions, and exclusions from earned and unearned income including countable income from the Supplemental Security Income program. Earned income by children in school is excluded, as are child support payments (deduction subject to a cap). Other eligibility conditions include whether the child's parent is unemployed, a part-time worker, single or two-parent, mentally or physically disabled (with applicable earned income exclusions), and so on.

The figures also show estimated (time-weighted) linear trends based on observations between 2000 and 2008. The trends are calculated by running a simple regression of the rate in question against the year index with later observations receiving a larger weight.<sup>19</sup> As **Figures A2.1** and **A3.1** show, Medicaid eligibility rates increased during the last decade among children of all ages and both genders in Texas. About 85 percent or more of all child age-gender groups were Medicaid-eligible by 2008.

Enrollment data are based on the MSIS. **Figures A2.2** and **A3.2** show shares of eligible children in Texas that are enrolled in Medicaid. During the early 2000s, enrollment rates were much smaller for older children compared to younger ones. However, enrollment rates for older children have increased steadily so that by 2008, more than 60 percent of all eligible children are enrolled in the program.

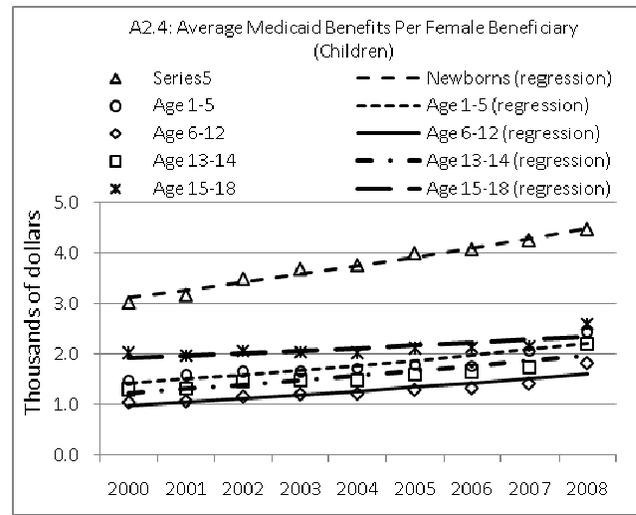
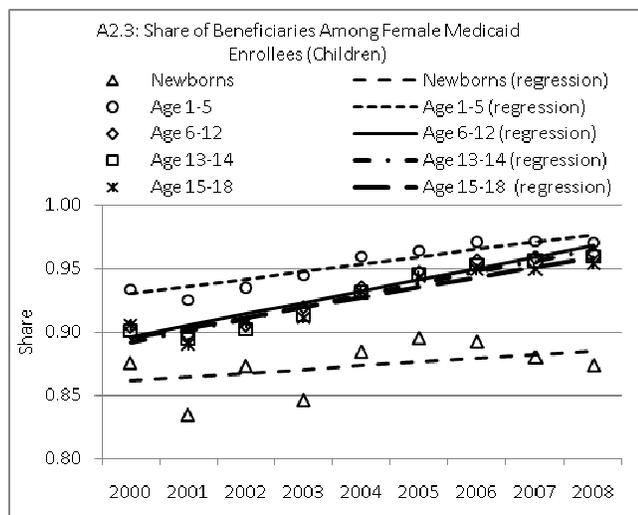
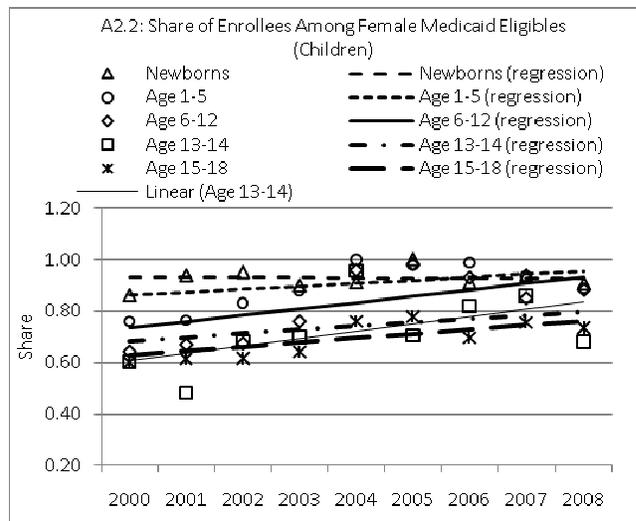
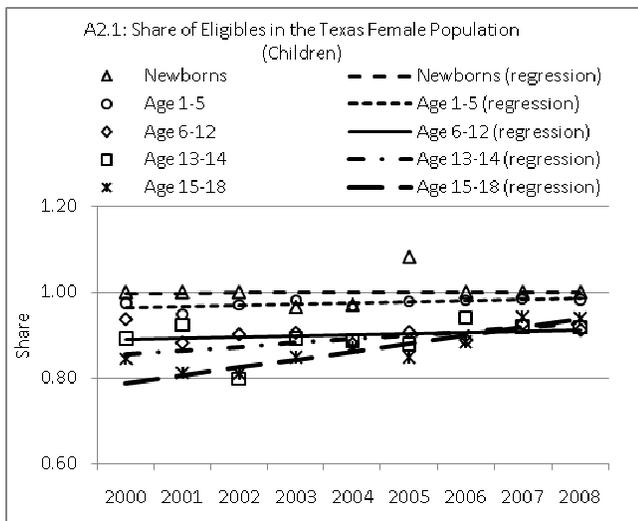


Figure A2: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, Recipients and Average Benefits per Recipient—Female Children; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

Figures A2.3 and A3.3 show Medicaid reciprocity rates in Texas—the share of enrollees that actually received benefits. Again, Texas Medicaid reciprocity rates were quite high during the early 2000s and have increased consistently during the last decade: At least 85 percent of all child groups received Medicaid benefits during 2008. The charts show that among both males and females, newborns have the smallest reciprocity rates.

