

# Texas Medicaid Reform Model: *A Market-Driven, Patient-Centered Approach*



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# Texas Medicaid Reform Model: *A Market-Driven, Patient-Centered Approach*

by John Davidson, Director, and Vance Ginn, Economist

## Executive Summary

The Texas Medicaid program is on an unsustainable trajectory. Steadily rising healthcare costs and growing enrollment mean that Medicaid is consuming an ever-growing share of the state budget. If no reforms are put in place to control spending growth, the Medicaid program will eventually crowd out other state spending priorities.

Because Medicaid is a jointly funded state-federal program and therefore subject to myriad federal rules and regulations, state lawmakers have few options for controlling costs and enacting reforms. They also have a strong disincentive to limit or reduce Medicaid spending, since every state tax dollar spent on the program is matched by \$1.50 of federal tax funds, on average. This makes cutting the Medicaid budget politically difficult because to save \$100 of state funds lawmakers must cut \$250 from the program.

The result of these misaligned incentives in Texas is that Medicaid has gradually increased as a share of the state budget. The program now consumes almost 25 percent of General Revenue appropriations, an increase of the share by 42 percent in just over a decade. In the current biennium, the program's growth has caused total state spending on health and human services to exceed total education spending for the first time in Texas history. Without structural reform, Texas lawmakers will be unable to contain the future growth of Medicaid, which will eventually overwhelm the budget.

Given sufficient flexibility from federal rules, however, lawmakers could create a defined contribution Medicaid program for certain risk groups that uses state and federal Medicaid funds to subsidize private health coverage. Enrollees would be responsible for any healthcare costs beyond the subsidy amount, but with private coverage they would enjoy greater access to providers and likely experience better health outcomes.

In this paper, we model cost savings under such a system using historical and projected per member per month (PMPM) acute care costs and enrollment data from the Texas Health and Human Services Commission (HHSC), applied to Medicaid risk groups most suited for private health coverage: pregnant women, children, and adults eligible for Temporary Assistance for Needy Families (TANF). We determine the average monthly costs to subsidize these risk groups by first calculating average silver and gold plan health insurance premiums for 2015 available on the federal exchange established by the Patient Protection and Affordable Care Act (ACA) for the top 10 most populated Texas counties. These average premiums represent 60 percent of the state's total population and include locations where most Medicaid recipients reside.

If the state enrolled only these risk groups in subsidized private coverage, we calculate that the savings to the state compared with the status quo would total \$4 billion in 2015. These annual cost-savings would continue to mount over the next decade and reach \$6.1 billion in 2023. Combined with other market forces not included in this model, such as the downward pressure on premium prices that would result from competition for enrollees, savings could be even greater.

If Texas is to maintain a healthcare safety net for its most vulnerable residents—those whom the Medicaid program was designed to serve—lawmakers must begin addressing the program's structural problems, and seek greater flexibility from the federal government to enact the kinds of fundamental reforms outlined here.

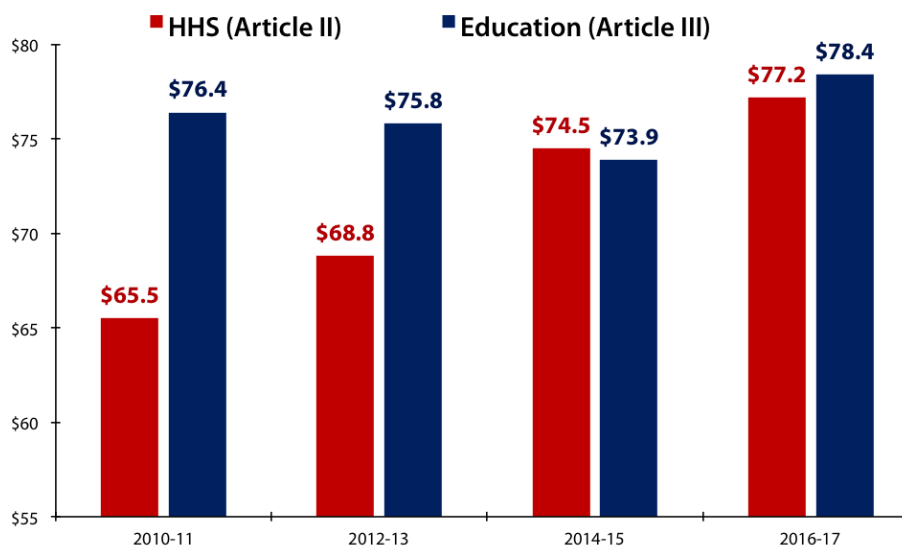
## Introduction

For years, the Texas Medicaid program has been plagued by rising health care costs, inadequate access to providers, and poor health outcomes. A declining number of Texas physicians accept new Medicaid patients even as enrollment continues to rise, straining network adequacy and hampering patient access to care. As a result, Medicaid patients often seek routine care in hospital emergency rooms, further driving up costs for taxpayers at the state and local level.

A number of interrelated factors are contributing to a gradual, long-term rise in state spending on Medicaid, including the rising cost of health care nationwide, a growing caseload driven in part by general population growth in Texas, and increasing enrollment in Medicaid because of the Patient Protection and Affordable Care Act (ACA). State spending growth in health and human services, it is beginning to crowd out other budget priorities, raising concerns about the long-term viability of the Medicaid program in its current form.

