Texas Public Policy Foundation

Health Care

Legislator's Guide to the Issues 2017-18

Medicaid Block Grants

The Issue

Medicaid was created by Congress in 1965 and came to Texas two years later, a program designed to provide health benefits to specific groups—initially, to recipients of certain cash assistance programs. Since then, eligibility has gradually expanded and caseload growth has made Medicaid the single largest program in the state budget. In 2001, Medicaid consumed 20% of the All Funds (AF) budget but now accounts for nearly 30% of the 2016-17 budget.

Medicaid spending in Texas is experiencing steady, long-term growth. In the 2014-15 budget, for the first time in Texas history, spending on all health and human services (HHS) exceeded spending on education. The Medicaid program accounts for almost 80% of all HHS spending, or $61.2 billion of the $77.2 billion budget. This is a large increase from just a few years ago; in 2010-11 the total HHS budget was only $65.5 billion with Medicaid accounting for $45 billion of that.

The Medicaid program is unsustainable financially for the state. Access is a problem as 70% of physicians in the state will no longer accept new Medicaid patients. Further, numerous studies indicate that Medicaid delivers worse health outcomes than private insurance, and in some cases, than being uninsured. The answer is to reform the program, which states cannot do effectively under current federal law. Regardless of the promise that waivers can be utilized to reform the program, the restrictions of benefit and entitlement requirements prevent real reform. Unless exempted from the federal requirements of mandatory benefits and mandatory eligibility, reforms that change behavior cannot be implemented. Such reforms would include:

1. Sliding scale cost sharing, as utilized by Federally Qualified Health Centers and the more innovative public hospital indigent care programs like Carelink in San Antonio. Cost sharing would include participation in the state-funded health savings account (HSA) and/or co-pays.
2. Personal responsibility for managing the HSA, which would be restricted to medical services, equipment, insurance premiums, etc. Additional co-pays would be required for inappropriately accessing the emergency room. The recipient could be suspended from the program for six months if they failed to carry out their responsibilities.
3. Personal freedom to choose a health plan, available in the private market, that fits the needs of the recipient rather than the one-size-fits-all entitlement benefits.

Economic modeling such common sense reforms demonstrated cost savings of $4 billion per year or $8 billion per biennium to the cost of Medicaid in Texas, growing to $12 billion per biennium in 2022-23. The modeling considered HHSC data for only three cohorts—pregnant women, Texas Temporary Assistance for Needy Families (TANF) adults, and children.

The Facts

- For the 2012-13 biennium, the Legislature appropriated $39 billion in All Funds for the Medicaid program alone. In the current biennium, that figure is about $61.2 billion—a 57% increase.
- Children have increased as a percentage of total Medicaid enrollment due to economic factors and provisions of the ACA that are causing children to move from the Children's Health Insurance Program (CHIP) into Medicaid. The Aged, Blind, and Disabled (ABD) population in Medicaid is also expected to increase consistently as the Baby Boom generation ages.
- The 84th Legislature approved $180 million in All Funds supplemental Medicaid spending for the 2014-15 biennium that caused estimated spending for HHS to exceed estimated spending for Education for the first time in Texas history.

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- States must adhere to strict federal rules about how much Medicaid enrollees are allowed to contribute to the cost of care and what benefits they are entitled to receive. As long as the state participates in the program, Texas must provide medically necessary care to all eligible individuals, regardless of whether the enrollee needs or wants those benefits.
- States are not allowed to use federal Medicaid dollars to pay for private coverage for Medicaid-eligible individuals unless the state pays for wrap-around benefits not covered by the private plan.

Recommendations

- The state should continue to pursue a block grant for Medicaid in order to give the state greater flexibility to reform the program and greater certainty in the Medicaid budget from year to year. This includes petitioning the state's congressional delegation to pursue block grant legislation in Washington, D.C.
- The Legislature should pass a contingency Medicaid block grant act that would go into effect if and when block grant funding is passed by Congress. Such a bill would send a strong message nationwide that Texas has developed a detailed plan for how to amend its state plan and enact fundamental Medicaid reform if it were given the opportunity to do so.

Resources

Texas Medicaid Reform Model: A Market-Driven, Patient-Centered Approach by John Davidson, Texas Public Policy Foundation (Sept. 2015).

"Drop in Physician Acceptance of Medicaid, Medicare Patients," Texas Medical Association (July 9, 2012).

"Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured" by Kevin D. Dayaratna, Heritage Foundation (Nov. 2012).

Save Texas Medicaid: A Proposal for Fundamental Reform by James Capretta, Arlene Wohlgemuth, and John Davidson, Texas Public Policy Foundation (March 2013).