Figures A2.4 and A3.4 show average Medicaid benefits paid per recipient in inflation-unadjusted (nominal) dollars. They show that newborns incur the highest expenditures. Excluding newborns and those aged 1-5,

Average Medicaid expenditures per recipient are smaller for younger children and they increase with age. Nevertheless, average expenditures for the oldest children are only about one-half of those for newborns. Average expenditures have trended upward during the last decade—reflecting the general rapid increase in health care costs. These figures also show estimated (time-weighted) exponential trends based on observations between 2000 and 2008. The trends are calculated by running an exponential regression of the average per-recipient spending rate for the group in question against a year index, again, with later observations receiving a larger weight.<sup>20</sup>

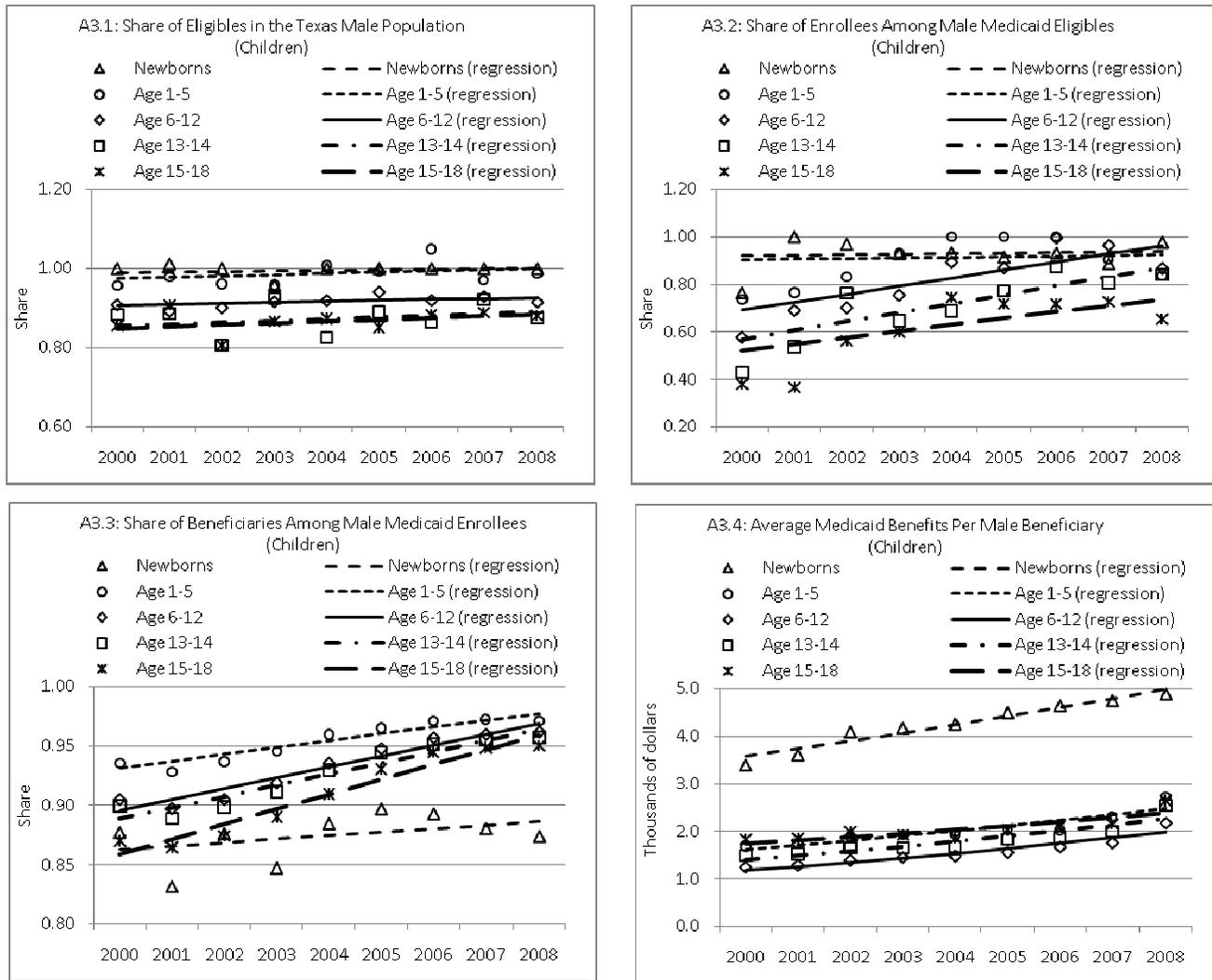


Figure A3: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, and Recipients and Average Benefits per Recipient—Male Children; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