As **Figure 1** shows, in the 2014-15 budget, for the first time in Texas history, spending on health and human services (Article II) exceeded spending on education (Article III). The 84th Legislature approved \$180 million in All Funds (AF) supplemental Medicaid spending for the 2014-15 biennium that caused estimated spending for Article II to exceed estimated spending for Article III.<sup>1</sup> Funding Medicaid with supplemental spending for the current biennium is not unprecedented; the 83rd Legislature approved \$4.2 billion in supplemental Medicaid spending from General Revenue (GR).

**Figure 1. Texas Medicaid Biennial Budget Continues to Rise**



Source: [Legislative Budget Board, Summary of 2016-17 Conference Committee Report for HB 1](#)

It is not unreasonable to conclude that the 85th Legislature might approve an amount of supplemental Medicaid spending for the 2016-17 biennium that would exceed the \$1.2 billion difference between Articles II and III currently in the 2016-17 budget. This state of affairs might establish a new status quo: public health care programs, funded either through supplemental spending or through the normal appropriations process, will become the number one spending priority for the State of Texas.

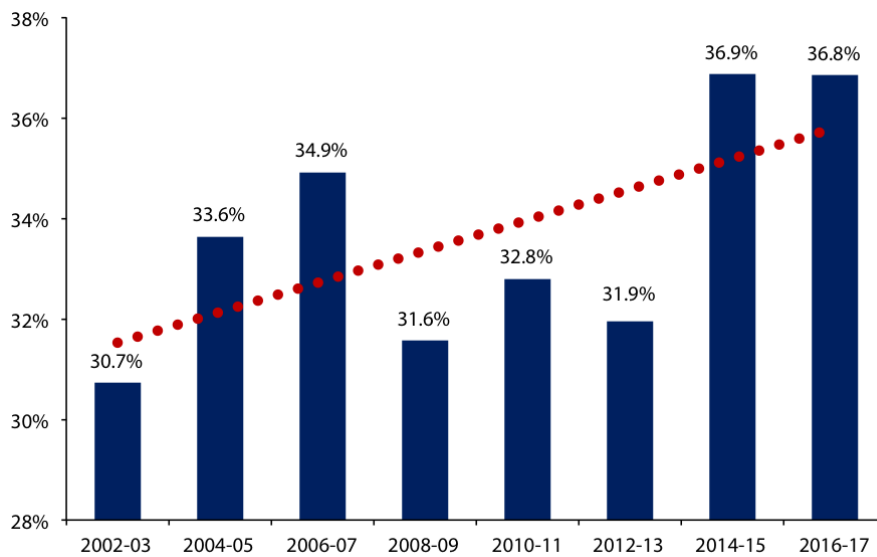
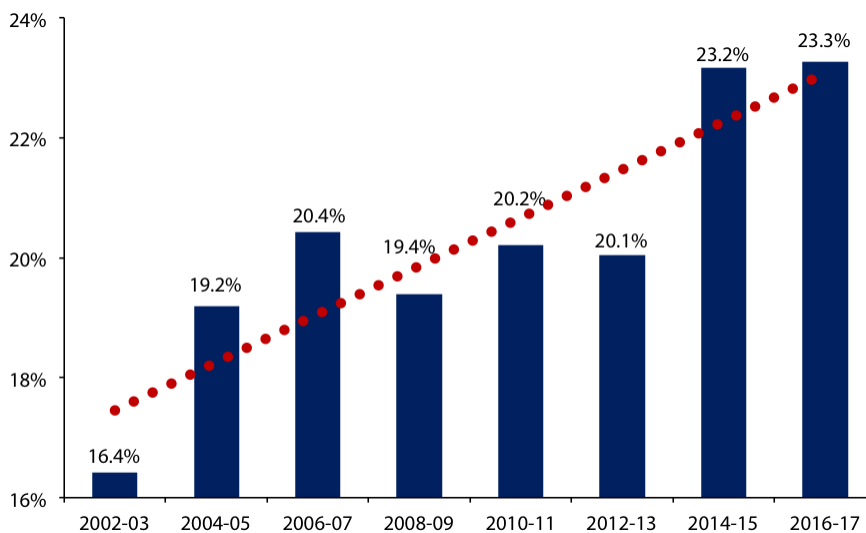
While Figure 1 compares spending in Article II with Article III, it should be noted that the Medicaid program is the driving force behind spending growth in health and human services. In the 2016-17 AF budget, the Medicaid program

accounts for nearly 80 percent of all health and human services spending (\$61.2 of \$77.2 billion),<sup>2</sup> and nearly 30 percent of the total \$209.4 billion state budget.<sup>3</sup> The 2016-17 budget increases AF health and human services spending by a total of \$2.7 billion compared to the 2014-15 budget. Of that increase, the vast majority—\$2.1 billion—is for Medicaid.

As spending on health and human services continues to rise, Medicaid is consuming a growing share of total state appropriations. This persistent trend goes back more than a decade. As a share of the state budget—both Article II as a share of AF and Medicaid as a share of General Revenue—health care continues to grow at an outsized pace, as shown in Figures 2 and 3, compared to other state budget priorities.