**b) Working-aged Adults**

Working aged adults are split between disabled adults, non-disabled adults and others, where the last category includes medically needy individuals and women eligible for benefits from the Breast and Cervical Cancer Act under Medicaid. For non-disabled adults, eligibility rates under Medicaid are distinctly different for males versus females. As **Figure A4.1** shows, female eligibility rates among the 0-100 percent FPL category barely increased during the last decade.<sup>21</sup> That is not surprising because women are more likely to be part of a low-income family. **Figure A5.1** shows that Medicaid eligibility rates are much smaller for men (as they are less likely to have a Medicaid eligible child as a dependent), and the age-pattern is

reversed compared to females, perhaps because a higher proportion of men work in strenuous jobs and become disabled or unemployed at older working ages.

**Figure A4.2** shows that Medicaid enrollment is low but increasing among women—about one-half of Medicaid eligible women appear to be enrolled in the program in Texas. For men, enrollment among younger workers increased rapidly during the mid-2000s, whereas that among older workers has remained low and has declined to well below 20 percent of those eligible.

**Figure A4.3** and **A5.3** show that both genders exhibit reciprocity rates at the 80 and 90 percent levels. Reciprocity

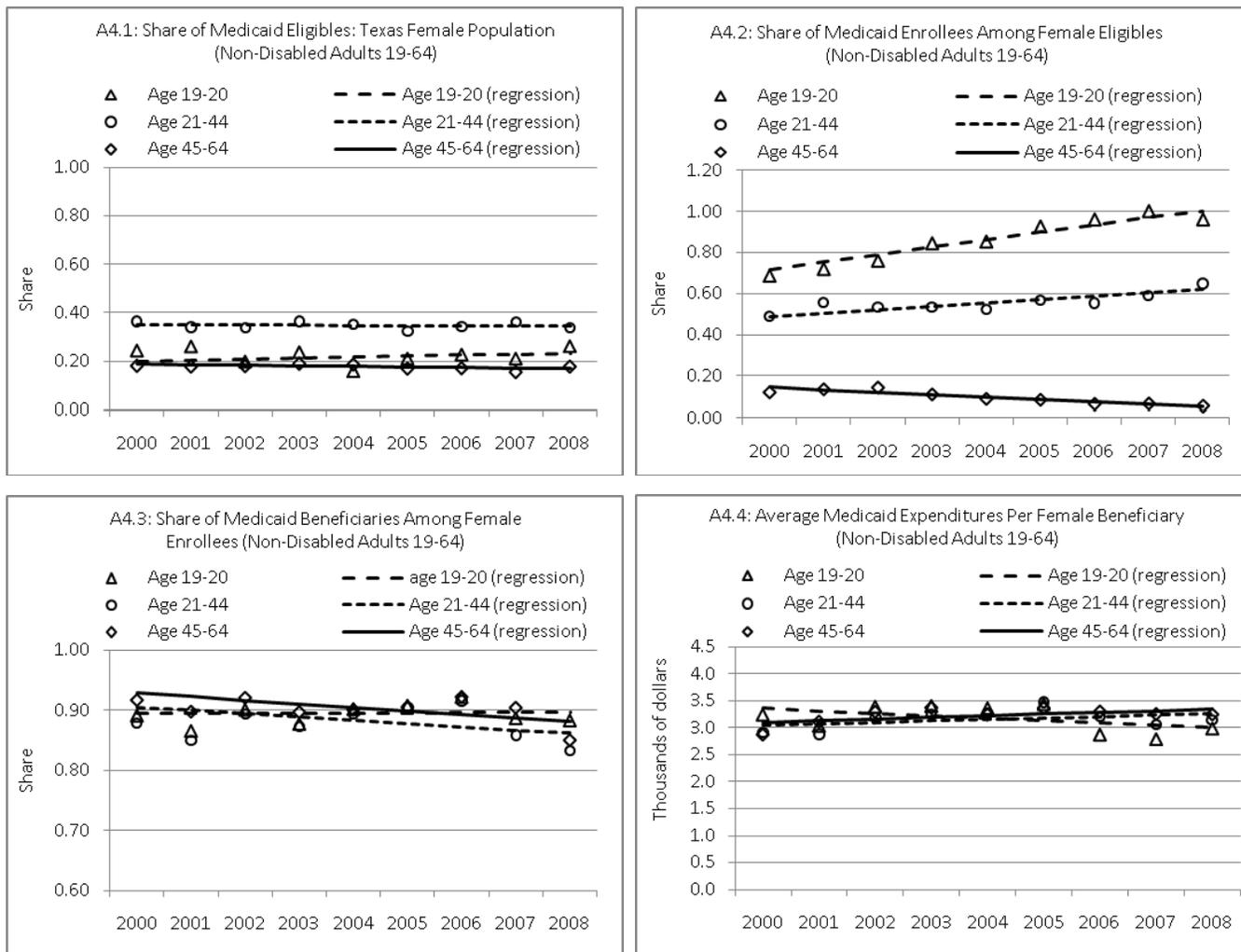


Figure A4: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, and Recipients and Average Benefits per Recipient—Female Non-Disabled Adults aged 19-64; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

rates are closely bunched at 90 percent for women. Among men, they are larger for older compared to younger and middle-aged men and have trended upward during the last decade. **Figures A4.4** and **A5.4** show that older non-disabled adult beneficiaries receive larger Medicaid benefits, on average, compared to younger ones—the differences by age being quite large for men but very small for women. And the Figures show that benefit levels have increased slowly among most age-gender groups among non-disabled adults.

*c) Retirees*

Among those aged 65 and older in the 0-100 percent FPL range, eligibility rates are well above 80 percent among younger retirees and close to 100 percent among older

ones according to **Figures A6.1** and **A7.1**. **Figures A6.2** and **A7.2** show, however, enrollment rates remain at about 50 percent for Medicaid-eligible retirees. Enrollment rates increased for the oldest retirees but remained constant or declined for younger ones. **Figures A6.3** and **A7.3** show that Medicaid reciprocity rates were initially quite high—about 80 percent during the early 2000s—but have declined since for both genders. The reason may be the expansion of Medicare Part B coverage and the shift of many retirees' Medicaid coverage for prescription drugs to the Medicare program. Finally, **Figures A6.4** and **A7.4** suggest that average Medicaid expenditures per recipient has increased for younger retirees but has remained stable for older ones during the last decade.

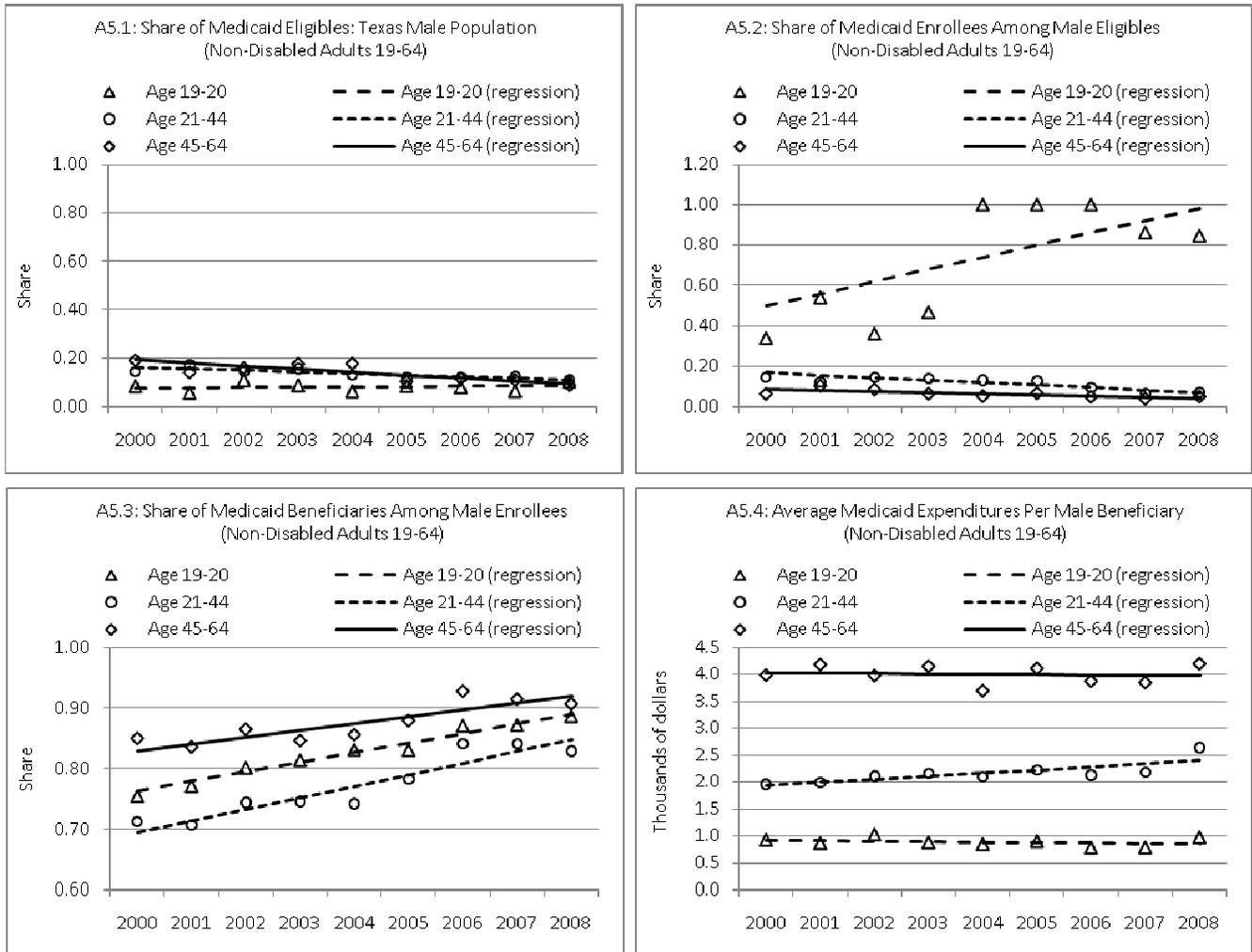


Figure A5: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, and Recipients and Average Benefits per Recipient—Male Non-Disabled Adults aged 19-64; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