The Medicaid program itself is plagued by fraud, waste, and an administrative structure that fractures accountability across multiple state agencies. As Medicaid spending has grown, the management of numerous programs, facilities, contracts, and agencies at the state level has become increasingly difficult. The Sunset Review Advisory Commission found that HHSC's fragmented approach to administering the Medicaid program, "hinders consistent decision making toward a shared vision... and a shared awareness of program problems and how to fix them. This structure also impedes cohesive Medicaid policy



**Figure 2. Upward Trajectory of Article II Appropriations as a Share of All Funds**Source: [Legislative Budget Board](#)**Figure 3. Rising Texas Medicaid Appropriations as a Share of General Revenue**Source: [Legislative Budget Board](#)

changes and program administration, efficient delivery of medically necessary services, and proper administrative oversight.”<sup>4</sup>

Stakeholders and policymakers across the political spectrum agree that Texas’ Medicaid program is in need of fundamental reform. The current system leaves enrollees with inadequate access to providers and delivers poor health outcomes. Nearly 70 percent of Texas physicians will not accept new Medicaid patients,<sup>5</sup> who are often forced to seek primary care in hospital emergency rooms or forego needed treatment. As a result, numerous studies show that Medicaid patients have worse outcomes than those with private health insurance and often worse outcomes than the uninsured.<sup>6</sup> Rising enrollment and increasing health care costs, exacerbated by the implementation of the ACA, oblige state lawmakers to consider structural changes to the Medicaid program that would only be possible with a federal block grant of Medicaid funds to the state.

In particular, a defined contribution of federal funding combined with broad flexibility for the State to redesign Medicaid would allow Texas to implement market-based reforms designed to lower state expenditures while maintaining current enrollment levels and improving access to, and quality of, health care.

Free from federal restrictions, Medicaid enrollees who do not have a disability—primarily pregnant women, children, and adults eligible for the Temporary Assistance for Needy Families (TANF) program—could be enrolled in private health insurance plans, the premiums for which would be subsidized with Medicaid funds based on a sliding scale determined by the federal poverty level (FPL). As an enrollee’s income increases into a higher FPL category, the subsidy amount for monthly private health insurance premiums would decrease from 100 percent of the premium for the 0 to 50 percent FPL range. At higher income levels, enrollees would be required to contribute to the cost of their coverage at a level that keeps the share of their income spent on health care to a minimum 5 percent. Most will be substantially below 5 percent, except for pregnant women, whose share of the premium cost could reach as high as 9 percent for enrollees at 185 percent FPL.

A sliding scale system like this would mirror the subsidy scheme for individual coverage under the ACA, in which subsidies for private health plans are available to those earning between 138 and 400 percent FPL, with the subsidy amounts

based on an individual's income. By folding certain Medicaid risk groups into the individual health insurance market, enrollees would have a greater stake in their health coverage; instead of being passive recipients of government-mandated benefits, enrollees would be actively managing a defined contribution of Medicaid funds towards their own private health plans. The result is that enrollees would enjoy greater access to healthcare and more control over how their Medicaid dollars are spent, especially those enrollees who select a high deductible plan with a health savings account.

This relatively modest reform could save the state at least \$4 billion per year, on average, during the next decade compared to projected spending under the status quo. The savings could reach at least \$6.1 billion per year by 2023 once the reforms are fully in place. Over time, this could also reduce federal expenditures as the reforms lower Medicaid costs, reducing the mounting burden of healthcare expenditures on taxpayers. Such savings, combined with program reforms described below, would help stabilize Medicaid expenditures and control long-term cost growth.

## Background

A pair of studies published by the Texas Public Policy Foundation (TPPF) in 2011 and 2012 examined the acute and long-term care portions of Medicaid, respectively, and proposed systematic reforms that laid the foundation for a patient-centered, market-driven Medicaid program for Texas. Among the findings of the 2011 study<sup>7</sup> was that given the flexibility, Texas could design a defined contribution Medicaid program that covers the current Medicaid population at a substantially lower cost than the current program. The 2012 study<sup>8</sup> finds that if long-term care cost growth was limited to 4 percent per year, savings would build over time, and by 2020, the state would spend \$6 billion less than it would if the program remained unreformed.

These studies' results formed the basis for the recommendations set forth in a third paper, published in 2013,<sup>9</sup> which outlined the structure of a fundamentally reformed Medicaid program based on a defined contribution of funds from the federal government, possibly in the form of a block grant. This would be accompanied by greater flexibility at the state level to enact programmatic reforms such as enrolling certain risk groups in private coverage coupled with a health savings account. By making program enrollees cost-conscious participants in their care, and by transitioning from a defined benefits model to a defined contribution model for most Medicaid eligibility groups, Texas could ensure the long-term sustainability of its Medicaid program and improve health outcomes for those who rely on it.

The current study models the structure and cost of such a Medicaid program using real-world data and projections from the HHSC, as well as 2015 premium prices from the federal health insurance marketplace established in Texas under the ACA.

## Block Grants Address the Unreliability of Federal Medicaid Funding

Block-granting Medicaid is not a new idea. Proponents have long argued that block-granting the program would reduce administrative costs by creating a single, streamlined regime of federal requirements for Medicaid, eliminating the confusing and sometimes contradictory requirements of categorical grant programs. Block grant funding would also clarify accountability for Medicaid, which is currently divided between federal and state agencies, and, because of the way many categorical grant programs are designed, divided again among several state-level agencies. Fracturing accountability across so many agencies creates inefficiencies and reduces incentives to control cost growth.

For example, if the federal Centers for Medicare and Medicaid Services (CMS) reduces a state's Federal Medical Assistance Percentage (FMAP), state lawmakers face pressure to increase state appropriations to compensate for the loss of federal Medicaid funds even though state officials had no input or control over the federal FMAP rate. This is precisely what happened in Texas during the 84th Legislative Session. In 2013, the state's FMAP was 59.3 percent, meaning the federal government funded 59.3 percent of Texas' Medicaid program. In 2014, CMS set the FMAP rate at 58.69 percent and lowered it again for 2015, 2016 and 2017 to 58.05, 57.21, and 57 percent, respectively.<sup>10</sup> In practice, that means the state is gradually taking on a greater share of the cost of Medicaid.

For the 2016-17 biennium, this less favorable FMAP shifted an estimated \$797.3 million in Medicaid program costs to GR because of a reduction in federal funding. In addition, the loss of a specific enhanced FMAP shifted another \$77 million in federal funds into GR. At the same time, an enhanced FMAP for certain children in Medicaid who were previously enrolled in the Children's Health Insurance Program (CHIP) decreased GR spending by \$278.7 million. All told, then, FMAP changes

resulted in a transfer of responsibility of \$595.6 million in Medicaid funding from the federal government to the state.<sup>11</sup> Such fluctuations in federal funding creates significant instability in the Medicaid program at the state level, leaving state appropriators unsure how much GR they will have to set aside for the program in any given budget year, and whether they will need to cut provider reimbursement rates to compensate for decreases in federal funding, raise new state revenues to pay for higher-than-anticipated costs, or cut funding for other budget priorities.

## History of Federal Block Grants

Federal block grant programs to the states have been a part of the federal system since 1966 and comprise one of three types of grants-in-aid programs, along with categorical grants and general revenue sharing. President Richard Nixon proposed a series of block grants that eventually resulted in the consolidation of a number of federal domestic assistance programs into three large block grant programs by the late 1970s. During the first Reagan administration, Congress consolidated 77 federal programs into nine separate block grants, although total funding for these block grants was lower than aggregate funding for the programs they were designed to replace.

In the mid-1990s, Congress passed welfare reform under the Clinton administration, replacing Aid to Families with Dependent Children (AFDC), an open-ended entitlement program, with TANF, a state block grant program that remains in place today. In FY 2014, there were 21 funded federal block grants totaling \$50.8 billion—less than 10 percent of total federal grant-in-aid to the states.<sup>12</sup> Various versions of a Medicaid block grant were proposed by the executive branch or passed by Congress, but ultimately rejected, in 1981, 1995, 2004, 2011, and 2012.<sup>13</sup>

Compared with previous federal block grant programs, a Medicaid block grant would most closely resemble the transition from AFDC to TANF, which is the only time a federal entitlement program has been replaced by a defined contribution block grant program. Previous block grants merely consolidated discretionary grant programs, but the TANF program explicitly ended AFDC as an entitlement. Indeed, the enabling legislation for TANF, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, states that it “shall not be interpreted to entitle any individual or family to assistance under any state program funded under this part.”<sup>14</sup> However, like dozens of other federal block grant programs, TANF has state spending maintenance of effort requirements (MOE) to prevent states from replacing state and local funds with federal funds. For TANF, the MOE requirement replaced the state funding match requirement under AFDC and stipulated that a state must spend at least 75 percent of what it put toward the AFDC program in FY 1994. If a state fails to meet this MOE requirement, the amount of its subsequent TANF block grant can be reduced by the amount of the state funding shortfall.

TANF also implemented federal work requirements for program beneficiaries, so-called “workfare” provisions requiring 30 to 40 percent of the able-bodied TANF caseload to participate in work-related activities for 20 to 30 hours per week. While not exactly a straightforward work requirement, these measures nevertheless produced positive outcomes. Within a few years, welfare caseloads nationwide dropped by half, employment rates among welfare recipients sharply increased, and child poverty rates were substantially reduced.<sup>15</sup> By these metrics, welfare reform under TANF was a success.



A similar reform in Medicaid’s funding structure, one that decouples state and federal spending as well as caseload levels and funding amounts, is crucial for the Medicaid reform model described below to be successful. This reform envisions a shift in program design from defined benefits to defined contributions, a structure that incentivizes more efficient use of health care dollars by capping total federal expenditures and giving Medicaid enrollees greater choice in their health plan design, benefits, and out-of-pocket expenditures. The results of welfare reform under TANF showed that incentives can be effective in a program that has transitioned from an entitlement to a defined contribution program.