**d) Other Groups**

Calculations were implemented separately for foster-care children, medically needy individuals, women qualifying under the Breast and Cervical Cancer Act (BCCA), family planning program, and blind-disabled adults. Except for blind-disabled adults, CPS data does not allow identification of the eligible populations for these groups.<sup>22</sup> Hence, calculations are based on directly calculating the share of enrollees in the population based on MSIS data for foster-care children, BCCA women, family planning, and medically needy individuals. For blind-disabled adults, however, we incorporate eligibility co-criteria based on income (including spousal income where applicable), again counting all eligible sources and net of applicable exemptions, deductions, and income disregards. Only

results for blind/disabled adults among the 0-100 percent FPL range are shown here: **Figures A8.1 and A9.1** show that Medicaid eligibility rates have been high and rising more rapidly for older blind/disabled adults compared to younger ones in Texas. **Figures A8.2 and A9.2** show increasing enrollment rates for most blind/disabled women; and enrollment rates have been high, but stable overall, for disabled/blind men during the last decade. **Figures A7.3 and A8.3** show that enrollment rates have been stable or declining for most disabled adults—perhaps, because of the shift to coverage under Medicare since 2006. However, **Figures A8.4 and A9.4** show that Medicaid expenditures per blind/disabled recipient are among the highest among all population groups and have increased consistently for both genders during the last decade.

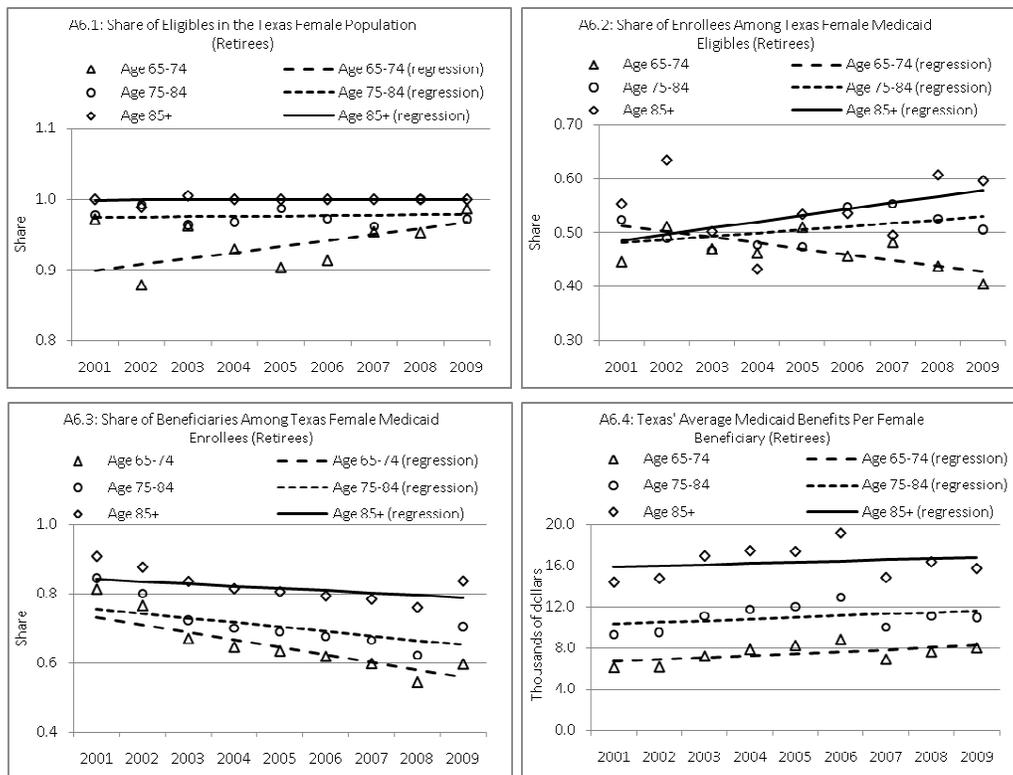


Figure A6: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, and Recipients and Average Benefits per Recipient—Female Adults aged 65 and older; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