## Methodology and Results

### *Current Medicaid Costs*

With this history and these principles in mind, we model the results of such a reform for the Texas Medicaid program. To compare Medicaid costs under the current system with our reform model, we collect data from HHSC for FY 2013 and their conservative projections\* over the next decade through FY 2023. Specifically, the data include average monthly recipients and average monthly total All Funds cost per recipient for acute care risk groups, Texas Department of Aging and Disabilities Services (DADS) fee-for-services (FFS) long-term care service programs, and HHSC's long-term care risk groups.

- ★ HHSC separates acute care costs into the following risk groups: aged and Medicare related, disabled and blind, breast and cervical cancer program (BCCP), medically needy, STAR Health (foster care children), TANF adults, pregnant women, newborns, children ages 1-5, children ages 6-18, children ages 19 and over, and other non-full benefit costs.† (The total acute care costs for all risk groups in FY 2013 were \$17.6 billion with average monthly recipients of 3.7 million.)
- ★ DADS FFS long-term care services includes the following programs: skilled nursing facility, nursing facility, rider community based alternatives (CBA), waiver CBA, rider medically dependent children program (MDCP), waiver MDCP, primary home care, and day activity health services. (The total costs for these programs in FY 2013 were \$2.7 billion with average monthly recipients of 92,188.)
- ★ HHSC long-term care services include the following risk groups: aged and Medicare related, disabled and blind under 21 years, and disabled and blind 21 years and over. (The total costs for these risk groups in FY 2013 were \$2 billion with average monthly recipients of 405,947.)

Combining acute and long-term care services in FY 2013, total Medicaid costs for these services were \$22.4 billion.

Using FY 2013 average monthly recipients and total costs for acute and long-term care services as the baseline, HHSC considers both trends and the changes in a number of risk groups and programs per the ACA to project through 2023.‡ HHSC made the following assumptions and changes that affected its forecast models:

- ★ Enhanced primary health care at Texas Department of State Health Services (DSHS) will result in reduced (averted) births in Medicaid that affect pregnant women and newborn risk groups;
- ★ Beginning July 2014, the ACA affects 12-month recertification, particularly caseload and cost figures for CHIP to Medicaid, hospital presumptive eligibility, foster care up to age 26, and “welcome mat” and MAGI changes;
- ★ A policy impact for aged clients to account for the increased numbers as a result of baby boomers aging into Medicare at a much higher growth rate, especially in the last half of the current decade;
- ★ Managed care rollouts and implementations that affect cost and caseload movement, such as reductions in Medicare costs due to A&B premium savings from the Dual Eligible Integrated Care Demonstration Project (Dual Demo); and
- ★ Other issues such as presumptive eligibility for hospitals, health insurer issuance tax and federal income tax, and new drug approvals.

Accounting for these assumptions and changes, HHSC forecasts total Medicaid costs, including acute and long-term care services, based on an expected 6 percent increase to \$23.8 billion in FY 2014, a 7 percent increase to \$25.5 billion in FY 2015, and a 7 percent increase during most subsequent years to arrive at a total cost of \$42.4 billion in FY 2023.

\* HHSC assumes “conservative” cost estimates in their static model. In other words, they project future Medicaid costs at a level that is below what the costs might actually be in a dynamic world. This is important to note here because the savings of our recommendations may actually be much greater than they appear when compared to the current conservative cost estimates.

† Non-full benefit costs include the Type Program 30 (undocumented alien, emergency care only), cost settlement fees, etc.

‡ HHSC discusses some of these changes in their report [Consolidated Budget Fiscal Years 2016-17](#).



## Texas Medicaid Reform Model

To provide a consistent comparison between the current and reform Medicaid costs, we include the current system's costs and projections for the following acute care risk groups: aged and Medicare related, disabled and blind, BCCP, medically needy, STAR Health (foster care children), children ages 19 and older, and other nonfull benefit costs. Given that our recommended reforms do not include immediate changes to Medicaid's long-term care costs, our model uses current costs.

For the acute care costs of newborns, children ages 1-5, children ages 6-18, pregnant women, and TANF adults risk groups, we calculate average monthly costs to subsidize monthly premiums for private health insurance plans sold on the individual market. We determine the average monthly costs to subsidize these risk groups by first calculating average silver and gold plan health insurance premiums for 2015 available on the federal exchange established by the ACA.\* These plans are for children and adults across all ages using the qualified health plans (QHPs) for the top 10 most populated Texas counties.† These average premiums represent 60 percent of the State's total population and include locations where most Medicaid recipients reside.‡

The average premium to cover children with a silver plan is \$155.46 and gold plan is \$185.35, and to cover adults with a silver plan is \$365.65 and gold plan is \$435.93. Though these average premiums are higher than statewide averages, they provide conservative cost-savings estimates. Premiums could be substantially lower after our reforms were adopted because premiums under the current ACA regulatory regime tend to be higher than they otherwise would be and they do not account for the behavioral changes from enrollees paying a portion of their health care costs. Our reform model assumes greater flexibility from federal rules and would foster more in-state competition among private insurance companies and more diversity of plans available in the private insurance market.

**Table 1. Texas Medicaid Reform Model's Individual Private Health Insurance Premium Subsidy Increases as the FPL Level Decreases**

Federal Poverty Level (FPL)	Percent Premium Subsidy
0 – 50%	100
50 – 75%	98
75 – 100%	90
100 – 125%	85
125 – 150%	80
150 – 175%	75
175 – 200%	65

The average monthly subsidy to purchase individual private health insurance is based on a sliding scale determined by the 2013 federal poverty level (FPL) up to the maximum FPL for each risk group under the current Medicaid system.§ In general, **Table 1** below breaks down the sliding scale subsidies for health plan premiums.

The maximum FPL for the risk groups for which we calculate subsidy amounts is 185 percent for newborns and pregnant women, 133 percent for children ages 1-5, and 100 percent for children ages 6-18 and TANF adults. For those risk groups that have a maximum level between the FPL ranges above, we weight the subsidy amount based on that particular range. Though HHSC did not have the exact share available for the recipient population in each FPL range, they did provide

\* 2015 Qualified Health Plan Individual Market Medical Premiums were collected from <https://data.healthcare.gov> on December 10, 2014.

† According to the [U.S. Census Bureau, the top 10 most populated Texas counties in 2013](#): Harris, Dallas, Tarrant, Bexar, Travis County, Collin, El Paso, Hidalgo, Denton, and Fort Bend.

‡ We provide results in the Appendix for statewide average premiums and cost-savings compared with the status quo and the top 10 most populated counties. Our model's results using either data set are not substantially different.

§ We chose the 2013 federal poverty level (FPL) because that is the base year of the HHSC projections. The federal poverty level (100 percent FPL) was \$11,490 in 2013.

approximate shares in the 100 percent or less, 100 percent to 150 percent, and 150 percent-plus FPL ranges for TANF adults, pregnant women, and non-disabled children.\* We use the latter category for all children in our calculations. We calculate an average monthly subsidy for each risk group in question across all FPL ranges. Given the high health care costs for newborns and pregnant women relative to other recipient groups, we index premium subsidies using average premium costs for the more expensive gold plans. We use the less expensive silver plans for the other risk groups that have relatively lower health care costs.

As an example, consider the calculation of the monthly subsidy cost for the pregnant women risk group that has a 185 percent maximum FPL coverage. The average monthly premium subsidy is based on the gold plan, for \$435.93. We calculate the monthly government subsidy cost for this plan by taking the following steps. First, we calculate the average of the full \$435.93 subsidy up to 50 percent FPL, \$427.21 between 50 and 75 percent FPL for the 98 percent subsidy, and \$392.34 between 75 and 100 percent FPL for the 90 percent subsidy. We then multiply this simple average by the 90 percent share of pregnant women at 100 percent or below FPL. Second, we calculate the average of \$370.54 between 100 percent and 125 percent FPL for the 85 percent subsidy and \$348.75 between 125 and 150 percent FPL for the 80 percent subsidy. We multiply this simple average by the 6 percent share between 100 and 150 percent FPL. Third, we calculate the average of \$326.95 between 150 and 175 percent for the 75 percent subsidy and \$283.36 between 175 and 185 percent. Since this is only a 10 percentage-point range compared with the other 25 percentage-point ranges, we multiply this average by 10/25 then multiply that amount by the 4-percent share between 150 and 185 percent FPL. Finally, we add these amounts to get the monthly subsidy cost of a gold plan for pregnant women of \$410.95. We do a similar calculation for each of the other risk groups in our reform model.

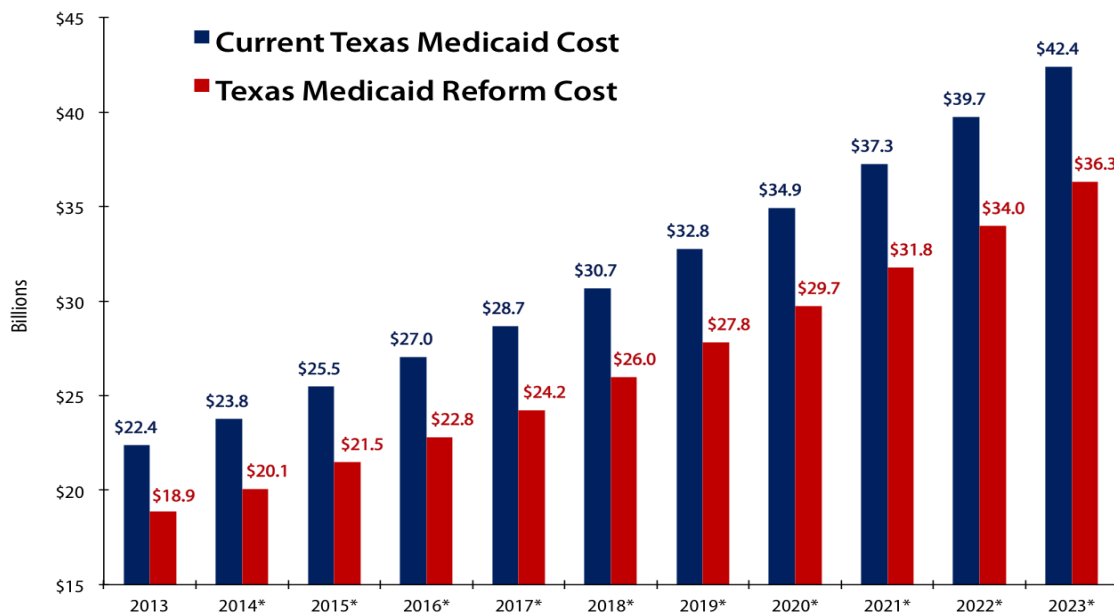
Making a similar calculation for each of the other risk groups in our reform model and their average health insurance premium with the sliding scale, **Table 2** shows average costs under the status quo and average monthly subsidy amounts under the Texas Medicaid Reform Model. The average monthly subsidies paid to recipients in these risk groups are lower in our model than the current Medicaid cost to fund them.