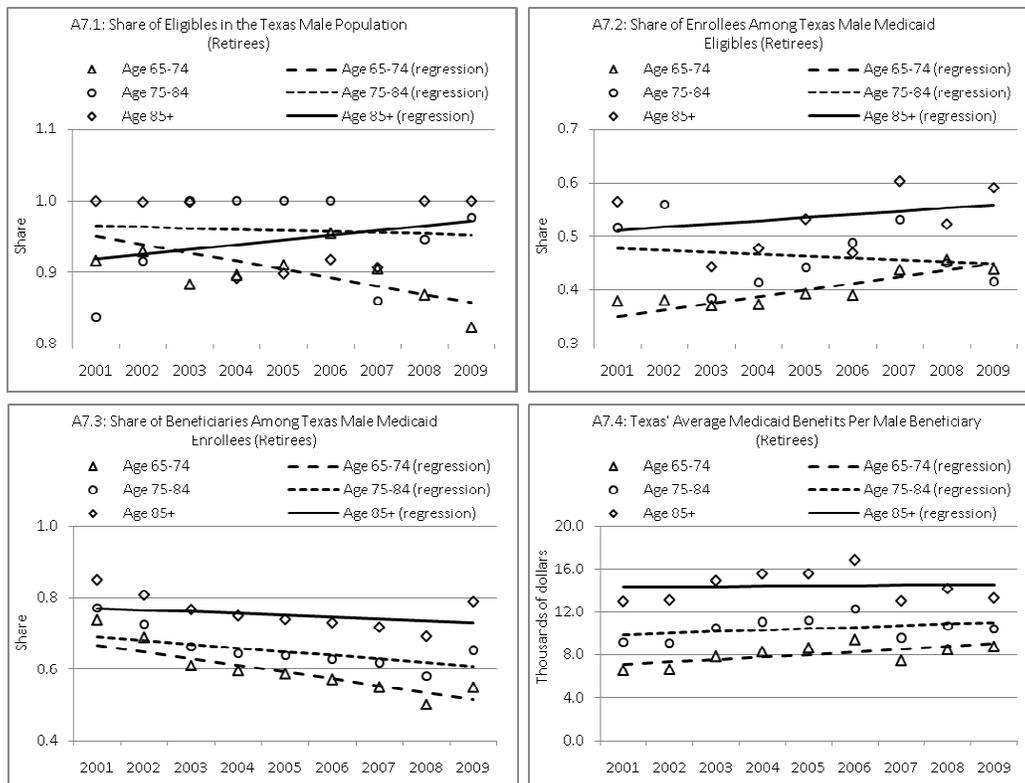


Figure A7: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, and Recipients and Average Benefits per Recipient—Male Adults aged 65 and older; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

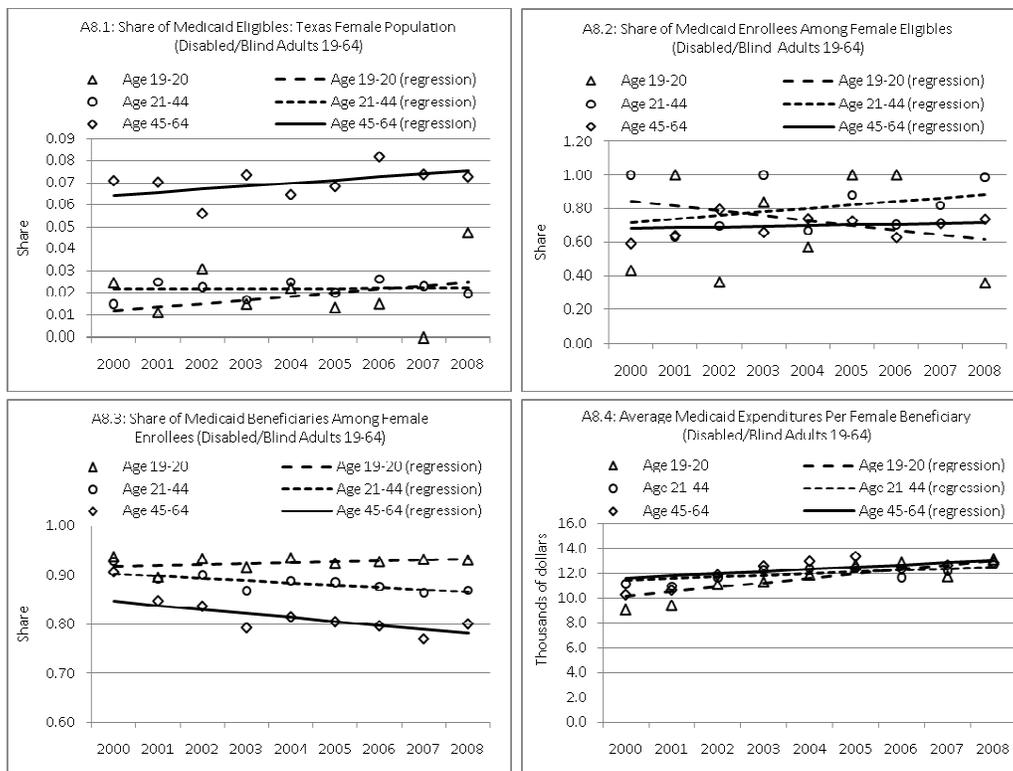


Figure A8: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, and Recipients and Average Benefits per Recipient—Female Disabled Adults aged 19-64; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

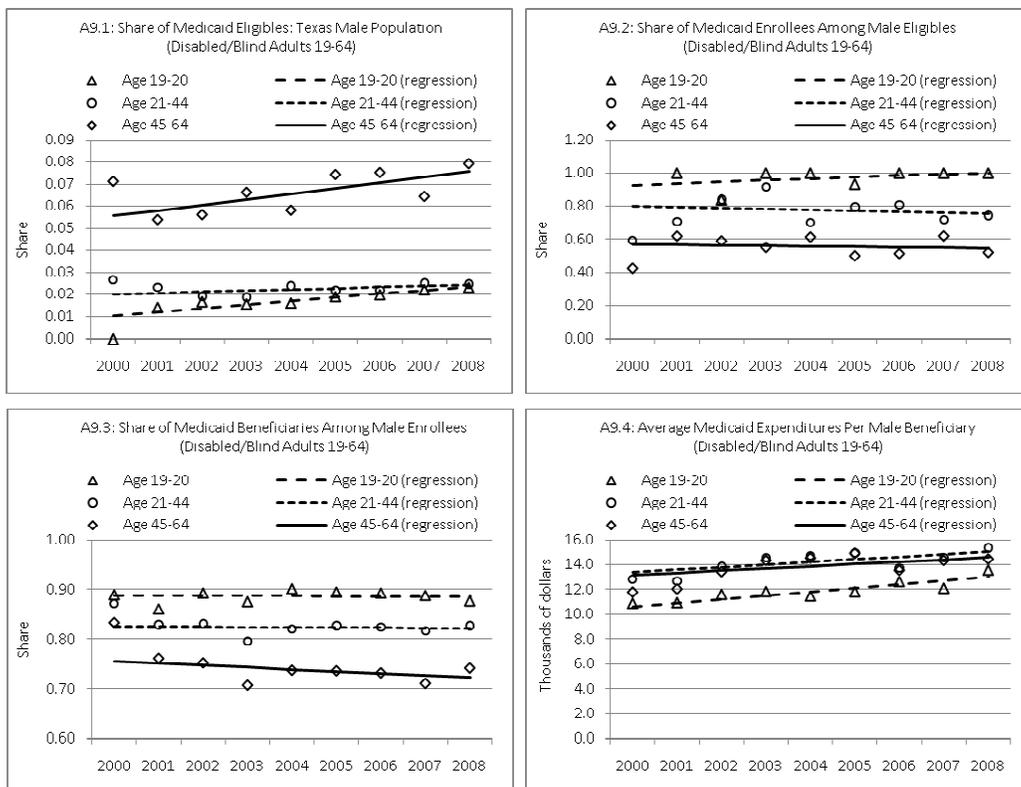


Figure A9: Historical Shares and Estimated Trends for Medicaid Eligibles, Enrollees, and Recipients and Average Benefits per Recipient—Male Disabled Adults aged 19-64; 0-100 percent FPL; 2000-08. *Source: Authors' calculations.*

## Endnotes

<sup>1</sup> The author thanks the Texas Public Policy Foundation for research support, Angela Erickson for excellent research assistance and Caitlin Buck, Sloane Frost, and Spencer Harris for valuable data searches and other research inputs.

<sup>2</sup> To qualify for Medically Needy Program benefits, an applicant must be (1) a pregnant woman with no child eligible for the Temporary Assistance for Needy Families (TANF) Program; a child under 19 years of age; or an adult caretaker, whom HHSC includes in the certified group, and who ordinarily receives and manages the benefits for the certified group, except that the caretaker's countable income exceeds TANF limits, the caretaker's 60-month time-limited TANF benefits are exhausted, the caretaker chooses Medicaid-only benefits, or the caretaker is disqualified from TANF for a reason that is not applicable to Medicaid; and have countable income that meets the applicable income limit. The income limit is defined based on family size; for a family of two people, it is \$216 per month. Applicants whose income exceeds the limit may spend down excess income to pay medical bills and qualify.

<sup>3</sup> The formula equals 100 percent minus state's share where state's share equals  $0.45 \times (\text{SPCI}/\text{USPCI})^2$ , where SPCI is state's per capita income and USPCI is United States' per capita income. A higher SPCI translates into a lower FMAP value.

<sup>4</sup> The 2012 FMAP value for Texas is expected to be published by the federal department of Health and Human Services in November 2010.

<sup>5</sup> Texas does not levy income taxes, revenues from which have declined even more significantly in several other states. Texas also does not levy property taxes, revenues from which have increased nationwide between 2008 and 2009 because of the lagged impact of property appreciations on state property tax bases. The decline in property values during 2007 through 2010, however, will begin to negatively affect property tax revenues in many states during 2010 and later. See the state tax reports available at [http://www.census.gov/govs/statetax/historical\\_data\\_2008.html](http://www.census.gov/govs/statetax/historical_data_2008.html).

<sup>6</sup> Texas has four constitutional limits on spending: a "pay-as-you-go," or balanced budget limit; a limit on welfare spending; a limit on the rate of growth of appropriations from certain state taxes; and a limit on debt service.

<sup>7</sup> Texas enjoys a competitive advantage relative to other states: Its tax revenues per \$1,000 of personal income per capita equal \$45.60—much lower compared to the national average of 64.45. See "Fiscal Size-Up: 2010-11 Biennium," cited in Note 4.

<sup>8</sup> Texas Legislative Budget Board, "Fiscal Size-Up: 2010-11 Biennium" (Dec. 2009) 2.