**Table 2. Estimated Average Monthly Costs by Risk Group are Lower Under the Texas Medicaid Reform Model**

Risk Group (FY 2013)	Current (Status Quo)	Texas Medicaid Reform Model with the Top 10 Most Populated Counties Data
Newborns	\$661.95	\$168.92 (Gold)
Children ages 1-5	\$195.65	\$134.59 (Silver)
Children ages 6-18	\$196.77	\$150.80 (Silver)
Pregnant women	\$718.45	\$410.95 (Gold)
TANF adults	\$455.66	\$354.68 (Silver)

By including our model's average monthly subsidies and multiplying these amounts by total recipients for each risk group, we find the total acute services Medicaid costs of \$14.1 billion in FY 2013. We add the DADS and HHSC long-term care services costs of \$4.8 billion to the acute care services costs resulting in the total costs under our model of \$18.9 billion that year. We then assume the trends under the HHSC's forecasts and project our model's costs over the next decade through FY 2023.

\* HHSC provided the following population shares for each risk group: TANF adults, 100 percent at 100 percent FPL; pregnant women: 90 percent at 100 percent and below FPL, 6 percent between 100 and 150 percent FPL, and 4 percent at 150 percent-plus FPL; non-disabled children: 75 percent at 100 percent and below FPL, 18 percent between 100 and 150 percent FPL, and 7 percent at 150 percent-plus FPL.

**Figure 4. Texas Medicaid Reform Model Could Provide Substantial Cost-Savings**

Source: Texas Health and Human Services Commission and Authors' Calculations (with top 10 most populated counties data). \*Projections

**Figure 4** presents Medicaid costs based on HHSC's projections compared to our reform model's projections. We find that the savings from our reform model compared with the status quo would total \$4 billion, or 15.7 percent, in 2015. These cost-savings continue to mount over the next decade to \$6.1 billion, or 14.4 percent, in 2023.

## Conclusion

We find that the Texas Medicaid Reform Model would provide substantial cost savings through a federal block grant that allows Texas to shift some risk groups into a defined contribution program that subsidizes private health insurance premiums and includes an incentive to choose a high-deductible plan with a health savings account. This model would ask Texans to have some skin in the game, providing an incentive to deter overuse of healthcare while providing quality, cost-effective health care and superior access to providers compared to the status quo.

Our results show that the annual cost savings to the Medicaid program under the reform model will be in the \$6 billion range after ten years. These results are likely conservative for several reasons: 1) The prices of premiums for the private health insurance plans we use as a baseline for calculating subsidy amounts are inflated due to overregulation and lack of competition on the ACA exchanges; 2) Our reforms would likely lead to lower growth rates in long-term care costs over time as behavioral changes by many receiving such care and related services would, under a defined contribution model, opt for more affordable home and community-based programs and use care more efficiently; and 3) As providers competed for clients under such a system, market forces would exert downward pressure on prices relative to the status quo, while improving the quality of care.

To prevent the current Medicaid program from crowding out a larger share of the Texas budget, and to provide needy Texans with the best healthcare possible, Medicaid must undergo structural reform. The Texas Medicaid Reform Model provides an approach that would satisfy these concerns and improve the well-being of all Texans. It could also help other states seeking to adopt a similar approach, although further modeling would be required to estimate cost savings in states that adopt such reforms. ★

## Appendix

While average premiums for the top 10 most populated counties provide valuable information, we present additional results for comparison of what the costs and cost-savings would be if marginally lower statewide average premiums were included in our model.\*

If the individual health insurance market is freed from federal overregulation after implementation of the reforms previously described, additional health insurance providers are likely to enter the market, helping to drive down premium rates relative to those currently available on the federal exchange. The premiums could drop below current statewide averages, but this at least provides a robustness check of our results with the top 10 most populated counties.

The average statewide health insurance premium to cover children with a silver plan is \$152.48 and gold plan is \$184.49, and to cover adults with a silver plan is \$358.64 and gold plan is \$433.91. Using the appropriate average statewide premiums for each group and the sliding scale calculated in the same manner as discussed previously, **Table 3** shows average monthly subsidy amounts under the Texas Medicaid Reform Model with statewide data are lower than those amounts with the top 10 most populated counties and status quo costs.