<sup>9</sup> Texas House Bill 4586 appropriates a total of \$1.9 billion to the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS) for fiscal year 2009; it includes a \$1.6 billion financial adjustment for fiscal year 2009 because of the temporary increase in Medicaid FMAP under ARRA; and the bill includes appropriations to DADS and the Department of Family and Protective Services (DFPS) for 2010–11 of \$144.7 million.

<sup>10</sup> Increases in future Medicaid expenditures in Texas will also depend on how successful are efforts to repeal ObamaCare: Thirteen U.S. states have filed court cases to challenge the new health care law on two grounds: (1) that mandating purchase of health insurance by individuals (with failure punishable by a fine) is unconstitutional under the 10th Amendment and Article I of the U.S. Constitution (the commerce clause) and, (2) that the new health care law increases states' Medicaid costs without recompense from the federal government—that is, it constitutes an unfunded mandate.

<sup>11</sup> The assumption of constant enrollment rates could be challenged. Indeed, incoming information shows that Medicaid enrollment rates in Texas are increasing. It implies that the estimates reported herein of future Medicaid cost growth in Texas err on the conservative side.

<sup>12</sup> Historical annual growth rates of the Texas economy (Texas gross state products) are first divided by those of the overall U.S. economy (U.S. gross domestic product) for corresponding years between 2000 and 2008. The average factor of proportionality is used to benchmark future Texas growth rates based on the economy wide growth projections adopted by the Congressional Budget Office in "The Economic Outlook and Fiscal Policy Choices" (Sept. 2010) 9, [http://cbo.gov/ftpdocs/118xx/doc11874/09-28-EconomicOutlook\\_Testimony.pdf](http://cbo.gov/ftpdocs/118xx/doc11874/09-28-EconomicOutlook_Testimony.pdf).

<sup>13</sup> U.S. economic projections based on the author's microsimulation reported in *Social Security: A Fresh Look At Policy Alternatives*, University of Chicago Press, 2010: Chicago and London.

<sup>14</sup> In the case of retirees, coverage under Medicare in addition to private insurance is accounted for when applying the procedure described in the Appendix. We acknowledge that post-ObamaCare Medicaid reciprocity rate among retirees who are dual eligibles in Medicare and Medicaid is uncertain and difficult to forecast. The assumption made here is that the pre-law reciprocity rate will prevail. The expected enrollment facilitation drive under ObamaCare, however, may render that to be an underestimate.

<sup>15</sup> Texas Health Institute, *Responding to the Epidemic: Strategies for Improving Diabetes Care in Texas* (Nov. 2010).

<sup>16</sup> The age categories correspond to those of the Medicaid State Information System's age ranges: 0, 1-5, 6-12, 13-14, 15-18, 19-20, 21-44, 45-64, 65-74, 75-84, and 85+.

<sup>17</sup> The income ranges are defined according to the applicable cut-offs before and under the new health care law. Those cut-offs are generally different for population groups served by various Medicaid programs in Texas.

<sup>18</sup> Combining CPS, Census Bureau, and MSIS leads to a few anomalies. For example, the eligibility rate turns out to be more than 100 percent in a very few cases. The reason is that the CPS weights generate a larger population for some age-gender groups than is reported by the Census. Such anomalies are left uncorrected because they are very few and small in size. Moreover, arbitrary corrections would not add any new information and would not make much difference to overall historical trends and to the projections based on them.

<sup>19</sup> The regression function used is  $y = a_0 + a_1t$ , with  $t=1$  for the year 2000,  $t=2$  for year 2001..., and  $t=9$  for year 2008. The observation weights are set equal to  $t$ .

<sup>20</sup> The regression function used is  $y = \exp(a_0 + a_1t)$ , with  $t=1$  for the year 2000,  $t=2$  for year 2001..., and  $t=9$  for year 2008. The observation weights are set equal to  $t$ .

<sup>21</sup> Although post-ObamaCare Medicaid eligibility is based only on an income test, pre-ObamaCare eligibility requires an asset test as well. The pre-ObamaCare asset test is incorporated based on information from the 2007 Survey of Consumer Finances (SCF). Calculations show that the population share of adult non-disabled household heads who fail the Medicaid asset test and who do not receive Medicaid is 13.2 percent for the nation as a whole. Unfortunately, the SCF does not allow separate identification of Texas residents, nor of blind/disabled individuals. Therefore, an approximate asset-based constraint is applied to pre-ObamaCare eligibility rates, to restrict Medicaid eligibility to 86.8 percent (100 percent minus 13.2 percent) of the income-based eligibility rate as calculated from the Current Population Survey.

<sup>22</sup> Medicaid eligibility criteria for children in foster-care and younger than age 18 are the same as those for non-foster-care children aged less than 18. Eligibility under AFDC/TANF rules are based on incomes of household that they were in before foster care placement. For children older than age 18 there is the "Medicaid for Transitioning Foster Care Youth" program whereby the person must have aged out of foster care, must be aged between 18 and 20 years, must not be covered under another health plan offering adequate benefits, and must have income at or below 400 percent of the Federal Poverty Level. Medicaid eligibility criteria for persons with breast and cervical cancer: Must be diagnosed with breast cancer (men and women) or cervical cancer (women only), must not have income more than 200 percent of the Federal Poverty Level, and must not have alternative medical insurance coverage.

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