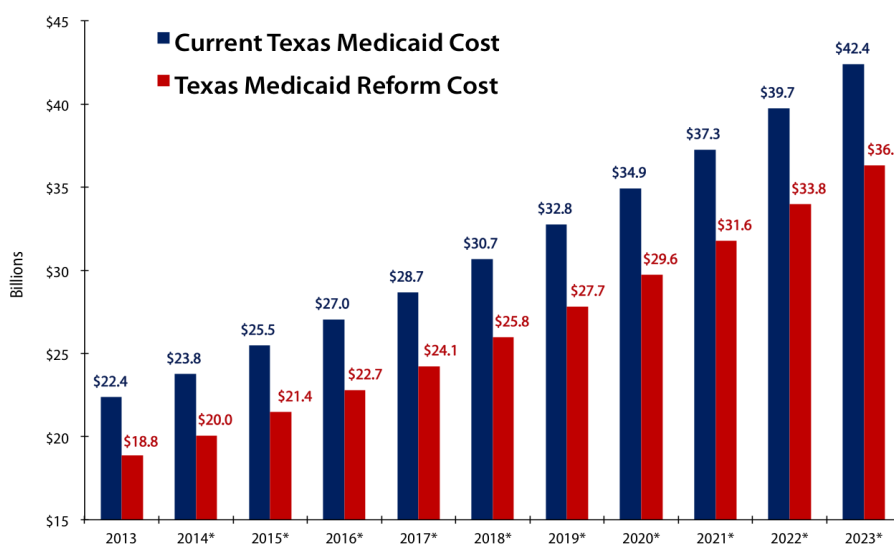
**Table 3. Comparison of Estimated Average Monthly Costs by Risk Group**

Risk Group (FY 2013)	Current (Status Quo)	Texas Model, Top 10 Most Populated Counties Data	Texas Model, Statewide Data
Newborns	\$661.95	\$168.92	\$168.13
Children ages 1-5	\$195.65	\$134.59	\$132.01
Children ages 6-18	\$196.77	\$150.80	\$147.91
Pregnant women	\$718.45	\$410.95	\$409.05
TANF adults	\$455.66	\$354.68	\$347.88

Calculating our model's total costs with statewide data as described above, **Figure 5** presents Medicaid costs based on HHSC's projections compared to our reform model's projections with statewide data. Our results suggest that the reform model provides savings compared with the status quo of \$4.1 billion, or 16.2 percent, in 2015, and \$6.3 billion, or 14.8 percent, in 2023.

Though these savings are greater than those from the top 10 most populated counties data, they show our results are robust to providing cost-savings relative to the status quo. These results are a function of our model because we suggest spending less than the current system by providing specific risk groups a subsidy to purchase private health insurance.

**Figure 5. Texas Medicaid Reform Model Could Save At Least \$6.3 Billion in FY 2023**



Source: Texas Health and Human Services Commission and authors' calculations (with statewide data). \*Projections

\* 2015 Qualified Health Plan Individual Market Medical Premiums were collected from <https://data.healthcare.gov> on December 10, 2014.



## Notes

<sup>1</sup> [“Summary of Conference Committee Report for House Bill 1: Appropriations for the 2016-17 Biennium”](#) (May 2015): 47, 63.

<sup>2</sup> [Ibid.](#), 47.

<sup>3</sup> [Ibid.](#), 3.

<sup>4</sup> [“Health and Human Services Commission and System Issues, Sunset Advisory Commission, Staff Report with Commission Decisions”](#) (Dec. 2014): 4.

<sup>5</sup> [“Drop in Physician Acceptance of Medicaid, Medicare Patients,”](#) Texas Medicaid Association (July 9, 2012).

<sup>6</sup> Kevin D. Dayaratna, Ph.D., [“Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured,”](#) Heritage Foundation (Nov. 7, 2012).

<sup>7</sup> Spencer Harris, Arlene Wohlgemuth, and Brittani Harris, [“Medicaid Reform: Constructive Alternatives to a Failed Program,”](#) Texas Public Policy Foundation (Feb. 2011).

<sup>8</sup> James C. Capretta, Andrew Croshaw, Michael Deily, and Laura Summers, [“Assuring a Future for Long-Term Care Services and Supports in Texas,”](#) Texas Public Policy Foundation (Dec. 2012).

<sup>9</sup> James C. Capretta, Arlene Wohlgemuth, and John Davidson, [“Save Texas Medicaid: A Proposal for Fundamental Reform,”](#) Texas Public Policy Foundation (Mar. 2013).

<sup>10</sup> [“Texas Medicaid Program and Mental Health: Overview and Funding,”](#) Legislative Budget Board (Feb. 2015): 2.

<sup>11</sup> [“Summary of Conference Committee Report for House Bill 1: Appropriations for the 2016-17 Biennium”](#) (May 2015): 10.

<sup>12</sup> Robert Jay Dilger and Eugene Boyd, [“Block Grants: Perspectives and Controversies,”](#) Congressional Research Service (July 15, 2014): 1.

<sup>13</sup> [Ibid.](#), 2.

<sup>14</sup> United States Code § 601(b). [“The Public Health and Welfare: No individual entitlement.”](#) Title 42, Subchapter IV—Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services (2011).

<sup>15</sup> Robert Rector and Patrick F. Fagan, [“The Continuing Good News About Welfare Reform,”](#) Heritage Foundation Backgrounder No. 1620 (Feb. 6, 2003).





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